Coverage of Maternal, Infant, and Early Childhood Home Visiting Services

Wednesday, November 9, 2016  3:00-4:30pm ET

Please call in: 1-877-918-6628 Passcode:  3925405
You have the option to either call-in or listen through computer speakers

Sign-In Link: https://hrsa.connectsolutions.com/hrsa-cms_national_webinar/

Supported by the Health Resources and Services Administration through the Alliance for Innovation on Maternal and Child Health: Cooperative Agreement Expanding Access to Care for the Maternal and Child Health Population
I. Welcome, Introductions, and Webinar Logistics
Karen VanLandeghem, Senior Program Director, NASHP

II. Federal Efforts to Advance Evidence-Based Home Visiting Programs and Services
David Willis, MD, Division Director of Home Visiting and Early Childhood Systems, MCHB, HRSA

III. Home Visiting Services – Opportunities for Medicaid Coverage
Marguerite Schervish, JD, Technical Director, Division of Benefits and Coverage, CMS, CMCS

IV. Questions and Discussion

V. Medicaid and Home Visiting Learning Network: Summary and Lessons
Kay Johnson, President, Johnson Group Consulting

VI. State Strategies and Approaches to Covering Home Visiting Services
William Camp, MHA, South Carolina Department of Health and Human Services

VII. Questions and Discussion

VIII. Wrap Up
David Willis, MD, MCHB, HRSA
Marguerite Schervish, JD, CMS, CMCS
Karen VanLandeghem, NASHP
Evidence Based Home Visiting: An Overview of Key Resources and Opportunities for Medicaid Engagement

Federal Efforts to Advance Evidence-Based Home Visiting Programs and Services

November 9, 2016

David W. Willis, MD
Director, Home Visiting and Early Childhood Systems
Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
The Federal Home Visiting Program

Legislative Authority and Appropriation

• Affordable Care Act of 2010
  $100M FY2010
  $250M FY2011
  $350M FY2012
  $379.6M FY2013*
  $371.2M FY2014*

• Protecting Access to Medicare Act of 2014
  $400M FY 2015

• Medicare Access and CHIP Reauthorization Act (MACRA) of 2015
  $400M FY 2016
  $372.4M FY 2017*

*Reflects the sequestration reduction.
The Federal Home Visiting Program

• **Supports Families**
  - Evidence based parent support services to address family needs
  - Partnership between parents and home visitors

• **Voluntary**
  - For families that ask to be empowered with better knowledge, health and parenting

• **Evidence-based**
  - Built on four decades of rigorous research and evaluation
  - Includes a rigorous national randomized controlled trial evaluation and local evaluations
  - Models that meet HHS criteria for evidence of effectiveness
The Federal Home Visiting Program

• **Positive Return on Investment**
  
  • HV prevents child abuse and neglect, encourage positive parenting and promotes child development and school readiness
  
  • Long term reduction of school drop out, teen pregnancy and crime

• **Locally designed and run**
  
  • Provides states with maximum flexibility to tailor programs to fit needs of different communities
  
  • States and territories can choose from the models that meet the HHS criteria for evidence of effectiveness that are eligible for program funding
  
  • Programs run by local organizations
The Federal Home Visiting Program

A tiered-evidence and place-based strategy

- Programs are in all 50 states, DC and five territories and 787 counties (2015)
- Programs have provided nearly 2.3M home visits since start of program
- In 2015, states reported serving 145,561 parents and children.
The Federal Home Visiting Program

Provide voluntary, evidence-based home visiting services to improve

- Prenatal, maternal, and newborn health
- Child health and development, including the prevention of child injuries and maltreatment
- Parenting skills
- School readiness and child academic achievement
- Family economic self-sufficiency
- Referrals for and provision of other community resources and supports
Families

Priority Populations

• Low-income families
• Pregnant women under age 21
• Families with a history of child abuse or neglect
• Families with a history of substance abuse
• Families that have users of tobacco in the home
• Families with children w/low student achievement
• Families with children w/ DD or disabilities
• Families with individuals who are serving or have served in the Armed Forces, including those with multiple deployments

Populations Served in 2015

• 79% of families < 100% federal poverty
• 48% of families < 50% federal poverty
• 69% did not go to college
• 68% minority
• 27% of newly enrolled pregnant teens
• 20% of newly enrolled with history of child abuse and neglect
• 12% of newly enrolled with history of substance abuse
## Evidence-Based Models

State Grantees Selection of Home Visiting Models for FY 16

<table>
<thead>
<tr>
<th>Evidence Based Model</th>
<th>Number of States Implementing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Families America</td>
<td>36</td>
</tr>
<tr>
<td>Nurse-Family Partnership</td>
<td>39</td>
</tr>
<tr>
<td>Parents as Teachers (PAT)</td>
<td>35</td>
</tr>
<tr>
<td>Early Head Start</td>
<td>15</td>
</tr>
<tr>
<td>Home Instruction for Parents of Preschool Youngsters (HIPPY)</td>
<td>6</td>
</tr>
<tr>
<td>Family Spirit</td>
<td>4</td>
</tr>
<tr>
<td>Child First</td>
<td>1</td>
</tr>
<tr>
<td>Health Access Nurturing Development Services (HANDS) Program</td>
<td>1</td>
</tr>
<tr>
<td>SafeCare</td>
<td>2</td>
</tr>
<tr>
<td>Family Check-up</td>
<td>1</td>
</tr>
<tr>
<td>Family Connects (pilot)</td>
<td>1</td>
</tr>
</tbody>
</table>
The Federal Home Visiting Program Growth

Number of Counties with Federal Home Visiting Program Services (2010-2015)

- Number of Counties Served
- Number of Participants
- Number of Home Visits

Map of the United States showing the distribution of counties with Federal Home Visiting Program Services (2010-2015).
Three Types of Measurement

• Performance & Results Accountability
  • Performance reporting

• Evaluation and Research
  • MIHOPE and MIHOPE-SS
  • Home Visiting Research Network (HVRN)
  • Grantee-led Evaluations
  • Multi-site Implementation Evaluation of Tribal Home Visiting

• Quality Improvement
  • Home Visiting Collaborative Innovation and Improvement Network (HV CoIIIN)
# New Performance Measures

## Benchmark Areas

<table>
<thead>
<tr>
<th>Area</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Maternal and Newborn Health</td>
<td>Preterm Birth; Breastfeeding; Depression Screening; Well-Child Visit; Postpartum Care; Tobacco Cessation Referrals</td>
</tr>
<tr>
<td>II. Child Injuries, Maltreatment, and Reduction of ED Visits</td>
<td>Safe Sleep; Child Injury; Child Maltreatment</td>
</tr>
<tr>
<td>III. School Readiness and Achievement</td>
<td>Parent-Child Interaction; Early Language and Literacy Activities; Developmental Screening; Behavioral Concerns</td>
</tr>
<tr>
<td>IV. Crime or Domestic Violence</td>
<td>IPV Screening</td>
</tr>
<tr>
<td>V. Family Economic Self-Sufficiency</td>
<td>Primary Caregiver Education; Continuity of Insurance Coverage</td>
</tr>
<tr>
<td>VI. Coordination and Referrals</td>
<td>Completed Depression Referrals; Completed Developmental Referrals; IPV Referrals</td>
</tr>
</tbody>
</table>
The Federal Home Visiting Program

A new standard of care

• Focusing on improving health care and access for mothers, children and families

• Increasing child developmental screening and referral

• Increasing Maternal depression screening, referral and support

• Monitoring child safety and risks for child abuse and neglect

• Providing parenting support and education

• Providing at-risk families with linkages to needed community supports
Collaborations across Early Childhood Systems

• Race to the Top – ELC States
• ECCS (Early Childhood Comprehensive Systems)
• Help Me Grow – 25+ affiliates
• Project LAUNCH (SAMHSA)
• TANF, Child Welfare and Trauma-informed systems
• Part C, IDEA
• Housing Authorities
• AAP, child and family health providers and community health centers
• TECCS (Transforming Early Childhood Community Systems)
• Place-Based Initiatives, BBZ, Promise Neighborhoods, Promise Zones, Rural Impact, etc.
Sustainability: Medicaid Opportunities

- **State Medicaid policy**
  - Home Visiting
  - Maternal depression screening and treatment
  - Developmental screening
  - Promoting prevention – community health workers

- **Medicaid Managed Care**
  - The drive towards quality and value

- **Children’s Hospitals- non-profit**
  - Community benefit

“What can we contribute to help you with your (Medicaid) goals?”
Contact Information

David W. Willis, MD
Director, Division of Home Visiting and EC Systems
Maternal and Child Health Bureau (MCHB)
Health Resources and Services Administration (HRSA)
Email: dwillis@hrsa.gov
Phone: 301-443-4998
Web: mchb.hrsa.gov
Coverage of Maternal, Infant and Early Childhood Home Visiting Services

Presentation: Home Visiting Services – Opportunities for Medicaid Funding

Marguerite Schervish, J.D., Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services
Webinar, November 9, 2016, 3:00 – 4:30 p.m.
IB is intended to assist states in designing a benefit package to provide home visiting services for pregnant women and families with young children

• **Common Services**
  - Screening
  - Case Management
  - Family Support
  - Counseling
  - Skills Training
Medicaid Program Administration

• Medicaid is a federal and state partnership
• Shared financing based on formulas for matching funds
• State have flexibility in the administration of its Medicaid programs within federal guidelines
• Single state agency:
  – Administers program
  – Serves as point of contact for CMS
  – Pays claims
  – Assures funds available for state share
• Amount, duration, and scope of services:
  • Adequate to achieve purpose of service
  • Cannot be reduced based on diagnosis, type of illness, or condition of patient
• Comparability
• Statewideness
• Any willing provider
• Freedom of choice
• Provider qualifications
• Waivers of Requirements
  – Allowed in managed care programs (e.g., can waive free choice of provider)
  – Allowed in home-and community-based services programs (e.g., can waive comparability and statewideness)
  – Allowed in “section 1115” demonstration programs (can waive any requirement in section 1902 of Social Security Act)
  – Not allowed in “state plans” unless waived in governing statute
Medicaid State Plan Authority

- States’ “contract” with CMS to administer the Medicaid program
- Includes mandatory services and eligibility groups
- Includes optional services and eligibility groups selected by states
- State plan amendments – necessary to make any changes in coverage or reimbursement for services
• No state plan benefit called “home visiting”
• State Medicaid agencies can cover individual component services if requirements are met
• Likely benefit options for states: EPSDT, Extended Services to Pregnant Women, Home Health Services, Case Management, Other Licensed Practitioners, Preventive Services, Rehabilitative Services, Therapies
Medicaid Section 1905(a) Mandatory State Plan Benefits:

- Early and Periodic Screening, Diagnostic and Treatment Services Benefit
  - A comprehensive and mandatory benefit for children under age 21 that requires screening services, as well as physical, mental, vision, hearing, and dental services they need
  - Allows states to target services to children under age 21
  - Requires states to make available to all children under age 21 all the services that fit within a covered state plan benefit (section 1905(a) of the Social Security Act) that a child is determined to need that will correct or ameliorate a physical or mental condition
Medicaid Section 1905(a) Mandatory State Plan Benefits:

- **Extended Services to Pregnant Women**
  - Services to treat pregnancy-related conditions and other medical conditions which may complicate pregnancy
  - Pregnancy-related services include prenatal care, delivery, postpartum care up to 60 days after birth of child, and family planning services.
  - Can target services to pregnant and postpartum women

- **Home Health Services**
  - Must be ordered by a physician according to a written plan of care
  - 4 parts – 3 are required: 1) nursing services, 2) home health aide services, and 3) medical supplies, equipment and appliances. (The 4th is optional: PT, OT, Sp Pathology and Audiology Services.)
  - **New regulation**: Published on February 2, 2016 and can be found at [https://federalregister.gov/a/2016-01585](https://federalregister.gov/a/2016-01585).
• Medicaid Section 1905(a) Optional State Plan Benefits:
  • **Case Management Services**
    • Help Medicaid-eligibles gain access to needed medical, social, educational and other services
    • States may target services to a specific population (e.g., pregnant women and infants or individuals residing in a particular area of the state, or both)
  
• **Other Licensed Practitioner Services**
  • Medical or remedial services furnished by any practitioner that the state licenses (but not physicians who are covered under the “physicians' benefit”)

• Medicaid Section 1905(a) Optional State Plan Benefits:
  • Preventive Services
    • Recommended by a physician or licensed practitioner
    • Purposes: Prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency.
    • Must involve direct patient care
    • Examples: screening and counseling services
  • As of January 1, 2014, may be furnished by non-licensed practitioners that meet qualifications established by the state
Medicaid State Plan Authority (cont’d.)

• Medicaid Section 1905(a) Optional State Plan Benefits:
  • Rehabilitative Services
    • Recommended by a physician or licensed practitioner
    • Medical and remedial services that reduce a person’s disability and restore the person’s best possible functioning
    • Example: Family therapy
  • May be furnished by licensed qualified practitioners, or non-licensed qualified practitioners
• Medicaid Section 1905(a) Optional State Plan Benefits (cont’d):
  • Therapy Services
    • PT, OT and Sp/L services (including audiology services)
    • PT and OT must be prescribed by a physician or other licensed practitioner
    • Must be provided by a qualified therapist that meets Medicaid qualifications or a practitioner under the direction of the qualified therapist
• Medicaid Section 1945 State Plan Authority:
  • Health Homes
    • Optional state plan program under section 1945 of Social Security Act
    • Allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions or serious mental illness
    • Focuses on improving outcomes and disease management for beneficiaries with chronic conditions and obtaining better value for state Medicaid programs
    • Can integrate primary care, behavioral health, and long-term services and supports
    • Services include: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up patient and family support, and referral to community and social support services
Other Medicaid Authorities:

- Managed Care - Sections 1903(m) and 1932 of the Social Security Act
- Waivers under section 1915(b) of Social Security Act
- Home and Community Based Services Waiver Programs – Section 1915(c) of Social Security Act
- Demonstration Programs - Section 1115 of Social Security Act
Questions and Discussion
Medicaid and Home Visiting Learning Network: Summary and Lessons

Presentation by Kay Johnson
National Academy for State Health Policy Webinar
November, 2016
Acknowledgements

Thanks to our funders:

- The **Pew Charitable Trust** for providing core funds to support this project as a legacy of the Pew Home Visiting Campaign.
- The **Heising Simons Foundation** for providing a grant to support participation of an expanded number of states and state team members.

Johnson Group Consulting, Inc. is solely responsible for the content of these slides and other materials developed for this project.
Project Purpose and Goals

- To provide a forum for **peer-to-peer learning** among states about using Medicaid to finance home visiting services for mothers and young children.

- To assist states in **development of policies and mechanisms** needed to maximize Medicaid as one among public and private sources of funding.

- To support **state goals** (i.e., no specific common policy aim for this project).
Medicaid and Home Visiting Learning Network Participating States
Medicaid and Home Visiting

- States have used Medicaid to finance home visiting for more than 20 years.
- A variety of approaches and mechanisms have been used.
- Most families in HV are eligible for Medicaid.
  - 79% of MIECHV in 2014 < 100%FPL
- States have funded both evidence-based models and hybrid/home-grown programs.
- Distinct from in-home services via prenatal case management, early intervention, etc.
State interests based on applications \( n=8 \)

- How to use emerging concepts such as "pay for success"?
- Can HV demonstrate cost savings needed for Medicaid waivers?
- How do states measure or evaluate their success?
- What about using other capitated payment arrangements?
- What about ACOs to support and finance home visiting?
- How are states optimizing the EPSDT benefit?
- What would be included in managed care contract language?
- What is state potential for using Medicaid managed care?
- How does MIECHV affect use of Medicaid?
- How are states using QI?
- How do state Medicaid agencies set rates?
- What HV models or provider structures have been funded?
- What are the key approaches?
- What is typically included in a SPA for HV?
- What benefit categories have been used?
- What approaches have been used by other states?
KEY QUESTIONS FOR STATES TO CONSIDER BASED ON LEARNING NETWORK DISCUSSIONS
Key considerations related to Medicaid Approach / Authority

- Does your state have an existing authority under the current state plan?
- Is a state plan amendment (SPA) needed to create authority to finance home visiting?
- What dollars will be used as match to draw down federal financial participation (e.g., state general revenue, local funds)?
- How will you use leverage to contain program and costs (e.g., limits on population, geographic areas)?
Considerations about Medicaid Benefits Categories

- Has your state team reviewed the *CMS-HRSA Joint Informational Bulletin*?
- What benefits fit with the model, providers, and home visiting system in your state?
- Are case management/administrative services or a direct medical care services more appropriate?
- Does the state have an existing case management/targeted case management program that might be used?
- How can EPSDT be used to finance home visiting for children?
- Do most new mothers in your state lose Medicaid at 60 days postpartum?
Key Considerations for Provider Structures and Qualifications

- Who is the Medicaid provider?
- What are qualifications for HV programs supported by MIECHV, state general funds, or Medicaid?
- What is number, type, and distribution of providers?
- What is structure of relationship between Medicaid and the state HV program office (accountability to whom, for what)?
Key Considerations for Medicaid Managed Care

- What is number and geographic distribution of MCOs?
- How best to structure HV contract provisions between state and MCOs?
- How will state ensure adequacy and appropriateness of HV provider network?
- How will contract define relationships with public agencies vis-à-vis HV?
- Will payment/capitation be adjusted?
- What HV quality improvement, data, consumer protections, and other mechanisms for accountability will be in contract?
Key Measurement Considerations for Medicaid

- Who is responsible for collecting Medicaid data related to HV?
- Can HV services be tracked in Medicaid claims data?
- How can Medicaid claims data be linked to HV, vital statistics, or child welfare data?
- Can fiscal, utilization, and outcomes data be tracked?
- What is required in Medicaid contracts with MCOs regarding HV data, quality, and performance?
- What is the role of Medicaid in standardized HV reporting?
Key Measurement Considerations for State Home Visiting Systems

- Who is responsible for MIECHV data collection and reporting?
- Does the state have legislatively mandated reports on HV?
- Has a standardized, common outcomes/measurement framework for HV been adopted?
- For HV evaluations, how are Medicaid recipients’ utilization and outcomes incorporated?
- Does the state have a “cross-walked” version of MIECHV, Medicaid/CHIP, and larger HV system measures?
OUR THANKS TO STATES PARTICIPATING IN THE MEDICAID AND HOME VISITING LEARNING NETWORK

Contact:
Project director: kay.johnson@johnsongci.com
Project assistant: kyla.leary@johnsongci.com
State Strategies and Approaches to Covering Home Visiting Services

Will Camp
South Carolina Department of Health and Human Services
November 2016
South Carolina Department of Health & Human Services (SCDHHS) provides Medicaid coverage to South Carolina residents. Our mission is to purchase the most health for our citizens in need at the least possible cost to the taxpayer.

South Carolina experiences one of the highest rates of pre-term birth in the nation at 10.8%.

Medicaid covers the cost of over half the births in the state.

The net cost of pre-term birth is ~$25,000 in SC.

Goal: Reduce negative child and maternal health outcomes for Medicaid beneficiaries while also using taxpayer $ for services that work.
What is Pay for Success (PFS)?

• Ties payment to achievement of desired/measurable outcomes.

• Gov’t contracts with a service provider to meet pre-determined outcomes, and pays success payments if outcomes are met based on rigorous evaluation.

• Investors --in SC case foundations-- provide upfront capital for project and are reinvested in future NFP services if the services are successful.

• SC used PFS in an effort to measurably improve the health and well-being of newborns and first-time mothers in South Carolina through early childhood home visiting services.
Service Provider: Nurse-Family Partnership

Families Served: 3,200 Medicaid-eligible mom/child pairings over 4 years (plus 800 funded by MIECHV)

Sites: 9 implementing agencies serve 26 counties

Services: Nurse home visiting from 28 weeks gestation until the child’s second birthday.

Eligibility:
- Medicaid eligible, First-time mothers
- 28 weeks gestation or less

1915(b) waiver: Allows NFP to bill SCDHHS for half the cost of the home visit in real time
• Project evaluation will assess NFP’s impact based on the following 4 outcome metrics.
  • Reduce preterm birth
  • Increase healthy birth intervals/birth spacing
  • Reduce ER visits due to child injury
  • Enroll 65% of moms from low-income zip codes

• SCDHHS will make up to $7.5M in success payments depending on NFP’s performance on each metric.
• December 2015: 1915b waiver from CMS approved
• December 2015: Contract signed with SCDHHS and NFP
• January – March 2016: 3-month pilot to test enrollment
• April 2016: Full service delivery launched
• Today: As of 10/25/16 we have enrolled 811 moms in the project
Questions and Discussion
Thank you!

Karen VanLandeghem
Senior Program Director
National Academy for State Health Policy
kvanlandeghem@nashp.org

Alex King
Research Analyst
National Academy for State Health Policy
aking@nashp.org