Washington State Health Care Authority

Washington State Home Visiting & Medicaid Financing Strategies

Submitted to the Department of Early Learning

August 22, 2017

Forward

The Washington State Health Care Authority (HCA) submits this Washington State Home Visiting & Medicaid Financing Strategies recommendation report as a deliverable under contract K1647.

This report represents the continuing growth and exploration of critical cross-agency work to create a healthier Washington where every child enters kindergarten with a solid foundation for success in school and life.

HCA and the Department of Early Learning (DEL) are both deeply engaged in transforming and strengthening the local, regional and state level work they do on behalf of Washington's families. The recommendations discussed in this paper take into account the current activities, goals and requirements elevated as important by the two agencies, as well as the experiences and learnings of other health and early childhood thought leaders at the state and national level engaged in similar work.

Since this paper was tailored to executive level needs for decision making, it was written broadly and without an undue amount of detail. However, it does offer concrete suggestions to help achieve a more coordinated, responsive, cross-systems and client-centered system of care.

As research shows, how families are supported during critical periods of infant and child development matters to achieving optimal outcomes and the best return on investment. Accessing sustainable funding for home-based early childhood services as well as addressing barriers to systems coordination across health and early learning sectors are discussed in the recommendations paper.

Proposed strategies consider:

- HCA and DEL initiatives currently underway regionally and statewide;
- Complex funding mechanisms and policies that impact braiding funds and coordinating services;
- Limitations associated with Medicaid funding and with home visiting program services;
- Experiences and observations shared by other states engaged in similar work; and,
- Culturally relevant services that can build upon approaches already existing that reflect the interests and needs of the community to be served.

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Executive summary

> States should identify strategies to leverage alternative sources of funding—such as Medicaid—to expand the reach of home visiting . . . and identify opportunities in their current Medicaid programs to support home visiting.
>
> ***Taking Action on Early Learning***
> **November 18, 2016**

The Washington State Health Care Authority (HCA) and the Department of Early Learning (DEL) are working together to create a healthier Washington where every child enters kindergarten with a solid foundation for success in school and life. Maternal, infant and early childhood services provided in the home can help providers offer coordinated, responsive, client-centered care during critical periods of infant and child growth and development.

Accessing sustainable funding for home-based early childhood services and improving coordination across the health and early learning sectors is being explored at local and national levels. This report examines approaches taken by other states and organizations, provides specific recommendations to infuse Medicaid-financing strategies into Washington's developing system of maternal, infant and early childhood home visiting services, and explores opportunities to better coordinate and leverage health, home visiting and comprehensive early learning services.

Proposed strategies consider:

- The HCA and DEL initiatives working towards a ***healthier Washington*** where the ***right services are delivered in the right place at the right time*** so that ***every child enters kindergarten with a solid foundation for success in school and life***;
- The complex funding mechanisms and policies for maternal, infant and early childhood services and supports, seeking ways to ***bridge gaps and avoid duplication*** which are crucial considerations when ***braiding funds*** and ***coordinating services***;
- The ***limitations of Medicaid funding***, as not all home visiting program services meet the Centers for Medicare and Medicaid Services (CMS) requirements and the ***limitations of home-visiting models*** which primarily offer services to targeted populations by non-medical professionals;
- The ***experiences and observations*** shared by ***other states*** also analyzing and applying financing strategies, polices and systemic changes to shared services ***across complementary sectors*** more accustomed to operating independently of one another; and,
- The importance of funding approaches that respect ***culturally relevant*** services for ***marginalized and vulnerable communities***, and that can maximize and build upon the services already existing that ***reflect the interests and needs*** of the community to be served.

On October 2, 2017 HCA and DEL leadership met to review the report, discuss alignment strategies, and select financing options**.** Results of the cross-agency discussion can be reviewed on page 32 of this report.

Introduction

Maternal, infant and early childhood services provided in the home setting can improve outcomes for long-term health, school and life success. A clear opportunity exists for HCA and DEL to partner in creating a healthier Washington where every child enters kindergarten with a solid foundation for success in school and life by developing integrated and sustainable programs, services and funding that:

- Expands access to a cohesive portfolio of home-based services;
- Engages and serves families based on their interests and needs;
- Provides careful stewardship of resources, maximizing a return on investments.

Washington State's Five Year Needs Assessment indicated a need to prioritize high risk pregnancy care, substance misuse screening, social and emotional well-being and improved access to and quality of services for pregnant women.

Washington State Breaking Down the Insurance Barrier, March 2016

A key strategy is proactively aligning the health and early learning systems to address systems complexities and to leverage and maximize currently available resources.

While HCA and DEL share a common purpose and goal, agency services and programs are delivered separately from each other. This increases parent burden in accessing services, and provider burden in drawing down funding. Therefore, an overarching recommendation is to rigorously coordinate programs and policies as an important cornerstone in improving population health, education and life outcomes.

This report also describes the following options for HCA and DEL executive leadership to consider as potential financing strategies for home visiting and early learning programs:

- **Contract with HCA for Medicaid Administrative Claiming (MAC) reimbursement** for qualified administrative activities provided by DEL.
- **Contract with managed care plans** to provide specific qualified home visiting services as part of the MCO benefit package.
- **Enroll as a case management agency with HCA** to deliver qualified home visiting services through Targeted Case Management services: 42 CFR 440.169 and 42 CFR 441.18 and through Extended Services to Pregnant Women: 42 CFR 440.250(p).
- **Develop a 1915b Medicaid waiver** to provide a home visiting services benefit package with a set monthly payment.

Background

Washington State is at the forefront of implementing the federal 2010 Affordable Care Act. Increasing access to whole-person health care is a major step towards realizing the state's health transformation goals. The *Washington State Health Care Innovation Plan* identified several new potential health investment strategies, including expanding evidence-based home visiting to improve maternal and child health outcomes (2014, p. 55). It also specifically called for "better alignment at the state and community level" and "closing the gaps between prevention, primary care, physical and behavioral health care, public health, social and human services, early learning/education, and community development systems" under Strategy 2 (p. iii).

Effective health care delivery often requires addressing environmental factors that are not traditionally seen as health care delivery . . .

The challenge is defining which non-medical services may be covered and how, as well as making the case for coverage.

Medicaid Funding of Community-Based Prevention
June 2013

Washington State is also recognized for its pioneering approach to developing a comprehensive, interconnected early learning system. A key service in this system includes supporting at-risk expectant parents and families with babies and young children through voluntary, family-focused home visits. Home visiting has been shown to improve maternal and child health, encouraging and supporting parent behaviors and choices which can lead to reduced adverse maternal and infant health outcomes, and improved longer-term education, career and life goals. Home visiting shows a strong return on investment in prevention and early learning, and is prioritized as a key strategy in the *Washington State Early Learning Plan* (2010, p.5) and the *Washington State Birth to Three Plan* (2010, p.7).

Nationally, the federal Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA) have provided information about programmatic and policy options to finance comprehensive, home visiting services for pregnant women and families with young children. Medicaid has the capacity to cover some medically necessary services typically found in home visiting programs, such as screening and case management. In the joint bulletin *Coverage of Maternal, Infant, and Early Childhood Home Visiting Services* (Wachino & Macrae, 2016, p.4), CMS and HRSA state that while there is "no single dedicated funding source available for home visiting services," state agencies are encouraged to thoughtfully pair federal funds with state and local funds to design a Medicaid benefits package providing evidence based home visiting services for pregnant women and families with young children.

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

HRSA's Home Visiting Evidence of Effectiveness (HOMVEE) website (https://homvee.acf.hhs.gov/) lists specific home visiting program models that might be funded through braided resources, including Medicaid. A limited number of Washington state families currently participate in home visiting through these models, including Nurse-Family Partnership (NFP), Parents as Teachers (PAT), and Early Head Start. Both the benefits of – and the need for – additional home visiting services has been identified across health and early learning sectors. Future challenges are to identify sustainable funding, address any systemic barriers, and adequately support community capacity to implement and/or expand home visiting services.

Benefits of partnering across health and early learning systems

Washington State shares common goals across public and private sectors to support and build healthier communities. Any Medicaid-financing option must consider cross-system impacts to Washington's developing home visiting and health transformation systems. Developing a clear understanding of how the health care and early learning systems operate, including identifying service gaps and overlaps, will aid in coordinating services and leveraging opportunities to better serve shared clients, which in turn can positively impact the shared work and desired outcomes.

> There is growing recognition that a broad range of social, economic, and environmental factors shape individuals' opportunities and barriers to engage in healthy behaviors.
>
> *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity November 2015*

Within DEL, comprehensive, family-focused services are designed and funded with the vision of building a world-class early learning system in which children and families have access to the programs, support and resources they need so children grow up healthy, confident and capable. DEL works closely with at-risk, expectant parents and families with babies and young children. A common experience for these families is being low-income and therefore generally eligible for Washington Apple Health (Medicaid).

Within HCA, Healthier Washington envisions better health and better care at lower cost. To do this, HCA is working at local and regional levels to identify health priorities and test new methods of delivering high-quality, cost-effective care that treats the whole person. This requires comprehensive, coordinated and collaborative care focused on linking clinical and community-based services, and includes reimbursement strategies paying for quality and outcomes rather than volume of services.

The Qualis Health *Comparative Analysis Report* highlights the importance of aligning reporting requirements across agency efforts and establishing additional maternal health and well-child measures to "encourage improved performance on State goals," (2015, p.4). Since individual and population-level outcomes are impacted by both clinical and community-based variables, HCA is also working on addressing the social determinants of health, which requires strong community partnerships and innovative cross-sector efforts.

The HRSA and CMS joint bulletin summarize evidence-based home visiting research, noting that it generally "improves the lives of children and families by preventing child abuse and neglect, supporting positive parenting, improving maternal and child health, and promoting child development and school readiness" (p.2) and more specifically by "providing a positive return on investment . . . through savings in public expenditures on emergency room visits, child protective services and special education," (p. 3). These are measurable outcomes in both clinical and social determinants of health, and point to the importance of proactive collaboration and coordination across sectors.

Common Goals, Similar Measures

Results Washington
WA State Common Measurement Set
WA State Home Visiting Performance Measurement

- Access to primary care and continued coverage
- Increased breastfeeding rates
- Tobacco and substance use cessation
- Maternal depression screenings and referrals
- Reduced rates of child injury, ER admission
- Intimate partner violence screening and referrals

Addressing system complexities from competing policies, reporting and billing mechanisms and requirements is commonly noted as a barrier to client access, effective service delivery and desired outcomes.

Considering how to better harmonize policies, service delivery, and data collection as part of any financing strategy can benefit providers, local programs, clients and the agencies.

Medicaid financing: developing a common understanding

Home Visiting Models	Medicaid Services
Comprehensive package of services and supports for children and their families.	Distinct, separate services provided in response to a specific health care need.
Programs must deliver services meeting fidelity elements which vary by home visiting model.	Medicaid-funded services must be medically necessary and approved by CMS.
Programs are typically funded by private and public funds on a per-slot basis for a set period of time.	State funds must be identified and allocated to draw down federal funds to pay for specific services.
Home visiting model developers set provider education, licensing and credentialing requirements.	States can set provider licensing and credentialing rules greater than federal requirements.

In the simplest terms, Medicaid financing combines federal and state dollars to pay for a benefits package of mandatory and optional benefits, authorized and broadly described in federal regulations called Medicaid Authorities.

In order for states to implement and pay for Medicaid-funded benefits, CMS must approve the benefits program or service through a State Plan or waiver.

For governmental entities pursuing Medicaid reimbursement for administrative expenses, a Cost Allocation Plan (CAP) must be developed, and then reviewed and approved by CMS.

Services must be provided by a licensed, qualified health care professional that meets federal and state requirements.

State matching funds must be identified and allocated for all Medicaid services, waivers or CAPs. State match is required to draw down federal funding for CMS-allowed services; additionally, state or private funds must fully finance service components that are not allowed by CMS.

CMS-approved benefits that qualify for payment include discrete medically necessary services tied to specific diagnoses, delivered by providers meeting specific licensing or credentialing requirements. Not all home visiting or early learning services will meet CMS-requirements to qualify for Medicaid reimbursement. This makes it critically important to identify the component services in home visiting and early learning programs to determine if they are allowable.

Traditional Medicaid benefit packages must meet CMS requirements including comparability, freedom of choice, statewideness, provider qualifications, and state match. These requirements can be adjusted through managed care provisions and waivers -- which also require CMS review and approval. Such adjustments can allow states to target service delivery, serve specific populations or geographic regions, or restrict service provision to certain qualified providers.

State plan amendments generally address administrative changes to the state plan such as provider payment rates, adding or cutting optional services, adding managed care provisions, and changing benefit structures like prescription limits or cost-sharing.

Process details such as billing codes, payment rates and reimbursement procedures are generally described in agency publications, such as HCA's *Billing Guides and Fee Schedules* (https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides).

Each state, within federal guidelines, decides how to finance its share of the Medicaid program. Funding usually comes from a variety of sources, such as:

Not all home visiting or early learning services will meet CMS-requirements to qualify for Medicaid reimbursement.

This makes it critically important to identify the component services in home visiting and early learning programs to determine if they are allowable.

State general revenue. While this revenue is generally appropriated directly to the state Medicaid agency, it may also be appropriated to other state government entities. These entities must then transfer the funds to the Medicaid agency or certify direct expenditures on Medicaid services and administration to claim federal financial participation (FFP).

Local contributions. Counties, municipalities, and other units of local government, including providers operated by local governments, can contribute to the non-federal share of Medicaid spending through an intergovernmental transfer or through certified public expenditures.

Health care related taxes. Health care related taxes are defined by federal statute as taxes in which at least 85 percent of the tax burden falls on health care providers. States commonly use these taxes to establish supplemental payments for providers that pay the tax; increase or avert reductions in Medicaid rates; and/or finance other areas of the Medicaid program.

The federal share of most health care service costs is determined by a state's federal medical assistance percentage (FMAP), calculated annually and based on a statutory formula including per capita income and other factors. The federal share for Medicaid administration does not vary by state and is generally 50%.

States describe their methodologies for determining provider service rates for CMS approval in their State Plans. Any changes to this methodology requires public notification and CMS review and approval through a State Plan Amendment (SPA). State plans also identify provider payment processes, most often through fee-for-service (FFS), managed care, or administrative claiming.

Managed Care	Fee for Service (FFS)	Medicaid Administrative Claiming
• HCA contracts with managed care organizations (MCOs) who in turn subcontract with community service providers. • MCOs must provide services within a set per-member-per-month (PMPM) fee. • MCOs can provide additional services or incentives outside of what is minimally required within the PMPM. • MCOs are not required to follow FFS rules for paying providers, although plans must make payments sufficient to ensure appropriate access for enrollees.	• Qualified providers contract directly with HCA under the Core Provider Agreement. • Providers bill HCA through Provider One for rendered services. • Providers are paid based on an established rate per unit of service. • Federally, rates can be based on a variety of measures: costs of providing the service, a review of what commercial payers pay in the private market, and a percentage of what Medicare pays for equivalent services. (https://www.medicaid.gov/medicaid/financing-and-reimbursement/index.html)	• Governmental entities contract with HCA to receive partial reimbursement for specific Medicaid administrative activities performed by staff. • Eligible activities can include outreach, application assistance, referring clients to services and Medicaid program development. • Governmental entities must develop a cost allocation plan for CMS review and approval. • Reimbursement is based on random moment time study results, the percent of Medicaid individuals served and the federal financial participation rate.

States recognize that home visiting services complement Medicaid . . . and . . . improve the health and well-being of participating families by addressing many of the health and social risk factors that lead to poor outcomes later in life. These states see Medicaid funding as an important supplemental funding source to bolster their home visiting systems.

Medicaid and Home Visiting: Best Practices from States January 2017

Key recommendation: proactively align early learning and health systems

The federal 2010 Affordable Care Act significantly changed health care policy, emphasizing greater access to affordable, quality health care. It also set the stage to transform the health care system to deliver better care with smarter spending. In Washington State, the HCA has been leading health transformation efforts under the Healthier Washington umbrella (https://www.hca.wa.gov/about-hca/healthier-washington) with specific goals to:

- Build healthier communities through a collaborative regional approach.
- Integrate physical and behavioral health needs so health care focuses on the whole person.
- Improve how health care services are paid for by rewarding quality over quantity.

A key Healthier Washington approach includes the development of innovative, sustainable and systemic project proposals by regional Accountable Communities of Health (ACHs). Each ACH project is to be tailored to community needs and priorities; address health systems capacity building, care delivery redesign, prevention and health promotion activities; and reflect value-based payment (VBP) models rewarding whole-person care leading to improved health outcomes. Each ACH is expected to include primary and behavioral health care providers, hospitals, social service agencies, and other community partners in this process.

The diversity and reach of ACH projects requires cross-systems work and strong partnerships that include multiple sectors, not just health care. This was clearly articulated in the *Washington State Health Care Innovation Plan*, acknowledging the importance of the "contributions of and commitment from all state actors" to successfully implement the *Innovation Plan*, requiring "action on multiple levels [to] bridge from planning to implementation" (2014, p. ii).

Evidence-based home visiting was identified as a crucial prevention and intervention strategy to improve maternal and child health outcomes in the *Innovation Plan* (2014, p. J33). Community input on the Medicaid Transformation Project Toolkit also called out home visiting and enhanced maternal-infant services as valued project approaches to achieving health transformation goals (https://www.hca.wa.gov/assets/program/project_toolkit_comments.pdf).

The final CMS-approved Medicaid Transformation Project Toolkit does provide for the inclusion of evidence-based home visiting models as an optional approach under Project 3B: Reproductive and Maternal/Child Health. However, cross-sector and cross-system work offers both great opportunities and functional challenges.

Cross-sector and cross-system work offers both great opportunities and functional challenges.

Home visiting and early learning providers are relatively new players to the health policy and planning transformation table, and report difficulty in identifying suitable ways to fully join regional health care transformation planning activities and projects. Likewise, health care providers and

insurance systems have limited knowledge of the range of benefits and return on investment possible by partnering with home visiting and early learning programs. According to other states, this is not an uncommon experience, and is rooted in the need to develop a shared understanding across the different health and social services systems

***Alignment Strategy*: *Guide and sustain cross-agency opportunities at the state and regional level to support the inclusion of home visiting and early learning services in Healthier Washington projects*.**

In the May 19, 2017 National Academy for State Health Policy (NASHP) webinar State Strategies for Building Integrated Care Infrastructure, Jennifer Blanchard, Director of Community and Care Integration, Minnesota Department of Human Services, described building integrated care across existing robust and complicated case management and care coordination systems.

According to Ms. Blanchard, a flexible framework for consistent utilization of the key components of care integration that could apply across different provider types and organizational mission and values was required. To achieve this framework, she facilitated cross-sector meetings to develop common language, shared understandings and guiding principles across diverse systems. This approach was important to successfully implementing Minnesota's integrated care strategies.

Washington State also has well-established administrative systems operating independently from each other. Additional state leadership could help develop a common language, shared understanding and guiding principles across systems and providers. These traits are necessary to forging unified approaches to meeting agency goals. Without them, invaluable time and energy navigating cross-system complexities can impede a provider's ability to deliver effective services and supports.

In addition to supporting stronger connections and shared understandings at the state agency level, leadership in each agency could explore ways to more intentionally support connections and shared understandings at the regional level. Currently, each agency sponsors regional coalitions that help identify and implement innovative approaches that best reflect community interests and needs as they work toward improving health, school and life success throughout the state.

A common language, shared understanding and guiding principles across systems and providers are necessary to forging unified approaches to meeting agency goals.

Without them, invaluable time and energy navigating cross-system complexities can impede a provider's ability to deliver effective services and supports.

Alignment Strategy: Include HCA's Medicaid-funded First Steps Maternity Support Services (MSS) and Infant Case Management (ICM) in the Home Visiting Services Account (HVSA) portfolio.

Jointly administered by DEL and Thrive Washington, the HVSA leverages state, federal and private dollars to support a portfolio of high-quality home visiting models. State model leads are experts in a specific home visiting model, and provide technical assistance, coaching and training to community agencies to help ensure compliance with model fidelity requirements, determined by the national model developers. Model leads, with their diverse skills and experiences can deepen training and technical assistance opportunities through cross-systems learning. They can also help programs navigate differing fidelity and funding requirements when programs offer multiple home visiting models.

What is First Steps?

First Steps is a Medicaid program for pregnant women and their infants with:

- Apple Health full medical coverage including prenatal care, delivery, post-pregnancy follow-up, family planning.
- Maternity Support Services including enhanced preventive individual and group health-related services as early in pregnancy as possible by an interdisciplinary team.
- Infant Case Management to help connect at-risk infants and their parent or caregiver to medical, social, educational, and other support services.
- Group Childbirth Education.

Home visiting models vary in emphasis and content, some focused on improving maternal and infant health outcomes, such as Nurse-Family Partnership (NFP) and others on improving parenting skills, self-sufficiency and school-readiness, such as Parents as Teachers (PAT). All offer some degree of case management, care coordination and assistance accessing community services. Model eligibility requirements also vary; for example, NFP only serves first-time mothers enrolled no later than the 28th week of pregnancy.

By comparison, First Steps/MSS&ICM provides services regardless of the woman's previous pregnancies or births. The MSS component focuses on improving birth outcomes for mother and baby through an interdisciplinary team approach, starting at any point during pregnancy through 60-days post-partum. The ICM component connects at-risk infants and their parent or caregiver to appropriate services and supports, and begins after the MSS eligibility period ends, lasting until the infant is age one.

Combined First Steps/MSS&ICM for a high-risk mother and infant without any limitation extensions or childbirth education can provide a maximum of 12.5 hours of services. In comparison, home visiting models may establish enrollment deadlines based on stage of pregnancy or age of child, and offer multiple years of service, sometimes lasting through a child's preschool years, and typically provide 90 - 150 total service hours per client, through monthly or more often home visits. Longer duration services can help preserve the continuity and impact of services leading to better and sustained outcomes.

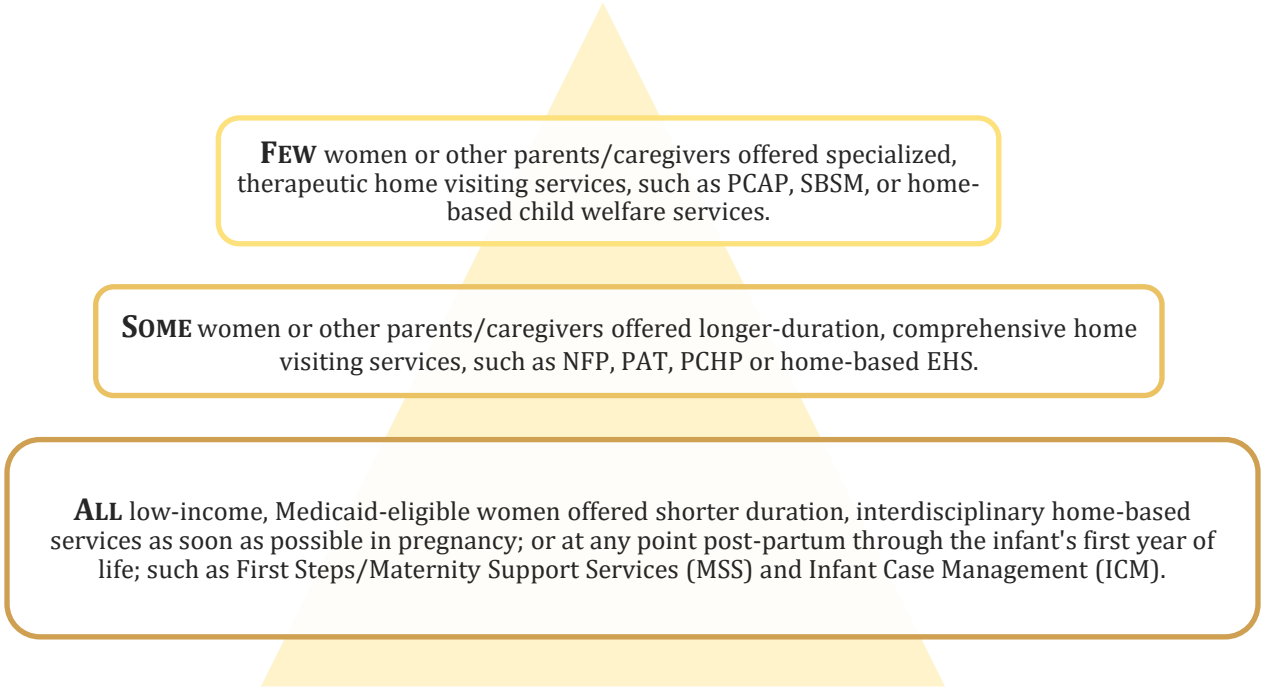
Since 2010, the HVSA has grown to serve 2,000 children statewide. However, need far outweighs current capacity and resources, with an estimated nearly 40,000 families eligible for home visiting services (https://thrivewa.org/home-visiting/). Most of these families are also eligible for, or already insured through, Medicaid (Apple Health).

Apple Health benefits cover roughly one-half of total births in Washington State, and of those births, around one-half of pregnant women also choose to receive First Steps/MSS and/or ICM. For example, in 2015, around 22,300 women received MSS, and around 9,700 infants received ICM services (https://www.hca.wa.gov/assets/billers-and-providers/characteristics-women-washington-state.pdf).

Including First Steps/MSS&ICM in the HVSA portfolio with HCA's program managers functioning as the state model leads could help close service gaps resulting from strict home visiting model eligibility requirements by providing interdisciplinary, shorter-duration, medically focused services to high risk pregnant women, and targeted case management services to at-risk infants and their parents. After the child turns one year of age, if risk indicates continued services, these families could then transition to other home visiting services in the HVSA, such as Parents as Teachers (PAT).

This intentional alignment would support stronger system coordination and referrals, connecting clients to the most appropriate service or program that meets their interests and needs. It would also support better utilization of limited resources, building program and service capacity through provider cross-training. When considering unmet need, as well as community and provider capacity and diverse funding requirements, closer coordination has many benefits, including maximizing limited resources by:

- **Connecting families to appropriate services based on risk factors, interests and needs.** This can ease service navigation for parents, increase enrollment and retention, lead to improved health outcomes and school readiness, and help ensure consistent, sustained access to needed services.
- **Supporting First Steps providers and HVSA Local Implementing Agencies (LIAs) through the Implementation Hub**. A centralized evidence-based approach can increase provider knowledge of diverse program strategies, and support improved quality, service delivery and outcomes, capitalizing on scarce training resources.
- **Maximize limited resources through careful coordinatio**n. Close coordination can help effectively distribute limited resources, supporting a healthier Washington by providing the right services in the right place at the right time, so every child enters kindergarten ready to learn. By leveraging Medicaid resources within the HVSA, services could be expanded to a wider population.



The Maternal Infant Health Program (MIHP) and home visiting system in Michigan (discussed on the next page) provides an example of how coordinating and braiding Medicaid-funded home based services with other home visiting models can increase service capacity and improve maternal and infant health outcomes.

Michigan's Medicaid-Funded Maternal Infant Health Program
A Vital Part of their State's Home Visiting System

Similar to Washington State, in 1987 Michigan's Medicaid State Plan included extended maternal support services through 60-days post-partum (42 CFR 440.250(p)) to reduce infant mortality and morbidity among pregnant and infant Medicaid beneficiaries, and to remove barriers to prenatal care. A few years later, Michigan added infant-focused support services through targeted case management to promote healthy development during infancy. Services were generally home-based, and provided by registered nurses, licensed social workers, and registered dietitians. Providers had flexibility in services delivery, creating wide variation in the program model and outcomes.

In 2004, Michigan consolidated its Maternal Support Services and Infant Support Services into the Maternal Infant Health Program, a population-based management model, addressing individual health within the population. MIHP provides care coordination and health education services, including childbirth and parenting education classes. Registered nurses and licensed social workers now use a standardized validated risk screener, tying evidence-based interventions to client risk levels. Appropriate services based on need and risk are provided statewide; transportation assistance is also provided. The mother can receive up to nine visits; the infant can receive nine visits, plus nine more with a physician's order.

A centralized database tracks outcomes and quality; data shows MIHP has a positive impact on birth outcomes and infant mortality. Quasi-experimental evaluations of MIHP demonstrate increased prenatal care use; improved birth outcomes such as reduced rates of low birth weight, very low birth weight, and extreme prematurity; increased maternal postnatal care; and increased infant preventive services and well-child visits during the first year of life. Randomized trials to prove effectiveness were not considered feasible since Medicaid is an entitlement program and all insured pregnant women are eligible for MIHP.

MIHP is part of Michigan's home visiting system, which includes the Department of Community Health, Department of Education and Department of Human Services. Other home visiting models within Michigan's home visiting system include: Early Head Start Home Visiting, Healthy Families America, Family Spirit, Infant Mental Health, Nurse Family Partnership, and Parents as Teachers. Each model is funded through one or more resources: MIECHV, State School Aid Section 32p Block Grant Funds, CBCAP, state general funds, and private funding.

Michigan's state legislature passed Public Act No. 291, their 2012 Home Visiting Initiative, to guide their developing home visiting system. PA 291 is similar to Washington's 2010 Home Visiting Services Account (HVSA) under RCW 43.215.130. Both pieces of legislation take steps to address the systemic complications in supporting effective, accountable programs funded by diverse resources and administered across different agencies. Additionally, Michigan's initiative is intended to "build a system of administrative support to expand the capacity of home visiting" and is nested within their early childhood system to "facilitate a comprehensive menu of services for Michigan's most at-risk families."

One of Michigan's key requirements for achieving PA 291 goals is for "affected departments to create an internal process that provides for greater collaboration and sharing of relevant home visiting data and ensure a stronger home visiting continuum of services."

Through this intertwining of programs, Michigan reported that 36,000 families were enrolled and received home visiting services in 2015.

http://www.michigan.gov/documents/homevisiting/PA_291_2015_Home_Visiting_Legislative_Report_528782_7.pdf

Four financing strategies to consider

Home visiting programs generally operate through community-based organizations under a per client, funded enrollment level (FEL). The FEL represents actual direct and indirect costs, with program capacity determining the number of clients served over a set period of time. Funds are usually awarded through grants from private investors or through service contracts with government entities. Funding application processes vary in complexity and can require significant effort to prepare.

In comparison, CMS ties cost reimbursement to approved, medically necessary direct services delivered by licensed, credentialed health care providers. Receiving CMS approval varies greatly in length of time; complex Medicaid regulations often requires considerable staff investment in up front time and energy.

The task of developing financing options then becomes one of matching allowable discrete home visiting services to the appropriate Medicaid Authority. In order to sustain selected financing recommendations, it will also be crucial to address the complexities of the health and early systems through proactive guidance and alignment at state, regional and local levels, as discussed earlier in this paper.

It is also important to keep in mind that no Medicaid financing option will provide an immediate infusion of funds. However, the first and third options below offer shorter-term "low-hanging fruit" for a more rapid, albeit modest source of funds. The second and fourth options would take longer to develop. Each option below is discussed in greater detail on pages 16-25.

- **Medicaid Administrative Claiming (MAC)**. Government entities can be reimbursed for performing necessary, reasonable Medicaid State Plan administrative activities on behalf of the Health Care Authority (HCA). Expenses may include staff salary and benefits and other costs as described in OMB 2 CFR Part 225—Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A–87).
- **Integration with Apple Health (Medicaid) Managed Care Plans**. Under managed care, states contract with MCOs to deliver Medicaid benefits through provider networks. MCOs reimburse providers in their network through subcontracts. MCOs must provide mandatory Medicaid benefits; depending on the state plan and contract provisions, they may provide some or all of the optional Medicaid benefits (https://www.macpac.gov/subtopic/mandatory-and-optional-benefits/).
- **Targeted Case Management under 42 CFR 440.169**. Targeted case management services are allowed without adherence to statewide provision of services (§ 431.50(b)) or comparability (§ 440.240), and may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.
- **Develop a 1915b Medicaid Waiver**. A 1915(b) waiver offers the potential of funding LIAs to deliver home visiting services through a more familiar contracting process that pays for services on a per-slot basis by braiding Medicaid, state match and private funds. This option could also support Washington's interest in implementing social innovation financing of home visiting.

Contract with HCA for Medicaid Administrative Claiming (MAC) Reimbursement	
Medicaid Authority	***1903 (w)(6)(A) of the Social Security Act*** The Medicaid Administrative Claiming (MAC) program reimburses government entities for administrative expenses incurred performing necessary and reasonable Medicaid State Plan activities on behalf of the Health Care Authority (HCA). Expenses may include staff salary and benefits and other costs as described in OMB 2 CFR Part 225—Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A–87).
Washington's Medicaid Title XIX State Plan	MAC is a voluntary program that reimburses governmental entities for the time staff spends performing administrative activities on behalf the HCA's Medicaid program, as described in the Medicaid State Plan.
What specific home visiting services would qualify for reimbursement?	MAC contractors can receive partial reimbursement for activities such as: • Developing, planning, and creating programs related to Medicaid. • Evaluating and improving access to Medicaid-covered services through program planning, policy development, and interagency coordination. • Providing or receiving training related to Medicaid services or MAC. • Informing individuals about Medicaid benefits or services, and assisting them to complete an application for Medicaid eligibility determination. • Linking individuals to Medicaid-covered services by arranging interpretation and transportation services. • Referring individuals to Medicaid-covered medical, dental, vision, mental health, family planning, pharmacy, and/or substance abuse treatment.
What are the potential benefits of this option?	This strategy has the potential to leverage additional resources by: • Increasing DEL's capacity to participate in cross-sector program development and planning that involves Medicaid activities. • Partially reimbursing DEL and its vendors engaged in qualified Medicaid administrative activities. • Allowing services in the office, clinic, client home or other site.
Administrative considerations	**A two-pronged approach is required to fully maximize this option:** A. Under this proposal, DEL would contract with HCA as a sub-recipient. HCA would work with DEL to develop a cost allocation plan (CAP) describing the time allocation method, funding mechanisms and the staff and activities eligible for reimbursement. Once the CAP is completed, HCA works directly with CMS for their review and approval. Based on the approved CAP, DEL could then receive partial reimbursement of necessary and reasonable expenses incurred performing administrative activities on behalf of HCA's Medicaid program. Other expenses, such as staff travel and training, or vendor contracts may be allowed so long as they comply with 2 CFR 225, clearly define the MAC activities performed, and clearly identify the portion allocated to Medicaid. Some key components of DEL's MAC participation would include: • Assigning a Coordinator to manage the program and work with HCA. • Paying a biannual administrative fee. • Participating in the ongoing random moment in time study (RMTS) or developing a direct charge methodology. • Providing local matching funds through the certified public expenditure (CPE) process. • Complying with program rules and monitoring requirements. As with any other sub-recipient contract, DEL must maintain complete backup documentation clearly

	linked to source documentation for all expenses submitted to HCA for MAC reimbursement.
	
	B. To pursue MAC reimbursement for home visiting and early learning vendors, DEL and HCA would need to develop a documented method for determining the Medicaid and non-Medicaid portion of allowable necessary and reasonable expenses incurred while performing administrative activities on behalf of HCA's Medicaid program. Options include:
	• Using time studies; or
	• Applying a Medicaid Eligibility Rate (MER); or,
	• Determining a Medicaid Single Cost Objective within the vendor contract for:
	  ○ the entire contract, or
	  ○ an explicit percentage/amount.
	
	MAC program elements and individual source documentation requirements would be bundled into the DEL vendor contracts, with DEL providing on-going monitoring and compliance activities. DEL would directly invoice HCA, and reimburse vendors the approved reimbursable amount.

What are the provider qualifications for Medicaid reimbursement?	Governmental entities under contract with HCA can bill for MAC reimbursement of allowed administrative activities on behalf of HCA's Medicaid program.
Estimated Timeline to Implement	Six months to one year to complete administrative requirements to begin billing HCA for Medicaid reimbursement for DEL state agency staff.
Additional Considerations	Once the HCA-DEL contract is in place, DEL's MAC coordinator would work with HCA to develop the process for MAC reimbursement through vendor subcontracts for allowable necessary and reasonable expenses incurred while performing administrative activities on behalf of HCA's Medicaid program.
Other State Approaches	According to the January 2017 Center for American Progress report, California reimburses some home visiting components through TCM and others through Medicaid administrative match. Home visitors must meet specific professional requirements (such as NFP's registered nurses) to qualify for reimbursement under TCM; however, the use of Medicaid administrative match expands the pool to non-degreed, professional providers. This, in turn, expands home visiting services to include mothers who might not meet the enrollment requirements for other home visiting models to receive services.
Potential pay-out	MAC reimbursement of approved costs varies based on governmental entity and includes: • Expenses after federal funds/grants are subtracted. Only non-matched state and private funds may be used. • Time study results (percent of time documented as Medicaid). • Percent of individuals served who are Medicaid eligible (MER). • Federal Financial Participation rate of 50%.

CONTRACT WITH MANAGED CARE PLANS TO PROVIDE SPECIFIC QUALIFIED HOME VISITING SERVICES AS PART OF THE MCO BENEFIT PACKAGE.	
Medicaid Authority	***1932(a)(1)(A) of the Social Security Act*** Under this authority, a state can require certain Medicaid beneficiaries to enroll in managed care without obtaining a waiver or being out of compliance with the Medicaid requirements of statewideness (42 CFR 431.50), freedom of choice (42 CFR431.51) or comparability (42 CFR 440.230). Certain groups are exempted (for example, beneficiaries who are dually eligible for Medicare and Medicaid, Native Americans and children with special health care needs). Under managed care, states contract with health plans to deliver Medicaid benefits, paid through a monthly premium (capitation) payment per enrollee. Plans must provide mandatory Medicaid benefits; depending on the state plan and contract provisions, they may provide some or all of the optional Medicaid benefits.
Washington's Medicaid Title XIX State Plan	June 2014 -- Approved with an effective date of January 1, 2014. State Plan Amendment (SPA) Transmittal Number 14-0004 Under the current approved state plan amendment, Washington is moving towards fully integrated managed care (FIMC) in 2020. A Healthier Washington initiative, FIMC aims to provide whole-person care through an integrated network of managed care providers. As part of FIMC, mental health and substance use disorder services were combined into behavioral health organizations (BHO) in 2016. The structure and administration of the BHOs is expected to transfer from DSHS to HCA in January 2018, helping facilitate the transition to FIMC.
What specific home visiting services would qualify for reimbursement?	Community-based home visiting programs all provide some level of case management and care coordination. While home visiting is not a covered Medicaid benefit, discrete services provided during a home visit (such as case management when delivered to a Medicaid-enrolled or Medicaid-eligible client) are allowable. MCO's do have the budgetary flexibility within their PMPM to purchase optional or incentive services. For example, in Washington each MCO offers a different set of incentives or services for pregnant women and new parents, to encourage timely preventive care and move toward better maternal and infant health outcomes. Home visiting services could be an added incentive for the enrollee, as well as assist the MCO in achieving desired health outcomes.
What are the potential benefits of this option?	• The majority of Washington's Medicaid clients are enrolled in managed care. In a formal partnership, home visiting outreach and recruitment can be formally coordinated with MCOs, streamlining LIA efforts who currently juggle multiple partnerships and community events to market and promote home visiting. • Managed care organizations have somewhat greater flexibility than FFS in how they provide and pay for services, including the ability to identify and assign codes and rates beyond what is described in HCA's Provider Guides. However, any potential financial benefits must be negotiated with each MCO. • Home visiting programs and managed care entities both desire to show improved health outcomes. FIMC improves coordination and collaboration between providers. However, improved health outcomes also require consistent client engagement. Home visitors work 1:1 with clients to facilitate access to and coordination of needed services and supports to reduce adverse maternal and infant health outcomes, and improve longer-term education, career and life goals. Home visiting programs can help maximize FIMC systemic changes including network adequacy and meeting the outcomes required to earn incentive payments.

Administrative considerations	Medicaid Apple Health operates through five statewide MCOs, and covers most pregnant women, children, and parents. It provides a full range of physical health services, as well as most non-acute behavioral health services. The state selects MCOs through a competitive procurement process and sets base rates using actuarial analysis. MCOs subcontract with a wide variety of community-based providers to ensure a sufficient network of preventive, primary, specialty and other health services. Under this recommendation: • DEL would directly negotiate and contract with interested MCOs to provide specific qualified home visiting services and then sub-contract with the appropriate HVSA LIAs. This process would include exploring each MCO's interest in available home visiting services, and building the case for home visiting's value to the MCO's contract goals and obligations, especially as they relate to individual health outcomes. • HCA, as the state Medicaid agency, would broker introductions and facilitate initial meetings between DEL and the appropriate MCO staff, as well as continuing to provide consultation to DEL on the complexities of Medicaid, Apple Health benefits and coverage, and managed care contracting processes. A longer-term option would involve: • HCA developing state plan language to allow specific qualified home visiting services (as offered through the HVSA portfolio) in the state plan under FFS, with the final goal of incorporating those services into managed care contracts to meet the 2020 goal of integration. HCA and DEL would work together to identify budget implications based on proposed service provisions and develop the legislative state match request for an increased PMPM. • DEL, as the lead agency for early learning, would provide consultation and subject matter expertise on home visiting models, the developing home visiting system and geographic coverage, and HVSA service delivery intricacies. If DEL chose to pursue a MAC contract in addition to the managed care option, the work involved in developing, planning, and creating programs related to Medicaid through managed care, as well as evaluating and improving access to Medicaid-covered services through program planning, policy development, and interagency coordination would be eligible for partial reimbursement.
What are the provider qualifications for Medicaid reimbursement?	Professional health care provider types are listed in federal and state statute. Medicaid state plans identify those providers determined qualified to provide specific medically necessary services. In Washington, the State Department of Health licenses, permits and certifies health care professionals. MCOs follow those requirements. However, MCOs do have the flexibility to contract for optional Medicaid services which may be delivered by other provider types, such as community health workers.
Estimated Timeline to Implement	The goal would be for 2020 as part of fully integrated managed care (FIMC).
Additional Considerations	Even if agency leadership elects to not pursue managed care contracting to provide home visiting services, there are a number of ways in which HCA and DEL could intentionally develop stronger coordination, starting at the agency and policy level, and being supported through contract lanaguge, communications, and supporting partnership efforts at the local level with MCOs. For example: • Under Section 14 in the Washington Apple Health – Fully Integrated Managed Care Contract template, DEL's Early Support for Infants and Toddlers (ESIT) program is

	identified as an external coordinating entity. While ESIT provides valuable interventions, home visiting provides valuable prevention services that usually start in pregnancy. It would make sense to also identify effective preventive services which can help reduce the need for more costly interventions. • Continue to work together across the agencies to develop specific communication tools that HCA and DEL can use to support increased understanding and collabortion between the diverse systems and providers. • Current MCO performance improvement projects (PIPs) are targeting desired rate increases in specific health indicators. Each year there are different PIPs selected. Home visiting is also working to move the needle on several indicators; there may be opportunities for collaboration in the following areas: o Access to primary care and continued coverage o Timely prenatal and postpartum health care o Decreased preterm births and low birthweight o Increased breastfeeding rates o Tobacco and substance use cessation o Maternal depression screenings and referrals o Timely developmental screens, referrals, well-child exams o Reduced rates of child injury, ER admission o Intimate partner violence screening and referrals
Other State Approaches	According to the Center for American Progress, even though managed care is used for Medicaid delivery in over one-half of states, home visiting services are more typically reimbursed via FFS, and not through capitation. • Minnesota is starting to integrate home visiting into managed care, requiring MCOs to include in their provider networks public health agencies that offer home visiting (NFP, HFA, and Family Spirit). MCOs reimburse public health agencies for Medicaid-covered services provided as part of the home visit. Payments vary based on the contracts between the MCO and public health agency, and do not cover the full cost of a home visit, but related services such as case management and follow-up on referrals. Specialized training is being developed to assist agencies in maximizing allowable reimbursement. • Michigan transitioned Maternal Infant Health Program (MIHP) services from fee for service to managed care January 1, 2017, requiring managed care plans to refer all pregnant women to a MIHP or equivalent evidence-based home visiting program, or to document the women's refusal to receive these services. Each MIHP provider needed to contract with one or more managed care plans to receive reimbursement for in-network services provided to MIHP enrollees.
Potential Pay-Out	States typically pay MCOs for risk-based managed care services through fixed periodic payments for a defined package of benefits. States must ensure capitation rates adequate to meet MCO contractual requirements regarding availability of services, assurance of adequate capacity and services, and coordination and continuity of care. Payments are distributed to MCOs per member/per month (PMPM); MCOs negotiate and subcontract directly with individual providers for service and payment provisions to create their provider networks.

ENROLL AS AN INFANT CASE MANAGEMENT AGENCY WITH HCA	
Medicaid Authority	***Case management services: 42 CFR 440.169*** (a)Case management services means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with § 441.18 of this chapter. (b) Targeted case management services means case management services furnished without regard to the requirements of § 431.50(b) of this chapter (related to statewide provision of services) and § 440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.
Washington's Medicaid Title XIX State Plan	Under Section 3.1-A Supplement 3.1-C: Infant Case Management Services in the Washington State Plan, infant case management services are allowed under targeted case management, as a component of the First Steps program. ICM services help infants and their parent or caregiver access needed medical, social, educational, and other services through: • comprehensive in-person screening and assessment, • care plan development, • monitoring and referral to services, and • client advocacy. ICM services can be delivered in the office, clinic, infant's home or other site. ICM services can start the day after the 60-days post-partum period and last through the infant's first birthday.
What specific home visiting services would qualify for reimbursement?	Enrolling with HCA as an infant case management agency allows reimbursement for: • Screening and assessing for client/family needs, analyzing family situations, and collecting information needed to develop service delivery plans. • Arranging and coordinating services on behalf of a family or child, including advocacy on behalf of the client, consultations with other staff and providers, and identifying appropriate resources.
What are the potential benefits of this option?	Increasing access to targeted case management services through ICM supports Healthier Washington goals using research-based prevention strategies, aligning data collection efforts, and increasing provider opportunities for technical assistance and training. Additionally, this increases community awareness of ICM and encourages stronger links to longer-duration services to help maintain health goals and outcomes. Additionally, this strategy has the potential to leverage additional financial resources for home visiting by: • Reimbursement through fee-for-service (FFS) for targeted case management services for an eligible infant and his or her parent/caregiver for up to 20 units (5 hours) of service. *Note: Approved limitation extension requests can add additional units of service.* • Freeing up longer-duration home visiting enrollment slots such as PAT or PCHP by serving families interested in shorter duration services in a variety of settings. • Streamlining effective referral processes which can help maximize available resources and decrease duplication of services. • Supporting coordinated contracting and monitoring processes, if administered through DEL.

Administrative considerations	**Two methods of administration under this proposal:** A. DEL would secure a federal NPI number and enroll with HCA as a billing provider, and then subcontract with HVSA LIAs. DEL would incorporate ICM requirements into the subcontracts, and provide monitoring, technical assistance and training on ICM services. DEL would maintain individual source documentation to meet federal reporting requirements for each subcontract. DEL would report to and bill HCA for ICM services rendered by HVSA LIAs, and then reimburse the HVSA LIAs under the subcontract terms and conditions; **or,** B. HCA would work with DEL and Thrive to assist interested HVSA LIAs not currently billing for ICM services to secure a federal NPI number and enroll as billing providers with HCA. HVSA LIAs would maintain source documentation to meet federal reporting requirements and directly bill HCA through Provider One. **As defined in the WA SPA, under Infant Case Management Services, Supplement 1-C to attachment 3.1-A, agencies allowed to provide ICM services:** • Are public or private social, health or education agencies employing staff with infant case managers. • Demonstrate the ability to refer, link and collaborate with individual practitioners, social, health and education agencies. • Have experience working with low-income families including pregnant and parenting women and children. • Meet applicable state and federal laws and regulations governing the participation of providers in the Medicaid program. **WAC 182-502-0002** The following health care professionals, health care entities, suppliers or contractors of service may request enrollment with the Washington state health care authority (medicaid agency) to provide covered health care services to eligible clients. For the purposes of this chapter, health care services include treatment, equipment, related supplies, and drugs. (2) Agencies, centers and facilities: (f) Case management agencies; (bb) Maternity support services agencies; maternity case managers; infant case management, first steps providers.
What are the provider qualifications for Medicaid reimbursement?	**Individual ICM providers must:** • Work for a case management agency with a National Provider Identification (NPI) number; and, • Meet licensure requirements as determined and established by the Washington State Department of Health (DOH); and, o Be part of an MSS team at the RN, BHS or RD level; or o Have a BA or higher in social service field plus at least one year full-time social service work experience; or, o Have an AA in social service field plus at least two years full-time social service work experience and work under the direct supervision of an MSS-team member or a supervisor with a BA or higher in the social service field.
Estimated Timeline to Implement	Six months to one year to complete administrative requirements to begin billing HCA for Medicaid reimbursement.

Additional Considerations	***Currently, HCA is working to reengage former First Steps/MSS&ICM providers and bring on-board new providers. HCA and DEL could work together to bring on new providers through qualified home visitors and LIAs. In addition to home visiting providers billing ICM, there is also the potential for some home visiting providers to bill MSS.*** **Under** WAC 182-533-0327 (3) **the MSS-interdisciplinary team requirement is waived for Tribal & Indian Health Programs, and for counties reporting fewer than 55 Medicaid-paid births per year**. HVSA LIAs meeting the above conditions and with at least ONE provider meeting the qualifications below could provide MSS services. • Currently licensed registered nurse under WAC 246-840; or, • Currently credentialed or licensed behavioral health specialist under WAC 246-809, 246-810, and 246-924; or, • Currently registered with the Commission on Dietetic Registration and certified under WAC 246-822. • In addition, a community health representative (CHR) can offer services under the direct supervision of the qualified MSS provider. MSS also reimburses qualified providers for group sessions providing preventive health and education services as described in the Maternity Support Services and Infant Case Management Billing Guide. Group sessions are not an allowable home-based services. Telemedicine is allowed as a real-time service delivery substitute for in-person, face-to-face, hands' on encounters. MSS services can start the day the mother's pregnancy is confirmed and she is enrolled in Medicaid, and continue through 60-days post-partum. During post-partum, the provider can screen for risk and need for services provided through infant case management for a seamless transition to ICM services.

Other State Approaches	Case management and the subset of targeted case management (TCM) is the Medicaid Authority most commonly utilized to help support home visiting, according to the January 2017 Center for American Progress report. For example:
	
	In Wisconsin
	• NFP and Heathy Families America (HFA) bill Medicaid under prenatal care coordination (PNCC) which is similar to the First Steps/MSS component, and then TCM which is similar to Washington's First Steps/ICM component.
	• PNCC providers include community-based health organizations, social services agencies, county or city public health agencies, and physicians' offices. Medicaid-certified PNCC providers may subcontract with non-Medicaid certified agencies to provide PNCC.
	• Services are typically provided in a client's home by registered nurses. HFA and NFP meet this criteria and are able to receive payment for PNCC services.
	  ○ Qualified PNCC service providers bill Medicaid separately for the initial assessment and care plan development.
	  ○ Home visitors then bill for service coordination, such as the work nurses perform to make referrals to other health care providers or to coordinate transportation to health care appointments.
	  ○ Medicaid will not pay for diagnostic or treatment services during the home visit, only for health education and nutrition counseling.
	• After the end of the MSS eligibility period, the infant becomes eligible for additional home visiting services up to age 5 under the TCM authority.
	• Certified TCM providers generally include public entities such as counties, tribes, or municipalities who may contract with home visiting programs.

	In Colorado: • NFP bills Medicaid under the TCM authority. All state-funded home visiting program sites are required to maximize Medicaid billing. • Medicaid reimburses monthly for targeted case management services delivered by NFP RNs. • TCM does not allow reimbursement for direct interventions provided by NFP RN. • Colorado has hired an outside expert consultant to help address missed Medicaid billing opportunities.
Potential Pay-Out	Under the current *HCA Billing Guide*, ICM providers can bill for: • A minimum of 2 units to screen the infant and parent/caregiver for risks. • 6 units of service for infants with a lower level of risk. • 20 units of service for infants with a higher level of risk. Providers can request additional units of service for the client through the limitation extension request process. Each fifteen-minute unit is reimbursed at $20.00. A provider could potentially bill for 20 units (5 hours) of service for one high-risk infant and her parent or caregiver at $20/unit for a maximum total of $400.00. Under the current *HCA Billing Guide*, MSS providers can bill: *For a woman enrolled during pregnancy, with services through 60-days post-partum*: • 7 units of service for pregnant women with a lower level of risk. • 14 units of service for pregnant women with a medium level of risk. • 30 units of service for pregnant women with a high level of risk. American Indian/Alaska Native clients are automatically eligible for 30 units of service. *For a woman enrolled after giving birth, with services through 60-days post-partum:* • 4 units of service for post-partum women with a lower level of risk. • 6 units of service for post-partum women with a medium level of risk. • 9 units of service for post-partum women with a high level of risk. Providers can request additional units of service for the client through the limitation extension request process. Each fifteen-minute MSS unit is reimbursed at $25/unit, unless the service is provided in the client's home. Home-based services are reimbursed at $35/unit. A provider could potentially bill for 30 units (7.5 hours) of home-based service for a woman enrolled during pregnancy at $35/unit for a maximum total of $1,050.00. Combined, a qualified HVSA LIA home visitor could be reimbursed $1,450.00 for 50 fifteen-minute units (7.5 hours of MSS and 5 hours of ICM) of home-based case management services starting in the woman's pregnancy and lasting through the infant's first birthday with no limitation extension requests or childbirth education classes. DEL reported 2,100 families (416 pregnant) received home visiting in 2015, with nearly three-quarters enrolled in MIECHV-funded Parents as Teachers (PAT) or Nurse-Family Partnership (NFP). If NFP, PAT and MSS/ICM services were appropriately stacked and funds braided, the HVSA could have potentially leveraged approximately $600,000 in Medicaid funding serving pregnant women and infants through age one (416 clients x $1,450.00).

DEVELOP A 1915(B) FEE-FOR-SERVICE (FFS) SELECTIVE CONTRACTING PROGRAM WAIVER	
Medicaid Authority	***Section 1915(b) of the Social Security Act*** Using a 1915(b) managed care waiver, states can: • Restrict enrollees to services in the managed care network under (b)(1); and/or, • Utilize a "central broker" under (b)(2); and/or, • Provide extra non-Medicaid services through cost savings under (b)(3); and/or • Restrict the pool of providers through selective contracting under (b)(4).
Washington's Medicaid Title XIX State Plan	Washington currently has a 1915 (b) waiver for Integrated Community Mental Health Services (WA-08), approved in 1993. Amended March 29, 2016 to help address RCW 71.24.850 to fully integrate behavioral health and physical health care by January 1, 2020, the current waiver is due to expire June 30, 2017.
What specific home visiting services would qualify for reimbursement?	This waiver has the potential to fully fund home visiting through evidence based models by braiding Medicaid, state match and private funds, using a selective contracting process, and targeting specific populations.
What are the potential benefits of this option?	Some of the potential benefits include: • Using a bundled rate, per slot contract approach to pay LIAs. • Enhancing and expanding maternal and infant home-based service options. • Supporting care continuity and a two-generation approach for better outcomes. • Improving health outcomes leading to decreased Medicaid expenditures. • Supporting Washington's interest in social innovation financing of home visiting.
Administrative considerations	• CMS's Technical Guide for the 1915(b)(4) Application notes that this specific subsection applies to both fee-for-service as well as managed care arrangements, and the implementing regulations at 42 CFR §431.55. • CMS is simplifying the application process under 1915(b). • A FFS selective contracting waiver is expected to give states a more efficient way to deliver services, and CMS expects payment methodologies for waiver services to be the same those in the approved State Plan reimbursement pages. • Cost-effectiveness measurement is a projected estimate of the cost of services pre-waiver compared to the cost of services provided under the waiver.
What are the provider qualifications for Medicaid reimbursement?	Provider qualifications (for services outside of First Steps/MSS&ICM) would depend on the selected home visiting model(s).
Estimated Timeline to Implement	Variable. No less than one year. Given the requirement to identify and allocate both state funds for Medicaid match as well as additional funds for non-covered components, it would be more likely to take two to three years.
Additional Considerations	There are four different waiver options within 1915(b) which can be used singly or concurrently depending on the objectives.
Other State Approaches	See following page for a discussion of South Carolina's 1915(b) waiver.
Potential Pay-Out	The South Carolina model reflects a braided funding portfolio, with approximately 45% of the total pilot project cost covered by Medicaid. Private philanthropists provided up-front expansion dollars, with the potential for $7.5 million in success payments for positive results. South Carolina also expects state plan savings in reduced care expenditures by improved maternal and infant health outcomes. (http://www.payforsuccess.org/project/south-carolina-nurse-family-partnership)

South Carolina's 1915(b) Waiver

South Carolina provides statewide comprehensive managed care through the 1932(a) Medicaid Authority, enrolling eligible individuals into a risk-based managed care organization. Under their state plan, pregnant and post-partum women can also receive extended services through 60-days post-partum, including two home-based nursing visits after the baby is born. Using a 1915(b) waiver, South Carolina can provide enhanced prenatal, postpartum, and infant services that were not otherwise available under their state plan. To do so, the state selectively contracts with Nurse Family Partnership (NFP) to serve first-time mothers with an expanded scope and duration of maternal and infant services.

Medicaid only funds specific components of home visiting, therefore South Carolina also incorporated social innovation financing strategies to fully fund NFP local implementing agency home visiting services. Through this approach, the five-year pilot project is financed by $13 million in Medicaid-funded services and $17 million in philanthropic funds. An additional $7.5 million in success payments to sustain NFP services is possible if the independent evaluation shows a reduction in preterm births, and in childhood hospitalization and emergency department use due to injury; an increase in health spacing between births and in the number of first-time moms served in high-poverty ZIP codes.

States requesting a 1915(b) waiver must also demonstrate that expected costs are "less than or equal to the trended FFS costs for the same services in an 'any willing provider' environment." South Carolina expects to see improved birth outcomes and greater overall future cost savings by investing in enhanced maternal and infant health services. As part of the waiver, the state expects to spend a portion of the achieved Medicaid savings on providing the non-state plan home visiting services. The portion spent must be less than the state plan savings. Potential state plan savings were estimated based on reducing deliveries with hypertension, complicated birth costs (hospital and physician), and a reduction in state plan postpartum home-based nursing visits. Additional savings are expected through a reduced expenditure in health care for children ages 0-2.

Washington Potential

Under HCA's leadership, Washington provides comprehensive managed care through the 1932(a) Medicaid Authority, enrolling eligible individuals into one of five Apple Health risk-based MCOs. Washington's state plan also offers fee-for-service extended maternal health services through 60-days postpartum and targeted case management services through First Steps. Washington also has a strong, established public-private partnership between DEL and Thrive Washington to identify and secure federal, state and private philanthropic funds for home visiting services.

Washington is well-poised to develop a successful 1915(b) waiver to demonstrate improved health outcomes and decreased Medicaid costs by providing enhanced maternal and infant health services of expanded scope and duration not otherwise available under the state plan. For example, all pregnant Medicaid-eligible and Apple Health enrolled women could be screened for medical risk, geographic proximity to, and service capacity of specific home visiting programs or a First Steps provider. Since the waiver requires demonstrating that expected costs are less than or equal to trended FFS costs, the project would be evaluated for its effectiveness and cost-savings.

States have considerable flexibility to design their Medicaid payment methods—whether they are direct payments to providers under fee-for-services arrangements, capitation payments to managed care plans, or some combination of the two. States also can make supplemental payments to certain classes of providers.

https://www.macpac.gov/publication/federal-requirements-and-state-options-provider-payment/

Why did these recommendations rise to the top?

Both HCA and DEL identified several important factors to consider when researching and recommending potential Medicaid financing for home visiting. In addition to **strengthening coordination across Washington's health and early learning systems**, the primary concern for DEL was identifying sustainable financing options through fee for service (FFS) reimbursement, managed care integration, and Healthier Washington involvement.

For HCA, financing options also needed to **avoid duplicating or supplanting existing resources and services**. The impact of key HCA initiatives, such as Healthier Washington's Medicaid Transformation and the 2020 goal of fully integrated managed care also needed to be considered.

An important part of this work has been -- and will continue to be -- **increasing the cross-sector understanding of barriers and opportunities to accessing Medicaid to support maternal, infant and early childhood services in the home setting**. HCA and DEL work within very different regulatory environments. Proactively addressing system complexities and competing policies at federal, state and local levels will be crucial to successful implementation of selected financing options.

Washington is not alone in its interest in aligning health and early learning. Other states are also incorporating Medicaid funds into their approaches to financing home visiting services. Model eligibility requirements, home visitor caseload limits, and community capacity to support home visiting programs make meeting the CMS requirement for statewide services under a single home visiting model extremely difficult.

The 2017 Center for American Progress report *Medicaid and Home Visiting: Best Practices from States* identified targeted case management (TCM) as the most common Medicaid authority tapped by states to help pay for allowable home visiting service components. According to the study, about 15 percent of Healthy Families America (HFA) sites and over one-half of Nurse-Family Partnership (NFP) agencies nationwide receive some Medicaid funding through TCM for case management services (Herzfeldt-Kamprath, R., Caslyn, M., & Huelskoetter, T., para. 39).

TCM allows states to restrict services to specific populations or geographic regions, which is critical when scaling up home visiting. In Washington State, medically necessary home-based case management services are currently authorized under the TCM authority for First Steps Infant Case Management (ICM) services. This offers a clear opportunity for qualified home visitors to access Medicaid reimbursement.

Another common approach, noted by the 2017 Center for American Progress report, is Medicaid Administrative Claiming (MAC). Governmental entities and their contractors can receive partial reimbursement for specific administrative activities, such as developing, planning and creating programs related to Medicaid, or by conducting outreach and education to improve enrollment and usage of Medicaid services. Washington State's Medicaid Administrative Claiming (MAC) program can provide DEL with an accessible route to partial reimbursement of Medicaid-related administrative activities.

Coordination and alignment between health and early learning systems can help children and families thrive by ensuring:

- Each child's needs are identified;
- Referrals to needed services are made and completed;
- Services are not duplicated; and,
- Messages families hear are clear, aligned, and consistent.

Policy Statement Supporting Health and Early Learning System Alignment
U.S. Department of Health and Human Services
U.S. Department of Education

While home visiting is not a specifically covered service under Medicaid, Medicaid-enrolled providers can seek reimbursement for components of home visiting [such as] case management services or by referring patients to Medicaid for enrollment.

Medicaid and Home Visiting: Best Practices from States
January 2017

DEL, at the state office level, already works on a variety of cross-sector Medicaid related activities which can qualify for this funding stream. Additionally, DEL contracts with comprehensive early learning and home visiting programs throughout the state. These programs offer a variety of supports at the local level, including helping families access needed supports such as Medicaid (Apple Health) insurance and locating community-based Medicaid providers.

Another plus for early learning and home visiting programs in using MAC is that reimbursement for allowable administrative tasks does not have the same stringent provider qualifications required under other Medicaid authorities for medical professionals. In fact, provider qualifications will be a significant hurdle to address moving ahead. While home visiting model developers set specific education, training and experience prerequisites for home visitors, those requirements rarely meet the criteria associated with medical professional licensing and credentialing. Most often, home visitors would fall under the designation of community health worker (CHW) or the Tribally-preferred designation of community health representative (CHR).

The 2017 Center for American Progress report does note that Medicaid gives states a great deal of flexibility in setting professional standards and licensure requirements where a licensing category does not currently exist or match the qualifications needed to provide particular services within a state's Medicaid program. In those cases, the state can define in its state plan the required background, training and education for a paraprofessional to deliver the medically necessary services through the program model, such as was done for Washington's First Steps/ICM component.

Managed care organizations (MCOs) have additional flexibility in this area. According to Ashley Gray from the Institute for Medicaid Innovation during a March 30, 2017 webinar, MCOs can contract with providers to offer innovative and creative alternatives to enrich mandatory services required by Medicaid.

In the value-based payment environment, MCOs want measurable results that improve quality of care and health outcomes, and reduce gaps in care. Providers who can work with clients to complete health risk assessments and preventive screenings, improve client adherence to care, and reduce emergency department use offer a return on investment that interest MCOs.

Providers who can work with clients to complete health risk assessments and preventive screenings, improve client adherence to care, and reduce emergency department use offer a return on investment that interest MCOs.

There does appear to be potential for MCO and home visiting partnerships for care coordination activities. Certainly, strengthening referral and follow-up processes would benefit not only MCOs and home visitors, but also the parents and children they both serve. Apple Health MCOs are currently required by HCA to provide pregnant women with information about First Steps MSS & ICM, and to inform their provider network at least annually about other appropriate community-based services.

While Apple Health MCOs cover some home-based medical services such as nursing care to administer 17P shots to prevent premature birth, enrollment in a home visiting model is not offered as part of a package of Medicaid

Managed Care and Home Visiting

States also vary as to which benefits and services are managed and paid for by the MCO and which are "carved out" and paid for on a fee-for-service basis or through a different managed care plan.

Often, services that are less typically managed by insurance companies or are unique to Medicaid, such as home-based services, medical supplies, dental care, or services delivered in the schools, are carved out of the managed care plan.

From *Public Insurance Programs and Children with Special Health Care Needs: A Tutorial*
Section 7: Service Delivery Models
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benefits. Case management and care coordination services are provided telephonically; referrals to home visiting programs are made differently by the different MCOs and providers.

It is unclear to what extent each MCO could or would support the cost of a complete home visiting model within their networks. Given current federal regulatory requirements, it seems braiding fund sources and policies must happen first at the state level, to develop clear guidance and expectations for managed care and home visiting. Michigan and Minnesota are also in the early stages of incorporating home visiting into managed care, and could be valuable thought partners along the way.

States also use Medicaid waivers to implement innovative approaches to meeting the triple aim of better health and care at lower costs. As discussed earlier, the HCA is engaged in a five year waiver to develop innovative, sustainable and systemic approaches to building healthier communities through a collaborative regional approach, whole person care, and rewarding quality of care over quantity of services. Within Healthier Washington, regional Accountable Communities of Health (ACH) are working with primary and behavioral health care providers, hospitals, social service agencies, and other community partners to tailor approaches and projects to community needs and priorities. Evidence-based home visiting is allowed as an optional approach as part of Medicaid Transformation activities.

Other states are using other waiver options to help fund evidence home visiting. South Carolina's unique approach to braiding private and public funds provides a ready template for Washington to develop its own 1915(b) waiver. This waiver allows states the flexibility to selectively contract with providers and to serve a targeted population. The waiver must be cost-neutral and show improved health outcomes in the population being served. This option would also allow a more familiar funding approach for HVSA LIAs, reducing administrative complexity and keeping the focus on service provision.

Conclusion and next steps

Since this paper was tailored to executive level needs for decision making, it was written broadly without an undue amount of detail. An important piece of the work moving forward will be to ***consider other critical and unique perspectives of Tribal communities, home visiting providers, and the families being served*** as to how selected option(s) fit community interests, needs and capacity.

Another crucial matter for executive leadership to consider is the recently passed state legislation creating the new department of children, youth, and families (DCYF), reorganizing state services to better serve children, youth and families. House Bill 1661 opens many opportunities to address and resolve system complexities to achieve better outcomes for Washington's children and parents. The legislation initially consolidates the DEL and the Children's Administration (CA) into the new agency, adding Juvenile Rehabilitation Administration (JRA) later.

> ***We need many voices talking about how to advance the health of entire groups.*** More sectors using a population-focused approach could help:
>
> - Create new funding streams;
> - Build broader support across the political spectrum;
> - Foster better integration of innovative ideas; and,
> - Accelerate the uptake of research into practice.
>
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> **July 2017**

HCA is specifically named in Part I. Section 103 (2)(d) of the legislation which requires the office of innovation, alignment and accountability (OIAA) in the DCYF to execute cross-agency planning work with all impacted agencies, including:

- *Developing an integrated portfolio management and administrative structure for the DCYF that includes establishing effective partnership mechanisms with community-based agencies, courts, small businesses, federally recognized tribes in Washington, providers of services for children and families, communities of color, and families themselves; and,*
- *Establishing outcomes that the DCYF and other partner state government agencies will be held accountable to in order to measure the performance of the reforms and the priorities created in this section; and,*
- *Coordinating, partnering, and building lines of communication with other state agencies including, but not limited to, the department of social and health services, the health care authority, the office of the superintendent of public instruction, the administrative office of the courts, and the department of commerce.*

An important take-away from this report is that the health and early learning systems operate in vastly different administrative and programmatic worlds. One of the first hurdles will be to support the development of cross-sector understanding and operating agreements moving forward.

There needs to be buy-off early in the process or implementation could stall through miscommunication or fear of the unfamiliar. Policy makers and funders at all levels must be attentive to the impact of regulations, and of reporting and reimbursement processes on providers and the families they serve, and take the lead in addressing concerns.

Provider and community input can help identify specific challenges in doing this work, and preferred approaches to system improvements. While one size will never work for all, some common threads can be teased out of stakeholder discussions to identify factors that matter to client, community, provider and funder.

Additionally, both agencies are heavily invested in many demanding and intensive regional and statewide initiatives. A common concern shared by both system's providers is feeling overwhelmed by the number of initiatives, competing goals and reporting requirements they navigate each day in serving families.

Given the rapidity and complexity of on-going work, it will be important to allow sufficient time to include DEL home visiting experts and HCA subject matter experts to plan and strategize the needed actions steps, timelines and cross-system considerations in developing a guiding work plan to implement the selected option(s).

Because developing a Medicaid benefits package and securing state and federal approval and funding is time and labor intensive, it makes sense to explore ways to strengthen cross-systems coordination and leverage available Medicaid resources in the short term, as well as look for longer-term opportunities. This recommendations paper is the culmination of phase one, setting the stage for phase two, in which HCA and DEL executive leadership review the recommendations and:

- Identify the specific opportunities they wish to build upon within the health and early learning systems; and
- Select actionable home visiting and early learning financing recommendation options to implement.

Once the options are selected, HCA and DEL can embark on the third phase, which includes gathering stakeholder input and buy-in, and developing the timeline and action steps such as identifying and allocating state matching funds, drafting state plan language, and addressing other administrative and procedural needs involved in successful implementation. The work plan, due by December 31, 2017 will provide a road map that the agencies can follow to fully implement the selected option(s).

Addendum: Cross-Agency Leadership Review and Discussion

On October 2, 2017 HCA and DEL leadership met to review the report, discuss alignment strategies, and select financing options**.** Both agencies are steadfast in their desire to ensure coordinated, responsive, client-centered care during critical periods of maternal, infant and early childhood growth and development. The discussion focused on key alignment strategies and prioritizing financing options. The next steps will involve creating an actionable roadmap to implement selected financing strategies and to continue deepening cross-sector understanding and alignment.

Key Alignment Strategies

There was agreement that focused leadership was needed to proactively align and support HCA and DEL's shared goal of improving outcomes for expectant parents and families with young children to help bridge gaps and create a strong foundation for the HCA and DEL partnership. The discussion also addressed the need for careful, intentional alignment to better support the inclusion of home visiting and early learning services into Healthier Washington projects, as well as integrating the First Steps/MSS&ICM program into Washington's developing home visiting system through the HVSA. The importance of developing a shared understanding, common language and guiding principles in order to successfully implement selected strategies and to reduce the system complexities was also considered.

Financing Options

Each of the four financing options were discussed and prioritized.

Targeted Case Management. This was DEL's top option to infuse Medicaid financing into home visiting services. Enrolling qualified HVSA providers as infant case management agencies can also support cross-system alignment and coordination efforts, and increase the number of Infant Case Management (ICM) providers. HCA can work with DEL to provide the necessary technical assistance and training providers need to enroll and bill for Medicaid-allowed services.

Medicaid Administrative Claiming (MAC). Using MAC to finance home visiting is not currently an option for DEL. However, MAC is an important mechanism to support DEL's Medicaid-related activities in other specific early learning programs, especially as DEL transfers into the new DCYF, which will bring DEL and DSHS/Children's Administration under one agency. DSHS/Children's Administration currently carries an approved cost allocation plan for Medicaid administrative reimbursement with CMS. DEL prefers the direct federal match contract option, similar to the process in place for DSHS, DOH or OSPI. HCA is well-situated to support DEL in accessing MAC as a financing strategy.

Integration with Apple Health (Medicaid) Managed Care Plans. DEL understands the importance of this approach given HCA's 2020 FIMC goal. This option would require DEL to connect with each MCO to assess their interest in home visiting as an effective and evidence-based strategy that can help MCOs achieve certain value-based outcomes. HCA can help facilitate DEL's connections to MCOs. HCA can also work to educate strengthen MCO contract language to include requiring home visiting and early learning information for providers to use in service referrals and coordination (similar to what is currently required in the MCO contract to maximize referrals to ESIT or First Steps Maternity Support Services).

Develop a 1915b Medicaid Waiver. DEL expressed interest in further discussions of this option as a potential longer-term strategy. There is also interest in reconnecting with S. Carolina on any lessons learned two years into their waiver project. While S. Carolina uses a PFS approach to providing the Medicaid-match, it is not a requirement to use PFS. It was also noted that HCA does have work in progress around a PFS project which could provide some "lessons learned" in this approach and provide coordination opportunities.

Appendix A: Other potential financing avenues to explore

Washington State's early learning world covers an array of services and supports, from child care licensing to parent education to formal preschool programs. There has been strong interest in connecting all early learning services, not just home visiting, to Medicaid funding. Just as with home visiting, a first step in identifying potential funding strategies includes looking for the common threads that could meet the definition of medically necessary services (https://www.del.wa.gov/).

For example, the state funded Early Childhood Education and Assistance Program (ECEAP) serves children and families at or below 110% of federal poverty level through comprehensive preschool and family support services. ECEAP contractors are required to provide health coordination, screening and referral activities, and case management to help families connect to needed community resources and supports (https://del.wa.gov/sites/default/files/public/ECEAP%20Performance%20Standards.pdf).

While this paper explored select options, there are other longer-term possibilities that may be worth considering more thoroughly, for both home visiting and early learning. Appendix A briefly describes those possibilities.

Appendix A: (continued)

- ***Explore contracting with Health Home lead entities to provide allied care coordination services through home visiting.*** Health Homes is joint partnership between the Health Care Authority (HCA), the Centers for Medicare and Medicaid Services (CMS) and the Department of Social and Health Services (DSHS). Health Home helps Medicaid clients improve and manage health conditions through comprehensive care management, care coordination, health promotion, transitional planning and follow-up, individual and family support and referrals to relevant community and social support services. Clinical providers such as a nurse, physician's assistant, social worker, behavioral health specialist or chemical dependency professional provide care coordination; allied staff support the Coordinator by providing outreach, engagement and patient advocacy, helping connect the client to medical services and resources, distributing health education materials and messages, and identifying and facilitating on-going access to community and social support services. The State contracts with lead entities who subcontract with community based care coordination organizations who directly employ or contract for clinical care coordinators and allied staff. Three tiers of payments are made by HCA to lead entities for approved services.

- ***Work with HCA to enroll interested home visiting local implementing agencies (LIAs) as childbirth education (CBE) providers.*** Home visiting LIAs that currently offer group education or socialization opportunities may be interested in this option. Qualified CBE providers must be certified or credentialed as defined by the International Childbirth Education Association (ICEA). Education must be group based with a minimum of eight hours of instruction covering a specific list of topics on pregnancy, labor and birth, newborns and family adjustment. Enrolled providers would bill HCA through Provider One under a fee-for-service agreement that pays $60/client for the series of classes. The agency covers one series of CBE classes per client per pregnancy, and the client must attend at least one CBE class to be paid.

- ***Explore integrating early learning providers into the developing community health worker structure as part of the health and health care system.*** In Washington, community health workers are certified but not licensed and provide community-based health care services. A 2015 Taskforce report to Healthier Washington recommended identifying the "health, social service and educational system changes necessary to optimize CHW best practices," as well as financing options such as managed care contracts and ACH incentives, and prioritizing CHWs as a key strategy in creating community linkages. The crucial piece would be uncovering ways to more closely connect CHWs to physicians or other licensed practitioners, for supervision and Medicaid reimbursement purposes. Minnesota outlines CHW specific requirements and allowed services that can provide a starting point for Washington's consideration.

- ***Explore financing available under therapeutic child care under Section 13.d.8 (p. 54 of Attachment 3.1-A) in the state plan.*** This section is currently used by the Department of Social & Health Services to authorize specialized child care staff allowed under Rehabilitative Services, 42 CFR 440.130(d). Therapeutic child-care is provided directly to children 21 and younger and their families to treat psycho-social disorders. Line staff must have an AA degree in ECE or Child-Development or related studies, plus five years' of related experience. Supervisory staff must have a BA in Social Work or related studies, plus experience working with parents and children at risk of child abuse and/or neglect. Agencies and individual providers must meet Medicaid agency criteria and certification requirements under state law as appropriate. DSHS requires an Agency Affiliated Counselor Credential (AACC) or higher counseling-related credential from the Department of Health.

Appendix B: Cost comparison

A great deal of interest has been consistently expressed in the comparison of services, providers and programmatic costs related to different home visiting models and HCA's First Steps/MSS&ICM components. The following table attempts to compare these areas across several models. It is important to keep in mind that there are specific differences between home visiting models and Medicaid home-based services. Home visiting models are funded as a comprehensive package of services based on a per family enrollment slot over a specific period time. Medicaid reimburses for medically necessary services allowed by federal regulations. In order to develop a baseline for comparison, certain assumptions were made regarding program service entry and duration, including:

- Each home visit is assumed to be 1 hour in duration.
- Client receives program services for complete allowed duration.
- MSS and ICM service hours were determined without the allowance of additional units through approved limitation extension requests.

Program and Brief Description of Services		***Service duration in months*** *(with services starting at 28 weeks pregnant)*	***Maximum hours of service*** *(as determined by program standards*	***Reported average annual cost*** *(see discussion above)*	***Average monthly cost*** *(average annual cost divided by 12 months)*	***Program cost over complete duration of services*** *(average monthly cost x service duration in months)*	***Hourly service cost*** *(program cost over complete duration divided by maximum hours of service)*	***Cost per 15-minute unit of home-based service*** *(hourly service cost divided by 4)*
First Steps: MSS & ICM	With enrollment by 28 weeks pregnant: • home-based MSS services through 2 months post-natal; and then, • home-based ICM services from the end of the MSS-period through infant's first birthday . *Note: Scenario does not include any limtation extension requests, childbirth education or costs of Apple Health medical insurance coverage.)*	**14**	**7.5 MSS 5.0 ICM**	**N/A**	**N/A**	**$1,450.00**	**$116.00**	**$29.00**
NFP	With enrollment by 28 weeks pregnant, visits occur: • Once/week for 4 weeks; and then, • Every other week for the rest of the pregnancy. • Postpartum once/week for first 6 weeks; and then, • Every other week until the baby is 21 months old. • Once/month for last 4 months until the baby turns 2.	**27**	**64**	**$6,043.80 .**	**$503.65**	**$13,598.55**	**$212.47**	**$53.11**

Appendix B: (continued)

Program and Brief Description of Services		***Service duration in months*** *(with services starting at 28 weeks pregnant)*	***Maximum hours of service*** *(as determined by program standards*	***Reported average annual cost*** *(see discussion above)*	***Average monthly cost*** *(average annual cost divided by 12 months)*	***Program cost over complete duration of services*** *(average monthly cost x service duration in months)*	***Hourly service cost*** *(program cost over complete duration divided by maximum hours of service)*	***Cost per 15-minute unit of home-based service*** *(hourly service cost divided by 4)*
PAT	With enrollment by 28 weeks pregnant for families with two or more high-risk characteristics, visits take place: • Twice per month for a total of 24 visits/year • Monthly group connections meeting for 12/year *Note: PAT serves families for at least two years and can serve families until the child enters kindergarten. For this scenario, service duration is assumed to last till child is age 3.*	**39**	**117**	**$4,362.01**	**$363.50**	**$14,176.50**	**$121.16**	**$30.29**
Family Spirit	With enrollment by 28 weeks pregnant: • weekly through the child's first 3 months; • biweekly from 4 to 6 months; • monthly from 7 to 22 months; and • every other month from 23 to 36 months of age.	**39**	**52**	**$4,375.00**	**$364.58**	**$14,218.87**	**$273.43**	**$68.35**
EHS: Home-based	With enrollment by 28 weeks pregnant: • Weekly 90-minute home visit • At least 22 2-hours each socializations/year	**39**	**278**	**$9,189.37**	**$765.78**	**$29,865.45**	**$107.42**	**$26.85**
PCHP	Provides at least 46 30-minute visits/year, starting as early as age 16 months, with services lasting for two years.	**24**	**46**	**$3,745.14**	**$312.09**	**$7,490.28**	**$162.83**	**$40.70**

Appendix C: A Point in Time Snapshot

The following table presents a crosswalk of services by county funded through the:

- The Home Visiting Services Account (HVSA) which is a mix of federal, state and philanthropic funds;
- HCA's Medicaid-funded First Steps/MSS&ICM program;
- HCA's School-Based Healthcare Services program;
- DEL's Early Support for Infants and Toddlers (ESIT) program funded under multiple federal and state sources;
- DEL state-funded Early Childhood Education and Assistance Program (ECEAP); and
- Federal Head Start programs.

As financing options with an eye to avoiding duplication or supplanting are considered, it will be important to keep in mind community characteristics, different funding sources and requirements, and the different providers.

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Adams			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	18,951	Adams County Health Department		x	x				
DOH Births	383	Columbia Basin Health Association	x	x			x		
Medicaid Births	298	ESD 101							x
Pop 0-5	2,067	ESD 123			x				x
Fam in Poverty	13%	Inspire Development Centers						x	
HS Grad +	66%	Othello School District				x			
Asotin					**x**	**x**	**x**	**x**	**x**
2014 Total Pop	21,955	Asotin-Anatone School District			x	x			
DOH Births	255	Asotin County Community Services					x		
Medicaid Births	7	Asotin Co Health District			x				
Pop 0-5	1,241	ESD 123			x				
Fam in Poverty	10%	Clarkston School District				x			
HS Grad +	89%	Lewis-Clark Early Childhood Program						x	x

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Benton			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	182,053	Benton-Franklin Health District	x	x	x				
DOH Births	2,660	Benton Franklin Head Start						x	
Medicaid Births	1,538	Enterprise for Progress in the Community							x
Pop 0-5	13,386	ESD 123			x				x
Fam in Poverty	10%	Finley School District				x			
HS Grad +	89%	Inspire Development Centers						x	x
		Kennewick School District				x			x
		Kiona-Benton City SD				x			x
		Prosser SD				x			
		Richland School District				x			x
		The Arc of Tri-Cities					x		
		Tri-Cities Community Health Center – La Clinica		x					
Chelan					**x**	**x**	**x**	**x**	**x**
2014 Total Pop	73,664	Cascade SD				x			
DOH Births	935	Cashmere SD				x			
Medicaid Births	641	Chelan-Douglas Child Services Association						x	x
Pop 0-5	5,055	Chelan-Douglas Health District			x				
Fam in Poverty	10%	Manson School District							x
HS Grad +	84%	North Central ESD (171)					x		
		Wenatchee School District			x	x			
Clallam			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	72,024	Cape Flattery School District				x			
DOH Births	689	Clallam Co HHS			x				
Medicaid Births	434	Concerned Citizens					x		
Pop 0-5	3,366	Crescent SD				x			
Fam in Poverty	9%	First Step Family Support Center	x	x					
HS Grad +	92%	Lower Elwah Klallam Tribe		x				x	
		Makah Tribe			x			x	
		Olympic Community Action Programs						x	x

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Clallam, con't			**x**	**x**	**x**	**x**	**x**	**x**	**x**
		Port Angeles School District			x	x			
		Quileute Tribe			x			x	
		Quinault Indian Nation						x	
		Quillayute Valley School District				x			
		Sequim School District				x			
Clark			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	438,272	Battle Ground School District			x	x			
DOH Births	5,571	Camas School District			x				
Medicaid Births	2,618	Clark County Public Health	x	x	x				
Pop 0-5	28,925	Educational Opportunities for Children and Families						x	x
Fam in Poverty	9%	ESD 112					x	x	x
HS Grad +	91%	Green Mountain-via subK with ESD112				x			
		Hockinson School District				x			
		Innovative Services NW							x
		Ridgefield-via subK with ESD112				x			
		Sea Mar Community Health Centers		x					
		Vancouver Public Schools		x		x			
		Washougal School District				x			
Columbia				**x**	**x**	**x**	**x**		**x**
2014 Total Pop	4,031	Columbia Co Health Dpt			x				
DOH Births	38	Dayton School District				x			x
Medicaid Births	20	ESD 123			x		x		
Pop 0-5	197								
Fam in Poverty	13%								
HS Grad +	88%								
Cowlitz			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	102,072	Castle Rock School District				x			
DOH Births	1,168	Children's Home Society of Washington	x						
Medicaid Births	751	Cowlitz County Health Department	x		x				

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Cowlitz, con't			**x**	**x**	**x**	**x**	**x**	**x**	**x**
Pop 0-5	6,273	Cowlitz Family Health Center		x					
Fam in Poverty	13%	Cowlitz Indian Tribe			x				
HS Grad +	87%	Educational Opportunities for Children and Families						x	x
		Kalama-via subK with ESD112				x			
		Kelso School District				x			
		Longview SD				x			
		Lower Columbia College						x	x
		Progress Center, Inc.					x		
		Toutle Lake-via subK with ESD112				x			
		Woodland School District			x	x			
Douglas					**x**	**x**	**x**	**x**	**x**
2014 Total Pop	39,183	Bridgeport School District				x			
DOH Births	530	Chelan-Douglas Health District			x				
Medicaid Births	348	Chelan-Douglas Child Services Association						x	x
Pop 0-5	2,789	Enterprise for Progress in the Community							x
Fam in Poverty	11%	ESD 105 - Yakima						x	
HS Grad +	80%	Grand Coulee Dam School District				x			
		North Central ESD (171)					x		
		Okanogan County Child Development Assn.						x	
		Orondo-via subK with ESD112				x			
		Waterville-via subK with ESD112				x			
Ferry			**x**		**x**	**x**	**x**	**x**	**x**
2014 Total Pop	7,657	Colville Confederated Tribes	x					x	
DOH Births	85	Curlew SD				x			
Medicaid Births	65	ESD 101					x		x
Pop 0-5	370	NE Tri-County Health District			x				
Fam in Poverty	16%								
HS Grad +	88%								

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Franklin			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	84,508	Benton-Franklin Health District	x	x	x				
DOH Births	1,638	Benton Franklin Head Start						x	
Medicaid Births	1,158	ESD 123			x				x
Pop 0-5	8,741	Inspire Development Centers						x	x
Fam in Poverty	16%	Kahlotus-via subK with ESD112				x			
HS Grad +	72%	North Franklin School District				x			
		Pasco School District				x			
		The Arc of Tri-Cities					x		
		Tri-Cities Community Health Center – La Clinica		x					
Garfield					**x**		**x**		**x**
2014 Total Pop	2,240	Boost Collaborative					x		
DOH Births	24	ESD 123			x				
Medicaid Births	3	Walla Walla Community College							x
Pop 0-5	102								
Fam in Poverty	5%								
HS Grad +	97%								
Grant				**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	91,458	Family Services of Grant County						x	
DOH Births	1,484	Grant Co Health District			x				
Medicaid Births	1,119	Inspire Development Centers						x	x
Pop 0-5	8,008	Moses Lake Community Health Center		x			x		
Fam in Poverty	15%	Moses Lake School District				x			
HS Grad +	76%	Royal School District				x			
		Wahluke School District							x
		Warden School District				x			

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Grays Harbor			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	71,734	Aberdeen School District			x	x			x
DOH Births	766	Answers Counseling, Consultation & Case Management Services		x					
Medicaid Births	551	Confederated Tribes Of The Chehalis Reservation						x	
Pop 0-5	4,106	Elma School District			x	x			
Fam in Poverty	12%	ESD 113			x			x	
HS Grad +	87%	Grays Harbor County Public Health & Social Services Department	x		x				
		Hoquiam School District				x			
		Lake Quinault School District			x	x			x
		McCleary School District				x			
		Montesano School District				x			
		North Beach School District			x				
		Oakville School District				x			
		Ocosta School District				x			
		Parent to Parent Support Program of Thurston County					x		
		Satsop School District				x			
		Sea Mar Community Health Centers		x					
		Quinault Indian Nation						x	
		Wishkah School District				x			
Island				**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	78,951	Coupeville Schools				x			
DOH Births	880	Island County Public Health		x	x				
Medicaid Births	301	Island Hospital		x					
Pop 0-5	4,498	Oak Harbor				x			
Fam in Poverty	7%	Skagit Valley College						x	x
HS Grad +	95%	Toddler Learning Center					x		

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Jefferson			**x**	**x**	**x**	**x**	**x**	**x**	
2014 Total Pop	29,978	Chimacum School District				x			
DOH Births	183	Concerned Citizens					x		
Medicaid Births	120	Jefferson County Public Health	x	x	x				
Pop 0-5	1,107	Olympic Community Action Programs						x	
Fam in Poverty	7%	Port Townsend School District				x			
HS Grad +	94%	Queets Clearwater School District				x			
		Quilcene School District				x			
King			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	2,008,997	Auburn School District			x	x			
DOH Births	25,348	Bellevue School District				x			x
Medicaid Births	9,196	Children's Home Society of Washington	x					x	x
Pop 0-5	124,655	Chinese Information and Services Center	x						
Fam in Poverty	8%	City of Seattle							x
HS Grad +	92%	Country Doctor Community Health Centers		x					
		Denise Louie Education Center	x					x	
		El Centro de la Raza	x						
		Enumclaw School District				x			
		ESD 121 - Puget Sound ESD						x	x
		Federal Way Public Schools				x			
		Friends of Youth	x						
		Group Health Coop -- Teen Pregnancy and Parenting Clinic		x					
		Harborview Medical Center		x					
		Highline School District			x	x			
		Institute for Family Development	x						
		International Community Health Services		x					
		Issaquah School District				x			
		Kent SD				x			
		King Co. Dpt. Cmty & Human Svcs DD Divison					x		

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
King, con't			**x**	**x**	**x**	**x**	**x**	**x**	**x**
		King Co. Superior Courts Juvenile Probation Services			x				
		Lake Washington SD				x			
		Mary Bridge Children's Hospital and Health Center	x						
		Mercer Island School District				x			
		Muckleshoot Head Start						x	
		Navos	x						
		Neighborhood House Incorporated	x					x	x
		Open Arms Perinatal Services	x						
		Public Health – Seattle & King County	x	x	x				
		Renton School District			x	x			
		Riverview School District				x			
		Sea Mar Community Health Centers		x					
		Seattle Indian Health Board		x					
		Seattle Public Schools			x			x	
		Seattle School District				x			
		Shoreline School District				x			
		Skykomish School District				x			
		Snoqualmie Valley SD				x			
		Step By Step		x					
		Tahoma School District				x			
		Tukwila School District			x	x			
		United Indians of All Tribes	x						
		U.W. School of Dentistry			x				
		Vashon Island School District				x			
Kitsap			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	253,614	Answers Counseling, Consultation & Case Management Services		x					
DOH Births	3,068	Bremerton SD				x			
Medicaid Births	1,080	Central Kitsap School District			x	x			
Pop 0-5	14,668	ESD 114 - Olympic ESD						x	x
Fam in Poverty	8%	Holly Ridge Center, Inc.					x		
HS Grad +	94%	Kitsap Community Resources						x	x

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Kitsap, con't			**x**	**x**	**x**	**x**	**x**	**x**	**x**
		Kitsap Public Health District	x	x	x				
		North Kitsap School District			x	x			
		Port Gamble S'Klallam Tribe			x			x	
		South Kitsap School District			x	x			
		Suquamish Tribe						x	x
Kittitas			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	41,705	Bright Beginnings for Kittitas County					x	x	x
DOH Births	371	Cle Elum-Roslyn School District				x			
Medicaid Births	206	Community Health of Central Washington		x					
Pop 0-5	2,090	Easton School District				x			
Fam in Poverty	12%	Ellensburg School District				x			
HS Grad +	91%	Kittitas Co Health Dpt			x				
		Thorp SD				x			
Klickitat			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	20,668	ESD 112 - Vancouver					x		x
DOH Births	202	Centerville-via subK with ESD112				x		x	
Medicaid Births	19	Glenwood-via subK with ESD112				x			
Pop 0-5	1,116	Goldendale-via subK with ESD112				x			
Fam in Poverty	12%	Inspire Development Centers						x	
HS Grad +	87%	Klickitat County Health Department		x	x				
		Klickitat SD-via subK with ESD112				x			
		Lyle-via subK with ESD112				x			
		Mid-Columbia Children's Council	x					x	x
		Roosevelt SD-via subK with ESD112				x			
		Trout Lake SD-via subK with ESD112				x			
		White Salmon Valley School District			x	x			
		Wishram-via subK with ESD112				x			
Lewis			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	75,382	Adna School District				x			
DOH Births	862	Answers Counseling, Consultation & Case Management Services		x					

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Lewis, con't			**x**	**x**	**x**	**x**	**x**	**x**	**x**
Medicaid Births	579	Boistfort School District				x			
Pop 0-5	4,465	Centralia College	x						x
Fam in Poverty	11%	Centralia School District			x	x			
HS Grad +	87%	Chehalis School District				x			
		ESD 113			x				
		Evaline School District				x			
		Lewis Co HHS Administration			x				
		Morton School District				x			
		Mossyrock School District				x			
		Napavine School District				x			
		Onalaska School District				x			
		Pe Ell School District				x			
		Reliable Enterprises					x	x	
		Toledo School District				x			
		White Pass School District				x			
		Winlock School District				x			
Lincoln						**x**	**x**		**x**
2014 Total Pop	10,409	ESD 101					x		x
DOH Births	99	Davenport School District				x			
Medicaid Births	54	Harrington School District				x			
Pop 0-5	503	Odessa School District #105				x			
Fam in Poverty	8%	Reardan-Edwall School District				x			
HS Grad +	92%	Sprague School District				x			
Mason			**x**	**x**	**x**	**x**	**x**	**x**	
2014 Total Pop	60,728	Answers Counseling, Consultation & Case Management Services		x					
DOH Births	611	ESD 113			x			x	
Medicaid Births	415	Holly Ridge Center, Inc.					x		
Pop 0-5	3,292	Hood Canal School District				x			
Fam in Poverty	10%	Mason Co Public Health & Human Services	x		x				
HS Grad +	87%	North Mason School District				x			

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Mason, con't			**x**	**x**	**x**	**x**	**x**	**x**	
		Parent to Parent Support Program of Thurston County					x		
		Pioneer School District				x			
		Shelton School District			x	x			
		Skokomish Indian Tribe						x	
		Southside School District				x			
Okanogan			**x**		**x**	**x**	**x**	**x**	**x**
2014 Total Pop	41,241	Brewster SD				x			
DOH Births	499	Colville Confederated Tribes	x					x	
Medicaid Births	381	Enterprise for Progress in the Community							x
Pop 0-5	2,769	Methow Valley SD-via subK with ESD112				x			
Fam in Poverty	16%	Okanogan Behavioral Health Care					x		
HS Grad +	82%	Okanogan County Child Development Association	x					x	x
		Okanogan Co Public Health			x				
		Omak School District				x			x
		Oroville School District				x			
		Tonasket School District				x			
Pacific				**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	20,665	Educational Opportunities for Children and Families						x	
DOH Births	204	ESD 112					x		x
Medicaid Births	89	ESD 113			x				
Pop 0-5	979	Naselle-Grays River Valley SD-via subK with ESD112				x			
Fam in Poverty	9%	Ocean Beach School District			x	x			
HS Grad +	88%	Pacific County Health Department		x	x				
		Shoalwater Bay Tribe			x				
		South Bend School District							x

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Pend Oreille			**x**		**x**	**x**	**x**	**x**	**x**
2014 Total Pop	12,965	Cusick SD				x			
DOH Births	112	Eastern Washington University						x	
Medicaid Births	80	ESD 101					x		x
Pop 0-5	597	NE Tri-County Health District			x				
Fam in Poverty	16%	Newport SD				x			
HS Grad +	90%	Rural Resources Community Action							x
		Selkirk School District			x				
Pierce			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	812,689	Answers Counseling, Consultation & Case Management Services		x					
DOH Births	11,664	Bethel School District				x			
Medicaid Births	5,343	Clover Park School District				x			
Pop 0-5	56,438	Community Health Care		x					
Fam in Poverty	9%	Dieringer School District				x			
HS Grad +	91%	Eatonville School District				x			
		ESD 121 - Puget Sound ESD						x	x
		Fife School District				x			
		Franklin Pierce School District			x	x			
		Institute for Family Development	x						
		KinderCare Learning Centers LLC							x
		Mary Bridge Children's Hospital and Health Center	x						
		Orting School District			x	x			
		Peninsula School District				x			
		Pierce County Community Connections DD Division					x		
		Puyallup School District				x			
		Sea Mar Community Health Centers		x					
		Steilacoom Historical School District			x	x			
		Step By Step		x					
		Sumner School District				x			
		Tacoma-Pierce County Health Department	x	x	x				

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Pierce, con't			**x**	**x**	**x**	**x**	**x**	**x**	**x**
		Tacoma Public Schools				x		x	
		Tender Moments LLC Daycare & Preschool							x
		University Place School District				x			
		White River School District				x			
San Juan				**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	15,847	Lopez Island School District				x			
DOH Births	92	Orcas Island School District				x			
Medicaid Births	50	San Juan County Health and Community Services		x	x		x		
Pop 0-5	485	San Juan County							x
Fam in Poverty	7%	San Juan Island School District				x			
HS Grad +	95%	Skagit Valley College						x	
Skagit			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	118,364	Anacortes School District				x			
DOH Births	1,429	Burlington-Edison School District				x			
Medicaid Births	870	Community Action of Skagit County		x					
Pop 0-5	7,487	Conway School District				x			
Fam in Poverty	10%	Inspire Development Centers						x	x
HS Grad +	88%	La Conner School District				x			
		Mount Vernon School District				x			
		Sea Mar Community Health Centers		x					
		Sedro-Woolley School District				x			
		Skagit County Public Health	x	x	x				
		Skagit/Islands Head Start and ECEAP							x
		SPARC (Skagit Preschool and Resource Center)					x		
		Skagit Valley College						x	x
		Snohomish County							x
		Swinomish Tribe			x				
		Upper Skagit Tribe			x			x	

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Skamania					**x**	**x**	**x**	**x**	
2014 Total Pop	11,194	ESD 112					x		
DOH Births	89	Mid-Columbia Childrens Council						x	
Medicaid Births	22	Mill A S.D.-via subK with ESD112				x			
Pop 0-5	573	Mt. Pleasant S.D.-via subK with ESD112				x			
Fam in Poverty	10%	Skamania Co Cmmty Health			x				
HS Grad +	90%	Skamania SD-via subK with ESD112				x			
		Stevenson-Carson SD-via subK with ESD112				x			
Snohomish			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	735,351	Arlington School District				x			
DOH Births	9,524	ChildStrive	x						
Medicaid Births	3,810	Darrington School District			x	x			
Pop 0-5	47,180	Edmonds Community College						x	
Fam in Poverty	7%	Edmonds School District				x			
HS Grad +	92%	Enchanted Little Forest Childcare							x
		Granite Falls School District				x			
		Lake Stevens School District				x			
		Lakewood School District				x			
		Marysville School District			x	x			
		Northshore School District				x			
		Sauk-Suiattle Indian Tribe							x
		Sea Mar Community Health Centers		x					
		Snohomish County					x	x	x
		Snohomish Health District	x	x	x				
		Snohomish School District				x			
		Step By Step		x					
		Sultan School District				x			
		Tulalip Tribes						x	

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Spokane			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	476,950	Central Valley School District				x			x
DOH Births	5,892	CHAS Health (Community Health Association of Spokane)		x	x				
Medicaid Births	3,351	Cheney Public Schools				x			
Pop 0-5	29,860	Children's Home Society of Washington	x					x	
Fam in Poverty	10%	Community Colleges of Spokane						x	x
HS Grad +	93%	Early Learning Child Development Resources							x
		Early Learning Child Development Resources							x
		ESD 101							x
		KinderCare Learning Centers LLC							x
		Medical Lake School District				x			
		Orchard Prairie School District				x			
		Selkirk School District	x						
		Spokane Public School District							
		Spokane Regional Health District	x		x		x		
		Spokane Tribe			x				
		West Valley School District				x			
Stevens					**x**	**x**	**x**	**x**	**x**
2014 Total Pop	43,541	Chewelah School District				x			
DOH Births	468	ESD 101					x		x
Medicaid Births	321	Evergreen School District				x			
Pop 0-5	2,224	Kettle Falls School District			x				
Fam in Poverty	13%	Loon Lake School District				x			
HS Grad +	91%	Mary Walker School District				x			
		NE Tri-County Health District			x				
		Onion Creek School District				x			
		Rural Resources Community Action						x	x
		Spokane Tribe			x			x	

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Thurston			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	259,330	Answers Counseling, Consultation & Case Management Services		x					
DOH Births	3,184	Community Youth Services	x						
Medicaid Births	1,243	ESD 113			x			x	x
Pop 0-5	15,708	Nisqually Indian Tribe						x	
Fam in Poverty	8%	North Thurston Public Schools			x				
HS Grad +	94%	Olympia School District			x				
		Parent to Parent Support Program of Thurston County					x		
		Rochester School District				x			
		Sea Mar Community Health Centers		x					
		Tenino School District				x			
		Thurston County Public Health and Social Services	x		x				
		Tumwater School District			x	x			
		Yelm School District			x	x			
Wahkiukum			**x**	**x**		**x**	**x**		**x**
2014 Total Pop	4,016	St. James Family Center	x						x
DOH Births	28	Progress Center, Inc.					x		
Medicaid Births	11	Wahkiakum County Health & Human Services		x					
Pop 0-5	138	Wahkiakum SD-via subK with ESD112				x			
Fam in Poverty	15%								
HS Grad +	93%								
Walla Walla			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	59,476	Children's Home Society of Washington	x					x	
DOH Births	664	College Place School District				x			
Medicaid Births	382	Columbia School District				x			
Pop 0-5	3,602	Dixie SD-via subK with ESD112				x			
Fam in Poverty	12%	ESD 123			x		x		x
HS Grad +	89%	Inspire Development Centers						x	x
		Prescott School District				x			

Appendix C: (continued)

County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Walla Walla, con't			**x**	**x**	**x**	**x**	**x**	**x**	**x**
		Waitsburg School District				x			
		Walla Walla Community College							x
		Walla Walla County Health Dpt			x				
		Walla Walla Public Schools				x		x	x
Whatcom			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	204,855	Answers Counseling, Consultation & Case Management Services		x					
DOH Births	2,286	Blaine School District				x			
Medicaid Births	1,140	Ferndale School District				x			
Pop 0-5	11,413	Lummi Indian Business Council						x	x
Fam in Poverty	11%	Lydia Place	x						
HS Grad +	91%	Lynden School District				x			
		Meridian School District				x			
		Mount Baker School District				x			
		Nooksack Indian Tribe						x	
		Nooksack Valley School District				x			
		Opportunity Council					x	x	x
		Sea Mar Community Health Centers		x					
		Whatcom County Health Department	x		x				
Whitman				**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	46,003	Boost Collaborative					**x**		
DOH Births	441	Community Child Care Center						x	x
Medicaid Births	164	Colfax				x			
Pop 0-5	2,020	Pullman School District				x			
Fam in Poverty	13%	Whitman County Public Health		x	x				
HS Grad +	96%								

Appendix C: (continued)

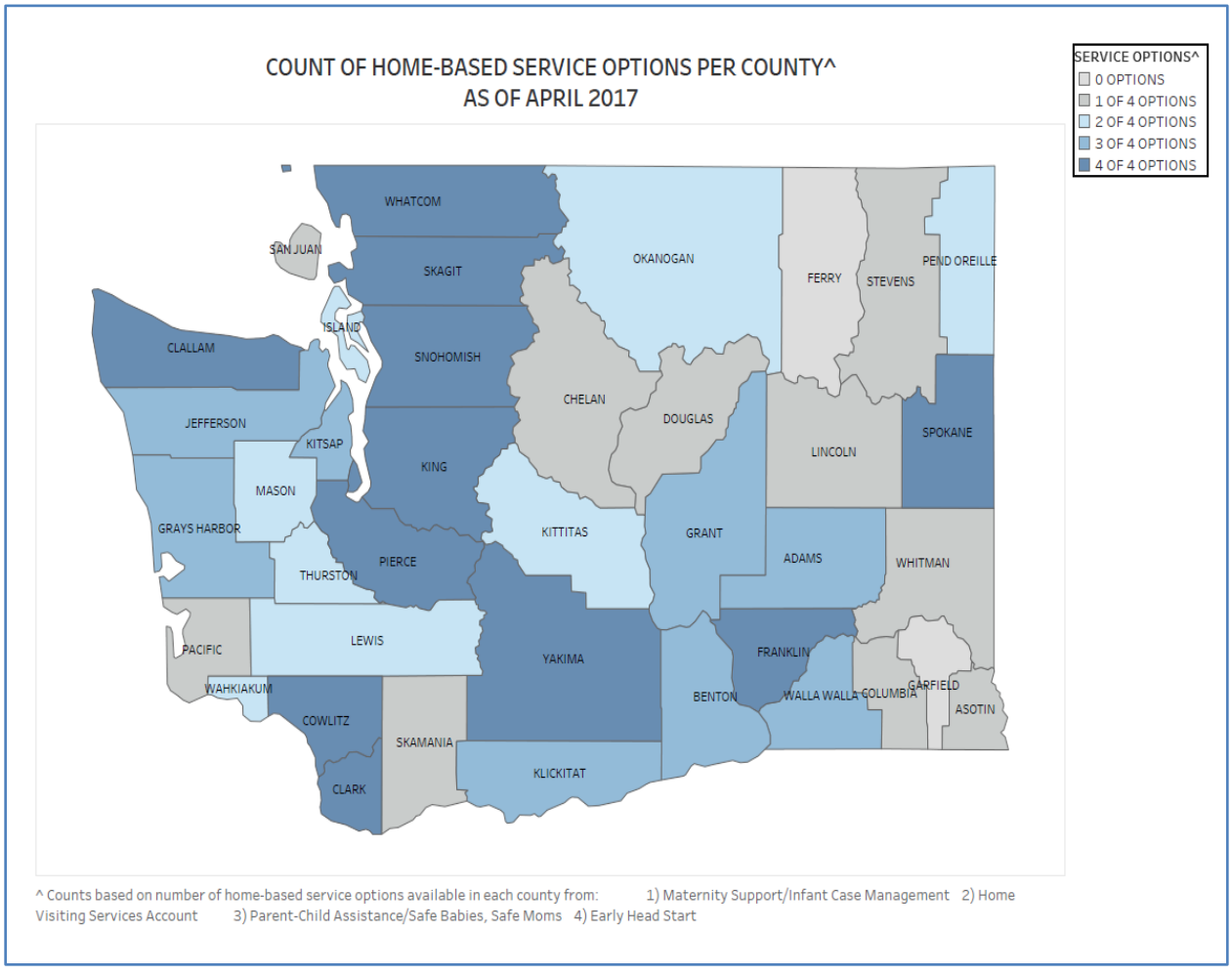
County & Funded Organizations			HVSA	MSS/ICM	MAC	SBHS-Part C	ESIT	Head Start	ECEAP
Yakima			**x**	**x**	**x**	**x**	**x**	**x**	**x**
2014 Total Pop	246,402	Catholic Charities of the Diocese of Yakima	x						
DOH Births	4,135	Catholic Family and Child Services							x
Medicaid Births	3,354	Community Health of Central Washington		x					
Pop 0-5	21,314	Enterprise for Progress in the Community							x
Fam in Poverty	18%	ESD 105						x	x
HS Grad +	72%	ESD 112						x	
		Granger School District							x
		Highland School District				x			
		Inspire Development Centers						x	x
		Mabton School District				x			
		Selah School District							x
		Sunnyside School District			X	x			
		Toppenish School District			X				
		Union Gap School District				x			
		West Valley School District #208	X			x			
		Yakima Indian Health Center		X					
		Yakima Health District			X				
		Yakima Neighborhood Health Services		X					
		Yakima School District			X	x			
		Yakama Nation						x	
		Yakima Valley Farm Workers Clinic	X	X					
		Yakima Valley Memorial Hospital	X	X			x		

2014 Total Population by County: http://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2014/
2014 DOH Births: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/Birth/BirthTablesbyYear
Medicaid-Paid Births: http://hca.wa.gov/assets/program/medicaid_status_births.pdf
Pop 0-5, Fam in Pov., HS Grad +: http://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2014/
HVSA: per provided listing of HV contractors from DEL June 2016
MSS/ICM: http://hca.wa.gov/assets/billers-and-providers/fs_provider_directory.pdf
MAC: per provided list from MAC unit staff May 2016
ECEAP: per provided list from DEL May 2016; Listed only at contractor level -- each contractor may have multiple subcontracts
ESIT: https://del-public-files.s3-us-west-2.amazonaws.com/ESIT/LLA-Referral_Contacts_Directory_by_County.pdf.pdf (listed at LLA level)
Head Start: per provided list from DEL May 2016 -- listed only at main grantee level; each grantee may have sub-grantees

SBSH Notes:
Educational Service District #112** -- subcontracts with local school districts within and outside of ESD
Educational Service District 123 -- currently not billing for Part C

Appendix D: A Statewide Picture of Home-Based Service Types

This map provides a visual picture of the available types of home-based maternal, infant and early childhood service options by county, and reveals the uneven distribution of services across the state. Keep in mind this only looks at types of available option. As financing recommendations are considered, it would also be important to consider what approaches would have the potential to increase service types in underserved counties by best matching community interest and need.



Appendix E: Medicaid Benefit Categories

The following table outlines possible Medicaid benefit categories described in the March 2016 HRSA and CMS joint bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf) which could fund or reimburse specific components of home visiting programs.

Medicaid Benefit	Required Elements
Case management services **42 CFR 440.169 & 441.18**	Direct services are not covered. Benefit assists individuals to gain access to medical, social, educational services through comprehensive assessment, care plan development, monitoring and referral to services. *Note*: May be targeted to specific individuals. State can define practitioner qualifications.
Other Licensed Practitioner services **42 CFR 440.60**	Medical/remedial services provided by *other licensed practitioners* (not physicians) within the scope of practice defined by State law. *Note*: A state plan amendment may not be necessary if practitioners are currently listed in the approved state plan.
Preventive services **42 CFR 440.130(c)**	Direct patient care recommended by physician/other licensed practitioner to diagnose, treat, prevent, minimize adverse effects of illness, injury, impairments to an individual. *Note*: As of 1/1/14, may be furnished by non-licensed practitioners meeting state qualifications.
Rehabilitative services **42 CFR 440.130(d)**	Includes medical/remedial services recommended by physician/other licensed practitioner for maximum reduction of physical/ mental disability, and restoration to best possible functional level. *Note*: State can define practitioners. Home-based family therapy and counseling may be authorized under this benefit.
Therapy services **42 CFR 440.110**	Physical and occupational therapy prescribed by a physician or other licensed practitioner, and provided to beneficiary by or under the direction of qualified therapist.
Home Health services **42 CFR 440.70**	Ordered by physician with written plan of care. Mandatory components: nursing services, home health aide services, medical supplies, equipment and appliances. Optional: physical therapy, occupational therapy, speech pathology, and audiology services.
EPSDT **Section 1905(a)**	Comprehensive array of medically necessary prevention, diagnostic, and treatment services for individuals under age 21. State can target services to children, including home-based.
Extended Services to Pregnant Women **42 CFR 440.250(p)**	Prenatal/delivery/postpartum care up to 60 days after birth; family planning services. States can target home visiting services to pregnant/postpartum women.
Health Homes	Integrates primary/behavioral health care, long-term services/supports with care management/coordination, health promotion, transitional care/follow-up, patient/family support, referrals to services.
Managed Care	Must assure access to full set of state plan services and EPSDT with at least 2 plan choices.
Waivers	*Section 1915(b) Freedom of Choice*. Allows states to restrict free choice of provider, such as in managed care approaches. *Section 1915(c) Home and Community-Based*. Allows services to be provided in the community, rather than in an institution. *Section 1115 Research and Demonstration Waiver*. Allows flexibility to design/improve programs, such as Washington State Medicaid Transformation waiver.

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