

Minnesota — Managed Care

Since 1992, Minnesota has funded and administered maternal and early childhood home visiting for low-income families. The Minnesota Department of Health (MDH) shares responsibility for home visiting with 91 local health departments throughout the state. The goals of the Family Home Visiting program (FHV) are to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, encourage positive parenting and resiliency in children, and improve family health and economic self-sufficiency.

Strong stakeholder support and advocacy at the Minnesota legislature resulted in the passage of an FHV statute in 2001, amended in 2007,⁵⁵ which defines the goals of the program and the duties of both the state and local health departments. The statute directs Temporary Assistance for Needy Families (TANF) funding to all Community Health Boards and Tribal Governments in the state for FHV to families at or below 200 percent of federal poverty guidelines with a pregnant woman and/or minor children and that meet specific risk criteria.⁵⁶

All local health departments must screen FHV participants for income eligibility and provide an initial screening for various risk factors to ensure they are serving the at-risk population. As part of their services, these departments may also screen for infant growth and development, infant-child social and emotional health, home safety, maternal depression, and domestic violence. Following the initial assessment, the home visitor provides relevant referrals and information on infant care, child growth and development, parenting approaches, disease prevention, preventing exposure to environmental hazards, and support services available in the community.

Most local health departments described program duration varying from two to seven visits during pregnancy, with visits after delivery continuing until the baby is one or two years old. Nurses conduct the screenings, and home visits are conducted by nurses or trained paraprofessional home visitors. Local health departments are also required to collect and submit annually data on various indicators to the state, allowing MDH to monitor statewide measures and to submit a biennial legislative report. While MDH does not currently require local health departments to implement a particular evidence-based home visiting model, the consultation

and training provided by MDH is focused on building statewide capacity for such models. Detailed plans are submitted by the local health departments and are used as planning guides, indicating readiness and progress toward evidence-based programs.

Currently, 25 counties use the Nurse-Family Partnership (NFP) model, 11 use the Healthy Families America model, and three use both in an integrated approach.⁵⁷ The remaining counties are not currently affiliated with an evidence-based model, but many more are in various stages of training or learning about federally recognized models. The White Earth tribal government and the Fond du Lac tribal government, as recipients of MIECHV funds, are also implementing NFP.

In addition to administrative oversight and statewide evaluation of FHV, MDH provides training, technical assistance and reflective practice mentoring to local health departments and American Indian tribes to support evidence-based FHV interventions. MDH also administers a program under MIECHV and directs these funds to build capacity at the state and local levels to promote evidence-based home visiting, specifically NFP and reflective practice.

Family Home Visiting Program Financing

Local health departments in Minnesota have a strong history of direct service provision, including well-child and home visits. As a result, these health departments have the capacity to bill third-party payers for medical services. Local FHV programs are funded through a variety of mechanisms, including TANF, Title V, state general funds, local levies, Medicaid and other sources such as grants. Local departments receive varying amounts of funds from these mechanisms, depending upon funding formulas, managed care contracts, and other variables. Furthermore, not every county makes use of all funding streams nor provides the same set of services.

Each of the funding mechanisms is accompanied by its own eligibility and implementation requirements. The funds allocated by the FHV statute are distributed via block grant to local health departments using a formula based on the population at risk and require local departments to perform specific functions (i.e., targeting services, initial assessment during home visit, client evaluation). TANF, Medicaid, and Title V all have income requirements; clients must be legal residents to receive Medicaid and TANF but not Title V; and Title V clients must meet additional high-risk criteria not required for Medicaid.

FHV financing from the Medicaid program is distributed via two avenues: fee-for-service (FFS) and managed care. Sixty-three percent of Medicaid beneficiaries in Minnesota are enrolled in managed care plans, and the remaining beneficiaries are enrolled in FFS.⁵⁸ Individuals enrolled in FFS may receive home visiting services, which are billed using standard billing codes and an additional code indicating the home as the place of service. These codes are summarized in Table B4 below.

DHS continues to evaluate evidence-based home visiting models to determine which home visiting services can be considered medical services and may qualify for FFS reimbursement. By their very nature, many home visiting activities fall outside the sphere of medical services. In order to justify reimbursement for non-medical services, cost savings would have to be demonstrated to accrue to the Medicaid agency.

Home Visiting and Managed Care

Medicaid managed care has been the predominant structure within Minnesota for several decades. Twelve managed care plans are currently contracted by the state to provide services to Medicaid beneficiaries. The state pays each plan a monthly, risk-adjusted rate for each client, and in return, each plan must provide certain required benefits. Home visiting is not a required benefit, but all 12 plans have added home visiting as a service because of the proven cost-effectiveness of high-quality home visiting models.

The Medicaid managed care plans do not provide home visiting services directly but, instead, contract with local health departments to provide FHV. Each plan negotiates contracts individually with those local health departments in its service area. The result is that one Medicaid managed care

Table B4

Minnesota Fee-For-Service Billing Procedure

Service	Code	Code Definition
Home visit: Mother	99501	Home visit for postnatal care and assessment
Home visit: Infant	99502	Home visit for newborn care and assessment
Health promotion and counseling	S9123	Nursing care in the home
At-risk care coordination	H1002	Prenatal care coordination, at-risk
Prenatal nutrition education	97802	Medical nutrition therapy
Maternal depression screening	99420	Administration and interpretation of health risk assessment instrument

*Place of service for all services conducted in home is POS 12.

Source: Minnesota Department of Human Services, "Home visiting services for pregnant women or new mothers, 2009-2010, by payment system-Minnesota Health Care Programs," (March 9, 2011).

plan has arrangements with many local health departments, and most of those departments have contracts with multiple Medicaid managed care organizations. Each of these arrangements is an independent proprietary contract between each local health department and each plan. Medicaid managed care plans have flexibility as to the provider types that may serve families during home visits. Some managed care plans offer financial incentives for clients receiving home visiting services (i.e. \$20 Visa gift card for a prenatal visit within the first trimester of pregnancy).⁵⁹

Lessons Learned

There are strengths and limitations to this complex approach to providing statewide home visiting services. The development and implementation of home visiting programs by local health departments allow services to be tailored to the unique qualities and needs of each county's population. However, the diversity of approaches creates obstacles for uniform evaluation. To support enhanced programmatic evaluation, the legislature added evaluation criteria to the FHV statute when it was amended in 2007. These include the specific indicators of participant satisfaction, rates of children who pass early childhood screening, and utilization of preventive services.

Discussions to promote standardization of evidence-based home visiting services across local health departments are active. MDH continues to provide training and consultation and to leverage the federal evidence-based home visiting initiatives to further enhance the FHV delivery. Local departments may continue to utilize other FHV funding sources in ways that best meet their capacities and needs.

Among the 12 managed care plans and 91 local health agencies in the state, potential exists for variation in the payment for home visiting. Nonprofit organizations that support home visiting programs, such as Metro Alliance for Healthy Families and Minnesota Coalition for Targeted Home Visiting, are investigating strategies to promote standardization of managed care payments to local health departments for FHV services.

For references, please visit www.pewstates.org/homevisiting.