



# Medicaid and Home Visiting

Presentation by

Kay Johnson

Johnson Group Consulting, Inc.

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# PROJECT OVERVIEW

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# 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 a grant to support participation of an expanded number of states and state team members.

## ❖ Appreciation for the contributions of more than 80 state leaders in teams who participated in this learning network.

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



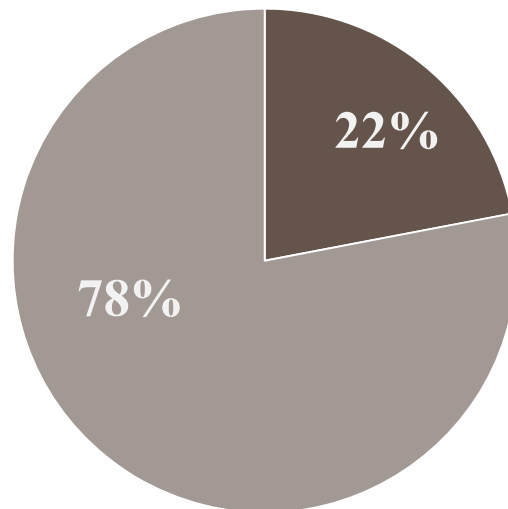
# Medicaid and Home Visiting Learning Network Participating States



# Network states represent nearly quarter of MIECHV visits and families served in FFY15

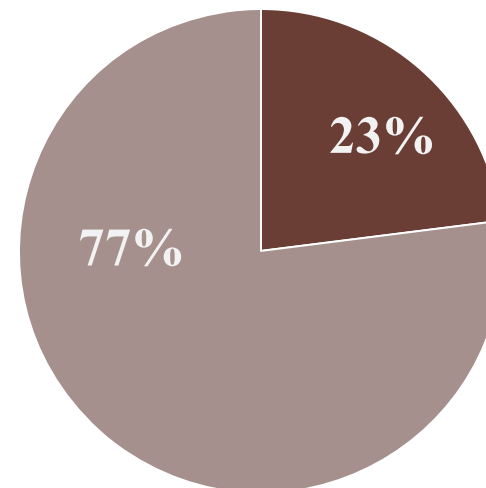
**Number of MIECHV-funded families visited as percent of US total**

- Families in network states
- Families served in other states



**Number of MIECHV-funded home visits as percent of US total**

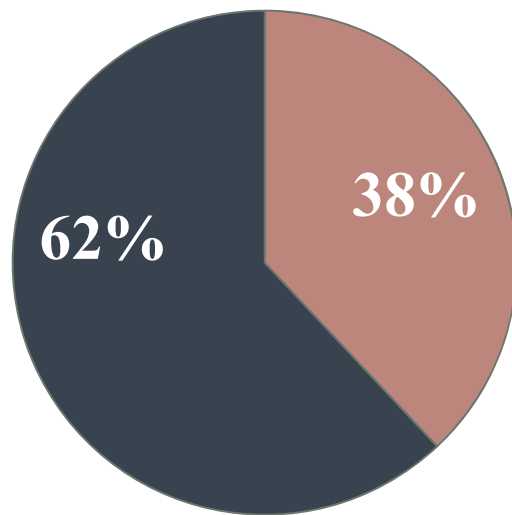
- MIECHV home visits in network states
- MIECHV home visits in other states



## Network states represent nearly 1 in 4 children enrolled in Medicaid/CHIP in January 2016

**Number of MIECHV-funded families visited as percent of US total**

- Children in network states
- Children in other states



In Learning Network states:

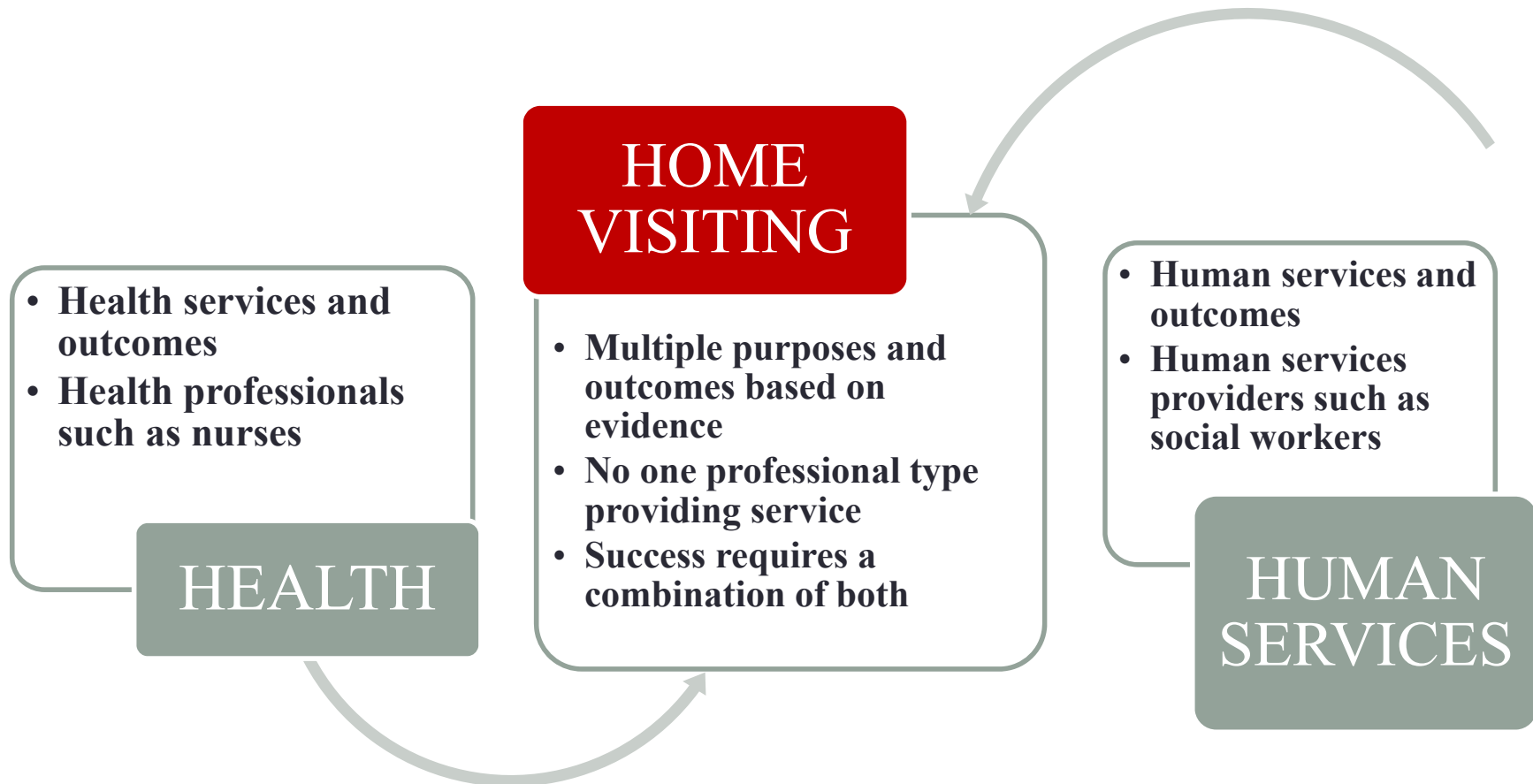
- Children represent 37% to 74% of Medicaid/CHIP enrolled population.
- Medicaid finances 42% to 60% of births.



# BASICS OF MEDICAID AND HOME VISITING



# Home visiting is at the intersection of health and human services.



## Medicaid and Home Visiting

- ❖ States using Medicaid to finance HV for more than 20 years.
- ❖ Medicaid funds both evidence-based models and hybrid/home-grown programs.
- ❖ A variety of approaches and mechanisms.
- ❖ Most families in HV eligible for Medicaid.
- ❖ HV distinct from in-home services.



## CMS-HRSA Informational Bulletin 2016

“States select and implement different home visiting models that may include services eligible for Medicaid coverage...”

“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... may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs.”

<https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf>



## The Three E's in Medicaid

- ❖ Eligible services for
- ❖ Eligible women and children delivered by
- ❖ Eligible providers



# Prime Medicaid Benefit Categories

- ❖ **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for children.**
- ❖ **Administrative and targeted case management.**
- ❖ **Extended “pregnancy-related” services.**
- ❖ **Preventive services for adults.**



# Key Medical Assistance Categories

Approach	Authority	Population	Services	Match rate
<b>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)</b>	Existing authority, mandatory	Children birth to 21 (would include teen parents)	Comprehensive set of screening, anticipatory guidance, diagnostic, and treatment services.	Standard FMAP
<b>Enhanced prenatal/pregnancy-related benefits</b>	Existing authority, optional	Pregnant women and mothers 60 days postpartum	<ul style="list-style-type: none"> <li>Broad set of pregnancy related services</li> <li>HV may be distinct from prenatal case management</li> </ul>	Standard FMAP
<b>Preventive services for women/adults</b>	Existing authority, optional	Women and men	State determined, may choose recommended by USPSTF and IOM	Standard FMAP

Adapted from: National Academy for State Health Policy. *Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities, and Challenges*. 2012.

## Key Administrative Service Categories

Approach	Authority	Population	Providers/Services	Match rate
<b>Targeted case management*</b> (* <i>technically medical assistance</i> )	Requires state plan amendment (SPA)	Permits targeting to select women, infants, & children	May limit providers; four core service components	Standard FMAP
<b>Administrative case management</b>	Existing authority	Pregnant women, mothers, infants, & children	May limit providers; only administrative services	50/50 match
<b>EPSDT administrative services</b>	Existing authority, for some states SPA	Pregnant women and mothers 60 days postpartum	A specific area of administrative case management	50/50 match
<b>Skilled medical personnel</b>	Existing authority, for some states SPA	Pregnant women, mothers, infants, & children ( <i>and eligible fathers</i> )	Requires skilled medical personnel in activities that require their skills.	75% enhanced FMAP

Adapted from: National Academy for State Health Policy. *Medicaid Financing of Early Childhood Home Visiting Programs: Options, Opportunities, and Challenges*. 2012.

## EPSDT Benefit

- ❖ EPSDT sets broad authority to finance a range of screening, diagnostic, and treatment services.
- ❖ In HV context, EPSDT encompasses:
  - screening, health education and anticipatory guidance,
  - case management, and
  - any medically necessary type of medical assistance service determined to be medically necessary.
- ❖ CMS-HRSA identified core HV services
  - 1) screening; 2) case management; and 3) family support, counseling, and skills training



## Provider / model standards

- ❖ For Medicaid, states might choose to qualify:
  - All models/programs serving Medicaid recipient families.
  - Only evidence-based home visiting (EBHV) or only EBHV funded by state MIECHV program.
  - EBHV, evidence-informed, and promising practices.
  - Models/programs meeting state defined standards or with plans submitted to/approved by state.

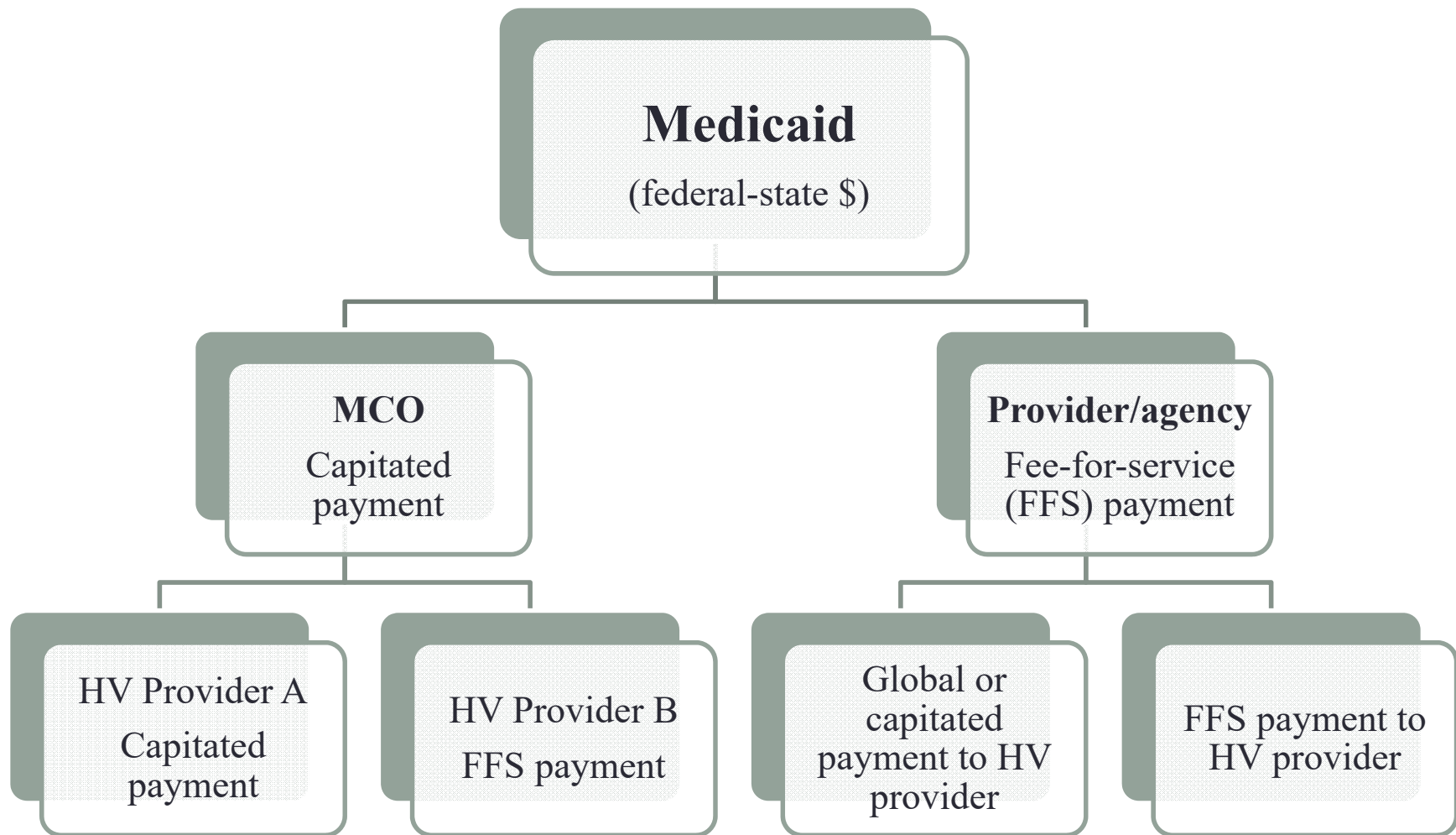


## Payment approach

- ❖ Fee-for-service or capitated?
- ❖ Rate setting considerations
  - What share of cost?
  - Specific to model or uniform?
  - Whole visit or increments?
  - What will be excluded (e.g., data collection, staff training)?



# Payment Structures



## Managed care

- ❖ Most Medicaid recipient mothers and children are in managed care arrangements.
- ❖ HV may be in or out of managed care organizations (MCOs).
- ❖ If HV in managed care, strong and clear contract specifications are essential.



## CMS-HRSA Bulletin re Managed Care

“...states may deliver Medicaid-covered services through managed care plans.... must continue to assure access to the full set of state plan services, including EPSDT... Contracts... are subject to CMS approval, capitation rates must be actuarially sound, and network adequacy is reviewed.”

<https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf>



# Medicaid Managed Care Contracting

- Delineate which Medicaid-covered services are the contractor's responsibility and which remain the residual responsibility of state agency
- Define standards related to the voluntary nature of home visiting, family eligibility, models/programs, or provider subcontracts;
- Require that MCOs include existing home visiting programs in their provider networks;
- Address the legal and structural issues in relationship between the managed care service system and home visiting system;
- Specify data to be collected for home visits and families served, as well as public health and MIECHV agencies' access to data;
- Delineate applicable and expected outcomes; and
- Fiscal arrangements.



# KEY CONSIDERATIONS FOR STATES

BASED ON NETWORK MEETINGS



## Key Considerations in Defining Medicaid Approach / Authority



- Use existing authority under the current state plan.
- Develop state plan amendment (SPA) or waiver application.
- Identify dollars to use as match.
- Use levers to contain program and costs (e.g., limits on population, geographic areas).
- Seek legislative authority when necessary.



## Key Considerations in Selecting Medicaid Benefit Categories



- Review *CMS-HRSA Joint Informational Bulletin*.
- Determine fit of benefits with state HV models, providers, and system.
- Choose administrative services or medical assistance.
- Use existing case management.
- Maximize EPSDT.
- Consider mothers losing Medicaid at 60 days postpartum.



## Key Considerations for Provider Structures and Qualifications



- Assess number, type, and distribution of HV providers.
- Set qualifications for HV programs supported by MIECHV, state general funds, or Medicaid.
- Consider Medicaid status of HV providers.
- Set provider payment rates.
- Define relationship between Medicaid and state HV office.



## Key Considerations for Medicaid Managed Care



- Consider number and distribution of MCOs.
- Modify contracts between state and MCOs.
- Revise payment/capitation rate.
- Assure HV provider network adequacy and appropriateness.
- Define relationships with public agencies involved in HV.
- Specify QI, data, consumer rights protections, etc.



## Key Measurement Considerations for Medicaid



- Collect HV fiscal, utilization, and outcomes data in Medicaid.
- Link Medicaid claims data to HV, vital statistics, or other data.
- Specify MCO duties regarding HV data, quality, and performance.
- Define role of Medicaid in standardized HV reporting.
- For HV evaluations, use data on Medicaid utilization and outcomes.



## Key Measurement Considerations for State Home Visiting Systems



- Build upon standardized, common outcomes/measurement framework for HV.
- Use a “cross-walked” version of MIECHV, Medicaid/CHIP, and larger HV system measures.
- Align MIECHV and Medicaid data collection and reporting.
- Complete cohort for legislatively mandated reports on HV.



# STATE EXAMPLES



# BUILDING ON WHAT YOU HAVE

❖ Michigan used maternal and infant case management to build a strong, population-based home visiting program in Medicaid.

- Available to all pregnant women in Medicaid
- Coordination agreement with MCOs

❖ Maternal Infant Health Program (MIHP)

- Improves utilization of prenatal care and well-baby visits; and
- Reduces risk for adverse birth outcomes, particularly among Black women.

<http://www.michigan.gov/mihp/>

[http://www.michigan.gov/documents/mihp/2014\\_HOME\\_VISITING\\_INITIATIVE\\_REPORT  
- State of Michigan 489446\\_7.pdf](http://www.michigan.gov/documents/mihp/2014_HOME_VISITING_INITIATIVE_REPORT_-_State_of_Michigan_489446_7.pdf)



# MAXIMIZING BENEFITS DESIGN

- ❖ By 1998, Oklahoma HV in all 77 counties under agreement between Health and Medicaid.
- ❖ Oklahoma has learned from experience and used more than one benefit over time.
  - Transition from Targeted Case Management (TCM) only to Nursing Assessment & TCM in 2008
- ❖ Today >100 registered nurses who meet HV training requirements are certified by OSDH
- ❖ Medicaid is roughly 15-20% of funding for Children First (NFP).



# MANAGING IN MANAGED CARE

- ❖ Minnesota Department of Health shares responsibility with 49 community health boards for delivering multiple HV models.
  - HV is not required in Medicaid managed care, but all MCOs added.
  - Locals have independent provider contracts with one or more MCOs to deliver home visiting services.
- ❖ Complexity of this approach led to:
  - Burden on MCOs and local health agencies
  - Uneven rates, inconsistent data, and unclear outcomes
- ❖ State leaders working on redesign

<http://www.health.state.mn.us/fhv/>



# USING CAPITATION OUTSIDE MANAGED CARE

- ❖ Vermont uses global waiver demonstration authority to advance prevention strategies, including HV as part of a package of early childhood / family services.
  - Capped capitation offered flexibility but not adjusted for increased caseloads or costs
- ❖ State agencies now exploring ways to expand use of Medicaid funding for other models.

[http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs\\_assets/2012/vermontcasestudy.pdf](http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2012/vermontcasestudy.pdf)

[http://healthvermont.gov/reg/documents/home\\_visiting\\_rule.pdf](http://healthvermont.gov/reg/documents/home_visiting_rule.pdf)



# USING A DEMONSTRATION WAIVER

- ❖ Maryland proposed using Medicaid waiver demonstration authority for a HV project.
- ❖ *A good place to begin...* waiver affords opportunity to test and evaluate:
  - costs and savings,
  - performance and outcomes,
  - provider networks,
  - family engagement, and
  - measures.



## BUILDING AN EVIDENCE-BASED PROGRAM

❖ Kentucky developed its own statewide home visiting model: Health Access Nurturing Development Services (HANDS) Program now recognized by HOMVEE as evidence-based.

❖ Uses Medicaid targeted case management (TCM) benefit, with structure explicitly in program regulations.

- <http://www.kyhands.com/>



## TRANSFORM & INTEGRATE SYSTEMS

Local empowerment  
(flexibility)

+

Outcomes  
accountability



- Oregon leading in integration & transformation of health and early learning
- Coordinated Care Organizations
  - 16 statewide to integration of physical, mental, & dental health
- Early Learning Hubs
  - 16 statewide to coordinate local community early childhood sectors (including health, home visiting, and early learning)



# SPENDING SMARTER



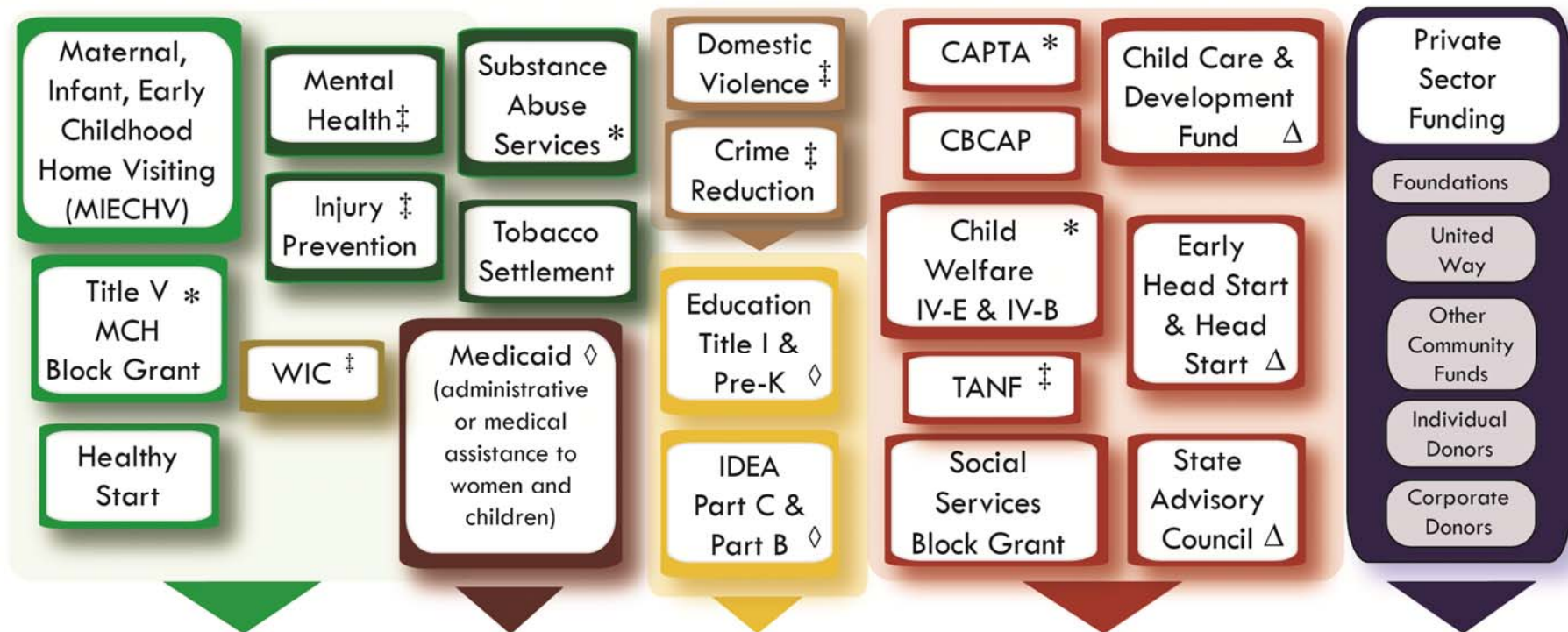
*Our work to promote maternal and child health, child development, and family well-being begins before birth, must be intensive 0-3.*

*It depends on adequate and sustainable financing.*



# Funding Streams to Support & Sustain Home Visiting

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## State General Revenue and Required State Matching Funds

plus state and local special funds (e.g., Children's Trust Fund, license plates)

Blend and braid funds, as allowable, to maximize resources.

Leverage federal dollars with state and local, public and private funds.

Develop administrative mechanisms to permit state and local flexibility.

Translate aggregate dollars into support for effective and efficient local service capacity.

Make investments and provide financing sufficient to support and sustain quality.

Include funds for R&D, QI, data systems, and evaluation.

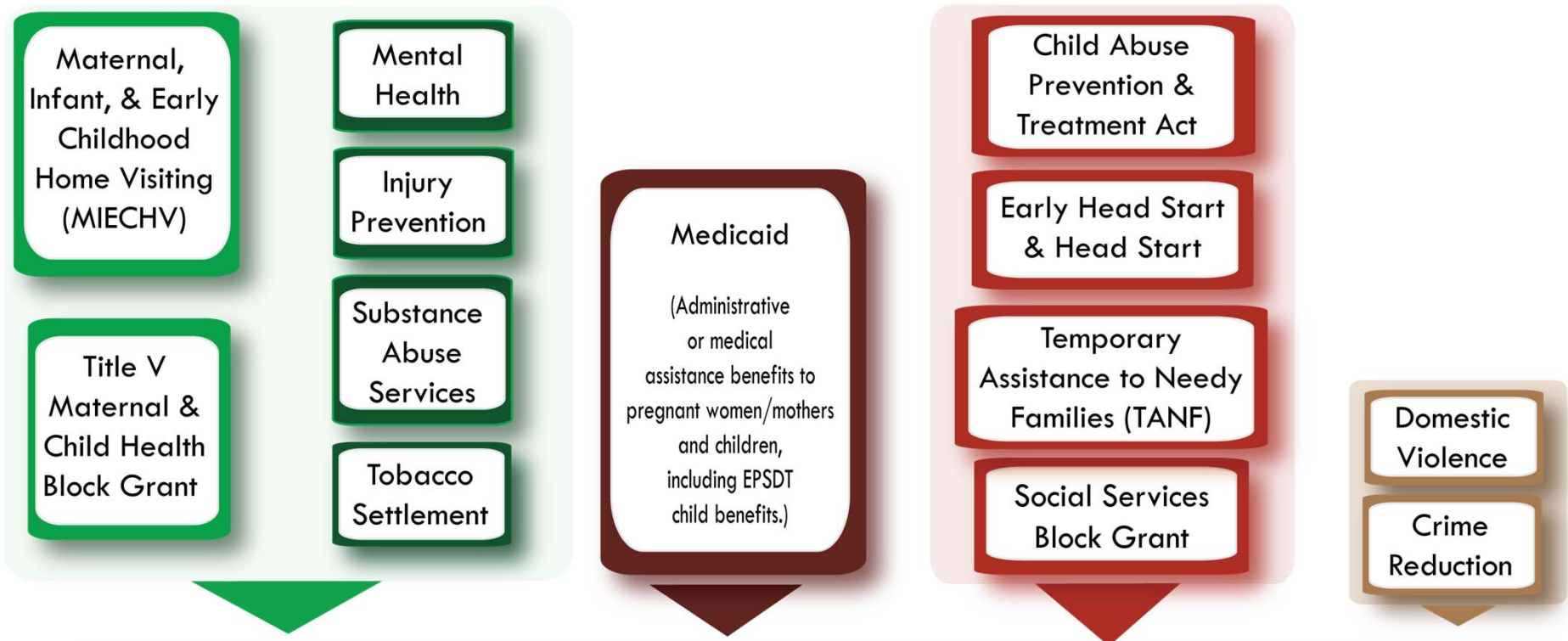
\* Memoranda of Concurrence required for MIECHV application.

Δ Memoranda of Concurrence for two of these required for MIECHV.

◇ Strongly urged to seek consensus for MIECHV from these entities.

‡ Encouraged to coordinate MIECHV application with these entities.

## Key Funding Streams to Support Home Visiting, 2015



### State General Revenue Appropriations and Required State Matching Funds

plus state and local special funds (e.g., Children's Trust Fund, license plates)

Blend and braid funds, as allowable, to maximize resources.

Leverage federal dollars with state and local, public and private funds.

Develop administrative mechanisms to permit state and local flexibility with accountability.

Translate aggregate dollars into support for effective and efficient local service capacity.

Provide financing sufficient to support and sustain quality.

Include funds for R&D, QI, data systems, and evaluation.



## Spending Smarter

- ❖ Maximize federal funding streams.
- ❖ Leverage, blend, and braid funds.
- ❖ Secure private sector funds.
- ❖ Use flexible funds to fill gaps.
- ❖ Focus on efficiency and effectiveness.
- ❖ Pay for high quality, appropriate services.



## Take Away Messages for Action

- ❖ Adequate financing for HV will depend on multiple funding sources.
- ❖ Securing future funding requires advocacy.
- ❖ Bipartisan support exists for HV.
  - States have the lead in Medicaid.
  - MIECHV has support beyond ACA.
  - HV successes of recent years must be conveyed to Trump Administration, new Congress, new governors, and state legislatures.



# Watch for:

- Project report
- Checklist for state decision-making
- Model managed care contract specifications
- More examples of state best practices.



# Thank you



# Additional Resources and References

(in chronological order)

- ❖ *No Place Like Home*. (Johnson, Commonwealth Fund)  
[http://www.commonwealthfund.org/usr\\_doc/johnson\\_home\\_452.pdf](http://www.commonwealthfund.org/usr_doc/johnson_home_452.pdf)
- ❖ *State-based Home Visiting*. (Johnson, National Center for Children in Poverty) [http://www.nccp.org/publications/pdf/text\\_862.pdf](http://www.nccp.org/publications/pdf/text_862.pdf)
- ❖ *Home Visiting Model Policy Framework*. (Pew Charitable Trusts)  
[http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs\\_assets/2011/homevisitingmodelpolicyframeworkpdf.pdf?la=en](http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2011/homevisitingmodelpolicyframeworkpdf.pdf?la=en)
- ❖ *Medicaid Financing and Home Visiting*. (Witgert et al. Pew Charitable Trusts & National Academy for State Health Policy)  
[http://www.nashp.org/sites/default/files/medicaid.financing.home\\_visiting.programs\\_0.pdf](http://www.nashp.org/sites/default/files/medicaid.financing.home_visiting.programs_0.pdf)
- ❖ *CMS-HRSA Informational Bulletin*.  
<https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf>

