



# Medicaid Financing of Home Visiting Services for Women, Children, and Their Families

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## Introduction

States have a long history of using home visiting to promote the health and well-being of women, children, and their families, and to target interventions for some of their most vulnerable populations. Home visiting typically provides social, health, and/or educational services to parents and young children that can help support healthy child development, prevent health and social problems such as child abuse and neglect, and identify opportunities to intervene early in a child's life to avoid costlier interventions in the future. Home visiting programs, which families enroll in on a voluntary basis, have positive impacts on child outcomes, such as reduced hospitalizations and increased school readiness, and promote safe and healthy homes by fostering positive parenting practices.

Home visiting programs also generate a wide range of cost savings to society. A recent review of evidence-based programs found the average cost of home visits to a family for 45 weeks was \$6,554,<sup>2</sup> however, every dollar invested in the programs can yield up to \$5.70 in savings in the long run. These sizeable savings result from reduced health services utilization -- including emergency department visits -- and decreased special education placements and grade repetition, which leads to higher educational attainment and economic success later in life.<sup>3</sup>

States use public and private funds to support home visiting programs, including state general revenue, Medicaid, and federal funding, such as the Maternal and Infant Early Childhood Home Visiting (MIECHV) program. In 2010, 46 states and the District of Columbia invested close to \$1.4 billion in home visiting programs and other early childhood programs that included home visiting services.<sup>4</sup> In spite of these investments, many states' programs only reach a fraction of eligible families due to insufficient resources and funding.<sup>5</sup> In 2016, the Centers for Medicaid and Medicare Services (CMS) and the Health Resources and Services Administrations (HRSA) highlighted available federal funding sources, including Medicaid, for these programs and underscored the importance of using multiple funding streams to expand these valuable home visiting programs across the country.<sup>6</sup>

This issue brief highlights the Medicaid financing authorities and mechanisms available to support home visiting services. It also explores:

- New opportunities to integrate home visiting into state health reform efforts;
- How states are currently using Medicaid to finance home visiting; and
- Additional funding sources, including MIECHV, that states are using to implement and/or expand home visiting programs.

### Defining Evidence-Based Home Visiting Programs

Evidence-based home visiting programs provide a comprehensive array of in-home services and supports to families and young children on a voluntary basis. To be recognized as an evidence-based model, the home visiting program must have positive impacts across several domains, such as child and maternal health, child development and school readiness, family economic self-sufficiency, and reductions in child maltreatment.<sup>7</sup>

There are a variety of models that have demonstrated effectiveness in serving pregnant women and children from birth through kindergarten.<sup>8</sup> These models differ in respect to the intensity of services provided and their target population. Common program components include the use of trained providers such as nurses, social workers, child development professionals, and other paraprofessionals, to deliver services, and standard curricula or operation manuals to ensure fidelity to the home visiting model.

Home visiting programs also typically include the following services.<sup>9</sup>

- **Screening:** Home visitors use standardized screening tools to identify potential physical, social-emotional, and developmental issues in infants and young children, and identify problems among parents, such as trauma, intimate partner violence, and mental health and substance use disorders.
- **Case Management:** Case management services support individuals in accessing medical, social, and other services that can mitigate any identified issues. The support can include developing a care plan, referring the child and family members to additional services and supports, assisting in coordinating services, and following up to ensure the child and families' needs were met.
- **Family Support and Counseling:** Family support and counseling helps parents and caregivers address the specific needs of their children, and promotes the use of healthy coping mechanisms, positive parenting skills, and problem-solving techniques.

## Pathways for Using Medicaid to Support Home Visiting Services

Medicaid is the largest single source of health insurance in the U.S., covering more than 68 million individuals as of April 2017.<sup>10</sup> It plays a significant role in covering children and pregnant women, financing nearly half of all U.S. births.<sup>11</sup> Many states use Medicaid to fund individual home visiting services or home visiting programs. Home visiting services are discrete medical, behavioral or educational activities provided in the home, whereas home visiting programs provide a comprehensive set of health, social, and educational services and typically include several program components (e.g., screening, case management, family support and counseling). An estimated 33 states cover home visiting services for pregnant women, new parents, or infants through Medicaid,<sup>12</sup> and approximately one-quarter use Medicaid to support home visiting programs.

Home visiting is not a mandated or fully-defined set of services under the federal Medicaid program. As such, states must leverage one or more categories of Medicaid benefits in order to use federal funds for home visiting services. Medicaid financing of home visiting is complex because of the range of services that home visiting can entail, and the requirements underlying the various federal Medicaid authorities and mechanisms that states can use in order to pay for services.

Some states use existing authorities under their Medicaid state plan, or they design their approaches and seek approval from CMS through state plan amendments to cover Medicaid-eligible services that are provided through the home visit. Other states use Medicaid waiver authorities, either separately or in addition to state plan benefits, to achieve the desired design, scope, and program goals of their

home visiting programs. These waiver authorities allow states to waive certain federal Medicaid requirements<sup>13</sup> in order to restructure how Medicaid pays for and delivers care to beneficiaries. Under some waivers, states can expand services to include those that go beyond what Medicaid traditionally covers, such as housing supports.<sup>14</sup>

### **The State-Federal Medicaid Partnership**

Medicaid is a joint federal-state program that provides health care coverage to low-income populations, which has historically included children and their parents, seniors, individuals with disabilities, and pregnant women. Medicaid is funded by both the state and federal government, with states administering the Medicaid program following federal guidelines. CMS, the federal agency that oversees the Medicaid program, uses the Federal Medical Assistance Percentage (FMAP) to determine the proportion of Medicaid service costs that it provides to each state. FMAP provides a higher reimbursement -- or federal match rate -- to states with lower per capita incomes compared to the national average. Each state must develop a state plan that details the scope of services provided and get it approved by CMS in order to receive the federal match. CMS requires states to cover a set of mandatory benefits (e.g., hospital, physician, and nursing home services), and states can also receive a federal match for optional services (e.g., prescription drugs, and targeted case management).

Some approaches pose a greater administrative burden than others. States consider a range of factors when selecting Medicaid financing mechanisms to support home visiting. These factors can include:

- Whether the state already has authority to fund home visiting services under the existing Medicaid state plan or if it needs to develop a state plan amendment or waiver in order to create the authority to finance home visiting services; and
- Which Medicaid benefits categories fit the models, providers, and home visiting systems currently in use in the state.<sup>15</sup>

Targeted case management (also known as medical assistance case management) is a Medicaid service that has been widely used to support interventions for pregnant women, infants, and young children, as many of these services are provided in a home setting. Targeted case management is a service under Medicaid that assists beneficiaries in gaining and coordinating access to necessary medical, social, and educational care and other services tailored to their needs.<sup>16</sup> Traditionally, states have used targeted case management to increase use of prenatal care through maternal and infant case management programs.<sup>17</sup> Increasingly, states are using targeted case management to fund services delivered as part of home visiting programs, which are typically more robust in intensity and structure than maternal and infant case management programs.

While targeted case management is the most common financing approach used by state Medicaid agencies to support home visiting services, states have a variety of other Medicaid financing strategies that they can use. For example, Early Periodic Screening, Diagnostic, and Treatment (EPSDT) is the benefit within Medicaid for children and adolescents under the age of 21. EPSDT is a comprehensive set of services that can include any Medicaid-covered service deemed medically necessary to correct and ameliorate a health condition.<sup>18</sup> EPSDT covers screenings, case management, and counseling -- all of which are key components of home visiting programs -- and these services can be delivered in a home setting.<sup>19</sup> Additional Medicaid financing strategies for home visiting services include traditional medical assistance services and administrative case management,<sup>20</sup> as well as the use of waiver authorities, such as 1115 waivers and 1915(b) waivers.

Other Medicaid waivers and service options that states could use to support home visiting services include Medicaid home health services, rehabilitative services, therapy services, preventive services, 1915(c) Home and Community-Based Waiver Services, and other benefit categories. Few, if any, state Medicaid agencies use these mechanisms to cover early childhood home visiting programs. Their under-utilization may result from their tightly targeted definitions of which populations can be served or what services can be covered. Ultimately, the selected financing mechanism depends on each state's unique environment. See Table 1 (on **page 10**) for a summary of key Medicaid financing authorities and mechanisms that states typically use to support home visiting.

The following highlights key states with longstanding home visiting programs supported, in part, by Medicaid.

**Kentucky's Health Access Nurturing Development Services (HANDS)** is a statewide voluntary home visiting program that is supported by Medicaid through targeted case management, along with other state and federal funds. HANDS, which is administered by the Kentucky Department of Public Health, serves parents during the prenatal period through the child's third birthday (families must enroll before a child is 90 days old). HANDS began as a pilot program operating within 15 local county health departments in 1999 and was expanded to every county in the state by 2003. In 2002, the state began covering certain home visiting services within HANDS under Medicaid targeted case management through a state plan amendment. The state uses State Tobacco Funds as the state match for federal Medicaid dollars.<sup>21</sup>

Services provided through HANDS include health education, developmental and social-emotional screenings for children, domestic violence and perinatal depression screenings for parents/caregivers, and referral coordination. Health prevention is also a key focus of the program. Home visitors work with families to establish medical homes and maintain up-to-date immunizations and well-child visits. Home visiting providers can be licensed public health or registered nurses, social workers, early childhood education specialists, or paraprofessionals (high school or GED completion) with home visiting training.<sup>22</sup> While HANDS was originally limited to first-time mothers, Kentucky was able to leverage MIECHV funds to expand the program to women who already had a child. It currently serves all counties in Kentucky and supports 12,000 families annually.

Originally piloted in 1997, **Oklahoma's Children First program** is a statewide effort designed to provide family support through home visiting services to low-income mothers expecting their first child. Children First, which uses the Nurse Family Partnership (NFP) model and is administered by the Oklahoma Department of Health, is one of three home visiting programs operating in the state. Currently, it is the only home visiting program in Oklahoma that can bill Medicaid for services. Trained public health nurses located in county health departments provide home visiting services. Services are billed to Medicaid under targeted case management (HCPC<sup>23</sup> T1017) or nurse assessment (HCPC T1001). These billing codes only cover a subset of services provided during a home visit. The annual program budget is \$8.5 million, which comes from state general revenue funds (\$7.5 million), Medicaid (\$1 million), and the federal MIECHV program (\$400,000).

The services provided through Children First are voluntary and are available starting at a woman's pregnancy through her child's second birthday. To be eligible, a woman must be a first-time mother, earn up to 185 percent of the poverty level (women who qualify for WIC or Medicaid meet the criteria), and enroll prior to her 29th week of pregnancy. In FY 2016, Children First served about 2,500 families in Oklahoma with 90 percent receiving coverage through Medicaid.

**Michigan's Maternal Infant Health Program (MIHP)** is the largest home visiting program in Michigan, serving Medicaid-eligible pregnant women and their infants. MIHP originated from Michigan's Maternal Support Services (MSS) and Infant Support Services (ISS) programs, which addressed maternal and infant psychosocial and developmental issues and barriers to perinatal care. In an effort to increase coordination, promote standardization, and support a population-based approach, the Michigan Department of Health and Human Services (MDHHS) merged MSS and ISS -- creating MIHP. MIHP is administered by the state Medicaid agency, located within MDHHS. The program is included in Michigan's state Medicaid plan. Until recently, MIHP had been administered as a fee-for-service benefit. As of Jan. 1, 2017, the state rolled MIHP services into the state's Medicaid managed care contracts. A managed care organization (MCO) can contract with MIHP providers to provide services to pregnant women and infants enrolled in that specific MCO.<sup>24</sup>

The goal of MIHP is to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. Services are designed to supplement regular prenatal/infant care and to assist medical care providers in managing the beneficiary's health and well-being. MIHP services include social work, nursing services (e.g., health education and nutrition education), breastfeeding support, nutritional counseling, and beneficiary advocacy services. Services are provided by a licensed social worker or licensed registered nurse. An infant mental health specialist, international board certified lactation consultant, or registered dietician can also provide services depending on the needs of the mother and child.<sup>25</sup>

## State Health Reforms Generate New Opportunities

State Medicaid agencies are in a period of rapid transformation to improve health outcomes and the quality of care provided to Medicaid beneficiaries while containing costs. States are testing and implementing a variety of alternative payment models and care delivery strategies that are designed to offer greater flexibility in how they deliver and pay for care. These models include provision of services as part of managed care, value-based payment approaches, and formation of accountable care organizations (ACOs). Such health reform initiatives provide new opportunities to consider the role of Medicaid in supporting home visiting.

### Medicaid Managed Care

Increasingly, state Medicaid programs are serving Medicaid beneficiaries through managed care delivery systems. As of July 2017, nearly all state Medicaid agencies (47 states and the District of Columbia) provided services to beneficiaries through managed care organizations (MCOs). State Medicaid agencies contract with MCOs to provide a defined set of services to Medicaid enrollees. MCOs receive a monthly per member per month (PMPM) fee or a monthly case management fee, depending on the MCO model used. While some programs carve home visiting services out of managed care and continue to cover them through a fee-for-service system, some states, such as Minnesota, Michigan (previously discussed), and Virginia, partner with MCOs to cover home visiting services through contract requirements or other arrangements.

In **Minnesota's Family Home Visiting program**, local public health departments and tribal nations administer voluntary home visiting programs. They have the option of providing traditional home visiting or selecting from one of four evidence-based models (NFP, Healthy Families America, Family Spirit, or Family Connects) that best fits the needs of their communities. Minnesota requires its Medicaid MCOs to contract with local public health departments that provide home visiting services to eligible Medicaid enrollees. The MCO covers Medicaid-eligible services provided in the home by a public health nurse,



such as health counseling, medication management, and nursing assessment and diagnostics testing. The Minnesota Department of Health provides additional funding to the local public health departments and tribal nations through Temporary Assistance to Needy Families (TANF), state-designated NFP funding, the Title V Maternal and Child Health Services Block Grant, and the MIECHV program to cover services that are not Medicaid-eligible and to support administration of the home visiting programs.

**Virginia** has a robust set of voluntary home visiting programs<sup>26</sup> representing each of the state-level public and non-profit organizations that deliver in-home parent education and family support services to families from pregnancy to school entry. The programs were designed to bring together home visiting and early childhood leaders to enhance collaboration and facilitate more effective system building at the state and local level. Virginia also established Early Impact Virginia, which serves as a consortium of early childhood home visiting programs to promote coordination across the various programs.<sup>27</sup> Currently, three of the home visiting programs receive funding from Medicaid – two have contracts with MCOs and the third receives reimbursement through targeted case management.

The Comprehensive Health Investment Project (CHIP) of Virginia was the first home visiting program to successfully secure funding from Medicaid MCOs for home visiting services. CHIP of Virginia is a locally-developed hybrid model, utilizing a team approach consisting of a parent educator and a community health nurse to work with families. CHIP of Virginia programs are either Parents as Teachers (PAT) affiliates or they utilize the PAT curriculum. To be eligible, a family must have a child between birth and age 6 or be pregnant, and have an income at or below 200 percent FPL (i.e., Medicaid-eligible). The core services provided include screening, assessment and planning; education and support; and follow-up, referral and outreach. In 2003, CHIP of Virginia received a grant to partner with Optima Health Plan, a Medicaid MCO, to pilot “Partners in Pregnancy,” which provides home visiting and case management services to high-risk pregnant women and infants enrolled in the plan. An evaluation of Partners in Pregnancy found that the program resulted in average net savings of \$2,287 per pregnancy.<sup>28</sup> Based on the pilot’s positive outcomes, Optima expanded Partners in Pregnancy, covering the Medicaid-eligible services that CHIP of Virginia provides to high-risk pregnant women. CHIP of Virginia also was able to establish a contract with a second MCO based on the demonstrated return on investment. Through its contracts with the MCOs, CHIP of Virginia is able to bill for specific Medicaid-covered services. NFP also has contracts with several Medicaid MCOs in Virginia. Additionally, Healthy Families programs that are hosted by a public behavioral health organization may receive reimbursement for targeted case management services for children at risk of serious emotional disturbance.

## Value-Based Payment Models

State Medicaid programs also are implementing a range of alternative payment models to both support innovative delivery models and improve the quality of care. In addition to PMPM payments, alternative payment models currently being used by Medicaid include episode-based payments, through which a provider receives a set payment for a defined set of services, and population-based payments, through which providers receive a set budget and are accountable for covering the majority of services for a specific population.

### Defining Alternative Payment Models

To improve health outcomes and contain costs, state Medicaid agencies are moving away from a fee-for-service payment system that rewards volume, to value-based payment models that link payments to performance and quality. Such alternative payment models include the following:<sup>29</sup>

**Additional payments:** An additional PMPM payment that is paid to providers to cover care management and other support services provided to Medicaid beneficiaries, or to support practice transformation efforts.

**Episode-based payments:** A fixed amount paid to a provider for a defined and discrete set of services involved in treating a specific condition or health event.

**Population-based payments:** A provider or provider group are accountable for delivering the majority of services to a specific population for a set amount of money.

New York has integrated home visiting into its Medicaid payment reform initiative. In 2014, CMS approved New York's Delivery System Reform Incentive Payment (DSRIP) Waiver program,<sup>30</sup> a component of its Medicaid 1115 Waiver demonstration. New York's DSRIP program, implemented by the New York State Department of Health, is designed to incentivize provider collaboration at the community level to improve the quality of care delivered to Medicaid beneficiaries. Its goal is to achieve a 25 percent reduction in avoidable hospitalizations.<sup>31</sup> Through DSRIP, New York is funding Performing Provider Systems (integrated delivery networks made up of Medicaid providers and community-based organizations) to implement a range of care management and population health initiatives. New York is aiming to shift at least 80 percent of its managed care payments to value-based payments by 2020.

Each Performing Provider System must implement between five to 11 projects, under the guidance of the state, that fall under three domains: system transformation projects, clinical improvement projects, and population-wide projects. Participating providers receive incentive payments for reporting measures and for meeting the project performance goals. One project they can opt to implement is an evidence-based home visiting model for high-risk pregnant women in order to, "...reduce avoidable poor pregnancy outcomes and subsequent hospitalization as well as improve maternal and child health through the two years of the child's life."<sup>32</sup> Currently, two Performing Provider Systems (Bronx-Lebanon Hospital Center and Sisters of Charity Hospital of Buffalo) are using DSRIP funds to expand home visiting programs in their communities.<sup>33</sup>

### Accountable Care Organizations

With increased awareness of the impact that economic and social conditions have on health outcomes, states are looking for new service delivery models that can better support population health, such as ACOs. ACOs are groups of providers and hospitals that have agreed to be accountable for the coordinated care of a given population, and typically use a population-based payment approach. ACOs allow flexible spending to cover services and programs that may go beyond state plan services, or allow such programs to be built into global budgets.<sup>34</sup> ACOs present another opportunity to support home visiting through Medicaid, however no state is known to have integrated early childhood home visiting services into their ACO models to date.

## Other Government and Private Programs That Support Home Visiting

Most states use a combination of multiple federal programs and state and private funds to support home visiting programs. The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program is one of the largest federal investments supporting evidence-based home visiting programs. MIECHV, which is administered by HRSA in collaboration with the Administration for Children and Families (ACF), provides grants to states, territories, and tribes to implement home visiting models. In FY 2016, MIECHV-funded home visiting programs served more than 160,000 parents and children in all 50 states, the District of Columbia, and five territories, which represented a five-fold increase over those served in FY 2012.<sup>35</sup> Other federal programs that support home visiting include the federal Title V Maternal and Child Health Services Block Grant, Temporary Assistance for Needy Families (TANF), and Child Abuse Prevention Funds. States also use general revenues for home visiting at varying levels of investment.

Additionally, states use philanthropic and private funds to support their programs. Pay for Success (PFS), is an emerging model for private-public partnerships that has been garnering interest for its potential to support home visiting programs. In the PFS contracting 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 goals. South Carolina is currently using PFS, in conjunction with Medicaid, to expand its home visiting program.

In April 2016, **South Carolina** launched the nation's first PFS initiative focused on improving health outcomes for Medicaid-eligible mothers and children. The South Carolina Department of Health and Human Services, which administers Medicaid and the PFS initiative, used a 1915(b) Medicaid Waiver to support the efforts of NFP program.<sup>36</sup> 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, among other items. This program serves 30 of the state's 46 counties and is available for Medicaid-eligible, first-time mothers. To receive nurse home visiting services, a woman must enroll by the 28th week of her pregnancy, and the family can continue to receive services until the child's second birthday. The program focuses on four outcome metrics to assess NFP's impact. The state made \$7.5 million available for success payments based on NFP's performance on each metric.<sup>37</sup> As of December 2016, the program had enrolled more than 1,100 mothers, which represented one-third of the total enrollment authorized by the waiver.

### **South Carolina's Nurse Family Partnership Program evaluation metrics:**

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

Federal, state, and private funding sources typically have different eligibility requirements, service provisions, and measurement standards, and may only support a subset of the home visiting programs administered by a state. Additionally, multiple state agencies may be involved in the administration of home visiting programs. Utilizing multiple funding sources requires states to develop strategies for coordination and alignment of the funding in order to maximize resources and leverage investments.



## Conclusion

Home visiting programs provide valuable services that have demonstrated positive impact on the health and well-being of women and children while generating savings. States have a long history of supporting home visiting by using a variety of private and public funding streams, including Medicaid. Medicaid provides multiple pathways that states can use to finance home visiting services, from waivers -- such as 1115 and 1915(b) waivers -- to state plan coverage options, such as targeted case management and EPSDT. The optimal pathway depends on a state's unique environment, target population, and capacity to develop a state plan amendment or waiver if the coverage authority does not already exist. As Medicaid payment and delivery systems evolve and provide more flexibility in the types of services covered and how they are paid for, there may be new opportunities to leverage Medicaid support for this valuable service.

Table 1. Federal Medicaid Waiver and State Plan Authorities<sup>1</sup>

Financing Mechanism	Overview	Population Served	Key Considerations for Home Visiting Financing
<b>1115 Waiver</b>	Section 1115 waivers give states additional flexibility to design and improve their programs by waiving certain provisions of federal Medicaid law. These waivers are typically used to expand eligibility to individuals not otherwise eligible for Medicaid, provide services not traditionally covered, or implement innovative service delivery systems.	Defined in the waiver; can be statewide or target specific populations	<p><b>Advantages:</b></p> <ul style="list-style-type: none"> <li>- 1115 waivers give states flexibility to waive freedom of choice of provider, comparability, and statewideness, which allows them to develop home visiting programs that target specific populations.</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>- Developing an 1115 waiver is a time- and resource-intensive process, which typically involves extensive state and federal review.</li> <li>- Waivers must be budget-neutral.</li> <li>- 1115 waiver programs are limited to five years.</li> </ul> <p><b>Examples of States Using This Mechanism:</b> MD and VT</p>
<b>1915(b) Medicaid Freedom of Choice Waiver</b>	The 1915(b) waivers allows states to forego statewideness, comparability of services, and the freedom for Medicaid beneficiaries to choose their providers. The 1915(b) waivers are typically used to implement managed care programs.	Defined in the waiver; can be statewide or target specific populations	<p><b>Advantages:</b></p> <ul style="list-style-type: none"> <li>- In allowing states to waive statewideness, freedom of choice, and comparability of services, states can provide a specific set of services, such as home visiting services, to a targeted population.</li> <li>- It allows for the use of cost savings to provide additional services to beneficiaries, such as non-medical services that are sometimes difficult for Medicaid to reimburse.</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>- Waivers must be cost-effective based on actuarial rates.</li> <li>- 1915(b) waivers are limited to two years.</li> </ul> <p><b>Example of State Using This Mechanism:</b> SC</p>
<b>Traditional Medical Assistance Services</b>	As defined in Section 1905(a) of the Social Security Act, states must offer mandatory benefits and may choose which optional benefits to offer, which are detailed in the state plan. These services can be provided in an office setting or as a part of a home visit.	All Medicaid recipients statewide	<p><b>Advantages:</b></p> <ul style="list-style-type: none"> <li>- No additional state plan amendment is needed to offer these services in the home if they are already included in the state plan; services provided in the home and office setting are covered by the same Federal Medical Assistance Percentage rate.</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>- Only services that are defined as “medical assistance” are covered, which may not include all educational and case coordination activities provided through home visiting programs.</li> </ul> <p><b>Examples of States Using This Mechanism:</b> MI</p>
<b>Administrative Case Management</b>	Administrative case management (ACM) facilitates access to and coordinates Medicaid program services, such as eligibility determination, outreach, securing service authorizations, and assisting with service coordination.	All Medicaid recipients statewide	<p><b>Advantages:</b></p> <ul style="list-style-type: none"> <li>- Provides states flexibility in determining the entities that can provide home visiting services.</li> <li>- ACM does not require a state plan amendment.</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>- ACM does not cover direct medical services, so states would need to cover such services provided during a home visit under an alternative service category.</li> </ul> <p><b>Examples of States Using This Mechanism:</b> IL</p>
<b>Early, Periodic Screening, Diagnosis, and Treatment (EPSDT)</b>	EPSDT is the Medicaid program benefit for eligible children and adolescents under age 21. This benefit provides a comprehensive array of prevention, diagnostic, and treatment services.	All Medicaid recipients under age 21 statewide	<p><b>Advantages:</b></p> <ul style="list-style-type: none"> <li>- EPSDT covers a comprehensive set of services (e.g., screenings, case management, and counseling) that can be provided in a home setting</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>- EPSDT covers children and pregnant women up to the age of 21. Pregnant women ages 21 or older would not be eligible to receive services through this option.</li> </ul>
<b>Enhanced Pregnancy Benefit</b>	The Enhanced Pregnancy Benefit gives states the option to provide additional non-clinical benefits to pregnant women beyond what it typically provides to other Medicaid-eligible individuals, as long as the services are related to pregnancy or to conditions that may complicate the pregnancy.	Pregnant Medicaid recipients	<p><b>Advantages:</b></p> <ul style="list-style-type: none"> <li>- This benefit option allows states to target home visiting services to help ensure delivery of prenatal and postpartum services to pregnant and post-partum women.</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>- This benefit option requires a state plan amendment.</li> <li>- Women are only eligible to receive services through this option during pregnancy and 60 days postpartum.</li> </ul>
<b>Targeted Case Management</b>	Targeted case management (TCM) includes services that help eligible individuals access needed medical, social, educational, and other services. Services must include: assessment services, development of a specific care plan, referral to services, and monitoring of activities.	States identify targeted groups to receive TCM	<p><b>Advantages:</b></p> <ul style="list-style-type: none"> <li>- TCM allows states to target home visiting services to specific populations and/or geographic areas.</li> <li>- States have flexibility in defining the qualifications of providers who can deliver these services, which allows them to reimburse for services delivered by lay providers.</li> </ul> <p><b>Other Considerations:</b></p> <ul style="list-style-type: none"> <li>- TCM requires a state plan amendment.</li> <li>- Medical services are not a part of TCM and must be billed separately.</li> </ul> <p><b>Examples of States Using This Mechanism:</b> CO, KY, NY, OK, OR, SD, TN, VA, WA, WI, and WV</p>

1. Table 1 highlights the key Medicaid financing authorities and mechanisms that states typically use to support home visiting. The state examples are non-exhaustive and reflect those known to be using the specified Medicaid financing mechanism to support home visiting services or programs.

## Resources for Additional Information on Home Visiting

### [Coverage of Maternal, Infant, and Early Childhood Home Visiting Services: Joint Informational Bulletin](#)

This bulletin, released by the Centers for Medicare & Medicaid Services (CMS) and Health Resources and Services Administration (HRSA), describes how components of home visiting programs can be funded or reimbursed by federal sources.

### [Evidence-Based Home Visiting Models](#)

This webpage, created and maintained by U.S. Department of Health and Human Services, provides an up-to-date list of evidence-based home visiting models, including descriptions of the programs and evidence of their effectiveness.

### [Expanding Home Visiting Research: New Measures of Success](#)

The Pew Charitable Trusts' Home Visiting Campaign sponsored independent research to build evidence to inform policymakers' decisions and advance effective practices in home visiting programs. This brief highlights key findings from that work and identifies opportunities for program improvements.

### [Home Visiting: Improving Outcomes for Children](#)

The National Conference of State Legislatures maintains a webpage highlighting the current research on home visiting programs and policy options for states. It also tracks state home visiting legislation that has been enacted since 2008.

### [Home Visiting Promising Practices in the States](#)

The Pew Charitable Trusts produced a series of briefs that highlight promising state practices in home visiting that can serve as models for improving the efficiency and efficacy of state home visiting investments.

### [Maternal, Infant, and Early Childhood Home Visiting \(MIECHV\) Program](#)

This HRSA webpage provides additional information about MIECHV, including information on the state and tribal grantees and the latest reports about the program.

### [Medicaid and Home Visiting: Best Practices from States](#)

This report from the Center for American Progress highlights states' strategies for using Medicaid to support home visiting. It discusses barriers and challenges to leveraging Medicaid funding for these services and outlines state and federal policy options for streamlining the accessibility of Medicaid funds to support home visiting.

### [The Next Horizon for Home Visiting: A White Paper on Policy Discussions Among Stakeholders](#)

This white paper by Zero To Three documents a policy discussion involving local and national stakeholders about next steps for the MIECHV program. It explores the successes and challenges of MIECHV and discusses priorities for moving the program forward.

### [State-based Home Visiting Strengthening Programs through State Leadership](#)

This issue brief, written by Kay Johnson with support from the National Center for Children in Poverty, examines how state-based home visiting programs are structured, financed, and responding to diverse family needs. It also describes strategies states are using to strengthen home visiting programs.

### [Successful Early Childhood Home Visitation State Systems](#)

Zero to Three held a webinar and released a self-assessment tool to inform and evaluate the development of state-based home visitation systems. The webinar highlights innovative components of home visiting systems in four states (Colorado, New Jersey, Virginia and Washington), and the toolkit helps states define their home visiting system, assess their system's capacity, and prioritize areas for improvement.

## Endnotes

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