Using Medicaid to Finance Home Visiting Services:
A Checklist for State Decision Makers

States have been using Medicaid to finance home visiting for more than 20 years. Currently, more than a dozen states are financing a portion of home visiting services to pregnant women, infants, and young children with Medicaid federal-state funds. A variety of approaches, benefit categories, and mechanisms are being used. (For examples of how states use Medicaid, visit: http://www.nashp.org/sites/default/files/medicaid.financing.home_.visiting.programs_0.pdf). Notably, home visiting services are distinguished from other services such as those provided in home under the Part C Early Intervention Program for Infants and Toddlers with Disabilities, which also may be financed in part by Medicaid.

States use Medicaid to finance home visiting services for three primary reasons. First and foremost, a large majority of families who voluntarily participate in home visiting programs are eligible for and enrolled in Medicaid. Second, many states have long used general revenue funds to finance home visiting, which can be used to "match" federal Medicaid dollars. The third reason is the potential for home visiting to improve child health and other family outcomes, thus reducing Medicaid costs.

Since enactment of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, grants to states, tribal organizations, and non-profit organizations have provided funding to support evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. In Fiscal Year 2015, more than three-quarters (77%) of families participating in the Federal Home Visiting Program had family incomes at or below poverty, and 46% had incomes at or below half of the federal poverty level. (For more information on the Federal Home Visiting Program visit: http://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview).

In March 2, 2016, the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) issued a

Joint Informational Bulletin regarding "Coverage of Maternal, Infant, and Early Childhood Home Visiting Services." The Joint Informational Bulletin was intended to inform and assist states in designing a Medicaid approach and benefits package to finance home visiting services for pregnant women and families with young children. (To download the Bulletin, visit: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf).

The Joint Informational Bulletin specifically says:

"While there is no single dedicated funding source available for home visiting services, federal funding streams can be paired with state and local funds to support a full package of services for pregnant women, families, infants, and young children. States select and implement different home visiting models that may include services eligible for Medicaid coverage..." (page 4)

"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." (page 5)

"…state agencies should work together to develop an appropriate package of services... may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs." (page 10)

This document is based on the work of the Medicaid and Home Visiting Learning Network convened in 2016. The project was designed to provide a forum for peer-to-peer learning among state teams regarding ways to use Medicaid to finance home visiting services for mothers and young children. The network engaged teams from 11 states (see map below), including more than 80 state leaders, in web-based discussions. Collaborative thinking helped states learn from one another about ways to maximize: Medicaid benefit design, state plan amendments, quality improvement, managed care contracting, provider qualifications, and data systems.

Generally, the content for the online meetings was guided by states' questions and need for information. The discussions led to a set of key questions that can be used by any state to consider whether or not they will seek to use Medicaid to finance home visiting, and if so, what mechanisms, policies, and infrastructure are needed to maximize Medicaid as one among other federal, state, public, and private sources of funding for home visiting. Those questions are provided here in the form of a checklist for state decision makers to use as a guide.

Medicaid and Home Visiting Learning Network Participating States

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Medicaid Approach / Authority

❁ What general approach looks promising? For example, does the state want to use general authority, or a waiver?

❁ Does your state have an existing authority under the current state plan that has been approved but not implemented?

❁ What process might be used to design a state plan amendment (SPA) if needed to create the authority to finance home visiting? To develop a waiver proposal?

❁ What available dollars qualify to be used as match to draw down federal financial participation (e.g., state general revenue)? Note that no federal funds such as MIECHV or Title V Maternal and Child Health Block Grant funds may be used.

❁ What levers—such as a waiver demonstration project—might be used to contain program size and costs (e.g., limits on population, geographic areas)?

❁ Is legislative authority needed?

❁ What is structure of relationship between Medicaid and the state home visiting program office (accountability to whom, for what)?

In addition, if a waiver or anther method such as targeted case management is not going to be used, the Joint Informational Bulletin affirms that:

"In creating a home visiting program using state plan authority, states should consider the following requirements:

Comparability: A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees. For example, if a state wants to provide home visiting services to address the needs of pregnant women, it would have to make the same services available to all pregnant women who need the services.

Freedom of choice: Medicaid beneficiaries must be permitted to choose a health care provider from any qualified provider who undertakes to provide the services (for example, nurses who are enrolled

as providers in the Medicaid program and visit beneficiaries' homes to provide covered services).

State-wideness: Services provided under the state plan must be available statewide to all eligible individuals." (page 6)

Medicaid Benefits Categories

❁ What Medicaid benefits categories fit with the models, providers, and home visiting system in your state? (See the CMS-HRSA Joint Informational Bulletin for a list of options.)

❁ Are case management/administrative services or a direct medical care services a better approach for your state?

❁ Does the state have an existing case management or targeted case management program that might be used as basis for developing a home visiting finance approach (e.g., enhancement to prenatal case management)? 42 CFR 440.169 and 42 CFR 441.18

❁ Can the state make effective use of the Early, and Periodic Screening, Diagnostic and Treatment (EPSDT) comprehensive benefit for children to finance home visiting? EPSDT permits states to target services to children, including those provided in the home. It also permits preventive and, as needed, interperiodic visits. (To learn more about EPSDT visit: https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf).

❁ In your state, do most new mothers in Medicaid lose coverage at 60 days postpartum (after birth)?

❁ Does your state cover preventive services for adults? 42 CFR 440.130(c) Note that as of January 1, 2014, preventive services may be furnished by non-licensed practitioners who meet qualifications set by the state.

❁ Which extended pregnancy-related services are covered by Medicaid in your state? 42 CFR 440.250(p)

❁ Does your state use "two-generation" strategies such as coverage for maternal depression screening under a child's Medicaid number?

Provider Structures and Qualifications

❁ Who might be the Medicaid provider (i.e., be a Medicaid enrolled provider who can bill for services)?

❁ What are the number, types, and distribution of home visiting providers/agencies?

❁ What are the qualifications for home visiting programs supported by MIECHV, state general funds, or Medicaid? Does the state require approval for specific types of financing?

❁ In terms of Medicaid, will your state choose to qualify providers based on their funding, research, or participants' status? For example:

- All home visiting models and programs serving Medicaid recipient families;
- Only evidence-based home visiting models (EBHV) or only EBHV funded by state under the MIECHV program;
- EBHV, evidence-informed, and promising practices; or
- All home visiting models and programs meeting state defined standards or with plans submitted to/approved by state

(To learn more about EBHV, visit: http://homvee.acf.hhs.gov/).

Payment approach

❁ What payment approach will fit with the Medicaid design, home visiting providers, and home visiting system in your state?

❁ How will funds from the Federal Home Visiting Program (MIECHV) be kept separate from Medicaid financing?

❁ Will you use a fee-for-service or capitated payment approach? A capitated approach can be used inside or outside of a managed care arrangement.

❁ How will Medicaid payments be set? Rate setting considerations:

- Specific to each model or uniform across models?
- Whole visits or units of time?
- What share of cost? Will some costs be excluded (e.g., data collection, staff training)?

Medicaid Managed Care

The Joint Informational Bulletin specifically says: *"…states may deliver Medicaid-covered services through managed care plans. States must continue to assure access to the full set of state plan services, including EPSDT... Contracts providing for capitation rates are subject to CMS approval, capitation rates must be actuarially sound, and network adequacy is reviewed."*

❁ What is the number and geographic distribution of managed care organizations or accountable care organizations (MCO/ACO)?

❁ What is the process for developing strong and effective home visiting contract provisions between the state and MCO/ACO?

❁ Will current payment/capitation rates for MCO/ACO be adjusted?

❁ How will the state ensure the adequacy and appropriateness of the home visiting provider network? What provisions in the contract will encourage or require use of existing qualified providers in the state home visiting system?

❁ What home visiting quality improvement, data, consumer protections, and other mechanisms for accountability will be in contract?

❁ How will contract define relationships with public agencies vis-à-vis home visiting?

Measurement within Medicaid

❁ Who is responsible for collecting Medicaid data related to home visiting?

❁ Will the state be able to track home visiting services with Medicaid claims data? Can fiscal, utilization, and outcome data be tracked?

❁ How can Medicaid claims data be linked to home visiting, vital statistics, or child welfare data?

❁ What is required in Medicaid contracts with MCO/ACO regarding home visiting data, quality, and performance?

❁ What is the role of Medicaid in standardized home visiting reporting?

Measurement in a Home Visiting System

❁ Who is responsible for data collection under the Federal Home Visiting Program (MIECHV)?

❁ Does the state have legislatively mandated reports on home visiting? Will Medicaid data related to home visiting be available for such reports?

❁ Has a standardized, common outcomes/ measurement framework for home visiting been adopted? If so, how will Medicaid be accountable?

❁ What Medicaid data will be available for home visiting evaluations (e.g., utilization and outcomes)?

❁ Does the state have a "cross-walked" version of MIECHV, Medicaid/CHIP, and larger home visiting system measures?