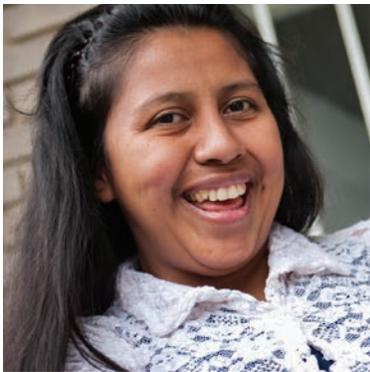


# Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities, and Challenges



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The **Pew Center on the States** is a division of The Pew Charitable Trusts that identifies and advances effective solutions to critical issues facing states. Pew is a nonprofit organization that applies a rigorous, analytical approach to improve public policy, inform the public, and stimulate civic life.

The **Pew Home Visiting Campaign** partners with policy makers and advocates to promote smart state investments in quality, voluntary home-based programs for new and expectant families.

The **National Academy for State Health Policy (NASHP)** is an independent academy of state health policymakers. We are dedicated to helping states achieve excellence in health policy and practice. The organization provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states.

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## Introduction

Home visits to new parents and young families help ensure that both mothers and children receive the health services they need to thrive. Home visiting programs vary widely in scope and intensity, but studies of certain models have found them effective at improving outcomes for both new mothers and young children.

Various funding streams — federal, state, and private — support state home visiting programs. Recently, however, in light of Medicaid’s ability to reach so many low-income and at-risk women, interest has

been growing in its potential to finance home visiting services for eligible mothers and children.

The Pew Home Visiting Campaign engaged the National Academy for State Health Policy (NASHP) to investigate how states are using — or could use — Medicaid to finance home visiting services. NASHP conducted a literature review and a scan of state policies and practices nationwide to identify mechanisms for supporting home visiting services through Medicaid and facilitated an expert meeting

at which state and federal government representatives and national home visiting experts discussed the benefits and challenges of different Medicaid funding mechanisms.

Within the Medicaid program, various mechanisms are available to support home visiting programs. Five of these were found to be currently in use by states: targeted case management, administrative case management, enhanced prenatal benefits, traditional medical assistance services, and managed care.

Other Medicaid financing mechanisms may also lend themselves to funding home visiting services. The expert panel discussed several options and felt that three in particular are potentially viable for home visiting: Medicaid preventive

services, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and 1915b Freedom of Choice waivers. The panel also identified four additional mechanisms — Home and Community Based Services (HCBS) waivers, benchmark plans, home health services, and family planning services — that might be applied in specific circumstances.

This report discusses the findings of the NASHP scan and the expert panel regarding both currently used and potential additional mechanisms through which Medicaid could pay for home visiting and provides state examples where applicable. Six in-depth case studies illustrate states' experiences with Medicaid financing of home visiting services.



## Background

Many different home visiting program models are available and often multiple home visiting programs operate independently of one another within one state. Some home visiting programs follow a federally approved, evidence-based model, others are state-specific adaptations of those models, and still others are independently developed by states or local agencies (See Table 1).<sup>1</sup>

Each home visiting program consists of a set of services delivered by trained providers — registered nurses, social

workers, paraprofessionals, or volunteers — to participating families. Home visiting programs vary widely in both scope and intensity. Services typically begin during a woman's pregnancy and may end shortly after the birth or continue through the child's early years. Some programs are restricted to first-time mothers while others are open to all mothers deemed at risk.<sup>2</sup> The services that comprise a home visiting program may include medical care, behavioral health care, health education, counseling, and assistance with social services.<sup>3</sup>

Table 1

## Select Home Visiting Models\*

Model Name	Description	Research-Documented Outcomes
<b>Child FIRST</b>	Connects high-risk children, birth to age six, with a clinician and care coordinator to decrease the incidence of serious emotional disturbance	<ul style="list-style-type: none"> <li>• Maternal Health</li> <li>• Child Development and School Readiness</li> <li>• Reductions in Child Maltreatment</li> <li>• Linkages and Referrals</li> </ul>
<b>Early Intervention Program for Adolescent Mothers</b>	Provides public health nurses who offer education to pregnant Latina and African American adolescents through the child's first year of life	<ul style="list-style-type: none"> <li>• Child Health</li> <li>• Family Economic Self-Sufficiency</li> </ul>
<b>Family Check-Up</b>	Helps high-risk parents address challenges that arise with young children through consultation with professionals with advanced degrees in psychology	<ul style="list-style-type: none"> <li>• Maternal Health</li> <li>• Child Development and School Readiness</li> <li>• Positive Parenting Practices</li> </ul>
<b>Healthy Families America</b>	Uses trained paraprofessionals to provide support to parents	<ul style="list-style-type: none"> <li>• Child Health</li> <li>• Child Development and School Readiness</li> <li>• Reductions in Child Maltreatment</li> <li>• Positive Parenting Practices</li> <li>• Family Economic Self-Sufficiency</li> <li>• Linkages and Referrals</li> </ul>
<b>Healthy Steps</b>	Enhances relationships between health care professionals and parents by connecting parents with a team of medical practitioners	<ul style="list-style-type: none"> <li>• Child Health</li> <li>• Positive Parenting Practices</li> </ul>
<b>Nurse-Family Partnership</b>	Provides one-on-one home visits by a trained public health nurse to first-time, low-income mothers and their children	<ul style="list-style-type: none"> <li>• Maternal Health</li> <li>• Child Health</li> <li>• Child Development and School Readiness</li> <li>• Reductions in Child Maltreatment</li> <li>• Reductions in Juvenile Delinquency, Family Violence, and Crime</li> <li>• Positive Parenting Practices</li> <li>• Family Economic Self-Sufficiency</li> </ul>

\*These models represent a subset of those designated by the U.S. Department of Health and Human Services as evidence based at press time. These six models were recognized for evidence of maternal and/or child health outcomes.

Source: U.S. Department of Health and Human Services "Home Visiting Evidence of Effectiveness" found at <http://homvee.acf.hhs.gov/programs.aspx>.

Several studies have found that certain home visiting models are most effective at improving maternal and child outcomes and yielding strong returns on investment for states. Nurse home visiting programs, in particular the Nurse-Family Partnership (NFP), have been shown to improve children's health, cognitive functioning, and emotional and behavioral development.<sup>4</sup> Other home visiting models, such as Healthy Families America and Child FIRST, have also demonstrated evidence of effectiveness in improving health and developmental outcomes.<sup>5</sup>

### **The Maternal Infant and Early Childhood Home Visiting Program**

Created as part of the Affordable Care Act (ACA), the Maternal Infant Early Childhood Home Visiting (MIECHV) program provides \$1.5 billion over five years for home visiting. MIECHV is a partnership between two federal agencies — the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) — which administer the grants, and the states, which operate the home visiting programs.

To be eligible for grant funds, states had to conduct a needs assessment that included identifying communities that lack home visiting programs. Formula grants were disbursed to all 50 states in September 2011 based on the number of

children in poverty. In addition, 32 states won competitive grants to either develop or expand existing home visiting programs.<sup>6</sup>

MIECHV allocates 75 percent of its funding to evidence-based home visiting programs that follow federally approved models.<sup>7</sup> (As of December 2011, nine models are federally approved.) The remaining 25 percent of grant funds can be spent on promising approaches to home visiting, which states must commit to evaluate. This infusion of federal grant funds is driving interest in home visiting and in additional funding options to help states sustain and expand these services.

### **Other Funding for Home Visiting Programs and Services**

A variety of public and private funding streams support the services that make up home visiting programs. Major federal sources include Temporary Assistance to Needy Families (TANF), the Title V Maternal and Child Health Block Grant (Title V), Individuals with Disabilities Education Act Part C, and Medicaid.<sup>8</sup> Each federal, state, and private funding stream is characterized by its own rules and definitions governing which women and families are eligible for home visiting services, which services are offered, which providers may deliver services, and the length and intensity of home visits. As a result, public funding for home visiting programs is administered by different state agencies through various categorical funding streams.

**In 2003, Medicaid financed approximately 1.7 million births, or 41 percent of all U.S. births.**

— National Governors Association, *MCH Update: States Increase Eligibility for Children's Health in 2007*. Washington, D.C.: National Governors Association, 2008.

State departments of health and their maternal and child health programs often take the lead in administering health-related home visiting programs. State departments of education or child welfare typically administer home visiting programs with an emphasis on educational development or prevention of child abuse, respectively. State Medicaid agencies are often involved as payers when particular Medicaid-reimbursable services that are part of a home visiting program are delivered to Medicaid enrollees. Less frequently, Medicaid agencies themselves administer a home visiting program for their enrollees. (See Washington case study in Appendix B, for example.)

Proponents of home visiting see the ability of Medicaid to reach many vulnerable women and children as an asset. In 2003, Medicaid financed approximately 1.7 million births, or 41 percent of all U.S. births.<sup>9</sup> The Medicaid eligibility expansions included in the ACA have the potential to extend Medicaid-supported home visiting services to even more new and expectant mothers and young children. Given the high cost of remedial care for poor birth outcomes, state Medicaid agencies and the federal Centers for Medicare and Medicaid Services (CMS) have a deeply rooted interest in assuring healthy pregnancies, positive birth outcomes, and optimal early childhood development.

Home visiting programs not only improve the short-term health of children and mothers, they also reduce overall health care expenditures due to chronic disease later in life. The purchasing power of Medicaid can be a significant policy lever for promoting program quality and improving health outcomes. For this reason, many experts suggest that home visiting is a worthwhile investment for Medicaid programs.<sup>10</sup>



## Commonly Used Medicaid Financing Mechanisms

In 2010, the Pew campaign surveyed state agency leaders at offices of maternal and child health, early learning, child abuse prevention and other state entities with a focus on children's health and wellbeing in an effort to collect vital funding and other data on home visiting programs in all 50 states and the District of Columbia. The resulting inventory provides the most recent information on state home visiting programs and their financing sources.

Fifteen states listed Medicaid as a funding source for at least one home visiting program.<sup>11</sup>

An earlier survey, conducted by NASHP for the March of Dimes in 2007, asked state Medicaid agencies whether they offer home visiting through Medicaid as an enhanced pregnancy benefit. Thirty-two states reported that they offered this benefit.<sup>12</sup> This apparent discrepancy may

hinge both on which state agencies were surveyed and the specific way the question was asked in the two surveys. Significantly, the Pew inventory asked about offering a home visiting program financed in whole or in part through Medicaid, while the NASHP survey identified states offering home visiting services as a Medicaid benefit.

This distinction is important: home visiting programs consist of a variable but comprehensive set of services, including medical care, behavioral health care, social services, and health education. In contrast, home visiting services may be discrete medical, social, or educational activities conducted in the home. State Medicaid programs may fund components of comprehensive programs or may choose to reimburse for discrete, individual home visiting services. There is no federal requirement that Medicaid funding be applied solely or preferentially to evidence-based programs.

Within the Medicaid program, various financing mechanisms are available that can be used to fund home visiting programs and services. The expert panel convened by NASHP discussed the benefits and challenges of various Medicaid financing mechanisms currently in use by states to fund home visiting services. The major features of each mechanism are summarized in Table 2.

## MEDICAID FINANCING: A FEDERAL-STATE PARTNERSHIP

State funds spent within the Medicaid program are matched by the federal government based on a formula that takes into account the number of persons living in poverty in each state. The federal government's share, known as the federal medical assistance percentage (FMAP), ranges from 50 percent to nearly 75 percent.<sup>i</sup> When Medicaid expansions take effect in 2014, the FMAP for newly eligible individuals will be 100 percent.<sup>ii</sup> This enhanced FMAP will gradually decline to reach 90 percent in 2020.<sup>iii</sup> In addition, states receive a federal financing participation (FFP) rate of 50 percent for the majority of administrative activities necessary for the proper and efficient operation of the Medicaid program.<sup>iv</sup>

i Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for FY 2012." <http://aspe.hhs.gov/health/fmap12.shtml>.

ii Patient Protection and Affordable Care Act [P.L. 111-148 §2001].

iii Ibid.

iv Email communication from Jean Close of CMS to Kathy Witgert of NASHP.

Table 2

## Commonly Used Medicaid Financing Mechanisms for Home Visiting Services

	Targeted Case Management	Administrative Case Management	Enhanced Prenatal Benefit	Managed Care	Traditional Medicaid Service
<b>CMS Regulations</b>	Helps beneficiaries gain access to medical, social, educational, and other services; waives rules that comparable services be offered to all enrollees statewide; allows states to specify provider qualifications [42 CFR 440.169 and 42 CFR 441.18]	Helps beneficiaries gain access to Medicaid services; may include eligibility, outreach, and prior authorization	Allows states to provide additional services to pregnant women than it provides to other Medicaid-eligible individuals as long as the services are related to pregnancy or conditions that may complicate pregnancy [42 CFR 440.250]	Social Security Act §1932	Medicaid statute defines mandatory and optional services. [Social Security Act §1905a]
<b>Federal Medical Assistance Percentage (FMAP)</b>	Standard FMAP	50% federal financial participation	Standard FMAP	Standard FMAP	Standard FMAP
<b>State Plan Amendment</b>	Required	Not needed; reflected in an approved cost allocation plan	Required	Not needed for HV services	Required
<b>Services Provided</b>	Assessment and reassessment, development of a care plan, referrals and scheduling, monitoring and follow-up	Outreach, utilization review, prior authorizations, eligibility determinations	Non-clinical and medical services related to pregnancy; includes, but not limited to, prenatal care, delivery, post-partum care, and family planning services	Subject to state contract with the Managed Care Organization (MCO)	Traditional Medicaid services, location of service is client home
<b>Payment</b>	Fee-for-service	Subject to the principles in OMB Circular A-87	Fee-for-service	Subject to state contract with MCO	Fee-for-service
<b>Population Served</b>	Specific demographic population or eligibility category within Medicaid	Activities for the proper and efficient administration of the state plan	Pregnant Medicaid recipients	Subject to state contract with MCO	All Medicaid recipients statewide

### Targeted Case Management

CMS defines targeted case management (TCM) as those medical assistance services that help beneficiaries gain access to medical, social, educational, and other services. TCM includes four components: assessment services, development of a care plan, referrals and scheduling, and monitoring and follow-up for Medicaid enrollees. Services offered as TCM may be targeted to a sub-group of beneficiaries (e.g. pregnant or post-partum women) and are not subject to the standard Medicaid rules requiring that any Medicaid benefit offered in a state be available to all Medicaid enrollees statewide. States specify targeted groups to receive TCM in the state plan amendments filed with CMS and receive their regular FMAP for TCM services.

NASHP's environmental scan found that TCM is the Medicaid financing mechanism states use most often for home visiting services. Benefits of using TCM are the ability to target home visiting services to specific enrollees — women or children — and to target services in specific geographic areas. This allows states to tailor programs to high-risk women or to offer services in specific parts of the state even when services cannot be offered statewide. For example, Kentucky, which uses TCM to fund a home visiting program, limits participation to high-risk, first-time parents.

While TCM can be used to reimburse some portions of home visiting programs, it does not cover a full package of services. Notably, medical services themselves are not a part of TCM and must be billed and reimbursed separately. An additional challenge to using TCM cited by the panel is the CMS policy that prohibits a case manager from recommending and providing additional services at the same visit. To guard against conflicts of interest, the state must first authorize any recommended additional services.

### Administrative Case Management

Administrative case management (ACM) is designed to help Medicaid beneficiaries gain access to needed medical services. ACM activities are available statewide to all Medicaid recipients and can include eligibility determinations, outreach, and securing authorizations needed to access medical services. The federal government provides 50 percent federal financial participation for certain ACM activities. States can offer these activities without filing a state plan amendment.

ACM is currently used by a few state Medicaid agencies (California, Illinois, Michigan, North Dakota, Washington, and Wyoming) to reimburse for certain home visiting activities. A major benefit to using ACM is that states can limit the entities eligible to deliver Medicaid-funded home visiting. For example, states may require that local health departments conduct home visiting. This allows states to prescribe and monitor the activities provided.

By definition, ACM cannot be used to reimburse for direct medical services. Some states, such as Illinois, use ACM to reimburse administrative outreach and coordination activities provided through home visiting and then bill Medicaid fee-for-service (FFS) for any specific medical services provided.

### **Enhanced Prenatal Benefits**

Recognizing the value of non-medical, psychosocial support services in promoting prenatal care, in 1985, Congress gave states the option to provide non-clinical benefits to pregnant women enrolled in Medicaid without also offering the same additional benefits to all Medicaid recipients.<sup>13</sup> In 2007, 32 states reported offering home visiting as an enhanced prenatal Medicaid benefit for pregnant women. In this context, states use home visiting to provide women who are pregnant or have recently given birth with pregnancy-related medical and non-clinical support services.<sup>14</sup> States receive the regular FMAP for all services provided as enhanced prenatal benefits.

Offering home visits as an enhanced prenatal benefit has several benefits. First, home visiting is a recognized service category within enhanced prenatal benefits. A state can add home visiting by filing a state plan amendment with CMS and can use the filing to designate approved providers, define the services to be provided during home visits, and ensure consistency of those services.

The major drawback to offering home visiting as an enhanced prenatal benefit is that women are eligible only during pregnancy and for 60 days post partum. To provide new mothers and their infants with Medicaid-funded home visiting beyond that time period, states must use another reimbursement mechanism to pay for those services.

### **Traditional Medical Assistance Services**

The federal Medicaid statute defines the mandatory and optional medical assistance services to be provided to Medicaid enrollees.<sup>15</sup> (Because these services are defined at Section 1905(a) of the Social Security Act, they are sometimes known as “1905(a) services.”) States must offer mandatory benefits and may choose which optional benefits to offer. Each state lists the optional benefits offered to beneficiaries in its state plan. These Medicaid optional services can be offered by licensed, enrolled Medicaid providers, either in a traditional office setting or as part of a home visit. No additional state plan amendment is needed for offering these services in the home.

The main benefit to using 1905(a) Medicaid services as a way to provide home visiting services is that no additional administrative actions are required on the part of the state. The standard federal FMAP is provided regardless of the place of service, though some states reimburse providers an additional fee for a service

performed in the home rather than in the office. (Reimbursement forms usually include a space to note place of service.)

The main drawback to using only 1905(a) Medicaid services to fund home visiting is that it excludes many of the educational and case management activities that are typically part of a home visiting program because they are not medical assistance services. Some states, including Washington, have combined this mechanism with TCM to provide a full complement of home visiting services.

### Home Visiting Within Medicaid Managed Care

States have several options when home visiting services are offered to Medicaid beneficiaries who are participating in a managed care plan. Some states, such as Kentucky and Washington, provide home

visiting on a fee-for-service basis as a “carve out”<sup>16</sup> from managed care. Michigan requires its contracted Medicaid managed care organizations to, in turn, contract with the same providers who deliver the state’s FFS home visiting program. Other states, such as Minnesota, have seen managed care organizations offer home visiting programs as a way to capitalize on their proven cost-effectiveness but do not specify home visits as a required service in Medicaid managed care contracts. Where Medicaid managed care organizations do offer home visiting, however, state agencies often lack direct access to claims or encounter data, and so cannot adequately monitor the service delivery or outcomes.

The extensive and growing use of Medicaid managed care across states — nearly 72 percent of Medicaid enrollees participated in managed care in 2010 compared with nearly 57 percent of enrollees in 2001<sup>17</sup> — calls for further investigation of how best to finance home visiting services in the managed care environment. Some considerations for states wanting to provide home visiting within managed care include: ensuring providers are included in managed care organization networks, calculating a per-member, per-month rate for services; and ensuring contracted services are delivered to eligible enrollees. State contracts with managed care organizations can be used to define criteria for home visiting programs.

**Nearly 72 percent of Medicaid enrollees participated in managed care in 2010 compared with nearly 57 percent of enrollees in 2001.**

— Centers for Medicare and Medicaid Services, National Summary of Medicaid Managed Care Programs and Enrollment as of June 30, 2009.



## Other Potential Medicaid Financing Mechanisms

The previous section examined the benefits and challenges of the five Medicaid financing mechanisms states currently use to pay for home visiting services. Additional Medicaid mechanisms may also lend themselves to funding services provided as part of a home visiting program. NASHP's environmental scan did not uncover any home visiting programs currently using these options to finance their services. The NASHP-convened expert panel, however, discussed the following options and felt that they are

potentially feasible and appropriate. States that wish to pursue any of these options will need to work with CMS to develop the appropriate state plan amendment or waiver.

### **Section 1905a Preventive Services**

As previously discussed, Section 1905a of the Social Security Act lists the services that state Medicaid programs must and may provide. The list of optional services includes broadly defined preventive services eligible for medical assistance



payments. Specifically, Medicaid will finance “other diagnostic, screening, preventive, and rehabilitative services.” Effective January 1, 2013, the ACA may afford states a new opportunity to optimize Medicaid financing for home visiting by increasing the FMAP for some of these services, including any clinical preventive services that are assigned a grade of A or B by the U.S. Preventive Services Task Force; certain immunizations for adults; and other medical or remedial services recommended by a physician or other licensed practitioner, including services provided at a home visit.<sup>18</sup> States that include these services in their state plans and prohibit cost sharing for their delivery will receive a 1 percent increased FMAP.

Preventive services under this section will be defined by each state as part of its Medicaid state plan and must be offered to all enrollees statewide. A state could make the case that evidence-based home visiting programs can prevent negative health outcomes and should therefore be included as a preventive service. In an August 2011 letter to NFP, CMS suggested this option would be an acceptable mechanism for financing NFP services, “as long as services are provided by a physician or other licensed practitioner within the scope of the practice under State law.”(See Appendix E)<sup>19</sup> The U.S. Preventive Services Task Force is currently reviewing topics including screening and counseling of alcohol misuse, healthy

lifestyle counseling, and counseling to prevent unintended pregnancies, in addition to the many preventive screenings it already recommends for pregnant women and women of child-bearing age.<sup>20</sup>

Participants at the expert panel expressed interest in this option, but it has not yet been tested as a mechanism for financing home visiting services through Medicaid. An interested state would need to work with CMS to craft a state plan amendment that either defines a list of services typically delivered at a home visit as preventive services or defines a single bundle of home visiting services for new mothers and young children as a preventive service.

### **Early and Periodic Screening, Diagnosis, and Treatment**

The Medicaid statute requires states to provide eligible children with periodic screening, vision, dental, and hearing services.<sup>21</sup> It also requires states to provide children with any medically necessary health care services identified through required screenings and diagnosis even if the service is not available to adults. These Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services must be available to all Medicaid enrollees under age 21 statewide. States receive their regular FMAP when providing EPSDT services.

States can further define a package of services to be offered under EPSDT. For example, Minnesota created a program of flexible mental health services called “children’s therapeutic services and supports” through rehabilitative services and included in the state under EPSDT. These services include individual, group, and family therapy; crisis counseling; and the services of a behavioral health aide.<sup>22</sup> The state defined the services within this benefit, required providers to have certain training, and established a range of payment methods.

A similar bundle of services could be created within EPSDT for home visiting. A state would need to work with CMS to define qualifying services and could then further define approved providers. States using EPSDT to offer home visiting could include benefits for new mothers younger than 21 or young children or both. States would want to assess what proportion of their target population meets the EPSDT age criterion.

### **Section 1915b Freedom of Choice Waiver**

The §1915b Medicaid waiver, known as a “Freedom of Choice” waiver, is most commonly used by states instituting Medicaid managed care. A §1915b waiver allows states the flexibility to forego “statewideness,”<sup>23</sup> comparability of services, and the freedom for Medicaid beneficiaries to choose their providers.

That is, states can selectively contract with specific providers for specific services. There are four Freedom of Choice waivers, three of which could be useful individually or in combination to pay for home visiting services provided to Medicaid-eligible women and children:

- 1915(b)(1) mandates Medicaid enrollment into managed care;
- 1915(b)(3) uses cost savings to provide additional services;
- 1915(b)(4) limits the number of providers for services.

By using a §1915b waiver, a state could define a home visiting service package and develop a set monthly payment for that package. Resulting cost savings could be used to finance the non-medical services that are sometimes difficult to reimburse through other Medicaid mechanisms. With this approach, a state also could define the required qualifications of providers, limit the services to a defined geographic area, or identify a target population to receive the home visiting services. Using a §1915b waiver could reduce the administrative burden on providers delivering home visiting services by allowing them to be paid a fee based on utilization data rather than having to file a reimbursement claim for each discrete home visit or service.

## LESS LIKELY MEDICAID FINANCING MECHANISMS

The expert panel also discussed other possible Medicaid financing mechanisms that might be used to fund home visiting services – the Section 1915c Home and Community Based Services waiver, Medicaid Benchmark plans, home health services, and family planning state plan amendments. These financing mechanisms appear to support some of the services used in home visiting programs. However, the panel concluded that these mechanisms are less well suited to home visiting services. In specific circumstances, however, they may be applicable, so they are briefly discussed in Appendix A.

States interested in pursuing this option will have to craft their waivers carefully and work with CMS for approval. Section 1915b waivers must be cost effective based on actuarial rates. Data demonstrating the cost-effectiveness of home visiting programs are available and could help states with this requirement.<sup>24</sup> CMS has expressed an openness to state flexibility and a willingness to work with states on a variety of §1915b waivers.<sup>25</sup>



## Braided Funding: Combining Medicaid with Other Funding Sources

States can and do use Medicaid in combination with other sources of federal (e.g. Title V MCH Services Block Grant), state (e.g. general revenue funds), and private (e.g. foundation) funding to support home visiting programs that reach both Medicaid-eligible and other populations. However, states may only spend Medicaid dollars for services and activities provided to Medicaid-eligible

home visiting program participants. While this use of multiple funding streams in complementary fashion requires careful accounting and reporting, such braiding of funding streams could lead to the most efficient use of funds and extend the reach and benefits of home visiting programs to the largest number of children and families.

### **Lessons from Early Intervention Financing: Part C and Medicaid**

As maternal and early childhood home visiting programs build stronger partnerships with Medicaid, there is an opportunity to leverage the lessons learned from other early intervention programs, which offer a mix of medical and non-medical services for young children. Early intervention programs were authorized in 1986 by the Infants and Toddlers with Disabilities Program (Part C) of the Individuals with Disabilities Education Act (IDEA). Part C is administered at the federal level through the Department of Education, and at the state level by a range of agencies including education, health, and social services as well as some interagency systems.<sup>26</sup> Early intervention programs provide services for infants and toddlers (birth to age three) who have or are at high risk for developmental delays. Each state defines its own eligibility criteria, services, and provider requirements; however, services typically include physical, occupational, speech-language-hearing therapies and parent-child developmental therapy. Some states offer more than 90 percent of Part C services within the home.

Medicaid and IDEA regulations permit Medicaid financing for section 1905(a) services provided under Part C and specify that Part C is the payer of last resort, meaning Medicaid funds are to be used before Part C funds to finance Medicaid-covered services for children eligible for both programs. Medicaid billing generally occurs through EPSDT and TCM,<sup>27</sup> and providers must be Medicaid qualified in order to receive reimbursement. Medicaid-covered services must be medically necessary and may include physical therapy, speech and language therapy, psychological and psychiatric services, and EPSDT services. Given the history of early intervention programs in each state over the last 25 years, additional research on Medicaid financing of early intervention is recommended to identify potential lessons relevant to the relationship between home visiting and Medicaid.

### **A Possible Future for MIECHV and Medicaid**

As ACA-funded MIECHV grant programs mature and demonstrate health outcomes, Medicaid is one possible source of funding to help bring home visiting programs to scale and ensure their long-term sustainability. State agencies in charge of MIECHV programs may wish to engage their Medicaid agency counterparts to

discuss potential financing mechanisms that can support home visiting services provided to Medicaid enrollees. Such a partnership could benefit both MIECHV-administering and Medicaid agencies through the improved health outcomes and cost savings that home visiting programs can achieve.

The section of the ACA that establishes the MIECHV grant program does not explicitly cite the portion of Title V that addresses interagency agreements with Medicaid,

which has raised questions as to whether the intent is that the relationship between Medicaid and MIECHV be the same as that between Medicaid and the core Title V services. (In the latter instance, Medicaid is the primary and Title V a secondary payer.) However, the Medicaid regulations that require interagency agreements with Title V agencies remain unchanged. States that wish to braid MIECHV and Medicaid funds should review their interagency agreements to ensure MIECHV programs are included.







## Conclusion

Medicaid pays for health care services to enrollees and also makes funds available for administrative purposes, including administrative case management activities that help enrollees obtain medical services. Quality, voluntary home visiting programs provide a combination of medical and non-medical services and often struggle to optimize Medicaid's financing for these technically distinct program components.

States that wish to support home visiting services through Medicaid must first choose the most appropriate financing mechanism for their circumstances.

Factors to consider include the population to be served, the services to be offered, the providers who will deliver services, and the applicable federal matching rates. States must also consider the administrative burdens involved in preparing a state plan amendment or waiver, and they will want to work closely with CMS throughout the process. As with any complex state plan amendment or waiver process, states may wish to consult experts who can assist with drafting language, interpreting statutes and regulations, and making budget projections.

While it is unlikely that a single Medicaid financing mechanism can fund an entire home visiting program, different mechanisms can fund various services that are part of a comprehensive approach to supporting new and expectant families. Some states are already using a combination of Medicaid funding mechanisms to support home visiting services, and still others are combining Medicaid funding with other sources of public and private funding. In addition, states may have the opportunity to create bundles of services that greatly simplify the administrative burden associated with using Medicaid to pay for home visiting. Ultimately, state home visiting programs will need to embrace a variety of strategies to maximize their resources, most efficiently provide quality services to the greatest number of children and families, and deliver cost savings for Medicaid programs and taxpayers.

# Additional Potential Medicaid Financing Mechanisms for Specific Circumstances

The following Medicaid financing mechanisms might be used to fund home visiting services in specific circumstances in individual states. A NASHP-facilitated expert panel evaluated these Medicaid financing options along with those discussed in the body of this report. While the panel concluded that other mechanisms are likely better suited to support home visiting, some states may want to consider these options, perhaps in combination with others. Each of these financing mechanisms appears to support some of the services used in home visiting programs. In addition, those states developing a global §1115 Medicaid waiver can include home visiting within that structure.

## **Section 1915c Home and Community Based Services Waiver**

Section 1915c Medicaid Home and Community Based Services (HCBS) waivers are available as an option for providing certain services to a defined target population in a state and are

traditionally employed by states to serve people with complex needs and avoid institutionalization. An HCBS waiver program may provide a combination of both traditional medical services as well as non-medical services including case management. States may administer multiple HCBS waiver programs for different populations and can limit the number of Medicaid enrollees in each.

States wishing to target home visiting programs to defined subsets of Medicaid enrollees with complex needs could apply a §1915c waiver if the population were appropriately defined. However, it may be difficult to define a population of new mothers and young children who would be institutionalized but for the availability of home visiting services. In addition, states are concerned about the increase in reporting requirements CMS has instituted for §1915c waivers. States should carefully evaluate whether a §1915c waiver will adequately support the delivery of maternal and early childhood home visiting services.

### **Secretary-approved Benchmark Plans**

The Deficit Reduction Act of 2005 (DRA) allows states to develop alternative benefits plans for targeted populations of Medicaid enrollees. The DRA defines five types of “benchmark” plans including “Secretary-approved” plans,<sup>28</sup> which states have used to target special populations by need, geography, and risk. To obtain approval for such a plan, states must submit a state plan amendment using a CMS-designed template. Under the DRA, states can generally require healthy women to participate in a benchmark plan. Pregnant women with special medical needs can be voluntarily enrolled in a benchmark plan.<sup>29</sup>

A state could develop a Secretary-approved plan targeting pregnant women or new parents that includes home visiting services. In an August 2011 letter to NFP, CMS suggested that states could adopt this approach to providing home visiting services to targeted populations or in limited geographic regions. (See Appendix E.)<sup>30</sup> However, enrollment and disenrollment from such a plan would need to be carefully coordinated to avoid gaps in coverage. Similarly, states would need to ensure provider networks in such a plan mirror those in other plans to avoid discontinuity in care. These considerations may make this option impractical for most states.

### **Home Health Services**

Home health services include part-time or intermittent nursing services, home care assistant services, and medical supplies and equipment and must be provided through Medicaid when medically necessary. At the state’s option, Medicaid also may cover audiology, physical, occupational, and speech therapies delivered in the home.

Given the common use of the home as the primary service delivery site, home health services may initially be an appealing Medicaid financing mechanism for providing home visiting to pregnant women, new parents, and young children. However, the services included in home health services may not be appropriate to include in a maternal and early childhood home visiting program. Two additional drawbacks are that a physician must order home health services and that services must be reauthorized every 60 days. These requirements are inconsistent with many home visiting programs that are often designed to use non-physician providers and to operate for a full year or longer.

### Family Planning State Plan Amendment

As of 2008, 27 states had in place Medicaid §1115 family planning demonstration waivers that allow Medicaid coverage of family planning services and supplies to women, and sometimes men, who are not otherwise eligible for Medicaid coverage. These expansions are highly cost effective for states, since the FMAP for family planning services is 90 percent.<sup>31</sup> The ACA includes an option to offer family planning services to persons not otherwise eligible for Medicaid through

a state plan amendment rather than a waiver.<sup>32</sup> The expert panel discussed whether some home visiting services might fall into the category of family planning, and concluded that few do. The group did recommend that delivery of family planning services, especially those provided postpartum, could be good case-finding opportunities for home visiting programs. In addition, there is nothing in Medicaid statute or regulation to prohibit family planning services being delivered in the home, possibly with other services for women, between pregnancies.



# Medicaid and Home Visiting State Case Studies

Based upon NASHP's environmental scan of states' use of Medicaid to fund home visiting for new and expectant families, and in consultation with the Pew Home Visiting Campaign, six states that use different home visiting models and different Medicaid financing methods were selected to participate in case studies. Key information illustrating these six states' experiences with Medicaid financing of home visiting service was gleaned through interviews with Medicaid and home visiting program officials in these states (See Table B1).

The case studies include the history and rationale for using Medicaid, describe the services provided by the home visiting programs, and outline the provider<sup>33</sup> requirements and Medicaid billing procedures used. We chose states with experiences representing a range of

Medicaid financing mechanisms and did not limit our case studies to states using U.S. Department of Health and Human Services-recognized evidence-based home visiting programs. Indeed, many of these Medicaid financing mechanisms were in place long before the MIECHV-related review of program models was conducted.

Among these states, a number of limitations were noted that impede the optimal delivery and financing of home visiting, including inability to finance both medical and non-medical services through a single mechanism; difficulty overseeing home visiting services offered through a Medicaid managed care plan; and concern about proper adherence to CMS regulations and how to appropriately bill Medicaid for home visiting services. Negotiation of these factors is key to successful Medicaid financing.

Table B1

## Home Visiting Programs Featured in Case Studies

State	Home visiting program name	Medicaid financing mechanism
Illinois	Family Case Management	Administrative case management
Kentucky	HANDS	Targeted case management
Michigan	Maternal & Infant Health Program	Traditional Medicaid service
Minnesota	Family Home Visiting	Managed care
Vermont	CIS Nursing & Family Support	Global §1115 waiver
Washington	First Steps	Targeted case management and traditional Medicaid service

## Illinois — Administrative Case Management

Illinois' Family Case Management program is a statewide effort designed to connect at-risk families that include a pregnant woman, an infant, or a child with special health care needs to medical and social services that promote healthy pregnancies and infant development. Since 1994, home visiting services have been offered as a component of Family Case Management. Housed within the Illinois Department of Human Services (DHS) Bureau of Maternal and Infant Health (the state's Title V agency), the Family Case Management program represents the largest home visiting effort in the state, serving approximately 312,389 pregnant women and children in FY 2010.<sup>34</sup> In addition to Family Case Management, DHS administers three federally recognized, evidence-based home visiting program models throughout Illinois: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers.<sup>35</sup> However, Family Case Management has significantly wider geographic and population reach than these programs and is therefore the focus of this case study.

Across the state, DHS administers Family Case Management funds to 115 local service providers, including health departments, federally qualified health centers, and other community-based

organizations, to serve as contracted Family Case Management agencies. Integral to this local agency infrastructure are DHS-contracted case managers working within local agencies that are responsible for connecting eligible families with various supports. The Illinois Maternal and Child Health Services Code defines and regulates all Family Case Management program activities. The Code classifies case management activities as including, but not limited to:

- Assessment of needed health and social services,
- Development of individual care plans,
- Referral of individuals to appropriate community providers,
- Ongoing follow-up with program participants or service providers to ensure accessed services, and
- Periodic reassessment of participants' needs.<sup>36</sup>

Within Family Case Management, home visiting services are considered to be an activity of program case management. If case managers refer mothers to receive this service, they may choose to participate in a minimum of one prenatal home visit and one home visit during the first year of a child's life. For infants and children whose mothers are identified as being at high risk for poor pregnancy outcomes,

families may be referred to receive targeted intensive prenatal case management, which provides one monthly home visit and one additional face-to-face visit each month with a registered nurse or social worker. Families can remain in this intensive program for up to six weeks during their prenatal period, at which time they are gradually transitioned back to the regular Family Case Management home visiting service activities.

Case managers must be either a registered professional nurse, a clinical social worker or a licensed social worker, or must possess a master's or baccalaureate degree in a health-related field, if supervised by a registered nurse. The program also utilizes paraprofessionals and lay workers as supervised case manager assistants to help facilitate participant intake, follow-up, and outreach activities.<sup>37</sup>

### **Medicaid and Family Case Management Home Visiting**

In order to qualify for Family Case Management services, pregnant women or new mothers must have incomes at or below 200 percent of the federal poverty level.<sup>38</sup> During intake assessments, case managers are required to note each family's Medicaid eligibility and enrollment status.<sup>39</sup> If a home visiting recipient is enrolled in Medicaid managed care, the managed care organization must notify the

enrollee's primary care provider that she is receiving Family Case Management in an effort to avoid duplication of services.

Home visiting services rendered by DHS-qualified agencies are eligible to be reimbursed by Medicaid. DHS is able to claim a 50 percent federal match rate for outreach and case management activities "for coordination of medical and medically-related services for the health and well-being of the participant." Local Family Case Management providers are able to submit Medicaid administrative case management (ACM) claims to finance home visiting activities. When a case manager refers mothers or children for specific medical services, Medicaid-enrolled providers bill those services through fee-for-service (FFS). Programmatic expenses not reimbursable by Medicaid are covered using state general funds.

In order to bill for ACM, Family Case Management case managers are required to report information regarding the time, activity, and participant information of each home visiting encounter. At a minimum, activity categories must be identified as case management, outreach, administration of outreach and case management, or a description of other direct services provided. The Family Case Management program does not distinguish

between place of service for billing purposes, which allows case managers to use the same billing codes for services delivered in a participant's home as they would in a clinical setting. However, if a provider agency is a local health department, they are permitted to provide direct services (such as screenings and vaccines) in a client's home with a signed standing order from a physician. In this case, the agency will be reimbursed on an FFS basis, and they are still able to claim the Medicaid administrative match for non-direct services provided in the home.

### Lessons Learned

Illinois' choice to finance Family Case Management home visiting services through Medicaid ACM has enabled the state to efficiently provide case management services through local health departments and other entities that have historically had the capability to provide these services. However, state budget shortfalls have affected the workforce capacity within local health departments and community health centers as well as their ability to support Family Case Management activities.



## Kentucky — Targeted Case Management

Since 1999, the Health Access Nurturing Development Services (HANDS) home visiting program has promoted healthy pregnancy and birth outcomes for Kentucky residents. The statewide program served more than 11,000 families in FY 2010.<sup>40</sup> Program goals include positive pregnancy and birth outcomes; optimal child growth and development; healthy homes; and family self-sufficiency. The health prevention curriculum, based on Growing Great Kids,<sup>41</sup> consists of multiple home visits with health professionals and paraprofessionals to ensure a developmentally appropriate, healthy, and nurturing environment for children ages birth to three years.

The voluntary home visiting services administered by the state include HANDS, Early Head Start, and home visits provided by Child Protective Services. HANDS was not identified by the U.S. Department of Health and Human Services as an evidence-based model, but the state is currently conducting an evaluation of the program that is intended to yield that classification. Nurse-Family Partnership and Parents as Teachers have several privately run sites in various parts of the state.

HANDS is administered by the Kentucky Department for Public Health (DPH) and implemented by local health departments.

The program, available to all first-time parents, regardless of income or insurance status, offers a basic screening to determine potential stressors for all participants. Clients found to be high-risk receive a more in-depth assessment, educational curriculum, and case management.<sup>42</sup> HANDS boasts high retention rates, with approximately 40 percent of clients receiving services for more than 18 months.<sup>43</sup>

### Medicaid and HANDS Home Visiting

HANDS was not originally designed with the participation of Medicaid. Originally, the Kentucky Department of Public Health used state funding for implementation in 15 pilot areas. Initial evaluation of the pilots demonstrated positive birth outcomes for participants, and DPH set a goal to expand the program in order to promote healthier pregnancies and positive birth outcomes throughout the state.

In 2000, the Kentucky General Assembly created the early childhood development act known as Kids Now, which receives 25 percent of Kentucky's Phase I tobacco settlement resources. Several years after the inception of HANDS, Kids Now reviewed client data to find that more than 90 percent of participating mothers were eligible for Medicaid. DPH, seeking to form a collaborative agreement with the agency, approached Kentucky Medicaid to discuss the benefits of HANDS services and potential for reimbursement. In their

collaborations, DPH offered to use Kids Now funds to pay the state share of HANDS services provided to Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries. This arrangement was key to the partnership between Medicaid and DPH and has limited the political and financial challenges associated with adding HANDS as a reimbursable service.<sup>44</sup>

Convinced by the positive outcomes shown in program evaluations, Kentucky used a Medicaid state plan amendment to make HANDS available to Medicaid-enrolled first-time parents statewide. As a component of targeted case management (TCM), HANDS receives the full FMAP, which in Kentucky is currently 71 percent.<sup>45</sup>

Licensed nurses and social workers as well as paraprofessionals deliver HANDS services.<sup>46</sup> All HANDS services are reimbursable for Medicaid and CHIP beneficiaries, and HANDS does not bill other third-party payers.

Tobacco settlement dollars, in addition to funding the state share of Medicaid reimbursements, are used to cover costs for individuals without Medicaid coverage.

Kentucky CHIP is a separate program that utilizes all Medicaid structures, including billing procedures. CHIP beneficiaries are also eligible for HANDS reimbursement. Within the fee-for-service system, three Current Procedural Terminology (CPT) billing codes are used for both Medicaid and CHIP — one for the assessment, one for a home visit by a professional nurse or social worker, and one for a home visit by a paraprofessional. The reimbursement rate is contingent on which service is provided and on the type of provider.

The billing provider for all claims is the state DPH, and the rendering provider is the local health department. Each entity has its own provider code. DPH submits a claim in the Medicaid system using the CMS 1500 form. Home visiting, as a component of prenatal care, is billed using the parent’s Medicaid identification

Table B2

### Kentucky HANDS Medicaid Billing Codes

Service	Code	Code Definition	Payment
Professional Home Visit	S9444	Parenting classes, non-physician provider	\$160
Paraprofessional Home Visit	S9445	Patient education, non-physician provider	\$120
Assessment	T1023	Program intake assessment	\$170

number. Home visiting services delivered after birth are billed with the child's Medicaid identification number, given many mothers are no longer Medicaid-eligible after 60 days postpartum.

### Lessons Learned

Collaboration with Medicaid has significantly expanded the capacity of HANDS, helping Kentucky to offer the program in all 120 counties. Although the state plan amendment was laborious in its initial development, the highly collaborative relationship between DPH and Medicaid has yielded few challenges. Perhaps the most significant challenge is the determination of which Medicaid beneficiaries qualify for participation in the program. As outlined in the state plan amendment, HANDS is intended only for first time parents. Participation in the program is voluntary and guidelines for participation as outlined in state regulation include:

- A pregnant woman who has not reached her 20<sup>th</sup> birthday and who will be a first-time parent;
- A pregnant woman who is at least 20 years old, will be a first-time parent, and a risk is deemed likely for the pregnancy or the infant;
- An infant or toddler, up to his third birthday, whose mother meets one of the eligibility criteria listed in the two previous bullets;
- A firstborn up to 12 weeks of age whose family is determined to be at risk; or

- A first-time father or guardian of a child identified above.

In order to ensure that recipients meet qualifications for participation in the program, the Department for Medicaid Services implemented a series of claim edits and audits. The edits and audits consist of checking for previous births using the mother's Medicaid identification number and comparing claims history for all participants in the program. These procedures ensure that only qualified families participate and provide data to support paid claims for audit purposes. DPH implemented a rigorous web-based system to track which services are provided to each client and performs site visits and audits of local health departments annually to monitor implementation. This information supports statewide assessment of HANDS and thorough internal evaluation, illustrating improvements in health outcomes among participants.

As Kentucky transitions to Medicaid managed care, HANDS will not be required of managed care organizations nor included in their payment rate. The program will continue to be administered by DPH and its utilization monitored by Medicaid. As a result, HANDS financing and management is anticipated to remain relatively consistent despite this shift, which will allow the program to continue to promote positive birth outcomes for one of Kentucky's most vulnerable populations.

## Michigan — Traditional Medicaid Service

Although various home visiting programs are supported by state funds in local communities, Michigan's Maternal and Infant Health Program (MIHP) is the largest home visiting program developed, administered, and monitored by the state.<sup>47</sup> The fundamental elements of the MIHP are credited to the state's previous home visiting programs, Maternal Support Services (MSS) and Infant Support Services (ISS). Developed in 1987 and enhanced in subsequent years, MSS and ISS sought to address the psychosocial and access barriers to prenatal care for Medicaid beneficiaries and to promote healthy infant development, respectively.

In 2004, MSS and ISS were consolidated into the MIHP, which was designed to correct the inefficiencies of MSS and ISS care coordination and improve service delivery. Today, MIHP is administered by two sub-agencies within the Michigan Department of Community Health (MDCH) — the Medical Services Administration (MSA) and the Public Health Administration (PHA).<sup>48</sup> MSA is responsible for ensuring that Medicaid services, provider policies, and reimbursement are upheld throughout MIHP and for ensuring that MIHP beneficiaries enrolled in Medicaid managed care plans receive the

appropriate level of care coordination. PHA ensures that MIHP providers follow program fidelity and is also responsible for training and monitoring program providers. MIHP is currently seeking opportunities to become recognized by the U.S. Department of Health and Human Services as an evidence-based home visiting model within MIECHV.

### MIHP Eligibility and Services

MIHP operates as a population-management model, which emphasizes meeting the health needs of an entire target population, as well as the health of individuals within that population. All Medicaid-enrolled pregnant women (women living at or below 185 percent of the federal poverty level) and infants are eligible to participate. In this way, MIHP is offered as a benefit of the state Medicaid program. Pregnant beneficiaries can receive services until 60 days postpartum or the end of the month in which the 60th day postpartum falls, and infants are eligible following hospital discharge until their first birthday.

MIHP services supplement routine prenatal and infant health care through care coordination and intervention services. Care coordination services are provided by a registered nurse and a licensed social worker, one of whom acts as the Care Coordinator. Intervention services are provided by a team of a registered nurse and licensed social worker and may also include

a registered dietician (with a physician order) and an infant mental health specialist, depending on the level of care needed and service intensity.

In general, reimbursable MIHP services can be categorized as an assessment (in home or office), a professional visit (in home or office), childbirth and parenting education classes, or transportation. Specifically, the Michigan Medicaid Provider Manual lists the following services as being foundational to MIHP:

- Psychosocial and nutritional assessment;
- Plan of care development;
- Professional intervention services, including health education, nutrition education, social work, nutrition counseling, and infant mental health services;
- Arranging transportation as needed for health care, substance abuse treatment, support services, and/or pregnancy-related appointments;
- Referral to community services (e.g., mental health, substance abuse);
- Coordination with other medical care providers and Medicaid managed care plans;
- Family planning education and referral;
- Coordinating or providing childbirth or parenting education classes.<sup>49</sup>

### Medicaid Financing of MIHP Home Visiting Services

MIHP is part of Michigan's Medicaid state plan and is included in the total state general fund allocation that supports the state's Medicaid program. In order to bill Medicaid for providing MIHP services, an agency must submit an application to the state Department of Community Health to obtain program certification. There are approximately 115 MIHP provider agencies operating across Michigan counties, and each provider serves one or more counties. As of January 2010, 39 percent of MIHP providers were local health departments, and 61 percent were federally qualified health centers or private facilities (i.e. hospitals, home health agencies, and individually owned businesses).

When a mother or infant is enrolled in MIHP, a provider administers a required *MIHP Maternal Risk Identifier* or the *MIHP Infant Risk Identifier* assessment. These tools are used to identify the level of service intensity required and to develop a plan of care. For mothers, the initial assessment and up to nine professional visits per pregnancy are billable to Medicaid. The infant assessment and nine professional visits per infant/per family are billable, but a medical provider can approve an additional nine visits if needed.<sup>50</sup> Professional visits can be delivered either in a client's home or in an office setting, but visits are required to last at least 30 minutes, must be face-to-face with the beneficiary,

and must be conducted by a MIHP licensed professional.<sup>51</sup> A licensed MIHP provider must be a licensed social worker or registered nurse with appropriate competencies.

Upon delivering MIHP services, providers bill MDCH through the department's Community Health Automated Medicaid

Processing System (CHAMPS). This system reimburses MIHP provider agencies for services rendered on a fee-for-service (FFS) basis. Table B3 shows the fee schedule, describes the procedural billing codes, and outlines the reimbursement amounts for Medicaid-eligible MIHP services as of November 2010.

Table B3

### MDCH Maternal Infant Health Program Database\*

Use Code for Maternal or Infant Services	Current Procedural Terminology or Healthcare Common Procedure Coding System Codes	Short Description	Description Used for Billing and Payment of MIHP Services	Fee
Maternal and Infant	99402	Prevention Counseling, individual	Professional Visit in Office	\$60.72
Maternal and Infant	99402	Prevention Counseling, individual	Professional Visit in Home	\$83.72
Maternal and Infant	A0100	Nonemergency transport taxi	Transportation Taxi	\$21.31
Maternal and Infant	A0110	Nonemergency transport bus	Transportation Bus/Van	\$21.20
Maternal and Infant	A0170	Transport parking fees/tolls	Transportation/Other	Determined by review of provider documentation
Maternal and Infant	H2000	Comprehensive multidisciplinary evaluation	Assessment in Home	\$99.07
Maternal and Infant	S0215	Nonemergency transportation mileage	Transportation Volunteer	\$0.26
Maternal	S9442	Birth class	Childbirth Education	\$29.46
Maternal	H1000	Prenatal care at-risk assessment	Maternal Assessment in Office	\$79.91
Infant	T1023	Program intake assessment	Infant Assessment in Office	\$79.91
Infant	96154	Intervention health/behavior, family with patient	Prof. Visit/Drug Exposed	\$40.51
Infant	S9444	Parenting class	Parenting Education	\$39.46

\*Michigan Department of Community Health Maternal Infant Health Program Database. Available at [http://www.michigan.gov/documents/mdch/MIHP-11-1-2010\\_337924\\_7.pdf](http://www.michigan.gov/documents/mdch/MIHP-11-1-2010_337924_7.pdf).

As the fee schedule describes, MIHP services reimburse at higher levels when provided during home visits versus in office settings. Therefore, it is imperative that providers document place of service when seeking Medicaid reimbursement. Generally place-of-services codes describe if the visit was conducted in a homeless shelter, office setting, home, or mobile unit. Providers are also required to report the beginning and end time of each visit, risk factors discussed during the encounter, and any additional actions taken. While providers are encouraged to conduct maternal visits in the beneficiary's home, only one prenatal home visit is required. For professional infant visits, however, it is expected that 80 percent will be made in the home. Additionally, since mothers' and infants' eligibility periods may overlap, some services may be "blended" during professional visits (i.e. maternal and infant services may be rendered), but providers are allowed to bill only for services delivered to either the mother or the infant in a single visit.

As of December 2010, there were 14 managed care entities operating in Michigan, and all Medicaid-eligible pregnant women are mandatory Medicaid managed care plan enrollees.<sup>52</sup> The Michigan Department of Community



Health contracts with each Medicaid managed care plan “to provide medical health care, out-patient mental health care for mild or moderate mental health concerns, transportation, and case management for Medicaid beneficiaries.”<sup>53</sup> Moreover, these contracts typically require that managed care organizations develop agreements with MIHP providers to perform outreach and refer pregnant beneficiaries to MIHP services. Having these agreements in place allows the MDCH to monitor and evaluate how well MIHP and managed care plans communicate client data to avoid duplication of effort.

### Evaluation of MIHP

In collaboration with Michigan State University Institute for Health Care Studies, MIHP has designed a multifaceted approach to program evaluation. The goals of this approach are to provide data for effective administration, identify areas of strength and opportunity, ensure fidelity (consistency and appropriate intensity of interventions based on client risk status), and facilitate policy improvements to benefit pregnant women and infants. The primary intent of the evaluation is to satisfy MDCH and state legislative requirements; however, because state and federal MIECHV requirements are consistent, Michigan's additional goal is for MIHP to satisfy federal standards for home visitation programs. The MIHP evaluation will consist of a quasi-experimental study, administrative data analysis, program fidelity review, and analysis of client satisfaction surveys.<sup>54</sup>

### Lessons Learned

The relationships among the public health agency, Medicaid managed care plans, and the state Medicaid agency have been integral to MIHP's success in Michigan. As previously discussed, the program was specifically designed to enhance pregnancy and birth outcomes of Medicaid beneficiaries and has been written into Michigan's Medicaid state plan since its inception. This historical relationship has allowed the MDCH to reach a critical volume of Medicaid beneficiaries in need of MIHP services, even in the state's changing Medicaid managed care environment. Moreover, the experience MDCH has in negotiating with managed care organizations will allow MIHP to increase its reach within expanding Medicaid populations.

The state could potentially benefit from exploring other Medicaid financing options. The current FFS structure allows MIHP providers to bill for only a limited number of visits that do not always reflect the intensity of the services performed or needed for higher risk beneficiaries. Using ACM as a financing mechanism may cover more of providers' actual costs for case management services.

## 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,<sup>55</sup> 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.<sup>56</sup>

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.<sup>57</sup> 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.<sup>58</sup> 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).<sup>59</sup>

### **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.

## Vermont — Global §1115 Waiver

In 2004, Vermont created Children's Integrated Services (CIS) to promote coordination among several existing programs serving new and expectant mothers and children through age six. The vision of CIS is to connect high-risk families with the appropriate maternal, child and family supports and services. Currently, four services operate under the CIS umbrella.

- **Nursing and Family Support** services are designed for high-risk pregnant women and new mothers and children (birth through five years) to promote healthy maternal and child health outcomes using a prevention and early intervention case management approach.
- **Early Childhood and Family Mental Health** services utilize community-based mental health clinicians to enhance the wellbeing of children (birth through five years), who are experiencing or at risk of experiencing severe emotional disturbance, and their families.
- **Early Intervention Services** is the state's name for Part C of the Individuals with Disabilities Education Improvement Act (IDEA)

2004. Early Intervention provides services to infants and toddlers, who have developmental delays or a health condition that may lead to delays, and their families.

- **Specialized Child Care Services** provide assistance to families experiencing significant stress due to concerns about appropriate shelter, safety, emotional stability, substance abuse, or child behaviors; and those with children in protective services or who have special physical or developmental needs.

Of these four programs, nursing and family support relies most heavily on Medicaid funding, and for this reason, will be the focus of this case study.

CIS nursing and family support, formerly known as Healthy Babies, Kids and Families, is a statewide Maternal and Child Health (MCH) program. Nursing and family support was developed by the state in 1994 as a case management service that was based on the Nurse-Family Partnership program. The U.S. Department of Health and Human Services has not recognized the program as an evidence-based model. Today, CIS nursing and family support services reach approximately 4,420 individuals per year.<sup>60</sup>

Nurses, social workers, or paraprofessional family support workers offer a variety of services to promote parent and child health and wellbeing. Because the program serves such a large range of ages, the services are flexible to meet the needs of the family and include: planning for pregnancy, delivery, and becoming a parent; finding medical and dental care during pregnancy and for the child through age five; providing information about nutrition; or locating community resources, such as counseling, physical therapy, breastfeeding classes, play groups, and help with educational goals.

To receive services, parents or children must be an eligible or enrolled Medicaid beneficiary and identified as experiencing health, social, or behavioral risks. Currently, the majority of referrals come from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the medical home, hospital, or other health provider; or another community agency and are processed through a regional CIS team, which meets weekly. Core team membership includes a CIS coordinator, MCH public health nurse, home health nurse, a child care specialist, representative(s) from a Parent Child Center, and an early childhood mental health agency staff person. This referral team decides which type of provider is most appropriate based on the referral information. The CIS provider and family develop a plan together to address the identified risks.

### **Medicaid and CIS Nursing and Family Support Home Visiting**

Vermont's Medicaid program is financed through two §1115 Waivers with CIS covered under the "Global Commitment to Health" waiver. The terms of the waiver cap the federal Medicaid funds the state will receive over five years in exchange for flexibility in their use. The Vermont Agency of Human Services contracts with the Department of *Vermont* Health Access (DVHA), which operates, in effect, as a state-run managed care entity. DVHA receives a per-member-per-month capitated fee to provide Medicaid services to the enrolled beneficiaries. If, after providing services to the beneficiaries, there are unspent funds, DVHA may invest those funds in any of four broad areas, including increasing access to quality health care services to the uninsured or underinsured. This provision allows CIS to be provided to other high-risk families who not eligible for Medicaid, an arrangement currently being tested in pilot areas.

A state plan amendment for targeted case management has supported home visiting programs in Vermont since 1987. Targeted case management (TCM) services are voluntary and include a comprehensive assessment of need, development of a specific care plan, referral, and monitoring. Nursing and family support services are one example of CIS services that are offered as a TCM component. Vermont's

state plan amendment states that CIS services be provided on a voluntary basis to all Medicaid enrollees who are identified as at risk.

Vermont’s billing code is aligned with the Healthcare Common Procedure Coding System (HCPCS) to better facilitate billing. HCPCS codes, used by Medicare, Medicaid, and private health insurers, support consistency across the state (See Table B5). The payment rates for home visiting depend on which services are provided, to which beneficiary (mother or infant), the family risk level, and the type of provider. An excerpt of the billing code for CIS services is below:

In November 2010, Vermont initiated a pilot to improve coordination among early childhood services. Three communities received a bundled rate for all CIS services. To allocate funds to each pilot region, the state first calculated the funds previously used to administer all CIS services then contracted that amount to a designated fiscal agent for each region. Fiscal agents contract with local providers to deliver services.

Providers in the pilot communities receive one monthly rate for every client. If providers serve their minimum Medicaid beneficiary caseload, they are allowed to also provide services to families that do not receive Medicaid. The minimum

Table B5

### Vermont Billing Codes

Service Description	Client	Provider	Current Procedural Terminology	Code Definition	Reimbursement
Home Health, Home visit – High risk	Woman	RN	T1022	Contracted home health agency services	\$125
Home Health, Home visit – Low risk	Infant	RN	T1022	Contracted home health agency services	\$95
Home visit, Not Home Health – High risk	Age 1-5	MSW	S9445	Patient education, non-physician	\$95
Home visit, Not Home Health – High risk	Age 1-5	FSW	S9445	Patient education, non-physician	\$55
Perinatal Group Education	Woman	Non-physician	S9436	Childbirth preparation, non-physician	\$1.50 per unit of service

Source: Information provided by Vermont program staff.

caseload is determined by historical Medicaid claims data and the population of children, birth through age five, living in poverty. The pilots also allow providers the flexibility to tailor services to meet family needs and to meet with other care providers to discuss case reviews and care management.

### Lessons Learned

The CIS pilots were designed to address gaps in the current system, namely care coordination. Because nursing and family support are billed fee-for-service, except in the three pilot areas, there is no appropriate code to bill for care coordination provided through CIS. This limits the coordination that can occur.

Vermont is building on current data collection efforts to improve tracking and evaluation of services. CIS currently collects data on the number of individuals that complete plan goals by annual review or transition to another service; the percent of clients who receive services within 45 days from referral; the percent of those that have no further or immediate support when leaving CIS services; and the percent served through CIS that report satisfaction.

With the spirit of innovation and dedication to supporting families, Vermont has a strong basis upon which to adapt to the needs of the population and advance efficient delivery systems.



## Washington — Targeted Case Management and Traditional Medicaid Service

Established under the 1989 Maternity Care Access Act, Washington State’s First Steps program is an umbrella program designed to provide prenatal care and pregnancy support services to low-income pregnant women and their children. Created to address access shortages to prenatal care and obstetric providers in the most rural communities, the program serves about 50 percent of the approximately 47,000 annual Medicaid-eligible births in the state.<sup>61</sup> Previously administered by the Washington State Department of Social and Health Services (DSHS), First Steps is now administered by the state’s Medicaid agency, the Washington State Health Care Authority (HCA). The following service areas represent the foundational components of the First Steps program:

- **Medical services**, including prenatal care, delivery, and post-pregnancy follow-up services. Additionally newborns receive one year of full medical care, and family planning services are offered for up to one year for eligible women post-pregnancy.
- **Enhanced services**, which include Maternity Support Services (MSS), Infant Case Management (ICM), and Childbirth Education (CBE).
- **Expedited alcohol and drug assessment and treatment services**, which are provided to eligible women and their infants, and
- **Ancillary services**, which includes expedited eligibility determinations, “case finding,”<sup>62</sup> outreach, and transportation services.<sup>63</sup>

Although First Steps offers these four service areas to Medicaid-eligible women and infants, this case study will focus on the enhanced services offered through Maternity Support Services (MSS) and Infant Case Management (ICM), as they are more closely aligned with the goals of maternal and infant home visiting programs.

The MSS/ICM programs offered through First Steps provide enhanced support services to mothers throughout pregnancy and for infants through the month of their first birthday.<sup>64</sup> Both programs are designed to deliver interventions early in pregnancy to promote healthy births and positive parenting skills. Within MSS and ICM programs, services may be offered in an office setting, in a beneficiary’s home, or in a non-office setting (See Table B6).

The goal of the MSS program is to facilitate access to preventive health services for eligible pregnant women. This program is designed to supplement routine prenatal medical visits and to increase access to

services such as screening, assessment, education, intervention, and counseling. Other Medicaid covered services available to women enrolled in MSS and ICM include medical and dental care, transportation support, interpretation services, and specialized substance abuse treatment.<sup>65</sup>

Eligible women (those living at or below 185 percent of the federal poverty level) must be enrolled in a Medicaid benefit package prior to the end of pregnancy in order to receive services. Once a client is enrolled, she may elect to participate in MSS/ICM as well as the Childbirth Education program.<sup>66</sup> The eligibility period for MSS begins as soon as the client is approved for Medicaid and continues through the end of the month in which the 60th day post-pregnancy occurs. Teenage parents still living with a parent are allowed to use their own personal income when applying to receive MSS. Managed care enrollees can also receive MSS services.

At the local level, First Steps agencies are required to establish an interdisciplinary MSS provider team consisting of a community health nurse, registered dietitian, behavioral health specialist, and, depending on the agency, a community health worker. This team is responsible for delivering MSS services, including assessment, education, intervention, and case management, as well as developing individual care plans for each mother.<sup>67</sup>

When the MSS eligibility period ends for a mother, the infant may still be eligible to receive Infant Case Management. ICM is specifically designed to serve Medicaid-eligible high-risk infants and to improve the self-sufficiency of their parent(s).<sup>68</sup> To qualify, infants must reside with their parent(s), documentation must exist of the parents' lack of access to needed services, and the infant or parent must meet HCA high-risk eligibility criteria.<sup>69</sup> Infants enrolled in Medicaid and CHIP are eligible to receive ICM.

The eligibility period begins in the first day of the month following pregnancy and concludes at the end of the month of the infant's first birthday. ICM provides referrals and linkages for families in need of educational, medical, and mental health services. Program services are delivered by MSS certified providers (a community health nurse, registered dietitian, or behavioral health specialist), experienced bachelor's- or master's-level professionals, or an ICM-qualified paraprofessional, who must have a two-year associate of arts degree and two years of field experience and be supervised monthly by a bachelor's- or master's-level MSS/ICM professional.

Table B6

## Washington State Health Care Authority Covered Services\*

Maternity Support Services	Infant Case Management Services
<ul style="list-style-type: none"> <li>• Screening and assessment of risk factors related to pregnancy and birth outcomes;</li> <li>• Education that relates to improving pregnancy and parenting outcomes;</li> <li>• Brief counseling;</li> <li>• Interventions for risk factors identified on the care plan;</li> <li>• Basic health messages;</li> <li>• Case management;</li> <li>• Care coordination;</li> <li>• Family planning screening and referral;</li> <li>• Screening, education and referral(s) for tobacco usage and second hand smoke exposure; and,</li> <li>• Infant case management (ICM) screening.</li> </ul>	<ul style="list-style-type: none"> <li>• An initial in-person screening which includes developing a care plan;</li> <li>• Case management services and care coordination;</li> <li>• Referring and linking the infant and parent(s) to other services or resources;</li> <li>• Advocating for the infant and parent(s); and</li> <li>• Follow-up contact(s) with infants and their parent(s) to ensure the care plan continues to meet their needs.</li> </ul>

\* Medicaid Purchasing Administration (MPA), Maternity Support Services/ Infant Case Management Billing Instructions [WAC 388-533-0300 and 388-533-0386]. [http://hrsa.dshs.wa.gov/Download/Billing\\_Instructions/MSS-ICM/MSS-ICM\\_BI.pdf](http://hrsa.dshs.wa.gov/Download/Billing_Instructions/MSS-ICM/MSS-ICM_BI.pdf).

### Medicaid and First Steps Home Visiting

First Steps program services, including MSS and ICM, are available only to Medicaid-enrolled mothers, fathers, or infants. In order to bill Medicaid for MSS/ICM, an agency must be authorized by the Washington State HCA to provide First Steps services. These public and private agencies may be contracted by HCA in every county. When MSS or ICM services are delivered, the HCA-authorized provider agency submits the

reimbursement claim to Washington’s ProviderOne System, the HCA’s centralized Medicaid provider payment system. For MSS, the HCA reimburses services on a fee-for-service basis, in which one unit of service is equivalent to 15 minutes. For ICM, providers claim service reimbursement through Medicaid TCM, where one unit of services equals 15 minutes as well. Table B7 describes the specific payment fee schedule associated with MSS/ICM service reimbursement.<sup>70</sup>

Table B7

## Washington Medicaid Purchasing Agency (MPA) Fee Schedule, Effective July 1, 2009

### Maternity Support Services

Procedure Code	Modifier*	Service Description	Maximum Allowable Office Setting	Maximum Allowable Home Setting	Policy/Comments
96152	HD	Behavioral Health Specialist	\$25.00	\$35.00	1 unit= 15 minutes during a MSS Behavioral Health Visit
S9470	HD	Nutritional Counseling, dietician visit	\$25.00	\$35.00	1 unit= 15 minutes during a MSS Dietician Visit
T1002	HD	RN services	\$25.00	\$35.00	1 unit= 15 minutes during a MSS Community Health Nursing Visit
T1027	HD	Family training and counseling for child development	\$14.00	\$18.00	1 unit= 15 minutes during a MSS Community Health Worker Visit

### Infant Case Management

T1017	HD	Targeted Case Management	\$20.00	\$20.00	1 unit= 15 minutes
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\*HD= Pregnant/Parenting Program.

As this table demonstrates, MSS program services provided during a home visit reimburse higher per unit of service than those provided in an office setting. HCA limits the number of service units that can be claimed per mother. For example, when mothers enter MSS in the prenatal period, their assessment may flag them to receive different levels of service

based on intensive need (Basic=7 units, Expanded=14 units, or Maximum=30 units) throughout their pregnancies. For mothers that begin MSS post-pregnancy, they are eligible to receive different levels of service (Basic= 4 units, Expanded=6 units, or Maximum= 9 units) until the end of the post-pregnancy eligibility period.

In the case of ICM, all services provided to infants and their families are billed as Medicaid TCM. All services rendered must be delivered to the family in a face-to-face meeting with the enrolled infant present. Similar to MSS, an ICM Screening Tool is used to assess the level of service (Lower Level or Higher Level) the family needs. Throughout the infant's eligibility period, a family may receive a maximum of 6 units of Lower Level services and 20 units of Higher Level services.

In 2010, the Washington State Legislature created the Home Visiting Services Account (HVSA). The primary purpose of the HVSA is to align and leverage public funding with private matching funds to increase the number of families served through home visiting programs. The legislation authorizes an account under the purview of the state treasury that will consist of state appropriations and private dollars “to develop, support and evaluate evidence-based, research-based, and promising home visiting programs.”<sup>71</sup> The Department of Early Learning, which supports home visiting programs aiming to reduce child abuse and improve school readiness, is the designated public agency leading the HVSA.

The account expenditures will be used to provide the state match for home visiting programs, and the funds are administered by Thrive by Five Washington,<sup>72</sup> the designated “nongovernmental private-public partnership.” As directed by the

statute, Thrive by Five will manage and administer the HVSA, including overseeing competitive grant-making processes, direct service implementation and technical assistance, evaluation, and engaging an advisory committee. Thrive by Five is also designated to raise the private dollars needed for the HVSA. In FY 2012, the HVSA portfolio includes programs funded through the federal MIECHV program, state general funds designated for home visiting, and private match dollars. The HVSA does not currently support First Steps.

### Lessons Learned

A significant proportion of pregnant women and children are enrolled in Medicaid managed care in Washington, and First Steps has always been a carved-out program available to managed care as well as FFS enrollees. While managed care programs do not offer maternal and child home visiting services, many of them have contracted with provider agencies to offer telephonic support to high-risk pregnant women. First Steps programs and providers do not, however, have access to the utilization data of these services or which women are receiving these services. HCA is currently working with new managed care entities in the state to develop contract provisions that will allow the Authority to access this patient information. This would allow both First Steps and managed care entities to collaborate in care management for overlapping populations.

# Medicaid Glossary

**“at-risk” or “high-risk”** - Maternal and child home visiting programs may apply criteria to assess the level of risk for poor health or developmental outcomes posed to mothers and children by developmental, educational, and environmental factors. These criteria may follow guidelines set forth by national home visiting program models or may be defined by an individual home visiting program.

**1905(a) Services** - Section 1905(a) of the Social Security Act [42 U.S.C. 1396d] — the federal Medicaid statute — defines and provides guidance on “medical assistance” services, or services provided to Medicaid beneficiaries, that are paid for in part by the federal Medicaid program.

**1915(b) Freedom of Choice Waivers** - Section 1915(b) of the Social Security Act [42 U.S.C. 1396n] permits states to contract with managed care entities to provide services to Medicaid recipients and thus waive the rights recipients otherwise have to choose their providers and plans. States may use the waiver to:

- [1915(b)(1)] - Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits
- [1915(b)(2)] - Allow a county or local government to act as a choice counselor or enrollment broker in order to help people pick a managed care plan
- [1915(b)(3)] - Use the savings that the state gets from a managed care delivery system to provide additional services
- [1915(b)(4)] - Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation).

**Administrative Case Management (ACM)** -

Section 1903(a) of the Social Security Act defines case management as Medicaid reimbursable activities deemed necessary for the “proper and efficient administration of a state’s Medicaid plan.” Eligible activities may include those provided for eligibility determinations, outreach, and securing authorizations needed to access Medicaid services. Administrative case management activities may not include those activities directly associated with providing a medical assistance service.

**Centers for Medicare and Medicaid Services**

**(CMS)** - is a branch of the U.S. Department of Health and Human Services. CMS is the federal agency that administers Medicare, Medicaid, and the Children’s Health Insurance Program.

**Children’s Health Insurance Program (CHIP)** -

provides health coverage to uninsured children up to age 19 in families with incomes that exceed income eligibility requirements for the Medicaid program. States administer their CHIP programs, which are jointly funded by federal and state governments. States may administer CHIP programs as Medicaid expansion programs, separate CHIP programs, or as a combination of these two approaches.

**Deficit Reduction Act of 2005 (DRA)** - affects many

aspects of federal entitlement programs, including Medicaid. The DRA amended Section 1937 of the Social Security Act to give states the flexibility, with CMS approval, to define alternate benefit packages, known as benchmark plans, for targeted populations of Medicaid enrollees. Some protected populations, such as pregnant women, have the option to enroll in their states’ benchmark plans or remain in the regular Medicaid benefit program.

**Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT)** - is the component of Medicaid designed to improve the health of low-income children. EPSDT services are required to be offered by every state, and finance appropriate and necessary pediatric services, including medical assistance services that may not be in the state's plan and not available to adults.

**Federal Medical Assistance Percentage (FMAP)** - determines the amount of federal matching funds for state expenditures for the Medicaid program. FMAPs are published annually for each state. Section 1905(c) of the Social Security Act specifies the formula used to calculate the FMAP for each state. In FY 2011, the FMAP ranged from 50% to 74.73%.

**Fee-for-Service (FFS)** - is a health insurance payment method that reimburses providers per unit of service provided, rather than on a per-person-per-month or other basis.

**Individuals with Disabilities Education Act Part C (IDEA Part C)** - authorizes states to “develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families.” Early Intervention services may include state home visiting that addresses infants’ or toddlers’ developmental needs (i.e. physical, cognitive, communicative, social or emotional, or adaptive.)

**Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)** - Authorized by the Affordable Care Act, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program was designed to improve health and development outcomes for at-risk children through evidence-based home visiting programs. In 2011, federal MIECHV funds were awarded to all states through a formula grant and additional competitive funds were awarded to 22 states.

**Medicaid Managed Care** - In this system, states contract with organizations that agree to offer all or most Medicaid services to beneficiaries in exchange for an agreed-upon payment from the state. Managed care entities include ‘managed care organizations’ that agree to provide most Medicaid services to beneficiaries in exchange for a per-member monthly payment; ‘limited benefit plans’ that provide specific Medicaid benefits like mental health or dental services in exchange for a per-member monthly payment; and ‘primary care case managers’ who act as a patient’s primary care provider and also receive a small monthly payment for helping to coordinate referrals and other medical services. States may require Medicaid beneficiaries to enroll in managed care or enrollment may be voluntary.

**Medicaid Section 1115 Family Planning Demonstration Waiver** - can be used, upon approval from CMS, to provide family planning services to individuals deemed ineligible for state Medicaid or CHIP programs. Section 2303 of the Affordable Care Act allows states to also offer family planning services to persons not otherwise eligible for Medicaid by filing a State Plan Amendment.

**National Academy for State Health Policy (NASHP)** - is a nonpartisan, nonprofit organization with a mission of promoting excellence in state health policy and practice. NASHP conducts analytic and technical assistance work designed to support states in their efforts to improve health care and health.

**Patient Protection and Affordable Care Act (ACA)** - is the federal law, passed in 2010, that aims to ensure quality and affordable care for all Americans. Specific objectives of the law include promoting health insurance market reforms, establishing consumer protections in health insurance markets, increasing access to health insurance coverage for eligible and special populations, and providing funds for health programming to promote the public’s health.

**Section 1915(c) Medicaid Home and Community**

**Based Services Waiver (HCBS)** - can be used to provide care and community-based services to targeted state Medicaid populations. Approved programs can offer medical and non-medical services, including case management supports and service coordination. Section 1915(I) of the Deficit Reduction Act of 2005 allows state Medicaid programs to also offer HCBS by filing a State Plan Amendment.

**State Plan Amendment (SPA)** - States operate their Medicaid programs under agreements with CMS known as state plans. The state plan defines the state's Medicaid eligibility guidelines and describes benefits offered. Any changes to a state plan, known as a state plan amendment, must be approved by CMS.

**Targeted Case Management (TCM)** - consists of those medical assistance services that help beneficiaries gain access to medical, social, educational, and other services. TCM includes four components: assessment services, development of a care plan, referrals and scheduling, and monitoring and follow-up for Medicaid enrollees.

**Temporary Assistance for Needy Families (TANF)** - is a block grant program designed to provide federal funds to needy families in states, tribes, and territories. These funds are used to cover benefits and services to needy families, such as programs that support economic self-sufficiency and family services.

**Title V Maternal and Child Health Services Block Grant** - Administered by the Maternal and Child Health Bureau at the Health Resources and Services Administration, the Title V Maternal and Child Health Services Block Grant Program aims to ensure the health of the nation's mothers, women, children and youth, and children with special health care needs. Programs supported by this federal block grant program increase access to quality health care services for low-income women and mothers, and include funds for direct care services, enabling services, population-based services, and infrastructure building services.

# States Using Medicaid to Finance Home Visiting\*

	State	Lead Agency	Model
1	Colorado	Department of Public Health and Environment	Nurse Family Partnership
2	Kentucky	Department for Public Health	Health Access Nurturing Development Services (HANDS)
3	Louisiana	Department of Health and Hospitals	Nurse Family Partnership
4	Massachusetts	Department of Public Health	Early Intervention Partnership Program
5	Michigan	Department of Community Health	Maternal Infant Health Program
6	New Hampshire	Department of Health and Human Services	Home Visiting New Hampshire
7	New York	Department of Health Department of Health	Nurse Family Partnership Community Health Worker
8	Oklahoma	Department of Health	Children First (Nurse Family Partnership)
9	Oregon	Department of Human Services Oregon Commission for Children and Families	Maternity Case Management Healthy Start/Healthy Families
10	Rhode Island	Department of Health	The First Connections Program
11	South Dakota	Department of Health	Bright Start
12	Tennessee	Department of Health	Help Us Grow Successfully (HUGS)
13	Vermont	Agency for Human Services Agency for Human Services/ Children's Integrated Services	Healthy Babies, Kids, and Families Early Childhood and Family Mental Health
14	Virginia	Department of Health	Resource Mothers
15	West Virginia	Department of Health and Human Resources	Right from the Start

\* This list reflects states that, in a 2010 survey conducted by the Pew Home Visiting Campaign, reported offering home visiting program(s) financed in whole or in part through Medicaid. The campaign's web inventory defines home visiting as a state-administered program that:

- Is managed by a state agency — such as health and human services — that directs funding to local communities to support service delivery, articulate standards and regulations, set performance measures and provide oversight and infrastructure;
- Delivers services mainly in families' homes, though visits may be complemented with other supports such as group classes; and
- Receives support through state allocations, using state or federal dollars.
- The survey excluded programs that employ home visiting as a strategy but do not fully satisfy the definition above, such as:
  - Involuntary visits resulting from a child protective services investigation or a court order;
  - Programs targeting children four or older, unless they are enrolled before the age of two;
  - Programs that use home visiting as a component of a broader family support strategy but do not identify the home as the primary location for service delivery (such as family resource centers or other primarily center-based initiatives);
  - Home-based services delivered as required by the federal Individuals with Disabilities Education Act;
  - Federal funding allocated directly to localities and not state-administered (such as Healthy Start and Early Head Start); and
  - Funding from private organizations and local communities.

Source: Pew Home Visiting Campaign Web Inventory. 2010. [http://www.pewcenteronthestates.org/initiatives\\_detail.aspx?initiativeID=61051](http://www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=61051).

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, MD 21244-1850



**Center for Medicaid, CHIP and Survey & Certification**

AUG 12 2011

Ms. Tamar Bauer  
Nurse-Family Partnership  
1900 Grant Street, Suite 400  
Denver, CO 80203

Dear Ms. Bauer and Ms. Kalajjian:

Thank you for your letter regarding Medicaid coverage of the Nurse-Family Partnership (NFP) nurse home visitation program. It was a pleasure meeting with you and hearing more about your

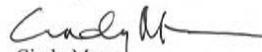
You ask in your letter about specific coverage options for NFP services. As you know, each State has flexibility in determining the types of services it will offer under the Medicaid program. Any State interested in covering the many comprehensive services employed in the Nurse-Family Partnership model may choose to submit a State plan amendment, a section 1915(b) or other waiver program request to achieve the goal of providing these services using existing or new coverage categories arising from the Affordable Care Act.

Another option would be to cover NFP services under the preventive service authority of 42 CFR 440.130(c) as long as services are provided by a physician or other licensed practitioner within the scope of the practice under State law. Comparability and statewideness apply to "preventive" services as well as to all the other 1905(a) services. However, a State could develop a benchmark benefit (Secretary-approved) that would target specific populations in certain parts of the State to receive State plan services plus NFP-type "preventive" or other 1905(a) services. Benchmark State plan benefits can be provided without regard to comparability and statewideness.

campaign in the coming months that will improve maternal and child health in Medicaid by testing promising models of care and pairing them with supporting payment strategies.

Improving birth outcomes is a high priority for CMS and we appreciate the value that nurse home visiting brings to improving the health outcomes of mothers and babies, especially in high risk populations. We look forward to our continued partnership.

Sincerely,

  
Cindy Mann  
Director

In this August 2011 letter to the Nurse-Family Partnership (NFP), the Centers for Medicare and Medicaid Services (CMS) outlined specific coverage options for NFP home visiting services. This letter suggests that states could adopt one or more of these approaches to providing home visiting services. See pages 14 and 24, above, for more information.

# Methodology

The National Academy for State Health Policy (NASHP) conducted a literature review and environmental scan to identify mechanisms for financing home visiting services in Medicaid. Based on this scan, six states that use different home visiting models and different Medicaid financing methods were selected to participate in case studies. NASHP researchers conducted key informant interviews with Medicaid and home visiting program officials in these states. The resulting case studies are presented in Appendix B. In addition, NASHP conducted interviews with three national experts and facilitated an expert meeting that included representatives from some of the case study states; federal representatives from CMS, the Health Resources and Services Administration (HRSA), and the Administration for Children and Families (ACF); and national home visiting experts from academia and practice. This report reflects what was learned through these efforts.

# Acknowledgments

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*Washington:* Christine Bess, Beth Blevins and June Hershey, Washington State Health Care Authority; Judy King, Washington State Department of Early Learning; Barbara Lantz, Washington State Health Care Authority.

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delivery; support program administration; identify opportunities of program strength and opportunities for improvement; drive policy improvements; and monitor program costs; *Program Fidelity Review*: MDCH works collaboratively with MSU IHCS to assess MIHP program fidelity. IHCS registered nurses with experience in maternal and child health collect data from client records to assess adherence to MDCH policy, intensity of interventions by risk level, frequency and location of visits, and consistency of program delivery across the state; *Satisfaction Surveys*: MDCH and IHCS developed a uniform client satisfaction survey in FY 2011, and a provider satisfaction survey will be developed in FY 2012. Evaluation information provided by Brenda Fink and Jackie Prokop at the Michigan Department of Community Health upon review of a draft case study.

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56 Eligible families must meet one of the following criteria: adolescent parents; a history of alcohol or drug abuse; a history of child abuse and neglect, domestic abuse or other types of violence; reduced cognitive functioning; a lack of knowledge of child growth and development stages; low resiliency to adversity and environmental stressors; insufficient financial resources to meet family needs; a history of homelessness, and a risk of long-term welfare dependence or family instability due to employment barriers.

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