Medicaid and Home Visiting

The State of States' Approaches

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Medicaid and Home Visiting: The State of States' Approaches

The purpose of this issue brief is to report on states' use of Medicaid to finance home visiting services. The content is based on work with states through technical assistance projects funded by the Heising-Simons Foundation, as well as several prior surveys or scans of state approaches.[1,2] While a number of reports have looked in detail at how some states use Medicaid to finance home visiting, [3,4,5,6] no up-to-date list of states has been widely available.

Home visiting for families during pregnancy and the early childhood years is a strategy for offering health education, parenting support, and other interventions at home. As with terms such as "outreach" and "case management," the label "home visiting" has taken on many meanings. A typical "home visiting program" is designed to improve some combination of health outcomes, child development, parenting skills, and family self-sufficiency, particularly for families at higher social risk. Programs use specially trained nurses, social workers, early childhood educators, or others as home visitors.

As defined in this report, home visiting includes models identified as evidence-based and others that offer a series of home visits to families during pregnancy and early childhood by trained staff, typically of at least one year duration and under a structured curriculum or formal protocols. For example, it excludes from the definition programs that have few or infrequent home visits, such as: medically-related home health visits (e.g., nurses visiting to provide specific care for medical conditions), child protective services visits to homes, and in-home delivery of services under the Individuals with Disabilities Education Act (IDEA) Part C Early Intervention program. States' Medicaid perinatal case management programs are also not included here; however, a separate brief that distinguishes these programs from home visiting is forthcoming in 2019.

What is the history of using Medicaid to finance home visiting?

For more than two decades, states have used Medicaid to finance home visiting services for mothers, infants, and young children. Early adopters in the 1990s included states such as Kentucky and Oklahoma. Other states' early and ongoing efforts combined Medicaid maternal and infant case management approaches with home visiting models to create hybrid programs of family support focused on improving maternal, infant, and child health outcomes. In the absence of substantial dedicated federal funding for home visiting (see box on the history of federal policy), these "early adopters" learned lessons about how to optimize Medicaid and other sources of federal funding to finance home visiting. A number of states were braiding a combination Medicaid, and other funding.[7]

In 2016, a Joint Informational Bulletin of the Centers for Medicare and Medicaid Services (CMS) and Health Resources and Services Administration (HRSA) affirmed the flexibility and opportunity states have to finance home visiting with Medicaid in addition to other funds.

"Medicaid coverage authorities offer states the flexibility to provide services in the home.… However, home visiting programs may include some component services, which do not meet Medicaid requirements, and may require support through other funding options…. state agencies should work together to develop an appropriate package of services… [that] may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs." [8]

The Bulletin affirms that the current law permits states to use Medicaid funding to pay for the core components of home visiting when furnished to Medicaid beneficiaries. This communication from CMS should put to rest any notion that home visiting services are not currently recognized under existing federal Medicaid policies.

Home visiting for families during pregnancy and the early childhood years is a strategy for offering health education, parenting support, and other interventions at home. For more than two decades, states have been using Medicaid and other federal, state, and local funds to finance home visiting services.

Time line of federal policy and financing for home visiting

- **Mid-1980s.** *Responding to published research, the National Commission to Prevent of Infant Mortality took an interest in home visiting. Created by Congress and including members of Congress and other officials and experts, the Commission studied home visiting and, in 1989, issued a report "Home Visiting: Opening doors for America's Pregnant Women and Children."*[9]

- **1989.** *Congress passed amendments to Title V (P.L. 101-239 Section 6501(a)(1)), created what became known as the Community Integrated Service Systems (CISS) projects designed to reduce infant mortality and improve the health of mothers, pregnant women, and children through support for the development and expansion of community integrated service systems. The legislation "set aside" a portion of Title V Maternal and Child Health Services (MCH) Block Grant funds for special activities, including: "maternal and infant health home visiting programs in which case management services…, health education services, and related social support services are provided in the home to pregnant women or families with an infant up to the age one by an appropriate health professional or by a qualified non-professional acting under the supervision of a health care professional" (Section 501 [42 USC 701] (a)(3)(A)).*

- **1994.** *Early Head Start was established in 1994 as part of landmark legislation passed by Congress to strengthen Head Start (P.L. 103-252). The program focuses primarily on children birth-to-three in low-income families, and local sites may offer a home-based option, a center-based option, or both. The Early Head Start home-based option is designated as an evidence-based home visiting program. In 2007, a new formula for directly funding the program was established, ending a set-aside approach within Head Start (P.L. 110-134). In 2009, as part of the American Recovery and Reinvestment Act (P.L. 111-5), expanded funding nearly doubled the number of infants and toddlers served by Early Head Start.*

- **2004.** *The Education Begins at Home Act (S. 2412; 108th Congress) was introduced by Senator Christopher ("Kit") Bond and co-sponsors to create a new federal home visiting program. This bill was revised and reintroduced— and similar bills were introduced—in Congressional sessions through 2009, with bi-partisan interest and occasional hearings. No bill was passed and signed into law.*

- **2008.** *Congress funded a home visiting pilot program proposed by the President G.W. Bush as a set-aside to the Child Abuse Prevention and Treatment Act (CAPTA). The US HHS Administration on Children and Families,-Children's Bureau carried out this initiative known as "Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment."*

- **2009.** *As part of his FY 2011 budget proposal, President Obama included billions of dollars over ten years for evidence-based home visiting.*

- **2010.** *Bipartisan Congressional support for evidence-based home visiting led to the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program as a new Section 511 of Title V of the Social Security Act. The legislation was enacted as part of the Affordable Care Act (P.L. 111-148). MIECHV has been subsequently reauthorized through statutory amendments (P.L. 113-93, P.L. 114-10, and P.L. 115-123).*[10, 11, 12]

Why do states use Medicaid to finance home visiting services?

States have used their options to make Medicaid funding available for home visiting services for multiple reasons. Chief among these is to expand home visiting capacity, particularly for the low-income families covered by Medicaid. In addition, home visiting goals are aligned with the goals of the Medicaid program in the context of pregnancy, infancy, and early childhood and with the functions of the pediatric medical home.[13,14] Through referrals, health education, and other direct interventions, home visiting services that achieve their goals can help to achieve the triple aim of improving the experience of health care (including quality and satisfaction), improving population health, and reducing per-capita health care costs.[15]

Medicaid can help to expand capacity and reduce unmet need for home visiting.

Enactment of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program as part of the Affordable Care Act in 2010—a focused federal investment of $1.5 million over the initial five years—created a larger federal funding stream for home visiting services and also placed emphasis on defining home visiting programs in terms of their evidence-base.[16, 17, 18] MIECHV funds were initially disbursed in 2011 in all 50 states (as well as tribal entities and U.S. territories), and, with Congressional reauthorizations, additional funds have been made available. In 2018, the MIECHV program was allocated $400 million per year through fiscal year (FY) 2022, with funding being awarded in 2018 to 56 states, territories, and nonprofit organizations to support communities in providing voluntary, evidence-based home visiting services. Altogether, since 2010, $1.85 billion in MIECHV funding has been invested.

These funds supported home visiting services to an average of more than 150,000 mothers, infants, and young children in nearly 80,000 families each year in FY 2015-2017;[19] however, this is only a fraction of families who need and could benefit from the services. Using data from the American Community Survey of the U.S. Census Bureau, the 2018 Home Visiting Yearbook estimated that about 18 million families (including 4.6 million with income below the federal poverty level) with young children under six and pregnant women and that all these families could potentially benefit from home visiting. The proportion of potential beneficiary families with one or more demographic risk/target criteria (i.e., have an infant, below poverty income, pregnant/parenting mothers under age 21, or parents/pregnant women with less than a high school education) varied by state, ranging from 43 percent in Utah to 62 percent in Mississippi and New Mexico. The Yearbook estimated that, in 2017, more than 300,000 of these families were served by some evidenced-based home visiting programs in the states, nearly 80,000 through MIECHV.[20] In sum, about 2 percent of families with children under six currently participate in an evidence-based home visiting program, with that percentage somewhat higher for children under three.[21]

The vast majority of children or pregnant women in home visiting programs are enrolled in Medicaid.

Generally, 8 out of 10 mothers, infants, and children participating in state or federally funded home visiting programs are low-income and enrolled in Medicaid, and 78 percent of adults and children participating in the MIECHV program in FY 2012-2017 were enrolled in Medicaid or the Children's Health Insurance Program (CHIP).[22] This in large part reflects the proportion of pregnant women and young children covered by Medicaid. Medicaid finances half of all births[23,24] State data reported by CMS indicate that 60 percent of infants and toddlers birth to 3 years and 56 percent of preschool age children 3 to 5 years were enrolled in Medicaid some time during FY 2016.[25] A share of these young

Table 1. Favorable Effects on Health Outcome Domains among 18 Home Visiting Models that Meet Federal Criteria for Evidence-Based Home Visiting

Model	Maternal Health	Child Health
Attachment and Biobehavioral Catch-up (ABC)	Not measured	Yes (primary)
ChildFirst®	Yes (primary, secondary)	Not measured
Head Start Home-Based Option (EHS-HBO)	No	No
Early Intervention Program for Adolescent Mothers (EIP)	No	Yes (primary)
Early Start (New Zealand)	No	Yes (primary, secondary)
Family Check-Up®	Yes (secondary)	
Family Connects®	Yes (secondary)	Yes (primary, secondary)
Family Spirit®	Yes (primary, secondary)	
Health Access Nurturing Development Services (HANDS)	Yes (primary)	Yes (primary)
Healthy Beginnings	Yes (secondary)	Yes (primary, secondary)
Healthy Families America®	Yes (secondary)	Yes (primary, secondary)
Home Instruction for Parents of Preschool Youngsters (HIPPY)®	Not measured	Not measured
Maternal Early Childhood Sustained Home Visiting Program (MECSH)	Yes (secondary)	Yes (secondary)
Minding the Baby®	Yes (primary)	Yes (primary)
Nurse Family Partnership (NFP)®	Yes (primary, secondary)	Yes (primary, secondary)
Parents as Teachers (PAT)®	No	No
Play and Learning Strategies (PALS) Infant	Not measured	Not measured
SafeCare Augmented®	Not measured	Not measured

Source: Sama-Miller E, Akers L, Mraz-Esposito A, et al. *Home Visiting Evidence of Effectiveness Review: Executive Summary.* Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. 2018. Adapted from Table 3. "Favorable impacts on primary and secondary measures for home visiting effectiveness, by outcome domain." To learn more, visit: http://homevee.acf.hhs.gov

children would benefit from home visiting programs focused on serving low-income families identified with higher risks. While the MIECHV program is used to fund a large share of home visiting services, some states see the value in leveraging Medicaid financing to expand home visiting capacity for the high proportion of eligible and enrolled pregnant women, new mothers, infants, and young children.

Evidence shows that home visiting can improve health outcomes and yield returns on investment.

Research indicates that home visiting can have a positive impact on child and family health and well-being.[26] Using a two-generation approach, home visiting has the potential to improve outcomes across a range of domains, such as maternal and child health, child development and school readiness, parenting practices and capacity, and family economic self-sufficiency and well-being.[27] While not all domains have been well studied or have demonstrated improvement for each home visiting model, many positive effects have been reported.[28] To the extent that home visiting programs improve parent capacity to provide safety, stability, and nurturing in the home, research points to increased chances for optimal development and improved health and well-being through the life course.

Several models give greater emphasis to improving maternal, infant, and young child health, beginning during pregnancy, and some have demonstrated greater impact on both short and long term health outcomes. As shown in Table 1, among 18 models approved as evidence-based by the U.S. Department of Health and Human Services, 14 have demonstrated favorable outcomes in the MIECHV domains of maternal health, child health, or both.[29] State Medicaid programs seeking to improve birth outcomes or increase utilization of preventive services such as prenatal and postpartum care, well-child visits, immunizations, or developmental screening can be aided by home visiting programs that emphasize health.

Specific evidence-based home visiting programs have been studied for their impact on future expenditures and costs and have reported very strong returns on investment. For example the Nurse-Family Partnership model has shown yields of $1.25 to $5.70 for every dollar invested, with net benefits to society of between $10,000 and $41,000 per child served (with variations partly reflecting levels of family risk).[30,31] These studies differ in what they look for in terms of cost offsets (which may be in education and special education, justice system involvement, future earnings potential and dependency upon public assistance, and, in some instances, health care costs).

As discussed above and shown in Table 1, some models have demonstrated favorable effects on the health of mothers and children. A larger group of home visiting models have shown positive effects on parenting, child development, and family self-sufficiency, and, through these improvements, yield savings in terms of life-long health and health care expenditures.

Table 2. States Using Medicaid to Finance Home Visiting, 2018

State	Approach
California	Multiple counties, varied mechanisms, no state-level policy
Colorado	Targeted case management (TCM) benefit
Illinois	Waiver including home visiting focused on perinatal substance use
Kentucky	TCM benefit; HANDS state model (HomVEE approved)
Maryland	Waiver including local demonstration projects in two counties
Michigan	TCM benefit; Maternal and Infant Health Program (MIHP) state model, managed care
Minnesota	Managed care (under prenatal and EPSDT benefits)
New Hampshire	TCM benefit
New Mexico	Funding approved for pilot projects
New York	TCM benefit; managed care and waiver
North Carolina	Waiver including pilot projects, planning and early implementation phase
Ohio	SPA for TCM not implemented; pilot funding approved
Oklahoma	TCM benefit and nursing benefit
Oregon	TCM benefit
Rhode Island	Payment for 3 visits, changes pending
South Carolina	Pay for Success approach, 1915b waiver
South Dakota	TCM benefit
Vermont	Waiver, per capita rate, part of Children's Integrated Services model
Virginia	TCM benefit; managed care, selected sites
Wisconsin	TCM benefit; managed care, selected sites

Table 2 identifies 20 states using Medicaid financing for home visiting through a variety of mechanisms. (Note while this list is based on the best available information in 2018, additional states using Medicaid may not have been identified.) Of this group, about a dozen states have longstanding policies and structures. Their scale varies, with some structures operating statewide, and others being localized. Other states are in the early stages of implementing pilot or demonstration projects (e.g., Illinois, Maryland, New Mexico, North Carolina, and Ohio). And, a third group permit Medicaid financing for home visiting at the local level, without a specific state-level Medicaid policy design (e.g., California, Virginia).

A dozen states have longstanding structures for using Medicaid to finance home visiting.

What mechanisms are states using Medicaid to finance home visiting?

To determine what can be financed under Medicaid, decisions follow the "Three E's"—eligible services delivered by an eligible/enrolled provider to an eligible/enrolled individual. In other words, for purposes of Medicaid reimbursement there must be a specific definition of the services, provider qualifications, and who is eligible to receive the service.

States have considerable flexibility in designing their approaches for covering home visiting, either in whole or in terms of different services or procedures provided during a home visit.[32] (See Appendix A for checklist on state decision making.) As shown in Table 2, most states using Medicaid to finance home visiting services are covered under a Medicaid State Plan Amendment (SPA) to use the targeted case management (TCM) benefit. Other states have made home visiting demonstration or pilot projects part of larger Medicaid Section 1115 or 1915(b) waivers (e.g., Maryland, South Carolina).[33] Still others use current authority and existing benefits. (See further discussion and examples below.)

Service Settings and Providers

Generally, Medicaid services can be provided as in-home services. The setting for the service does not determine coverage. Federal law permits states to use Medicaid to finance prevention, health education and counseling, and treatment services regardless of whether these are delivered in a medical/clinical setting, the patient's home, or a community-based setting. CMS has long encouraged states to provide services in home and community settings, particularly for children with special needs and risks.

Some states define and designate home visiting providers by model, setting up structures to reimburse for qualified providers of a model (e.g., Nurse Family Partnership, Healthy Families America, or ChildFirst). In other instances, home visiting is provided through entities that already qualify as Medicaid enrolled providers such as local health departments, or home health agencies (who may be subcontracting providers in managed care networks). In addition, at their option and with a state plan amendment, states can choose to reimburse for preventive services "recommended by a physician or other licensed practitioner… within the scope of their practice under State law" (42 CFR §440.130(c)). Using this option, state Medicaid agencies can provide reimbursement for preventive services delivered by an array of health and related staff, including: home visitors, community health workers, parent educators, early childhood specialists, and nutrition counselors and lactation consultants.[34,35,36] These CMS rules allow states the ability to reimburse unlicensed practitioners under these specified circumstances.

Medicaid does not pay the full cost of a home visiting program but can pay for full visits.

Payment approaches

Payment approaches and structures for Medicaid financed home visiting are determined by each state. In terms of billing and payment mechanisms, states use different approaches, including fee-for-service, global/capitated, and other approaches.[37] Services can be bundled under a global payment rate for an episode of care (e.g., a year of home visiting, or duration of pregnancy and 60 days postpartum) or a specific encounter rate (payment per visit). Most states pay for home visits on a unit of service/encounter basis paid to providers within a fee-for-service structure. Others position home visiting as part of capitated (per member, per month) fees under managed care contracts (e.g., Minnesota). A few states finance a bundled service covering the year or month when visits occurred (e.g., Vermont).

Currently, most state Medicaid agencies cover virtually all enrolled pregnant women and young children under Medicaid managed care arrangements. To finance home visiting as part of a managed care arrangement, states incorporate it into an actuarially based capitation rate and set contractual terms that ensure use of qualified providers and adherence to a specific protocol (e.g., one or more models or case management approaches). Alternatively, home visiting services could be covered and paid outside the contract, with the managed care organization responsible for identifying and referring patients who qualify for the service, but with payments outside the capitation rate on a fee-for-service or global payment basis. States also could include home visiting as part of integrated care models, accountable health care communities/organizations,[38] and other payment and system reform approaches.[39]

Notably, Medicaid does not pay for the full cost of operating home visiting programs, just as it does not pay for the full cost of operating a primary care practice or hospital. In the case of home visiting, elements such as training of home visitors, data management, supervision, and related administrative activities would typically not be directly billed or covered.

Some states pay for only portions or specific components of a visit; however, depending on the benefits and design decisions, states can and do pay for full visits. In some state approaches, the time to complete care plan updates and make effective referrals and linkages is included as part of the home visit cost to be reimbursed.

Benefits design

As discussed in the CMS-HRSA Joint Informational Bulletin, home visiting is not a specified covered benefit under Medicaid. (This is also true for more commonly financed services such as mental health.) States may, however, choose among various Medicaid benefit categories to cover home visiting. The Bulletin identifies three core services—1) screening; 2) case management; and 3) family support, counseling, and skills training—as the foundational elements of a home visiting program. These may be covered under various Medicaid benefits, including: case management services; extended services for pregnant women, other licensed practitioner services; preventive services; rehabilitative services; therapy services; home health services; health homes; and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit categories.

Tables 3a and 3b provide an overview of key benefit categories states might use to finance home visiting. While TCM is the benefit category most frequently used and perhaps offers the greatest flexibility, other benefit categories may be practical in a given state. These tables also show that some benefits qualify for matching at a state's Federal Medical Assistance Percentage (FMAP), which is generally more than the minimum 50 percent administrative matching rate.

Case management benefits

In the context of children's health, "care coordination" and "case management" are terms used to describe an array of activities that help to link families to services. Case management has existed as a separate, reimbursable benefit under Medicaid since 1986.[40] The Medicaid statute defines case management as "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services" (42 U.S.C. §§1396d(a)(19) and 1396n(g)(2)). Case management services must include: a) assessment of an eligible individual (42 CFR 440.169(d)(1)); b) development of a specific care plan (42 CFR 440.169(d)(2)); c) referral to services (42 CFR 440.169(d)(3)); and d) monitoring activities (42 CFR 440.169(d)(4)). Medicaid's case management benefit does not include the underlying medical, social, educational and other services themselves, integral components of covered Medicaid services, nor does it include activities integral to child welfare, special education, early intervention, or other non-medical programs. (This is particularly true for federal child welfare, special education, and early intervention programs, which come with requirements for case management/care coordination within the service packages or plans for children and families).

One type of case management is generally called administrative case management; however, the TCM benefit is much more likely to be used for home visiting and is distinctly different. The TCM benefit offers states the flexibility to provide case management services only to specific population subgroups who might be "targeted" based on medical condition or by geographic area.[41] This benefit option has been available to states since 1986 and has been used by virtually all states to better serve some populations (e.g., high-risk pregnant women, persons with disabilities, persons with condi-

tions such as HIV or mental illness). It is particularly applicable in the context of home visiting. States can use the TCM flexibility to specify select groups of women and children, geographic areas, identified home visiting models, and/or a set of approved providers (e.g., local health departments). To use TCM, states must submit a State Plan Amendment (SPA) and get approval from CMS.

Another advantage is that TCM services are matched at the Federal Medical Assistance Percentage (FMAP), which in most states is higher than the 50 percent administrative matching rate. Notably, TCM, because it is a "medical assistance" rather than an administrative benefit, is subject to rules on freedom of choice of provider in the absence of a freedom of choice waiver.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit

The goal of the EPSDT benefit is to ensure that children who are enrolled in Medicaid receive age-appropriate screenings, preventive services, and treatments that are medically necessary to correct or ameliorate any identified conditions—the right care to the right child at the right time in the right setting.[42] EPSDT is not simply one permissible benefit pathway; it provides the full coverage framework for the three core components of home visiting outlined by CMS. Home visiting can be viewed as a special component of EPSDT, used in cases in which higher health risks may be present. If EPSDT home visiting services are targeted to specific geographic areas, states would need permission to waive requirements for "statewideness." Targeting home visiting to specific subpopulations of infants and children who face elevated health risks (e.g., based on risk assessment or risk criteria) could be conducted as a normal utilization management which is authorized under federal regulations and would not require any waivers (42 C.F.R. §440.230). Moreover, any qualified provider operating within their scope of practice defined by state law can provide EPSDT screening services. Thus, if a state were to make home visiting a part of its statewide EPSDT benefit for any high risk infant and young child, no waivers would be needed; instead the change could be accomplished through state plan amendments related to the specifics of coverage, payment, and provider qualifications.[43]

The CMS-HRSA Bulletin's description places all of the three core components of home visiting services (screening, case management, counseling) within EPSDT's parameters. EPSDT encompasses screening, anticipatory guidance, case management, and any type of medical assistance service determined to be medically necessary.[44] Screening and case management are specifically covered under EPSDT.[45]

The third component—"family support, counseling, and parent/care"—falls within the EPSDT subcategory identified as "health education (including anticipatory guidance)" (42 U.S.C. §1396d(r)(1)(B)(v)). These home visiting family support services "*aid the parent/primary care giver with knowledge and skills to address specific infant/young child medical, behavioral, and or developmental treatment needs.*" The CMS-HRSA Bulletin also notes that "*[skills] training may involve topics such as stress management, child discipline and limit setting, and anger management.*"[46] This cluster of health education and parent guidance and counseling services would all qualify as anticipatory guidance as the term is used in high quality pediatric primary care and well-child visits, and thus can be covered under the EPSDT benefit.[47]

States electing to use EPSDT as the benefit category for home visiting would need to use a complementary benefit category to cover home visiting as extended pregnancy services for pregnant and postpartum mothers ages 21 and older. Every state covers some extended pregnancy benefits, and home visiting could be included in addition to elements such as prenatal and postpartum medical care, counseling and support services, breastfeeding services, genetic counseling, and perinatal case management.[48,49] Since federal law permits delivery of services in home, not only in clinical medical settings, states can permit in-home delivery of an array of pregnancy-related benefits and services.

EPSDT encompasses the three core components of home visiting.

Table 3. Key Medicaid Benefit Categories States May Use to Finance Home Visiting

Table 3a. Case Management Benefit Categories used for Home Visiting

Approach	Authority	Population	Providers/Services	Match Rate/ FMAP
Targeted case management* (*technically medical assistance)	Requires state plan amendment (SPA)	Permits targeting to select women, infants, & children	May limit providers; four core service components	State medical assistance FMAP
Administrative case management	Existing authority	Pregnant women, mothers, infants, & children	May limit providers; only administrative services	Administrative 50/50 match

Table 3b. Key Medical Assistance Benefit Categories used for Home Visiting

Approach	Authority	Population	Providers/Services	Match Rate/ FMAP
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Existing authority, mandatory	Children birth to 21 (would include teen parents)	Comprehensive set of prevention, screening, anticipatory guidance, diagnostic, and treatment services	State medical assistance FMAP
Extended prenatal/ pregnancy-related benefits	Existing authority, optional	Pregnant women and mothers to 60 days postpartum	• A broad set of pregnancy related services • Home visiting may be distinct from Medicaid perinatal/prenatal case management	State medical assistance FMAP
Preventive services for women/adults	Existing authority, optional	Adult women and men	As defined under the Affordable Care Act	State medical assistance FMAP

How is Medicaid financing for home visiting operationalized in various states?

The examples below highlight some of the different ways that states are using Medicaid to fund for home visiting. These brief summaries illustrate the flexibility states have to achieve their goals.

Sustaining statewide investment in home visiting

Oklahoma has a long history in home visiting policy and was one of the first states to use Medicaid financing for home visiting. By 1998, Oklahoma had an agreement between the Department of Health and the Medicaid agency (Oklahoma Health Care Authority) to finance Oklahoma's Nurse-Family Partnership program (known as Children First) in all 77 counties. State officials report that Medicaid represents approximately 15-20 percent of funding for Children First each year. In FY 2016, Children First served about 2,500 families in Oklahoma, with 90 percent receiving coverage through Medicaid.

Over time, Oklahoma has used more than one Medicaid benefit category for home visiting financing. In 2008, with federal pressure to narrow the scope of the TCM benefit, Oklahoma began to use the Nursing Assessment benefit as well. Services may be billed to Medicaid with codes for targeted case management (HCPC23 T1017) or nurse assessment (HCPC T1001), which cover a subset of services provided during a typical home visit. Most Medicaid billing for home visits in Oklahoma is provided under the Nursing Assessment benefit. The state also uses Medicaid administrative funds for skilled medical personnel to help support the program.

The Medicaid approach is supported by a strong and enduring partnership between the state's Medicaid agency and Department of Health. By 2016, more than 100 registered nurses who meet home visiting training requirements were certified by the Department of Health as providers whose services can be reimbursed by Medicaid.

More broadly, Oklahoma continues to have a robust home visiting system using multiple models and sources of financing. Models implemented included Early Head Start, Family Spirit, Healthy Families America, Nurse-Family Partnership (Children First), Parents as Teachers, and SafeCare. Statewide, 37 local agencies operated at least one of these models. As in all states, Oklahoma finances some home visiting services with federal grants from the MIECHV program

Using the potential under managed care arrangements

Minnesota has been financing and administering home visiting for low-income families since 1992, and has a statewide structure using multiple sources of funding, multiple models, and multiple accountability measures. The state has used Medicaid as one source of funds for more than a decade. Medicaid managed care has been the dominant structure for financing Medicaid services for many years, and the state currently authorizes contracts between managed care organizations and the local health departments (known as community health boards) providing home visiting services. While not a requirement in the state master Medicaid managed care contract, all of the managed care organizations contracting with the state Medicaid agency have subcontracts with local agencies to provide home visiting services to pregnant women and families with young children.

Minnesota's Family Home Visiting system uses multiple sources of funding and focuses on evidence-based home visiting models (e.g., Family Spirit, Healthy Families America, and Nurse Family Partnership).[50]

The Minnesota Department of Health provides administrative oversight and distributes funding for home visiting services provided under MIECHV, TANF, and Minnesota's Nurse-Family Partnership legislation. Funding administered by the Department of Health is granted to Community Health Boards and Tribal Governments. Other funding streams for home visiting in Minnesota include local tax levies and Medical Assistance reimbursement under the managed care contracts.[51] State leaders, in partnership with a state Family Home Visiting Advisory Group, continue to strive for improvements in administration of the complex service and financing structures for home visiting.

Developments through local Medicaid managed care structures also finance home visiting in California and Virginia. These states permit specific Medicaid managed care plans to subcontract with home visiting provider sites at the local level. The approach in these two states is different than having a requirement in the master state to plan contract or an active state-level Medicaid financing approach.

Prioritizing home visiting in Medicaid waivers and related initiatives

The **New York** First 1,000 Days on Medicaid initiative brought together an array of stakeholders and developed a set of recommendations for action that was embraced by the Governor and Legislature and approved in the 2018-19 Budget.[52] Expanding statewide home visiting using Medicaid financing is among the recommendations.[53] New York currently allows limited Medicaid reimbursement Nurse-Family Partnership through the First-time Mothers/Newborns Program, which uses Medicaid TCM to cover some services in Monroe County and New York City for low-income, pregnant women

who will be first-time mothers and for their child to the second birthday.[54] Consistent with the TCM benefit design, the key services provided are: 1) assessment; 2) development of a care plan; 3) referrals to help the mothers obtain needed services that may include prenatal care; improving diets; reducing use of cigarettes, alcohol and illegal substances; improving child health and development; and reducing quickly occurring and unintended pregnancies; and 4) monitoring the care plan. While select sites can now bill Medicaid, the TCM benefit has been narrowly interpreted and not all elements of home visits are reimbursed.[55]

In 2014, CMS approved New York's Delivery System Reform Incentive Payment (DSRIP) program, as part of a Section 1115 Waiver demonstration aiming to reduce avoidable hospitalizations. As part of DSRIP, each "Performing Provider System" must implement between five and 11 projects, focused on: a) system transformation, b) clinical improvement, and/or c) population-wide projects. New York's DSRIP Project Toolkit identifies evidence-based home visiting as an example of a potential clinical improvement project.[56] DSRIP is not, however, a statewide approach to financing home visiting with Medicaid.

Using tobacco funds for prevention via Medicaid

The **Kentucky** Health Access Nurturing Development Services (HANDS) program is administered by the Kentucky Department of Public Health. This state-developed model has shown positive impact and been federally approved as an evidence-based model.[57] The program is designed to provide voluntary home visiting services to at-risk, first-time pregnant women, infants, and toddlers to the third birthday. HANDS began as a pilot program in 1999 and was expanded to every county in the state by 2003. This expansion was supported by use of Medicaid financing.

In 2000, a state plan amendment (SPA) for use of the TCM benefit to cover some HANDS home visiting services was approved by CMS; the state applied State Tobacco Funds as the state match for federal Medicaid dollars.[58] Notably, the state regulations for HANDS closely follows the TCM federal rules, emphasizing screening/assessment, care planning, referrals and follow-up for additional services, and monitoring progress.

Kentucky finances HANDS home visiting services, which are primarily delivered through local health departments, using

a fee-for-service approach even though the majority of Medicaid beneficiaries in the state are enrolled in managed care.

Through interagency collaboration between the Department of Public Health and Medicaid, strong fiscal management approaches have been devised.[59]

Notably, **Arizona, California, Colorado, Hawaii,** and **Maine** also use some form of tobacco-related dollars to support home visiting, directly, as Medicaid matching funds, or indirectly through local early childhood operations such as **Arizona** First Things First and California First 5.

In **Colorado**, tobacco-related dollars are used directly and the state also uses Medicaid TCM to finance home visiting.

In **California**, since 1998, First 5 has provide funds to address the needs of young children under the California Children and Families Act (Proposition 10), which generates tobacco tax revenues that are locally controlled. First 5 funds support home visiting in approximately estimated 29 local areas and, separately, 34 city/county local areas reported using Medicaid (Medi-Cal) to support home visiting in 2018.[60]

Financing with a "Pay for Success" approach

Using a Medicaid 1915(b) waiver, **South Carolina** will provide prenatal, postpartum, and infant home visiting using the NFP model to serve more than 3,000 families over the next six years. Since Medicaid reimburses only for select components of home visiting in the state, South Carolina launched the nation's first "Pay for Success" initiative focused on home visiting. Pay for Success projects (also known as Social Impact Bonds) combine nonprofit expertise, public/private sector funding, and rigorous measurement and evaluation to transform the way government and society respond to social challenges. In a Pay for Success project, funders provide upfront capital to expand social services and government pays for all or part of a program only if it measurably improves the lives of participants.

The South Carolina Department of Health and Human Services is leading the project, and worked closely with the Nurse-Family Partnership and philanthropic partners (e.g., BlueCross BlueShield of South Carolina Foundation, The Duke Endowment, The Boeing Company, Greenville First Steps, Laura and John Arnold Foundation, and The Children's Trust Fund of South Carolina) and additional partnership (i.e., Social Finance, Inc.; J-PAL North America; Government Performance Lab at the Harvard Kennedy School; WilmerHale; and Nelson, Mullins, Riely & Scarborough LLP).

For this Pay for Success initiative, philanthropic funders have committed $17 million and Medicaid will fund approximately $13 (federal and state dollars combined) through the 1915(b) waiver. An addition $7.5 million in payments for success will be committed if independent evaluators find positive results.

Pay-for-success provisions were considered or included in recent legislative or administrative policy developments in **Ohio**, **Utah**, and **Wisconsin**.

Piloting use of Medicaid for home visiting

Using a Medicaid Section 1115 demonstration waiver, the **Maryland** Department of Health offered local government entities (e.g., local health department, local management board) the opportunity to apply for federal matching funds under a Home Visiting Services Pilot project. Funds may be used to expand capacity for evidence-based home visiting models serving high-risk pregnant women and children up to age two (i.e., Nurse Family Partnership and Healthy Families America). Local lead entities must fund 50 percent of the costs for the home visiting services using local dollars through an intergovernmental transfer process. The pilot project is effective from July 1, 2017 through December 31, 2021 and is scheduled to be funded for the duration of the waiver. Up to $2.7 million in matching federal funds are available annually, and when combined with the local non-federal share, HVS Pilot expenditures could total up to $5.4 million annually. In November 2017, a Round One award was granted to Harford County serve 30 families. In April 2018, a Round Two award was granted to Garrett County to serve 13 families.

Legislative and administrative action in states such as **New Jersey**, **New Mexico**, **North Carolina**, **Ohio**, and **Washington State** provided funds or directed planning for use of Medicaid to finance home visiting services. For example, **New Jersey** Act No 2017-50 established a three-year Medicaid home visitation demonstration project to provide ongoing health and parenting information, parent and family support, and links to essential health and social services during pregnancy, infancy, and early childhood.

In 2018, **Illinois** received approval from CMS for a Medicaid Section 1115 waiver. The project includes coverage of evidence-based home visiting services for mothers during the 60-day postpartum period and Medicaid-eligible children up to 5 years old following a birth with neonatal abstinence syndrome/drug withdrawal symptoms.

In comparison to some state approaches, only a small number of families are served by Medicaid-financed home visiting in states such as **South Dakota**, mainly through the Nurse-Family Partnership. The federal Medicaid funds are braided

with MIECHV, state general revenues, and other funds in the state. The South Dakota Bright Start Home Visiting Program has been serving families in select communities (Sioux Falls, Rapid City, and Pine Ridge) for more than a decade. Increased investment is expected to expand access to home visiting.

Creating a home visiting model from a perinatal case management program

Michigan has been using Medicaid to finance home visiting for more than two decades. Multiple models are being supported with MIECHV and state funding,[62] but the centerpiece of their statewide effort is the Medicaid Maternal and Infant Health Program (MIHP).[63] MIHP is administered by the state Medicaid agency and is the largest home visiting program in the state. Michigan built upon Medicaid maternal and infant (perinatal) case management programs developed in 1987 to create MIHP in 2004 as a strong, population-based home visiting program that is available to all pregnant women enrolled in Medicaid and their infants up to 12 months.[61]

The redesigned program uses a standardized, validated risk screening tool, as well as more structured protocols and evidence-based interventions. This evidence-informed home visiting program is designed to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. The long-term goal of the MIHP is to reduce maternal and infant morbidity and mortality. Services are delivered by teams of registered nurses, social workers, registered dietitians, infant mental health specialists, and lactation consultants, with such teams typically based in local health departments, federally qualified health centers, and other health providers (e.g., hospitals, home health agencies).[64] MIHP has been shown through evaluation studies to improve

States have flexibility in design of home visiting systems and financing approaches.

utilization of prenatal care and well-baby visits; and to reduce the risk of adverse birth outcomes, particularly among black women.[65]

In 2017, after years of operation as a fee-for-service Medicaid program, MIHP was integrated into Medicaid managed care arrangements. As part of this transition, health plans are required to refer all Medicaid managed care enrolled pregnant women to MIHP (or an equivalent evidence-based home visiting program) or to document women's refusal to receive these services. Moreover, each MIHP provider needs to have a contract with one or more health plans to receive reimbursement for in-network services provided to MIHP enrollees.

Beyond MIHP, Medicaid has designed a multi-model home visiting system initiative under which Medicaid funds are braided with MIECHV, Child Abuse Prevention and Treatment Act (CAPTA), state general funds, state school aid, and private Children's Trust Fund dollars. Annual accountability reports with data from multiple models and structures are submitted to the governor.[66]

Strategies often are tailored to fit with a state's Medicaid, home visiting, and health system.

Distinguishing home visiting from perinatal case management

A majority of states—approximately 30—have Medicaid perinatal case management programs. Most were created in the 1980s using the TCM benefit and have since evolved.[67,68] Notably, while some state Medicaid perinatal case management programs (e.g., Illinois, Oregon, Tennessee, and Washington State) have been included in reports about home visiting, most states do not consider perinatal case management programs as part of their home visiting system and, to date, none are approved on the HomVEE evidence-based home visiting list.

As noted above, Kentucky built upon a perinatal case management program to create the HomVEE approved, evidence-based HANDS program. Michigan redesigned perinatal home visiting to create the MIHP program, which the state considers home visiting.

With the advent of MIECHV and emphasis on evidence-based home visiting, more states may see the need for making clear distinctions between evidence-based home visiting and perinatal case management, particularly if Medicaid funding is used for both. While both focus on pregnant women, infants, and young children, and they have some overlapping purposes (e.g., improving maternal and infant health; and providing information, referrals, and care coordination), they are not the same. Research points to different staffing patterns, protocols, and structures, as well as different impact on birth outcomes and service utilization.[69,70] Moreover, many home visiting models continue beyond the perinatal period (pregnancy and infancy), into the early childhood years.

Looking broadly at home visiting financing with federal dollars

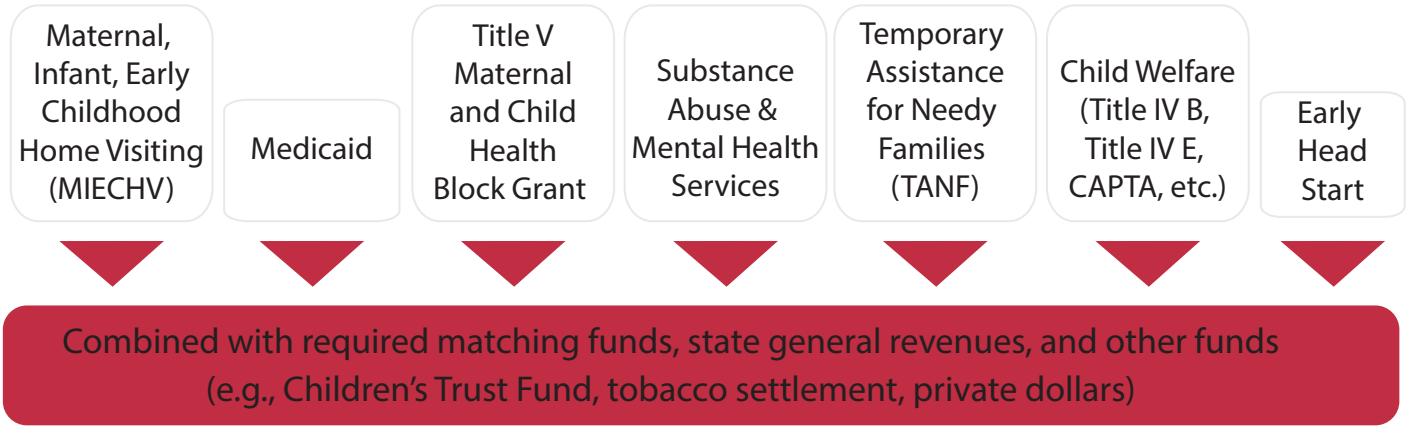
Working under broad federal rules, states are making decisions regarding which children and families are eligible for home visiting services, which models/services are offered, and which providers may deliver services. Another important decision is which funds to use for which families and models. Medicaid is one, but only one, of the federal funding streams that states can and are using to increase the capacity of home visiting.

Given that MIECHV is the driving legislative and grant-making authority for home visiting, states could benefit from greater clarification on how federal funds can (or cannot) be braided. For example, while the law (either statutory or regulatory language) specifies how Medicaid can be braided (i.e., used in combination) with the Title V Maternal and Child Health Services Block Grant, Child Welfare (foster care), and IDEA Part B Special Education and Part C Early Intervention programs, no such federal law clarification exists for MIECHV. In the absence of written federal guidance, states are often choosing to use Medicaid for only one model or only certain local agency sites, making for simpler administrative separation of and accounting for funds.

States are leading the way in advancing home visiting finance and statewide systems with multiple models.[71,72,73] Across the nation, states are using a variety of public and private funding streams to finance home visiting services. As shown in Figure 1, key federal funding streams used by states for home visiting include: MIECHV, Medicaid, Title V Maternal and Child Health Services Block Grant, Substance Abuse and Mental Health Services, Temporary Assistance to Needy Families (TANF), Child Welfare, and Head Start. These federal funding streams are being used to varying degrees and for different models. For example Medicaid is more likely to be used to fund models that have impact on health outcomes, and Child Welfare funding is more likely to be used for models such as ChildFirst and SafeCare that have shown impact on families at higher risk for involvement in the child welfare system. In most cases, in addition to required matching funds, state general revenues are part of braided funding for home visiting. In a few states, additional funds such as tobacco-related funds, Children's Trust Fund, or philanthropic funds are dedicated to home visiting services. Diversified funding can increase home visiting capacity, support quality, and optimize use of different models for prevention and intervention purposes.

States use an array of federal funding streams to finance home visiting.

Figure 1. Key Federal Funding Streams Used to Support Home Visiting



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