Collaborations Between State Title V Maternal and Child Health Programs and Medicaid

The Title V Maternal and Child Health (MCH) Services Block Grant and Medicaid programs are fundamental in improving maternal and child health in every state across the nation. This paper provides background on the context for strengthening collaborative interagency agreements between Title V and Medicaid agencies, outlines strategies for MCH leaders, and includes case studies of two states and how they strengthened their collaborations with Medicaid.

OVERVIEW

Medicaid and the MCH Services Block Grant programs share a common mission to improve the health of women and children. The two programs have operated collaboratively for more than five decades. Because these programs have different cultures, complex statutory requirements, and vary regarding the resources available to them, the two programs must stay focused on honing well-defined partnerships to ensure they cooperate to the greatest extent possible in the pursuit of improving maternal and child health status, including for children with special health care needs.

To promote collaboration, both the Medicaid and Title V authorizing statutes include language directing states to create interagency agreements (IAAs) to guide their collaboration and program operation. The IAA provisions focus on maximizing services, clarifying processes for payments, avoiding duplication of services, and sharing information. Currently, the Title V law requires that state MCH programs:

- Establish coordination agreements with their state Medicaid programs
- Help coordinate services within the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program
- Provide a toll-free number for families seeking Title V or Medicaid providers
- Provide outreach and facilitate enrollment of Medicaid-eligible children and pregnant women
- Share data collection responsibilities, particularly those related to infant mortality and Medicaid
- Provide services for children with special health care needs that are not covered by Medicaid.[1]

(For specific statutory references, refer to Box A.)

[1] Social Security Act, Section 505 (E and F). Available at https://www.ssa.gov/OP_Home/ssact/title05/0505.htm

MISSION: The Association of Maternal & Child Health Programs is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.

VISION: AMCHP leads and supports programs nationally to protect and promote the optimal health of women, children, youth, families, and communities. AMCHP envisions a nation that values and invests in the health and well-being of all women, children, youth, families, and communities so that they may thrive.

The Code of Federal Regulations also delineates specific Medicaid state plan requirements for the content of agreements between Medicaid and Title V grantees. All IAAs must include the following elements:

1. The mutual objectives and responsibilities of each party to the arrangement;
2. The services each party offers under certain circumstances;
3. The cooperative and collaborative relationships at the state level;
4. The types of services to be provided by local agencies; and
5. Methods for

    (i) Early identification of individuals under 21 in need of medical or remedial services;

    (ii)Reciprocal referrals;

    (iii) Coordinating plans for health services provided or arranged for beneficiaries;

    (iv) Payment or reimbursement;

    (v)Exchange of reports of services furnished to beneficiaries;

    (vi) Periodic review and joint planning for changes in the agreements;

    (vii) Continuous liaison between the parties, including designation of state and local liaison staff; and

    (viii) Joint evaluation of policies that affect the cooperative work of the parties.[2]

WHY COLLABORATE?

A 2008 study of state Medicaid and Title V partnerships determined that IAAs support collaboration in several important ways:

- They provide a formal structure that delineates the programmatic and administrative responsibilities of each agency.
- They provide continuity in the way policies are implemented over time.
- They integrate a system of communication and accountability between programs.

The study found that "bolstered by these IAAs, strong partnerships have been established on the state level that address, and often go beyond, the legislative requirements."[3]

However, a more recent review in 2017 found wide variation in the timeliness and thoroughness of state Title V/Medicaid interagency agreements.[4] This finding, along with rapidly changing state health care environments, presents a window of opportunity to use new strategies to revisit and strengthen collaborations between these programs.

[2] Code of Federal Regulations. § 431.615 *Relations with state health and vocational rehabilitation agencies and Title V grantees.* Available at: https://www.law.cornell.edu/cfr/text/42/431.615

[3] U.S. Department of Health and Human Services. (2008). *State MCH/Medicaid coordination: A review of Title V and Title XIX interagency agreements (2nd edition).*

[4] National Academy for State Health Policy. (April 3, 2017). *Strengthening the Title V-Medicaid partnership: Strategies to support the development of robust interagency agreements between Title V and Medicaid.* Available at https://nashp.org/wp-content/uploads/2017/04/Strengthening-the-Title-V-Updated.pdf.

OPPORTUNITIES FOR ACTION: AN OVERVIEW OF STRATEGIES

The following six strategies are useful for strengthening collaborations between state Title V programs and Medicaid:

- Strategy 1: Examine the current context for Medicaid
- Strategy 2: Start with relationships: Emphasize a shared mission and acknowledge resource imbalances and possible cultural differences
- Strategy 3: Ground your approach in the spirit of the statute, but lead with a value proposition, not a legislative mandate
- Strategy 4: Assess the status of your IAA: Does it meet legislative requirements? What components are missing? What could be improved?
- Strategy 5: Utilize available technical assistance resources
- Strategy 6: Highlight the successes

STRATEGY 1: EXAMINE THE MEDICAID CONTEXT

Although the Title V MCH Block Grant and the Medicaid program share the same mission, leaders must understand the key differences between these programs to forge successful collaborations.

Differences Between Medicaid and the Title V MCH Block Grant
Medicaid provides insurance coverage to about 74 million Americans (1 out of 5) and is especially vital for MCH populations. Medicaid provides coverage for nearly half of all births in a typical state, and for 76 percent of children living in poverty and 48 percent of children with special health care needs.[5] In total, approximately 37 million children, many with special health care needs, and more than 25 million low-income women receive Medicaid coverage.

Core Medicaid medical services are set by statute, although some states have flexibility to add optional services and shape delivery systems. Total Medicaid spending was $553 billion in fiscal year 2016; the federal government paid 63 percent, and the states paid 37 percent.[6] Thus, Medicaid is by far the largest payer of MCH services, which include primary and preventive care, family planning, maternity care, and specialized services for children with special health care needs. Eligibility for Medicaid is defined in the statute; services are generally restricted to individuals in poor or near-poor families.

In contrast, Title V has a statutory mission to improve the health of *all* women and children and allows states considerable flexibility to determine the services provided, including direct, enabling, and population-based services. Title V had a federal appropriation in 2018 of $652 million, which generated an additional $2.6 billion in state matching funds and $2.1 billion in program income.[7] Even with the partnership funds, the Title V budget represents only 1 percent of total Medicaid funding. Over the past few decades, as Medicaid coverage expanded, many state Title V programs have shifted away from directly providing health care services and have instead embraced more population-based and infrastructure building services. Some states continue to utilize Title V funds to support medical services and fill gaps in services not paid for by Medicaid or for populations that remain ineligible or unable to pay for health insurance. Although Medicaid programs have far greater financial resources than Title V, the inherent flexibility of Title V can benefit new collaborations.

When approaching Medicaid colleagues, Title V leaders need to be mindful that traditionally many peers in Medicaid have felt that federal government regulations and directives inhibit their flexibility. Medicaid professionals also are highly sensitive to ‘unfunded mandates.’ In other words, they have hesitations about requirements to provide a new service

[5] Kaiser Family Foundation. (April 12, 2018). *10 things to know about Medicaid: Setting the facts straigh*t, April 12, 2018. Available at https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/.

[6] Kaiser Family Foundation. (October 25, 2018). *Medicaid enrollment & spending growth: FY 2018 and 2019*. Available at https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2018-2019/?utm_campaign=KFF-2018-October-Medicaid-50-State-Budget-Survey-NAMD&utm_source=hs_email&utm_medium=email&utm_content=2&_hsenc=p2ANqtz-9SuRBkLtC8QhOjavlz8CRYJ37B_sOZU9eBY174ug_Gin_HKyrtIOhtdi0Onuq1slwhN9ZJzGBVLSevChKoli2qCapHZg&_hsmi=2

[7] Title V Federal-State Partnership FY 2018 Expenditures. Available at https://mchb.tvisdata.hrsa.gov/

without the provision of new resources. Some also report feeling at times that other public health peers perceive the Medicaid program as having unlimited resources to address public health goals. In reality, Medicaid often has substantial budgetary constraints.

STRATEGY 2: START WITH RELATIONSHIPS: EMPHASIZING A SHARED MISSION AND ACKNOWLEDGING RESOURCE IMBALANCES AND POSSIBLE CULTURAL DIFFERENCES

Getting to know the right leaders in the Medicaid program can be challenging due to the size, turnover, and competing demands of agency staff. Similar to public health agencies that are sometimes siloed by program or population, Medicaid agencies often have different divisions for separate functions, such as outreach and enrollment, data collection and analysis, medical affairs, quality improvement, and the like. An important starting point for building relationships is to identify leaders who can pull together all of the relevant functions. Skilled collaborators do not create a perception that a collaboration is desired to simply increase Medicaid payments for MCH-related services; the focus needs to be on building a shared mission and respecting Medicaid's unique budgetary demands.

STRATEGY 3: GROUND YOUR APPROACH IN THE SPIRIT OF THE STATUTE – BUT LEAD WITH A VALUE PROPOSITION, NOT A LEGISLATIVE MANDATE

Although the underpinning for collaborations between Medicaid and Title V is explicit in the authorizing statutes for both programs, Title V leaders who are having difficulty gaining traction with their IAAs should consider crafting a softer approach. Opening a request to Medicaid with the statement that they are "required" to collaborate and produce an IAA can undermine the concept that collaborations ideally are entered into freely by both parties, both of which fully understand the expected mutual benefits. Title V leaders have recently reported that beginning a dialogue with a clearly defined value proposition that articulates mutual benefits for both programs can be more effective than starting the conversation with references to the statutory requirements.

Customizing a value proposition that emphasizes the strengths in your state is also important. The value proposition can center on several of Title V's unique characteristics. Consider which of these would be best to emphasize:

- The program's broad, inclusive definition of health care that includes prevention and early intervention services
- The program's experience working with and coordinating broad networks of service providers and public health experts
- The program's experience with surveillance of health status and data systems in place to collect and monitor data
- Knowledge of services that insurance plans do not cover as well as services for Medicaid beneficiaries with special needs
- Leadership experience with performance guidelines, such as the *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents* that directly relate to the EPSDT services required by Medicaid
- A deep and enriching history of fostering family engagement and leadership.

STRATEGY 4: ASSESS THE STATUS OF YOUR INTERAGENCY AGREEMENT

Does it reflect your current mutual needs? When was it last revised? Does it include the elements addressed in the statutes and regulations? What is missing? What could be improved? The Title V and XIX statutes and regulations enumerate 12 main areas that should be included in an IAA:

- Objectives and responsibilities
- Services provided by each agency
- Cooperative relationships
- Services provided by local agencies
- Identification and outreach
- Reciprocal relationships
- Coordination of plans
- Reimbursement
- Reporting and sharing data
- Review
- Liaison

- Evaluation.

STRATEGY 5: UTILIZE AVAILABLE TECHNICAL ASSISTANCE RESOURCES

Several helpful resources are online; most are conveniently centralized in a toolkit by the National Center for Education in Maternal and Child Health's library at https://www.mchlibrary.org/IAA/index.php.

This toolkit supplements an environmental scan of state IAAs of Title V and Medicaid programs and supports the report entitled *State MCH-Medicaid Coordination: A Review of Title V and Title XIX Interagency Agreements, 2nd edition*. The toolkit includes access to the final report; full-text, current IAAs (collected from the MCH Title V Block Grant fiscal year 2016 application/fiscal year 2014 annual reports); and the 36 IAAs used in the scan, a searchable database, recommendations, and additional resources.

A recent (2017) report by the National Academy for State Health Policy also provides a series of suggested strategies for strengthening Title V/Medicaid partnerships, including:

- Complete an assessment of current state health care activities and MCH programs to identify areas for coordination and collaboration
- Examine the status of the partnership and possible strategies to enhance a culture of collaboration within and across both programs if needed
- Monitor state health care delivery and payment reforms for potential new and emerging opportunities for Title V and Medicaid collaboration
- Consider including specific content within the IAA to formalize and strengthen descriptions and plans for coordination and collaboration on shared priorities as follows:
- Envision the IAA as a tool to support cross-agency coordination and collaboration and the priorities of both agencies
- Document the roles and responsibilities for each of the agencies
- Describe how joint activities will be planned and implemented
- Establish ongoing activities to maintain strong cross-agency communication
- Designate individuals responsible for maintaining communication across the agencies
- Select individuals responsible for ensuring tasks that require collaboration and coordination take place and the terms of the agreement are met
- Describe how each agency will identify potential eligible individuals and support cross-agency referrals
- Include information on the use of and exchange of data to support both agencies
- Include a plan for the periodic joint review of the agreement
- Ensure the IAA is clearly written and accessible at all times to all involved parties[8]

STRATEGY 6: HIGHLIGHT THE SUCCESSES

Success breeds success. Sharing stories of even small progress with key leaders and stakeholders can build momentum for additional collaborations.

The following case studies illustrate collaboration success stories.

[8] National Academy for State Health Policy. (2017). *Strengthening the Title V-Medicaid Partnership: Strategies to support the development of robust interagency agreements between Title V and Medicaid*. Available at https://nashp.org/wp-content/uploads/2017/04/Strengthening-the-Title-V-Updated.pdf.

CASE STUDIES: COLLABORATING IN AN EVOLVING SYSTEM IN WEST VIRGINIA

Title V MCH Director for West Virginia, Jim Jeffries, says that collaborating with Medicaid is a joy "99 percent of the time." Although he was only recently appointed West Virginia's Director of the Office of Maternal, Child and Family Health, Jeffries brings more than 20 years of relevant experience, including prior service as the state's Children and Youth with Special Health Care Needs (CYSCHN) Director, as well as a five-year stint operating the HealthCheck Program, which is West Virginia's version of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Like many state Title V programs, West Virginia has shifted away from paying for clinical services and instead is focusing on quality assurance. Jeffries describes this shift as core to the Title V mission, in addition to care coordination and family engagement. Another common theme has been adapting to the Medicaid program's shift to managed care. Jeffries acknowledges that one of the greatest benefits of Title V collaboration with Medicaid has been the enhanced quality of care for CYSHCN populations. In West Virginia, managed care companies receive a higher payment per member, per month for children with special health care needs who participate in Title V Block grant programs. Consequently, the Title V and Medicaid programs work together to set a higher bar of accountability for health plans by including contract provisions that set expectations for better service utilization and care coordination.

Components of the West Virginia's Interagency Agreement and MOU that Lead to Success

West Virginia uses an interagency agreement (IAA) to guide the Title V/Medicaid coordination, and renews this agreement annually. The Medicaid Commissioner, State Health Officer, and a representative of the state's Office of Nutrition Services must also sign the agreement. The representative from the Office of Nutrition Services ensures that the Women, Infants, and Children (WIC) program is integral to the MCH system. Although the IAA is vague in some places, the agreement helps the programs jointly develop policies and health programs that meet national standards of practice. Consequently, the purchase of service provider agreement between the State of West Virginia's Medicaid program and each managed care organization (MCO) requires a formal memorandum of understanding (MOU) with West Virginia's Title V agency to implement coordination strategies to better serve children under the age of 21, including individuals with special health care needs who are eligible for Medicaid managed care services. This MOU requires that managed

care organizations collaborate with the Title V agency care coordinators to share plans of care for children with special health care needs and also share data necessary to improve service delivery and improved outcomes.

Additional focus areas include conducting quality reviews, utilizing the National Standards for Systems of Care for CYSHCN, and promoting medical home and well child visits. Jeffries says that they use the IAA to assure that managed care organizations are making all reasonable efforts to follow established plans of care. The IAA also uniquely requires that Title V staff have the opportunity to review and suggest language for all Medicaid contracts with managed care organizations.

Successes and Challenges

Jeffries cites a few benefits of their collaboration. One is that the Title V program is utilizing the Medicaid programs' fiscal agent to process Title V claims for CYSHCN services. Another is that a joint effort makes it easier to ensure that families needing medical foods experience no gaps in meeting their needs. Jeffries notes that language in the EPSDT allows for Medicaid to pay for most medical foods, except for supplements, in which case Title V fills the gap. Roughly $300,000 a year is paid for supplements with Title V funds.

The only real challenge Jeffries recalls in his years of working with Medicaid related to communication issues, saying that the flow of information about transitioning people receiving SSI to managed care "was not all it could have been." However, he notes that their Title V expertise in family engagement helped. Overall, Jeffries describes the Title V/ Medicaid relationship as a valued partnership since day one. Having the health department and Medicaid agency located in the same building enhances the partnership. "We see each other in the elevator," Jeffries says, and having a designated liaison helps as well.

Tips for Other Title V Leaders

Jeffries offers the following advice to other Title V leaders who are contemplating how to strengthen collaborations with Medicaid:

1. *Tactfully* demonstrate to Medicaid leaders that they are legally required to work together to serve the programs' common interests. "This can be overplayed," Jeffries notes, so being able to articulate the value proposition from both perspectives—Title V and Medicaid—is very important." In West Virginia, he says, that value proposition is clear to Medicaid and Title V, and is now being confirmed with managed care organizations as well.
2. Build the collaboration on trust, credibility, and experience. "Medicaid partners need to know that you are not out to squeeze their budget," he says. "You need to respect also that the programs have different missions and regulatory requirements."
3. Finally, Jeffries says "….it's very important to reach consensus with Medicaid partners on the concept of a medical home. The Title V agency should not simply concede the medical home as just a primary care practice; rather, the Title V agency must advocate for defining medical home as both a setting and a team approach to providing comprehensive health care (especially for CYSHCN)."

CASE STUDIES: WISCONSIN BOUNDARY SPANNERS INTEGRATE TITLE V AND MEDICAID

Jody Brassfield worked for several years in the Wisconsin Medicaid Adult Long-Term Care program before becoming the Family Health section chief in the state's Public Health Division. Being a boundary spanner between these worlds, Brassfield brought a keen sense of the nuances of Medicaid to his new role. He assessed the state's IAA between the Title V and Medicaid programs and found several strengths, including a clearly defined process for both programs to make suggestions for new issues or projects to be added or removed. Sharon Fleishfresser, the state's CYSHCN medical director, agrees with these strengths, noting that many strengths of the current agreement were incorporated by studying other states' IAA's and learning at AMCHP meetings from others how they fared using these agreements.

Brassfield says the state's agreement is driven by the legislative requirements and includes a strong focus on the state's priority of reducing infant mortality and related work to improve prenatal care and data sharing. Fleishfresser notes that additional components of the IAA are reviewing discrete CYSHCN issues related to Supplemental Security Income (SSI) determinations. A collaboration has emerged from this, which utilizes Title V to provide information to families determined ineligible for SSI benefits. The Title V program also helps link them to other available services. Fleishfresser says that, outside of the IAA, the state also convenes a workgroup on a complex care Medicaid benefit for CYSHCN and is seeking new service improvement opportunities. This work benefits from relationships forged through the IAA.

Brassfield adds that the state's IAA in some places seems to be a bit too rigid and imposes unnecessary administrative burdens (e.g., a clause that limited the agreement to two years). He says rather than scrambling every two years to renew the current agreement, he and his colleagues are working to make the agreement evergreen. Their vision is to strike a balance between accountability and flexibility, with the hope that conducting regular check-ins through quarterly meetings can keep them on track. Both Brassfield and Fleishfresser credit the professionalism of the Medicaid program's contract and procurement staff for taking the lead in developing an agenda and facilitating effective meetings.

Fleishfresser and Brassfield say that the greatest value for MCH populations in Wisconsin has flowed from their collaboration's efforts to revitalize a state Medicaid prenatal care coordination (PNCC) benefit, for which there had been a decline in utilization. The state's need to address infant mortality and the contributing factor of prematurity led to a new urgency to promote the PNCC benefit. Brassfield says that leading with a message that increasing utilization of this benefit reduces the state's neonatal intensive care unit costs in the long term was a critical factor in the Medicaid program's enhanced promotion of the benefit. The Title V program now helps administer the prenatal benefit and is helping to document the projected return on investment as part of its planned evaluation. The Title V MCH program provides training and technical assistance to regional PNCC networks to improve quality assurance. They have also facilitated

quality improvement efforts focused on improving utilization of the benefit and experience for families.

Another good collaboration example they cite is utilizing a return-on-investment argument to support Medicaid funding for early intervention specialists in the state's Individuals with Disabilities Education Act (IDEA)-mandated Birth to Three program. Fleishfresser also notes that collaboration and the impetus of a previous Centers for Medicare and Medicaid Services (CMS) Innovation Grant helped support winning proposals that resulted in Medicaid paying for care coordinators to help administer the state's complex care benefit. Birth to Three is a comprehensive, integrated care model that integrates the social, behavioral, and medical needs of a defined set of high-need, high cost Medicaid recipients.

Despite good progress, Fleishfresser acknowledges the challenges in making all CYSHCN a consistent priority. She and Brassfield agree that data access also remains a challenge. Although relationships are important, they sometimes do not override the pressing additional priorities of Medicaid colleagues who must scramble to meet extensive state and federal requirements. Brassfield notes that Medicaid and public health professionals sometimes utilize different jargon even as they are applying the same principles of epidemiology. Brassfield also says that the state has not exhausted all opportunities to maximize Medicaid's administrative match so they can extend services to the greatest extent legally possible. He notes success in a recent Governor's budget proposal that includes five state positions to bolster work reducing infant mortality and using the administrative match to help fund the positions. He also pointed to the opportunity to help local health departments receive training to build billing expertise.

Tips for Other Title V Leaders

Brassfield and Fleishfresser offer the following advice to MCH colleagues:

1. Seek out staff with experience as boundary spanners working in both roles, i.e. Medicaid staff working in public health positions and vice versa.
2. Meet Medicaid colleagues where they are. Speak their language and ensure they understand why you are making your request, using a return on investment strategy. Jody Brassfield notes that when the public health division showed Medicaid colleagues that underutilizing the state's Birth to Three benefits would cost them more, their response was "How can we fix this?"
3. Try to "distill away the complexity of public health." No need to over-explain. Honor the time constraints of your partners so you don't lose them.

Checklist for Action

☑ Consider additional organizations and individuals that might help strengthen and support your state's IAA. Seek perspectives and input from your American Academy of Pediatrics chapter, Family Voices, children's hospitals, other patient and provider groups, as well as your local health agency and community MCH leaders.

☑ Find out if your state's IAA is up to date. When was it last revised or evaluated? How has the changing health care system created new opportunities to revisit old collaborations?

☑ Consider the State Intake Form and Model IAA framework (available at https://www.mchlibrary.org/IAA/index.php) as the starting point to write or revise your state's IAA.

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