



Expression of Interest Medicaid and School-Based Health Services Delivery Affinity Group

CMS is offering a **new affinity group for state Medicaid agencies** interested in collaborating with schools and public health to improve access to and the delivery of important preventive health services for children and adolescents. In the space provided below, please let us know how this affinity group can support the work your state is already doing as well as new areas you wish to explore in these critical health delivery areas. Six to eight states will be chosen to participate in the affinity group. All interested states who submit an Expression of Interest form will be given the opportunity to join the group expert webinars.

A. Your Project and Goals

1. Does your state Medicaid program currently work with school partners to improve quality and utilization of health services?

Yes No (Previous work is not required to participate.)

If yes , please describe your efforts below:

2. Does your state Medicaid agency currently reimburse for any school-based health services? If **yes**, please describe the services covered by Medicaid and what authorities your state uses to allow payment.

Yes No

Services Covered by Medicaid	Authorities Used to Allow Payment

3. What results does your state hope to achieve during the 12-month affinity group?

Please list results below:

4. Is there any specific assistance your state will need, or are there barriers to your success that you can anticipate? **If so**, please describe below.

Specific Assistance Needed	Barriers you Anticipate

5. In the list below, please choose the school-based health services subject areas that your state would be interested in receiving technical assistance during the one-year affinity group period. Please check all that apply.

- Core measure improvement** (oral health, immunizations, well visits, and Early and Periodic Screening, Diagnostic, and Treatment)
- Care coordination between school health personnel and primary care providers** (behavioral health integration, effective use of screening and risk tools, and referrals)
- Access** (consent, youth engagement strategies, and effective local delivery reforms)
- Data sharing and health information technology issues**
- Financing and sustainability** (state authorities, Title V, and billing issues)
- Other** (Describe: _____)

B. Your Team

1. Please identify the state Medicaid agency official who will lead your team.

Name	Title	Mailing address	Phone	Email

2. Who else will participate on your team? Please specify names and roles (e.g., quality leader, data manager, health plan representative, external quality review organization representative, health care provider, consumer/patient representative, other).

Name	Role

3. Will representatives from your state’s public health department be part of your team? If yes, please list names and organizations.

Name	Organization

4. Will members of the department of education or other school system officials be part of your team? If yes, please list names and organizations.

Name	Organization

C. Medicaid Senior Leadership Expression of Support

1. State teams are expected to have the support of the Medicaid Medical Director or some other senior leadership in the agency to demonstrate the state’s interest in achieving the project’s goals. Please indicate below the name of the senior Medicaid official supporting participation.

Name	Title	Agency

Send completed Expression of Interest forms or any questions about participating to:
MedicaidCHIPPrevention@cms.hhs.gov by August 23, 2017.
 Six to eight states will be chosen to participate. All interested states who submit the EOI will be given the opportunity to join the group expert webinars.