Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Medicaid Financing and Home Visiting Services

Recommendations to Leverage Medicaid Funding for Home Visiting

Engrossed Second Substitute House Bill 2779; Section 4; Chapter 175, Laws of 2018

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Medicaid Financing and Home Visiting Services

Washington State Health Care Authority

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Introduction

On March 22, 2018 Governor Jay Inslee signed into law Engrossed Second Substitute House Bill 2779 (ESSHB 2779). Section 4 required the Health Care Authority (HCA) to:

- Collaborate with the Department of Children, Youth and Families (DCYF) to identify opportunities to leverage Medicaid funding for home visiting services; and
- Provide recommendations building upon the research and strategies in the August 2017 *Washington State Home Visiting and Medicaid Financing Strategies* report (available online at www.hca.wa.gov).

The August 2017 report describes Medicaid financing options as allowed under specific Centers for Medicare and Medicaid Services (CMS) Authorities through the Social Security Act (SSA). These options include:

- **Medicaid administrative claiming** under Sec. 1903 [42 U.S.C. 1396b] (w)(6)(a), which allows reimbursement for qualified administrative activities provided by governmental entities and their sub-contracted vendors.
- **Managed care contracting** under Sec. 1932 [42 U.S.C. 1396u–2](a)(1)(A), which allows reimbursement for discrete home visiting services as part of the Managed Care Organization (MCO) benefit package.
- **Targeted case management** under Sec. 1905 [42 U.S.C. 1396d] (a)(19), which allows reimbursement for helping clients access medical, social, educational or other services during a home visit, including activities such as screenings, assessments, referrals, and care plan development.
- **Medicaid waiver development** under Sec. 1915 [42 U.S.C. 1396n](b)(1-4), which allows reimbursement for home visiting services by waiving certain Medicaid program requirements; these waivers can support braiding Medicaid, state match, and private funds with a selective contracting process targeting specific populations and providers.

A key strategy to successful implementation of the financing options requires proactive alignment of Medicaid and home visiting to address system complexities and maximize efficiency. HCA and DCYF operate separately under very different and complex funding mechanisms and policies. This can increase program and provider burden when drawing down funding streams with different administrative and reporting requirements. It can also increase parent burden in accessing services that best fit their interests and needs. Sustainable options must consider the impact to provider and parent, and move to address them at the state level for successful local implementation.

HCA contracted with the Athena Group July 1, 2018 through legislatively-allocated funds to support the ongoing cross-agency collaboration to identify opportunities to leverage Medicaid funding for home visiting services, and to conduct eight statewide workshops with home visiting provider organizations, tribes, and interested stakeholders to explore impacts of the different financing options.

This report identifies the options and next steps in financing home visiting services with Medicaid.

Executive Summary

The Washington State Health Care Authority (HCA) and the Department of Children, Youth and Families (DCYF) are working to identify sustainable Medicaid funding for early childhood home visiting services, and to improve coordination across the health and early learning sectors.

This report builds on earlier cross-agency work to identify Medicaid-financing strategies for early childhood home visiting services.

The following financing options were identified by HCA and DCYF as the top choices based on agency criteria from the previous work and stakeholder criteria from recent statewide workshops.

When blending or braiding funding streams, consider:

- Potential resistance to change.
- Funding source requirement variations.
- Differences in agency culture, mission, and approach.
- Capacity to undertake new initiatives.
- Competing state and federal regulations.

Braiding & Blending Funding Streams to Meet the Health-Related Social Needs of Low-Income Persons: Considerations for State Health Policymakers, February 5, 2016

Develop a Medicaid Home Visiting State Plan Amendment for Case Management

Under this option, HCA would work with DCYF to develop a proposed State Plan Amendment to reimburse targeted case management services to assist families in accessing medical, social, educational, or other services during home visits and may include screenings, assessments, referrals and care plan development provided by DCYF home visiting programs funded through the Home Visiting Services Account (HVSA).

Contract with Managed Care Organizations for discrete home visiting services

Under this option, HCA would work with Managed Care Organizations (MCOs) to support contracting with DCYF for home visiting services funded through HVSA programs which could include clinical, behavioral health, and case management services.

Administration Considerations

Local home visiting programs consistently expressed the need for Medicaid financing to flow through the current centralized administrative and reporting structures set up by DCYF under RCW 43.216.130 Home Visiting Services Account (HVSA) as a way to limit increased administrative burden to home visiting staff.

The HVSA is intended to help coordinate and build a statewide home visiting system. It currently funds a portfolio of home visiting models. HVSA service providers range from local health jurisdictions to non-profit organizations, and currently include two Tribal providers.

The HVSA statute requires all state and federal appropriations for home visiting to be deposited into the HVSA. Therefore, a key strategy in sustainable Medicaid funding remains the proactive alignment across HCA and DCYF to best leverage, maximize, and ensure the non-duplication of limited resources.

Medicaid and Home Visiting: What's Possible, What's Not Possible, and Why It Matters

Regulatory

There are regulatory limits to what Medicaid will reimburse, just as there are limits to which home visiting services meet Medicaid requirements for reimbursement. Federal regulations currently do not authorize proprietary home visiting models in their entirety, although some medically necessary home-based services may be allowed. In a 2016 joint bulletin, CMS (Centers for Medicare and Medicaid Services) and HRSA (Health Resources & Services Administration) encouraged states to look for ways to pair Medicaid, state dollars, and private resources to create and fund a home visiting benefit package.

To create this sort of home visiting benefit package, it is critical for policymakers to understand the key differences between Medicaid and home visiting, and how these differences can impact the delivery of home visiting services. Braiding multiple funding streams without careful attention to the different federal and state administrative requirements can significantly increase program and provider burden, which in turn can lessen the time spent on direct services to families, and thus negatively impact the return on investment. A wise investment includes allocating sufficient time and resources to identifying pathways that make full use of existing administrative contracting and reporting systems, rather than creating new ones.

Proprietary Home Visiting Models	Home-Based Medicaid Services
Comprehensive package of services to directly support pregnant women and families in raising physically, socially, and emotionally healthy children ready to learn .	Distinct medical services provided to patients in the home environment. The service is delivered in response to a specific diagnosed health care need.
Home visiting programs must meet specific model fidelity elements. Fidelity requirements vary by model. Changes to the home visiting model must be approved by the developer.	Services must be medically necessary and approved by CMS. Mandatory and optional services are described in each state's Medicaid plan. Changes to a Medicaid state plan require CMS review and approval.
Model developers set provider requirements which generally address education and model-specific training, and may include a medical credential or license.	States set and monitor medical provider licensing and credentialing rules. Only specific medical providers are federally allowed to bill for medical services.
Comprehensive services are typically funded "at-cost" based on a set budget determined by the number of enrollment slots a home visiting program can reasonably serve over a specific period of time. Home visiting programs contract with funders for monthly reimbursement based on the number of slots served.	Distinct medical services are typically reimbursed by Medicaid at less than cost and must have an assigned diagnosis and billing code. Services may be reimbursed under a fee-for-service arrangement or as part of a capitated rate. Non-billing providers must work under Medicaid billing providers to receive reimbursement.

Financing Considerations

States that access Medicaid to help support home visiting services report 2 to 40 percent of specific home visiting services are Medicaid reimbursable. The amount varies by model, state plan, allocated matching state funds, and administrative processes. The larger reimbursement generally includes home visiting services that are more clinical in nature. States also tend to use more than one Medicaid Authority in order to more fully maximize reimbursement potential.

Washington's FMAP (federal medical assistance percentage) is 50 percent. Medicaid match may include unmatched state funds or, in some cases, private funds. Funds from other federal agencies are not eligible to be used as Medicaid match. State funds already used as match or as maintenance of effort (MOE) are also not eligible to be used as Medicaid match.

An additional financing consideration surfaced in the stakeholder workshops. Participants noted the need to set aside sufficient state general funds to serve special populations such as undocumented immigrants or refugees, and to explore differential costs in serving urban and rural populations. This is consistent with Washington State's emphasis on equity across populations.

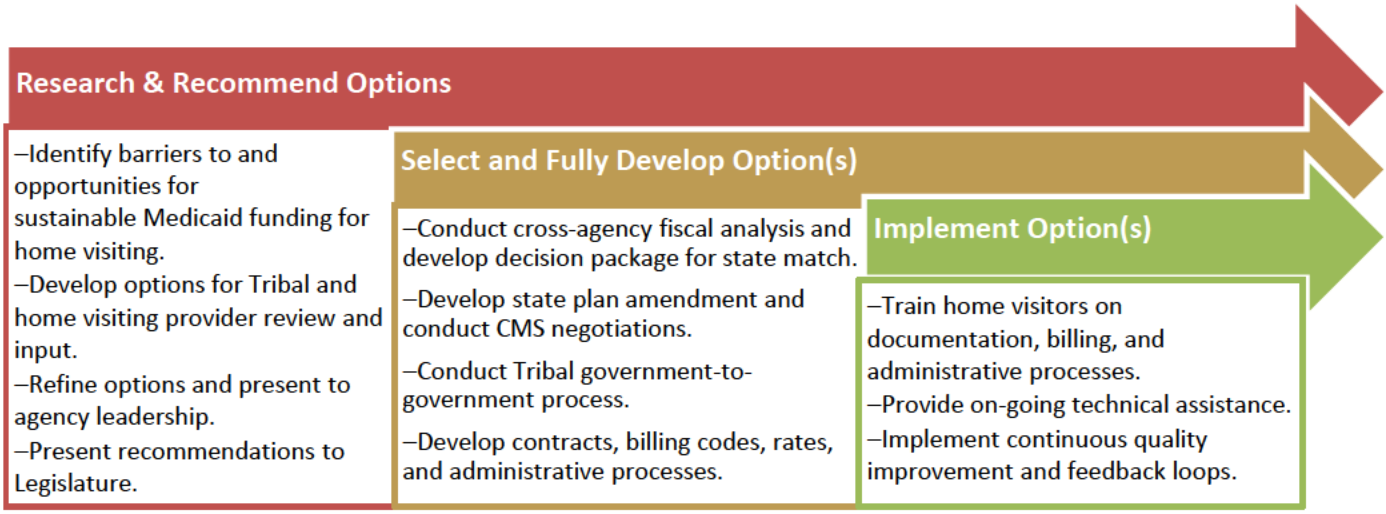
Administrative Considerations

Starting in state fiscal year 2018, DCYF assumed administration of HVSA contracts. This shift allows DCYF to braid federal, state, and private funds into one coordinated contract for each HVSA contractor, which helps reduce administrative burden on local programs.

During the workshops, HVSA-funded providers clearly articulated their preference to maintain a coordinated contract arrangement under DCYF as opposed to negotiating separate contracts with HCA or each MCO. They also hoped reporting requirements could be met by using data they currently collect, rather than by adding additional, duplicative reporting requirements and systems. Such an approach would require HCA and DCYF to set up a cross-agency contract allowing DCYF to sub-contract with vendors and tribes in order to maintain the current coordinated contract and reporting structure, and expand to include more vendors (assuming more funds).

Timeline

Implementing financing options also requires developing a cross-sector understanding of the process timeline with its overlapping steps and priorities. Infusing Medicaid funds into early childhood home visiting will cut across federal and state regulations and decision makers, touching on many different home visiting models and provider organizations. Participants in the community workshops were emphatic about their interest in, and need to be a part of, the implementation planning process. They were equally clear about the importance of the state agencies taking the time to "do it right." Ongoing input from community-based providers will be important in developing sustainable strategies that provide the most support and the least disruption to current administrative and programmatic processes.



Financing Options: Community Workshop Discussions

Medicaid and early childhood home visiting programs operate in vastly different worlds at the policy and programmatic levels. To better understand potential impacts for each option and to gauge local provider preference for each option, half-day workshops in September 2018 were held in Spokane, Lacey, Tukwila, Sequim, Burlington, Vancouver, Yakima, and Olympia. Two themes emerged:

- Home visiting providers already operate under a high level of reporting and administrative burden, which influences home visiting model implementation.
- State agencies and legislators are encouraged to "think big" and "take time to get it right" and to continue to include local providers in the planning process for any selected option.

Attendees identified the following criteria for agency leadership and legislators to consider, asking if the preferred option(s) would:

- Promote a high level of coordination at local and state levels;
- Limit (or reduce, if possible) administrative burden on home visitors;
- Promote sustainability;
- Increase continuity of care;
- Include families with children prenatal to 5 years old;
- Reach more families; and
- Provide flexibility/equity for rural/urban and other specialized population needs.

Workshop participants identified two financing options as most desirable, especially if administered through the DCYF centralized contract process utilizing current administrative and reporting structures, rather than adding new ones. The two preferred options included:

(1) Developing a ***state plan amendment specific to early childhood home visiting*** for targeted case management services under a fee-for-service structure allowing services from prenatal through age five.
(2) Requiring ***managed care organizations to contract for allowable home visiting services*** including clinical, behavioral health, and targeted case management services provided by HVSA home visiting programs.

Generally speaking, workshop input into the other financing options found that:

- Developing a ***1915(b) waiver*** was seen as less secure than a state plan amendment, given renewal requirements and political uncertainties. There were concerns about identifying Medicaid state match for covered services, as well as additional funds to cover non-Medicaid home visiting services and supports to fully fund the cost of a home visiting slot.
- Enrolling as a ***First Steps Infant Case Management provider*** was not perceived as financially viable. Concerns included the time-limited nature of services, limited service units, low reimbursement rates, and the perceived burden in administering the program.
- Contracting under the ***Medicaid Administrative Claiming*** program was generally set aside as most eligible entities that offer home visiting already access this resource (such as local health jurisdictions), and DCYF is currently integrating the Children's Administration Medicaid direct administrative match program into the agency.

Additional detail on community workshop input and criteria can be reviewed at: https://bit.ly/2P5LUuG

Tribal Considerations

Tribal Involvement in Home Visiting Development in Washington State

This report builds upon the August 2017 *Washington State Home Visiting and Medicaid Financing Strategies* report which identified options to infuse Medicaid financing into the HVSA (Home Visiting Services Account), codified in RCW 43.216.130.

The HVSA is intended to help coordinate and build a statewide home visiting system. HVSA-funded programs serve approximately 2,200 families per year, and represent only a fraction of other home-based services. It currently funds a portfolio of home visiting models, including Nurse Family Partnership, Parents as Teachers, home-based Early Head Start, and the Tribally-developed Family Spirit model.

HVSA service providers range from local health jurisdictions to non-profit organizations, and currently includes the Lummi Nation, the Suquamish Tribe, and the United Indians of All Tribes. Additionally, the Port Gamble S'Klallam Tribe, South Puget Intertribal Planning Agency (SPIPA), and the United Indians of All Tribes Foundation (UIAT) are funded separately by the United States

Department of Health & Human Services to provide Tribal home visiting services under Tribal MIECHV (Maternal Infant Early Childhood Home Visiting) funding.

It is important to keep in mind that this report focuses on infusing Medicaid financing into the HVSA. It does not tackle home visiting expansion, which DCYF is exploring through a different process. This report does call out the importance of considering Tribal home visiting interest and need in a separate government-to-government process, to ensure full opportunity for Tribal input into financing options, and to ensure:

(1) Alignment with ongoing Tribal home visiting development work.
Tribal home visiting development work is underway through the joint efforts of the American Indian Health Commission (AIHC), the Department of Health (DOH), and the DCYF. This work is Tribally-led and can be reviewed at the AIHC website. It complements and supports strategies identified in AIHC's *Healthy Communities: Maternal Infant Strategic Plan* to address health disparities and improve the health outcomes of American Indian/Alaska Native (AI/AN) mothers, babies, and families.

(2) Maximum flexibility and Tribal control over Medicaid-funded home visiting services.
Medicaid operates very differently with respect to Tribes and American Indians and Alaska Natives (AI/AN). Medicaid State Plan Amendments, MCO contracts and Waivers that affect Tribes and AI/ANs require consultation between sovereign nations and agency leadership as established under both the Medicaid State Plan with CMS and Washington State's Centennial Accord (codified in RCW 43.376.020).

(3) Maximum access to the 100 percent FMAP under SSA Section 1902(b).
As provided for federally, any amounts expended as medical assistance for services received through an Indian Health Service facility, whether operated by the Indian Health Service or by an Indian tribe or tribal organization, would qualify for the 100 percent FMAP.

Financing Options — A Brief Tribal Perspective

Representatives from the Yakama Nation, SPIPA, and UIAT attended the Home Visiting & Medicaid Financing community workshops held in September. There was keen interest in funding home visiting services through Medicaid, and acknowledgement that preferences for any financing option would vary by Tribe. There was common interest in supporting Tribal home visiting models, provider types, communities, or geographic regions. Representatives felt strongly that there would need to be additional opportunities to consider home visiting financing options.

Many Tribes do not participate in ***Managed Care***, and AI/ANs have the federal right to opt out of or into managed care. Funding home visiting services only through managed care would undermine both Tribes' ability to use Medicaid funds to take care of their citizens' health and AI/AN's access to home visiting. In any managed care approach, it will be critical to ensure that Tribes maintain control over who and how home visiting case management services are provided to their members.

Tribes may be most supportive of using the ***Targeted Case Management*** (TCM) option, as it makes home visiting services available through a Fee-For-Service structure. Tribal workshop participants expressed interest in the possibilities of defining TCM provider types that would allow for home visitors as community health representatives, or trusted members of the community with specific knowledge of her or his Tribal culture and/or language. Workshop participants were also interested in developing a per visit or per family rate, prenatally through age five.

The ***1915(b) waiver option*** was also of some interest to Tribal workshop participants, providing they retain control as program administrators and service providers.

In addition, Medicaid funds are available through ***Medicaid Administrative Claiming*** (MAC) to reimburse governmental entities for a portion of administrative costs related to Medicaid administration. Most home visiting provider organizations work with families to ensure they are enrolled in Medicaid, and assist Medicaid clients in identifying and accessing Medicaid services and supports. Many tribes already participate in MAC. However, there was interest by at least one Tribe in reenergizing their participation in the MAC program. HCA has been working with Tribes to support them in more fully leveraging this valuable resource.

Moving ahead, it will be important to harmonize HCA and DCYF's work around home visiting and Medicaid financing with that of other Tribal home visiting development work. There are many opportunities for Tribes, community providers, and state agencies to more strongly align this important body of work.

Top Financing Options: Elements to Consider

Option: Develop a Targeted Case Management Home Visiting State Plan Amendment
Developing a State Plan Amendment specific to early childhood home visiting for targeted case management services under a fee-for-service structure would have the potential to include all HVSA models, as all HVSA-funded models offer case management services, including screenings, assessments and referrals for parent and child. This option:

- Allows greater flexibility to define:
    - Providers with other qualifications than medical licensing or credentialing;
    - Service areas;
    - Eligible models;
    - Length of service period; and
    - Method of reimbursement (per timed unit, per visit, or per family).
- Reimburses for case management services only. Models offering more clinical or medical services may have more opportunity for reimbursement through the managed care option.
- May be the preferred approach for Tribal communities who have the right to opt-out of managed care.
- May be the only approach to ensure equitable participation for other specialized populations, such as undocumented persons who may only be eligible for state-funded services.

Option: Contract with Managed Care Organizations for HVSA Services

Supporting contracting between DCYF and Managed Care Organizations (MCOs) for discrete home visiting services provided by HVSA-funded programs aligns with Washington State's goal of fully integrated health care by 2020. This option also:

- Provides additional reimbursement opportunities for HVSA models which offer more clinical services or behavioral health services than just case management.
- Help MCOs meet contract targets for incentive payments based on health outcome improvements in such areas as:
    - Access to primary care and continued coverage;
    - Increased well child visit rates;
    - Increased vaccination rates;
    - Increased breastfeeding rates;
    - Tobacco and substance use cessation;
    - Maternal depression screenings and referrals;
    - Reduced rates of child injury and emergency room admission; and
    - Intimate partner violence screening and referrals.
- May limit participation by Tribal communities who have the right to opt out of managed care.
- May exclude participation by other specialized populations, such as undocumented persons who may only be eligible for state-funded services.

Administrative Considerations

Local home visiting programs consistently expressed the need for Medicaid financing to flow to local programs through the current centralized administrative and reporting structures set up by DCYF under RCW 43.216.130 Home Visiting Services Account. Local programs stressed the importance of not adding additional, duplicative billing, and reporting requirements to an already heavy administrative burden, cautioning policymakers to remember that these requirements can detract from direct service provision.

Conclusion and Next Steps

Given that the health and early learning systems operate in vastly different administrative and programmatic worlds, it was important to offer statewide workshops to help home visiting providers and stakeholders better understand the possibilities and limits of Medicaid financing. These workshops also gave them the chance to identify any challenges and concerns from their perspectives on incorporating a new funding stream into an already complex system. It will continue to be important to fully engage both state agencies, Tribes, and HVSA-funded programs in developing a common cross-sector understanding of the necessary process steps to successfully implement selected Medicaid financing options.

Given the complexity of on-going work, it will also be important to allow sufficient time for DCYF and HCA subject matter experts — as well as HVSA-funded programs — to plan and develop action steps, timelines, and cross-system considerations to implement the selected option(s). Policy makers and funders at all levels must be attentive to the administrative impact of regulations, and of reporting and reimbursement processes on providers and the families they serve — and take the lead in addressing those issues.

Moving forward, HCA and DCYF are scheduling a cross-agency executive leadership meeting in late December 2018 to solidify recommendations and to identify specific next steps in moving ahead. Coordinated cross-agency work will be required to develop a joint funding proposal for the 2020 legislative session, and includes:

- Determining fiscal impacts for Medicaid federal financial participation (FFP) related to managed care capitation and/or a state plan amendment.
- Determining fiscal impacts related to the administrative workload to manage CMS negotiations, contract negotiations, and the administration and implementation of Medicaid funding and reporting.
- Continuing cross-agency coordination and work with HVSA-funded programs to develop implementation strategies that limit redundant reporting and administrative requirements.