Public Insurance Financing of Home Visiting Services: Insights from a Federal/State Discussion

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Introduction

Home visiting is a long-standing strategy that states use to improve the health and well-being of women, children, and their families, particularly those living in underserved and vulnerable communities. Home visits are often provided to families to deliver social, health, and educational services and can play an important role in addressing health needs throughout the life course. Home visiting programs can include screenings for physical, social-emotional, and developmental issues, case management, and family support and counseling. Services can also include promotion of well child visits and immunizations, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, prenatal and postpartum care, and education about healthy nutrition and physical activity.

They have been shown to increase important services, such as:

- Screening caregivers for depression and intimate partner violence;
- Improving school readiness for children; and
- Improving coordination and referrals to community resources.[1]

Home visiting programs have demonstrated cost savings in several areas, including reducing unnecessary health service utilization through a decrease in emergency room visits and decreased placement in special education services and grade repetitions.[2] One of the largest benefits from home visiting is decreasing a family's need for public assistance.[3] Home visiting is a cost effective way to address social determinants of health and a way to support health care providers by ensuring that the diverse needs of families can be addressed and met outside of clinical care settings.

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program was established in March 2010. The federal program, administered by the Health Resources and Services Administration (HRSA), supports evidence-based, voluntary home visiting services for families with young children that reside in communities at risk for poor health outcomes.[4] In 2019, the program awarded approximately $351 million to 56 states, territories, and nonprofit organizations to support home visiting services, serving over 154,000 parents and children, and providing more than 1 million home visits nationwide.[5] While MIECHV is a critical federal program for states, the need for home visiting services far exceeds federal MIECHV funding to states. Approximately 18 million pregnant women and families could have benefited from home visiting services but were not served, according to 2018 data.[6]

Financing of home visiting services is a key factor in the availability of and access to home visiting services. States finance home visiting services through multiple federal and state funding streams in addition to MIECHV. These funding streams include Medicaid and the Children's Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), the state

Title V Maternal and Child Health (MCH) Services Block Grant, state general revenue funds, and private foundation support. Medicaid and CHIP can play a key role in supporting home visiting services. In 2019, nearly three-quarters (76 percent) of participants in the MIECHV program were enrolled in Medicaid.[7] Recognizing this important role, the Centers for Medicare & Medicaid Services (CMS) and HRSA issued a Joint Informational Bulletin in 2016 containing guidance to states on federal authorities, opportunities, and strategies for supporting home visiting services through Medicaid and the Children's Health Insurance Program (CHIP).[8]

The National Academy for State Health Policy (NASHP), with support from the HRSA Maternal and Child Health Bureau (MCHB), hosted a meeting in January 2020 of state and federal leaders in Medicaid, public health, and home visiting to discuss key opportunities, challenges, and innovative approaches to enhancing public insurance financing of home visiting services. It is important to note that this meeting was held prior to the COVID-19 pandemic and states are now facing the ramifications of the pandemic, including reduced state budgets. Participants discussed strategies to enhance Medicaid and CHIP financing of home visiting services in states and strengthen state financing systems to support home visiting. The meeting provided an opportunity to collectively identify and discuss strategies for enhancing federal and state financing of home visiting programs. This document summarizes the key themes that were discussed at this meeting, and reflects discussion among state officials who participated in the meeting about the critical policy levers, state strategies, and key considerations for enhancing efforts in this area.

State Policy Opportunities to Increase Use of Public Insurance Financing

States have long-standing programs and investments that support home visiting for women, children and their families. Public insurance financing is a key part of these efforts in many states. A recent national report found that approximately 20 states use Medicaid and CHIP to finance home visiting services.[9] Several policy questions persist concerning the use of public insurance financing and braiding the array of federal, state, and private funding options available to states

- Limited awareness about which elements of home visiting Medicaid and CHIP can reimburse for;
- Varying knowledge levels among home visiting stakeholders about how to navigate the Medicaid program;
- The administrative burden around tracking and reporting the impact of home visiting services on health outcomes;
- The need for integration and alignment among home visiting services and other child-serving systems; and
- The variability among states' policy, programmatic, and system considerations resulting in the need for tailored and targeted financing strategies.

State health leaders who participated in the federal/state meeting (see Appendix B) identified the following policy areas that need additional focus and support relating to public insurance financing of home visiting services.

How can states ensure that home visiting programs are fully funded, particularly given the looming fiscal crises, to meet the needs of all eligible families. This requires complex braiding of federal, state, and private funding streams. Home visiting programs provide an array of services and supports to pregnant women, infants, and children, not all of which are Medicaid- and CHIP-reimbursable. Therefore, home visiting programs must be supported by multiple federal and state funding streams. State health leaders expressed the need to ensure that the full array of services (e.g., health services, social supports, home visitor transportation, provider training) are provided through home visiting programs, while leveraging financing of those services that can be covered by Medicaid and CHIP.

Limited awareness about public insurance financing options and the use of federal authorities in Medicaid and CHIP can hinder the use of these options in states. State Medicaid, MIECHV, and Title V MCH programs, and other stakeholders that administer home visiting services expressed the need for additional information and technical assistance about public insurance financing options and how to use and leverage them in states. Home visiting is not a mandated benefit or fully defined set of services under the federal Medicaid program. States must leverage one or more categories of benefits (e.g., case management, preventive services, and home health services) in order to use federal Medicaid and CHIP funds for home visiting services.[10] To leverage them effectively requires an in-depth understanding of the financing options available under Medicaid and CHIP, knowing which services are reimbursable, and strong cross-sector partnerships among state Medicaid and public health programs.

Complexities in state Medicaid and managed care plan rate setting can lead to variability in reimbursement rates for home visiting services among states. Rate setting for Medicaid is a complex process that involves ensuring rates are actuarially sound based on economy, efficiency, and quality.[11] State Medicaid agencies set their own rates for services through an actuarial process that takes into account base utilization, medical trend inflation, and risk adjustment.[12,13] The actuarial process used to set Medicaid payment rates takes into account cost savings and the benefits of a service over a period of time. In the case of home visiting services, cost savings may not be realized until years after the service is delivered. Additionally, low usage of services can result in lower projected costs for the service, and therefore a lower baseline for the service when determining the overall capitation rate. Home visiting rates for select states underscore this variability – in Oregon, reimbursement is $355 per visit for home visiting delivered through targeted case management, in Minnesota public health nurses are able to bill $140 per visit, and in South Carolina, Medicaid reimburses $176 per visit.[14]

In addition to overall rate setting, state Medicaid agencies also must negotiate rates for home visiting services provided by managed care plans, in states that serve Medicaid beneficiaries through Medicaid managed care. Negotiating rates with managed care plans can be a challenge for several reasons. First, a wide range of services are provided in home visiting, making it difficult to establish a rate that fully covers all components of a home visit. Also, the benefits of home visiting services, like school readiness, reduced crime or domestic violence, and improved parent-child relationships,[15] may not be fully realized while a Medicaid beneficiary is a member of the Medicaid managed care plan and Medicaid enrollees often transition on and off of coverage over time, resulting in a potential disincentive for health plans to invest in services.

Medicaid and CHIP reimbursement rates can impact the availability of home visitors. Because home visiting is not a discrete service, reimbursement rates may be lower than what is needed to cover a full home visit, which includes costs for transportation for the home visitors and assistance in accessing non-Medicaid related services. Reimbursement levels can hinder the ability of states and community-based organizations to hire and retain professionals (e.g., public health nurses and other health and social service professionals) who deliver home visiting services. In a national survey of home visiting program managers, low salary was the most common reason (51 percent) for staff turnover.[16] Home visitor workforce shortages can lead to an inability for programs to fully reach and support the large population of families that need and can benefit from services.

Navigating state Medicaid billing policies and billing codes when providing services using a two- generation approach requires dedicated staff time. Home visiting programs are intentionally designed using a two-generation approach – a model that promotes caring for the mother and child together as one unit. In this case, determining correct codes for billing can be complicated and also depend on state Medicaid policy for Medicaid reimbursement of two-generation services. Federal guidance allows states to reimburse for services to a Medicaid-eligible mother or a Medicaid-eligible child for services that actively involve the child, are directly related to the needs of the child and such services must be delivered to the child and mother together, but can be claimed as a direct service for the child.[17] Given the different funding streams used to support services, administrators need to know what types of providers can be reimbursed by which funding streams (e.g., Medicaid or MIECHV) and the appropriate billing codes and procedures for all of the different services that home visitors provide.

Rules governing qualified provider requirements in Medicaid state plan amendments can limit which home visitors are reimbursed. Evidence-based home visiting models vary in their requirements for who qualifies as a home visitor.[18] Some programs require that nurses conduct a home visit, while other programs promote the use of community health workers or other trained staff. Federal Medicaid law[19] allows states to set reasonable standards relating to qualifications of providers under Medicaid.[20] Depending on the benefit, services can be provided by unlicensed practitioners who meet qualifications established by a state. Such benefits include the case management benefit, preventive services, and rehabilitative services benefit. Examples of reasonable standards states must set for providers include the ability to perform the service in a professionally competent manner and the infrastructure to bill.[21] State policies vary regarding terms for qualified providers for home visiting. Some states set the qualified provider based on the home visiting model being used (e.g., nurse family partnership), while others may use local health departments or other community-based organizations that already have qualified providers to deliver services.[22] The types of providers a state deems to be an eligible qualified provider may not always include the provider who is the home visitor. Additionally, in most cases the qualified provider rendering the home visiting service is not the same as the qualified *billing* provider (e.g., a physician, local implementing agency, or health department), which can add another layer of complexity to Medicaid reimbursement.

Navigating federal Medicaid authorities such as waiver requirements can impact the use of some Medicaid strategies. Federal Medicaid Section 1115 demonstration project authorities provide states with additional flexibility to design policy initiatives and programs that improve

health care for Medicaid beneficiaries. The federal Section 1115 Medicaid waiver, for example, is a research demonstration waiver that is approved for an initial five-year period, and can be extended for up to an additional three to five years depending on the populations served.[23] A few states (e.g., Maryland and Vermont) have used Section 1115 waivers to support home visiting through Medicaid.[24] However, states at the meeting discussed that due to the intricacies of the federal waiver process this strategy is not commonly used to support home visiting services. One factor may be that states are required to demonstrate budget neutrality over the life of the demonstration project, usually lasting just a few years. While some home visiting outcomes, like those for pregnant women and newborns, may be more immediate, other health outcomes may not be evident until several years after the service is provided. Because of this states can experience challenges in demonstrating cost savings to continue to use Medicaid dollars through the 1115 demonstration waiver.[25]

Lack of alignment across federal and state data reporting requirements adds to complexities in demonstrating the impact of home visiting programs. States must submit separate federal program reports for different performance measures and indicators across the programs that support home visiting, creating challenges for state performance reporting. States often have to implement planning processes and dedicate resources to integrate home visiting efforts, create data tracking and reporting systems that align measures across an array of programs, and ultimately, build a statewide integrated home visiting program from multiple federal and state funding sources. These challenges are compounded by a lack of staff capacity to report on data, inadequate state reporting systems, and lack of comparability of data and reporting measures across federal programs including Medicaid and CHIP. Most states have few-to-no home visiting data tracking and reporting systems that fully capture home visiting data and thus, ease the reporting process as it relates to home visiting.

Financing Strategies and Innovations to Address Key Opportunities

State Medicaid, public health, and MIECHV officials who participated in the federal/state discourse meeting agreed that while there are policy areas in need of further support and focus, public insurance financing of home visiting provides important opportunities to increase the ability of states to provide critical home visiting services to MCH populations.

Participants described a range of public insurance financing strategies and innovations that they are using to support home visiting programs. These strategies include the use of:

- Medicaid-targeted case management;
- Medicaid managed care contracting processes;
- Federal Medicaid authorities (e.g., Section 1115 waivers);
- CHIP Health Services Initiatives (HSIs);
- Public/private partnerships, such as the Pay for Success model in South Carolina; and
- Value-based payment and bundling of home visiting services payments.

The state examples included below represent some of the leading innovations using public insurance financing and were reflected in the discussions and strategies highlighted during the meeting. These states – many of which were represented at the federal/state discourse meeting – took unique approaches to integrating public insurance into their financing of home visiting.

Because lessons learned from these models formed the basis of discussions at the meeting, summaries of these models and some of their more innovative elements are highlighted. Additional information about these models is included in Appendix C and also has been previously widely reported on by NASHP and others.

Targeted Case Management

The most common Medicaid mechanism for financing home visiting is targeted case management (TCM). TCM is a service under Medicaid that helps enrollees gain and coordinate access to necessary medical, social, and educational care and other services tailored to their needs.[26] TCM helps enrollees gain access to needed services, but cannot be used to provide the underlying needed services. Traditionally, one way states have used TCM for MCH populations is to increase use of prenatal care through maternal and infant case management programs.[27] Use of TCM requires submission of a state plan amendment to CMS for approval. At least 33 states currently use TCM to finance home visiting services for prenatal care as a Medicaid benefit, and at least 30 cover it as a postpartum Medicaid benefit.[28] TCM was outlined in the CMS and HRSA joint informational bulletin as a strategy states could use to promote public insurance financing. Additionally, using TCM can help address the challenge of navigating the federal Medicaid Section 1115 demonstration process by only requiring a state plan amendment.

- The **Kentucky Health Access Nurturing Development Services** (HANDS) program, administered by the Kentucky Department of Public Health, is a voluntary statewide home visiting program that serves Medicaid-eligible parents during the prenatal period through the child's third birthday. The program is supported by Medicaid through TCM and other state and federal funds. Kentucky uses state tobacco funds as the state match for federal Medicaid dollars. Services provided include health education, developmental and social-emotional screenings for children, domestic violence and perinatal depression screenings for parents/caregivers, and referral coordination.[29] Through coordinated efforts across state Medicaid and public health agencies, the program is delivered through local health departments using a fee-for-service payment model. Kentucky was able to leverage MIECHV funds to expand services beyond just first-time mothers.

Medicaid Managed Care Contracting

Nearly all states serve a majority of their Medicaid enrollees through Medicaid managed care (MMC) programs. As of 2017, 47 states and Washington, DC enrolled some of their Medicaid enrollees in Medicaid managed care plans.[30] The MMC contracting process presents opportunities for states to promote home visiting services for eligible pregnant women. State Medicaid programs contract with managed care plans to provide services and agree to a set per member per month payment for the services provided. Home visiting services can be included in the capitated payment rate in MMC. As more states transition Medicaid-eligible pregnant women to managed care, they are using MMC contracts to promote home visiting services.

- **Michigan's Maternal and Infant Health Program** (MIHP) is administered by the state Medicaid agency and is the largest home visiting program in the state. MIHP is available to all pregnant women enrolled in Medicaid and their infants up to 12 months. The program promotes healthy pregnancies and positive birth outcomes via a standardized,

system-wide process of case management.[31] The MIHP program is written into the Medicaid State Plan to allow Medicaid to fund the program. MIHP services have been rolled into the state's Medicaid managed care contracts and managed care organizations (MCOs) can contract with MIHP providers to provide services. MIHP services include social work, nursing services (e.g., health education and nutrition education), breastfeeding support, nutritional counseling, and beneficiary advocacy services.[32] Recently, MIHP was approved as a MIECHV evidence-based model.

- **Minnesota** includes home visiting as part of its capitated payment rate under its managed care contracts. The state has a long history of using Medicaid to finance home visiting services. Minnesota requires the managed care plans to contract with local health departments to administer voluntary, evidence-based home visiting programs to Medicaid enrollees. At least five additional states use managed care to finance home visiting. The state legislature set the rate at $140 per visit to help ensure the reimbursement rate was not too low. Two states (Illinois and New Mexico) are working to implement demonstration projects through their managed care plans.[33]
- In its biennium budget, **Virginia** Medicaid seeks federal authority through waivers and state plan amendments to implement a home visiting benefit for at-risk pregnant women and postpartum women at risk of poor health outcomes. The intention is for this benefit to be included as part of the state's managed care plans contracts allowing MCOs to contract with local providers for these services. At this time, funding for this process is unallotted due to COVID-19 and the Virginia General Assembly is expected to meet in a special legislative session to make a determination on this budget item. Early Impact Virginia officials, which is the alliance for early childhood home visiting programs, meets regularly with the Office of the Secretary of Health and Human Resources, the Office of the First Lady of Virginia, the Virginia Department of Health, Virginia Medicaid, and other relevant stakeholders to ensure in the development of the benefit and the potential for evidence-based models.

Federal Medicaid Section 1115 Demonstration Projects

Federal Medicaid waivers give states the flexibility to design home visiting services for Medicaid recipients. As previously mentioned, the Section 1115 demonstration project gives states additional flexibility to design and improve their programs by waiving certain provisions of federal Medicaid law. A few states have taken advantage of this federal Medicaid authority.

- **Maryland's Section 1115** demonstration project allows local government entities to apply for federal matching funds for Maryland's Home Visiting Services (HVS) Pilot. The HVS Pilot provides home visiting services for high-risk pregnant women and children up to two years of age. The HVS Pilot is aligned with two-evidence-based models – (Nurse Family Partnership and Healthy Families America) – that focus on the health of pregnant women. Local government entities can apply to the program if they are able to fund 50 percent of HVS Pilot costs with local dollars. Key community partners must be identified to help deliver the pilot program. Approximately $2.7 million in matching federal funds are available on an annual basis and the HVS Pilot expenditures can total up to $5.4 million annually. The pilot operates until Dec. 31, 2021.[34]

CHIP Health Services Initiatives
An emerging federal initiative to increase public insurance financing of home visiting are CHIP Health Service Initiatives (HSIs). CHIP HSIs have been available to states since shortly after the passage of CHIP in 1997 to support a range of child health services including home visiting. CHIP HSIs are intended to serve children under age 19 who are eligible for Medicaid or CHIP, but can be designed to improve the health of a broader population of children.[35] HSIs are funded by a combination of state and federal money. States draw federal funds from the their CHIP administrative allocation, which is 10 percent of its CHIP block grant. HSIs can focus on direct services, public health initiatives, or ongoing social, and behavioral health needs. State HSIs are subject to CMS approval through a state plan amendment and must include metrics to measure impact and outcomes of the program.

At the meeting, some state officials expressed interest in developing a home visiting HSI. However, officials raised concerns about ensuring that programs are able to provide the full scope of home visiting services and the challenges of working in coordination with additional payers. Because home visiting is not a discrete health care service, leaders raised considerations and challenges, similar to ones raised for Medicaid, about using a CHIP HSI to fully support home visiting services. At least four states have home visiting CHIP HSIs.

- **Arkansas's HSI – SafeCare** – focuses on delivering home visiting services to children at risk for placement in foster care. SafeCare is a structured, evidence-based, and in-home parenting program that has a home visitor and parent work together to create a safe home environment.[36] The home visitor assists the parent in providing structure and routines, while encouraging systematic health decision-making to keep children safe while in their homes. Parents are provided with useful tools, such as books, thermometers, childproof safety locks, and other learning materials to use in their natural family environment to keep children safe. The home visitor delivers weekly or biweekly home visits for approximately 18 to 22 weeks.[37]

Public/Private Partnerships
Some states have developed unique public/private partnerships to leverage home visiting to advance priorities for MCH populations. South Carolina wanted to improve birth outcomes and address infant mortality rates. State officials built a public/private partnership to further support the state's Nurse Family Partnership (NFP) home visiting program. During the discourse, state officials acknowledged needing significant incentives and political will from an array of state agencies, the legislature, and the private sector to create the Pay for Success (PFS) program. While the public/private partnership is an opportunity states are interested in exploring, there is a significant amount of administrative work to get this type of model off the ground.

- **South Carolina's Pay for Success** model relies on strong private-public partnerships. In the model, a private investor provides the upfront capital to implement an evidence-based social service program in collaboration with a government agency. The government repays the investor if the program meets the agreed-upon goal. South Carolina is currently using the PFS model in conjunction with Medicaid to expand the home visiting programs in the state. The PFS initiative focuses on improving health outcomes for

Medicaid-eligible mothers and children. In 2016, the South Carolina Department of Health and Human Services, which administers Medicaid and the PFS initiative, used a 1915(b) Medicaid waiver to support NFP's efforts.[38] The PFS initiative directed $30 million — $17 million from philanthropic funders and $13 million from Medicaid — to expand the NFP's evidence-based services to an additional 3,200 first-time, low-income mothers across the state. South Carolina used a 1915(b) waiver because it allowed NFP to bill in real time for the cost of home visiting services, expand home visiting services, and waive the freedom of choice of providers for the NFP program. The program focuses on four outcome metrics to assess NFP's impact:

- A reduction in preterm births;
- A reduction in child hospitalizations and emergency department usage due to injury;
- An increase in healthy spacing between births; and
- An increase in the number of first-time mothers served in areas with high concentrations of poverty.

The state made $7.5 million available for success payments based on NFP's performance on each metric.[39]

Value-based Payment and Bundling of Home Visiting Services

Value-based payment (VBP) models and bundled payments were discussed as an opportunity states could use to increase public insurance financing of home visiting services. State Medicaid agencies are turning to VBP models as part of health system reform. Moving away from the traditional fee-for-service model that is based on volume of care, VBP models reward providers for reaching specific goals around the quality of care while taking into account cost considerations.[40] VBP models have been implemented to help better serve MCH populations using benchmarks such as prenatal care initiation, postpartum care, and reduction in early elective delivery rates.[41]

Bundled payments represent a single payment to providers for all services given to treat a condition during a predefined episode of care.[42] For example, Medicaid agencies can use a bundled payment for labor and delivery services. Currently, few states are using VBP or bundled payments for home visiting. State leaders expressed interest in pursuing these policy levers but acknowledged they are newer strategies that need further exploration.

- **New York** used a Section 1115 demonstration to promote Medicaid financing of home visiting services. The Medicaid Redesign Team (MRT) demonstrations assisted in delivery system transformation in New York with its transition towards VBP. Part of the demonstration included delivery system reform incentive payments (DSRIP). DSRIP programs that incentivize infrastructure improvements, care delivery redesign, and improvements in the quality of care for low-income populations and assist states in developing the infrastructure necessary for successful transition to VBPs. New York provides incentive payments for meeting milestones on both system reform projects and outcome measures.[43] In addition to the DSRIP and VBP efforts, New York also pursued a First 1000 Days on Medicaid Initiative, in conjunction with the MRT waiver, aimed to

improve outcomes for a child's first three years of life. The initiative works across systems to improve outcomes for children on Medicaid. Statewide home visiting services are a key part of the initiative's action plan to address social determinants of health for children on Medicaid, and has since been incorporated through a separate Children's Design Home and Community-Based Services (HCBS)-focused program in its MRT demonstration. While expenditure authority for the DSRIP component of the MRT demonstration ended on March 31, 2020, expanded HCBS remains an active component of the MRT demonstration.[44]

Key Considerations and Next Steps

State leaders discussed several key considerations and opportunities to strengthen public insurance financing of home visiting services. In addition to the array of available Medicaid financing options, state leaders discussed the importance of taking advantage of federal authorities and initiatives, particularly CHIP HSIs, integrating home visiting into broader state health reform efforts, and aligning and coordinating home visiting efforts with new federal opportunities, such as reporting requirements for the CMS Child Core Set (i.e., Medicaid children's health care quality measures). They also identified opportunities for federal agencies to continue to support state public insurance financing of home visiting services.

Considerations for Federal Agencies

- **Provide ongoing education about home visiting program successes, technical assistance, and resources available to increase awareness and understanding among state Medicaid and CHIP, Title V MCH, and MIECHV program leaders and other key stakeholders about the array of federal Medicaid and CHIP authorities, policy levers, and strategies to support home visiting services.**
  One of the key challenges states and other key stakeholders identified was the need for ongoing education about state innovations and approaches to public insurance financing of home visiting services. While nearly half of states use Medicaid and CHIP to support home visiting services, ongoing education and technical assistance detailing what public insurance is available to cover home visiting and how to successfully braid public insurance with other federal, state and private financing streams could help states and key stakeholders develop strategies to maximize their home visiting programs. A deeper understanding of how to use Medicaid and CHIP to finance home visiting services could help states expand use of public insurance financing mechanisms.

- **Stress the importance of integrating home visiting services into existing programs and services for parenting and pregnant women, children and their families, and align financing strategies so they support a comprehensive system.**
  Service integration is a key factor in improving the health and well-being of MCH populations. States are using public insurance to finance as many different types of services (e.g., screening, case management, and education) as possible to support home visiting. Interagency partnerships and collaboration have been key to service integration. States work across agencies to ensure that a wide range of services are available to

Medicaid beneficiaries. Additionally, with multiple home visiting programs operating in states, streamlining enrollment applications for families is a priority. To promote service integration, states are moving towards health care models that treat both caregiver and child, and Medicaid agencies are beginning to develop financing strategies to support reimbursement of services in this area.[45] Home visiting programs provide an opportunity to develop financing strategies that support a two-generation model of care.

- **Ensure that financing of home visiting programs, including the use of Medicaid and CHIP, integrates evidence-based programming and practices, such as the two-generation approach.**
  Home visiting models use the two-generation approach and home visitors are meeting with and providing services for both mother and baby. This requires new funding considerations and outcome measurement strategies to support home visiting models. Providing education about how to finance and bill home visiting programs can help states strengthen home visiting services that target both caregivers and their children. Education detailing how to measure outcomes when a home visitor is meeting with the whole family may clarify questions that states have about best practices around data monitoring.

- **Coordinate home visiting measurement with the CMS Adult and Child Core set to foster alignment among public health and Medicaid performance and quality measures.**
  State participants identified coordinating data measurement as a key opportunity to help overcome some of the challenges around data collection and reporting, and to optimize new federal reporting requirements and opportunities under Medicaid. In particular, the Child and Adult Core sets are measures identified by CMS that have been shown to improve child and adult health outcomes. Starting in 2023, state Medicaid programs will be required to report on the measures set annually; currently reporting is voluntary.[46] These standardized measures present an opportunity for states, and in particular state Title V MCH program and MIECHV program leaders, to align their home visiting outcome measures with child and adult core measures under Medicaid. While there is no core measure for home visiting, the services provided may be represented by a measure in the core set. Alignment of these measures can help ensure home visiting services are considered as part of state child and adult health measure sets for Medicaid and identify the impact the programs have on health outcomes. Additionally, coordination with the Child Core set presents states with an opportunity to leverage integrated data systems that could help facilitate coordination of reporting to different agencies.

Considerations for States

- **Integrate public insurance financing as part of state health reform efforts in Medicaid and CHIP, including strategies to move towards value-based payment (VBP).**

State Medicaid health reform efforts are a key opportunity for states to maximize public insurance financing. Many state Medicaid agencies, like New York, are advancing VBP reforms providing an opportunity to use this strategy for public insurance financing of home visiting. At the meeting, state officials suggested considering bundled payment options for home visiting services. With an increase in VBP reforms and interest in alternative payment models, there is an opportunity for states to weave home visiting services into these broader health reform efforts. Because VBP and bundled payments are newer areas of focus for states, strategies, policy levers, and approaches for using these newer forms of payment and financing of home visiting services may be needed. In September of 2020, CMS released a letter to state Medicaid directors on Value-Based Care Opportunities in Medicaid detailing information on federal Medicaid regulatory authorities available to states and key considerations for states seeking to advance VBP, from level and scope of financial risk for payers and providers to assessment of delivery system readiness.[47] Additionally, the letter highlights various payment strategies states have used to advance value-based care like payment models built on fee-for-service architecture and episode-of-care payments. The letter presents additional opportunities for states to consider how to advance public insurance financing of home visiting as a part of value-based care efforts.

- **Incorporate public insurance financing of home visiting services as part of state efforts to build and improve comprehensive, integrated systems of programs and services for women, children, and their families.**
  In order to promote and increase the use of public insurance financing of home visiting, there is a clear need to strengthen infrastructure support for home visiting. Through universal enrollment forms, partnerships with public health agencies, and by taking advantage of federal authorities, states are taking steps to strengthen infrastructure to support systems-based approaches to financing of home visiting programs that reach as many women and families as possible. Using a systems-wide approach involves multiple agencies and health systems that align and embed home visiting programs as part of coordinated care. This approach can help ensure the longevity and success of these programs. Public insurance is a key opportunity for states to strengthen systems, like early childhood, that include their home visiting networks and increase public health capacity to address social determinants of health.

- **Promote cross-sector partnerships as a critical element of public insurance financing of home visiting.**
  States involved in the federal-state discourse meeting had strong public/private and cross-sector partnerships. When states are considering increasing or restructuring their use of public insurance to finance home visiting services, it is essential to have strong working relationships across agencies and teams and engage executive leadership to help promote coordination. A strong cross sector partnership between state Medicaid, Title V, and MIECHV officials is integral to successfully using public insurance to finance home visiting. States also identified the private sector as a helpful partner in building and sustaining home visiting services. Bringing different agencies together to work on public

insurance financing of home visiting services can strengthen overall systems and gain the political momentum to move the work forward.

- **Continue to advance financing strategies that promote the use of multiple federal and state financing streams, including Medicaid and CHIP, to support home visiting programs.**
  State participants underscored the importance of braiding different funding streams to help support home visiting programs. There are clear opportunities for states to expand home visiting services with public insurance financing and expand services like upstream interventions to help address social determinants of health. However, state officials underscored the need to ensure that public insurance financing considerations are part of a range of approaches to financing home visiting. State leaders spoke about how braiding funds, especially public insurance, is a key strategy to bolster home visiting and serve as many women, children, and families as much as possible.

Conclusion

Public insurance financing of home visiting programs is a complex issue that requires each state to decide what strategy works best and fits its specific needs. Numerous states, including those represented at this federal/state discourse meeting, are developing and implementing a range of innovative strategies and taking advantage of federal Medicaid and CHIP authorities to support home visiting services. Use of Medicaid and CHIP to support home visiting programs may be best advanced through education, technical assistance, resources, and efforts that promote cross-sector partnerships and collaboration among state Title V MCH programs, MIECHV program directors and state Medicaid agencies. Indeed, convening states to discuss different approaches and providing technical assistance to states may be the best approach to help them design home visiting programs that are supported by Medicaid and CHIP, among a variety of federal and state funding streams. Furthermore, public health crises (e.g., opioid crisis and the COVID-19 pandemic) and other emergent issues can increase the need for home visiting services, but also provide new opportunities for financing and delivery of services to reach individuals through such strategies as telehealth. Home visiting programs provide valuable services, such as care coordination and referrals to social and community supports to MCH populations that states can leverage to continue work on social determinants of health. As states move forward with exploring public insurance financing, state budgets will be an important factor to consider when investing in home visiting services. Using public insurance to finance home visiting services is a key opportunity for states to improve the health and wellbeing of women and their families.

Appendix A: Key Informants

The National Academy for State Health Policy (NASHP) conducted key informant interviews to gather detailed information from subject matter experts and state officials on public insurance financing of home visiting services. Six subject matter experts and nine states were identified. State Medicaid, Title V, and MIECHV officials were invited to participate in the interviews to gather a wide range of perspectives. Key informant interviews with states and subject matter

experts were scheduled for 30 minutes and conducted in the fall of 2019. Interviewees were specifically asked about opportunities, challenges, and barriers to public insurance financing of home visiting services and were given the opportunity to provide additional information on the topic.

- Medicaid, Title V, and MIECHV officials from the following states were interviewed. In some cases, we spoke with multiple state representatives.
    - Alabama
    - Colorado
    - Kentucky
    - Michigan
    - Minnesota
    - New Jersey
    - New York
    - South Carolina
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Appendix C: Additional Resources on Financing of Home Visiting Programs

- Joint Informational Bulletin: Coverage of Maternal, Infant, and Early Childhood Home Visiting Services
- Medicaid Financing of Home Visiting Services for Women, Children, and Their Families
- Medicaid and Home Visiting: The State of States' Approaches
- State Home Visiting Approaches Improve Early Childhood Outcomes and Systems
- Funding Home Visiting with a Pay for Outcomes Approach
- Financing Public Health Interventions through Pay for Success: South Carolina and the Nurse-Family Partnership Seek to Improve Maternal and Child Health through Pay for Success
- Home Visiting: Improving Outcomes for Children
- Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change
- Health Care Payment Learning & Action Network (HCPLAN): Alternative Payment Model (APM) Framework
- Health Affairs: A Roadmap for Driving High Performance in Alternative Payment Models
- American Academy of Pediatrics: Pediatric Accountable Care Organizations: Insight from Early Adopters
- CMS State Medicaid Director Letter on Value-Based Care Opportunities in Medicaid
- Developing Data Exchange Standards for MIECHV Home Visiting Programs

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