State MCH-Medicaid Coordination

A Review of Title V and Title XIX Interagency Agreements

2nd Edition

U.S. Department of Health and Human Services
Health Resources and Services Administration

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HRSA
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State MCH-Medicaid Coordination:

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Table of Contents

Introduction

A. Background 1
B. Purpose 1
C. Organization 2
D. Interagency Agreements (IAAs) Web Page and Resources 3

I. Overview of Title V and Title XIX

A. The Title V MCH Block Grant Program 4
B. The Medicaid Program 8
C. Comparing the Title V Program and Medicaid: At a Glance 11
D. Coordination Between Title V and Title XIX 13
E. The Importance of Interagency Agreements 14

II. Federal Legislation, Regulations and Policy

Overview and Summary Tables 17
A. Federal Legislation and Regulations 20
Title V Requirements 20
Title XIX Requirements 20
B. Federal Policy 22
Title V Requirements 22
Title XIX Requirements 23

III. Analysis of State Title V/Title XIX Interagency Agreements

A. Documents Reviewed 26
B. Methodology: Format of the State IAA Tables 28
C. Analysis and Findings 30

IV. Development of Successful IAAs and Promising Practices

A. Summary of Key Goals and Components 52
B. A "Model" IAA 53
C. Promising Practices and Lessons Learned 71

V. State Title V/Title XIX Interagency Agreements

A. Overview of Data and Tables 73
B. State-by-State Summary Tables 75

Appendices

A. Resources 194
B. List of Abbreviations 195
C. Glossary 196
D. Supplemental Figures 200
E. Document Development 202

Introduction

A central goal of public health is to identify causes of ill health and to develop actions to reduce these causes…Interagency partnerships give a sense of order to the issues. In maternal and child health, each issue, in a sense, is everybody's business and thus the various "bodies" need to be involved in the resolution.

-- Vince L. Hutchins, M.D., M.P.H.
Celebrating Events, delivered at the 50th Anniversary meeting of The Association for Maternal and Child Health, March 18, 1985

A. Background

The Maternal and Child Health (MCH) Services Block Grant and Medicaid, authorized by Title V and Title XIX of the Social Security Act (SSA), serve complimentary purposes and goals. Coordination and partnerships between the two programs greatly enhance their respective abilities, increase their effectiveness, and guard against duplication of effort. Such coordination is the result of a long series of legislative decisions that mandate the two programs to work together. Interagency Agreements (IAAs), required by both Title V and Title XIX legislation, can serve as a key factor in ensuring coordination and mutual support between the two agencies (or divisions within an agency) that administer the two programs.

B. Purpose

This publication, now in its second edition, serves as a tool to provide technical assistance to State Title V and Medicaid agencies in achieving successful and required coordination between their programs, updating seminal work carried out by the Association of Maternal and Child Health Programs (AMCHP) in the first edition. The document begins with a review of the Federal legislation regarding Title V/Title XIX IAAs and a summary of how States have incorporated this legislation and other components into their IAAs. It continues by presenting recommended components and methodologies in developing new IAAs and a "model" IAA as a template for States. Finally it highlights "promising practices" being carried out by States that have developed successful partnerships through their IAAs.

This document is available both in print and online (with additional electronic resources) at:

http://www.mchlibrary.info/IAA

C. Organization

Chapter I of the report serves as an overview, consisting of:

- A background on Title V, Title XIX, and partnerships between the two programs.
- An overview of the importance of interagency agreements (IAAs)

Chapter II provides an overview of the current statutes, regulations, and Federal policies regarding Title V and Title XIX collaboration, focusing on the requirements set forth for Title V and Title XIX agencies.

Chapter III summarizes individual State interagency agreements (IAAs), focused on specific components common to the majority of these documents and includes:

- A discussion of the documents reviewed and the scope/limitations of the materials surveyed.
- An explanation of the review components used in analyzing the IAAs and examples of State IAAs that either differ greatly from or reflect the norm.
- State-by-state analysis of the IAAs based on specific key components with references to the summary charts included in Chapter V.

Chapter IV focuses on an analysis of IAA components as well as "best practices" gathered from specific States of varying characteristics (e.g., geographic location, economic status of population served, and racial/ethnic diversity of population) and consists of:

- An analysis of components that are often found in successful IAAs.
- Explanations of the importance of each IAA component and what additional factors should be considered when drafting new IAAs.
- A "model" IAA that can be modified by States as a technical assistance tool in the drafting of future IAAs.
- A discussion of methodologies employed by the Title V agencies in forging meaningful partnerships with Medicaid.
- Specific examples of the partnership process and motivating factors as well as problems and difficulties encountered.

Chapter V presents the State-by-State summary charts compiled as the basis of analysis for the document, including:

- An explanation of the charts.
- Detailed summaries of the IAAs for each State based on each of the review components.
- Highlighted text where specific IAA sections either differ greatly from or reflect the norm with cross references back to a more detailed analysis in Chapter Two.
- Additional State-specific information, such as contact information, Web sites of State agencies, and links to full-text versions of each IAA analyzed.

D. Interagency Agreement (IAA) Web Page and Resources

This publication and additional electronic resources are available through the MCH Library Web site at *http://www.mchlibary.info/IAA*. This electronic "toolkit" includes:

- Links to the full-text document.
- Each IAA reviewed (in PDF and/or Word versions, as available).
- Links to background print resources, to State agencies profiled, and to Web sites that maintain data on State contacts, Title V and Medicaid agencies, and MCH hotline numbers.
- A database of the State IAAs, searchable by State, region, and keyword.
- An online glossary of terms and links to glossaries used by Title V and Title XIX professionals.

Chapter One

Overview of Title V and Title XIX

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

-- Introduction to §501 of the Social Security Act

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

A. The Title V MCH Block Grant Program

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

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

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

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

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

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

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

Funding

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

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

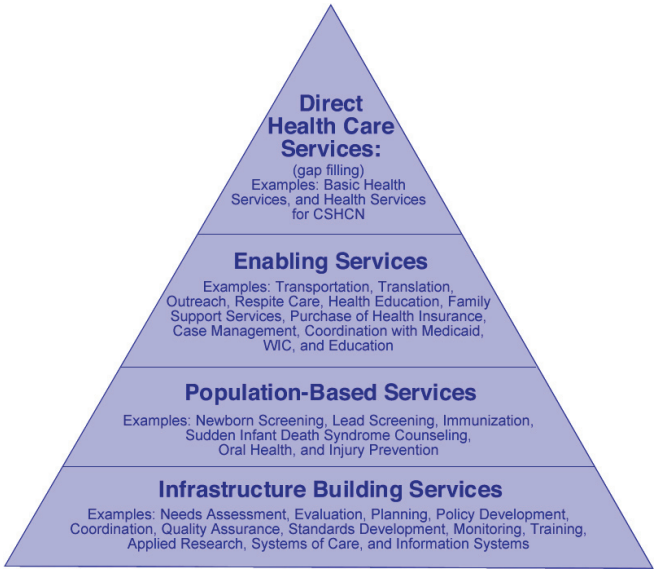
Funding Category 1: Title V MCH Block/Formula Grants to the 59 States and jurisdictions are awarded according to a formula based on (1) the historical share awarded to each State in 1981 and (2) the remaining amount is distributed based on the number of children in a State who are at or below the Federal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

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

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

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

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



The MCH Pyramid of Health Services

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

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

- ***Community Integrated Service Systems (CISS) discretionary grants*** that seek to reduce infant mortality and improve the health of mothers and children – including those living in rural areas and those with special health care needs – by funding projects for the development and expansion of integrated services at the community level. These systems are public/private partnerships of health-related and other relevant community organizations and individuals working collaboratively to use local resources to address community-identified health problems. Such projects include home health visiting programs; projects to increase participation of health care providers under Title V and Title XIX programs; integrated MCH service delivery systems; MCH centers providing pregnancy, preventive, and primary care services; MCH projects to serve rural populations; and outpatient and community-based services programs for CSHCN.

Division of Funding

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

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

Services

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

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

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

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

B. The Medicaid Program

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

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

Programmatically operating under broad Federal standards, States are given flexibility to determine eligibility requirements, set service standards, set payment rates, and administer their State programs. More than 52 million people received Medicaid-supported services in 2004, including 26 percent of all children, 50 percent of low-income children, 37 percent of pregnant women, and 20 percent of persons with disabilities; State and Federal Medicaid funds for such services topped $305 billion in that year. In light of these numbers, Medicaid is the largest funding source for health services for the country's most financially strained populations.

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

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

Eligibility

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

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

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

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

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

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

Services

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

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

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

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

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

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

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

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

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

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

Title V and Medicaid, Compared

	Title V	Medicaid
Authorized By	Sections 501-510, SSA, in 1935	Sections 1901-1936, SSA, in 1965
Administered By	U.S. Department of Health and Human Services (HHS), Health Resources Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).	U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations (CMSO).
Overarching Goal	To improve the health of *all* women, children, youth, and families.	To pay for medical assistance to both "categorically" and "medically" eligible children and families with low incomes.
Funding Mechanism	Discretionary Federal "block" grant.	Joint Federal/State entitlement program.
Funding and/ or Beneficiary Requirements	**Funding Requirements:** • Every $4 of Federal funds must be matched by at least $3 of State/ local funds. • At least 30% of funds must support CSHCN. • At least 30% of funds must support preventive and primary care services for children. • No more than 10% of funds can be used for administration.	**FMAP Requirements:** • Federal funds (the "Federal Medicaid matching rate") are provided for services/administration dependant on State per capita income (from 50-83% with average of 57%). **Eligibility groups include:** • "Mandatory" categorically needy persons (pregnant women and infants at or below 133% FPL). • "Optional" categorically needy persons (pregnant women and infants with incomes between 133%-185% FPL). • Medically needy persons (who qualify for coverage because of high medical expenses).

Title V and Medicaid, Compared (continued)		
	Title V	**Medicaid**
People Served and/or Covered	**Title V *provides services* to:** • Over 33 million women and children total, consisting of: • 2.5 million pregnant woman • 3.9 million infants less than 1 year • 22.5 million children 1 to 22 years • 1.4 million CSCHN • Of the 33 million individuals: • 1.1 million are Medicaid-eligible pregnant women • 1.4 million are Medicaid-eligible infants under 1 year old • 6.9 million are Medicaid-eligible children 1-22 years old. • 0.5 million are Medicaid-eligible CSHCN.	**Medicaid *covers*:** • 52 million people total (2004 data), consisting of: • 26% of all children, • 50% of low-income children • 37% of pregnant women • 20% of persons with disabilities
Legislative Reform/ Program Services	• Omnibus Budget Reconciliation Act (OBRA-1981): • Incorporated five other smaller, related programs into Title V. • Granted States increased spending flexibility. • Required each State Title V agency to participate "in the arrangement and carrying out of the coordination agreements …related to coordination of care and services under this title and Title XIX" [§505(2)(F)(ii)]. • OBRA-1989: provided stricter application, spending, and reporting requirements. • 1998: Title V Information System developed to collect and report data.	• Personal Responsibility and Work Opportunity Reconciliation Act (1996): restricted eligibility for SSI coverage for certain populations. • Balanced Budget Act (BBA) (1997): reinstated eligibility for those children and those included under SCHIP. • Ticket to Work and Work Incentives Improvement Act (1999): provided a sliding scale payment income-based premium. • Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) (2000): allowed for additional payments to hospitals serving large Medicaid populations. • Deficit Reduction Act (DRA) (2005): scheduled to create $39 billion in Medicaid reductions from 2006-2010 by shifting costs to beneficiaries and limiting certain services for low-income recipients.

D. Coordination Between Title V and Title XIX

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

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

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

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

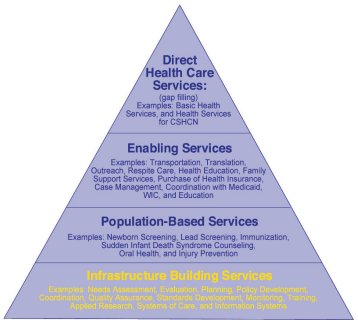
Partnerships between Title V and Medicaid have had a long history of providing increased services and preventing duplication of effort. Such coordination is the result of a long and well-planned series of legislative decisions that mandate that the two programs work together (these legislative mandates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

E. The Importance of Interagency Agreements

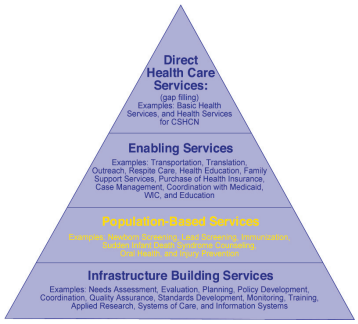
Interagency Agreements (IAAs) [required in §509(a)(2) and referenced to in §1902(a)(11)(b)], can serve as a major resource in coordinating activities and providing mutual support between the two agencies (or divisions within an agency in the State department of health) that administer the two programs.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

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

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

Methods Through Which Title V and Medicaid Coordinate	
Infrastructure Building Services: *These include evaluation, policy development, coordination, standards development, training, and information systems.*	
	• Title V provides funding and experience for development and implementation of model programs that benefit Medicaid beneficiaries. • Title V and Medicaid develop jointly agreed upon policies and standards of care for Medicaid beneficiaries (especially relevant with EPSDT services). • Title V provides expertise to Medicaid in analyzing utilization patterns and recommending ideas for services provided such as more effective treatment services or options for families. • On a State level, Medicaid utilizes Title V population data collected through such systems as the Title V Information System to provide key population and service statistics, performance and outcome measures, and benchmarks. • Medicaid uses materials developed by Title V grantees, either directly or with modifications for Medicaid audiences. • Title V and Medicaid collaborate in planning activities such as designing benefit packages, application forms, enrollment procedures, and referral and follow-up protocols.

***Population-based Services**: These include screenings, immunizations, oral health, nutrition and outreach, and public education.*

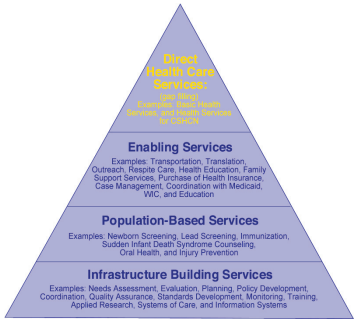


- Title V programs and Medicaid perform EPSDT services for infants, children, and adolescents, including CSHCN.
- Title V programs coordinate services such as lead screening and referral to Title V programs for additional evaluation and management, if necessary.
- Title V programs provide public education to Medicaid beneficiaries on nutrition and oral health issues, stressing the need for such services from an early age.

***Enabling Services:** These include outreach, health education, family support services, case management, and coordination with Medicaid.*

- Title V programs provide outreach and enrollment services to eligible beneficiaries, allowing Medicaid funds to pay for those services.
- Medicaid performs outreach to audiences traditionally supported by Title V programs and vice-versa.
- Title V agencies administer programs that support Medicaid beneficiaries, not only to ensure enrollment but to track and/or provide follow-up treatment.
- Medicaid utilizes Title V programs for care coordination and assistance in accessing treatment services (e.g., facilitating transportation).

***Direct Health Care Services**: These include basic health services and health services for CSHCN.*



- Title V pays for gap-filling services to Medicaid beneficiaries.
- Title V provides funds for services needed by uninsured children and pregnant women and for necessary services not covered by Medicaid or other sources.
- Medicaid coordinates with Title V programs to pay for community specialists who provide appropriate care for CSHCN.

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

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

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

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: o Participate in developing and carrying out agreements on coordination of care and services [§1902(a)(11); §505(a)(5)(E)(ii)]. o Coordinate activities with the EPSDT program [§505(a)(5)(E)(i)]. o Assist in identifying and registering pregnant women and infants who are eligible for medical assistance [§505(a)(5)(F)(iv)]. o 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: o 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)]. o 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)]. o 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).

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.

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

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."

Chapter Four

Development of Successful IAAs and Promising Practices

With the increasing cost of health care and tighter state budgets, states are examining ways to offer health care services with decreasing resources. It is more important than ever to maintain the necessary services for pregnant women, children and adolescents by using the expertise, creativity and resources of both Medicaid and Title V in joint program planning and development.

-- "Working Together – The Relationship Between MCH Title V and Medicaid"
2005 AMCHP Factsheet, available from
http://www.amchp.org/aboutamchp/pubs-amchp.htm

A. Summary of Key Goals and Components

The IAAs in the previous chapter present an array of creative working arrangements between State agencies that often have varying responsibilities but ultimately the same goal: ensuring appropriate and cost-effective services to some of their most vulnerable populations. These IAAs represent the work and best thinking of many individuals across the State who have collaborated to problem-solve issues that have arisen over the years.

Obviously, the needs and the working relationships between agencies differ widely from State to State; similarly, the States themselves vary in racial, ethnic, and economic diversity. It is not surprising, then, that each State's IAA is truly distinct and uniquely addresses the concerns and needs of the local population.

As such, it is not possible to point to any one State document and say that it could serve as a template for other States to use as a model. A pre-existing IAA that completely satisfies the needs of one State and population may not work simply transposed to another location and group of partners and beneficiaries.

However, despite the differences found in the IAAs, the documents *do* address many of the same basic needs and goals of the Title V and Title XIX agencies. The States themselves speak most clearly in outlining what those goals are: from the most overarching objective of improving the health of women, pregnant women, infants, children, and adolescents to detailed plans for increasing coordination and strengthening cooperative relationships between agencies.

With these common goals in mind, it is possible to survey the IAAs collected and the guiding framework provided by Medicaid regulations to come up with a "model" document that speaks to both goals and regulations. Despite its generalized format, this model document cannot serve as a simple "off-the-shelf" template for States in amending current or developing new IAAs, but rather can serve as a guide as to methodologies and formats that have proven successful in real-life settings and thus represents the best work of Title V and Title XIX staff across the country.

B. A "Model" Interagency Agreement

There are many caveats that must be addressed before presenting a model document such as this. First, this is only a general guideline of components that have been observed to work in current IAAs. A model template cannot address every need that arises, but can only provide a framework into which specific details can be placed that in turn *will* address such needs. For the model to be useful, it requires the commitment of knowledgeable individuals to take its skeleton and flesh it out with content relevant to their State's needs. As such, this model IAA can serve as a technical assistance tool amidst a whole toolkit of resources (many of which are outlined in this publication) in crafting IAAs that will serve as aids in strengthening partnerships between Title V and Title XIX agencies.

This model follows the framework set forth in Federal Medicaid regulations [42 CFR 431.615(c)] as a logical way to summarize the contents of successful IAAs. This does not imply that each State's IAA should also follow this structure; the organization of each IAA must follow the needs and priorities of the State for it to be useful as a coordination tool.

Each section of this model generally follows a basic structure:

- ***A summary of the respective IAA components.*** This section explains why each component is important and how it is incorporated into current IAAs.
- ***An "additional information" section.*** This section includes supplemental factors that may be considered when drafting new IAAs.
- ***A "model template."*** This template is a "bare bones" example of how each section of the IAA could be written. It consists of "fill-in-the-blank" sections (highlighted with <<color and angled brackets>>) that allow for customizing the language to a specific State.
- ***Example(s).*** The examples are taken from IAAs that can serve as models. Some examples (and model templates) are composites of currently successful IAAs; the original IAA is cited when used.

The model template does not specifically treat the overall format of a successful IAA. For example, as noted in Chapter Two about half of the States have developed a single IAA, while the other half rely on a series of IAAs to address Title V and Title XIX coordination. Because the needs of the States – and indeed the States themselves – are so varied, the model presented below can only serve as a general technical assistance tool.

Title and Author

At the most fundamental level, the IAA is a contract between agencies or divisions within State agencies. As such, it is a legal document of record and should contain some basic identifying information such as a title that details the type of agreement and the agreeing parties.

Additional information that may be useful to include:

- The State in which the agreement is to take effect in (a surprising number of IAAs lack this key piece of information, which had to be inferred from accompanying documentation).
- The agency that initiated or issued the document (or if it is a joint product), can also be useful as an identifier.

(a) Model Template for Title and Author

Title. **"**<<Type of Agreement>> between <<State Agency/Division 1>> and <<State Agency/Division 2>>."

Author. "This document has been authored by <<Authoring Agency/Division>>."
or "This document has been [jointly] developed and agreed upon by <<Agency/Division 1>> and <<Agency/Division 2>>."

(b) Example(s)

"INTERAGENCY AGREEMENT between the <<Insert State name>> Division of Medical Assistance and the <<Insert State name>> Division of Public Health, Department of Health and Human Services. This IAA has been developed and mutually agreed upon by the above agencies."

(1) Effective Date

Of the IAAs analyzed, roughly half include a specific effective date and about half specify that the document will take effect upon signature. Such language sometimes occurs at the beginning of the document and sometimes in the concluding paragraph, immediately followed by signatures from the agency representatives involved. To follow the structure set in Chapter Two, the effective date is listed here, but this convention is strictly for consistency.

Additional information that may be useful to include:

- An original issuance date and an amended date, if applicable.
- An effective date of signature and a specific date, with language such as "this document is to become effective on whichever date occurs first," if applicable.

(a) Model Template for Effective Date

"This <<Document>> will go into effect on the date this Agreement is signed/executed/issued by authorized representatives of each agency. The original date for this <<Document>> was <<Date>>."

(b) Example(s)

"This IAA and the policies established herein will go into effect on the date this IAA is signed or on January 1, 2006, whichever occurs later. The original issuance date for this IAA was January 1, 2000, with addenda approved on January 1, 2002 and June 30, 2003."

(2) Duration

The duration of the IAA, when stated, is most often linked to the effective date. The duration may consist of a defined period (usually 1, 3, or 5 years) from a specific date or a date range (from effective date to ending date). Conversely, it may be set to allow the IAA to remain effective in perpetuity or until cancelled or modified by one or both parties.

Additional information that may be useful to include:

- Language that requires periodic review (see *Section 16: Review*): often States specify that unless modifications are required based on this periodic review, the IAA may automatically renew at the end of each year.
- Language that details how agencies must notify each other if they require modifications to or cancellation of the IAA and the timeframe in which they must make notification.

(a) Model Template for Duration

"This IAA is to remain in effect for <<Duration or Ending Date or Date Range>> unless canceled or amended or renewed by mutual agreement with <<Amount of Time>> days notice by one party to the other party."

(b) Example(s)

- "From July 1, 2004 – June 30, 2005."
- "This IAA is to remain in effect for 1 year from the effective date of signature or until terminated or modified. Either party may terminate this Agreement through written notice to the other, at least 30 days prior to the effective date of such termination."
- "This contract supersedes and prior agreement between the parties and shall continue in effect for a period of 1 year from the date hereof. It shall remain effective for successive periods of 1 year each thereafter unless during any such period, this contract shall be canceled in accordance with the terms contained herein. This contract may be terminated, when either party requests termination, by giving 90 days written notice to the other party of its intention to terminate" (Michigan IAA).

(3) Type of Agreement

Most often, the type of agreement is stated in the title with little, if any, rationale as to why that specific method of agreement or contract is employed. The term "interagency agreements" typically is used to denote agreements between separate agencies, while the term "intra-agency agreement" is used to denote that both the Title V and Title XIX agencies are housed within the same agency. However, with other terms such as Memorandum of Understanding or Agreement, Joint Power Agreement, or Standard Business Agreement, there does not appear to be a recognizable pattern to the type of agreement employed. It has been surmised that State-specific procedures or requirements set forth the type of agreement that must be entered into by State agencies.

However, if there are specific reasons for one manner of agreement to be chosen over another, it may be revealing to list those reasons in the document itself. This, while by no means necessary for the purposes of the agreement, would shed further light on the working relationship between agencies.

(4) Agencies Involved

As a contract between agencies, it is important to list the involved parties at the beginning. Often this can be done in the title of the document, but most IAAs also begin the narrative by listing the agencies involved. While most often this consists of the Title V and the Title XIX agencies, other agencies such as Title XXI, WIC, and local provider groups can also be listed.

Additional information that may be useful to include:

- The role that each agency plays in the State, such as whether the agency is Title V or Title XIX.
- Abbreviations used for each agency throughout the document.

(a) Model Template for Agencies Involved

"This agreement has been made and entered into by and between <<Agency 1 Name>> (<<Title V or Title XIX Agency>>, hereafter referred to as <<Abbreviation>>) and <<Agency 2 Name>> (<<Title V or Title XIX Agency>>, hereafter referred to as <<Abbreviation>>)"…

(b) Example(s)

"This agreement has been made and entered into this 1st day of July 2003, by and between the NORTH DAKOTA DEPARTMENT OF HEALTH (HEALTH), the NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES (DHS), the PRIMARY CARE OFFICE (PCO), and the PRIMARY CARE ASSOCIATION (PCA) to define the responsibilities of the parties hereto…" (North Dakota Cooperative Agreement).

(5) Authority Cited

States can specify the relevant State and Federal authority (both statutory and regulatory) for entering into the IAA as well as more overarching provisions that address services and activities being agreed to. This documentation can then be referenced if at any point in the future either party needs to address disputes in activities that may be beyond legal requirements.

As summarized in Chapter Two, most IAAs cite specific legislative or regulatory Medicaid Federal law, the most often cited being:

- SSA §1902(a)(11) and related sections.
- 42 CFR 431.615.

Additional information that may be useful to include:

- "Whereas" statements: the authorities cited can be included in a series of "whereas" statements, following the example of many States (and to mirror the style many States have adopted for *Section 7: Responsibilities*).
- Specific programmatic requirements: in addition to the specific statutory and regulatory citation, it may also be beneficial to list the specific programmatic requirements that the authority speaks to. This helps provide the IAA with a sense of purpose rather than simply being a list of State and Federal requirements.

(a) Model Template for Authority Cited

"Whereas, <<Federal Authority Citation>> requires <<Specific Requirement(s)>> and <<State Authority Citation>> requires <<Specific Requirement(s)>> and <<Local or Program-Specific Authority Citation>> requires <<Specific Requirement(s)>>"…

(b) Example(s)

"Federal laws and regulations mandate cooperation between State agencies responsible for the administration and/or supervision of both Title V and Title XIX of the SSA. The following specific sections delineate the authority and intent of this Agreement:

Legislative. Whereas (i) Title XIX of the SSA [SSA §1902(a)(11)(A)] provides for entering into cooperative agreements with the State agencies responsible for administering and/or supervising the administration of services to ensure maximum utilization of such services. Section 1902(a)(11)(B) requires provision of appropriate reimbursement to any Title funded project by Title XIX for services and care provided to Medicaid consumers; and (ii) Title V of the SSA [§505(5)(F)] requires…

Regulatory. Whereas (i) 42 CFR 431.615 requires that the State Title XIX plan include written cooperative agreements with the State health agencies and Title V grantees to ensure that Title V recipients eligible for Medicaid receive services with particular emphasis on EPSDT services…" (Kansas IAA).

(6) Objectives

Objectives can be anywhere along the spectrum of extremely general to greatly detailed. Two of the main objectives often listed in current IAAs are (1) to define the responsibilities of each respective party and (2) to satisfy the statutory and regulative requirements set forth in *Section 5: Authority Cited* (see above). The more comprehensive documents usually list one or more overarching goals followed by more specific, measurable goals. Common objectives are listed in *Chapter Three*, but can be summarized under the following categories:

- General and Coordination.
- Programmatic and Local Relationship Building.
- Identification, Outreach, and Referral.
- Reimbursement and Financial.
- Data Sharing.

Additional information that may be useful to include:

- Categories: States that organize their objectives by category (such as the ones above) carry these categories through the entire narrative (e.g., Services Provided by Agency, Cooperative Relationships, etc.) so that a consistent structure is maintained.
- Activities: many States briefly list planned activities to achieve each objective. These activities are then discussed in detail in the rest of the document.
- Measurable goals: some States provide measurable goals within their objectives.

(a) Model Template for Objectives

"This IAA is entered into for the purpose of <<Overarching Objective>>. The implementation of this Agreement shall be guided by the following objectives: <<Specific Objectives, often organized by category>>."

(b) Example(s)

- This MOU has been established "to improve public health service delivery and public health outcomes for low-income populations through the sharing of available Medicaid, HUSKY Plan Part B, HUSKY Plus and Title V data.

  More specifically, through the implementation of the addenda to this MOU pertaining to specific data exchanges, the purposes are as follows:

1. To increase coordination between the Department of Public Health and the Department of Social Services for programs funded by the MCH Block Grant.
2. To increase coordination in the administration of programs that are designed to improve the health of children and adults in Connecticut.
3. To increase cooperation in reviewing and implementing fiscal policies that affect populations served by DPH and DSS and providers of services.
4. To implement a process that allows for joint access to critical Medicaid and public health data without duplication of effort.

5. To promote long-range planning as it relates to data sharing." (Connecticut Memorandum of Understanding #2).

- "An agreement is established… to continue to implement a State-wide program [the Well Child Outreach Project] designed to promote the health of children, adolescents, and pregnant women. The Department of Health's goal is to reduce the inadequate prenatal care rate to no more than 10% by year 2000. The Division of Medical Services' goal is to screen 80% of all Medicaid-eligible children each year." (Missouri IAA #2).

(7) Responsibilities

Defining specific agency responsibilities often begins by identifying which agency has oversight in administering the respective Title V, Title XIX, and other relevant programs. A summary of responsibilities or specific tasks can follow to further clarify each agency's role in the State.

These responsibilities can be contained in a series of "whereas" paragraphs; this format makes this section clearly identifiable and "sets the stage" for the rest of the agreement. Sometimes, this format is carry forwarded from *Section 5: Authority Cited* (see above). While this is often an editorial decision, it can help to provide a strong rationale and introduction to the rest of the document.

Responsibilities can be broken down into categories, such as:

- The Title V agency's responsibilities.
- The Title XIX agency's responsibilities.
- Other agencies' responsibilities.
- Joint or shared responsibilities.

Additional information that may be useful to include:

- A summary sentence that follows the listing of agency responsibilities and serves to introduce the discussion of services to be provided in support of these responsibilities.
- A specific contact or position within each agency who is responsible for making sure that responsibilities are being met.

(a) Model Template for Responsibilities

"Whereas <<Agency 1>> is the State agency responsible for administering <<Program 1>> and has further responsibility for <<Agency 1's Specific Responsibilities>>; <<Agency 2>> is the State agency responsible for administering <<Program 2>> and has further responsibility for <<Agency 2's Specific Responsibilities>>; etc….

Now, therefore, be it resolved that <<Agency 1, Agency 2, etc.>> agree to perform the following in connection with this agreement"…

(b) Example(s)

> "Whereas the Department of Health is responsible for administering the Title V program and has further responsibility for the following services: child health services; family planning services; dental health; genetic services; WIC services…
>
> And whereas the Department of Human Services is responsible for administering the Title XIX program and has further responsibility for all health planning issues in the State…
>
> And whereas the Title V and XIX agencies are jointly charged with direct responsibility to achieve…
>
> Now, therefore, be it resolved that the Department of Health and the Department of Human Services agree to the following services in order to fulfill their responsibilities as set forth above."

(8) Services Provided by Agency

There can be no single model that details services to be provided by each agency (Title V, Title XIX, and other relevant agencies and programs) in the IAA, since there is such wide variety of format and range of activities in current agreements. Overall, States have divided tasks to address their specific needs and working arrangements; some States provide great detail in documenting their respective services and responsibilities while other States summarize their division of responsibilities in a couple of paragraphs. However, there are several examples of services provided by agency that have appeared in IAAs across the country. These may be useful in drafting future agreements.

Model 1

In the most basic approach to delineating services, each agency's services are listed separately and are followed by a list of joint responsibilities (see below). This is the approach that most States currently use in their IAAs.

Model 2

An alternate approach to this straight-forward model would be to organize services according to type, similar to those presented in *Section 6: Objectives*. In this way, the services can be traced back directly to the objective that they are to support. The categories could still be as follows:

- General and Coordination.
- Programmatic and Local Relationship Building.
- Identification, Outreach, and Referral.
- Reimbursement and Financial.
- Data Sharing.

Other categories such as administration and policy, confidentiality, contract monitoring, training and technical assistance, etc. could be used to fit the specific needs of the State.

Model 3

A third approach, currently in use by some States, would be to organize services by the State program under which they fall. While many of the activities under each program have a tendency to be repetitive, this model can provide a high degree of detail for each program.

Model 4

Finally, many States currently issue separate IAAs for specific programs or sets of activities. By focusing individual documents on such specific topics, it may be easier to go into greater detail and delineation of responsibility than if one single IAA were to be issued.

Obviously, there are additional methods of organizing agency responsibilities; these are initial suggestions to generate thought when drafting new documents. The diversity among the activities themselves is even greater. States assign roles to agencies as the needs of their population demand. However, a listing of specific activities that appear repeatedly in current IAAs is presented in *Chapter Three*.

(a) Model Templates for Services Provided by Agency

Model 1

"The agency that administers Title V has the responsibility to:

- <<Responsibility 1>>
- <<Responsibility 2>>

The agency that administers Title XIX has the responsibility to:

- <<Responsibility 1>>
- <<Responsibility 2>>

Other/local agencies have the responsibility to:

- <<Responsibility 1>>
- <<Responsibility 2>>"

Model 2

"The agency that administers Title V has the responsibility to:

General and Coordination.

- <<Responsibility 1>>
- <<Responsibility 2>>

Programmatic and Local Relationship Building.

- <<Responsibility 1>>
- <<Responsibility 2>>

Identification, Outreach, and Referral.

- <<Responsibility 1>>
- <<Responsibility 2>>

Reimbursement and Financial.

- <<Responsibility 1>>

- <<Responsibility 2>>

Data Sharing.

- <<Responsibility 1>>
- <<Responsibility 2>>

The agency that administers Title XIX has the responsibility to…"

Model 3

"Program 1: <<Program Name>>

- The agency that administers Title V has the responsibility to…
- The agency that administers Title XIX has the responsibility to…

Program 2: <<Program Name>>

- The agency that administers Title V has the responsibility to…
- The agency that administers Title XIX has the responsibility to…"

Model 4

If a State chooses to use separate IAAs for specific programs or activities, such IAAs can be organized by any of the models above. The decision to issue separate agreements can give the State the flexibility to provide more detail about each program without any one document becoming overly long.

(b) Example(s)

Model 1

See the Virginia IAA for services organized by agency.

Model 2

See the Indiana MOU for services organized by topic.
See the Iowa Cooperative Agreement #2 for services organized by objective.

Model 3

See the Kansas Cooperative Agreement and the Colorado IAA #1 for services organized by program.

Model 4

See the six Missouri Cooperative Agreements for separate agreements based on program and/or service.

(9) Cooperative Relationships

Defining on paper the cooperative relationships between agencies is a very tricky process, since often the aspects that make up the relationships are mainly visible through the activities in which they participate. In writing an IAA, it becomes important to include language emphasizing cooperation and collaboration into each agency's required activities. By specifying that the agencies need to work collaboratively on activities the IAA forces the process of cooperation to occur if the activities are to be completed.

The importance of establishing and maintaining cooperative relationships between agencies can also be emphasized in other parts of the IAA, including *Section 13: Coordinating Plans* and *Section 17: Liaison* (both described below). Consideration should be given to having the IAAs include a provision encouraging the State Medicaid agency to involve the Title V agency in the planning, development and implementation of Medicaid changes made via State Plan Amendments and waivers.

(10) Services Provided by Local Agencies

In the IAAs collected, the trend is to list information that needs to be shared with local agencies, such as data relative to children enrolled in Medicaid and information on the services that Medicaid offers. Similarly, it is important to set forth the training and technical assistance to be provided to local health agencies by Title V and/or Title XIX staff.

If not included as part of the overall services provided by agency, it may be beneficial to include a section on local coordination and services as part of new IAAs.

(a) Model Template for Services Provided by Local Agencies

"Local Coordination and Services:

Collaboration with local agencies:

- Data and information sharing: <<List Data>>
- Training: <<List Training>>
- etc.

<<Local Agency Name>> has the responsibility to:

- <<Responsibility 1>>
- <<Responsibility 2>>

(b) Example(s)

Excerpted examples of collaboration with local agencies from the Wisconsin MOU:
"A. Encourage State, regional, and local health department staff to participate in any Medicaid managed care advisory groups.
B. Provide local health departments and WIC projects with essential information on how the Medicaid managed care system works, current information on Medicaid quality of care indicators, and the current Medicaid reimbursement.
C. Provide HMOs with information on local health departments and WIC projects and the services they provide.
D. Promote coordination and collaboration between local health departments WIC Projects, HMOs, and other Title XIX managed care programs."

(11) Identification and Outreach

Identification of individuals who are potential beneficiaries or who are not receiving Medicaid services and outreach to these groups needs to occur before appropriate referrals and/or services can be provided. The structure of how these activities will be accomplished can be included in *Section 8: Services Provided by Agency* or highlighted as a separate section of the IAA.

Additional information that may be useful to include:

- Follow up information on providing referrals and/or services to individuals once identified.
- Use of proper diagnosis codes to identify high-risk children.
- Reporting of data on outreach activities conducted in the State.

(a) Model Template for Identification and Outreach

"<<Agency Name>> shall identify infants, children, adolescents, and women who are potentially eligible for Medicaid and/or who have not received appropriate screenings or services. Once identified, the agency shall:

- Assist them in applying for such benefits.
- Provide the appropriate referral and/or services.
- Conduct outreach to inform the individuals about services for which they are qualified.

<<Agency Name>> shall also provide additional outreach activities by:

- 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."

(b) Example(s)

- See Kansas' Cooperative Agreement for an example of activities related to identification.
- See Iowa's IAA for an example of a specific agreement focused on outreach.

(12) Reciprocal Referrals

As with identification and outreach, reciprocal referrals are most often covered in *Section 8: Services Provided by Agency.* One of the challenges is to ensure that the importance for referrals does not become lost among a long list of activities.

(a) Model Template for Reciprocal Referrals

"<<Agency Name>> will establish a system of referrals for those services not directly rendered by the agency, but 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 <<List Programs>> will fall into this category." (Adapted from Kansas' Cooperative Agreement).

(b) Example(s)

See Nebraska's IAA for a rationale in establishing a system of reciprocal referrals.

(13) Coordinating Plans

A discussion of the activities to coordinate agency plans to provide appropriate Medicaid services helps support the clear need for the IAA in the first place. Without coordination between agencies, there can be no successful maintenance of the system that provides such services. Therefore, it is important to stress the ongoing need to have coordinated plans between agencies. The discussion of coordination can take place in *Section 8: Services Provided by Agency,* integrated as a specific activity under each category; likewise, coordination may also assume its own section in the IAA or a separate category of related activities.

Additional information that may be useful to include:

The benefits of coordinating plans, such as:

- Preventing duplication of effort among agency programs.
- Improving the cost effectiveness of the health care delivery system.
- Improving the availability of services.
- Focusing services on specific population groups or geographic areas.
- Maximizing effectiveness of service delivery.

(a) Model Template for Coordinating Plans

"In order to secure the following benefits: <<List Benefits>>, <<Agency 1>> and <<Agency 2>> jointly agree to work collaboratively and coordinate program activities in the following areas: …"

(b) Example(s)

> "The scope of services covered under 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…" (Virginia's IAA).

(14) Reimbursement

The requirements set forth by States for reimbursement are so varied and often so detailed, that it is not logical to present a model template for this section. However, there are many common elements that should be considered in drafting an IAA:

- The rate and/or total amount of reimbursement.
  - Often at the current Medicaid reimbursement rate or at the State match/share of costs based on a fee schedule.
  - Not to exceed the cost of providing the service.
- The activities (administrative and services provided) that are to be reimbursed.
- The documentation needed to ensure reimbursement.
- The mechanism and periodicity for filing reimbursement claims.
- The assignment of first and primary sources for payment and third party reimbursement.

For examples of how specific States treat reimbursement, see Chapter Two: C(14) or the individual summary tables in Chapter Four.

(15) Reporting Data

As with many of these sections, details of data reporting may take the form of specific activities to be performed by each agency or they may be explained in a separate section of the IAA. Since the mechanisms for reporting data can be extremely detailed and confusing, it may be beneficial to begin the IAA's section on data by explaining what the overall goals for the process are (e.g., to improve program administration and outcomes; develop performance measures that rely on linked data; gaining a better understanding of the needs of the Medicaid population). Data can be reported and shared through a variety of mechanisms, including:

- Monthly, quarterly, and/or annual reports (programmatic, agency summaries).
- Electronic access to reports through State-wide data systems that collect programmatic information (e.g., number of beneficiaries, number of services provided).
- Program procedural manuals.

Issues that need to be considered in reporting of data include:

- Security and confidentiality.
- Use of data only for specified purposes.
- Mechanisms for review and audit.
- Maintenance of records.

Additional information that may be useful to include:

- A reminder that financial reimbursement is tied to accurate documentation and reporting of data.
- What activities the data will be used for (e.g., needs assessment activities, program planning, evaluation, determination of barriers to enrollment and application assistance).
- The assignment of a key contact whose responsibility is to ensure secure, accurate, and timely transfer of data.

(a) Model Template for Reimbursement

This model is adapted from Indiana's MOU:

"Reporting Data:

A. Mutual Services.
1. Work together to improve the State's capacity to integrate data, link data files, and to utilize program data to improve program administration and outcomes.
2. Work collaboratively in the development of 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.
3. Collaborate among programs to guide the permissible sharing and dissemination of data for program administration, policy development, and to carry out the responsibilities listed in this Agreement.
4. Implement processes to ensure data sharing requests are in compliance with HIPAA and applicable State and federal statutes, regulations, and guidelines.
5. Assign specific program designees to accept and coordinate all data request from each respective agency in accordance with individual program procedures and protocols.
6. Provide specific agreed upon program data necessary for program monitoring and evaluation.

B. Title V.
1. Work collaboratively by providing, in compliance with HIPAA regulations, the necessary client data files and vital records data to facilitate client care administration and to permit matching of population-based and other programmatic data files for evaluation purposes.
2. Cross-match computerized participant files to generate lists of newly enrolled members who are not participating in all potential services to increase service coordination efforts.
3. Provide data through standard reports about population-based health care assessments.
4. Collaborate with Title XIX to determine joint outcome indicators and objectives to be evaluated regularly.

C. Title XIX.
1. Work collaboratively by providing, in compliance with HIPAA regulations, the necessary client data files and vital records data to facilitate client care administration and to permit matching of population-based and other programmatic data files for evaluation purposes.
2. Provide specified demographic data summaries regarding populations served by Title V programs needed to fulfill Title V Federal reporting requirements and to track MCH-related Healthy People 2010 Objectives.
3. Make available each month to other State agencies the names of newly certified Medicaid beneficiaries to be used for eligibility determination."

(b) Example(s)

- California's IAA devotes an entire objective 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." See the full document for details.
- Louisiana's Intra-Departmental Agreement details its data requirements in a section called "Methods of Exchange of Information."
- South Carolina's MOA deals exclusively with the maintenance and transfer of data files.

(16) Review

While the majority of IAAs currently do not build in an automatic process for review, the addition of this requirement would help ensure the document remains current and adequately addresses the needs of the Medicaid beneficiaries. Because it was noted that many of the IAAs were non-specific, out-of-date, or not signed, there should be a periodic review from each agency to help alleviate these issues.

(a) Model Template for Review

"This agreement shall be reviewed at least <<Periodicity of Review>> or at the request of either party by <<Established Committee or Representatives of Each Agency>> and, if necessary, amended upon mutual agreement of the agencies involved. Amendments shall be in writing and signed by the authorized representative of each party and will comprise an official component of the document from that time forward. This agreement may also be terminated at this time upon notification of either party."

(b) Example(s)

Illinois' IAA requires both an annual review of the entire agreement and a periodic review of sections at the request of either agency.

(17) Liaison

A successful IAA needs a defined mechanism to ensure that coordination between agencies is maintained and that the requirements of the agreement itself are being met. Establishing an official liaison(s) between agencies can help accomplish these goals.

Activities for the liaison(s) may include meeting with the corresponding agency on a regular basis for a variety of purposes that may include:

- Ensuring that the activities outlined in the IAA are met.
- Continuous communication between agencies.
- Coordinating areas of shared responsibility between agencies.
- Updating each agency on developments as they arise.

The assignment of a liaison is often discussed in the context of overall program coordination (see Section 13) and establishing cooperative relationships between agencies (see Section 9). The role of the liaison can be defined in either of these sections or as a separate section.

(a) Model Template for Liaison

"Meetings between agencies will take place at least <<Periodicity of Meeting>> to review progress toward meeting mutual objectives. <<Position or Name of Liaison Staff>> from <<Agency 1>> and the <<Position or Name of Liaison Staff>> from <<Agency 2>> shall jointly be responsible for serving as agency liaison for the purposes of implementing this agreement and ensuring that ongoing communication and coordination take place between the represented agencies.

(b) Example(s)

- Idaho's Cooperative Agreement summarizes the role of liaison in general terms.
- Georgia's Interagency Master Agreement assigns the role of liaison in terms of an overarching committee for review of progress in the implementation of the agreement.

(18) Evaluation

The evaluation of the effectiveness of the agreement and the corresponding collaboration between agencies should be integrated into the IAA itself along with measures of review and liaison. Most often, this evaluation can take place by committee that includes the designated liaisons from Section 17.

(a) Model Template for Evaluation

"The agencies that administer Title V and Title XIX will jointly establish an advisory committee for the following purposes:

- To monitor implementation of this Agreement.
- To coordinate services offered.
- To review and update its provisions as necessary.
- To ensure that all Medicaid-eligible persons in need of Medicaid services receive them.
- To ensure that appropriate fiscal documentation is ongoing.
- To ensure that collaboration between agencies and coordination of joint activities is ongoing.
- <<Additional Goals>>.

The committee will meet every <<Periodicity of Meeting>> when either agency requests that a formal meeting be conducted. The committee will be comprised of <<List Committee Members>>.

(b) Example(s)

Kansas' Cooperative Agreement and Missouri's IAAs are extremely detailed in regards to evaluation and form the basis for the model template above.

(19) General Contract Provisions

The general contract provisions are usually formulaic and based on both State and Federal regulations. As stated in Chapter Two, these provisions may consist of the following:

- 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.

Additional information that may be useful to include:

A section on definitions/terms and acronyms used in the document. Many of the IAAs collected (CO, HI, MO, NC, OH, and UT) contained a glossary of terms. This information proved valuable in wading through the abundance of agency names, State programs, etc. often encountered in such documents.

Georgia's Interagency Master Agreement, Ohio's IAA, and Kansas' Cooperative Agreement all contain detailed sections on general contract provisions that can be used as models.

C. Promising Practices and Lessons Learned

As can be seen, the amount and variety of information within the State IAAs is staggering. The ways that States have developed and use these documents is likewise as varied as their individual needs. However, one fact cuts across all the information presented above: States find their IAAs to be most successful when these documents are developed together and clearly delineate each agency's responsibilities in a measurable manner and in a stated time frame. After contacting many of the States who provided IAAs for this study, several other "promising practices" become clear.

First, in all cases where States feel that they have IAAs that address each agency's needs, there is a great willingness to work together on a personal level. Staff from each agency have long-standing relationships with their counterparts across the table. In each case, there is a personal dedication to making sure that the IAAs are in place and that the agencies are well aware of their details. Often the process of writing or updating the IAAs together serves as good practice in bringing staff from agencies together. When the documents become a shared project, the activities that they outline often flow out of a sense of partnership.

For the documents to be useful, staff have to know about them and have easy access to current versions. In cases where States feel that their IAAs are not sufficient, one of the major barriers is simply in obtaining a current signed copy that everyone could agree upon. This is particularly true when there is large staff turnover. States that felt that there could be room for improved coordination of activities often had agency positions that had been vacant for long periods of time. These positions, if consistently filled, could provide the liaison between agencies vital to the success of the IAAs. Another issue for staff is the simple ability to find the IAAs in a centralized location. Some staff interviewed said that they have multiple copies of their State IAAs in their desk, but were not exactly sure which one is most recent.

The need to be well acquainted with the IAAs also becomes evident. In States that are pleased with coordination between agencies, staff seem familiar with the purpose and details of their IAAs and how they serve to provide an outline for working together. Conversely, staff who feel that coordination between agencies could be improved often had only a cursory understanding of their State's IAA. Of course, IAAs that are clear and engaging and that address specific issues and responsibilities have a greater chance of being read and referred to. One State employee said that she never read the IAA because it was "too legal to be understood."

Overall, whether the Title V and Title XIX agencies are housed within the same State department or division (and whether their IAAs are thus interagency or intra-agency agreements), seems to have little impact on how agency staff feel they coordinate activities together. What becomes evident is that the IAAs that present detailed lists of services and responsibilities are the ones that seem to be most successful. While some States simply list mutually agreed upon activities in a long list while others link these activities to objectives and/or activity type, the most important factor is that the activities *are* spelled out so that there is no question as to responsibility. With the basics mapped out, staff are able to focus on innovative ways to collaborate.

Successful IAAs most often present each agency's responsibilities separately and then their shared responsibilities. These documents likewise present the services to be provided by each agency in a similar fashion. Whether a State has a single IAA to address coordinated activities broadly or several smaller IAAs that focus on specific programs, again the important message is that the documents are clear and specific. One Title XIX contact, while reading the IAA over the phone, said that he didn't realize all the services that his State Title V office actually offered.

There seems to be a fine line between the right amount of detail in the various IAAs and "just too much information." Many States have found that while a large amount of detail regarding specific issues (e.g., documentation and reimbursement) is necessary, a long "laundry list" actually is counter productive in facilitating meaningful collaboration. There is a balance that constantly has to be met between making the IAAs detailed enough to be useful but not making them so detailed that no one can agree upon them to begin with and then no one is familiar with them enough that they are useful. There is a sense that for IAAs to be successful, they need to be specific to State Title V and Medicaid offices rather than just a modified basic provider agreement.

A common concern among State agencies is ensuring that the agreed upon responsibilities in the IAAs actually get carried out consistently throughout the State. Often the list of activities, specifically those to be carried out locally, is ambitious; however, it sometimes is difficult to track that the activities are indeed carried out at this level. Many States feel that their IAAs would benefit from more specific processes to interact with local health departments or other Title V grantees and better ongoing communication with the "front line."

The counter balance to this desire is the constant fear of developing too many processes and reporting mechanisms that simply serve to "bog down" already busy agency staff. The fear of too much paperwork was evident in conversations with States. Successful IAAs, thus, need to find the right balance of communication and reporting required in order to remain useful tools for the agencies that developed them.

The driving point of State IAAs that cannot be emphasized enough is that they are more than just dusty legal documents providing standard contract language of roles and responsibilities. The time spent developing and refining these documents is well worth the time and effort. The linkages that they can facilitate have the potential to provide a more comprehensive system of services to those who need them the most. At their best – having been well conceived, written, and agreed upon – and in the hands of agency staff who understand their true value, the IAAs can serve as an essential road map to successful coordination.

Chapter Five

State Title V / Title XIX Interagency Agreements

To establish roles and responsibilities between the parties for the purpose of providing coordination of services to promote prompt access to high quality prenatal, intrapartum, postpartum, postnatal, and child health services for women and children eligible for benefits under Title V and XIX of the Social Security Act.

-- Stated objective from Maryland's 2004 IAA

A. Overview of Data and Tables

Explanation of the Tables

Each of the IAAs reviewed for this publication is summarized in the following tables. From the 36 States that submitted IAAs or other material, a total of 47 documents were analyzed; a number of States have multiple agreements to cover separate topics.

Each chart is divided into four sections:

- A description of the document itself, including:
  - Title and author.
  - Date of publication (year only).
  - Number of pages.
  - Link to the full-text of the document.
- A summary of contractual details, including:
  1. Effective date.
  2. Duration.
  3. Type of agreement.
  4. Agencies involved.
  5. Authority cited for the agreement.
- A summary of the agreement sections that relate to CMS requirements outlined in 42 CFR 431.615(d), including:
  6. Objectives of the agreement.
  7. Responsibilities of the agencies involved.
  8. Services provided by each State agency.
  9. Cooperative relationships at the State level.
  10. Services provided by local agencies.
  11. Identification and outreach activities.

12. Reciprocal referrals.
13. Plans for coordination of services for beneficiaries.
14. Methods for reimbursement.
15. Plans for reporting and sharing of data.
16. Plans for periodic review of the agreement.
17. System of continuous liaison between agencies.
18. Plans for joint evaluation of the agreement and other policies.

- A listing of general contract provisions (item 19) listing whether the document covers:
  - Amendment/modification of agreement.
  - Audit.
  - Confidentiality of records/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/recordkeeping.
  - Nondiscrimination clauses.
  - Methods for payment.
  - Regulations regarding subcontracts.
  - Tobacco policies (smoke-free workplace environment).
  - Grounds and methods for termination of agreement.

When information is gathered from different sections of the agreement or other supporting documentation (e.g., the cover letter sent by the State agency with the IAA) but is not clearly spelled out in the text, straight brackets [] are used to highlight this data.

Wherever possible, text in the summary tables is taken directly from the IAAs. While this practice has a tendency of making various tables lengthy, it more accurately preserves the tone and intent of the document than a simple summary paragraph could do. Modifications to the text (most often ellipses or other omissions) have been made for clarity and brevity. Large omissions have been noted in the summary tables with links back to the full-text agreements. The full-text of each IAA summarized along with a database of the components of the summary tables are accessible at *http://www.mchlibrary.info/IAA*.

States Summarized in the Tables

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

B. State-by-State Summary Tables

State: Alabama (Region 4)

Document:
Provider Contract between the Alabama Medicaid Agency and the Alabama Department of Public Health [Amendment to Original Contract]
Author: Alabama Medicaid Agency
Date: 2004 **Pages:** 3 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/AL_1_1.pdf*

Contractual Details:

1. **Effective Date:** March 1, 2004 [amendment date].
2. **Duration:** N/A
3. **Type of Agreement:** Provider Contract.
4. **Agencies Involved:**

A. The Alabama Medicaid Agency ("Medicaid") [Title XIX].
B. The Alabama Department of Public Health (ADPH) [Title V].

5. **Authority Cited:** N/A

Summary Related to CMS Requirements:

6. **Objectives:**

To amend the original T5/T19 provider contract regarding EPSDT services (care coordination).

7. **Responsibilities:** N/A

8. **Services Provided by Agency:**

A. Amendment: Care Coordination.
1. ADPH shall develop and maintain a care coordination system which shall ensure Medicaid-eligible children receive appropriate services.
2. ADPH shall utilize reports provided by Medicaid monthly to identify children who have not received screenings.
3. ADPH shall follow-up on positive findings for sickle cell and metabolic screenings, newborn hearing screens, and immunization status.
4. ADPH shall receive referrals from physicians and dentists regarding medically-at-risk clients.
5. ADPH shall arrange for necessary transportation.
6. ADPH shall utilize the appropriate diagnosis codes to identify high-risk children.
7. ADPH shall provide a monthly summary of EPSDT Care Coordination to the Agency's EPSDT staff.

B. Original Agreement.
Original agreement consists of the "respective responsibilities of Title V and Title XIX agencies

in the provision of services by perinatal coordinators. Title V is responsible for ensuring that perinatal coordinators meet professional standards. Perinatal coordinators provide following services: increasing awareness of and utilization of tertiary care centers and preventive health care; evaluation of resources; identification of areas of need; and development of new resources; research and development of more effective mechanism for the transfer of high risk mothers and babies. Title V will review compliance of each perinatal coordinator annually. Title X may seek replacement of any non-complying coordinator." (From 1st edition of *State MCH-Medicaid Coordination nation: A Review of Title V and Title XIX Interagency Agreements*).

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service A2, A6.

12. Reciprocal Referrals: See Section 8, Service A4.

13. Coordinating Plans: N/A

14. Reimbursement:
Medicaid will reimburse ADPH for care coordination services based on Medicaid's current reimbursement rates. ADPH agrees to reimburse Medicaid the state share of costs associated with providing care coordination services.

15. Reporting Data: See Section 8, Service A2, A7.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions: N/A

State: Arizona (Region 9)

Document: *[Arizona] Data-Sharing Request/Agreement*
Author: Arizona Department of Economic Security
Date: n.d. **Pages:** 10 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/AZ_1_1.pdf*

Contractual Details:

1. **Effective Date:** N/A
2. **Duration:** N/A
3. **Type of Agreement:** Standard Business Agreement.
4. **Agencies Involved:**

A. Arizona Department of Economic Security.
B. Arizona Department of Health Services, Public Health Prevention Services, Division of Public Health, Office of Women's and Children's Health [Title V].

5. **Authority Cited:** Field in agreement form left blank.

Summary Related to CMS Requirements:

6. **Objectives:**
To establish access to information used by the Pregnancy and Breast Feeding Hotline; the Newborn Intensive Care Program; and the Newborn Screening Program.

7. **Responsibilities:** N/A

8. **Services Provided by Agency:**
AzTECs access will be used to determine enrollment status with any/all DES-FAA programs. This includes but is not limited to: Baby Arizona; food stamps; health care plans; and cash assistance. This information is used to facilitate enrollment and/or answer enrollees' questions.

9. **Cooperative Relationships:** N/A

10. **Services Provided by Local Agencies:** N/A

11. **Identification and Outreach:** See Section 8.

12. **Reciprocal Referrals:** N/A

13. **Coordinating Plans:** N/A

14. **Reimbursement:** N/A

15. Reporting Data:
There are many contractual provisions regarding provision and security of data. Please see original document.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions: maintenance of records/recordkeeping

State: California (Region 9)

Document:
Interagency Agreement between California Department of Health Services, Title XIX Medicaid Agency and the Title V Maternal and Child Health Agency
Author: California Department of Health Services
Date: 1997 **Pages:** 15 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/CA_1_1.pdf*

Contractual Details:

1. Effective Date: Immediately (signed January 15, 1997).
2. Duration: Will continue in effect unless revised or canceled.
3. Type of Agreement: Interagency Agreement.
4. Agencies Involved:
A. California Department of Health Services (DHS), Medical Assistance Program (Medi-Cal) [Title XIX].
B. Maternal and Child Health Branch (MCH) [Title V].
C. Children's Medical Services Branch (CMS).
5. Authority Cited:
A. Public Health Law 89-97.
B. SSA §1902(a)(11), et al.
C. 42 CRF §431.615(b) and §431.615(c)(4).

Summary Related to CMS Requirements:

6. Objectives:
A. To enable CHS and its Title V and Title XIX programs to carry out the mandate of cooperation.
B. To protect and improve the health of California's women, pregnant women, infants, children and adolescents, particularly those who are low-income, by developing and implementing initiatives that systematically attack the underlying causes of preventable diseases and

conditions; strengthening relationships with local health agencies and expanding partnerships with multi-cultural and ethnic organizations; working to close the gaps in health status and access to care among the State's maternal and child health population; and, developing and implementing standards of care, program choices, data collection and surveillance processes, and contracting and reimbursement systems that promote outcome-oriented and business-like approaches to the administration of Title V and Title XIX programs.

7. Responsibilities:
A. Title V and XIX agencies are charged with direct responsibility to achieve the Year 2000 Objectives in California as they relate to women and children.
B. Programs within the Department that impact women and children have the responsibility of making resources available to achieve the goals and objectives of this Agreement.
C. Medi-Cal is responsible for the conduct of the Title XIX program.
D. MCH Branch is responsible for the conduct of the MCH program.
E. CMS Branch is responsible for the Child Health and Disability Prevention (CHDP) and California Children's Services (CCS) programs.

8. Services Provided by Agency:
A. Objective 1: Ensure and support the provision of a comprehensive, coordinated, and accountable health services delivery system for all eligible pregnant women, infants, children, and adolescents.

1. Medi-Cal Services.
a. Develop reimbursement methodologies for the payment of MCH care services.
b. Support the retention of culturally and linguistically competent, and geographically strategic, safety net and traditional providers of MCH services who have a positive track record of serving the Medi-Cal population.
c. Develop, in cooperation with MCH and CMS, provider manuals, billing instructions, and provider training.
d. Develop, in cooperation, health care standards, etc.

2. MCH and CMS Services.
a. Participate in joint development and implementation of pilot projects.
b. Maintain a specialty provider network.
c. Develop, in cooperation with Medi-Cal, provider manuals, billing instructions, and provider training.
d. Develop in cooperation health care standards.

B. Objective 2: Ensure the provision of high quality health care by organizations and providers who meet professional practice standards.

1. Medi-Cal Services.
a. Collaborate in developing standards.
b. Participate and collaborate in the development of program policies, etc.
c. Establish quality improvement standards.

d. Collaborate in setting standards for services.
e. Participate with MCH and CMS in the oversight and monitoring of services.

2. MCH and CMS Services.
a. Collaborate in developing standards.
b. Provide case management.
c. Participate with Medi-Cal in the oversight and monitoring of services.

C. Objective 3: Improve access to perinatal and preventive health care services for low-income women, particularly adolescents and children, respectively, and services to CSHCN.

1. Medi-Cal Services.
a. Refer potentially eligible Medi-Cal beneficiaries to the CCS program.
b. Develop eligibility procedures.
c. Develop and produce outreach materials and oversee the implementation of outreach campaigns.
d. Develop and implement Medi-Cal provider recruitment.
e. Maintain a MCH provider resource directory and database.

2. MCH and CMS Services.
a. Identify and fund local health departments and other contractors to provide the infrastructure for health care programs which may be utilized to provide services to the Medi-Cal program's beneficiaries and other low income women and children.
b. Support provider outreach.
c. Develop regulations that define CSHCN.
d. Provide health education and MCH expertise in the development of outreach materials.
e. Certify perinatal providers.
f. Conduct prenatal guidance and other outreach programs.

D. Objective 4: Ensure maximum utilization of Title XIX funds by Title V contractors and providers, including reimbursement by Medi-Cal for all medically necessary services within the Medi-Cal scope of benefits.

1. Medi-Cal Services.
a. Seek input from Title V staff into the development of Medi-Cal fee-for-service and managed care rates and reimbursement mechanisms.
b. Reimburse Title V contractors and providers, etc. with current Medi-Cal rates and fees for all services within the scope of Medi-Cal benefits.
c. Reimburse authorized providers for services delivered to Medi-Cal beneficiaries with CCS-eligible conditions.

2. MCH and CMS Services.
a. Require all Title V providers to be Medi-Cal providers.
b. Ensure that Title V funded contractors/providers bill for services.

(For the following objective, the respective agency services have been omitted for brevity. See the full-text document for a complete listing of these services).

E. 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.

F. 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.

G. 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).

H. 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.

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

9. Cooperative Relationships:
See Section 13. Cooperative relationship building is stressed throughout Section 8.

10. Services Provided by Local Agencies:
Identify and fund local health departments and other contractors to provide the infrastructure for health care programs which may be utilized to provide services to the Medi-Cal program's beneficiaries and other low income women and children (Section 8, Service C2a).

11. Identification and Outreach:
Title V will identify infants, children, adolescents, and women who are potentially eligible for Medi-Cal and, once identified, aid them in applying.

Title V in collaboration with Title XIX is responsible for outreaching and informing all EPSDT eligible individuals about the program.

See also Section 8, Service C1c.

12. Reciprocal Referrals: See Section 8, Service C1a.

13. Coordinating Plans:
To ensure high quality, coordinated services there will be joint development of policies and regulations between the Title V and XIX programs on services.

There will be coordination and collaboration in the development and implementation of managed care programs.

VIII. Cooperative and Collaborative Methods and Arrangements.
A. Arrangements for Resolving Operational Issues.
B. Arrangements for Reciprocal Referrals.
C. Arrangements for Payments of Reimbursement.
D. Arrangements for Exchange of Reports of Services Provided to Recipients of Title XIX.
E. Arrangements for Periodic Review of the Agreement and Joint Planning for Changes.

14. Reimbursement:
The Medi-Cal program is responsible for paying for those medically necessary program benefits to eligible Medi-Cal beneficiaries delivered by Title V programs.

See also Section 8, Service A1a, I.

15. Reporting Data:
Title V will maintain confidentiality of the medical records and release such information to a third party only with written consent.

There will be sharing of data and participation in joint planning efforts in order to identify service delivery gaps and to improve the delivery of services.

See also Section 8, Service F.

16. Review:
Arrangements for Periodic Review of the Agreement and Joint Planning for Changes: Meetings will be held at least once a year, and more frequently if necessary, among the Branch Chiefs, or their representatives, of the programs part to this Agreement for the purpose of reviewing the need for any changes or clarifications to the Agreement, carrying out the agreements specified herein, evaluating activities and policies set out and providing coordinated input to the required plans of the respective programs.

17. Liaison:
All parties will keep each other apprised of those services and scope of benefits available.

Each party will designate form their respective staff appropriate liaisons whose responsibilities shall include regular and periodic communication about the programs.

Continuous liaison among the parties will be the responsibility of the Chief of each of the programs and those staff designated as lead persons in their respective Branches.

See also Section 8, Service G.

18. Evaluation:
At the request of any party to the Agreement, a formal review may be scheduled to modify, enlarge, or clarify this Agreement. Any changes in this Agreement will be subject to full discussion and concurrence in writing prior to incorporation into this document.

19. General Contract Provisions:
confidentiality of records/HIPAA
amendment/modification of agreement
termination of agreement

State: Colorado (Region 8), document 1 of 2

Document: *[Colorado] Interagency Agreement*
Author: Colorado Department of Health Care Policy and Financing
Date: n. d. **Pages:** 18 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/CO_1_2.pdf*

Contractual Details:

1. Effective Date: July 1, 2004.
2. Duration: July 1, 2004 - June 30, 2005.
3. Type of Agreement: Interagency Agreement.
4. Agencies Involved:
A. Colorado Department of Health Care Policy and Financing ("the Department" or HPCF) [Title XIX].
B. Colorado Department of Public Health and the Environment (CDPHE) [Title V].
5. Authority Cited:
Encumbrance Number PO UHA 2105-2007 in Fund Number 100, Appropriation Accounts 450 and 460 and Organization Number 4111.

Summary Related to CMS Requirements:

6. Objectives: N/A

7. Responsibilities:
A. The Department is responsible for the administration of the Colorado Medical Assistance Program (Medicaid).
B. CDPHE is responsible for the administration of the Health Care Program for Children with Special Needs in Colorado.

8. Services Provided by Agency:
The following are the topics under which services are provided. See the original Agreement for a complete list of services.
A. Family Planning.
B. Prenatal Plus.
C. Health Care Program for Children with Special Needs (HCP).
D. Developmental Evaluation Clinic Services.

E. Immunization Program.
F. Lead Poisoning Prevention Program.
G. Breast and Cervical Cancer Program.
H. Nurse Home Visitor Program.

9. Cooperative Relationships:
The Department and CDPHE shall work together to provide program implementation and administration for all programs listed in this IAA. This program coordination includes, but is not limited to: joint meetings when necessary, telephone conference calls, review of printed materials, assistance with billing concerns, assistance with provider questions, and joint participation in program trainings.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
A. HPC Medical Home Initiative shall promote use of EPSDT outreach activities to Primary Care Physicians for Medicaid-enrolled families.
B. CDPHE shall work with Department EPSDT Program Outreach Coordinators to develop and maintain a mechanism whereby Medicaid-enrolled clients shall be informed of the availability of Title V funded services, and referred for these services as appropriate.

12. Reciprocal Referrals: See Section 11, Service B.

13. Coordinating Plans:
The Department shall collaborate via mutually agreed upon activities/conferences.

14. Reimbursement:
A. The Department shall intervene with the Department's Designated Entity to ensure payment of the correct rate for Medicaid covered services.
B. The Department shall bill the State match for Medicaid expenditures to CMS.
C. CDPHE shall bill the Department no less than quarterly.
D. CDPHE 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.

15. Reporting Data:
A. CDPHE shall provide an annual report to the Department on the program reporting the progress made.
B. The Department shall provide CDPHE with Internet access for materials that are relevant to the programs identified in this IAA.

16. Review: N/A

17. Liaison:
CDPHE and the Department shall each designate a primary contact for each activity under this IAA.

18. Evaluation: N/A

19. General Contract Provisions:
lack of funds
dispute resolution mechanism
confidentiality of records/HIPAA
maintenance of records/recordkeeping
failure to satisfy SOW
amendment/modification of agreement
termination of agreement

State: Colorado (Region 8), document 2 of 2

Document:
[Colorado] HIPAA Business Associate Interagency Memorandum of Understanding
Author: Colorado Department of Health Care Policy and Financing
Date: n. d. **Pages:** 9 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/CO_2_2.pdf*

Contractual Details:

1. Effective Date: July 1, 2001.
2. Duration: July 1, 2004 - [April 21, 2005].
3. Type of Agreement: Interagency Memorandum of Understanding.
4. Agencies Involved:
A. Colorado Department of Health Care Policy and Financing (HCPF) [Title XIX].
B. Colorado Department of Public Health and the Environment (CDPHE).
5. Authority Cited:
A. Interagency Agreement Number 2105-2007.
B. Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1302d-3120d-8 (HIPPA).
C. HIPAA Privacy Rule at 45 CFR Parts 160 and 164.

Summary Related to CMS Requirements:

6. Objectives:
A. To disclose certain information to Associate [CDPHE] pursuant to the terms for the contract, some of which may include protected health information.
B. To protect the privacy and provide for the security of protected health information disclosed.
C. To enter into a contract containing specific requirements with CDPHE prior to the disclosure of protected health information.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. CDPHE.
1. *Permitted Uses:* CDPHE shall not use Protected Information except for the purpose of performing CDPHE's obligations under and permitted by the terms of the MOU.
2. *Permitted Disclosures:* CDPHE shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule if disclosed by HCPF.
3. *Appropriate Safeguards:* CDPHE shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information.
4. *Reporting of Improper Use or Disclosure:* CHPHE shall report to HCPF in writing any use or disclosure of Protected Information other than as provided for by this MOU.
5. *CDPHE's Agents:* If CDPHE uses one or more subcontractors or agents to provide services under this MOU who have access to Protected Information, each subcontractor or agent shall sign an agreement containing the same provisions as this MOU.
6. *Access to Protected Information:* CHPHE shall make Protected Information maintained by CDPHE or its agents or subcontractors available to HCPF for inspection.
7. *Amendment of PHI:* CDPHE shall make Protected Information available to HCPF for amendment and incorporate any such amendment within 20 business days.
8. *Accounting Rights:* within 20 business days CDPHE shall make available to HCPF the information required to provide to HCPF.
9. *Governmental Access to Records:* CDPHE shall make its internal practices, books, and records available to the Secretary of the U.S. Department of Health and Human Services.
10. *Minimum Necessary:* CDPHE shall only request, use, and disclose the minimum amount of Protected Information necessary to accomplish the purpose of the request.
11. *Data Ownership:* CHPHE acknowledges that it has no ownership rights with respect to Protected Information.
12. *Retention of Protected Information:* CHPHE shall retain all Protected Information through the term of this MOU.
13. *Notification of Breach:* CHPHE shall notify HCPF within 2 business days of any breach of security.
14. *Audits, Inspection, and Enforcement:* Within 10 business days of a written request, CDPHE shall allow HCPF to conduct a resalable inspection.
15. *Safeguards During Transmission:* CDPHE shall be responsible for using appropriate safeguards to maintain and ensure confidentiality of Protected Information transmissions.

B. HCPF.
1. *Safeguards During Transmission:* HCPF shall be responsible for using appropriate safeguards to maintain and ensure confidentiality of Protected Information transmissions.
2. *Notice of Changes:* HCPF shall provide CDPHE with a copy of its notice of privacy practices as well as any subsequent changes.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. Coordinating Plans: N/A

14. Reimbursement: N/A

15. Reporting Data:
See Section 8 for security measures while reporting data as well as transmission of Protected Information.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
failure to satisfy SOW
indemnification/liability
subcontracts
lack of funds

State: Connecticut (Region 1), document 1 of 2

Document:
State of Connecticut: Memorandum of Understanding between the Department of Public Health and the Department of Social Services Regarding Data Exchanges
Author: State of Connecticut Department of Public Health
Date: 2005 **Pages:** 10 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/CT_1_2.pdf*

Contractual Details:

1. Effective Date: Amended May 20, 2005.
2. Duration:
This MOU shall be in effect until canceled by mutual agreement of the parties or "suspended" with 60 days advance notice by one party to the other party.
3. Type of Agreement: Memorandum of Understanding.
4. Agencies Involved:
A. Connecticut Department of Public Health (DPH).
B. Connecticut Department of Social Services (DSS).
5. Authority Cited: Section 19a-45a of the Connecticut General Statutes.

Summary Related to CMS Requirements:

6. Objectives:
To improve public health service delivery and public health outcomes for low-income populations through the sharing of available Medicaid, HUSKY Plan Part B, HUSKY Plus and Title V data.

More specifically, through the implementation of the addenda to this MOU pertaining to specific data exchanges, the purposes are as follows:

1. To increase coordination between DPH and DSS for programs funded by the MCH Block Grant.
2. To increase coordination in the administration of programs that are designed to improve the health of children and adults in Connecticut.
3. To increase cooperation in reviewing and implementing fiscal policies that affect populations served by DPH and DSS and providers of services.
4. To implement a process that allows for joint access to critical Medicaid and public health data without duplication of effort.
5. To promote long-range planning as it relates to data sharing.

7. Responsibilities:
The addenda specify that DPH and DSS are responsible for (note: no addendum 4 was submitted):
A. Identification of Medicaid births (Addendum 1).

B. Information regarding children receiving lead screenings (Addendum 2).
C. Children receiving Title V services (Addendum 3).
D. Children with asthma (Addendum 5).

8. Services Provided by Agency:
Addendum 1: DPH will send core demographics to DSS; DSS will complete a match of the birth records with HUSKY A enrollment data.

Addendum 2: DSS will provide DPH with a list of selected children enrolled in the Medicaid program; DPH will use the linking data to abstract data elements; DPH will analyze and report this data.

Addendum 3: DPH will provide DSS a list of children who received Title V services; DSS will determine which children enrolled in HUSKY A received Title V services and provide a file with these names to DPH.

Addendum 5: DSS will prove DPH with a file of children enrolled in HUSKY A who have had had any services related to asthma diagnosis or treatment along with total number of children enrolled in HUSKY A.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/

12. Reciprocal Referrals: N/A

13. Coordinating Plans: N/A

14. Reimbursement: N/A

15. Reporting Data:
A. Use of Data for Specified Purposes: DPH and DSS agree that the data they receive from each other will be used only for the purposes set forth in this MOU.
B. Confidentiality of Data: DPH and DSS will not further disclose the information they receive from each other.
C. Task-Specific Addenda: This MOU included addenda that specifies the data to be shared between DPH and DSS.
D. Disposition of Data: DPH and DSS will destroy all confidential individually identifiable health information as soon as the purposes for which they received the information have been accomplished.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
payment
amendment/modification of agreement
termination of agreement

State: Connecticut (Region 1), document 2 of 2

Document:
[State of Connecticut:] Memorandum of Understanding between Department of Public Health and (Name of Managed Care Organization)
Author: State of Connecticut Department of Public Health
Date: n.d. **Pages:** 4 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/CT_2_2.pdf*

Contractual Details:

1. Effective Date: N/A
2. Duration: N/A
3. Type of Agreement: Memorandum of Understanding.
4. Agencies Involved:
A. State of Connecticut Department of Public Health (DPH).
B. CYSHCN Regional Medical Home Support Centers (CT has contracted with 5 MCOs).
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives:
To recognize shared goals and to establish methods of coordination and cooperation to ensure that children and youth served by the Regional Medical Home Support Centers who are enrolled in Connecticut's HUSKY, Part A managed care program receive timely and comprehensive health care services under the EPSDT program.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. CYSHCN Regional Medical Home Support Centers.
1. Support CYSHCN and their families by assisting them with coordination of multiple systems of care.
2. Provide training and support to the Pediatric Primary Care providers by addressing family needs.

3. Assist the Pediatric Primary Care Providers with care coordination of CYSHCN who have high severity needs.
4. Assist with the coordination between the Pediatric Primary Care Providers and specialists.
5. Promote the establishment of a "Medical Home."
6. Contract with Parents Networ4k across the State to support families with CYSHCN.
7. Provide respite services to underinsured and uninsured families of CYSHCN.

B. MCOs.
1. Inform families about EPSDT.
2. Conduct outreach to ensure children receive EPSDT services.
3. Link children to primary care providers and dental providers.
4. Schedule EPSDT appointments for children.
5. Remind families when EPSDT exams are due.
6. Ensure that primary care providers participating in HUSKY A are knowledgeable about EPSDT.

9. Cooperative Relationships: See Section 8, Service A1, A3.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service B1, B2.

12. Reciprocal Referrals: See Section 8, Service B3.

13. Coordinating Plans: See Section 8, Service A4, A6, B6.

14. Reimbursement: N/A

15. Reporting Data:
The Regional Medical Home Support Centers (RMHSC) shall provide a copy of the RMHSC health information form to the MCOs.

16. Review: N/A

17. Liaison:
Each MCO shall provide DPH with the name of a liaison who shall serve as a consistent point of contact for the Regional Medical Home Support Centers (RMHSC). The liaison shall be responsible for providing assistance to the RMHSC to resolve any problems that arise.

18. Evaluation: N/A

19. General Contract Provisions: N/A

State: Florida (Region 4)

Document:
[Florida] Cooperative Agreement for the Health Start Coordinated Care System for Pregnant Women and Infants between the Agency for Health Care Administration and the Department of Health
Author: Florida Agency for Health Care Administration
Date: 2001 **Pages:** 4 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/FL_1_1.pdf*

Contractual Details:

1. Effective Date: N/A
2. Duration:
The expiration date of the interagency agreement shall coincide with the expiration date of the Medipass waiver, including extensions, or until otherwise canceled.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. Florida Agency for Health Care Administration ("the Agency") [Title XIX].
B. Florida Department of Health ("the Department") [Title V].
5. Authority Cited: Medipass waiver under 1915(b) of the Social Security Act.

Summary Related to CMS Requirements:

6. Objectives:
To better serve the needs of Florida's pregnancy women and children at risk for poor birth and health outcomes.

7. Responsibilities:
A. The Agency is responsible for the administration of the State's Medipass waiver.
B. The Department is responsible for being the Title V agency.

8. Services Provided by Agency:
A. Agency for Health Care Administration.
1. Provide TA to the Department.
2. Arrange for an independent assessment of waiver cost-effectiveness.
3. Provide Medicaid data.
4. Delegate administrative oversight of the waiver to the Department.
5. Be responsible for the submission of all Medipass Healthy Start Coordinated Care System waiver applications to CMS.
6. Form a staff and statewide advisory group with the Department to oversee the implementation of care coordination.

B. Department of Health.
1. Fund Healthy Start services.
2. Develop and implement Healthy Start's Standards and Guidelines.
3. Develop and implement Healthy Start's quality improvement activities.
4. Be responsible for contract management.
5. Provide programmatic TA.
6. Adhere to Title V requirements.
7. Assist the Agency in the development of waiver applications to CMS.
8. Invite communities to participate in the Healthy Start program.
9. Establish regional advisory groups.
10. Develop brochures and other materials for informing recipients about the program.
11. Bill the Agency monthly.
12. Certify the State match.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service B8, B10.

12. Reciprocal Referrals:
Exchange of information between the agencies will be affected through an established referral process, joint consultation, and regular meetings.

13. Coordinating Plans: N/A

14. Reimbursement: See Section 8, Service B1, B11, B12.

15. Reporting Data: See Section 8, Service A3.

16. Review: N/A

17. Liaison: See Section 8, Service A6. Also see Section 12.

18. Evaluation: N/A

19. General Contract Provisions:
confidentiality of records/HIPAA
amendment/modification of agreement
termination of agreement

State: Georgia (Region 4)

Document:
Interagency Master Agreement between the Georgia Department of Community Health and the Georgia Department of Human Resources for Services in Support of the Medicaid Program for the State of Georgia
Author: Georgia Department of Community Health
Date: n.d. **Pages:** 34 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/GA_1_1.pdf*

Contractual Details:

1. Effective Date: From the day of issuance.
2. Duration:
From the date of issuance until the close of the current State fiscal year (June 30th) unless renewed in writing.
3. Type of Agreement: Interagency Master Agreement.
4. Agencies Involved:
A. Georgia Department of Human Resources (DHR).
B. Georgia Department of Community Health (DCH).
5. Authority Cited: 42 CFR 431.615.

Summary Related to CMS Requirements:

6. Objectives:
To provide the various support services described in this Agreement and found at Supplements to this Agreement.

7. Responsibilities:
A. DCH is responsible for all health planning issues in the state and for providing a broad range of governmental services aimed at improving the lives of Georgia's citizens.
B. DHR is responsible for administering numerous programs of which some are directly related to the Georgia Medical Assistance Program.

8. Services Provided by Agency:
A. DCH Services.
1. Provide a single point of contact for coordination with DCH.
2. Provide copies of federal and state regulations pertinent to services provided.
3. Send DHR copies of all materials prepared.
4. Work with DHR related to any service delivery Agreement to be entered into with an outside vendor.
5. Review all deliverables submitted to DHR for approval to pay invoices and ensure compliance with this Agreement.
6. Reimburse DHR in accordance with this Agreement.

B. DHR Services.
1. Perform all services specified in the Supplements.
2. Provide Federal and State regulations, etc. to DCH.
3. Provide an annual report detailing all projects to DCH.

9. Cooperative Relationships: See Section 8, Service A4.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. Coordinating Plans: See Section 8, Service A4.

14. Reimbursement:
DCH agrees to provide to DHR the FFP payments received by DCH that are attributable to the administrative cost of these services on a quarterly basis. For specified services DHR agrees to pay DCH the appropriate non-federal share of the benefit cost on a regular basis.

DHR and DCH agree that this is a cost reimbursement Agreement. DHR agrees to provide the State portion of matching funds necessary to receive FFP for all applicable supplements. DHR 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.

15. Reporting Data:
DHR agrees to maintain and provide information descriptive of the services required under this Agreement necessary for DCH to meet the reporting requirements imposed by HHS. See also Section 8, Service A2, A3, B3.

16. Review: N/A

17. Liaison:
DHR and DCH have established a coordinating committee consisting of the Commissioner or his or her designee form DCH, the commissioner or his or her designee from DHR, and a representative of each appropriate program division of DHR and DCH. Said committee shall meet no less than once per quarter to review and evaluate the services, to explore other avenues of interaction, and to meet the requirements of the Agreement. See also Section 8, Service A1

18. Evaluation: N/A

19. General Contract Provisions:
drug-free workplace
amendment/modification of agreement
termination of agreement
confidentiality of records/HIPAA

State: Hawaii (Region 9)

Document:
[Hawaii] Memorandum of Agreement between Department of Human Services and Department of Health
Author:
State of Hawaii Department of Human Services, Med-QUEST Division, Health Coverage Management Branch
Date: 2004 **Pages:** 16 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/hi_1_1.pdf*

Contractual Details:

1. Effective Date: July 1, 2004.
2. Duration: July 1, 2004 - June 30, 2005.
3. Type of Agreement:
Memorandum of Agreement.
4. Agencies Involved:
A. Department of Human Services (DHS), Med-QUEST Division (MQD).
B. Department of Health (DOH), Family Health Services Division (FHSD).
5. Authority Cited:
Title XIX of the SSA; Part C of the Individuals with Disabilities Education Act (IDEA); Hawaii Revised Statutes Section 321.357 - the Part C Early Intervention State Plan approved by the U.S. Department of Education under Part C of IDEA.

Summary Related to CMS Requirements:

6. Objectives:
To provide Early Intervention Services to QUEST-eligible infants and toddlers.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. FHSD.
1. Provide services to Hawaii QUEST clients between birth and age three who meet the eligibility requirements for developmentally delayed, biologically at risk and environmentally at risk.
2. Provide Early Intervention Services excluded from the medical QUEST plan contracts.
3. Determine the level, intensity, frequency, appropriateness, and service modality of Early Intervention Services to be provided.
4. Implement a process for notification upon a denied authorization for services.
5. Ensure that all families are informed regarding their rights when they disagree about services.
6. Implement a process for notification of the recipient's right to file for a State Fair Hearing.
7. Ensure that policies and procedures are in place to support the Quality Assurance Plan (QAP).
8. Ensure that early intervention providers meet appropriate qualifications.

9. Establish monitoring schedules and criteria and monitor early intervention providers.
10. Maintain records of covered services furnished to eligible children.
11. Ensure that medical and financial records are available for review by DHS or CMS.
12. Process electronic transmissions of daily and monthly rosters for QUEST eligible enrollees.
13. Provide monthly submissions of provider network and encounter data to the MQD.
14. Assume financial responsibility for payment of mandated IDEA Part C services.
15. Provide information to inform recipients and their families covered under this MOA of their benefits.
16. Comply with Federal and State rules and regulations.
17. Pay 100 percent of the State share for the services.
18. Reimburse DHS any amount disallowed by CMS.

B. Med-QUEST Division of DHS.
1. Pay DOH/FHSD according to the appropriate reimbursement rates.
2. Review the monthly rate on an annual basis.
3. Review the operations and policies of early intervention services.
4. Monitor DOH/FHSD to ensure its written QAP is implemented.
5. Ensure clients meet eligibility and enrollment criteria for Medicaid.
6. Ensure that enrollments and disenrollments are done accurately and in an efficient and timely manner.
7. Provide the DOH/FHSD staff with access to a mutually agreed-upon telephone or electronic system to ensure continuing eligibility of each client on a monthly basis.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service A2, A5, A6, B5, B6, B7.

12. Reciprocal Referrals:
A. The DOH will make training available on an annual basis to all PCPs on the screening tools available for identifying infants and toddlers with developmental delays.
B. The DHS will inform all PCPs of the existence of this agreement and encourage them to take advantage of the training.
C. As a result of the developmental screening, or other obvious need for services, any PCP or QUEST plan can refer an infant or toddler to H-KISS for the assignment of an interim care coordinator and the initiation of services.
D. The care coordinator will identify the PCP for each QUEST-eligible infant or toddler. If the PCP did not refer the infant or toddler, the care coordinator will inform the PCP of the services being received by the child.
E. The care coordinator will invite the PCP to participate in the IFSP meetings and will provide each PCP with a copy of the child's IFSP.

13. Coordinating Plans: N/A

14. Reimbursement:
The DOH shall submit a monthly invoice to DHS for Early Intervention Services provided to Medicaid infants and toddlers receiving services.
A. The DHS shall pay the DOH for the Federal share at the Hawaii Federal Medical Assistance Percentage (FMAP) in place for the month for which reimbursement is made. The DOH 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. DOH/FHSD shall reimburse DHS 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 MQD will provide DOH/FHSD with notice and such other due process protections as the State may provide. DOH/FHSD and DHS will collaborate to develop a Correction Action Plan that will include clearly stated objectives and time frames for completion.

15. Reporting Data: See Section 8, Service A10, A11, A12, A13.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
termination of agreement
amendment/modification of agreement

State: Idaho (Region 10)

Document:
Cooperative Agreement Between [the] Division of Health and Division of Welfare, Idaho Department of Health and Welfare
Author: Idaho Department of Health and Welfare
Date: 1993 **Pages:** 7 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/id_1_1.pdf*

Contractual Details:

1. **Effective Date:** January 6, 1994.
2. **Duration:** N/A [remains in effect as of 07/29/04].
3. **Type of Agreement:** Cooperative Agreement.

4. Agencies Involved:
(1) Idaho Department of Health and Welfare, Division of Health, Bureau of Maternal and Child Health (BMCH) [Title V].
(2) Idaho Department of Health and Welfare, Division of Welfare, Bureau of Medicaid Policy and Reimbursement (BMPR) [Title XIX].
5. Authority Cited: The Social Security Act (no title specified).

Summary Related to CMS Requirements:

6. Objectives:
A. To establish a cooperative and coordinative relationship between the Divisions and Bureaus in carrying out their mutual responsibilities in facilitating the provision of medical services to Idaho citizens.
B. To meet the requirements of the Social Security Act.

7. Responsibilities:
A. BMPR is often in the position of developing and implementing health policy which requires the knowledge and expertise of a variety of health professionals. It has a health professional staff who have special knowledge and expertise in rules and regulations concerning Medicaid programs and can provide consultation to the Bureau of MCH concerning Medicaid reimbursement for Title V and Title X MCH services.
B. The Division of Health has professionals on staff with knowledge and expertise in the area of MCH, health policy, etc. It can provide valuable consultation in drafting, developing, implementing, and monitoring certain aspects of some programs supported by the Bureau of Medicaid Policy and Reimbursement.

8. Services Provided by Agency:
A. Mutual Responsibilities.
1. Promote health services for all families in need of services.
2. Enhance and monitor perinatal care statewide.
3. Provide financial support/reimbursement to local health agencies, volunteer health agencies, and other groups and individuals engaged in the delivery of health services to mothers and children.

B. Division of Health, BMCH.
1. Needs assessment: collect and analyze health data. Identify needs.
2. Program planning: Serve as a focal point for statewide planning of health education, disease prevention, diagnosis, treatment, and rehabilitative services for mothers and children (including provide technical assistance in developing referral forms).
3. Program services implementation: monitor implementation of the statewide perinatal care improvement plan.
4. Program quality assurance: provide input into the development of standards and guidelines and provide training to MCH health care providers.
5. Program evaluation: plan, collect, analyze, interpret, and report data demonstrating the effectiveness of MCH services and the impact on the health status of mothers and children.

6. Assist Medicaid in provider relations with physicians and other health care providers.
7. Conduct outreach with potential clients.
8. Promote "one stop shopping" program services.
9. Use Medicaid funding to contract for development, implementation, and direction of an EPSDT Provider Training Program for registered nurses.

C. BMPR.
1. Medicaid utilization control and review: collect and analyze expenditure data for Medicaid-covered services; develop, implement, and monitor Medicaid provider and contract agreements; and investigate inappropriate billing/utilization of Medicaid reimbursement.
2. Coordinate with other bureaus within the Division of Welfare to facilitate referrals to WIC and other MCH Programs.
3. New or revised service coverage or program changes: develop and promulgate regulations governing new/revised Medicaid-covered services; coordinate with BMCH regarding changes; inform BMCH and providers of changes; and inform Regional Welfare program Managers of changes.
4. Financial arrangements: activities requested and performed are outlined in Appendix A.

9. Cooperative Relationships:
BMPR and BMCH will jointly participate in implementation of collaborative services, such as an outreach campaign and a toll-free information line and referral service.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
A client whose eligibility has been established in the Medicaid program is ensured income eligibility for the WIC program. See Section 8, Service B7 and Section 13 for outreach.

12. Reciprocal Referrals:
Intake staff for each program shall inform clients about the availability of the other program's services. Also see Section 8, Service B2 and C2 and Section 13.

13. Coordinating Plans: See Section 8, Service B9 for coordination of EPSDT.

14. Reimbursement: See Section 8, Service C1, C4, and Appendix A.

15. Reporting Data:
Each bureau will maintain records required and provide summary reports and program procedural manuals to the other agency. Also see Section 8, Service C1.

16. Review: N/A

17. Liaison:
Meetings between program managers and bureau chiefs will take place at least semiannually to review progress toward meeting mutual objectives. Central office bureau chiefs of the respective

programs shall promote liaison between the regional directors and the district health department directors.

18. Evaluation:
Evaluation of policies that affect the agreement shall be accomplished during special meetings. Also see Section 8, Service B5.

19. General Contract Provisions: N/A

State: Illinois (Region 5), document 1 of 2

Document:
Agreement Between Illinois Department of Public Aid and Illinois Department of Human Services - Office of Family Health Regarding the Maternal and Child Health Program
Author: Illinois Department of Public Aid
Date: 2000 **Pages:** 10 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/IL_1_2.pdf*

Contractual Details:

1. Effective Date: May 14, 2000.
2. Duration:
Either party may terminate at midnight on June 30 of any year with 360 days written notice to the other.
3. Type of Agreement: Interagency Agreement.
4. Agencies Involved:
A. Illinois Department of Public Aid (DPA) [Title XIX].
B. Illinois Department of Human Services - Office of Family Health (DHS-OFH) [Title V].
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives:
A. To delineate respective roles, responsibilities, and financial obligations associated with the administration of the Medical Programs.
B. To provide mutually agreed upon support functions to the Medical Programs.
C. To maintain clear communication between the agencies in the interest of the mutual clients.
D. To relate specifically to (a) the outreach and case management services of the MCH population and (b) the facilitation of the claim for Federal matching funds for the efficient and effective administration of the State Plan.

7. Responsibilities: N/A

8. Services Provided by Agency:

A. Mutual Services.

1. Develop interagency procedures to facilitate the necessary implementation of the Program Agreement and to include the procedures in their respective policy manuals.
2. Designate a liaison person from the central administrative offices for regular interagency communications.

B. DHS-OFH.

1. Request and obtain the necessary appropriation for outreach and case management activities.
2. Submit to DPA quarterly estimates of the claims to be submitted in the next quarter.
3. Ensure that the MCH program adheres to requirement for participation.
4. Direct the use and distribution of the funds appropriated to it.
5. Be responsible for the certification that the claims for FFP submitted are for expenses that have been paid prior to submittal as well as that the claims are the actual costs.
6. Provide to DPA all documents and other necessary information to allow DPA to submit the claim for payment.
7. Provide payment to agencies performing outreach activities.
8. Provide payment to agencies performing case management activities.
9. Perform quality assurance activities.
10. Provide DPA with a fiscal year summary report.
11. Provide to each MCO a monthly report.
12. Submit to DPA a draft of the next fiscal year Family Case Management Contract Attachment.

C. DPA.

1. Maintain a hotline to address case management client concerns.
2. Provide to DHS-OFH a data information exchange.
3. Provide to the local health departments data relative to children enrolled in the Medical Programs within their jurisdiction to increase EPSDT participation, including immunizations and lead screening.
4. Inform DHS-OFH of pending termination proceedings against certified providers.
5. Draw the eligible amounts of Federal monies for the applicable services.
6. Monitor the operation of services reimbursed.
7. Maintain responsibility for the coordination and implementation of State and Federal audit requirements relative to the Medical Programs.
8. Furnish DHS-OFJ data, reports, and information as may be required to ensure satisfying State and federal fiscal responsibility requirements.
9. Furnish DHS-OFH appropriate claims and eligibility information.
10. Provide DHS-OFH electronic access to client identifying information.

9. Cooperative Relationships: See Section 8, Service A1.

10. Services Provided by Local Agencies: See Section 8, Service C3.

11. Identification and Outreach:

The covered services for this Agreement are (a) outreach to persons who are potentially

eligible for services under the Medical Programs and (b) case management to identified MCH populations and chronically ill adults who are eligible for services under the Medical Programs.

12. Reciprocal Referrals: N/A

13. Coordinating Plans: See Section 8, Service A1.

14. Reimbursement: See Section 8, Service B2, B4, B5, B6, B7, B8, C5.

15. Reporting Data: See Section 8, Service B10, B11, B12, C2, C3, C4, C8, C9, C10.

16. Review:
This Program Agreement shall be periodically reviewed as follows:
A. Annual Basis: At least once a year the entire Program Agreement shall be reviewed. Such review shall be for the purpose of continuing the Program Agreement, maintenance of the Medical Programs Guide, and/or including clarifications as may be necessary.
B. Periodic Review: At the request of either agency, a formal review may be scheduled to modify, amend, or terminate this Program Agreement, and/or modify or amend the Programs Guide.

17. Liaison: See Section 8, Service A2.

18. Evaluation:
Any changes to this Program Agreement shall be subject to interagency discussion and concurrence in writing, thereafter to be reduced to writing and incorporating this document by reference.

19. General Contract Provisions:
audit
amendment/modification of agreement
termination of agreement

State: Illinois (Region 5), document 2 of 2

Document:
Intergovernmental Agreement between the Illinois Department of Public Aid and the Board of Trustees of the University of Illinois Regarding the Division of Specialized Care for Children
Author: Illinois Department of Public Aid
Date: 2004 **Pages:** 9 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/IL_2_2.pdf*

Contractual Details:

1. **Effective Date:** July 1, 2004.
2. **Duration:** July 1, 2004 - June 30, 2005.
3. **Type of Agreement:** Intergovernmental Agreement.
4. **Agencies Involved:**

A. Illinois Department of Public Aid (DPA) [Title XIX].
B. Board of Trustees of the University of Illinois on behalf of the University of Illinois at Chicago (UIC) Office of the Vice Chancellor Health Affairs, Division of Specialized Care for Children (OVCHA/DSCC) [Title V].

5. **Authority Cited:**

Article 7, Section 10(a) of the Constitution of the State of Illinois and the Illinois Intergovernmental Cooperation Act (5 ILCS 220/1 et seq.).

Summary Related to CMS Requirements:

6. **Objectives:**

To provide for effective and efficient administration of the respective programs by coordinating certain duties.

7. **Responsibilities:**

A. DPA is responsible for administering the Medical assistance (Medicaid) program.
B. OVCHA/DSCC is responsible for administering the CSHCN program.

8. **Services Provided by Agency:**

A. Mutual Services.
1. Assign responsibilities to staff related to the operation and evaluation of this Agreement.
2. Coordinate internal and intergovernmental procedures to facilitate implementation of this Agreement.
3. Ensure confidentiality.

B. OVCHA/DSCC.
1. Accept referrals for development an application for waiver services.
2. Provide an appropriate professional case administrator for every referral accepted.
3. Gather all reports and information to prepare a comprehensive individual waiver application.
4. Develop an individual service plan as agreed to by the child's community physician.

5. Submit to DPA the completed application and Medical Plan of Care (MCP).
6. Clarify any components of the application questioned by DPA.
7. Implement and case administer the prescribed individual service plan.
8. Notify DPA of any change in the status of the child.
9. Follow all State and Federal rules.
10. Advise DPA prior to implementing any change in policy.
11. Notify DPA and all waiver participants 6 months in advance if it intends to discontinue participation.
12. Forward all necessary documentation to process payments to all nursing agencies providing services to participants in the waiver.
13. Provide to DPA all information to allow DPA to claim FFP for those services.
14. Update each MPC and submit revised information, etc.

C. DPA.
1. Provide consultation and TA to OVCHA/DSCC.
2. Process all applications for the waiver.
3. Notify OVCHA/DSCC and the child's guardians of its decision.
4. Withdraw approval when notified by OVCHA/DSCC that case administration has been withdrawn.
5. Provide access to fair hearings for any waiver participant wishing to contest.
6. Provide to OVCHA/DSCC all necessary information to provide program and case administrative services for the waiver.
7. Provide OVCHA/DSCC with necessary computer access.
8. Assist OVCHA/DSCC in preparing the cost allocation plan.
9. Submit expenditures for FFP and deposit the resulting federal reimbursement into the General Revenue Fund. Determine the amount to be credited to OVCHA/DSCC. Directly reimburse DSCC the appropriate costs.
10. Submit all necessary documentation in order that claims submitted will be paid, etc.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service B3.

12. Reciprocal Referrals: See Section 8, Service B2.

13. Coordinating Plans: N/A

14. Reimbursement:
A. OVCHA/DSCC shall submit to the Comptroller of the State claims for nursing care provided to children in the waiver program.
B. DPA shall designate OVCHA/DSCC as its fiscal agent for said purpose and grants OVCHA/DSCC's designees the authority to pay claims for nursing services.
C. OVCHA/DSCC shall provide DPA records of all payments made.
D. OVCHA/DSCC shall monitor signature authority, etc.

15. Reporting Data: See Section 8, Service B12, B13.

16. Review:
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.

17. Liaison: N/A

18. Evaluation: See Section 16.

19. General Contract Provisions:
amendment/modification of agreement
failure to satisfy SOW
maintenance of records/recordkeeping
termination of agreement

State: Indiana (Region 5)

Document:
Memorandum of Understanding between Indiana State Department of Health and Indiana Office of Medicaid Policy and Planning for Data Sharing
Author: Indiana State Department of Health
Date: 2003 **Pages:** 28 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/in_1_1.pdf*

Contractual Details:

1. Effective Date: August 15, 2003.
2. Duration:
Shall remain in effect until terminated or modified. Either party may terminate this Agreement through written notice to the other, at least 30 days prior to the effective date of such termination.
3. Type of Agreement: Memorandum of Understanding.
4. Agencies Involved:
A. Indiana State Department of Health (ISDH) [Title V].
B. Indiana Office of Medicaid Policy and Planning for Data Sharing (OMPP) [Title XIX].
5. Authority Cited:
42 CRF 431.615 and with current federal policy regarding Title XIX and Title XXI coordination and IAAs.

Summary Related to CMS Requirements:

6. Objectives:
A. To promote high quality heath care and services for program members.

B. To comply with applicable State and Federal statutes, regulations, and guidelines, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
C. To specify the reimbursement and financial arrangements applicable in carrying out agreed upon administrative activities.
D. To assist local communities in developing cooperative relationships among local agencies and local providers.
E. To minimize service delivery duplication and fragmentation.
F. To promote timely sharing of programmatic data to support the business needs of the agencies and to support the evolving role of the State government in assuring appropriate, accessible, cost-effective care for vulnerable populations.
G. To improve the health status of Indiana residents by ensuring early intervention and the provision of preventative services, health examinations, and necessary treatment and follow-through care.

7. Responsibilities: N/A

8. Services Provided by Agency:
I. Coordination.

A. Mutual Services.
1. Work collaboratively to improve the health of Indiana residents.
2. Work collaboratively to improve the availability and quality of comprehensive health care and nutritional services.
3. Ensure that Title V, Title XIX, Title XXI, and WIC services are consistent with the needs of the participants and the programs' objectives and requirements.
4. Coordinate program initiatives to avoid duplication of efforts among agency programs.
5. Assign staff for coordination and planning activities and maintain representation on committees to ensure coordination of collection of data.
6. Work collaboratively in the development of mutually acceptable member and population objectives and outcome measures to be tracked on a routine basis.
7. Share and review results of any study or analysis based on shared participant data in accordance with HIPAA regulations.
8. Consult regarding the integration of public health services into the managed care programs and disease management programs for members covered by OMPP programs.
9. Collaborate to maximize State resources in maintaining compliance to HIPAA.
10. Coordinate administrative reimbursement for blood-lead testing and related supplies for Medicaid enrollees.

B. ISDH.
1. Develop and monitor ISDH services, policies, and quality of care assessment activities that include establishing professionally recognized protocols and standards of care, personnel standards, and tracking systems for programs receiving reimbursement from OMPP.
2. Review and provide comment to proposed managed care contract elements, disease management programs, vendor selection, and negotiations, and participate in ongoing monitoring of compliance upon request by OMPP.

3. Inform local MCH, WIC, and CSHCS offices and local health departments of the Agreement and of the responsibilities of the local program staff affected by this Agreement.

C. OMPP.
1. Furnish the ISDH with updated listings of enrolled IHCP providers.
2. Consult, as needed, with the ISDH to receive input on public health care issues relevant to managed care program and disease management services.
3. Inform the county DFC office of the establishment of this Agreement and of the responsibilities of the county department personnel as affected by this Agreement.
4. Inform the contracted providers of the establishment of this Agreement of the responsibilities of the providers as affected by this agreement.

II. Confidentiality.

A. Mutual Services.
1. Comply with all applicable State and Federal laws, regulations, and rules regarding confidentiality of participant information, ensuring that information is disclosed only for purposed of activities necessary for administration of the respective program(s) and for audit and examination authorized by law.
2. Establish administrative, technical, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized use or access to it.

III. Data Sharing.

A. Mutual Services.
1. Work together to improve the State's capacity to integrate data, link data files, and to utilize program data to improve program administration and outcomes.
2. Work collaboratively in the development of 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.
3. Collaborate among programs to guide the permissible sharing and dissemination of data for program administration, policy development, and to carry out the responsibilities listed in this Agreement.
4. Implement processes to ensure data sharing requests are in compliance with HIPAA and applicable State and Federal statutes, regulations, and guidelines.
5. Assign specific program designees to accept and coordinate all data request from each respective agency in accordance with individual program procedures and protocols.
6. Provide specific agreed upon program data necessary for program monitoring and evaluation.

B. ISDH.
1. Work collaboratively by providing, in compliance with HIPAA regulations, the necessary client data files and vital records data to facilitate client care administration and to permit matching of population-based and other programmatic data files for evaluation purposes.
2. Cross-match computerized participant files to generate lists of newly enrolled members who are not participating in all potential services to increase service coordination efforts.

3. Provide data through standard reports about population-based health care assessments.
4. Collaborate with IHCP to determine joint outcome indicators and objectives to be evaluated regularly.

C. OMPP.
1. Work collaboratively by providing, in compliance with HIPAA regulations, the necessary client data files and vital records data to facilitate client care administration and to permit matching of population-based and other programmatic data files for evaluation purposes.
2. Provide specified demographic data summaries regarding populations served by Title V programs needed to fulfill Title V Federal reporting requirements and to track MCH-related Healthy People 2010 Objectives.
3. Make available each month to the WIC-contracted computer firm the names of newly certified IHCP beneficiaries to be used for eligibility determination.

I*V. Reimbursement.*

A. Mutual Services.
1. Establish a mutually agreeable methodology and protocols for receiving Federal financial participation for approved costs incurred by the ISDH in sharing data.
2. Maintain and/or provide documentation of financial data and monitoring of records required to support program reimbursement.
3. Implement procedures to track, collect, or disseminate payments.
4. Provide assistance and information to resolve issues relating to billing and reimbursement for the cost of sharing data.

B. ISDH.
1. Provide required financial and statistical data to document costs of data sharing activities.
2. Maintain and furnish upon request appropriate records and data as necessary or required by OMPP to document requested reimbursement for data sharing activities to ensure that OMPP will be able to collect Federal match dollars.
3. Conduct internal auditing to ensure accurate submission of claims for data sharing activities.
4. Contribute the State match for Federal reimbursements for ISDH-operated programs claimed under this Agreement for administrative activities.

C. OMPP.
1. Provide timely reimbursement for costs of agreed upon data sharing activities allowable under Federal regulations.

9. Cooperative Relationships:
Coordination is woven through Section 8 by listing activities for collaboration between agencies under each main task.

10. Services Provided by Local Agencies: See Section 8, Service IB3, IC3.

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. Coordinating Plans:
Coordination is woven through Section 8 by listing activities for collaboration between agencies under each main task.

14. Reimbursement: See Section 8, Service IV.

15. Reporting Data: See Section 8, Service III.

16. Review: See Section 17.

17. Liaison:
The State Health Commissioner and the Director of the OMPP shall designate contact persons for purposes of regular communication or inquiries between the agencies regarding each agency's responsibilities under this Agreement.

The liaison persons shall oversee the investigation of any problem that arises from the operation of this Agreement. They shall mutually conduct an annual review of the effectiveness and shall initiate jointly any amendments to the Agreement.

18. Evaluation: See Section 17.

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
confidentiality of records/HIPAA
dispute resolution mechanism

State: Iowa (Region 7), document 1 of 4

Document:
Cooperative Agreement Between the Iowa Department of Human Services and the University of Iowa On Behalf of Child Health Specialty Clinics
Author: Iowa Department of Human Services
Date: 2004 **Pages:** 14 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/IA_1_4.pdf*

Contractual Details:

1. **Effective Date:** July 1, 2004.
2. **Duration:** July 1, 2004 - June 30, 2005.
3. **Type of Agreement:** Cooperative Agreement.

4. Agencies Involved:
A. The State of Iowa Department of Human Services (DHS) [Title XIX].
B. Child Health Specialty Clinics (CHSC) [Title V].
5. Authority Cited:
A. DHS: Iowa Code Chapter 217, 249A.4.
B. CHSC: Iowa Administrative Code, Chapter 76, Section 641 (76.1 - 76.17).
C. 42 U.S.C., Section 1396d(r).

Summary Related to CMS Requirements:

6. Objectives:
To define the responsibilities of the parties in assessment, planning, and care coordination activities related to the recipients of EPSDT and the HCBS-IH programs of the Iowa T19 program.

7. Responsibilities:
CHSC is responsible for providing services in accordance with defined performance expectations and employing staff that can provide DHS with technical assistance and consultation regarding children, under the age of 21, with complex special health care needs.

8. Services Provided by Agency:
Each service below contains multiple sub-tasks in the original Agreement, which have been omitted for clarity. See Agreement for full-text.

A. CHSC.
1. Provide needed services to recipients of the Title XIX programs who are children with complex special health care needs.
2. Assist DHS as needed or requested, for administration and quality assurance purposes.
3. Provide DHS with reports on MCH performance measures.
4. Assist in eligibility determination and service provision.

9. Cooperative Relationships:
CHSC shall work in collaboration with agencies that participate in the HCBS-IH Waiver program or who serve as EPSDT providers.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
CHSC shall explain to interested families the HCBS-IH Waiver program and /or the EPSDT program and/or other DHS programs.

12. Reciprocal Referrals:
CHSC shall provide resource and referral information, i.e., refer the child and family to appropriate services.

13. Coordinating Plans:
CHSC shall consult with DHS staff to determine if the HCBS-IH Waiver and EPSDT provider qualifications and conditions of the program, including services, are being met.

14. Reimbursement:
CHSC will be paid for services provided a fee not to exceed $853,1044 for the Agreement period of 07/01/04 - 06/30/05. The agreement will allow reimbursement of travel expenses. Expenses for meetings, including meals, will be reimbursed at cost.

15. Reporting Data:
CHSC shall submit detailed invoices on a quarterly basis for services rendered. The supporting documentation will be available for audit purposes. The invoices shall be reviewed by the Department for accuracy and adequacy of documentation.

16. Review: N/A

17. Liaison:
CHSC shall serve on the EPSDT/Care for Kids Advisory and the HCBS-IH Waiver Advisory Committees of DHS and related committees.

18. Evaluation: N/A

19. General Contract Provisions:
default
lack of funds
nondiscrimination
tobacco
termination of agreement
failure to satisfy SOW
confidentiality of records/HIPAA
maintenance of records/recordkeeping

State: Iowa (Region 7), document 2 of 4

Document:
Iowa Department of Human Services and Iowa Department of Public Health Cooperative Agreement
Author: Iowa Department of Human Services
Date: 2004 **Pages:** 11 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/IA_2_4.pdf*

Contractual Details:

1. Effective Date: July 1, 2004.
2. Duration: July 1, 2004 - June 30, 2005.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. The State of Iowa Department of Human Services (the "Department" or DHS) [Title XIX].
B. The State of Iowa Department of Public Health (IDPH) [Title V].
5. Authority Cited:
A. DHS: 42 CFR 431.615; CFR 441.61.
B. IDPH: SSA 1902(a)(11); 1902(1)(1)(A) or (B).

Summary Related to CMS Requirements:

6. Objectives:
A. To ensure the availability of comprehensive, cost-effective, and quality medical care for the mutual beneficiaries.
B. To ensure the following:
1. A mutually agreed-upon goal and set of objectives.
2. A definition of the scope of services provided by State and local agencies and the criteria each party utilizes in determining eligibility for benefits.
3. The development of a cooperative and collaborative relationship at the State level.
4. A delineation of the mutual and individual responsibilities of the parties to eligible beneficiaries.

7. Responsibilities:
A. Title XIX is responsible for the following services: physician; dentist; dental hygienist; prescription drugs; chiropractors; rural health clinics; federally qualified health centers; optometrists/opticians; ambulance; medical transportation; ambulatory surgical centers; podiatrists; orthopedic shoes; occupational therapy and speech therapy; physical therapy; hearing aids; home health agencies; medical equipment; family planning clinics; maternal health centers; psychologists; community mental health centers; independent laboratories; EPSDT; birth centers; nurse midwives; family and pediatric nurse practitioners; area education agencies; infant and toddler program; local education agencies; rehabilitation services for people with chronic mental illness; rehabilitative treatment services; lead investigation services; hospitals; nursing facilities; home and community based services.

B. Title V is responsible for the following services: child health services; hawk-i outreach program; maternal health services; Iowa Barriers to Prenatal Care project ; family planning services; dental health genetic services; WIC services; public health nursing and home care aides.

8. Services Provided by Agency:

A. Objective I: To increase the utilization of Title XIX, Title X, WIC, Title V, and Title XXI programs by mutual efforts of both state agencies.

1. DHS Shall:

a. Inform DHS applicants who are women ages 15 - 44 and children ages 0 - 21 of Title V programs in their community.

b. Notify individuals in the State who are determined t be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women or children below the age of 5 of the availability of WIC services.

c. Furnish local Title V programs with DHS application forms and brochures explaining application, eligibility, and services.

d. Furnish financial support for transportation of Title XIX clients to local family and child health services.

e. Administer the Title XXI program.

2. IDPH shall:

a. Refer all patients potentially in need of social services to local DHS offices for assistance and require Title V funded maternal health centers to participate in presumptive eligibility.

b. Provide potentially eligible patients with DHS application and brochures.

c. Furnish local DHS offices with brochures and other information explaining eligibility for Title V and WIC services locally available.

d. Furnish written information that the Medicaid program can send to recipients concerning the availability of family and child health services.

B. Objective II: To maximize resources and expertise of IDPH and DHS in order to increase the quality and continuity of care of eligible clients.

1. DHS shall:

a. Furnish IDPH with Title XIX provider manuals as requested.

b. Issue Title XIX vendor numbers to maternal health centers, child health centers, and lead investigation agencies that meet family and child health standards.

c. Provide training and TA to family and child health staff on federal laws and regulations governing Medicaid coverage and eligibility.

d. Coordinate and collaborate with family and child health and other state level entities involved in providing services to mothers and children around planning, financing, implementing, and evaluating of Medicaid services utilized by this population group.

2. IDPH shall:

a. Request Title XIX provider manuals as needed.

b. Develop standards and implement an accreditation process for maternal health centers, child health centers, and lead investigation agencies to ensure consistency and quality care throughout Iowa.

c. Provide training and TA to DHS staff on federal laws and regulations governing IDPH

programs.
d. Coordinate and collaborate with DHS and other state level entities involved in providing services to mothers and children around the planning, financing, implementing, and evaluating health services utilized by this population group.

9. Cooperative Relationships:
Policy decisions necessary for the implementation of this Agreement shall be developed through a communicative relationship between the parties to this Agreement. The appropriate division directors must approve in writing all mutually agreed-upon decisions.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
The parties to this agreement ensure that their staff or agencies they contract with for direct services will inform and refer Medicaid eligible persons under 21 for screening, diagnostic, and treatment services.

12. Reciprocal Referrals:
Each party will specify the referral mechanisms utilized to refer to each of the parties respective programs.

13. Coordinating Plans:
Ongoing communication between state level staff responsible for planning, financing, implementing, and evaluating health care services will occur so that a coordinated system can be ensured.

14. Reimbursement:
Each of the parties to this agreement shall continue to cooperated 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.

15. Reporting Data:
IDPH shall maintain records (both billing and service) which sufficiently and properly document all charges billed to the Department.

16. Review:
See Section 18.

17. Liaison:
Specific mechanism not addressed, although collaboration and coordination are woven throughout Section 8.

18. Evaluation:
This Agreement may be amended in writing from time to time by mutual consent of the parties. All amendments to this Agreement must be fully executed by both parties.

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
tobacco
nondiscrimination
confidentiality of records/HIPAA
maintenance of records/recordkeeping
lobbying

State: Iowa (Region 7), document 3 of 4

Document:
Iowa Department of Human Services and Iowa Department of Public Health EPSDT Program
Author: Iowa Department of Human Services
Date: 2004 **Pages:** 7 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/IA_3_4.pdf*

Contractual Details:

1. Effective Date: July 1, 2004.
2. Duration: July 1, 2004 - June 30, 2005.
3. Type of Agreement: Agreement.
4. Agencies Involved:
A. The State of Iowa Department of Human Services (DHS) [Title XIX].
B. The State of Iowa Department of Public Health (IDPH) [Title V].
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives:
To retain IDPH to coordinate administration of the EPSDT program in order to:
A. Develop and maintain local capability for conducting screening examinations required under the EPSDT program.
B. Increase program efficiency and effectiveness by ensuring that needed services are provided timely and efficiently.
C. Develop and maintain local capacity for MCH Services and to provide Medicaid information and care coordination to EPSDT clients.
D. Develop a cooperative and collaborative relationship at all levels to prevent duplication of services.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. IDPH.
1. Determine if local agencies requesting to be screening centers meet the recommended standards of medical practice established by the program, etc.
2. Provide consultation and TA in communities in assessing local needs for EPSDT services.
3. Implement the EPSDT program through contracts established with Title V agencies.
4. Provide consultation and TA to schools and Area Education Agencies in investigating participation in EPSDT activities.
5. Provide continued TA to MCH Centers conducting cost analyses to determine the cost of providing services in order to promote more cost efficient services.
6. Provide consultation and TA to communities in assessing local needs for Administrative Medicaid Claiming.
7. Coordinate meetings with DHS for Prevention for Disability Policy Council and other health care providers to facilitate coordinated efforts.
8. Provide TA for targeted issues such as immunization, lead screening, developmental screening, and newborn hearing screening.
9. Assist the editor of the EPSDT Care for Kids newsletter.
10. Participate in planning and implementing the Medicaid Enterprise Activities.
11. Provide an annual report which identifies the activities provided in the previous year.

B. DHS.
1. Reimburse EPSDT screening centers for the full cost of providing screening, outreach, and care coordination.
2. Provide to IDPH a daily list of Medicaid clients who are eligible for EPSDT outreach and care coordination services.
3. Maintain a vendor number for IDPH and provide a vendor number to screening centers.
4. Submit this Agreement to CMS.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: See Section 8, Service A1.

11. Identification and Outreach: See Section 8, Service A2, A4, A5, A6.

12. Reciprocal Referrals: N/A

13. Coordinating Plans: N/A

14. Reimbursement:
IDPH will be paid for the services described in Section 8 a fee not to exceed $310,175 for the Agreement period. Claims shall be submitted quarterly.

15. Reporting Data: See Section 8, Service A11, B2.

16. Review: N/A

17. Liaison: See Section 8, Service A10.

18. Evaluation: N/A

19. General Contract Provisions:
lack of funds
tobacco
lobbying
termination of agreement
failure to satisfy SOW
confidentiality of records/HIPAA

State: Iowa (Region 7), document 4 of 4

Document:
Iowa Department of Human Services and Iowa Department of Public Health Outreach
Author: Iowa Department of Human Services
Date: 2004 **Pages:** 5 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/IA_4_4.pdf*

Contractual Details:

1. Effective Date: July 1, 2004.
2. Duration: July 1, 2004 - June 30, 2005.
3. Type of Agreement: Agreement.
4. Agencies Involved:
A. The State of Iowa Department of Human Services (DHS) [Title XIX].
B. The State of Iowa Department of Public Health (IDPH) [Title V].
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives:
To provide outreach services to women and children who are or may be Medicaid eligible.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. IDPH.
1. Maintain 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.
2. Assess the adequacy of the medical care and other services the woman or child utilizing the line is receiving and distribute health information concerning medical services that would meet the woman's or child's individualized needs.
3. Conduct a minimum of 4 health education activities that link the target population with available health services. Health education activities will be mutually agreed upon by the Title V director and the EPSDT program specialist.
4. Submit an annual report combined with the EPSDT program report which identifies the activities provided in the previous year. This report will contain information on the outreach activities that occurred, the number of toll-free calls received, and other activities provided.

B. DHS.
1. Claim a Federal match for the funds expended and remit this match to IDPH.
2. Submit this agreement to CMS. Expenditures for outreach activities will be eligible for a 50 percent Federal match through the Medicaid program if approved by CMS.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
The focus of this document is outreach; thus, outreach activities comprise the bulk of Section 8.

12. Reciprocal Referrals: See Section 8, Service A1.

13. Coordinating Plans: See Section 8, Service A3.

14. Reimbursement:
IDPH will be paid for the services described in Section 8 a fee not to exceed $124,066 for the Agreement period. IDPH shall submit detailed invoices on a quarterly basis for services rendered.

15. Reporting Data: See Section 8, Service A4.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
lack of funds
tobacco
lobbying
amendment/modification of agreement

termination of agreement
failure to satisfy SOW
confidentiality of records/HIPAA

State: Kansas (Region 7)

Document:
Cooperative Agreement between the Kansas Department of Health and Environment and the Kansas Department of Social and Rehabilitation Services
Author: Graeber, CD and Schalansky, J
Date: 2002 **Pages:** 41 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/ks_1_1.pdf*

Contractual Details:

1. Effective Date: Upon signature by the Secretaries of both agencies (04/03/2002).
2. Duration: April 3, 2002 - June 30, 2007.
3. Type of Agreement: Interagency Agreement.
4. Agencies Involved:
A. Kansas Department of Health and Environment (KDHE).
B. Kansas Department of Social and Rehabilitation Services (SRS).
5. Authority Cited:
A. Legislative.
1. Section 1902(a)(11)(A), (B); 1905(a)(4)(B) of the SSA.
B. Regulatory.
1. 42 CFR 431.615; 34 CFR 303.321, 522, and 527; 7 CFR 246.4(a)8, (b)1.
2. The Food, Agriculture, Conservation and Trade Act of 1990 (Farm Bill).

Summary Related to CMS Requirements:

6. Objectives:
A. To provide an integrated system of high quality, comprehensive health services to citizens of Kansas, many of whom are underserved.
B. To ensure a mutually agreed upon goal and set of objectives that delineates both the mutual and individual responsibilities of the parties in the provision of services.
C. To ensure a definition of the scope of services provided either on-site or by referral.
D. To ensure the development of a cooperative relationship at the state level.
E. To ensure a joint plan to establish a fiscal protocol that will maximize utilization of funds in providing services to consumers.

The potential benefits from cooperation between KDHE and SRS include the following:
1. Promotion of continuity of care.
2. Sharing of medical, social, and technical expertise through staff consultations.
3. Reduction of duplication of effort.

4. Efficient allocation of resources based on need.
5. Utilization of Title V overmatch to provide Title XIX services.
6. Achievement of greater accountability in regard to outcome.

7. Responsibilities:
KDHE and SRS have authority and responsibility for the administration of health programs including Title V and Title XIX as well as programs such as Food Stamp, Farmworker, Refugee, family planning, WIC, Kansas Infant-Toddler services, and immunization.

8. Services Provided by Agency:
KDHE and SRS agree to very detailed services under each of the following areas:

A. General MCH Services.
1. Health Care Services.
2. Program Information and Service.
3. Collaboration, Consultation, and Continuing Education.
4. Fees and Reimbursement.

B. The Kan-Be-Healthy (EPSDT) Program.
1. General Services.
2. Expanded Nutrition Services for High Risk Consumers.

C. Services for CSHCN.
1. General Services.
2. Medicaid Managed Care Services.
3. Supplemental Security Income (SSI) Services.
4. Rehabilitation Services.

D. Prenatal Health Promotion/Risk Reduction.
1. General Services.
2. Expanded Nutrition Services for High Risk Pregnant Women.

E. Newborn/Postpartum Home Visit.

F. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

G. Commodity Supplemental Food Program (CSFP).

H. Family Planning.

I. Farmworker Health.

J. Refugee Health.

K. Services for Tuberculosis.

L. Immunizations.

M. Substance Abuse Services.
1. Consultation and Continuing Education.
2. Treatment Services.
3. Fees and Reimbursement.

N. Toll-Free Telephone Number.

O. Teen Pregnancy Case Management Project.

P. HIV/STD Programs ad Services.
1. Program Information and Services.
2. Consultation and Continuing Education.
3. Counseling, Testing, and Treatment Services.
4. Feed and Reimbursements.

Q. Quality Assurance.

R. Kansas Infant-Toddler Services.

S. Breast and Cervical Cancer.

Outcome measures are provided for each of these areas.

9. Cooperative Relationships:
A committee shall be appointed to ensure coordination between the State Title V Assurance Statement and the Title XIX State Plan. Appointment, by the Secretaries, of at least one (1) representative shall constitute the membership of this committee. The committee shall meet at the request of either agency Secretary or designee, or at least annually, to permit the parties to this Agreement to provide input, to resolve any problems/issues which may arise, to review, evaluate, and make recommendations to the Secretaries regarding the conditions outlined in other sections of this Agreement.

10. Services Provided by Local Agencies:
KDHE must encourage local health departments and agencies to provide follow-up and outreach activities for Medicaid consumers. SRS must work with KDHE and local providers to resolve barriers to health care services.

11. Identification and Outreach:
KDHE must promote early identification and referral of individuals to SRS who may be eligible for Medicaid benefits and must provide state and local SRS offices with MCH program brochures for distribution to Medicaid consumers.

12. Reciprocal Referrals:
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 the supplemental nutrition program for WIC, Food Stamps, and Healthy Start will fall into this category.

13. Coordinating Plans:
KDHE and SRS must participate in cooperative program planning and monitoring of MCH services covered by XIX.

14. Reimbursement:
Unless there are other third party resources, SRS 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.

15. Reporting Data:
KDHE will provide SRS with documentation of Title V overmatch and will report documented concerns relating to health services availability an barriers for Medicaid consumers.

16. Review:
See Section 9 for a detailed description of the review and evaluation process.

17. Liaison:
Continuous liaison among the parties to the Agreement shall be the responsibility of the Secretaries or their appointed staff designees.

18. Evaluation:
See Section 9 for a detailed description of the review and evaluation process.

19. General Contract Provisions:
dispute resolution mechanism
confidentiality of records/HIPAA
subcontracts
payment
termination of agreement

State: Kentucky (Region 4)

Document: *The Commonwealth of Kentucky Master Agreement*
Author: Commonwealth of Kentucky Department for Community Based Services
Date: 2003 **Pages:** 19 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/KY_1_1.pdf*

Contractual Details:

1. **Effective Date:** July 1, 2003.
2. **Duration:** July 1, 2003 - June 30, 2004.
3. **Type of Agreement:** Master Agreement.
4. **Agencies Involved:**

A. Department for Community Based Services (DCBS).
B. Department for Medicaid Services (DMS) [Title XIX].
C. Department for Public Health (DPH) [Title V].

5. **Authority Cited:** 1996 Kentucky Acts Chapter 380.

Summary Related to CMS Requirements:

6. Objectives:
To provide Medicaid reimbursement for targeted case management services for Medicaid eligible recipients including children in custody of or under the supervision of, or at risk of being in the custody of the state and, adults who may require protective services from the state, and for rehabilitative services for children in the custody of or under the supervision of, or at risk of being in the custody of, the state, as a component of the Title V MCH Program.

7. Responsibilities:
A. DCBS is responsible for providing protective services, such as targeted case management and rehabilitative services.
B. DMS is responsible for the administration of the Medical Assistance Program in Kentucky.
C. DPH is responsible for administering the Title V Program.

8. Services Provided by Agency:
A. DCBS.
1. Provide targeted case management services which assist an individual in accessing needed medical, social, educational, and other support services.
2. Provide rehabilitative treatment services, including treatment planning and support activities; living skills development activities; and counseling, therapy, consultation, and psychological assessments.
3. Ensure staff and subcontractors providing services meet DCBS standards.
4. Comply with the policy and procedures required in the Medicaid Services Provider Manual.
5. Comply with appropriate provisions of the SSA.
6. Encourage referrals between various programs.
7. Submit bills to all third party payers before billing the Title XIX Agency.

8. Submit services claims.
9. Prevent duplication of case management services.
10. Ensure access to any subcontractor's financial and program records by the Title XIX Agency.
11. Provide targeted case management and rehabilitative services data as requested.
12. Maintain records of all Medicaid targeted case management and rehabilitative services.
13. Provide to the Title XIX Agency required state match for claimed expenditures.
14. Provide to the Title XIX Agency TA with regard to DCBS targeted case management and rehabilitative services programs.
15. Participate in the Title V MCH Program as the provider responsible for the administration of the DCBS targeted case management and rehabilitative services program.
16. Be responsible for the Title XIX audit disallowances.
17. Participate with the Title V and the Title XIX Agencies in the development of policies and procedures.

B. DPH.
1. Include targeted case management services for Medicaid eligible recipients.
2. Ensure to the Title XIX Agency that the provider of services is a Title V service provider.
3. Comply with the policy and procedures as required in the Title XIX Agency Provider Manual.
4. Comply with appropriate provisions of the SSA.
5. Encourage referrals between various programs.
6. Ensure the provision of data for services.
7. Participate with DCBS and the Title XIX Agency in the development of policies and procedures.

C. DMS.
1. Certify and enroll qualified Title V providers.
2. Reimburse for the following services: targeted case management services; rehabilitative treatment services.
3. Reimburse DCBS as rates not to exceed cost for eligible services.
4. Provide payment and claims data to DCBS.
5. Provide other reports to DCBS and/or the Title V Agency.
6. Pay claims in a timely manner.
7. Provide TA to DCBS and the Title V Agency.
8. Participate with DCBS and the Title XIX Agency in the development of policies and procedures.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: See Section 8, Service A6, B5.

13. Coordinating Plans: See Section 8, Service A17, B7, C8.

14. Reimbursement:
A. DCBS shall bill the Title XIX Agency 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.

Specific services regarding reimbursement are also included in Section 8.

15. Reporting Data: See Section 8, Service A12, B6, C5.

16. Review: See Section 17 and 18.

17. Liaison:
All parties shall designate staff responsible for representing their agencies at annual meetings, or more frequently as necessary, for the purpose of reviewing and evaluating the policies that affect the cooperative work of the parties and the need for changes in the agreement.

18. Evaluation:
The agreement will be evaluated and reviewed annually in joint meetings among DCBS, the State Agency for Title V, and the State Agency for Title XIX.

19. General Contract Provisions:
amendment/modification of agreement
indemnification/liability
confidentiality of records/HIPAA
termination of agreement
subcontracts
payment
nondiscrimination

State: Louisiana (Region 6)

Document:
Department of Health and Hospitals Intra-Departmental Agreement between Office of Public Health (Title V) and Bureau of Health Services Financing (Title XIX)
Author: [Louisiana] Department of Health and Hospitals
Date: 1990 **Pages:** 4 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/la_1_1.pdf*

Contractual Details:

1. Effective Date: July 1, 1990.
2. Duration: N/A
3. Type of Agreement: Intra-Departmental Agreement.
4. Agencies Involved:
A. Office of Public Health (OPH or Public Health) [Title V] .
B. Bureau of Health Services Financing (BHSF or Medicaid) [Title XIX].
5. Authority Cited:
A. 42 CFR 431.615.
B. Section 1902(a)11 of the SSA.
C. Section 513(c) of the SSA.

Summary Related to CMS Requirements:

6. Objectives:
A. To improve the health status of children by ensuring the provision of preventive services, health examinations, and the necessary treatment, and follow-through care, preferably in the context of an on-going provider-patient relationship and from comprehensive, continuing care providers.
B. To ensure that the State MCH agency under Title V of the SSA and the State Medicaid Agency have in effect a functional relationship via an IAA which provides for the maximum utilization of the care and services available under the MCH programs, and utilizes the MCH programs to develop a more effective use of Medicaid resources in financing services to Medicaid-eligibles provided by Title V programs.

7. Responsibilities:
A. The Louisiana Department of Health and Hospitals is responsible for administering both the BHSF and the OPH.
B. The BHSF (Medicaid) is responsible for policies, planning, and management of the Medicaid Program.
C. OPH (Public Health) is responsible for program planning, policies, and operational management of the Title V programs and has organizational responsibility for the health units in all parishes of the State except Orleans and Plaquemines parishes.

8. Services Provided by Agency:
In this agreement, objectives and services are combined together under each agency:

A. MCH Objectives/Services.
1. To ensure mothers and children have access to quality MCH services.
2. To reduce infant mortality and the incidence of preventable diseases and handicapping conditions.
3. To reduce the need for inpatient and long-term care services.
4. To increase the number of children appropriately immunized; to promote the health of mothers and children.
5. To provide rehabilitation services under Title XVI.
6. To provide services for identifying, and for medical, surgical, corrective, and other services.
7. To identify Medicaid-eligible children and to refer these children for EPSDT services.
8. To provide EPSDT services.
9. To ensure that EPSDT patients receive the full range of services.
10. To assess quality of care provided by the Office of Public Health.
11. To have a major role in establishing standards, policies, and procedures for health care services.
12. To provide pertinent data for program evaluation.

B. Medicaid Objectives/Services.
1. To provide medical assistance to low-income persons who are age 65 or over, blind, disabled or members of families with dependent children or qualified pregnant women or children.
2. To provide EPSDT services.

9. Cooperative Relationships:
Public Health will establish, jointly with Medicaid, a Medicaid/Title V advisory committee to monitor implementation of this Agreement, to coordinate services offered, and to review and update its provisions as necessary.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. Coordinating Plans: N/A

14. Reimbursement: Public Health will be reimbursed on a fee-for-service basis.

15. Reporting Data:
Method of Exchange of Information.
A. Both parties shall maintain strict confidentiality of patient medical records and other similar records in accordance with the law and established ethical standards.
B. Both parties agree to establish accounting procedures, fiscal reporting, and other records to

ensure proper accountability for fiscal transactions and for documentation of Title V services delivered to Medicaid-eligibles.
C. The books, records, and documentation of Public Health, insofar as they relate to work performed or money received under this Agreement shall be maintained in conformity with generally accepted accounting principals for a period of 3 full years from the date of the final payment, and shall be subject to audit, at any reasonable time and upon reasonable notice by Medicaid or their duly appointed representative.
D. All services delivered by Title V agencies/clients to Medicaid-eligibles shall be documented in the patient's medical record in accordance with current accepted and approved standards and practices.

16. Review:
Method for Periodic Review and Joint Planning for Changes in the Agreement.
A. Public Health will establish, jointly with Medicaid, a Medicaid/Title V advisory committee to monitor implementation of this Agreement, to coordinate services offered, and to review and update its provisions as necessary.
B. The Advisory Committee will meet at least every 6 months when either party requests that a formal meeting be conducted.
C. The Advisory Committee, at a minimum, will be comprised of: (1) MCH Director; (2) MCH Medical Director; (3) WIC Director; and (4) Medicaid representative.

17. Liaison: See Section 16.

18. Evaluation:
Joint Evaluation of Policies.
It will be the function of the joint Medicaid/Title V Advisory Committee to review periodically the tenants of this Agreement with the aim of ensuring:
1. That all Medicaid-eligible in need of Title V services receive them.
2. That appropriate fiscal documentation is ongoing.
3. That information flows freely between both parties.

19. General Contract Provisions: N/A

State: Maryland (Region 3)

Document:
Cooperative Agreement between Maryland State Department of Health and Mental Hygiene (Title XIX) Medicaid Agency, (Title V) Maternal and Child Health Agency, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
Author: Maryland State Department of Health and Mental Hygiene
Date: n. d. **Pages:** 14 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/MD_1_1.pdf*

Contractual Details:

1. Effective Date: Effective upon the signatures of the authorized of the Family Health Administration and the Maryland Medical Assistance Program (signed July 2004).
2. Duration: Five years from the date the cooperative agreement is signed, or until either party provides written notification of termination.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. Maryland State Department of Health and Mental Hygiene [Title XIX] Medicaid Agency.
B. Maternal and Child Health Agency, Family Health Administration (FHA) [Title V].
C. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
5. Authority Cited:
A. Social Security Act, 42 U.S.C. 1397-aa-1397jj.
B. Maryland General Code Annotated, Title 15, Subtitle 301.
C. Title V Maternal and Child Health Block Grant of the Social Security Act-General Code Annotated, 18-107.

Summary Related to CMS Requirements:

6. Objectives:
To establish roles and responsibilities between the parties for the purpose of providing coordination of services to promote prompt access to high quality prenatal, intrapartum, postpartum, postnatal, and child health services for women and children eligible for benefits under Title V and XIX of the Social Security Act, and section 17 of the Child Nutrition Act of 1996, as amended.

7. Responsibilities:
A. The Medicaid Program is responsible for operating the Maryland Children's Health Program as a Medicaid expansion with the full benefit package.
B. FHA is responsible for the utilization of funds provided for by Title V MCH Block Grant and the Maryland Health -- §18-107, in the provision of MCH services and services for CSHCN and for administering the Title X/Family Planning Program.
C. WIC is responsible for providing supplemental foods and nutrition education to pregnant and postpartum women, infants, and young children from families with low incomes who are at risk by reason of inadequate nutrition or health care or both.

8. Services Provided by Agency:
A. Administration and Policy.
1. Medicaid Program.
a. Establish eligibility policy, regulations, and procedures.
b. Perform outreach to encourage low income maternal and child populations to apply for Medicaid and to utilize preventive and primary care services.,
2. FHA.
a. Provide services.
b. Provide Medicaid with expertise and TA related to programs and policies for CSHCN.
c. Refer clients who are eligible for Medicaid benefits and assist them in receiving services from providers who participate in the Maryland Medical Assistance Program.
3. Mutual Services.
a. All parties will coordinate activities to enhance customer service and work to resolve problems with impact on timely access to services.
b. All parties will coordinate strategic planning efforts to ensure coordination in the design, implementation, and evaluation of program services for women, infants, and children.
c. All parties will keep each other apprised of those services which are available to eligible individuals pursuant to Federal law and State regulations and guidelines.
d. All parties will collaborate when implementing significant changes to program policies that may impact the other.
e. All parties will develop program policies and regulations that address standards of quality care.
f. All parties will promote family planning and prenatal care.
g. All parties will promote the importance of a medical home.
h. FHA and Medicaid will collaborate on the development of tools and processes for identifying high-risk women and will jointly provide support for the Maryland Prenatal Risk Assessment system.
i. FHA and Medicaid will develop training and education programs for medical professionals and consumers.
j. WIC and Medicaid will notify each other of policy changes that may have an affect on access to services and will coordinate with FHA on initiatives to improve MCH.
k. FHA will coordinate with Medicaid regarding activities and programs regarding childhood health promotion and prevention programs.

B. Reimbursement and Contract Monitoring (see Section 14).
C. Confidentiality and Data Exchange (see Section 15).
D. Recipient Outreach and Referral (see Section 11).
E. Training and Technical Assistance.
F. Provider Capacity.
G. System Integration (see Section 13).
H. Quality Assurance Activities.

9. Cooperative Relationships: See Section 13.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
D. Recipient Outreach and Referral.
1. Primary and Preventive Care for Children.
a. FHA.
(1). Assist Medicaid with distribution of MA/MCHP applications.
(2). Verify Medicaid eligibility prior to providing services and will refer potential eligible Medicaid/MCHP families for eligibility determination.
(3). FHA/Oral Health will refer children.
b. Medicaid.
(1). Conduct outreach to Medicaid recipients.
c. Mutual Services.
(1). Medicaid and FHA will coordinate hotline activities.
(2). FHA/Oral Health and Medicaid will work collaboratively to update the resource guide of dental providers.

2. CSHCN (similar activities as above; for full list of activities, see original document).
3. Pregnant Women and Infants (similar activities as above; for full list of activities, see original document).
4. Family Planning (similar activities as above; for full list of activities, see original document).
5. WIC (similar activities as above; for full list of activities, see original document).

12. Reciprocal Referrals: See Section 11.

13. Coordinating Plans:
G. System Integration.
1. Primary and Preventive Care for Children: FHA and Medicaid will:
a. Collaborate to establish and maintain relationships with providers who serve low-income and Medicaid/MCHP enrolled children and to help facilitate problem resolution.
b. Collaborate to ensure that there are public forums for exchange of information such as the Medicaid Advisory Committee, Oral Health Advisory Committee, and other ad hoc advisory groups.
2. CSHCN (similar activities as above; for full list of activities, see original document).
3. Pregnant Women and Infants (similar activities as above; for full list of activities, see original document).
4. Family Planning (similar activities as above; for full list of activities, see original document).
5. WIC (similar activities as above; for full list of activities, see original document).

14. Reimbursement:
B. Reimbursement and Contract Monitoring.
1. FHA and Local Health Departments.
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. Will 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.
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.

15. Reporting Data:
C. Confidentiality and Data Exchange.
1. FHA and Medicaid.
a. Safeguard and maintain confidentiality.
b. Participate in the exchange of data necessary for the Title V and Title X reapplication.
c. Coordinate and participate in the exchange of data related to: births to women enrolled in Medicaid and utilization of Family planning services; maternal, fetal, infant, and child death reviews; prenatal risk assessment data; PRAMS; and treatment of children exposed to lead.
d. Exchange data necessary to conduct quality assurance and utilization studies.
2. FHA and WIC.
a. Maintain confidentiality of records.
3. Medicaid.
a. Provide FHA with access to select Medicaid files.
4. Medicaid and WIC.
a. Ensure that any sharing of client data is in accordance with appropriate regulations.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement

State: Michigan (Region 5)

Document: [Michigan Title V / Title XIX Interagency Agreement]
Author: [Michigan Department of Public Health]
Date: 1995 **Pages:** 10 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/MI_1_1.pdf*

Contractual Details:

1. Effective Date:
Original agreement: January 1, 1981, with addenda approved September 28, 1987 and October 1, 1995.
2. Duration:
This contract supersedes and prior agreement between the parties and shall continue in effect for a period of one year from the date hereof. It shall remain effective for successive periods of 1 year each thereafter unless during any such period, this contract shall be canceled in accordance with the terms contained herein. This contract may be terminated, when either party requests termination, by giving 90 days written notice to the other party of its intention to terminate.
3. Type of Agreement: [Interagency Agreement].
4. Agencies Involved:
A. Michigan Department of Public Health [Title V].
B. Michigan Department of Social Services [Title XIX].
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives:
To reduce infant mortality and morbidity and to reduce the incidence of mental retardation and other handicapping conditions.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. Public Health Services.
1. Promote cooperative program planning and monitoring efforts.
2. Identify individuals in need of preventive, diagnostic, treatment, and medical care and services.
3. Identify and refer to Social Services individuals who may be eligible of Medical Assistance Program benefits.
4. Provide or arrange for health care and services.
5. Request from Social Services reimbursement for the cost of covered Medical Assistance care and services provided by Title V projects to individuals eligible for Medical Assistance.
6. Establish and maintain standards and guidelines.
7. Certify to Social Services public providers of family planning services.
8. Designate hospitals, physicians, and transportation providers.

9. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of coordination, policy development, quality assurance, and reporting and evaluation.

B. Services Provided by Social Services.
1. Promote cooperative planning.
2. Determine the financial eligibility of individuals for whom application has been made.
3. Identify and refer individuals in need of health care and services available by and through Title V projects to Public Health.
4. Establish the scope of services and reimbursement levels available.
5. Reimburse, as first payer, the cost of care and services furnished by or through the Title V grantee in individuals eligible for Medical Assistance.
6. Designate appropriate personnel to work on a Public Health/Social Services task force to examine issues of coordination, policy development, quality assurance, and reporting and evaluation.

9. Cooperative Relationships: See Section 8, Service A1, B1.

10. Services Provided by Local Agencies:
Provide accurate lists of clients due for screening to local health departments or other organizations.

11. Identification and Outreach: See Section 8, Service A2, A3, B2, B3.

12. Reciprocal Referrals: See Section 8, Service A3.

13. Coordinating Plans: See Section 8, Service A1, B1.

14. Reimbursement: See Section 8, Service A5, B4, B5.

15. Reporting Data: See Section 8, Service A7.

16. Review: N/A

17. Liaison:
Title XIX to Designate a staff member to serve as EPSDT coordinator and liaison with Title V.

See also Section 8, Service A9, B6.

18. Evaluation: N/A

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement

State: Minnesota (Region 5)

Document: *State of Minnesota Interagency Memorandum of Understanding*
Author: [Minnesota Department of Health]
Date: 2003 **Pages:** 4 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/mn_1_1.pdf*

Contractual Details:

1. Effective Date:
July 1, 2003 or upon the date that the final required signature is obtained, whichever occurs later; or until a revised agreement is signed. (Signed on August 11, 2003).
2. Duration:
The agreement may be canceled by either department at any time, with or without cause, upon 30 days written notice to the other party.
3. Type of Agreement: Memorandum of Understanding
4. Agencies Involved:
A. Minnesota Department of Health (DOH) [Title V].
B. Minnesota Department of Human Services (DHS) [Title XIX].
5. Authority Cited:
A. Minnesota Statutes, Section 145.88.
B. Minnesota Statutes, Section 256.01, Subdivision 2, Paragraph (1), and 256B.04, Subdiv. 1.

Summary Related to CMS Requirements:

6. Objectives:
A. To promote quality health care services for low-income children, pregnant women, and CSHCN, including primary and preventive health services.
B. To coordinate and enhance efforts, streamline application processes, reduce duplicative efforts, and ensure compliance with federal and state laws and regulations and the appropriate use of public funds.

7. Responsibilities:
A. The DOH is responsible for administrating the Title V program.
B. The DHS is responsible for administrating the Medicaid program.

8. Services Provided by Agency:
A. DHS.
1. Participate in advisory or work groups related to MCH and child health issues including CSHCN.
2. Participate in quarterly joint meetings.
3. Enter into separate IAAs for those duties that require a transfer of personally identifying data and funds.
4. Accept referrals from the DOH for the Medical Assistance and Minnesota Care program.

B. DOH.
1. Participate in advisory or work groups related to MCH and child health issues including CSHCN.
2. Participate in quarterly joint meetings.
3. Enter into separate IAAs for those duties that require a transfer of personally identifying data and funds.
4. Accept referrals from the DHS and provide follow-up services to CSHCN and their families.

9. Cooperative Relationships:
Quarterly joint meeting are to cover, among other issues, coordination of departmental policies/procedures that impact health care services or the delivery of health care services to the MCH populations; identification how the departments can work together to identify individuals under 21 in need of services.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
The Department contracts with counties to perform outreach and follow-up EPSDT services for eligible children. In order to identify children under 21 in need of medical or remedial services, the Department receives screening and referral information from managed care health plans that is fed into the Department's "CATCH 3" tracking system.

12. Reciprocal Referrals: See Section 11.

13. Coordinating Plans: See Section 9.

14. Reimbursement: N/A

15. Reporting Data:
Information from the CATCH 3 tracking system (see Section 11) is downloaded to the counties for use in performing outreach activities. It is also used for referral follow-up activities. Also, the quarterly joint meeting are to cover, among other issues, sharing of appropriate and relevant aggregate data affecting health status or the delivery of health care services.

16. Review:
Quarterly joint meetings are to cover, among other issues, the review at least annually of this Memorandum of Understanding to determine if any changes are required.

17. Liaison: Authorized representatives and members of quarterly joint meetings are named.

18. Evaluation: See Section 16.

19. General Contract Provisions:
termination of agreement
amendment/modification of agreement
indemnification/liability

State: Mississippi (Region 4)

Document:
Cooperative Agreement between Mississippi State Department of Health and the Division of Medicaid in the Office of the Governor State of Mississippi (Perinatal High Risk Management Services)
Author: Mississippi State Department of Health
Date: 2004 **Pages:** 29 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/ms_1_1.pdf*

Contractual Details:

1. **Effective Date:** July 1, 2004.
2. **Duration:** July 1, 2004 - June 30, 2005.
3. **Type of Agreement:** Cooperative Agreement.
4. **Agencies Involved:**

A. Division of Medicaid, Office of the Governor (Division) [Title XIX].
B. State of Mississippi Department of Health (Department) [Title V].

5. **Authority Cited:** Miss. Code Ann. §43-13-117(19)(a); 43-13-117(5); 43-13-115.

Summary Related to CMS Requirements:

6. **Objectives:**

To provide case management and extended services through approved case management agencies over the state to those pregnant/postpartum women and infant Medicaid beneficiaries.

7. **Responsibilities:**

A. The Department is the State agency responsible for the general supervision of the health interests of the people of that State and is authorized to enter into contracts and agreements with other State or Federal agencies in effecting an efficient delivery of public health services.
B. The Division is responsible for providing case management and extended services for high risk pregnant/postpartum women through approved case management agencies and EPSDT.

8. **Services Provided by Agency:**

Exhibit A lists the criteria for case management and the enhanced services to be provided for various target groups.

A. High risk infants, age birth to one (1) year old.
1. Case management.
2. Medical risk assessment.
3. Enhanced EPSDT services for high risk infants.

B. High risk pregnant women (services to be provided during pregnancy and through the end of the month in which a 60-day postpartum period ends).
1. Case management.

2. Medical risk assessment.
3. Nutritional assessment/counseling.
4. Psychosocial assessment/counseling.
5. Health education.
6. Home visit.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
Any infants who are developmentally delayed and who meet early intervention criteria should be enrolled in early intervention.

12. Reciprocal Referrals: N/A

13. Coordinating Plans:
The Department shall coordinate with the Division in the purchase of case management and extended services for those individual Medicaid beneficiaries who are pregnant/postpartum and at high risk and for infants, birth to 1 year of age, who are at high risk for mortality and morbidity.

14. Reimbursement:
The case management agencies shall be reimbursed as a provider of medical services through the Division's Fiscal Agent on the basis of the service cost as set out in appropriate regulations. The case management agencies shall bill the Division 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. The Department will be responsible for providing state matching funds only for case management and extended services actually provided by the Department 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.

15. Reporting Data:
The Department shall submit a monthly report to the EPSDT Division and/or the PHRM Unit of the division, for Medicaid enrolled pregnant women and/or Medicaid enrolled infants receiving services. The Department shall report detailed information to the Division annually. The CMS1500 claim form information submitted by the Department to Medicaid's fiscal agent must show all Medicaid procedure codes for all services.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
indemnification/liability
nondiscrimination
confidentiality of records/HIPAA

State: Missouri (Region 7), document 1 of 6

Document:
Cooperative Agreement between the [Missouri] Department of Social Services, Division of Medical Services and the Department of Health, Division of Maternal, Child and Family Health, Bureau of Family Health: Prenatal Case Management and/or Service Coordination for Pregnant Women
Author: Missouri Department of Social Services
Date: 2000 **Pages:** 7 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/mo_1_6.pdf*

Contractual Details:

1. Effective Date: April 1, 2000.
2. Duration: Shall remain in effect until canceled by one or both parties.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. Department of Social Services (DSS), Division of Medical Services [Title XIX].
B. Department of Health (DOH), Division of Maternal, Child and Family Health, Bureau of Family Health [Title V].
5. Authority Cited: 42 CFR 431 Subpart M.

Summary Related to CMS Requirements:

6. Objectives:
To provide the most efficient, effective, and cost effective administration of Title XIX case management services.

7. Responsibilities:
Mutual Responsibilities.
A . Provide a plan for the coordination of services.
B. Improve and expand prenatal and preventive health services to Medicaid eligible recipients through education, cooperative planning, reducing barriers to access to health care, and follow-up activities.
C. Reduce the incidence of inadequate prenatal care.
D. Reduce the incidence of perinatal substance use of alcohol, tobacco, and drugs.

8. Services Provided by Agency:

A. DSS.

1. Reimburse DOH the Title XIX Federal share of actual and reasonable costs for service coordination.
2. Provide DOH access to the information necessary to properly administer the Prenatal Case Management Service Program and service coordination for the Perinatal Substance Abuse Program.
3. Meet and consult on a regular basis, at least quarterly, with DOH on issues related to this agreement.
4. Provide notification to DOH as soon as any changes are defined in the billing process and billing requirements affecting any local agencies included in this agreement.

B. DOH.

1. Employ administrative staff to provide TA to the Medicaid Case Management providers.
2. Ensure service coordination staffing for the Perinatal Substance Abuse Program.
3. Employ necessary staff to provide quality assurance activities and act as liaison with multiple disciplines on the medical aspects of the program.
4. Account for the activities of the staff employed.
5. Provide as requested by the State Medicaid Agency the information necessary to request Federal funds available under the State Medicaid match rate.
6. Return to DSS any Federal funds which are deferred and/or ultimately disallowed.
7. Maintain the confidentiality of client records and eligibility information.
8. Meet and consult on a regular basis, at least quarterly, with DSS.
9. Conduct all activities recognizing the authority of the single State Medicaid agency.

9. Cooperative Relationships:

DSS enters into the cooperative agreement with DOH for provider relations and quality assurance, including establishing standards, TA, coordination, and data management of the case management services, and service coordination for women enrolled in the Perinatal Substance Abuse Program.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals:

Case closure, referral, and realignment of service plan will be coordinated by DSS and DOH.

13. Coordinating Plans:

Service coordination will be conducted for perinatal substance abuse in the following:

1. Assistance to the clients/families in establishing a medical care home.
2. [Missing].
3. Service identification.
4. Service monitoring.
5. Case closure, referral, and realignment of service plan.

14. Reimbursement: See Section 8, Service A1.

15. Reporting Data: See Section 8, Service A2 and B5.

16. Review:
A task force consisting of the Directors of the respective departments or their designees and an equal number of other persons from their respective divisions chosen by the Directors shall 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. These activities shall include consideration of:
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.
3. Arrangements for continuous liaison between the divisions and departments and designated staff responsibility for liaison activities at both the state and local levels.

17. Liaison: See Section 8, Service A3 and B8.

18. Evaluation: See Section 16.

19. General Contract Provisions:
termination of agreement
amendment/modification of agreement
confidentiality of records/HIPAA

State: Missouri (Region 7), document 2 of 6

Document:
Interagency Agreement between the Missouri Department of Health and the Missouri Department of Social Services: Well Child Outreach
Author: Missouri Department of Social Services
Date: 1997 **Pages:** 3 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/mo_2_6.pdf*

Contractual Details:

1. Effective Date: July 1, 1997
2. Duration: Until canceled by one or both parties.
3. Type of Agreement: Interagency Agreement.
4. Agencies Involved:
A. The Missouri Department of Health (DOH), Division of Maternal, Child and Family Health (DMCFH) [Title V].
B. The Missouri Department of Social Services, Division of Medical Services [Title XIX].
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives:
A. To continue to implement a statewide program [the Well Child Outreach Project] designed to promote the health of children, adolescents, and pregnant women.
B. DOH's goal is to reduce the inadequate prenatal care rate to no more than 10 percent by year 2000.
C. DSS's goal is to screen 80 percent of all Medicaid-eligible children each year.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. DSS.
1. Designate one or more persons who will serve as a contact for DOH.
2. Reimburse DOH 100 percent of the Title XIX Federal share for staff responsible for implementing the Well Child Project.
3. Reimburse DOH 100 percent of the Title XIX Federal share for expense and equipment costs.
4. Provide DOH with Year to Date EPSDT participation rates.

B. DOH.
1. Employ staff and incur necessary expenses to carry out the Project; account for the activities of the staff.
2. Involve DSS in program process.
3. Keep records and provide written reports to DSS on relevant program data related to print material distribution, outreach activities, etc.
4. Evaluate the Project and share the results with DSS.
5. Return to DSS any Federal funds which are deferred and/or ultimately disallowed.
6. Provide the billing information necessary to obtain Federal financial participation. Maintain the confidentiality of client records.
7. Conduct all activities recognizing the authority of the single State Medicaid agency.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. Coordinating Plans: See Section 8, Activity B2.

14. Reimbursement: See Section 8, Activity A2, A3, and B5.

15. Reporting Data: See Section 8 Activity A4, B1, B3, and B6.

16. Review: N/A

17. Liaison: See Section 8, Activity A1.

18. Evaluation: See Section 8, Activity B4.

19. General Contract Provisions:
termination of agreement
confidentiality of records/HIPAA

State: Missouri (Region 7), document 3 of 6

Document:
Cooperative Agreement between the [Missouri] Department of Social Services, Division of Medical Services and the Department of Health, Division of Maternal Child and Family Health, Bureau of Special Health Care Needs: Head Injury Program
Author: Missouri Department of Social Services
Date: 2001 **Pages:** 9 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/mo_3_6.pdf*

Contractual Details:

1. Effective Date: July 1, 2001.
2. Duration: Until canceled by one or both parties.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. The Missouri Department of Health (DOH), Division of Maternal, Child and Family Health (DMCFH) [Title V].
B. The Missouri Department of Social Services (DSS), Division of Medical Services (DMS), Head Injury Program [Title XIX].
5. Authority Cited: 42 CFR 431 Subpart M.

Summary Related to CMS Requirements:

6. Objectives:
To provide the most efficient, effective administration of Head Injury Services.

7. Responsibilities:
Mutual Responsibilities.
A. To ensure early and appropriate response to a referral so that diagnosis, assessment, and treatment/intervention occur within the timelines established by DOH policy and procedure.
B. To ensure that services are of sufficient amount, duration, and scope to responsibly achieve the stated purpose of this agreement.
C. To establish a health care home for those Medicaid eligible individuals receiving Head Injury service coordination activities.

8. Services Provided by Agency:

A. DSS.

1. Reimburse DOH the Title XIX Federal share of actual and reasonable costs for Head Injury Administration activities.
2. Define the rates of reimbursement as per 42 CFR 433.15, 432.50,and 433.15(7).
3. Reimburse DOH the Title XIX Federal share of actual and reasonable costs for data research services.
4. Reimburse DOH the Title XIX Federal share of actual and reasonable costs incurred by Electronic Data Processing.
5. Provide DOH access to the information necessary to properly provide Head Injury Service Administration.
6. Meet and consult on a regular basis, at least quarterly, with DOH.

B. DOH.

1. Maintain direct employment of those staff necessary to provide the programmatic and operation oversight, management, and monitoring of the Head Injury Program.
2. Ensure that contracted service coordination staff furnish service coordination for the medical services available.
3. Provide linkage of data system for coordination, identification, and effective case planning.
4. Provide Head Injury Administration to assess the necessity for and adequacy of medical care and services provided, which include outreach; service coordination; program service case planning; service monitoring; and case closure, referral, and realignment of service plan.
5. Account for the activities of the DOH staff and contractual staff.
6. Provide the information necessary to request Federal funds.
7. Return to DSS any Federal funds which are deferred and/or ultimately disallowed.
8. Maintain the confidentiality of client records and eligibility information.
9. Seek General Revenue appropriations to provide the State match for the Federal matching share.
10. Meet and consult on a regular basis, at least quarterly, with DSS.
11. Conduct all activities recognizing the authority of the single State Medicaid agency.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:

DOH will assist in identifying possible Medicaid eligibles and referring them to the DFS for eligibility determination [this activity is highlighted in Section 8]

12. Reciprocal Referrals:

DOH will establish a health care home, provide referrals to Medicaid covered services, and make appointments for appropriate primary care and appropriate Medicaid services.

13. Coordinating Plans:

See Section 8, Service B2. DOH will also make plans for coordinating rehabilitation services

identified in the Program Service Plan.

14. Reimbursement: See Section 8, Service A1-A5.

15. Reporting Data: See Section 8, Service A6, B3

16. Review:
DOH will review the Program Service Plan, ensuring the plan relates to services the individual is receiving and documents the client's progress. DOH staff will also monitor contracted staff's performance of the SOW.

17. Liaison: See Section 8, Service B4.

18. Evaluation:
A task force consisting of the Directors of the respective departments or their designees and an equal number of other persons from their respective divisions chosen by the Directors shall 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. These activities shall include consideration of:
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.
3. Arrangements for continuous liaison between the divisions and departments and designated staff responsibility for liaison activities at both the State and local levels.

19. General Contract Provisions:
termination of agreement
confidentiality of records/HIPAA

State: Missouri (Region 7), document 4 of 6

Document:
Cooperative Agreement between the [Missouri] Department of Social Services and the Department of Health relating to Administration of the Medicaid Home ad Community-Based Services Waiver for Targeted Individuals with Physical Disabilities
Author: Missouri Department of Social Services
Date: 2001 **Pages:** 10 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/mo_4_6.pdf*

Contractual Details:

1. Effective Date: July 1, 2001.
2. Duration: Until canceled by one or both parties.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. The Missouri Department of Health (DOH) [Title V].
B. The Missouri Department of Social Services, Division of Medical Services (DSS-DMS) [Title XIX].
5. Authority Cited: 42 CFR 431 Subpart M.

Summary Related to CMS Requirements:

6. Objectives:
To provide the most efficient, effective administration of the Physical Disabilities Waiver (PDW).

7. Responsibilities:
Mutual Responsibilities.
A. To provide for cost-effective home and community-based services for individuals as cost effective alternative to Intermediate Care Facility for Mentally Retarded (ICF/MR).
B. To ensure necessary safeguards have been taken to protect the health and welfare of persons receiving services under the Physical Disabilities Waiver.

8. Services Provided by Agency:
A. DSS.
1. Reimburse DOH the Title XIX Federal share of actual and reasonable costs for the waiver program.
2. Provide DOH access to the information necessary to properly administer the PDW Program.
3. Meet and consult on a regular basis with DOH.
4. Provide the administration of Physical Disabilities Waiver and Personal Care Guidelines.
5. Provide training for DOH staff.
6. Determine recipients' eligibility for Medicaid.
7. Review on a yearly basis the most recent assessment and plan of care to ensure the need for services was documented in the plan of care and all services needs in the plan were properly

authorized prior to delivery.
8. Prepare the annual report on the impact of the PDW program.
9. Exchange data with DOH to compile periodic reports on the number of clients served, their costs, and the savings generated.
10. Review reports of a provider non-compliance submitted from DOH and pursue any action necessary to remedy.
11. Prepare, print, mail, and publish online material regarding Medicaid services.
12. Review materials to be published by DOH regarding Medicaid services.
13. Review and comment on policy and procedure for the internal operations of staff regarding Medicaid services.
14. Maintain the confidentiality of client records.
15. Conduct hearings for persons who have appealed denial or termination of services by DOH.
16. Designate an employee of DSS-DMS to serve as a liaison with DOH.
17. Assist DOH in the transitioning of eligible individuals to the adult Medicaid services.
18. Provide support as needed to DOH in developing plans of care.

B. DOH.
1. Directly employ qualified professional and support staff necessary to provide the administration and case management of services.
2. Maintain recipient to allow for coordination, identification, effective care planning, etc.
3. Collaborate with other State agencies in the client's assessment.
4. Collaborate with other State agencies in developing plans for care.
5. Provide PDW case management.
6. Prior authorize medically necessary PDW and Personal Care Program services.
7. Conduct, at a minimum, quarterly home visits.
8. Monitor provision of service.
9. Act as a liaison in the due process for the recipient and family in the event of a case closure, referral, and/or realignment of plan of care.
10. Account for the activities of the staff employed.
11. Provide the information necessary to request Federal funds.
12. Return to DSS any Federal funds which are deferred and/or ultimately disallowed.
13. Maintain the confidentiality of client records.
14. Meet and consult on a regular basis with DSS-DMS.
15. Conduct all activities recognizing the authority of the single State Medicaid agency.
16. Assume the financial responsibility for the development of print materials.
17. Follow the guidelines accepted by DSS and DOH.
18. Prepare policy and procedures for internal operations of DOH staff.
19. Ensure DOH staff participation in Medicaid related training.
20. Provide training as needed.
21. Participate in hearings in regard to DOH administration.
22. Report suspected provider abuse or non-compliance.

9. Cooperative Relationships: See Section 8, Service B3, B4

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service A6, B2.

12. Reciprocal Referrals: N/A

13. Coordinating Plans:
See Section 8, Service A3. Coordination language is integrated throughout Section 8.

14. Reimbursement: See Section 8, Service A1, B12.

15. Reporting Data: See Section 8, Service A2, A8, A9.

16. Review: See Section 8, Service A7; Section 18.

17. Liaison: See Section 8, Service A16, B14.

18. Evaluation:
A task force consisting of the Directors of the respective departments or their designees and representatives from each division shall meet annually, 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 eligible individuals. These activities shall include consideration of:
1. The evaluation of policies, duties, and responsibilities of each agency.
2. Feasibility of cost effectiveness.
3. Arrangements for periodic review of the agreements and for joint planning for changes in the agreements.
4. Review of liaison activities.

19. General Contract Provisions:
termination of agreement
confidentiality of records/HIPAA

State: Missouri (Region 7), document 5 of 6

Document:
Cooperative Agreement between the Missouri Department of Social Services, Division of Medical Services and the Missouri Department of Health, Bureau of Special Health Care Needs, Head Injury Program: Non-Emergency Medical Transportation
Author: Missouri Department of Social Services
Date: 2000 **Pages:** 5 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/mo_5_6.pdf*

Contractual Details:

1. Effective Date: January 1, 2000.
2. Duration: Until canceled by one or both parties.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. The Missouri Department of Health, Bureau of Special Health Care Needs, Head Injury Program (DOH/BSHCN) [Title V].
B. The Missouri Department of Social Services (DSS), Division of Medical Services (DMS) [Title XIX].
5. Authority Cited: 42 CFR 431 Subpart M.

Summary Related to CMS Requirements:

6. Objectives:
To provide the most efficient and cost effective Non-Emergency Medical Transportation (NEMT) services.

7. Responsibilities:
Mutual Responsibilities.
To ensure transportation services to and from covered Missouri Medicaid services for head injured Medicaid eligible recipients age 21 or over.

8. Services Provided by Agency:
A. DSS.
1. Reimburse DOH/BSHCN the Title XIX Federal share for NEMT services.
2. Provide DOH/BSHCN access to the information necessary to properly provide NEMT services.
3. Meet and consult on a regular basis, at least annually, with DOH/BSHCN.
4. Develop and conduct periodic utilization reviews to ensure payments do not duplicate.
5. Refer recipients who meet certain criteria to the DMS NEMT broker.
6. Maintain the confidentiality of client records.

B. DOH/BSHCN.
1. Identify Medicaid eligible head injury recipients.

2. Arrange/schedule the most cost-effective NEMT services appropriate.
3. Certify to DSS the provisions of the non-Federal share for transportation services.
4. Provide the information necessary to request Federal funds.
5. Accept responsibility for disallowances.
6. Meet and consult on a regular basis, at least annually, with DSS.
7. Conduct all activities recognizing the authority of the single State Medicaid agency.
8. Maintain all necessary information to support the claims and provide [CMS] any necessary data for auditing.
9. Maintain confidentiality of client records.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service B1.

12. Reciprocal Referrals: See Section 8, Service A5.

13. Coordinating Plans: N/A

14. Reimbursement: See Section 8, Service A1.

15. Reporting Data: See Section 8, Service A2, B4, B8.

16. Review: See Section 8, Service A4.

17. Liaison: See Section 8, Service A3,B6.

18. Evaluation:
A task force consisting of the Directors of the respective departments or their designees and representatives from each division shall meet annually, 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 eligible individuals. These activities shall include consideration of:
1. The evaluation of policies, duties, and responsibilities of each agency.
2. Feasibility of cost effectiveness.
3. Arrangements for periodic review of the agreements and for joint planning for changes in the agreements.
4. Review of liaison activities.

19. General Contract Provisions:
termination of agreement
confidentiality of records/HIPAA

State: Missouri (Region 7), document 6 of 6

Document:
Cooperative Agreement between the [Missouri] Department of Social Services, Division of Medical Services and the [Missouri] Department of Health, Division of Maternal, Child and Family Health, Bureau of Family Health: Administrative Case Management, Healthy Children and Youth Program (HCY)
Author: Missouri Department of Social Services
Date: 2000 **Pages:** 5 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/mo_6_6.pdf*

Contractual Details:

1. Effective Date: July 1, 1997.
2. Duration: Until canceled by one or both parties.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. The Missouri Department of Health, Division of Maternal, Child and Family Health, Bureau of Family Health (DOH) [Title V].
B. The Missouri Department of Social Services (DSS), Division of Medical Services (DMS) [Title XIX].
5. Authority Cited: 42 CFR 431 Subpart M.

Summary Related to CMS Requirements:

6. Objectives:
To provide the most efficient and cost efficient, effective administration of Title XIX EPSDT aka in the state as Healthy Children and Youth (HCY).

7. Responsibilities:
Mutual Responsibilities.
A. To ensure early and appropriate intervention and screening so that diagnosis and treatment occur in a timely manner.
B. To ensure that services are of sufficient amount, duration, and scope.
C. To establish a medical care home for those Medicaid eligible children receiving HCY services.
D. To ensure that services are provided by appropriate Medicaid enrolled providers.
E. To ensure that all children requiring technical and/or nursing services are provided service coordination.
F. To ensure that service coordination is available for all clients requiring service coordination as a result of substance abuse.

8. Services Provided by Agency:
A. DSS.
1. Reimburse DOH the Title XIX Federal share for HCY services.

2. Reimburse DOH the Title XIX Federal share for research services.
3. Reimburse DOH the Title XIX Federal share of costs incurred from EDP for their provision of data.
4. Provide DOH access to the information necessary to properly provide HCY services.
5. Provide DOH access to the information necessary to properly provide HCY administration.
6. Meet and consult on a regular basis, at least quarterly, with DOH.

B. DOH.
1. Employ all necessary professional staff.
2. Employ administrative staff.
3. Provide linkage of data systems for coordination, identification, and effective case planning.
4. Aid ad assist in the development of screening tools.
5. Provide HCY administration and act as liaison.
6. Account for activities of the staff employed.
7. Provide the information necessary to request Federal funds.
8. Return to DSS any Federal funds which are deferred and/or ultimately disallowed.
9. Maintain the confidentiality of client records.
10. Seek General Review appropriations to provide the Federal matching share for HCY services.
11. Meet and consult on a regular basis with DSS.
12. Conduct all activities recognizing the authority of the single State Medicaid agency.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
DOH will assist in identifying possible Medicaid eligibles. DOH will identify the kind, amount, intensity, and duration of services required.

12. Reciprocal Referrals:
DOH will assist in referring Medicaid eligibles to the Division of Family Services.

13. Coordinating Plans: N/A

14. Reimbursement: N/A

15. Reporting Data: N/A

16. Review: N/A

17. Liaison: N/A

18. Evaluation:
A task force consisting of the Directors of the respective departments or their designees and

representatives from each division shall 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 eligible individuals. These activities shall include consideration of:
1. The evaluation of policies, duties, and responsibilities of each agency.
2 Arrangements for periodic review of the agreements and for joint planning for changes in the agreements.
3. Arrangements for continuous liaison.

19. General Contract Provisions:
termination of agreement
confidentiality of records/HIPAA

State: Nebraska (Region 7)

Document:
Interagency Agreement between the Nebraska Department of Health and Human Services, Family Health Division and the Nebraska Department of Health and Human Services, Finance and Support, Medicaid (Title XIX)
Author: Nebraska Department of Health and Human Services
Date: 1998 **Pages:** 10 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/ne_1_1.pdf*

Contractual Details:

1. Effective Date: November 13, 1998
2. Duration:
In perpetuity (although original agreement continued through June 30, 1999 and has been renewed annually).
3. Type of Agreement: Interagency Agreement.
4. Agencies Involved:
A. Nebraska Department of Health and Human Services, Family Health Division (FHD) [Title V].
B. Nebraska Department of Health and Human Services Finance and Support, Medicaid (Title XIX Agency) [Title XIX].
5. Authority Cited:
A. Title V of the (Public Health) Social Security Services Act.
B. Child Nutrition Act of 1989, Section 17(e)(4)(b).
C. Title XIX of the Social Security Act (Medicaid), Section 1902(a)(11)(A).

Summary Related to CMS Requirements:

6. Objectives:
A. To promote continuity of care, sharing of scarce expertise, reduction of unnecessary

duplication of effort, efficient allocation of resources, and the achievement of greater accountability to produce an enhanced and expanded health care services system to mutual clients and improve the health of the families of the State of Nebraska.
B. To ensure maximum utilization of Title XIX resources by those served by the programs of the Family Heath Division and their providers.

7. Responsibilities:
The Nebraska Department of Health and Human Services is responsible for the conduct of the Family Health Division Programs and the Department of Health and Human Services Finance and Support is responsible for the conduct of the Title XIX Program.

FHD is broadly responsible for core public health functions as they specifically address the following population groups: pregnant women and all women of reproductive age, infants, children, adolescents, and their families

8. Services Provided by Agency:
FHD and the Title XIX Agency shall (each agency has multiple subtasks under each major activity):
A. Promote continuity of care, share expertise, reduce duplication of effort, etc.
B. Ensure maximum utilization of Title XIX resources.
C. Maximize the potential for delegation of tasks by the Title XIX agency to the FHD to ensure that Medicaid-eligible children have access to and receive the full range of assessment, diagnostic, and treatment services.
D. 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.
E. Increase access to and improve delivery of family planning, prenatal, and obstetric care to low income women, particularly teenagers.
F. Develop a system that ensures early identification of Title XIX eligible individuals, including pregnant women, in need of preventive health, medical, or remedial care and services, and assist and support such individuals in obtaining needed services.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies:
The Title XIX Agency shall inform and educate all Title XIX State and local health and human services to make them knowledgeable of the services offered by FHD programs.

11. Identification and Outreach:
The FHD shall promote preventive health care and encourage eligible children to receive EPSDT screening examinations.

12. Reciprocal Referrals:
See Section 8, Service D. Also, the Title XIX Agency shall provide FHD grantees referrals, data, reports, and other material needed to support outreach activities.

13. Coordinating Plans: N/A

14. Reimbursement:
A. Title XIX Agency.
1. Reimburse FHD program providers who are also Medicaid providers.
2. Establish a formal method of communication, collaboration, and cooperation with FHD regarding procedures, periodicity, and content standards for EPSDT, rates and reimbursement methods by regularly scheduled meetings.
3. Encourage and support the FHD 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 FHD programs.
4. Plan, in conjunction with FHD, to address billing concerns.
5. Identify overall services and provide the maximum allowable rate information for procedures.

B. FHD.
1. Ensure that FHD providers shall bill the Title XIX agency.
2. Respond to and attend annual meetings regarding rates and reimbursement methods.
3. Ensure that all third-party revenues shall be retained by the FHD provider.
4. Cooperate and participate in the planning process.

15. Reporting Data:
Program reports will be developed to support financial claims for Federal Medicaid financial match funding. The FHD or its grantees will maintain a method of readily identifying Medicaid eligible children benefiting from the activities within the scope of this Agreement.

The FHD shall provide documentation of Title V match and submit the required fiscal and program reports of Title V activities on a quarterly basis. The Title XIX Agency will provide financial reimbursement directly to the grantee based upon the grantee's invoice and narrative and on FHD's quarterly documentation.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
payment

State: New Mexico (Region 6)

Document:
State of New Mexico Human Services Department Medical Assistance Division Provider Participation Agreement
Author: State of New Mexico Human Services Department Medical Assistance Division
Date: 2003 **Pages:** 6 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/nm_1_1.pdf*

Contractual Details:

1. Effective Date: March 18, 2003.
2. Duration: Shall remain in effect until terminated.
3. Type of Agreement: Provider Participation Agreement.
4. Agencies Involved:
A. Human Services Department [Title XIX].
B. Children's Medical Services [Title V].
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives:
To specify the terms and conditions for the provision of medical services to Medicaid clients.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. Children's Medical Services.
1. Abide by all Federal, State, and local laws under Title XIX and Title XXI.
2. Furnish services, bill for services, and receive payment for services upon approval of this agreement.
3. Comply with all billing instructions, reimbursement, audit, recoupment, and withholding provisions.
4. Maintain and keep updated program policies, instructions on billing and utilization review, and other material.
5. Furnish and update complete information on provider address, licensing, certification, etc.
6. Comply with all laws regarding the provider's authority to operate a business.
7. Assume sole responsibility for all costs of doing business.
8. Verify that an individual is eligible for a specified medical program administered by HSD.
9. Maintain the confidentiality of client information.
10. Render covered services to eligible clients.
11. Assume responsibility for any and all claims submitted on behalf of the provider.
12. Retain any and all original medical or business records as are necessary to verify the treatment of clients.
13. Upon closure of office, notify HSD where records will be located.

14. Furnish to Medicaid at no cost access to records requested.
15. Accept as payment in full the amount paid by HSD for services furnished to clients in accord with the reimbursement structure.
16. Not collect payments from the client for services, except as allowed by HSD.
17. Seek payment from any other payer or insurer before seeking payment from HSD.
18. Not refuse to furnish services to an eligible client because of a third party's potential liability for payment.
19. Inform HSD when an attorney or other party requests information related to the services rendered to a client.
20. Agree to HSD regulations when furnishing services to clients who sustained injury in an accident or action that may be subject to a legal proceeding.

B. Human Services Department.
1. Distribute information necessary to participate in medical programs administered by HSD.
2. Process payments in a manner delineated by federal guidelines.
3. Reimburse providers for furnishing covered services or procedures to eligible clients.
4. Conduct administrative investigations and proceedings to ensure that providers comply with the terms of this agreement.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service A8

12. Reciprocal Referrals: N/A

13. Coordinating Plans: N/A

14. Reimbursement: See Section 8, Service A2, A4, A7, A15, A15, A17, A18, B2, B3.

15. Reporting Data: See Section 8, Service A5, A12, A13, A14, A19, B1.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
termination of agreement
dispute resolution mechanism
failure to satisfy SOW
indemnification/liability
confidentiality of records/HIPAA
default

State: New York (Region 2)

Document:
Medicaid/EPSDT - Title V Action Plan: New York State Department of Health
Author: New York State Department of Health
Date: n.d. **Pages:** 3 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/NY_1_1.pdf*

Contractual Details:

1. Effective Date: N/A
2. Duration: N/A
3. Type of Agreement: Action Plan.
4. Agencies Involved:
A. New York State Department of Health [Title V].
B. New York Office of Medicaid Management [Title XIX].
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives:
To provide:
A. Access to health insurance for every New Yorker.
B. Comprehensive, high quality and accessible medical services for every New Yorker.
C. A medical home for every New Yorker.
D. Non-discriminatory provision of assistance, and of medical services, to Medicaid applicants and recipients.
E. Delivery of all services to Medicaid applicants and recipients in a culturally and language appropriate manner.
F. An increase in the public's awareness of Title V and Title XIX services available to them.
G. Coordination of services delivery, to ensure services will be provided without duplication of effort, or fragmentation.

7. Responsibilities:
Shared responsibilities include:
A. Definitions and clarifications of the respective functions and responsibilities of each party.
B. Adherence by medical care and health services providers to Federal and State regulations and standards of medical care.
C. Education of Medicaid recipients relative to services available.
D. Share de-identified data.
E. Observing and requiring adherence to Federal and State laws.
F. Observing the Civil Rights Act of 1964.
G. Designating personnel for continuous liaison.

8. Services Provided by Agency:

A. Title V Services.

1. Maintain the Growing Up Healthy Hotline.
2. Review utilization, quality, etc. of care and services furnished by Medicaid.
3. Provide to Title XIX lists of institutions approved to provide care.
4. Provide consultation to Medicaid.
5. Provide advice and assistance in the design of data capture instruments.
6. Provide documentation instructions to Title V contractors.
7. Assist Title V contractors in qualifying for payment under Title XIX.
8. Make referrals to Medicaid; assist in identifying Title V clients of potential eligibility; and refer those clients to the appropriate agency.

B. Title XIX Services.

1. Access to lists of health care providers eligible to receive Title XIX reimbursement.
2. Access to lists of health care providers ineligible to receive Title XIX reimbursement.
3. Provide oversight/monitoring, guidance, support, and necessary assistance to the State's local Departments of Social Services (LDSS) in matters of Medicaid eligibility, enrollment, and maintenance of client records.
4. Arrange and promote partnerships, communication, and cooperation between Title XIX and LDSS Medicaid operations by mutual coordination, an attendance at meetings.

9. Cooperative Relationships: See Section 8, Service B4.

10. Services Provided by Local Agencies:
Provide oversight/monitoring, guidance, support, and necessary assistance to the State's local Departments of Social Services (LDSS) in matters of Medicaid eligibility, enrollment, and maintenance of client records (Section 8, Service B3).

11. Identification and Outreach: See Section 8, Service A1.

12. Reciprocal Referrals: See Section 8, Service A8.

13. Coordinating Plans: See Section 8, Service B4.

14. Reimbursement: See Section 8, Service A7, B1.

15. Reporting Data:
Title V and Title XIX share de-identified data relative to health outcomes, gaps in services, concerns for placement and proficiency of providers, and the utilization of the EPSDT program. See also Section 8, Service A3, A6, B1, B2.

16. Review: N/A

17. Liaison:
There is shared responsibility to designate specific personnel from Title V and Title XIX to be

responsible for continuous liaison activities. Designated personnel from relevant divisions will meet on a regular basis, with a minimum of 4 meetings a year, to discuss all areas of mutual and singular responsibility for respective programs, to update each other on new developments, and to maintain and enhance communication and cooperation between the entities.

18. Evaluation: N/A

19. General Contract Provisions: N/A

State: North Carolina (Region 4)

Document:
Memorandum of Understanding between the Division of Medical Assistance and the Division of Public Health, [North Carolina] Department of Health and Human Services
Author: North Carolina Department of Health and Human Services
Date: [2001] **Pages:** 52 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/nc_1_1.pdf*

Contractual Details:

1. Effective Date: April 1, 2001.
2. Duration: Will remain in effect until terminated by one or both parties.
3. Type of Agreement: Memorandum of Understanding.
4. Agencies Involved:
A. Division of Medical Assistance (DMA) [Title XIX].
B. Division of Public Health (DPH) [Title V].
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives: To improve the health of Medicaid eligible clients.

7. Responsibilities: N/A

8. Services Provided by Agency:
Mutual Services.
1. Collaborate in (a) planning, (b) consultation and TA to providers, (c) development of agreements with other State agencies.
2. Consult with appropriate groups and develop health services policies.
3. Administer the Baby Love Program.
4. Promote appropriate access to comprehensive care.
5. Take part in joint initiatives.
6. Coordinate activities between health programs.
7. Ensure allowable cost reimbursement for services provided to eligible Medicaid clients.

8. Provide public health specific program guidance as needed.
9. Update and develop program manuals and guidance.
10. Develop a system of local service providers to refer pregnant women and EPSDT children under age 5 to WIC and MCC programs.
11. Determine when changes are needed to the list of covered services.

The MOU also includes a detailed list of DPH and DMA responsibilities; local health department information; arrangements for immunizations; arrangements for purchase of medical care services for CSHCN; arrangements for HealthCheck/EPSDT; arrangements for fostered child health nurse screeners; arrangements for school-based health centers; arrangements for HIV case management and AIDS home and community-based services; and details on data exchange.

9. Cooperative Relationships:
DMA and DPH will cooperate in providing consultation, technical assistance, policy and program guidance to local service providers.

10. Services Provided by Local Agencies:
A local entity may enter into agreements with physicians and dentists for the provision of services that are to be reimbursed to the agency in accordance with the Medicaid Fee Schedules. When the local entity enters into an agreement, a supplemental provider agreement must be executed between the local health department and physician.

11. Identification and Outreach:
DMA and DPH shall provide outreach and marketing activities that promote appropriate health services utilization.

12. Reciprocal Referrals: See Section 8, Service 10.

13. Coordinating Plans: See Section 8, Service 1, 5, 6.

14. Reimbursement: See Section 8, Service 7.

15. Reporting Data:
A. DMA will:
1. Authorize access to Medicaid eligibility files.
2. Authorize access to Medicaid paid claims datasets.
3. Review reports, articles, data tables, and other products of analysis of Medicaid data.
4. Approve or disapprove written requests from CHIS for use of data.
5. Approve or disapprove written requests from CHIS to publish/release data.

B. CHIS will:
1. Use DMA datasets only for aggregate analysis of data.
2. Provide a copy of reports requiring linkages of vital records and Medicaid program files.
3. Obtain approval of DMA prior to release of information.
4. Obtain approval of DMA for any use of data.

16. Review: The parties to the agreement will review its contents at least once annually.

17. Liaison:
The Assistant Director of Medical Policy in DMA and the Deputy Division Director in DPH shall serve as agency liaisons for the purposes of implementing this MOU.

18. Evaluation: See Section 8, Service 11.

19. General Contract Provisions:
lack of funds
amendment/modification of agreement
termination of agreement

State: North Dakota (Region 8)

Document:
Cooperative Agreement between North Dakota Department of Human Services and North Dakota Department of Health and Primary Care Office/Primary Care Association
Author: North Dakota Department of Human Services
Date: 2003 **Pages:** 9 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/ND_1_1.pdf*

Contractual Details:

1. Effective Date: July 1, 2003.
2. Duration: Until further review required.
3. Type of Agreement: Cooperative Agreement.
4. Agencies Involved:
A. The North Dakota Department of Health (Health) [Title XIX].
B. The North Dakota Department of Human Services (DHS) [Title V].
C. The Primary Care Office (PCO).
D. The Primary Care Association (PCA).
5. Authority Cited:
42 CFR 431.615 and Chapter 50-24.1 North Dakota Century Code (NDCC).

Summary Related to CMS Requirements:

6. Objectives:
A. To define the responsibilities of the parties with respect to persons receiving Title XIX, TV, Title X, WIC, North Dakota Head Start-State Collaboration Office, Diabetes Prevention and Control Program, Right Track Program, Immunizations Program, and Birth Review Program services.
B. To ensure quality and accessible care to improve the health status of CSHCN, pregnant women, mothers, infants and children, especially those who are disadvantaged. Achievement of

this goal will be facilitated by formalizing and strengthening relationships between programs, reducing duplication, increasing accessibility, and providing mechanisms for enhanced program coordination.

7. Responsibilities:
A. DHS is the State agency responsible for administering Medicaid.
B. DHS is responsible for administering Children's Special Health Services (CSHS).
C. DHS is responsible for administering early intervention services.
D. Health is the State agency responsible for administering the MCH Program, WIC, the Title X Family Planning Program, the Immunization Program, and the Diabetes Prevention and Control Program.
E. Health is responsible for planning and implementing MCH and nutrition services.

8. Services Provided by Agency:
A. DHS/Title XIX.
1. Payment: DHS shall reimburse Title V and Title X Programs that have entered into provider agreements with DHS at the rates established. DHS will monitor and ensure that duplication of payment is avoided.
2. Local Coordination: County social service departments shall make Title XIX eligibility determinations for potentially eligible individuals referred by MCH, SCHS, Title X, Immunization, WIC, and other programs; promote and refer Title XIX eligible persons in need of services to the various programs listed in this agreement; inform Title XIX eligible recipients about the North Dakota Health Tracks Program and refer all eligibles for scheduling of screening appointments and any necessary follow-up; and inform and refer families who do not qualify for Title XIX to the Healthy Steps Program (SCHIP).

B. DHS/Title V.
1. Title V CSHS Service Programs: DHS shall conduct, coordinate, and fund, in part, local Title V CSHS Programs which provide health services to eligible CSHCN and their families; provide care coordination; and monitor and ensure that duplication of payment is avoided.
2. Local Coordination: CSHS shall refer CSHCN and their families to county social services to determine eligibility for Medicaid and other social service programs and to local WIC agencies; promote and refer to other programs for provision of health services to potentially eligible children and their families.

C. DHS/Developmental Disabilities (DD) Unit.
1. The DD Unit shall utilize Federal Part C funds to cover printing and postage costs of the Birth Review Program.
2. The DD Unit will print letters received by e-format from the HEALTH and mail them to families to inform them of available services.
3. The DD Unit will forward requests the CSHS has received for developmental screenings to regional HSC for Right Track screenings.

D. DHS/North Dakota Head Start and Early Head Start Programs (NDHS/EHS).
1. NDHS/DHS will work with other programs to promote an exchange of information.

2. Local Coordination: NDHS/DHS will refer children and their families to county social services to determine eligibility for Medicaid and WIC eligibility; promote and refer children and their families to other local public health programs as deemed appropriate.

E. Health/Title V.
1. Title V Service Projects: Health shall monitor, assess, and fund, in part, local Title V MCH Projects which provide public health services to eligible women, infants, and children in selected sites throughout the State; encourage eligible local Title V MCH Projects to apply for provider status and to apply for direct reimbursement; monitor and ensure that duplication of payment is avoided.
2. Local Coordination: Health shall refer potentially eligible women, infants, children, and their families to designated personnel to determine program eligibility; promote the use of appropriate programs for eligibles.

F. Health/Optimal Pregnancy Outcome Program (OPOP).
1. Title V OPOP Services Projects: OPOP shall monitor, assess, and fund, in part local OPOP agencies which provide direct health services and education.
2. Local Coordination: OPOP shall refer potentially eligible women, infants, children, and their families to designated personnel to determine program eligibility; promote the use of appropriate programs for eligibles.

G. Health/Title X Family Planning.
1. Title X Service Programs: Title X Family Planning shall monitor, assess, and fund Local Family Planning Programs to ensure the quality, cost, accessibility, acceptability, reporting and performance of delegate agencies.
2. Local Coordination: The Family Planning Program shall accept any Title XIX recipient for family planning services. Proper referrals shall be made and confidentiality maintained.

H. Health/WIC Program.
1. WIC Services: The state WIC Program shall fund, provide policies and procedures, and evaluate services of local WIC agencies.
2. Local Coordination: Information provided by applicants and participants may be provided to designated representatives of other programs for the purpose of establishing the eligibility of applicants. Local WIC Programs will promote and refer persons in need to the appropriate programs.

I. Health/Immunization Program.
1. Immunization Program: The State Immunization Program shall provide the following: vaccines to administer to eligible children; assessment of State/county provider immunization coverage levels; TA on immunization administration protocols and vaccine storage and handling; vaccine administration forms, information statement, etc.; quality assurance reviews of public and private vaccine providers; and laboratory testing of pregnant women for hepatitis B surface antigen.
2. Local Coordination: Aggregate and individual immunization data will be shared with various stakeholders (e.g., WIC, North Dakota Health Tracks, MCH CSHS, Title X, and the Medicaid

Vaccine for Children Program).
J. Health/Diabetes Prevention and Control Program.
1. Diabetes Prevention and Control Program: The State Diabetes Prevention and Control Program will provide the following: collection, analysis, and distribution of surveillance data; implementation of clinical practice guidelines, quality management indicators, and quality improvement projects; development and implementation of educational campaigns; development of community-based interventions; sponsorship of patient and professional education programs; advocacy for reimbursement; and establishing improved access to care.
2. Local Coordination: The Diabetes Prevention and Control Program will provide assistance with local diabetes systems.

9. Cooperative Relationships:
Language is integrated throughout Section 8.

10. Services Provided by Local Agencies:
Local Coordination is typically addressed as the second service under each of the program areas. See Section 8, Service A2, B2, D2, E2, F2, G2, H2, I2, J2.

11. Identification and Outreach: N/A

12. Reciprocal Referrals:
Referrals are treated in local coordination under each of the program areas in Section 8.

13. Coordinating Plans:
In addition to services outlined in Section 8, coordination is to occur at a state level and will include continuous liaison (see Section 17), the administration of the State Systems Development Initiative (SSDI) grant (see Section 15), periodic review (see Section 16), and evaluation of policies (see Section 18).

14. Reimbursement:
Funding and reimbursement is typically address in the first service under each of the program areas in Section 8.

15. Reporting Data:
DHS and Health, through administration of the State Systems Development Initiative (SSDI) grant, will work cooperatively to improve the data collection and analysis capacity in the Title V program. Data will be used to carry out needs assessment activities, including identification of health priority needs for the MCH population, and program planning and evaluation. Cooperation will include support in linking of data sets, research methodology, and statistical analysis from appropriate DHS and Health Department personnel.

16. Review:
The designated DHS and Health representatives shall meet as needed, but at least biannually, to evaluate and assess the joint efforts outlined in this agreement.

17. Liaison:
DHS and Health will identify staff that will serve as liaisons between state programs. These persons shall have the authority to represent their respective agencies in the development and implementation of work plans and in the resolution of any programmatic or procedural problems.

18. Evaluation:
Each agency will ensure an opportunity for the liaison staff and other affected staff to review and comment on proposed policy changes or initiatives.

19. General Contract Provisions:
indemnification/liability
termination of agreement
amendment/modification of agreement
confidentiality of records/HIPAA

State: Ohio (Region 5)

Document:
Interagency Agreement between the Ohio Department of Job and Family Services and the Ohio Department of Health
Author: Ohio Department of Health
Date: 2003 **Pages:** 11 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/oh_1_1.pdf*

Contractual Details:

1. Effective Date: Upon execution (signed 10/23/2003).
2. Duration: October 23, 2003 - June 30, 2005.
3. Type of Agreement: Interagency Agreement .
4. Agencies Involved:
A. The Ohio Department of Job and Family Services (ODJFS) [T19 and 21].
B. The Ohio Department of Health (ODH) [T5].
5. Authority Cited:
A. 42 U.S.C. Section 701, et. seq.
B. 7 CFR, Part 246.
C. 42 U.S.C. Section 705(a)(5)(F).

Summary Related to CMS Requirements:

6. Objectives:
A. To coordinate health services and to conduct outreach, program eligibility, and payment for services for Ohio mothers and children.
B. To support the State MCH Services Block Grant, the Early Childhood Comprehensive Services (ECCS) Plan, and the Healthy Child Care Ohio grant program.

C. To clarify issues, define problems, and propose alternatives related to promoting a statewide system of coordinated health services to eligible women and children.
D. To increase public awareness of the need for health care coverage and services for women and children.
E. To conduct outreach to ensure that eligible women and children receive access to health care coverage and receive needed health services and to ensure that the agencies signing this Agreement serve their common population.
F. To make available health services statewide that meet the requirements of the MCH Services Block Grant, WIC, etc. and the Title XIX Medicaid programs.
G. To coordinate the exchange of information and referrals between programs for the purposes of outreach, eligibility determination, and verification of outcome of referral.
H. To maximize the efficient use of Federal and State funds.
I. To participate actively in the planning and implementation of services.
J. To share the goal of interdepartmental cooperation in coordinating and implementing interagency systems.
K. To improve, expand, and maximize the efficiency and effectiveness of existing resources and services.
L. To increase public awareness of the need for health care coverage and a range of developmental screenings.
M. To coordinate the exchange of information between the parties.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. ODJFS.
1. Require CDJFS staff to identify participants potentially eligible for the WIC and MCH Programs and to refer them to the appropriate program.
2. Make available to the DFCHS the Ohio Medicaid Management Information System.
3. Provide ODH's DFCHS with current information about Medicaid eligibility, services, and policies.
4. Include with Medicaid eligible consumers' medical card a message regarding medical services provided by other programs.
5. Provide ODH with information on ODJFS programs for use by HMG Helpline employees.
6. Provide ODH with current lists of Managed Care Plans contracting with Medicaid.
7. Provide ODH with the Combined Program Application.
8. Provide ODH with updated lists of local DCJFS contact information.

B. ODH.
1. Require various programs to identify and refer to CDJFS those people who are potentially eligible for services and assist them in applying for Medicaid.
2. Keep all consultants informed of Medicaid eligibility guidelines and promote increased use of Medicaid by local health departments, public health agencies, and other agencies serving mothers and children.
3. Provide ODJFS with updated lists of MCH programs.
4. Require the local programs to have information regarding MCH programs available for

clients.
5. Operate the HMG Helpline.
6. Require that CFHS and CMH program providers are Title XIX and Title XXI providers.
7. Provide ODJFS's Bureau of Consumer and Program Support with information about policies governing the DFCHS programs.
8. Ensure that the CMH program shall not be the payer for services eligible for payments by ODJFS programs.
9. Notify ODJFS of any significant reimbursement policy and program changes.
10. Not make any changes to the CPA form.

C. Mutual Responsibilities.
1. Assist their respective local agencies in carrying out the provisions of this agreement by providing training and TA promoting improved health services for women and children.
2. Coordinate outreach, education, and program promotion.
3. Explore common issues and participate in meetings for joint planning.
4. Representatives of ODH and ODJFS shall meet upon request of either of the parties to review implementation of this Agreement.
5. Maintain representatives on committees, task forces or ad hoc work groups of the respective departments for the purpose of ensuring coordination of services, eliminating duplication, and maximizing resources.

9. Cooperative Relationships: See Section 8, Service C3.

10. Services Provided by Local Agencies: See Section 8, Service B4, C1.

11. Identification and Outreach:
See Section 8, Service A1, C2 (further requires developing joint outreach or public relations programs and/or materials for the purpose of promoting programs administered by ODH and/or ODJFS), B1, C2.

12. Reciprocal Referrals: See Section 8, Service B1.

13. Coordinating Plans: N/A

14. Reimbursement: See Section 8, Service B8, B9.

15. Reporting Data: See Section 8, Service A2, A3, A5, B7.

16. Review: See Section 8, Service C4.

17. Liaison: See Section 8, Service C5.

18. Evaluation: See Section 8, Service C4.

19. General Contract Provisions:
failure to satisfy SOW
amendment/modification of agreement
nondiscrimination
confidentiality of records/HIPAA
audit
dispute resolution mechanism
maintenance of records/record keeping

State: Oklahoma (Region 6)

Document: *[Oklahoma] Memorandum of Agreement*
Author: Oklahoma State Department of Health
Date: 2004 **Pages:** 4 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/ok_1_1.pdf*

Contractual Details:

1. Effective Date: October 1, 2004.
2. Duration: October 1, 2004 - September 30, 2005.
3. Type of Agreement: Memorandum of Agreement.
4. Agencies Involved:
A. Oklahoma State Department of Health (OSDH) [Title V].
B. Oklahoma Department of Human Services (OKDHS) [Title XIX].
5. Authority Cited: Title 74, O.S. 1991, section 581.

Summary Related to CMS Requirements:

6. Objectives:
To jointly seek to provide services to the CSHCN population of the State of Oklahoma.

7. Responsibilities:
A. The OSDH and the OKDHS are the agencies responsible for administering the MCH Block Grant in Oklahoma.
B. The OKDHS is responsible for administering the CSHCN Program, which is a portion of the Federal MCH Block Grant.

8. Services Provided by Agency:
A. OKDHS.
1. Develop and carry out a program for CSHCN in accordance with all Federal and State requirements, including capturing existing data or developing/identifying systems to capture data for reporting on national and State specific performance measures.
2. Participate in monthly coordination meetings with MCH Service and other meetings as are necessary to ensure collaboration between Title V services for CSHCN and Title V services

for pregnant women, mothers, infants, and children; and to ensure collaboration on the Title V Annual Report and Application process.
3. Designate the Division Director of Family Support Services Division (FSSD) as the Title V CSHCN Director; provide sufficient support and staff to ensure operation of the CSHCN Program to meet performance measures.
4. Commit to use all available resources of OKDHS to ensure systems development and to provide access to comprehensive community-based systems of care by offering fully integrated and comprehensive services.
5. Identify clear lines of responsibility and supervision for the CSHCN Program to improve coordination of CSHCN administered programs with all other OKDHS services; increase the infrastructure building activities of the CSHCN Program.
6. Be responsible for the development of the CSHCN portion of the annual block grant application and report; OKDHS will designate a contact person with whom MCH will coordinate.
7. Ensure compliance with State matching and maintenance of effort requirements applicable to the OKDHS share of block grant funds.
8. Ensure strict adherence to contracting procedures that include monitoring activities and claims auditing activities by the OKDHS staff.

B. OSDH.
1. Coordinate with the OKDHS in the development of the CSHCN portion of the annual block grant application and report; designate a contact person to whom OKDHS will provide all requested information.
2. Participate in monthly coordination meetings with CSHCN Program and other meetings as are necessary to ensure collaboration between the Title V services for pregnant women, mothers, infants, and children with the Title V services for CSHCN and to ensure collaboration on the Title V Annual Report and Application process.
3. Make CSHCN funds directly available to the OKDHS for program activities and administrative costs with payments to be made monthly or quarterly. Funding amount is based on appropriation information provided by HHS and is contingent upon the actual Block Grant Fund Award.

9. Cooperative Relationships: See Section 8, Service A6, B2.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. See Section 8, Service A2, A5, B2.

14. Reimbursement: See Section 8, Service A7, B3.

15. Reporting Data: See Section 8, Service A1.

16. Review: N/A

17. Liaison: See Section 8, Service A6, B1.

18. Evaluation: N/A

19. General Contract Provisions:
termination of agreement
audit
indemnification/liability
amendment/modification of agreement

State: Oregon (Region 10)

Document: *[Oregon] Intergovernmental Agreement [and Amendment]*
Author: Oregon Department of Human Services
Date: 1995, 2000 **Pages:** 10 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/or_1_1.pdf*

Contractual Details:

1. Effective Date:
July 1, 1995, amended July 1, 2000 (changes to agreement are underlined).
2. Duration:
This Agreement shall become effective on July 1, 1995, and shall expire unless otherwise terminated or extended, on June 30, 2005.
3. Type of Agreement: Intergovernmental Agreement.
4. Agencies Involved:
A. Department of Human Services, Office of Medical Assistance Programs (OMAP) [Title XIX].
B. Oregon Health Sciences University, Child Development and Rehabilitation Center (CDRC) [Title V].
5. Authority Cited:
A. Original Oregon Intergovernmental Agreement number 51290.
B. 42 CFR 431.615.

Summary Related to CMS Requirements:

6. Objectives:
To encourage appropriate and maximum utilization of the services of the CDRC by OMAP clients who are eligible for medical assistance under Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program).

7. Responsibilities:
A. CDRC is responsible for providing services for CSHCN under Title V and other highly specialized services, including services to adults with hemophilia.
B. OMAP is responsible for reimbursing CDRC at cost for services provided by CDRC to OMAP clients eligible for medical assistance under Title XIX.

8. Services Provided by Agency:
A. CDRC shall provide the following services to Medicaid recipients:
1. Multidisciplinary evaluation.
2. Case management and medical services such as physicians services, nursing services, laboratory and other diagnostic testing, physical and occupational therapy, evaluations and treatment, psychological/psychiatric evaluations, speech and audiological evaluations and treatment, hearing aids, dental services, amniocentesis and genetic counseling for parents of children with disabling conditions, prosthetic, orthotic, and other medical supplies and equipment, and EPSDT screenings.
3. Specialized treatment services through outpatient clinics at CDRC centers

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. Coordinating Plans: N/A

14. Reimbursement:
Billings will be done on the UB-92 in accordance with billing instructions and requirements in OMAP's Hospital Services Guide. CDRC agrees that it is not a direct provider of augmentative communicative devices or other large items of durable medical equipment. CDRC is not required to obtain prior authorization before billing for covered services, except CDRC agrees to conform to all limitation on services in the provision of hearing aids. (Additional details are given for overpayment, interim payment, third part billing, and the maximum compensation to be billed).

15. Reporting Data: N/A

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
confidentiality of records/HIPAA
indemnification/liability
failure to satisfy SOW

State: Rhode Island (Region 1), document 1 of 2

Document:
Rhode Island Department of Health, Division of Family Health: Medicaid/EPSDT Administrative Activities
Author: Rhode Island Department of Health, Division of Family Health
Date: 1995 **Pages:** 12 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/ri_1_2.pdf*

Contractual Details:

1. Effective Date: February 16, 1995.
2. Duration: N/A
3. Type of Agreement: N/A
4. Agencies Involved:
This document lists only the Department of Human Services (DHS), Division of Family Health's [Title V] administrative activities as they relate to Medicaid/EPSDT.
5. Authority Cited: Generally cites the SSA, but does not give specific reference.

Summary Related to CMS Requirements:

6. Objectives:
To specify the administrative activities related to the Medicaid/EPSDT programs that include all activities designed to ensure the availability, accessibility, and coordination of required health care resources.

7. Responsibilities:
The Department of Human Services (DHS), Division of Family Health is responsible for coordinating and care planning to assist individuals to enroll in a program; arranging for and providing a support plan of care; program planning and development to establish strategies and model projects to ensure system capacity; conducting activities that ensure needed services; and billing for activities that will not include costs for activities currently being provided in accordance with the Head Start, Early Intervention, and Adolescent Pregnancy Medicaid agreements.

8. Services Provided by Agency:
The Department of Human Services (DHS), Division of Family Health will provide the

following services (multiple examples of each type of service are provided in the document):
A. Outreach and Intensive Informing: using a combination of oral and written information methods that describe the range of services available through the programs and the benefits of preventive or remedial care offered by these programs.
B. Facilitating Medicaid Applications: assisting in determining eligibility.
C. Care Planning and Coordination Activities: coordinating screenings, assessments, examination, and evaluations, assisting individuals access services, etc.
D. Interagency Coordination: performing collaborative activities with other agencies to 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, or define the scope of each agency's programs.
E. Other Training: conducting or participating in training.
F. Program Planning and Development: performing activities that support the planning and development of programs.
G. Quality Management: performing activities such as program monitoring and auditing that are necessary for proper and efficient Medicaid administration.

9. Cooperative Relationships:
See Section 8, Service D (developing IAAs to maximize effectiveness of service delivery and accessibility to services, and to minimize duplication).

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service A, B.

12. Reciprocal Referrals: N/A

13. Coordinating Plans: See Section 8, Service C.

14. Reimbursement: N/A

15. Reporting Data: N/A

16. Review:
Reviewing program policies, procedures, standards protocols, and health related educational materials.

17. Liaison: N/A

18. Evaluation:
Working with other agencies to evaluate the effectiveness of service delivery systems and needed improvements.

19. General Contract Provisions: N/A

State: Rhode Island (Region 1), document 2 of 2

Document:
Memorandum of Agreement between the Department of Human Services, RI Department of Health, and RI Health Center Association Regarding the: Rhode Island Family Resource Counselor Program
Author: Rhode Island Department of Health, Division of Family Health
Date: 2004 **Pages:** 12 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/ri_2_2.pdf*

Contractual Details:

1. Effective Date: June 14, 2004.
2. Duration: N/A
3. Type of Agreement: Memorandum of Agreement.
4. Agencies Involved:
A. Department of Health (DOH) [Title V].
B. Department of Human Services (DHS), Division of Family Health [Title XIX].
C. Rhode Island Health Center Association (RIHCA).
5. Authority Cited: N/A

Summary Related to CMS Requirements:

6. Objectives: N/A

7. Responsibilities:
The Family Resource Counselor Program is designed to screen and refer pregnant women, children and families for RIte Care/RIte Share, Family Independence Program (FIP), Child Care Subsidy, Food Stamps and Women, Infants and Children (WIC) and to help them apply for RIte Care/RIte Share.

8. Services Provided by Agency:
A. DOH.
1. Explore ongoing funding sources in collaboration with DHS and RIHCA.
2. Analyze data provided by RIHCA and DHS for the purpose of program evaluation.
3. Conduct overall program evaluations.
4. Provide annual training on WIC eligibility and referrals.
5. Participate jointly with DHS and RIHCA in overall program oversight and policy development for the FRC program.
6. Participate in quarterly FRC planning meetings.
7. Participate in quarterly FRC trainings.
8. Participate in the monthly Covering Kids and Families FRC Network meetings.

B. CHS, Center for Child and Family Health (CCFH).
1. Explore ongoing funding sources.
2. Have a liaison or designee participate in quarterly FRC planning meetings.
3. Have a liaison or designee participate in quarterly FRC trainings.
4. Enter into a data sharing agreement with RIHCA.

C. DHS.
1. Assign a Field Operations Liaison to be responsible for ensuring that RIHCA is given timely updates and information.
2. Assign a Field Operations Liaison to participate in quarterly Field/FRC Issue meetings.
3. Assign a Field Operations Liaison to participate in quarterly FRC planning meetings.
4. Assign a Field Operations Liaison to participate in quarterly FRC trainings.
5. Have regional managers or their designees participate in semiannual meetings.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. Coordinating Plans: N/A

14. Reimbursement: See Section 8, Service A1.

15. Reporting Data:
RIHCA agrees to the following:
1. To collect data from the FRCs on a monthly basis.
2. To compile data from the FRC reports on the number of individuals screened for FIP, Food Stamps, WIC, and RIte Care, the number of RIte Care/RIte Share applications completed, and provide written reports to Health, DHS, Covering Kids and Families RI and FRC sites.
3. To track on a monthly basis systemic barriers to enrollment and application assistance.

16. Review: N/A

17. Liaison:
RIHCA agrees to the following:
1. To advocate on behalf of all FRCs to resolve barriers to application assistance and enrollment.
2. To act as a liaison between DHS, Health, and the FRCs.
3. To participate in quarterly Field/FRC Issue meetings with the DHS Field Operations Liaison to discuss specific issues and obtain policy and procedure updates.
4. To coordinate semiannual meetings at each field office with the Regional Manager, local DHS eligibility staff, and the FRCs to ensure continued positive working relationships and reduce barriers to enrollment and renewal.

18. Evaluation:
See Section 8, Service A3 for overall program evaluation.

19. General Contract Provisions: N/A

State: South Carolina (Region 4)

Document:
Memorandum of Agreement between South Carolina Department of Health and Environmental Control and State Budget and Control Board, Office of Research and Assistance to Link Maternal and Child Health Data Files for Public Health Research, Evaluation, and Surveillance
Author: South Carolina Department of Health and Environmental Control
Date: 2004 **Pages:** 12 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/SC_1_1.pdf*

Contractual Details:

1. Effective Date: July 1, 2004.
2. Duration: July 1, 2004 – June 30, 2006.
3. Type of Agreement: Memorandum of Agreement.
4. Agencies Involved:
A. South Carolina Department of Health, Environmental Control (DHEC) [Title V].
B. State Budget and Control Board, Office of Research and Statistics (ORS).
5. Authority Cited:
A. HIPAA 45 CFR, Parts 160 and 164.
B. Family Privacy Protection Act, South Carolina Procurement Code, Section 11-35-10, et. Seg.

Summary Related to CMS Requirements:

6. Objectives:
A. To cooperate in creating linked, de-identified data files that will be used for public health and health care research, program evaluation, and surveillance.
B. To establish the parameters for the linking and analysis of MCH data files with other State agency and hospital utilization data sets for public health and health care research, evaluation, and surveillance purposes.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. SC DHEC.
1. Provide client specific data from appropriate program specific information systems.
2. Provide ORS with documentation and code structure for each data set.
3. Ensure that DHEC and DHEC funding agencies have the authority to audit, confirm, and test that adequate procedural controls are in place to protect the confidentiality and use of data shared.

4. Geocode DHEC Public Health Information and Statistics (PHSIS) all linked address data using Census geography levels.

B. ORS.
1. Establish and maintain procedures and controls to maintain confidentiality.
2. Hold in strictest confidence the identity of all DHEC clients.
3. Perform the link between the DHEC datasets and other State agency and health care utilization data sets to create de-identified data sets for public health and health care research, evaluation, and surveillance.
4. Coordinate all requests for access to the linked data files.

9. Cooperative Relationships: N/A

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: N/A

12. Reciprocal Referrals: N/A

13. Coordinating Plans: N/A

14. Reimbursement: N/A

15. Reporting Data:
This Agreement deals exclusively with maintenance and transfer of data files. See Section 8 for details.

16. Review: N/A

17. Liaison: N/A

18. Evaluation: N/A

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
confidentiality of records/HIPAA
indemnification/liability
nondiscrimination

State: South Dakota (Region 8)

Document:
Joint Powers Agreement between South Dakota Department of Social Services, Office of Medical Services and South Dakota Department of Health, Division of Health and Medical Services
Author: South Dakota Department of Social Services
Date: n.d. **Pages:** 3 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/SD_1_1.pdf*

Contractual Details:

1. Effective Date: N/A
2. Duration: A period of 1 year from the date both parties sign this agreement.
3. Type of Agreement: Joint Powers Agreement.
4. Agencies Involved:
A. South Dakota Department of Social Services (DSS), Office of Medical Services [Title XIX].
B. South Dakota Department of Health (DOH), Division of Health and Medical Services [Title V].
5. Authority Cited: SDCL 1-24-2 though 1-24-9.

Summary Related to CMS Requirements:

6. Objectives:
A. To promote high-quality health care and services for Medical Assistance program recipients.
B. Whereas, DSS and DOH:
1. Intend to promote high quality health care and services for recipients under the Medical Assistance Program.
2. Intend to comply with State and Federal statues, etc.
3. Intend to ensure services provided under Title XIX and Title V are consistent with the needs of recipients and DSS and DOH objectives and requirements.
4. Intend to maximize utilization of MCH Services by DSS in the provision of medical assistance.
5. Intend to maximize utilization of the Medical Assistance Program by DOH in the provision of MCH Services.
6. Believe it is an efficient use of State resources to undertake this joint undertaking demonstrating the commitment of both parties to ongoing collaboration.

7. Responsibilities: See Section 6.

8. Services Provided by Agency:
A. DSS.
1. Refer Title XIX eligible children under 18 to DOH's SCHS whose physical functions and movements are impaired.
2. Refer all sexually active women of child bearing age and their male partners in need of

contraception counseling to the local Family Planning Clinic or other family planning providers.
3. Refer all Title XIX pregnant women to the Community Health Services Program.
4. Refer all known pregnant, postpartum, and breastfeeding women and young children potentially eligible to WIC for services.
5. Accept financial responsibility for reimbursement of medically necessary preventive, diagnostic, medical or remedial care and services provided to any individual under 21 or any individual who is pregnant to the extent of that individual's medical assistance entitlement.
6. Accept responsibility for payment of services within the scope of the Medical Assistance Program provided by any of the eligible individuals in accordance with fees allowed through the Medical Assistance Program and South Dakota Department of Health Programs.
7. Consult with DOH in developing the standards and periodicity and vaccination schedules for EPSDT program with DOH.

B. DOH.
1. Refer to DSS all those under 21 and women of child-bearing age in need of preventive, diagnostic, medical or remedial care and services and who are, or may be, eligible.
2. Inform any Title XIX/CHIP eligible families with children about the EPSDT program and make appropriate referrals.
3. Identify pregnant women and infants who are potentially eligible for Title XIX and assist them in applying.
4. Identify potentially eligible children and assist them in applying for the CHIP program.
5. Participate in the establishment of periodicity schedules and content standards for the EPSDT program.
6. Provide risk assessments and other services to Title XIX eligible pregnant women potentially in need of administrative case management services.
7. Participate in outreach efforts of the CHIP program by providing information with health fairs, immunization clinics, Community Health Services Offices, and public health alliance offices.
8. Provide a toll-free telephone number for use by parents and consumers to access information about physicians, practitioners, and other health care providers in South Dakota.

C. Mutual Services.
1. Enhance coordination between departments by establishing procedures for the early identification of individuals under 21 in need of preventive, diagnostic, medical or remedial care, and services provided by either department.
2. Retain the sole and exclusive right to terminate eligibility.
3. Make such reports that may be required.
4. Designate a professional staff person on behalf of each department to act as the liaison for the activities contained in this agreement.
5. Enhance coordination between departments by establishing procedures for early intervention of pregnant women in need of medical care and services provided by either department.

9. Cooperative Relationships: See Section 8, Service C5.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service A6, B7, B8.
12. Reciprocal Referrals: See Section 8, Service A1, A2, A3, A4, B1, B2, B3, B4.
13. Coordinating Plans: See Section 8, Service B5, C1.
14. Reimbursement: See Section 8, Service A5, A6.
15. Reporting Data: See Section 8, Service C3.
16. Review: N/A
17. Liaison: See Section 8, Service C4.
18. Evaluation: N/A
19. General Contract Provisions:
amendment/modification of agreement
termination of agreement

State: Texas (Region 6)

Document:
[Explanation on the Lack of Formal Title V/Title XIX Interagency Agreement in the state of Texas]

Contractual Details:

"In Texas, both state MCH programs (currently in the newly formed Texas Department of State Health Services) and the state Medicaid program (organizationally part of Texas Health and Human Services Commission) are both organizationally aligned under the Health and Human Services Commission (HHSC), the 'umbrella/oversight' agency for Texas' health and human services system. This organizational alignment permits the MCH and Medicaid programs to work collaboratively and cooperatively in the absence of formal interagency agreements, on most issues.

However, there are such instances where agreements become more formalized. For example, certain elements of the MCH program are formalized as part of an RFP and/or contracts made between the State and various contractors. For example, the RFP found at http://www.hhsc.state.tx.us/medicaid/procure/rfp.html relates to formalized activities related to the CSHCN program and Texas' Medicaid claims administrator."

-- Maria Vega, Title V Block Grant Coordination, Texas Department of State Health Services.

State: Utah (Region 8)

Document:
Memorandum of Agreement: Utah Department of Health, Division of Health Care Financing and Division of Community and Family Health Services: Interagency Coordination - Title V, Title XIX [Draft]
Author: Utah Department of Health
Date: 2001 **Pages:** 17 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/UT_1_1.pdf*

Contractual Details:

1. Effective Date: April 1, 2001.
2. Duration: Will not terminate unless in accordance with the terms of this agreement.
3. Type of Agreement: Memorandum of Agreement.
4. Agencies Involved:
A. Utah Department of Health, Division of Health Care Financing and Division of Community (DCFHS) [Title V] .
B. Utah Department of Health, Division Family Health Services (DFH) [Title XIX].
5. Authority Cited: 42 CFR 431.615(c4).

Summary Related to CMS Requirements:

6. Objectives:
A. To formalize and strengthen the relationship between DCFHS and DHCF in areas of mutual interest and concern, avoid duplication of effort, improve access to T19 and T5 to eligible Medicaid clients.
B. To enhance the quality and T19 and T5 services.
C. To enhance program coordination and information exchange to the extent possible.

7. Responsibilities: N/A

8. Services Provided by Agency:
A. DHCF.
1. Assign the Director of Health Care Financing, or designee, to be Division liaison to DCFHS.
2. Coordinate and collaborate with DCFHS in planning and implementing Medicaid services related to MCH populations.
3. Collaborate with DCFHS to improve access to and quality of services for Medicaid recipients who need MCH services.
4. Reimburse DCFHS, in accordance with 42 CFR 431.614(c4), for the cost of services furnished Medicaid recipients by DCFHS and Title V grantees.
5. Provide the CHEC Program Plan, which includes sections on needs assessment, outreach, and participation data, for use in the MCH Block Grant Application and Annual MCH Report.
6. Coordinate CHEC outreach activities with related programs.
7. Coordinate outreach efforts related to the “Baby Your Baby” program.

8. Collaborate with DCFHS in efforts to improve the immunization rates for all children.
9. Provide non-confidential and readily available enrollment, utilization, and quality assurance data to DCFHS.
10. Disseminate information, annually, through Medicaid Information Bulletins or other methods.
11. Coordinate and collaborate with DCFHS in planning, implementing, and evaluating QA/AI projects.
12. Coordinate and collaborate with DCFHS in monitoring services provided by MCOs.
13. Ensure that all managed care contracts include provisions requiring them to contract with CDFHS for minimum screening and follow-up services.
14. Establish the Division of Community and Family Health Services as a Medicaid provider.
15. Recognize the director of the Bureau of CSHCN as a member of the EPSDT subcommittee.

B. DCFHS.
1. Assign the Director, Bureau of MCH, with the responsibility to ensure the coordination of services, outreach, and education provided by the Title V programs.
2. Assign the Director, Bureau for CSHCN with the responsibility to ensure coordination of services, outreach, and education provided by the Title V programs.
3. Encourage Title V-funded and other DCFHS-sponsored programs to screen families for possible eligibility for Medicaid benefits
4. Provide health care consultation and TA for CHEC, CSHCN, Reproductive Health, Oral Health, and Preventive Child Health Services.
5. Provide dental consultation and serve as liaison with the dental provider community.
6. Designate DCFHS staff to coordinate the Child, Adolescent, and School Health Program and other related programs.
7. Provide to DHCF MCH data related to Medicaid clients.
8. Bill DHCF for selected eternal products.
9. Bill Medicaid for metabolic products.
10. Bill Medicaid for selected enterable and metabolic products for specific WIC clients.
11. Abide by this Agreement.
12. Coordinate and interface with Medicaid managed care plans to follow the care of any person covered through a managed care plan.

C. Mutual Services.
1. Conduct mutual collaboration and coordination. Each Division will designate specific individuals for each forum to coordinate activities.
2. All information regarding recipients of services provided shall be treated as confidential.

9. Cooperative Relationships:
See Section 8, Service A1, A2, A3, A6, A7, A8, A11, A12, B12.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach: See Section 8, Service A6, A7, B3.

12. Reciprocal Referrals: N/A

13. Coordinating Plans: See Section 8, Service A8, A11, A12, B11, B12, C1.

14. Reimbursement: See Section 8, Service A4, B8, B9, B10.

15. Reporting Data: See Section 8, Service A5, A9, A10, B7.

16. Review: Both parties will review this document annually and update as needed.

17. Liaison: See Section 8, Service C1.

18. Evaluation: See Section 16.

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
confidentiality of records/HIPAA
indemnification/liability

State: Virginia (Region 3)

Document:
Interagency Agreement Between Virginia Department of Medical Assistance Services and Virginia Department of Health
Author: Virginia Department of Medical Assistance Services
Date: n.d. **Pages:** 55 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/va_1_1.pdf*

Contractual Details:

1. Effective Date: This agreement shall become effective when signed.
2. Duration: This agreement shall become effective when signed and shall continue thereafter for a period of 3 years.
3. Type of Agreement: Interagency Agreement.
4. Agencies Involved:
A. Virginia Department of Medical Assistance Services (DMAS) [Title XIX].
B. Virginia Department of Health (VDH) [Title V].
5. Authority Cited:
A. 42 CFR, Subpart M, Section 431.610 (f).
B. 42 CFR, Subpart M, Section 431.615 (d).

Summary Related to CMS Requirements:

6. Objectives:
This Agreement consolidated DMAS-VDH agreements into one document. The agreements are organized into three discrete sections as follows:
1. Long-term Care Agreements.
2. Business Associate Agreement and Data Projects.
3. Maternal and Child Health Collaborative.

7. Responsibilities: N/A

8. Services Provided by Agency:
The IAA lists hundreds of services that each agency is responsible for under each of its three discrete sections. The following services are abstracted from the overwhelming list as representative services:

A. DMAS.
1. Require pre-admission screening of all individuals who are eligible for medical assistance.
2. Require local pre-admission screening committees to be available to render decisions.
3. Prepare documentation that describes current program procedures and criteria.
4. Provide training.
5. Authorize Medicaid reimbursement.
6. Provide TA as needed.

B. VDH.
1. Request the District health Director to convene a local community screening committee.
2. Ensure that all local health department personnel have been properly trained.
3. Refer individuals for appropriate services.
3. Determine the necessary for appropriate care in accordance with Medicaid guidelines.
4. Authorize Medicaid reimbursement when appropriate.
5. Submit required forms.

9. Cooperative Relationships:
A section on "Planning, Coordination, and Collaboration" or "Areas of Collaboration" is included in each of the programs listed in all three sections of the IAA and details the overarching call for cooperative relationships detailed in Section 9 above.

10. Services Provided by Local Agencies:
Engagement of local agencies is integrated in many of the services detailed. Plans for services to be provided are often developed locally on conjunction with community partners.

11. Identification and Outreach:
Mechanisms for outreach are given in each of the three sections. E.g., BABYCARE services encompass outreach conducted through medical clinics, physicians' offices, and hospitals.

12. Reciprocal Referrals: N/A

13. Coordinating Plans:
The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH's program plans and budgets. Similarly, actions of the VDH 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.

14. Reimbursement:
DMAS will reimburse VDH by one of three methods (Pass Through Transaction; Vendor Transaction; Licensure and Certification; Claims Processing). VDH shall bill DMAS 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.

15. Reporting Data:
This is a summary of processes to transfer data:

A. VDMSA.
1. Provide a key contact whose responsibility will be to ensure a secure data transfer process and establish proper data use safeguards.
2. Use data for the purpose of verification of a recipients' status and to check for payments made.
3. Acknowledge the receipt of information to VDH.
B. VDH.
1. Provide a key contact whose responsibility will be to ensure a secure data transfer process and establish proper data use safeguards.
2. Provide data on a quarterly basis.
3. Data exchange will be initiated by VDH in a confidential method.

16. Review: N/A

17. Liaison:
DMAS and VDH contacts are given for each of the programs listed in all three sections of the IAA.

18. Evaluation: N/A

19. General Contract Provisions:
amendment/modification of agreement
termination of agreement
confidentiality of records/HIPAA
dispute resolution mechanism

State: Washington (Region 10)

Document:
[Washington] Statement of Work: Interlocal Agreement [Exhibit A, B7, C, E, and F7]
Author: Washington State Department of Health
Date: n.d. **Pages:** 34 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/WA_1_1.pdf*

Contractual Details:

1. Effective Date: [January 1, 2000].
2. Duration: [January 1, 2000 - June 30,2004].
3. Type of Agreement:
Interlocal Agreement in 5 Exhibits: Exhibit A (Statement of Work); Exhibit B7 (Agency Responsibilities); Exhibit C (Administrative Match Reimbursable Activities: Outreach and Linkage); Exhibit E (Compensation and Administration); Exhibit F7 (DOH/DSHS-MAA Accounting Procedures).
4. Agencies Involved:
A. The Department of Social and Health Services (DSHS) - Medical Assistance Administration (MAA) [Title XIX].
B. The Department of Health (DOH) [Title V].
5. Authority Cited: Chapter 39.34 RCW and all relevant and associated statutes.

Summary Related to CMS Requirements:

6. Objectives:
A. To provide DOH reimbursement for a portion of the expenses incurred when performing Medicaid-related administrative activities as described in the Exhibits.
B. To document responsibilities for implementation of the shared DOH and MAA programs and activities and to ensure documented accounting procedures are adhered to and maintained.
C. To document the delegation of certain administrative duties from the T19 Single State Agency to the DOH and to designate responsibilities of DOH and DSHS in their jointly operated programs and activities.

7. Responsibilities:
DOH has responsibility for all MCH program activities, furnishing the necessary personnel and/or services and otherwise do all things necessary for or incidental to the performance of work set forth in this Agreement. Unless otherwise specified, the DOH shall be responsible for performing all fiscal and program responsibilities.

8. Services Provided by Agency:
Exhibit B7: Agency Responsibilities.
A. DOH.
1. MCH Administration.
2. CSHCN: DOH shall (a) promote collaboration with DSHS-MAA; (b) have the CSHCN-

SSI coordinator serve as liaison with the Disabilities Determination Service Unit; (c) maintain policies and procedures; (d) coordinate with DSHS to maintain guidelines on reimbursement; (e) assist MAA in facilitating access to health care for eligible SSI children; (f) coordinate with MAA to provide consultation to CSHCN contractors.
3. MCH Assessment: DOH shall (a) conduct PRAMS surveillance system; (b) reimburse MAA for providing analyses and reports.
4. Genetics: DOH shall (a) maintain and update prenatal genetic counseling information; (b) provide consultation to providers; (c) ensure availability of DOH funds for the State match for Title XIX reimbursement; (d) coordinate training and monitoring activities with MAA.
5. Maternal Infant Health: DOH shall assist with (a) Maternity Support Services (MSS) and childbirth education; (b) Infant Case Management (ICM); (c) First Steps training; (d) Pregnancy Risk Assessment Monitoring System (PRAMS); (e) Healthy Mothers, Healthy Babies (HMHB) outreach; (f) perinatal centers; (g) consultation; (h) home birth; (i) tobacco cessation activities.
6. Child and Adolescent Health / Child Profile: DOH shall coordinate with MAA in developing and implementing strategies to improve access to Medicaid services, including EPSDT, oral health and CHILD Profile health promotion materials.
7. Immunizations: DOH shall promote immunizations and related services for Medicaid and S-CHIP clients
8. MCH Programwide Activities: DOH shall contract with HMHB for a toll-free line and outreach activities.
9. Client Services: DOH shall coordinate with HIV/AIDS case management.
10. Family Planning and Reproductive Health.
11. WIC Program collaboration.
12. Newborn Screening collaboration.
13. Office of Community and Rural Health collaboration.
14. Health Services Quality Assurance collaboration.
15. Office of the Secretary collaboration.
16. Tobacco Prevention and Control Program collaboration.
17. Washington Breast and Cervical Health Program (WBCHP) Transition to Medicaid Case Management.
18. Accounting and Audit.
19. Exchange of Information: All client-specific and aggregate data exchanged shall be maintained. In keeping with measures to protect the confidentiality of records, DOH shall utilize strict security procedures and protection to ensure that these data are not disclosed to unauthorized third parties.

B. DSHS-MAA.
1. General Responsibilities: (a) reimburse approved providers billing for MSS, Prenatal Genetic Counseling Services, and HIV/AIDS Case Management through the MMIS; (b) provide updates to DOH regarding Medicaid and S-CHIP eligibility requirements and program changes; (c) assist Title V contractors in obtaining Title XIX administrative match; (d) DDDS will refer to the Title V CSHCN program all SSI blind and disabled childhood disability decisions who are under the age of 16; (e) designate individuals to coordinate with DOH staff on Medicaid related activities.
2. Immunizations collaboration.
3. Accounting collaboration.

4. First Steps Training collaboration.
5. Office of Community and Rural Health collaboration.
6. Tobacco Control and Prevention Program collaboration.
7. Washington Breast and Cervical Health Program (WBCHP) Transition to Medicaid Case Management.

9. Cooperative Relationships:
Cooperation and coordination of plans is integrated throughout Exhibit B7.

10. Services Provided by Local Agencies: N/A

11. Identification and Outreach:
Exhibit C: Administrative Match Reimbursable Activities: Outreach and Linkage.
Outreach and linkage activities reimbursed by MAA through the Administrative Match program are limited to activities that provide information about the Medicaid program, help potential Medicaid eligibles through the application process, and enhance the ability of Medicaid eligibles to access Medicaid services. Activities that link families with services other than Medicaid are not reimbursable under the Administrative Match program.

12. Reciprocal Referrals: See Section 8, Service B1(d).

13. Coordinating Plans: Cooperation and coordination of plans is integrated in Exhibit B7.

14. Reimbursement:
Exhibit E: Compensation and Administration.
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, DOH is responsible for maintaining compliance with Medicaid Federal regulations and any overpayments requested as a result of audit findings.

Exhibit F7: DOH/DSHS-MAA Accounting Procedures.

See also Section 8, Service B1(a, b).

15. Reporting Data: See Section 8, Service A19.

16. Review: N/A

17. Liaison: See Section 8, Service B1(e).

18. Evaluation: N/A

19. General Contract Provisions: audit

State: Wisconsin (Region 5)

Document:
[Wisconsin] Memorandum of Understanding: Title V, WIC, Title XIX and Title XXI
Author:
State of Wisconsin Department of Health and Family Services, Division of Public Health
Date: 2000 **Pages:** 7 pp.
Document URL: *http://www.mchlibrary.info/iaa/states/wi_1_1.pdf*

Contractual Details:

1. Effective Date: March 7, 2000.
2. Duration: Until terminated or amended.
3. Type of Agreement: Memorandum of Understanding.
4. Agencies Involved:
A. Wisconsin Department of Health and Family Services, Division of Public Health (DPH), including the CSHCN Program and the WIC Program [Title V].
B. Wisconsin Department of Health and Family Services, Division of Health Care Financing (DHCF) [Title XIX].
5. Authority Cited:
No overarching authority cited. Authority for specific programs (e.g., EPSDT and WIC) are cited.

Summary Related to CMS Requirements:

6. Objectives:
To improve the health status of low income women, infants, and children including special needs children by ensuring provision of preventive services and of any necessary treatment and/or follow-up care allowed under the SSA. in the context of an ongoing provider-patient-family relationship and from continuing care providers who can provide quality and comprehensive care.

7. Responsibilities:
A. Title V and WIC funded agencies will be encouraged to make available their range of services to the recipients of Medicaid, including outreach to ensure that all family members who may qualify are informed about the program and how to apply.
B. Recipients of Medicaid will be encouraged to utilize Title V and WIC services.
C. Title V-funded agencies will adhere to the precedence of Medicaid billing principles.
D. Title V program income from Title XIX reimbursed services will be applied as State matching resources, against requirements stated in Federal Title V regulation.
E. HealthCheck (EPSDT) services are to be mutually agreed upon.
F. The parties agree to periodically address issues and resolve problems, and to jointly develop formal procedures that will carry out the spirit and letter of the agreement. An ongoing liaison will be developed between the DPH and DHCF to review content standards for HealthCheck.
G. This Agreement will be reviewed annually by both parties and updated as necessary.

8. Services Provided by Agency:
Services have been designed to address the responsibilities in Section 7, including referring eligible clients between participating programs; obtaining reimbursement for services rendered; sharing of data, reports, and other relevant information; and developing collaborative and/or complementary service programs in the following areas.

A. Medicaid Managed Care Expansion.
B. Wisconsin's Program for CSHCN.
C. Wisconsin WIC Program.
D. Toll-Free Telephone Numbers.
E. HealthCheck (EPSDT).
F. Medicaid Applicant Identification and Assistance.
G. Cooperative and Collaborative Relationships.

9. Cooperative Relationships:
Title V, Title XIX, and the State WIC programs agree to establish cooperative and collaborative relationships, including work groups and periodic meetings, with respect to the following programs and services, including, but not limited to: HealthCheck (EPSDT); Immunizations; CSHCN; Recipient Access/Provider Participation including Electronic Benefits Transfer; Medicaid Clinical Review; Prenatal Care Coordination; Healthy Start; Birth to Three; Children Come First; Expansion of Medicaid Managed Care programs; Medicaid outreach and eligibility; DadgerCare including Title XXI; Family Planning waiver service; and Implementation of Medicaid eligibility functions with the Department of Workforce Development.

10. Services Provided by Local Agencies:
A. Encourage State, regional, and local health department staff to participate in any Medicaid managed care advisory groups.
B. Provide local health departments and WIC projects with essential information on how the Medicaid managed care system works, current information on Medicaid quality of care indicators, and the current Medicaid reimbursement.
C. Provide HMOs with information on local health departments and WIC projects and the services they provide.
D. Promote coordination and collaboration between local health departments WIC Projects, HMOs, and other Title XIX managed care programs.

11. Identification and Outreach: See Section 7, Activity A.

12. Reciprocal Referrals:
HMOs are to refer pregnant, breastfeeding, and postpartum women, infants, and children under age 5 years to the WIC Program. The WIC Program will refer WIC applicants/participants to Medicaid programs and services.

13. Coordinating Plans:
Wisconsin Title V, Title XIX, and WIC Programs agree to collaborate on programs and services to identify pregnant women and children who may be eligible for Medicaid and once identified, to assist them in applying for such assistance, including selecting an appropriate managed care delivery system.

14. Reimbursement:
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:
Electronic data exchange and other data exchange for the administration, evaluation, and analysis of the CSHCN Program.

16. Review: See Section 7 Activity G.

17. Liaison: See Section 7 Activity G.

18. Evaluation: See Section 7 Activity G.

19. General Contract Provisions:
termination of agreement
amendment/modification of agreement
confidentiality of records/HIPAA

Appendix A: Title V and Title XIX Resources

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

Title V/Title XIX Coordination

Association of Maternal and Child Health Programs. 2005. *AMCHP Fact Sheet: Working Together – The Relationship Between MCH Title V and Medicaid*. 2005. Washington, DC: Association of Maternal and Child Health Programs. Available at *http://www.amchp.org/aboutamchp/publications/web/working-together-mch-and-medicaid.php*.

Webcast. *Enhancing Partnerships Between Title V, Medicaid, and Local Health Departments Through EPSDT*. Available at *http://www.mchcom.com/archivedWebcastDetail.asp?aeid=234*

Title V

Association of Maternal and Child Health Programs. *The Title V Block Grant*. Available online at *http://www.amchp.org/aboutamchp/titlev.htm*.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Maternal and Child Health Services Title V Block Grant Program: Guidance and Forms for the Title V Application/Annual Report (Expires May 31, 2009)*. Available at *https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp*.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Understanding Title V of the Social Security Act: A Guide to the Provisions of the Federal Maternal and Child Health Block Grant*. Available at *ftp://ftp.hrsa.gov//mchb/titlevtoday/UnderstandingTitleV.pdf*.

Title XIX/Medicaid

American Academy of Pediatrics and National Association of Children's Hospitals. *State-by-State Medicaid Fact Sheets*. July 2005. Available at *http://www.aap.org/advocacy/washing/elections/med_factsheet_pub.htm*.

Centers for Medicare and Medicaid Services. *Medicaid: A Brief Summary*. Available at *http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp*

Centers for Medicare and Medicaid Services. State Medicaid Manual. Available at *http://www.cms.hhs.gov/manuals/pub45/pub_45.asp*.

Kaiser Commission on Medicaid and the Uninsured. 2006. *Deficit Reduction Act of 2005: Implications for Medicaid*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Available at *http://www.kff.org/medicaid/7465.cfm*.

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 know as the "Federal Medicaid matching rate," it is the share that the Federal government provides for Medicaid services or administration dependant 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 Halth Service Act, certain tribal organizations, and FQHC Look-Alikes. States are requied 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.

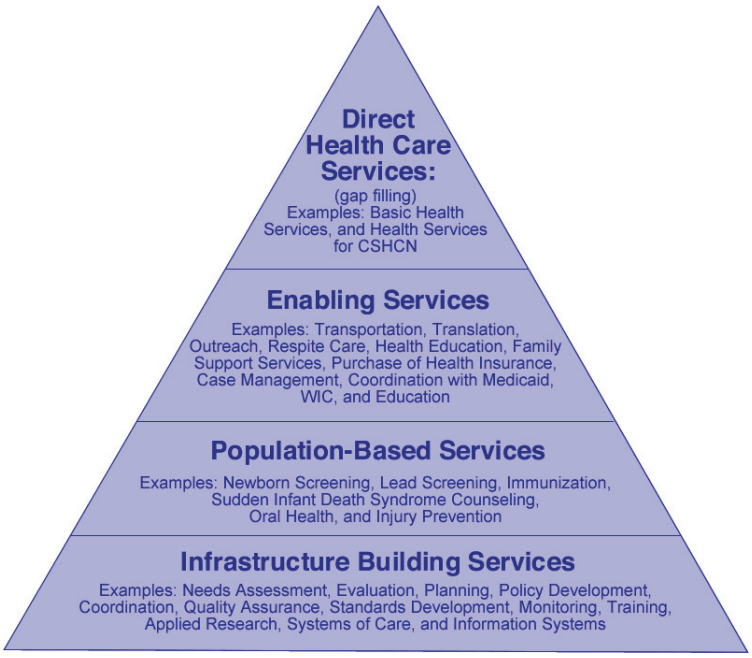
Temporary Assistance for Needy Families (TANF): A Federal block grant program that provided matching funds and services to States for low-income families with children.

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

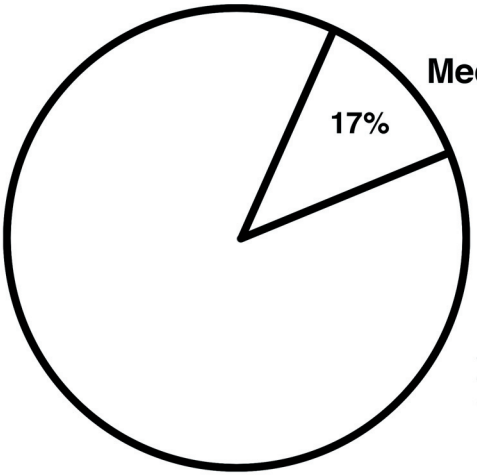


Supplemental Figure 2:
Recent Title V Block Grant Appropriations

Fiscal Year	Appropriation
1993	$664,534,000
1994	$687,034,000
1995	$683,950,000
1996	$678,034,000
1997	$681,000,000
1998	$681,079,404
1999	$699,777,000
2000	$710,000,000
2001	$714,230,000
2002	$731,615,000
2003	$729,965,000
2004	$729,800,000
2005	$723,900,000
2006	$693,000,000

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).

This edition was 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 contract with Georgetown University.

An Expert Panel provided review of the entire document:

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