National Academy for State Health Policy (NASHP)

**State Medicaid Financing of Home Visiting Services in Seven States**

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## Background

Home visiting is an important and long-standing strategy for improving the health and well-being of women, children, and their families. Home visiting programs deliver and help connect individuals to critical social, health, and educational services. They can include screenings for physical, social-emotional, and developmental issues, case management services, and family support and counseling. Studies have shown that home visiting programs can reduce child maltreatment and intimate partner violence and improve maternal and child health outcomes, including positive parenting and child development. These programs also show long-term cost savings, with benefits exceeding costs by an amount as high as 200 percent. Other areas of savings include a reduction of unnecessary emergency department visits and decreased use of public assistance programs such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and Medicaid.

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is the primary source of federal funding for home visiting programs and is administered through the Health Resources and Services Administration (HRSA). HRSA awarded approximately $341 million in September 2020 to 56 states, territories, and nonprofit organizations to support the provision of voluntary, evidence-based home visiting services.

In addition to MIECHV, states leverage multiple state and federal funding streams to finance home visiting programs. Prominent sources of funding include Medicaid and the Children's Health Insurance Program (CHIP), TANF, the state Title V Maternal and Child Health (MCH) Services Block Grant, state general revenue funds, and private foundation support. In addition to these sources, the Family First Prevention Services Act authorized new optional funding under Title IV-E of the Social Security Act for prevention services for mental health, substance abuse, and in-home parent skill-based programs, and may also serve as a prominent source of funding in the future.

At least 20 states use Medicaid to support home visiting programs. Targeted case management is the most common federal Medicaid authority that states use to support these programs. In a 2016 Joint Informational Bulletin on Coverage of Maternal, Infant, and Early Childhood Home Visiting Services, the Centers for Medicare & Medicaid Services (CMS) and HRSA encouraged states to use Medicaid and other federal and state funding sources to support home visiting programs. In 2019, the National Academy for State Health Policy, with support from the Maternal and Child Health Bureau, HRSA, convened state and federal Medicaid, public health, and home visiting leaders to discuss key opportunities, challenges, and innovative approaches to enhance public insurance financing of home visiting services. Participating states identified many questions and considerations for use of Medicaid to cover home visiting services. These considerations include:

- how to best integrate public insurance financing as part of state health reform efforts in Medicaid and CHIP, including strategies to move towards value-based payment (VBP);
- how to best braid multiple private, state and federal funding sources including Medicaid; and
- how to ensure providers meet qualified provider requirements in Medicaid programs, while still maintaining fidelity to the specific home visiting model.

**Highlights of Approaches to Medicaid Financing in Seven States**

NASHP reviewed Medicaid state plans, state Title V MCH Services Block grant applications and annual reports, state MIECHV program applications, and appropriation bills in seven states (Colorado, Kentucky, Michigan, Minnesota, New York, Oregon, and Wisconsin) in May 2021 to further understand and describe selected states' approaches to Medicaid financing of home visiting programs. These states were selected for their geographic diversity, length of history using Medicaid to support home visiting programs, and publicly available information. Key highlights of the Medicaid financing approaches in the seven states are below.

- **Five states (CO, KY, NY, OR, WI) support home visiting programs through Medicaid targeted case management, and two states (MI and MN) finance these programs through an extended service for pregnant women or an 'Other practitioner services' benefit.** Medicaid targeted case management (TCM) services often do not cover the full costs of a home visiting program. Medicaid TCM services entail a comprehensive and periodic assessment, development of a specific care plan, referral and follow-up as needed, and activity monitoring. The Extended Services for Pregnant Women authority is another avenue by which states can reimburse for home visiting services. A state can, under federal regulation 42 CFR 440.250(p), provide a greater amount of services in scope, duration, and amount for pregnant women compared to other Medicaid beneficiaries. Michigan used this authority, which broadly allowed for more services offered by a home visiting program/provider to be reimbursed compared to the targeted case management benefit. 'Other practitioner services' is an optional benefit allowable under Medicaid that can also be used to support home visiting programs. Minnesota used this benefit to cover prenatal and postpartum home visits by a Public Health Nurse or a registered nurse under the supervision of a Public Health Nurse.
- **Five of the seven states (MI, MN, NY, OR, WI) reimburse for home visiting services as part of capitated payments under Medicaid managed care (MMC) and two states (CO and KY) do so through direct payments to providers under fee-for-service arrangements.** State Medicaid programs determine the service delivery system in which home visiting services are provided, which can have implications for implementation and delivery. For example, a state can require Medicaid managed care organizations to refer eligible enrollees to home visiting programs approved by the state Medicaid agency as part of the state MMC contract.
- **The seven states describe specific provider qualifications in their Medicaid state plan, as is outlined in federal regulation.** States can set reasonable standards relating to qualifications of providers and often do to meet home visiting model provider requirements. This includes degree requirements (e.g., bachelor's or master's degree, certification), licensure requirements, professional qualifications (e.g., social worker, registered nurses, early childhood development specialist), and/or infrastructure to bill Medicaid. There are some exemptions to these qualifications when someone is not available in a geographic area or community.

- **The seven states leverage a variety of public and private funding sources, in addition to MIECHV and Medicaid, to support home visiting programs.** These sources include but are not limited to Tobacco Master Settlement Agreement revenue, state school aid, the Child Abuse and Prevention and Treatment Act (CAPTA) funds, and TANF. In many cases, the selected states also use state general revenue funds.

The following table summarizes Medicaid financing approaches in the selected seven states. This information is not meant to be an exhaustive list of all home visiting programs in the state. It includes state information on Medicaid authorities and benefit categories, services eligible for Medicaid reimbursement, the state's qualified provider requirements, other sources of funding, the state's delivery system approach, and other relevant information that can inform state efforts to enhance Medicaid support for home visiting programs.

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| State and Selected Home Visiting Program[1] | Medicaid Authority/ Benefit Categories[2] | Services Eligible for Medicaid Reimbursement | Qualified Provider Requirements | Medicaid Delivery System Approach and Other Relevant Information | Examples of Other Federal and State Financing to Support Home Visiting Programs |
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| **Colorado**<br><br>**Home Visiting Program:**<br>Nurse Family Partnership<br><br>**Eligible Population:**<br>First time pregnant and parenting women and their child up to the child's second birthday | State Plan/Targeted Case Management Services[1] | Targeted case management includes the following assistance: [2]<br>**1.** Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. Activities include taking client history and identifying the individual's needs and completing related documentation and gathering information from other sources.<br>**2.** Development of a specific care plan<br>**3.** Referral and related activities to help eligible individuals obtain needed services, including activities that help link an individual with medical, social, educational providers; or other programs and services that can provide needed services<br>**4.** Monitoring and follow-up activities, including activities and contacts (e.g., individuals, family members, providers, or other entities or individuals) that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and including at least one annual monitoring, to determine whether the following conditions are met:<br>**a.** services are being furnished in accordance with the individual's care plan<br>**b.** services in the care plan are adequate; and<br>**c.** there are changes in the need or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers<br><br>Additional benefits may be provided by registered nurses in homes to any Medicaid enrollee. These are being used by a pilot group of NFP sites to increase the sustainability of the program:<br>• Preventive Counseling Services<br>• Tobacco Cessation Counseling<br>• Depression Screenings | Providers must meet established program training requirements, program protocols, program management information systems, and program evaluation requirements on research-based model programs that have demonstrated significant reductions in infant behavioral impairments, the number of reported incidents of child abuse and neglect, the number of subsequent pregnancies, receipt of public assistance, and criminal activity.<br><br>All NFP services must be provided by a registered nurse. Nurse home visitors must be licensed as professional nurses pursuant to Article 38 of Title 12, C.R.S., or accredited by another state or voluntary agency that the state board of nursing has identified by rule pursuant to Section 12-38-108(1)(a), C.R.S., as one whose accreditation may be accepted in lieu of board approval.<br><br>The nurse supervisors are required to be nurses with Master's degrees in nursing or public health, unless the implementing entity can demonstrate that such a person is unavailable within the community or an appropriately qualified nurse without a Master's degree is available. [3] | **1.** Operates as fee-for-service.[4]<br>**2.** Case management services do not include: [5,]<br>**a.** Case management activities that are an integral component of another covered Medicaid service;<br>**b.** The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;<br>**c.** Activities integral to the administration of foster care programs; and<br>**d.** Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act<br>**3.** Fee-for-service payments for Targeted Case Management shall be made for each child/family visited under the program. [6]<br>**a.** Services to the mother shall be limited to 3 units per month with a lifetime maximum limit of 30 units.<br>**b.** Services to the child shall be limited to 3 units per month with a lifetime maximum of 75 units.<br>**c.** A different rate shall be calculated for each provider agency based on their actual historical cost and their projected budget for the next fiscal year.<br>**d.** At the end of the fiscal year, partners at the Department of Human Services reconcile payments with the actual costs for each agency based on agency cost reports, to assure that payment was not more than the actual cost of providing services. Overages shall be recovered. | **1.** In 2020, Colorado received $7.7 million under the MIECHV program to support implementation evidence-based home visiting models in the state. Models currently funded in CO by MIECHV include Home Instruction for Parents of Preschool Youngsters, Nurse-Family Partnership, and Parents as Teachers.<br>**2.** The 2020-21 state budget included over $29 million for HealthySteps, Nurse-Family Partnership (through Nurse Home Visitor Program), and SafeCare Colorado from State General Funds and Tobacco Master Settlement Agreement Revenue Allocations. |
| **Kentucky**<br><br>**Home Visiting Program:**<br>Kentucky Health Access Nurturing Development Services (HANDS) program<br><br>**Eligible Population:** | State Plan/Targeted Case Management Services[7] | There are two components to case management: 1) assessment and 2) home visitation. Both components or phases include assisting the infant/toddler, mother, or family in accessing needed services, developing a treatment plan, coordinating needed services, monitoring progress, preparing and maintaining case records, providing case consultation as specified by the plan, and providing follow-up and evaluation.[8]<br><br>Assessment: | The following are provider qualifications required for the HANDS program:[9, 10]<br>**1.** Be a Medicaid provider meeting certain criteria, including:<br>**a.** Demonstrated capacity to contract statewide for the case management services for the targeted population;<br>**b.** Demonstrated capacity to ensure all components of case management; | **1.** Operates as fee-for-service[11]<br>**2.** Operates in the entire state | **1.** MIECHV funds to provide services to non-first-time parents. In 2020, Kentucky received $7.1 million to support home visiting services. [12] Models currently funded in KY by MIECHV include the HANDS program and the Growing Great Kids Curriculum. [13] |

[1] The home visiting programs featured in this table are not meant to be an exhaustive list. Rather, this table is meant to feature how states currently use Medicaid funds to support home visiting programs.

[2] Medicaid benefits fall into two benefit categories – mandatory and optional services. States are required to cover mandatory benefit categories (e.g., physician services, nurse midwife services) and can cover optional benefits while still receiving the federal match (e.g., case management services). (Kaiser Family Foundation Brief 2001)

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| Pregnant women who will be first time parents and screen positive for high risk factors | | **1.** Provided by a Registered Nurse, Social Worker or Early Childhood Development Specialist;<br>**2.** Conducts a face-to-face needs assessment with the child, mother and family. The assessment shall include:<br>**a.** parent's childhood experience;<br>**b.** lifestyle behaviors and mental health status;<br>**c.** parenting experience;<br>**d.** stressors, coping skills and support system for the new family;<br>**e.** anger management skills;<br>**f.** expectations of infant's developmental milestones and behaviors;<br>**g.** perception of new infant, and bonding and attachment issues;<br>**h.** plans for discipline; and<br>**i.** family environment and support system;<br>**3.** Develops a written report of the findings and a service plan for the family; and<br>**4.** Assigns home visitor and arranges for the delivery of the needed services by other Medicaid and community providers as identified in the treatment plan.<br><br>Home Visitation:<br>**1.** A public health nurse, social worker, or family support worker who is supervised by a public health nurse, social worker or early childhood development specialist may perform a home visit;<br>**2.** Monitoring and screening for the child's development;<br>**3.** Assist the child and family, as it relates to the treatment plan, in accessing needed services and coordinating services with other programs;<br>**4.** Monitor progress by making referrals, tracking the appointments, performing follow-up services, and performing periodic evaluation of the changing needs;<br>**5.** Perform activities to enable the child and family to gain access to needed services;<br>**6.** Prepare and maintain case records documenting contacts, services needed, reports, progress;<br>**7.** Provide case consultation (i.e., with the service providers/collaterals in determining child's status and progress); and<br>**8.** Perform crisis assistance (i.e., intervention on behalf of the child, making arrangement for emergency referrals, and coordinating other needed emergency service). | **c.** Demonstrated experience in coordinating and linking such community resources as required by the target population;<br>**d.** Demonstrated experience with the target population;<br>**e.** Administrative capacity to ensure quality of services in accordance with state and federal requirements;<br>**f.** Demonstrated capacity to provide certified training and technical assistance to case managers;<br>**g.** Financial management system that provides documentation of services and costs;<br>**h.** Capacity to document and maintain individual case records in accordance with state and federal requirements;<br>**i.** Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider; and<br>**j.** Demonstrated capacity to meet the case management service needs of the target population.<br>**2.** Meet one of the following professional criteria:<br>**a.** registered nurse;<br>**b.** social worker;<br>**c.** early childhood development specialist; or<br>**d.** family support worker<br>**3.** Enrolled with a local health department | | **2.** State Medicaid match is funded from Master Settlement Tobacco Funds. In FY 2020-21, this amount totaled $7,000,000[14, 15]<br>KY General Funds to cover services in counties that were not previously covered by MIECHV[16] |
| **Michigan**<br><br>**Home Visiting Program:** Maternal Infant Health Program (MIHP) | State Plan/Extended Services to Pregnant Women and Early and | Medicaid reimbursable services under MIHP consist of:[19]<br>**1.** Professional visits/interventions of a licensed social worker and/or a registered nurse for counseling to prevent disease, disability, other health conditions or their progression and | The MIHP provider must be certified by the Michigan Department of Health and Human Services. Practitioners rendering the service must be either staff of the certified MIHP provider or under direct | **1.** Operates in Medicaid managed care<br>**2.** If a provider charges less than the program fee for MIHP services, then the department will reimburse the lesser of the two. | **1.** Sources of funding for other home visiting programs can come from the state's general fund, state school aid, MIECHV, the Child Abuse Prevention and |

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| **Eligible Population:**<br>Medicaid eligible pregnant women and infants up to age one[17] | Periodic Screening, Diagnostic, and Treatment [18] | coordination of care to promote physical and mental health and efficiency, and<br>**2.** Childbirth/parenting education programs that have been certified by the Michigan Department of Health and Human Services and delivered by a licensed practitioner as defined under this item.<br><br>MIHP services include:<br>**1.** Evidence-based health and psychosocial assessments, completed by registered nurses or social workers;<br>**2.** Individualized plans of care developed by teams comprised of registered nurses, licensed social workers, registered dieticians, lactation consultants and infant mental health specialists;<br>**3.** Coordination of services between MIHP providers, medical care providers and Medicaid health plans; and<br>**4.** Interventions which may include but are not limited to referrals for community services as needed; referral to local childbirth education or parenting classes. | contract to that certified agency and must be state licensed, rendering services within the scope of practice as defined by state law. Examples of agencies include: Federally Qualified Health Centers, Hospital based clinics, Native American tribes, Private providers, Local and regional public health departments.[20, 21] | **3.** If a provider charges less than the program fee for MIHP services, then the department will reimburse the lower of the two. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of MIHP Services.[22] | Treatment Act, and private funding.[23] |
| **Minnesota**<br><br>**Home Visiting Programs:**<br>Nurse Family Partnership, Healthy Families America, Family Spirit, Maternal Early Childhood Sustained Home Visiting, and Family Connects<br><br>**Eligible Population:**<br>Eligible populations vary by the following models:<br>**1.** Nurse Family Partnership[24]<br>**2.** Healthy Families America[25]<br>**3.** Family Spirit[26]<br>**4.** Family Connects[27] | State Plan/Other practitioner services/Public health nursing services | Providers must provide services in accordance with the requirements of the model in order to receive payment.<br><br>Medicaid covers prenatal and postnatal home visits provided in accordance with Department-approved, evidence-based treatment models, including Nurse Family Partnership, Healthy Families America, Family Spirit, and Family Connects. Postpartum visits can be provided up to three years after the birth of the child.[28] | Public Health Nurse or a RN under the supervision of a Public Health Nurse. In order to become a Public Health Nurse, a RN must:[29, 30]<br>**1.** be licensed and currently registered in Minnesota,<br>**2.** have a baccalaureate or higher degree with a major in nursing,<br>**3.** have completed course work which included theory and clinical practice in public health nursing, and<br>**4.** submit an application, affidavit of graduation and public health nurse education and $30.00 fee.<br><br>Community health workers[31] are also eligible to bill at a lower rate. In order to become a community health worker, one must hold a CHW certificate from a qualified school that offers a standardized curriculum. Specific schools can be found on the Department of Health's website. | **1.** Operates in Medicaid managed care<br>**2.** Medical Assistance covers prenatal and postnatal home visits provided in accordance with Department-approved, evidence-based treatment models. Postpartum visits can be provided up to three years after the birth of the child.[32]<br>**3.** Effective for services provided on or after January 1, 2018, bundled services provided as part of an evidence-based, home visit are paid the lower of:[33]<br>a. Submitted charge; or<br>b. $140 per visit.<br>**4.** Community health workers can also bill for services at $16 per visit[34]<br>**5.** The Department will periodically monitor the actual provision of services to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided. | **1.** TANF provides funding of $7,827,300 annually to all local public health departments and tribal nations for services provided.<br>**2.** In 2020, MIECHV provided $8.8 million to support evidence-based home visiting programs in the state. Models currently funded in MN by MIECHV include Nurse Family Partnership, Healthy Families America, Maternal Early Childhood Sustained Home Visiting, and Family Spirit.[35]<br>**3.** The MN Legislature appropriated $6 million per year in state fiscal years 2018 and 2019 ($12 million total) and $16.5 million per year starting in state fiscal year 2020 in Evidence Based Home Visiting (EBHV) Grants<br>**4.** In 2015, the Minnesota Legislature authorized $575,000 in State Fiscal Year 2016, and $2,000,000 in State Fiscal Year 2017 and thereafter, to provide grants to local public health agencies and tribal |

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| | | | | | nations to create or expand Nurse-Family Partnership (NFP) programs. [36] |
| **New York**<br><br>**Home Visiting Program:** First-time Mothers and Newborns Program<br><br>**Eligible Population:** Low-income, pregnant women who will be first-time mothers and their newborn children up to each child's second birthday. These services are limited to the following geographic areas: New York City, Monroe, Albany, Erie, Cayuga, Chautauqua, Nassau, Niagara, Chemung, Westchester, and Onondaga Counties | State Plan/ Targeted Case Management Services | Up to four (4) 15-minute units can be billed per service date when one or more of the Comprehensive Medicaid Case Management services are provided. Each recipient is allowed a maximum of 260 units (from the time of enrollment in the TCM program through the newborn's second birthday). Billable units are for time spent delivering a case management service. That service typically occurs face to face with the recipient but may also consist of telephone contacts, mail or e-mail contacts as necessary to provide referral linkages or conduct follow-up activities. Time spent traveling to a recipient to provide case management services is not billable. [37] [38]<br><br>**1.** Comprehensive assessment and period reassessment of the first-time pregnant woman and newborn to determine the need for medical, educational, social or other services. These assessment activities include:<br>**a.** taking the woman's history and assessing risk for poor birth outcomes;<br>**b.** identifying the needs of the first-time mother and newborn and completing related documentation; and<br>**c.** gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment.<br>**2.** Development (and periodic revision) of a specific care plan. A care plan will be developed based on the comprehensive assessment conducted of the first-time mother. A written care plan must be completed by the case manager within 30 days of the date of the woman's referral to the targeted case management program and must include, but not be limited to, the following activities:<br>**a.** identification of the nature, amount, frequency and duration and cost of the case management services required by a particular recipient;<br>**b.** Selection of the long-term and short-term goals to be achieved through the case management process;<br>**c.** Specification of the long-term and short-term goals to be achieved through the case management process;<br>**d.** Collaboration with health care and other formal and informal service providers, including discharge planners and other case managers as appropriate, through case conferences to encourage exchange of clinical information and to assure:<br>**i.** the integration of clinical care plans throughout the case management process; | Provider agencies: [39]<br>Case management services may be provided by agencies, facilities, persons and other groups possessing the capability to provide services that are approved by the Commissioner of the New York State Department of Health (DOH), the single state Medicaid agency, based upon an approved proposal submitted to the New York State DOH. Providers may include:<br>**1.** facilities licensed or certified under New York State law or regulation as Licensed Home Care Services Agencies (LHCSA) or Certified Home Health Agencies (CHHA);<br>**2.** a county health department, including the health department of the City of New York.<br><br>Case managers:<br>Case managers must have the education, experience, training and/or knowledge in the areas necessary to conduct case management services including the areas previously mentioned (i.e., New York City, Monroe, Albany, Erie, Cayuga, Chautauqua, Nassau, Niagara, Chemung, Westchester, and Onondaga Counties). Case managers under this program are required to be registered nurses with BSN degrees; and be licensed as professional nurses with the New York State Department of Education. In limited circumstances, an RN who does not have a BSN degree but is competent in a foreign language may be hired as a case manager in the First-time Mothers/Newborn program to provide TCM services to first-time mothers and their newborns who speak a language other than English (including, but not limited to Spanish, Chinese or Russian). | **1.** Operates in Medicaid managed care | **1.** In 2020, MIECHV awarded over $8.4 million to evidence-based home visiting models in the state. Models currently funded in NY by MIECHV include Nurse Family Partnership and Healthy Families New York. [40] |

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| | | ii. the continuity of service;<br>iii. the avoidance of duplication of services (including case management services); and<br>iv. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the recipient.<br>**e.** The care plan will state:<br>i. goals and actions to address the medical, social, educational, and other services needed by the woman and child;<br>ii. activities to ensure the active participation of the first-time mother (or the woman's authorized health care decision maker) and others to develop the goals;<br>iii. a course of action identified to respond to the assessed needs of the first-time mother and child; and<br>iv. an agreed upon schedule for re-evaluating goals and course of action.<br>**f.** The plan will be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six (6) months subsequent to the initial plan. Each time the care plan is reviewed, the goals established in the initial plan will either be maintained, or revised, and new goals and time frames established.<br>**3.** Referral and related activities (such as scheduling appointments for the mother and child) to help the first-time mother and newborn obtain needed services including activities that help link the mother and child with medical, social, educational providers or other program and services in the community that are capable of providing needed services to address identified needs, and achieve goals as specified in the care plan.<br>**4.** Monitoring and follow-up activities | Certification by a nationally-recognized organization, with an evidence-based program in nurse home visits and case management for high risk, first-time mothers and their newborn is preferred.<br><br>Case managers in this targeted case management program will meet or exceed the standards set by the single State Medicaid Agency. The case manager must have two years' experience in a substantial number of case management activities. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The two years of experience may be substituted by:<br>**1.** one year of case management experience and a degree in a health or human services field;<br>**2.** one year case management experience and an additional year of experience in other activities with the target population; or<br>**3.** a bachelor's or master's degree which includes a practical encompassing a substantial number of activities with the target population | | |
| **Oregon**<br><br>**Home Visiting Programs:**<br>Public Health Nurse Home Visiting,<br>Babies First CaCoon, Nurse-Family Partnership, Family Connects[3]<br><br>**Eligible Population:** | State Plan/ Targeted Case Management Services[41] | Targeted Case Management includes the following assistance:<br>**1.** Comprehensive assessment and periodic reassessment of individual needs<br>**2.** Development (and periodic revision) of a specific care plan<br>**3.** Referral and related activities (such as scheduling appointments for the individual) to help an eligible individual obtain needed services<br>**4.** Monitoring and follow-up activities | Public Health Nurse Targeted Case Managers may be an employee of a Local County Health Department, under the jurisdiction of the Local Public Health Authority or other public or private agency contracted by a Local Public Health Authority. The case manager must be: [42] | **1.** Infant and children eligibility can be found in the state plan on page 492<br>**2.** Provider organizations must be certified by the single state agency as meeting the following criteria:<br>a. Demonstrated capacity to provide all core elements of case management services including: comprehensive client assessment, comprehensive care/service plan development, linking/coordination of services, monitoring and | **1.** In 2020, MIECHV awarded over $8.3 million to support evidence-based home visiting models in the state. Models currently funded in OR by MIECHV include Early Head Start, Healthy Families America or Nurse-Family Partnership. [44] |

[3] These home visiting programs are within the Title V agency and are able to be reimbursed by Medicaid. This is not an exhaustive list of all home visiting programs in the state.

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| Pregnant women with one or more of the following risk factors qualify for home visiting services:<br>• A chronic health condition that places perinatal-infant outcomes at high risk,<br>• Complications of pregnancy,<br>• Inadequate prenatal care,<br>• History of poor birth outcomes<br>• History of child abuse, tobacco use (current or recent within one year),<br>• Substance use/abuse includes any teratogenic substance,<br>• A mental health condition,<br>• Experiencing intimate partner violence (current or within one year),<br>• Of a race or ethnicity with established health inequities,<br>• Inadequate resources to meet basic needs,<br>• Exposure to environmental hazards, age 18 years or less,<br>• Has not completed high school,<br>• An unsupportive partner, and/or lack of social supports,<br>• A history of incarceration,<br>• Meets Nurse-Family Partnership (NFP) evidence-based eligibility criteria, as defined by the NFP National Service Office, or | | Case management activities providing the direct delivery of underlying medical, educational, social, or other services are not eligible for federal financial participation. | **1.** A licensed registered nurse with experience in community health, public health, child health nursing; or<br>**2.** A Community Health Worker, Family Advocate or Promotor working under the supervision of a licensed registered nurse.<br><br>The minimum qualifications of the Community Health Workers, Family Advocates or Promotor are as follows:<br>**1.** High School Graduate, or GED with additional course work in human growth and development, health occupations or health education;<br>**2.** Two years' experience in public health, mental health or alcohol drug treatment settings;<br>**3.** Or any satisfactory combination of experience and training which demonstrates the ability to perform case management duties. [43] | follow-up of services, and reassessment of the client's status and needs<br>b. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.<br>c. Demonstrated experience with the target population.<br>d. A sufficient number of staff to meet the case management service needs of the target population.<br>e. An administrative capacity to ensure quality of services in accordance with state and federal requirements.<br>f. A financial management capacity and system that provides documentation of services and costs.<br>g. Capacity to document and maintain individual case records in accordance with state and federal requirements.<br>h. Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.<br>i. Ability to link with the Maternal and Child Health program Data System.<br>**3.** Public Health Nurse Home Visiting, Babies First!, CaCoon, and Nurse-Family Partnership services were approved by CMS effective January 1, 2017. Family Connect Nurse Home Visiting was approved by CMS effective July 1, 2019<br><br>Other important information includes:<br>**1.** SB 526 passed in 2019, directs the Oregon Health Authority to design, implement and maintain voluntary statewide program to provide universal newborn nurse home visiting services to families with infants up to six months of age. It also directs commercial health benefit plans to offer this benefit to their members. | |

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| • A parent of an eligible child with special health care needs.<br><br>NOTE: Family Connects is offered to all families with newborns. It does not have eligibility criteria. | | | | | |
| **Wisconsin**<br><br>**Home Visiting Programs:** Healthy Families America, Nurse Family Partnership, Parents as Teachers, Early Head Start Home Visiting Programs[45]<br><br>**Eligible Population:** Pregnant and postpartum women (up to 60 days after delivery) who are expected to have difficulty receiving proper medical care and determined by administering the Department-sanctioned risk assessment to be at high risk for adverse pregnancy outcomes such as a preterm births or low birth weight babies due to medical and nonmedical factors. [46] | State Plan/ Targeted Case Management Services, including Prenatal Care Coordination[47] | Prenatal Care Coordination services include the following assistance: risk assessment, care planning, ongoing care coordination and monitoring. Definitions seen below:[48]<br>**1.** Risk assessment: A risk assessment is a written appraisal of a recipient's pregnancy-related needs to determine if a recipient is at high risk of an adverse pregnancy outcome and to determine the type and level of the recipient's needs. When conducting the risk assessment, the certified provider utilizes a Department sanctioned instrument. The assessment must be performed by a person either employed by or contracted with the certified prenatal care coordination agency and must be reviewed by a qualified professional.<br>**2.** Care Planning: Care planning is development of an individualized written plan of care which will identify needs, problems and possible services to reduce the recipient's identified risk factors and therefore reduce the probability of the recipient having a preterm birth, low birth weight baby or other negative birth outcomes. Care planning provides the means to ensure that through all care coordination services the recipient has accessible, coordinated, adequate, quality, and continuous services to address identified needs. Care planning must be performed by a person employed by or contracted with the MA certified prenatal care coordination agency. To the maximum extent possible, the development of a care plan is done in collaboration with the recipient, the family or other supportive persons.<br>**3.** Plan of Care: The plan of care is a written document that may include, but is not limited to:<br>**a.** Identification and prioritization of risks found during the assessment;<br>**b.** Identification and prioritization of all services and service providers to be arranged for the recipient;<br>**c.** Description of the recipient's informal support system and activities to strengthen it;<br>**d.** Identification of individuals who participated in the development of the plan of care;<br>**e.** Arrangements made for and frequency of the various services to be made available to the recipient and the expected outcome for each service component;<br>**f.** Documentation of unmet needs and gaps in service; and | Prenatal Care Coordination Provider Certification Requirements:[49]<br>**1.** Clinics and agencies that have experience in serving low-income people, as well as pregnant women and their families. These clinics and agencies include but are not limited to: community-based agencies or organizations; county, city or combined local public health agencies; departments of human or social services; family planning agencies; federally qualified health centers (FQHCs); health maintenance organizations (HMOs); independent physician associations (IPAs); hospital facilities; physician offices and clinics; registered nurses or nurse practitioners; rural health clinics; tribal agencies and health centers; private case management agencies; and Women, Infant, Children (WIC) programs.<br>**2.** Agencies, organizations and providers eligible to become certified as prenatal care coordination providers will meet the following staffing standards:<br>**a.** A prenatal care coordination agency employs at least one qualified professional with experience in coordinating services for at risk and low-income women; and<br>**b.** Qualified professionals are employed by or under contract with a certified prenatal care coordination agency that bills for the services and may include: licensed and registered nurses, certified midwives, physicians, | **1.** Operates in Medicaid managed care<br>**2.** Wisconsin requires that all Prenatal Care Coordination (PNCC) providers have staff who can provide health and nutrition education. PNCC providers include community-based health organizations, social services agencies, county or city public health agencies, and physicians' offices. In addition, Medicaid-certified PNCC providers may subcontract with agencies not certified by the state's Medicaid agency for PNCC services. The services are typically provided in a client's home by registered nurses. Four of the home visiting programs offered in Wisconsin— Healthy Families America, Nurse Family Partnership, Parents as Teachers, Early Head Start Home Visiting Programs —meet these criteria and are thus able to receive payment for furnishing PNCC services. [50]<br>**3.** Key outcome indicators include: Tobacco Exposure, Alcohol Use, Breastfeeding, Safe Infant Sleep Practices, Perinatal Depression, Family Planning, and Involved Father.[51]<br><br>Other important information includes:<br>**1.** Eligibility for home visiting is based on model specific criteria. 60% of families enrolled must meet 3 or more of federal at-risk populations and 75% of enrolled families need to enroll prenatally.<br>**2.** Federal at-risk populations include:<br>a. Low-income eligible families;<br>b. Families with pregnant women who have not attained age 21;<br>c. Families that have a history of child abuse or neglect or have had interactions with child welfare services;<br>d. Families that have a history of substance abuse or need substance abuse treatment;<br>e. Families that have users of tobacco products in the home;<br>f. Families that are or have children with low student achievement; | **1.** The state receives Federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Temporary Assistance for Needy Families (TANF), and State General Purpose Revenue funds to support families served by evidence-based home visiting programs.[52]<br>**2.** In 2020, MIECHV awarded over $8.5 million to support evidence-based home visiting models in the state.[53]<br>**3.** Home visiting services rendered for children can also be reimbursed under target group B, which are recipients of early periodic screening, diagnosis and testing services (HealthCheck). This includes families with a child/children at risk of serious physical, mental, or emotional dysfunction (also referred to as family case management). There are five subgroups eligible for this benefit, one of which includes families where the mother required PNCC (prenatal care coordination) services.[54] |

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| | | **g.** Responsibilities of the recipient in the participation of the plan.<br>**4.** Ongoing care coordination and monitoring: Ongoing care coordination and monitoring is the supervision of the provision of the services to ensure that quality service is being provided and to evaluate whether a particular service is effectively meeting the recipient's needs and reaching the goals and objectives of the care plan. Ongoing care coordination and monitoring is performed by a person who is employed by or under contract with the prenatal care coordination agency and is supervised by or is a qualified professional. Ongoing care coordination and monitoring services may include, but are not limited to:<br>**a.** Face-to-face and telephone contacts with recipients and related individuals for the purpose of following up on arranged services;<br>**b.** Documentation to record care plan management activities | physician assistants, registered dieticians, bachelor's degree social workers and health educators.<br>**3.** Prenatal care coordination providers are required to meet the Medicaid Program's documentation, record keeping and reimbursement requirements. | g. Families with children with developmental delays or disabilities; and<br>h. Families that include individuals who are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States. | |

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