ASTHO*Report*

Center for Health Care Strategies

Leveraging Partnerships Between Public Health and Medicaid to Strengthen the Healthcare Safety Net

Authors: Liz Gipson, *MPH*, *CHCS*; Stephanie Paneca-Navarro, *MSW LSW*, *CHCS*; Jahira Sterling, *MPA, CHCS;* Alexandra Kearly, *MPH*, *ASTHO*

Contributors: Madison Hluchan, *MPH, CAPM*, *ASTHO*; Caroline Brazeel, *MPH*, *ASTHO*; Rachel Scheckman, *MPH, ASTHO*

October 2023

Table of Contents

Takeaways

- State and territorial public health agencies are an integral part of the healthcare safety net infrastructure and play a key role in addressing medical and social needs to promote population health and advance health equity.
- State and territorial public health agencies can leverage their population health and health equity expertise to inform health policy, including Medicaid policies and programs.
- State and territorial public health agencies can maximize existing opportunities and leverage federal revenue to partner with Medicaid agencies on strengthening safety net services.

Introduction

State and Territorial public health agencies (S/THAs) play a significant role in delivering clinical services and shaping and implementing policies in the healthcare safety net system, among other essential functions. As both S/THAs and Medicaid agencies prioritize efforts to advance health equity, there is further impetus for cross-agency collaboration. Partnerships between S/THAs and Medicaid enable the agencies to leverage limited resources, contribute complementary expertise, and develop cross-agency interventions to address shared priorities, such as reducing health disparities, promoting health equity, and improving population health.

To better understand the value of S/THAs in supporting the healthcare safety net, the Center for Health Care Strategies and ASTHO interviewed or surveyed 25 staff from public health and Medicaid agencies in **Arkansas**, **Massachusetts**, **North Carolina**, and **Oregon**. The four states were selected for their geographic, political, and programmatic diversity, as well as to learn more about if and how their recently approved Medicaid Section 1115 demonstration waivers or extensions were influenced by S/THA staff or programs.

This report draws from the interviews to explore the value that S/THAs contribute to inform more effective Medicaid policies and programs. The report outlines a set of recommendations to help develop and strengthen long-lasting and productive partnerships between public health and Medicaid agencies. State interviewees shared how highly they valued their interagency colleagues' skills, knowledge, and relationships. The interviews revealed that S/THAs are important policy development and implementation partners for Medicaid agencies as Medicaid works to embed health equity and community engagement into its programs and policies. For more on the role of S/THAs in the healthcare safety net, see a set of complementary profiles featuring each of the states.

To increase accessibility to healthcare, each S/THA provides clinical services throughout their state or territory, either directly or through contracted providers, local health agencies, community-based organizations (CBOs), or healthcare systems. S/THAs oversee a range of clinical services, including maternal, infant, and early childhood home visiting programs for new parents; vaccination administration; sexually transmitted infection (STI) testing and treatment; and chronic disease management. Just as the S/THA staff interviewed often knew only some of what their Medicaid colleagues were working on, the Medicaid staff interviewed generally reported only partial knowledge of the breadth of their S/THA's clinical programs. Even so, Medicaid staff readily acknowledged the value of S/THA staff's experience overseeing health services, citing S/THA staff's clinical and community expertise as important to designing and implementing new programs.

Medicaid staff interviewed noted that their S/THA colleagues are well-equipped to identify population health and community needs. By pulling from population-level data on disease burden and collaborating with community members through efforts like community advisory committees, interviewees noted that S/THA staff can often identify disparities and develop both statewide and community-level interventions more readily than other state agencies or providers in the healthcare safety net. This nimbleness, subject matter expertise, and easy access to statewide data were identified through the interviews as characteristics that make S/THAs key partners for Medicaid agencies.

In addition to direct healthcare provision, S/THAs collaborate with other agencies to address social determinants of health. To meet these needs, agency staff work with a range of stakeholders, from healthcare providers to CBOs, to promote health equity and address health disparities. Programs operated by S/THAs—like Massachusetts' Title V program for children and youth with special healthcare needs—are prime examples of how S/THAs use their community connections to refer patients to local social services and supports while simultaneously connecting them to healthcare services. These longstanding relationships with CBOs and community leaders give S/THA staff access to timely feedback from community members that is often difficult for other state agencies to attain.

State Public Health Agencies as Clinical Service Providers and Partners

A S/THA is an integral part of their state or territory's healthcare safety net infrastructure and provides clinical and social services that promote population health and health equity. S/THAs are responsible for ensuring public health services—including select clinical services—are available and accessible to all who live in the jurisdiction, including those who are uninsured or underinsured.

Interviews with state officials from across public health and Medicaid agencies in Arkansas, Massachusetts, North Carolina, and Oregon reflected S/THAs' diverse approaches to providing clinical services. For example, state health agencies in Oregon and North Carolina contract for certain clinical services, including for individuals who need complex care, through their local health agencies. S/THAs in Massachusetts and Arkansas contract with external clinical organizations but also directly employ providers as full-time employees to deliver clinical care and navigation support to patients. All states interviewed shared that their S/THAs provide at least some care management programs for populations with complex healthcare needs, including new parents, people living with HIV/AIDS, and those with severe mental illnesses. Approaches to funding S/THA clinical services also varied across the states. While most S/THA-provided clinical services are paid through state or federal funding mechanisms, including HRSA block grants described below, all states identified some programs that receive Medicaid funding to partially support some clinical services.

Interview questions about S/THA clinical services focused on understanding two large, well-established HRSA block grants: the Title V Maternal and Child Health Block Grant Program (Title V) and the Ryan White HIV/AIDS Program. Tables 1 through 4 in the appendix summarize select clinical services provided by or overseen by each state's health agency.

State Examples

Medicaid and S/THA officials from North Carolina and Massachusetts offered key examples of the critical role S/THAs play in clinical service delivery and how Medicaid agencies financially support those programs.

North Carolina

North Carolina's Department of Health and Human Services (NCDHHS) houses North Carolina Medicaid (NC Medicaid), the Division of Public Health (NCDPH), and the Division of Children and Family Well-Being (DCFW). NCDHHS offers an array of health services to support adults, children, and families across the state. NCDHHS clinical services, some of which are funded through Medicaid, are largely decentralized and provided by local health agencies. In interviews, officials at NC Medicaid and NCDPH pointed to care management programs for those with high-risk pregnancies and at-risk children as examples of how NCDHHS' divisions have partnered together on clinical program design and implementation. One Medicaid official said, "The state and local health departments help care for some of our most at-risk populations. Our care management model has evolved to ensure these critical services are maintained and strengthened."

- The Care Management for High-Risk Pregnancies (CMHRP) program delivers Medicaid-funded care management to Medicaid-enrolled pregnant people in North Carolina through partnerships with NCDPH via local health agencies. The program builds on the legacy model of care management for pregnant people administered by local health departments since 1988 and uses the standardized Pregnancy Risk Screening tool to help obstetric providers identify Medicaid recipients at risk for adverse birth outcomes. Those who screen positive are provided a warm handoff to a local health department's CMHRP care management team and referred to NC Medicaid's Pregnancy Medical Home.

- The Care Management for At-Risk Children (CMARC) program is a Medicaid program operated through contracts with local health departments that offers care management services for at-risk children ages 0-5. For eligible children, the local health department program staff coordinate services between healthcare providers, community resources, and family support programs.

- Both CMHRP and CMARC rely on healthcare and social service providers employed by the state or local health departments. The local health departments' care management team is funded through contracts with managed care organizations in NC Medicaid as well as other funding from NCDPH. Additionally, to support care management, NCDPH and DCFW have teams that provide technical assistance directly to local health department staff.

Massachusetts

Similar to NCDHHS, Massachusetts' Department of Public Health (MA DPH) offers a range of clinical, community, and social services for children, youth, and families throughout the state. MA DPH and MassHealth, Massachusetts' combined Childrens Health Insurance Program (CHIP) and Medicaid program, are working to grow, strengthen, and sustain their portfolios of clinical and community programs and the public health infrastructure and workforce to ensure access, quality, and equity.

To improve the health of children and youth, Massachusetts opts to use CHIP administrative funding to help support its Health Services Initiatives (HSIs). To implement the HSIs, the Centers for Medicare & Medicaid Services (CMS) allows states to use up to 10% of their total CHIP spending for activities designed to protect public health, including public health programs and certain preventive services, including clinical and supportive services, for children in CHIP and other low-income children otherwise ineligible for CHIP. All HSIs must be approved by CMS through a CHIP State Plan Amendment and the state must submit an annual report and provide an estimate of how many children were served by the programs.

With 18 approved HSIs, MassHealth has more initiatives than any other state. MassHealth's HSIs include a variety of programs, such as the MA DPH-administered programs: the Women Infants and Children Nutrition Program, the Youth Violence Prevention program, Safes Spaces for LGBTQIA+ youth, Pediatric Sexual Assault Nurse Examiner Program, Pediatric Palliative Care Network, and the Failure to Thrive nutrition program. For some of the additionally approved programs that include Medicaid covered services—like school health services and family planning—providers bill MassHealth or affiliated managed care organizations directly for reimbursement.

The state may receive federal funding for HSIs after covering regular CHIP program administrative costs. The federal share of HSI projects aligns with the state's CHIP match rate; for MassHealth, CHIP is matched at an average of 67.66% during 2023. MassHealth often reaches the 10% funding limit and is unable to receive CHIP funding for all the programs approved as HSIs.

State officials shared that MassHealth's finance team works closely with sister agencies, including MA DPH, to ensure that the state receives all available federal HSI funding. This collaborative funding approach is not restricted to HSIs; in interviews, Massachusetts state officials from both agencies shared that their finance teams consistently work together to identify funding strategies to support the state. As one Medicaid official said, "The fiscal work and the programmatic work happen in parallel. The fiscal teams are constantly thinking about what pieces of MA DPH's work fit in to Medicaid so we can make sure we're optimizing Medicaid reimbursement for the state."

State Public Health Agencies as Subject Matter Experts and Policy Partners

S/THAs have a deep understanding of the factors that influence health equity and health outcomes in their region, including health-related social needs. They are well-equipped to develop policies and programs that address these factors. Additionally, S/THA staff have longstanding relationships with CBOs, healthcare providers, and community leaders, which helps them understand the real-time needs of the populations they serve. As Medicaid agencies become increasingly invested in designing and implementing policies that advance health equity and address health-related social needs, S/THAs can serve as key policy partners.

Throughout the interviews with state officials, Medicaid staff frequently commented on how strongly they valued and relied on S/THA's knowledge and community connections in the initial phases of policy design. In all interviewed states, S/THA staff highlighted their expertise and experience with implementing and evaluating programs that have been effective in improving health equity and population health.

State Examples

Officials from Medicaid agencies and S/THAs in Arkansas, Oregon, Massachusetts, and North Carolina shared examples of how S/THAs have informed Medicaid policy design and program implementation in their states.

Arkansas

The Arkansas Department of Health (ADH) and the state's Division of Medical Services (DMS)—which houses the state's Medicaid program under Arkansas' Department of Human Services—collaborate extensively on programs to provide coverage and services for preventing and treating HIV/AIDS and sexually transmitted infections. In interviews, state officials at both agencies cited hepatitis C (HCV) prevention and treatment as an area of strong cross-agency collaboration, as evidenced by the statewide Hepatitis C Prevention Program. As the state began prioritizing population health efforts to address HCV, ADH staff knew that Medicaid coverage was a critical component to ensuring those living with or at risk of contracting HCV have access to preventive care and treatment. One Medicaid official acknowledged, "We identified gaps in coverage of hepatitis C and are working with ADH on strategies to improve those services across all state agencies and payors."

As an extension of ADH's HIV Prevention Program, the Hepatitis C Prevention Program is funded by CDC and collaborates with the statewide HCV Surveillance Program, community partners, and other state agencies. The program provides testing, education, and training opportunities to improve the lives of community members and address sexually transmitted infection-related inequities.

Additionally, DMS and ADH's Infection Disease branch are collaborating to develop a Hepatitis C Elimination Plan and have joined in HHS' Hepatitis C Medicaid Affinity Group. Together, the two agencies have implemented data-sharing agreements and identified additional gaps in Medicaid coverage for HCV. DMS is working closely with ADH to leverage its expertise to inform policy and develop strategies to improve HCV-related services, including changes to HCV care guidelines, with a focus on pregnant people and infants. State officials from ADH and DMS indicated that the relationship between the two agencies has enabled this collaboration and that the program is one of the state's strongest Medicaid-public health partnership efforts. In reflecting on this partnership, one state public health official said, "Medicaid's door is always open when we need to engage and talk to them about coordinating on hepatitis C elimination efforts. We continue to grow with that engagement."

Oregon

Oregon's public health and Medicaid divisions operate within the same agency, Oregon Health Authority (OHA). Within OHA, the Public Health Division (PHD) leads the HIV/STD/TB Section, which includes the HRSA-funded Ryan White HIV/AIDS Program (RWHAP) and CDC-funded prevention programs. PHD collaborates closely with Medicaid to ensure equitable access to HIV/AIDS treatment and prevention. For example, Oregon Medicaid covers pre-exposure prophylaxis (PrEP) for members and S/THA funds outreach workers who provide PrEP navigation services, which help members access those covered benefits. Cross-division collaboration and problem-solving are key to the success of the state's RWHAP.

PrEP is a daily medication that can reduce the risk of HIV infection and has a Grade A rating from the United States Preventive Services Task Force (USPSTF). Under the Affordable Care Act (ACA), all Medicaid-expansion programs must cover all Grade A recommended services at no cost to Medicaid beneficiaries. For all residents of Oregon, regardless of geographic location, there are personal health navigators who support community members in accessing RWHAP services. Personal health navigators for PrEP (and for post-exposure prophylaxis, or PEP), are available to help community members determine whether they could benefit from either medication and provide education on how to access and use the medications.

During interviews with Oregon Health Plan (OHP), the state's Medicaid agency, state officials shared an example illustrating how the public health division's strong community relationships allowed Medicaid to identify and address barriers to accessing PrEP. After hearing from community advocates that Medicaid beneficiaries were experiencing inappropriate barriers to PrEP access, the local health agencies alerted OHA PHD, which then reached out to their Medicaid colleagues.

State and local public health staff then worked collaboratively with Medicaid staff to gather information from enrollees and the coordinated care organizations (CCO) to understand and verify the barriers to PrEP. Some of the state's CCOs had outdated and cumbersome coverage policies for PrEP, which posed health equity concerns. Medicaid then used the lessons learned from working with its public health colleagues to require quick corrective action on the part of Oregon's CCOs. Since addressing the barriers, a recent OHA report suggests that those enrolled in OHP faced fewer barriers to PrEP access than those enrolled in private insurance.

Medicaid state officials reported that this inequity could not have been identified without the communication between community members, state and local public health, and the Medicaid division. As one Medicaid official said, "The public health staff were able to provide much clearer insight into what the actual patient experience was like for a member interacting with a CCO."

Massachusetts

Data sharing is a key component of strengthening collaboration and embedding consistent communication across agencies. Medicaid data can provide valuable information on healthcare utilization patterns, while public health data can provide insights into disease surveillance and health disparities. By sharing data, Medicaid and S/THAs can work together to identify and address gaps in healthcare delivery, improve access to care, and target interventions to those who need them most.

As with all Title V programs, Massachusetts has an existing Title V interdepartmental service agreement between MA DPH and MassHealth that includes limited data sharing. However, staff at both agencies knew that the agreement did not include the breadth of data each was interested in accessing. After several years of working together to develop appropriate guardrails and address organizational concerns, the agencies recently entered into two data sharing agreements (DSAs), one on childhood immunization data and the other on maternal morbidity and mortality data and vital records. One Medicaid official said, "This data-sharing agreement has been in the works for close to a decade, and it took a huge amount of collaboration to make it happen."

The DSA on child immunizations will allow MassHealth to identify children without recommended immunizations and more strategically encourage uptake of childhood vaccinations. While MA DPH had high-level data through the Massachusetts Immunization Information System, it was missing plan-level information and could therefore only provide limited outreach to providers. MassHealth, meanwhile, realized that its immunization data was frequently incomplete. Because of how well child visits are billed to MassHealth, clinical providers often do not code for each vaccine administered during a visit. This results in incomplete MassHealth data that does not provide a comprehensive picture of members' immunization status. Under the new DSA, MassHealth is now able to get Massachusetts Immunization Information System data directly from MA DPH and then use this information to identify children who are behind on their immunizations. This information is then communicated to MassHealth plans for targeted outreach to those children and families.

North Carolina

In interviews with North Carolina, state officials cited the state's Medicaid program's Healthy Opportunities Pilots (HOP) as an example of how working with interagency partners on program design can strengthen programs overall. As one Medicaid official shared, "The Division of Public Health played an important role in designing and setting the goals and vision for the Healthy Opportunities Pilots."

When the state began to work on its 1115 demonstration waiver, North Carolina (NC) Medicaid proactively included North Carolina Department of Public Health for input on HOP. NC Medicaid knew its public health colleagues would be able to offer subject matter expertise on social determinants of health that would improve the program. Reflecting on their involvement, one public health official said, "We were able to bring our expertise and experience—like working with community organizations to offer diabetes prevention programs—to the table to inform the development of the Healthy Opportunities Pilots."

Part of NC Medicaid 's 1115 demonstration waiver, HOP provide evidence-based non-medical interventions to support health-related social needs for Medicaid enrollees eligible for the program. Covered services include social supports like payment for housing deposits, provision of healthy food boxes, reimbursement for private transportation to services like a trip to the grocery store, and much more. HOP launched in 2022 and has served over 12,876 beneficiaries across three state regions as of July 2023. The pilots are currently being evaluated to determine their impact on Medicaid beneficiaries' health and total cost of care.

Under HOP, participating Medicaid beneficiaries are paired with care managers who provide personalized assistance to address their health and social needs. Each care manager connects patients with community resources and coordinates care across healthcare providers, social service organizations, and government programs, including programs run by NCDPH and local health departments.

HOP highlights how strong early collaboration between Medicaid and S/THA can strengthen policy development and improve programs overall. NCDPH's involvement in NC Medicaid's HOP design made the program stronger through including valuable health promotion programs, embedding CBO partnerships, and focusing on social determinants of health.

Key Opportunities to Strengthen State Public Health Agencies' Relationships with Medicaid

As S/THAs work to better serve their communities and influence health outcomes, strengthening relationships with peer state agencies, especially Medicaid, is a top priority. Developing strong, long-term relationships with cross-agency peers is critical for lasting, impactful Medicaid-public health partnerships. Throughout the interviews, the following key themes for how to build sustainable Medicaid-public health partnerships emerged:

1. **Learn more about other agencies' core operations, priorities, and programs.**

   In interviews, staff were often unfamiliar with core operations and programs of the other agency. Understanding how Medicaid is structured and operates is key for S/THAs to build long-lasting partnerships with Medicaid staff. S/THAs are eager to work with Medicaid but often reported a lack of understanding about Medicaid program development and financing. Similarly, Medicaid staff were frequently unfamiliar with the breadth of clinical and social services S/THAs provided.

   By reviewing publicly available information on Medicaid agencies' websites and reaching out directly to Medicaid peers, S/THA staff can familiarize themselves with eligibility requirements, enrollment processes, Medicaid's covered services, and more. Some S/THA staff in states with strong partnerships mentioned attending public-facing Medicaid meetings, including town halls, provider meetings, or other stakeholder forums, to learn more about their state Medicaid agency's operations and priorities while also building relationships with cross-agency colleagues.

   S/THA staff with strong relationships with their Medicaid peers reported a better understanding of Medicaid operations and greater respect for the limitations of Medicaid fiscal policy. Medicaid staff in some states shared a sensitivity to and awareness of their agency's financial power compared to their S/THA peers, while also emphasizing that limitations from federal Medicaid regulations could make fiscal partnership difficult. One Medicaid official shared, "I'm mindful that Medicaid is seen as this giant entity with an enormous budget. I know public health thinks we have a faucet of money pouring into our programs. That changes the power dynamics between state agencies."

2. **Create formal and informal channels to surface challenges and collaboratively problem-solve.**

   State officials from both agencies highlighted the importance of consistent interagency communication beyond highly visible work like Section 1115 demonstration waivers or COVID-19 public health emergency work. Regular communication builds trust and respect, develops shared priorities, and generates ideas for future collaboration. As a public health official shared, "There are the formal meetings, and then there are the actual relationships and informal conversations we have outside of those meetings. Those relationships are sometimes more impactful than the formal meetings themselves."

   In states with greater organizational separation between the two programs, state officials shared that maintaining regular bimonthly or quarterly Medicaid-S/THA meetings with leadership throughout the year was critical in building partnerships. Officials from states with strong cross-agency collaborations mentioned attending regularly scheduled interagency meetings, co-facilitating workgroups, and working to build informal relationships as key to strengthening their partnerships.

   Additionally, as interagency data sharing agreements are critical to improved visibility of statewide health challenges, developing a data-sharing structure can serve as a catalyst for partnership and greater communication. For example, a state could hold quarterly or bi-annual meetings to revisit the DSA, ensure data is flowing accurately, discuss challenges, and assess needed changes.

3. **Elevate public health agencies' health equity expertise.**

   In interviews, Medicaid staff consistently acknowledged how S/THAs' expertise in health equity impacted Medicaid policy development. Medicaid staff frequently praised their S/THA colleagues' progress in advancing health equity throughout the state and elevating it for other state agencies. As one Medicaid official shared, "Because of the foundation that public health built with health equity, our teams were able to finally get action going internally to prioritize health equity." S/THA staff in some states mentioned providing health equity-related technical assistance and training to other state agencies, including Medicaid, to help build their state's capacity to advance population health.

   Medicaid staff referenced how past conversations on health equity and collaborations with S/THA peers indirectly influenced Medicaid programs, even when S/THAs were not directly included in policy development. For example, one state Medicaid official shared that they were inspired by their S/THA colleagues' work with family engagement with policy and program development. S/THA colleagues at the same state shared, "We know our colleagues have looked at our model of family engagement in policy development to see how to make their policies racially equitable and culturally and linguistically appropriate."

   As S/THAs continue to partner with Medicaid colleagues, they can harness the power of their expertise to help develop policies and programs that improve health outcomes and advance health equity.

4. **Leverage the end of the COVID-19 public health emergency as an opportunity to reflect on successes.**

   Throughout the COVID-19 public health emergency, S/THAs have proven to be nimble, pivoting to provide additional clinical services and collaborate with Medicaid agencies under tight deadlines. Medicaid and S/THA staff in all states interviewed cited the emergency as a motivating factor for strengthening cross-agency collaboration and innovation. COVID-19 forced state agencies to work more closely together and center health equity, resulting in stronger relationships and better programs. A Medicaid official reflected, "The public health emergency strengthened our relationship and our ability to collaborate. It increased communication across our teams to discuss how our programs operate together."

   Following the COVID-19 public health emergency, S/THAs have a unique chance to reimagine the role they play in the broader healthcare safety net. As one Medicaid official shared, "We don't collaborate with public health as much as we could. During COVID, we had intense partnerships because we needed to get services to people that needed them. We should look at some of that work to see what we can learn." With the end of the public health emergency, Medicaid and S/THA staff may consider convening a formal cross-agency workgroup to review and reflect on how to sustain the promising partnerships that started during the public health emergency and identify areas for improvement.

Conclusion

Understanding their unique expertise and skillsets is crucial for S/THAs to maximize their influence on policy development and strengthen the healthcare safety net. Throughout our interviews, state officials shared examples of cross-agency collaboration that centered health equity and promoted population health. From strengthening data-sharing agreements to providing guidance on clinical services, S/THAs can use their expertise, past experiences, and community relationships to benefit their Medicaid counterparts and improve population health. By expanding their influence and working collaboratively with Medicaid agencies, S/THAs can work to improve access to quality healthcare services and support ongoing improvements to strength the effectiveness of the healthcare safety net.

Appendix: State Clinical Services Summary Tables

Summary of Select Clinical Services Provided or Overseen by State Health Agencies

The following tables summarize select clinical services associated with HRSA's Title V Maternal-Child Health Block Grant (Title V) and the Ryan White HIV/AIDS Program (RWHAP). All clinical services listed below—with the exception of North Carolina's early intervention program—are provided directly or overseen by state health agencies. The information was gathered through publicly available sources, including annual Title V State Applications, RWHAP Audit Reports, and state websites. The tables are not intended to be exhaustive, but highlight only some of the clinical services provided or overseen by state health agencies.

Arkansas

Table 1: Select Clinical Services Provided or Overseen by Arkansas Department of Health (ADH)

Arkansas			
Category 1: Maternal-Child Health Title V			
Service Type	**Program Notes**	**Funded by Medicaid?**	**Medicaid Funding Notes**
Care Coordination	ADH operates and contracts out care coordination programs for children with special healthcare needs. ADH serves as the safety net provider for those who are not eligible for AR Medicaid but would otherwise be enrolled in the Medicaid-funded Provider-Led Arkansas Shared Savings Entity (PASSE) program, which serves Medicaid beneficiaries with behavioral health or intellectual/development disabilities.	Partial funding	AR Medicaid funds care coordination for eligible beneficiaries as part of PASSE.
Behavioral and Mental Health Care	ADH provides mental health care screening, treatment, and referral in schools through its partnership with the Advancing Wellness and Resiliency in Education (AWARE) program.	None	Behavioral health and mental health care services provided or overseen by ADH are not reimbursable by AR Medicaid. AR Medicaid covers select behavioral health services—not provided by ADH—for eligible beneficiaries.
Primary and Preventive Care	ADH operates several primary care and preventive health programs including: • The Women's Health Program, which contracts with local health units to provide select clinical services. • The newborn screening program to identify serious or life-threatening conditions. ADH pays for some preventive and primary care for children with special healthcare needs who are uninsured.	Partial funding	AR Medicaid covers select primary and preventive care services provided by ADH for eligible beneficiaries.

Service Type	Program Notes	Funded by Medicaid?	Funding Notes
Prenatal and Early Childhood Home Visiting	ADH operates several home visiting programs for new parents, including: • Nurse-Family Partnership • Healthy Families America • Home Instruction for Parents of Preschoolers • Parents as Teachers • Following Baby Back Home	None	ADH funds home visiting programs through multiple mechanisms, including Title V and a public-private partnership with the Arkansas Children's Hospital as part of the Arkansas Home Visiting Network.
Category 2: Ryan White HIV/AIDS Program			
Service Type	**Program Notes**	**Funded by Medicaid?**	**Funding Notes**
Medication Coverage	ADH operates the AIDS Drug Assistance Program to cover the cost of HIV-related medications.	None	RWHAP Part B funds ADH's AIDS Drug Assistance Program.
Primary Care	ADH uses contracts with local health units to cover the following HIV/AIDS related clinical services: • Laboratory services • Primary care • Mental health care as part of RWHAP for people living with HIV/AIDS To help coordinate care across RWHAP services, ADH employs Ryan White Part B case managers.	Partial funding	AR Medicaid covers HIV/AIDS-related clinical services for eligible beneficiaries. Through RWHAP, ADH is the payer of last resort for people living with HIV/AIDS who are uninsured. ADH uses RWHAP Part C to fund select clinical services for those who are uninsured.

Massachusetts

Table 2: Select Clinical Services Provided or Overseen by Massachusetts Department of Public Health (MA DPH)

Massachusetts			
Category 1: Maternal Child Health Title V			
Service Type	**Program Notes**	**Funded by Medicaid?**	**Funding Notes**
Care Coordination	MA DPH operates care coordination programs for: • Children and youth with special healthcare needs • Children and families living with HIV/AIDS • Opioid-affected families MA DPH operates case management programs through: • The Childhood Lead Poisoning Prevention Program • The F.O.R. Families program (for families experiencing homelessness)	Partial funding	Title V funding is used to cover care coordination provided by MA DPH for MassHealth enrolled children with special health care needs. Through an Interagency Services Agreement, MassHealth will fund MA DPH's Care Coordination Assistance, Training, Education, and Resource (CCATER) Center. The CCATER Center will provide training on and technical assistance for enhanced care coordination best practices to MassHealth-funded Coordinating Aligned, Relationship-centered, Enhanced Support (CARES) for Kids provider care coordination teams.
Behavioral and Mental Health Care	MA DPH provides individual and family counseling through programs including the Center for Unexpected Infant and Child Death and the Pediatric Palliative Care Network. The Pediatric Palliative Care Network contracts with seven hospice programs to provide nurse-consultation, complementary therapies, and psychosocial support for the youth and family.	None	The Pediatric Palliative Care Network operates using state funding and is not covered by Title V funding.

Service Type	Program Notes	Funded by Medicaid?	Funding Notes
School-Based Health Centers	MA DPH provides comprehensive healthcare services, including primary and behavioral healthcare, through satellite clinics within schools.	Partial funding	MA DPH uses Title V funding and state funding via the School-Based Health State Budget Appropriation (4590-0250) to operate school-based health centers. MassHealth covers services provided by school-based health centers for eligible beneficiaries.
Primary and Preventive Care	MA DPH operates several primary care and preventive health programs including: • Childhood Lead Poisoning Prevention Program • Universal Newborn Hearing Screening Program	Partial funding	MassHealth covers primary care and preventive health screenings provided by MA DPH for eligible beneficiaries.
Prenatal and Early Childhood Home Visiting	MA DPH operates several home visiting programs for new parents directly and through contracts with local service agencies. Programs include: • Welcome Family (WF) • Early Intervention Parenting Partnerships (EIPP) • FIRST (Families In Recovery SupporT) Steps Together (FST) • Three evidence-based Maternal Infant Early Childhood Home Visiting (MIECHV) Models	None	MA DPH funds home visiting programs through multiple mechanisms, including Title V and state funding. HRSA funds WF and MIECHV, Title V funds EIPP, and the Substance Abuse and Mental Health Services Administration funds FST. MassHealth is represented on a workgroup but does not fund the program.

	Program Notes	Funded by Medicaid?	Funding Notes
Medication Coverage	MA DPH operates the HIV Drug Assistance Program through a contract with AccessHealth MA to cover the cost of HIV-related medications.	None	MassHealth covers HIV/AIDS-related medications for eligible beneficiaries. RWHAP Part B funds MA DPH's HIV Drug Assistance Program.
Early Intervention	MA DPH provides early intervention (EI) services for children from birth to 3 years old with or at-risk for developmental delays. EI services include: • Select medical services and therapies • Nutritional services • Family services Additional specialty supports for children who have been diagnosed with autism spectrum disorder, blindness/vision loss, deaf and hard of hearing, or who have complex medical needs	Partial funding	MassHealth covers EI services for eligible beneficiaries.
Primary Care	MA DPH's Bureau of Infectious Disease and Laboratory Sciences employs personnel or contracts with local agencies and community organizations to provide the following HIV/AIDS related clinical services: • HIV medical case management • Medical nutrition therapy • HIV care access • Other core medical services for people living with HIV/AIDS	Partial funding	MassHealth covers HIV/AIDS-related clinical services for eligible beneficiaries. HRSA's RWHAP Part C directly funds personnel and service delivery at 15 community health centers and hospital programs.

Service Type	Program Notes	Funded by Medicaid?	Funding Notes
Oral and Dental Health	MA DPH provides or reimburses for oral health services and community-based dental partnerships for people living with HIV/AIDS who do not have dental insurance through another source.	Partial funding	MassHealth covers oral and dental health services for eligible beneficiaries. The Boston Public Health Commission, a Ryan White Part A grantee for the Boston eligible metropolitan area, coordinates the Ryan White Dental Program to provide oral healthcare for people living with HIV/AIDS who reside in the Boston area. MA DPH uses HRSA Ryan White Part B funds to support oral health services for people living with HIV/AIDS statewide.
Massachusetts Community AIDS Resource Enhancement (MassCARE)	MassCARE provides HIV-related coordinated medical and social services for women, infants, children, and youth living with HIV/AIDS. The program operates out of three federally qualified community health centers.	None	RWHAP Part D funds MA DPH's MassCARE. MassHealth does not reimburse for MassCARE services.

North Carolina

Table 3: Select Clinical Services Provided or Overseen by North Carolina Division of Public Health (NCDPH)

North Carolina			
Category 1: Maternal Child Health Title V			
Service Type	**Program Notes**	**Funded by Medicaid?**	**Funding Notes**
Care Coordination	NCDPH contracts with local health departments to operate care coordination programs for: • Children with special healthcare needs • Infants exposed prenatally to substances • Children with sickle cell anemia • Pregnant people through the Healthy Start NC Baby Love Plus	Partial funding	NC Medicaid funds care coordination provided by or in partnership with NCDPH.
Care Management	Local health departments contract with Medicaid health plans to provide care management services to: • At-risk children • People with high-risk pregnancies	Yes	Medicaid funding for most care management services (other than Healthy Opportunities Pilots care management services) are part of the Medicaid health plan capitation payments. Additional Healthy Opportunities Pilots care management payments are funded outside of capitation. Local health agencies contract with the Medicaid health plans to provide these services.

Service Type	Program Notes	Funded by Medicaid?	Funding Notes
Behavioral and Mental Health Care	Local health agencies provide behavioral health assessments and provide counseling to women, youth, and children. Through Healthy Start NC Baby Love Plus, NCDPH funds mental/behavioral health support for pregnant women who screen positive for depression.	Partial funding	NC Medicaid covers select NCDPH provided services, including behavioral health screenings, referrals, and treatment through the above-mentioned care management programs.
School-Based Health Services	NCDPH provides nutrition services, behavioral health services, and primary and preventive care through school-based health centers. NCDPH funds six school nurse consultants and 31 of the state's 90 school-based health centers. NCDPH nurse consultants also offer case management for students with chronic health conditions.	Partial funding	NCDPH uses Title V funding to operate school-based health services. Local school districts may bill NC Medicaid for nursing services and other health services provided through school-based health centers to eligible beneficiaries.
Primary and Preventive Care	NCDPH contracts with local health departments to operate primary care and preventive services, including: • Well child visits • Newborn screenings, like Early Detection and Intervention Program for newborn hearing Local health agencies may also serve as the primary care provider for children with special healthcare needs	Partial funding	NC Medicaid covers primary care and preventive health services provided by local health departments for eligible beneficiaries.

Category 2: Ryan White HIV/AIDS Program			
Service Type	**Program Notes**	**Funded by Medicaid?**	**Funding Notes**
Prenatal and Early Childhood Home Visiting	NCDPH contracts with local health departments to operate several home visiting programs for new parents, including: • Nurse-Family Partnerships Healthy Families America	None	NCDPH funds home visiting programs through multiple mechanisms, including Title V and state funding.
Medication Assistance	NCDPH operates the North Carolina HIV Medication Assistance Program to cover the cost of HIV-related medications.	None	RWHAP Part B funds NCDPH's HIV Medication Assistance Program.
Primary Care	NCDPH uses contracts with local health agencies to provide HIV-related clinical services.	Partial funding	NC Medicaid covers HIV/AIDS-related clinical services for eligible beneficiaries. Through RWHAP, NCDPH is the payer of last resort for people living with HIV/AIDS who are uninsured.
Oral and Dental Health	NCDPH for oral health services for people living with HIV/AIDS who do not have dental insurance through another source.	Partial funding	NC Medicaid covers oral and dental health services for eligible beneficiaries.

Oregon

Table 4: Select Clinical Services Provided or Overseen by Oregon Health Authority (OHA)

Oregon			
Category 1: Maternal Child Health Title V			
Service Type	**Program Notes**	**Funded by Medicaid?**	**Funding Notes**
Care Coordination	OHA operates care coordination programs for: • Children and youth with special healthcare needs through a contract with Oregon Health and Science University • Perinatal care coordination through local public health agencies	Partial funding	OHP funds care coordination provided by OHA for enrolled children and youth with special healthcare needs. OHA is exploring the feasibility of Medicaid reimbursement for primary care providers who code for and participate in some care coordination programs.
Behavioral and Mental Health Care	OHA partners with local public health agencies and community-based organizations to provide behavioral health screenings and referrals for pregnant people and children. Behavioral health assessments and referrals also occur through OHA's Oregon MothersCare program.	Partial funding	OHP covers behavioral health assessments provided by OHA for eligible beneficiaries.
School-Based Health Centers	OHA provides services like well child exams, treatment of acute and chronic illnesses, vision and dental screenings, immunizations, and medication management through 78 school-based health centers.	Partial funding	Title V funding supports adolescent health policy development in Oregon, such as minor consent and safe school environments, which impact operations and access to school-based health services. OHP covers services provided by school-based health centers for eligible beneficiaries.

Service Type	Program Notes	Funded by Medicaid?	Funding Notes
Primary and Preventive Care	OHA operates several primary care and preventive health programs, including: • Nurture Oregon, an integrated care model for pregnant people that includes prenatal care and care coordination for families impacted by substance use disorder • Newborn screenings, through the Northwest Regional Newborn Bloodspot Screening Program	Partial funding	OR Medicaid covers select primary care and preventive health services provided by OHA or local health agencies for eligible beneficiaries.
Prenatal and Early Childhood Home Visiting	OHA provides several home-visiting programs for new parents, including: • Family Connects Oregon. • Three MIECHV programs (Early Head State Home Based, Healthy Families America, and Nurse-Family Partnership) • Three public health nursing programs (CaCoon, Babies First, and the MIECHV program Nurse-Family Partnership) OHA also supports several other home visiting programs, including Maternity Case Management.	None	OHA funds home visiting programs through multiple mechanisms, including Title V and state funding.
Early Intervention	OHA provides early intervention (EI) services for children from birth to 3 with or at-risk for developmental delays. EI services include: • Select medical screenings and supports • Family support	Partial funding	OR Medicaid covers EI services for eligible beneficiaries.

Category 2: Ryan White HIV/AIDS Program			
Service Type	**Program Notes**	**Funded by Medicaid?**	**Funding Notes**
Medication Assistance	OHA operates CAREAssist to cover the cost of HIV-related medications. CAREAssist also contracts with Ramsell, a pharmacy benefit manager, to offer medication therapy management.	None	RWHAP Part B funds Oregon's AIDS Drug Assistance Program.
Primary Care	OHA's HIV care and treatment programs cover HIV-related clinical services including care coordination.	Partial funding	OHA covers HIV/AIDS-related clinical services for eligible beneficiaries.
Oral and Dental Health	OHA's CAREAssist program provides dental insurance for people living with HIV/AIDS who do not have dental insurance through another source.	Partial funding	OHA covers oral and dental health services for eligible beneficiaries.

This report was developed through a collaboration between ASTHO and the Center for Health Care Strategies as part of a series to better understand how State and Territorial public health agencies can support the healthcare safety net. For the full report and additional profiles, visit our website.

This product was supported by funds made available from the Centers for Disease Control and Prevention, OT21-2103, National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities. Its contents are solely the responsibility of ASTHO and do not necessarily represent the official views of the U.S. Department of Health and Human Services/Centers for Disease Control and Prevention.