Paying It Forward

New Medicaid Home Visiting Option Would Expand Evidence-Based Services

By Rachel Herzfeldt-Kamprath, Meghan O'Toole, Maura Calsyn, Topher Spiro, and Katie Hamm

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Center for American Progress

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Introduction and summary

In the United States, rising income inequality increasingly is making it more difficult for low- and middle-income families to achieve the American Dream. The origins of persistent inequality can be traced to the vast differences in experience during early childhood.

Between birth and age 5, children are rapidly developing foundational capabilities in cognition, language and literacy, emotional growth, and reasoning that comprise the scaffolding for ongoing development.[1] Growing up in an environment that exposes young children to high levels of sustained stress, such as households experiencing poverty or violence, can impair vital early development and have a lasting effect throughout a child's life.

The detrimental effects of this kind of toxic stress directly relate to the disparities across socio-economic groups.[2] In addition, differences in cognitive ability are apparent even before a child enters preschool and continue to affect school readiness and academic achievement throughout a child's education, leading to decreased earnings over a lifetime.[3]

Fortunately, interventions in early childhood are becoming more sophisticated and effective at identifying key risk factors and preventing the ongoing effects of poverty and toxic stress. Home visiting programs are a critical part of this intervention, putting parents in the driver's seat by engaging them as their child's first teachers. These programs connect parents with nurses, social workers, or other professionals who provide coaching and guidance on healthy child development and link families with other important services. For decades, many home visiting programs have undergone rigorous evaluations, and they consistently prove that they are one of the most effective social programs ever studied.

Home visiting improves the lives of the families who participate and is proven to support better educational outcomes, improve the health of children and families, reduce medical costs, and increase family economic security. Beyond these out-

comes, home visiting services are proven to reduce federal and state spending over the long term, saving taxpayers money. Researchers have identified significant cost savings in major federal programs such as the Supplemental Nutrition Assistance Program, or SNAP, formerly known as food stamps; Medicaid; and the criminal justice system.[4]

These results have led to broad and bipartisan support for home visiting programs. For example, the Coalition for Evidence-Based Policy advocated for the reauthorization of funding for home visiting programs in 2014.[5] House Budget Committee Chairman Paul Ryan's (R-WI) plan to address poverty—"Expanding Opportunity in America"—highlights home visiting and Nurse-Family Partnership, or NFP, in particular as being evidence based and effective.[6] Former President George W. Bush created the first dedicated home visiting funding stream in 2008, and President Barack Obama proposed a large expansion as a candidate and during his first term.[7]

However, these programs are underfunded and unable to achieve their maximum impact. This year, the largest federal funding source for home visiting programs—the Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, program—was able to serve only about 115,000 parents and children, a small fraction of the children and families who live in poverty in the United States.[8]

Some states are patching together disparate funding sources to support home visiting on a limited basis. But the red tape, cumbersome administrative requirements, and detailed reporting processes involved in drawing on multiple sources have inhibited many states from leveraging available financing options, and even then, the funds are not available to fully bring home visiting programs to scale. The federal government could and should do more to provide dedicated financing and expand home visiting programs. In order to scale these programs and realize the future cost savings associated with evidence-based home visiting programs, a significant and sustained investment is necessary.

Policymakers should adopt a new, streamlined funding source by including evidence-based home visiting services as an optional Medicaid benefit. States that want to expand these services could access Medicaid funding for an approved home visiting model through a state plan amendment, or SPA, to their Medicaid programs. Additionally, the federal government should incentivize participation in this option and enable states to scale home visiting services by providing upfront funding to states in the form of a five-year loan. States would pay back this loan with the savings associated with participation in the programs.

A Center for American Progress analysis of research on the return on investment from evidence-based home visiting services finds that offering this kind of upfront funding to scale these services nationally could result in:

- 20,000 fewer infant deaths
- 400,000 fewer preterm births
- 1,680,000 fewer child maltreatment incidents
- 1,450,000 fewer intimate partner violence incidents
- 1,450,000 fewer youth arrests
- 1,640,000 fewer cases of youth substance abuse

The proposals presented in this report would use government funding more efficiently and are cost neutral; over 10 years, savings would be achieved at both the state and federal levels in the amounts of $2.4 billion and $813 million, respectively. The proposals also would remove funding barriers that hinder the expansion of home visiting programs, improving the lives of thousands of at-risk families.

Background on home visiting

Home visiting programs provide parents who choose to participate with a nurse, trained parent educator, or social worker who provides coaching and guidance on how to support and nurture the healthy development of young children.[9] Typically, home visiting services target key at-risk populations, such as low-income, first-time, or adolescent mothers. There are many different models for home visiting programs that vary in their methodology, eligibility requirements, duration, and target populations. In general, families that participate in this voluntary service become better equipped to provide the optimal environment for healthy child development: an environment that includes access to nutritious food, stable and nurturing relationships with adults, physical and emotional safety, and parents who have resources to support childrearing.

Evidence of home visiting's effectiveness

The evidence of home visiting's effectiveness is well documented; some models have produced positive social outcomes that result in significant government cost savings within the health, human service, and education sectors. Randomized controlled trials, or RCTs, are used to evaluate the effectiveness of programs and policies and are considered the gold standard of evaluations. RCTs that evaluate the impact of home visiting services have found that the most effective models reduce the risk of infant death; reduce the need for nutrition assistance and Temporary Assistance for Needy Families, or TANF, payments; lower criminal offenses and substance abuse later in children's lives; prevent child abuse and maltreatment; and increase breastfeeding and immunization rates.[10]

Home visiting services come in many different forms, and each model has produced different types of outcomes at varying levels of documented effectiveness. In 2009, the Department of Health and Human Services, or HHS, launched the Home Visiting Evidence of Effectiveness, or HomVEE, project to review and evaluate the research literature on home visiting models, with the goal of identifying home visiting programs that met specific criteria of effectiveness. Since 2009,

17 home visiting models have met the HHS threshold of being evidence based—meaning that these programs have undergone rigorous evaluations and have proven to be effective at achieving outcomes.[11]

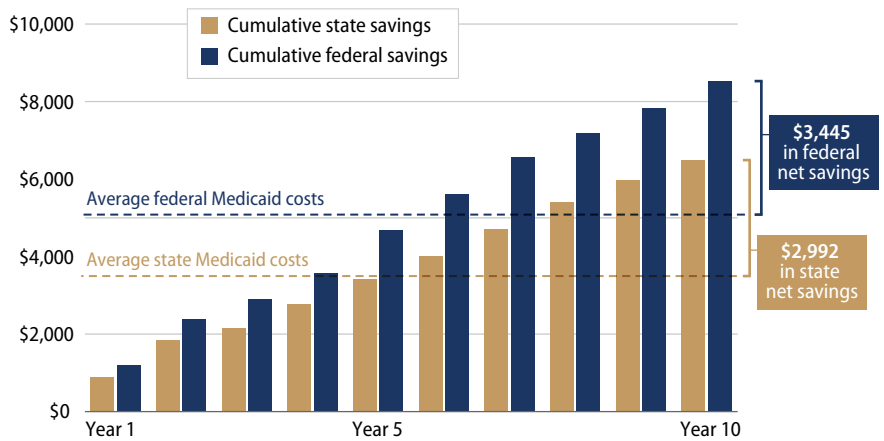
While many home visiting models considered in the HomVEE study meet HHS' threshold for being evidence based, not every model has demonstrated the cost effectiveness needed for the Congressional Budget Office, or CBO, to score savings over the long term. The CBO, the federal agency that provides official budget estimates and scores for federal legislation, has identified one home visiting model, Nurse-Family Partnership, which has produced enough evidence from RCT evaluations and cost-benefit studies to score long-term savings.[12]

The outcomes associated with NFP are supported by nearly four decades of research and evaluation. The first RCT of the NFP program began in 1977 in Elmira, New York, and was followed up by trials in Memphis, Tennessee, in 1988 and Denver, Colorado, in 1994.[14] In each of these early trials, results demonstrated the model's effectiveness at improving outcomes for the children and mothers who participated. Evaluations have found that NFP can reduce emergency room visits and childhood injuries, prevent child hospitalization, increase the amount of time between a mother's first and second births, increase maternal employment and earnings, reduce the use of welfare and cash assistance programs, and improve a child's cognitive abilities.[15]

FIGURE 1

Evidence-based home visiting programs pay for themselves in government savings

Cumulative savings per enrolled birth in the Nurse-Family Partnership program



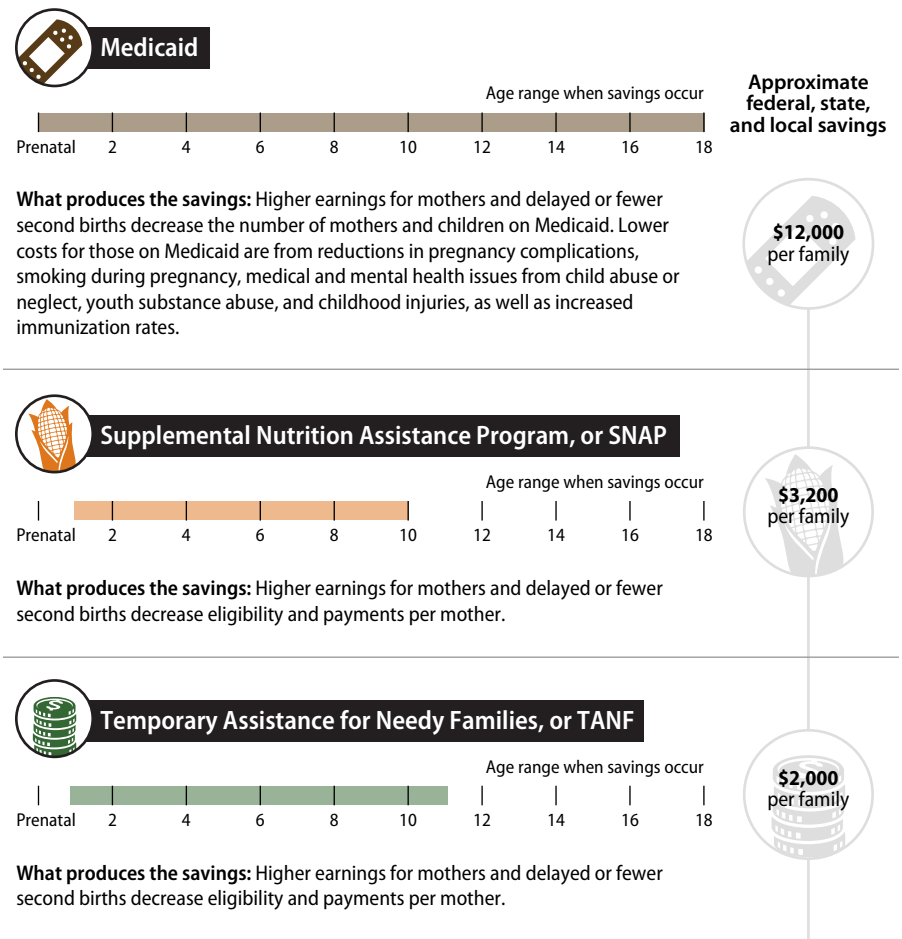
Source: Center for American Progress analysis based on Ted Miller, "Cost Savings of Nurse-Family Partnership in the United States" (Calverton, MD: Pacific Institute for Research and Evaluation, 2014). See Appendix B for more details.

Characteristics of the high-risk first-time mothers participating in the NFP program[13]

- Median age of 19
- 84 percent unmarried
- 55 percent completed high school
- Median household income of $9,000

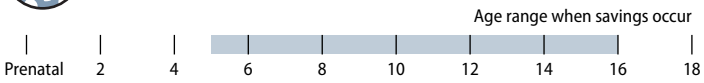
Furthermore, researcher Ted Miller's research on the return on investment associated with the NFP program provides an extensive and ongoing look at the savings associated with a home visiting model. His research shows that significant state and federal savings accumulate through at least the first 18 years after a mother and child enroll in the NFP program. (see Table A1 in Appendix C)* As Figure 1 shows, Miller's research finds that if Medicaid were to fund the NFP program fully, the resulting savings per enrolled family to the federal and state governments would exceed the costs of providing the program to that family by the time the child turned 6 years old.[16]

Government savings associated with the Nurse-Family Partnership home visiting program



* The costs and savings to the federal and state governments in Table A1 and Figure 1 differ slightly from Miller's research because we used the average 2016 Federal Medical Assistance Percentage rate, while he used a different average FMAP rate.

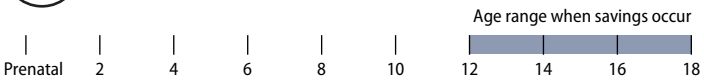
Child Protective Services



$1,700 per family

What produces the savings: Less child maltreatment decreases investigation and intervention costs, judicial expenses, and the number of children placed in foster care.

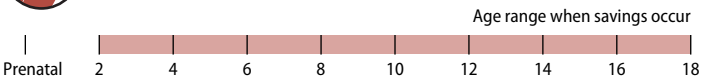
Police



$1,500 per family

What produces the savings: Reduced youth offenses decrease police investigations, adjudication, and sanctioning costs.

Special education



$850 per family

What produces the savings: Improved child language development decreases the use of remedial school services.

Child care

$400 per family

What produces the savings: Delayed or fewer second births decrease the use of federally subsidized child care.

Total savings: **$22,000** per family

Source: Ted Miller, "Cost Savings of Nurse-Family Partnership in the United States" (Calverton, MD: Pacific Institute for Research and Evaluation, 2014).

Home visiting financing

Despite the fact that home visiting services are a smart investment, programs are underfunded across the country. The Maternal, Infant, and Early Childhood Home Visiting program, which provides states with a dedicated funding stream to support evidence-based home visiting programs, represents the largest federal commitment to expand home visiting to more families across the country. But this landmark investment fails to reach the majority of eligible families and was only able to serve about 115,000 children and families in 22 percent of U.S. counties in 2015.[17]

While for some states and communities, MIECHV represents their entire investment in home visiting services, others have been able to blend together various funding mechanisms to support home visiting. In some states, services are supported by state appropriations or state general funds, dedicated revenue or taxes, and existing children's trusts.[18] Additionally, a number of states have directed their tobacco settlement funds toward home visiting services, though these funds are not sustainable—and in some states, nearly depleted.[19]

Because home visiting services have achieved a broad set of social outcomes, states also have been able to leverage multiple sources of federal funding. For example, states are using grants and funding available through Title V of the Maternal and Child Health Services Block Grant, foster care funds available through Title IV of the Social Security Act, Temporary Assistance for Needy Families funds, and Medicaid.[20] States and implementing communities are also partnering with philanthropic and private-sector partners to identify innovative funding sources, such as Pay for Success models and social impact bonds.[21]

While various funding opportunities exist, the approach of cobbling together multiple funding sources is ineffective and inadequate: States are still unable to reach the entire eligible population, and they are forced to spend limited resources on fundraising and the administration of different funding streams. Further, many of these funding sources are unreliable, unpredictable, and often dependent on appropriations processes. There are multiple programs and projects that draw on these funding sources that can make them less available to home visiting programs. Finally, available funding sources fail to provide enough upfront financing to bring home visiting programs fully to scale.

Medicaid financing

Overview

Medicaid is a joint federal-state program that generally provides health coverage to low-income adults, children, women who are pregnant, and individuals with disabilities.* States' contributions are matched at a specified percentage of Medicaid program expenditures called the Federal Medical Assistance Percentage, or FMAP, based on the state's relative wealth.[22] Federal law sets general requirements for states that must be in place in order for the federal government to pay for Medicaid services, but within these parameters, states have a significant amount of flexibility to design their Medicaid programs to meet their specific needs.[23] Federal law includes a number of mandatory services that all states must cover—such as inpatient and outpatient hospital services, family planning services, or physician services—but also includes optional state services, such as physical therapy, dental services, or case management.[24] Each state has a state plan that can be amended.

States typically modify their Medicaid program by submitting a state plan amendment to the federal Centers for Medicare & Medicaid Services, the federal agency that administers the Medicaid program. The process to amend a state plan through an SPA is relatively straightforward, and it is used when the changes the state wishes to make are already options available under the Social Security Act.[25]

In addition to an SPA, a state may make additional changes to its plan by applying for a waiver or a demonstration project, both of which allow states to adopt Medicaid policies that differ from the usual federal Medicaid requirements.[26] Waivers and demonstration projects involve a more rigorous and lengthy submission and approval process than SPAs, and waivers are generally approved for limited periods of time.[27]

Medicaid funding for home visiting services

Medicaid presents several financing options for states that hope to expand their home visiting services. However, home visiting is not a specifically covered category of Medicaid services in the Social Security Act, which means that states seeking to fund home visiting programs through Medicaid must piece together funding through a variety of existing funding mechanisms.[28] Even then, states must supplement Medicaid coverage with other sources in order to fund these services fully.

* The Affordable Care Act expanded Medicaid eligibility to low-income childless adults with incomes up to 138 percent of the federal poverty level. States could choose whether to expand eligibility; currently, 20 states have not expanded eligibility to these low-income adults. See Kaiser Family Foundation, "Current Status of State Medicaid Expansion Decisions" (2015), available at http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/.

As a result, states that want to access funding have to fit home visiting services into an existing area of coverage—such as enhanced prenatal care or case management—or apply for a waiver. These added layers of administrative complexity are often enough to deter home visiting providers from pursuing this option. Furthermore, fitting home visiting services into existing areas of Medicaid coverage often does not allow reimbursement for the full range and duration of home visiting services. For example, home visiting services covered by Medicaid as an enhanced prenatal benefit cannot continue beyond 60 days after birth, yet the NFP model provides services for about two and a half years.[29]

Home visiting activities that have been found to be eligible for Medicaid coverage and payment include: assessments; development of care plans and monitoring of progress; referrals; family planning activities; and mental health services. A study by the Pew Center on the States and the National Academy for State Health Policy has identified the most common Medicaid financing mechanisms used to finance components of home visiting programs, which include targeted and administrative case management, enhanced prenatal care benefits, and traditional Medicaid services.[30] States also have covered particular home visiting services as preventive services, as well as under the Early and Periodic Screening, Diagnostic and Treatment, or EPSDT, services benefit for children. States have used Medicaid waivers to cover these services as part of managed care arrangements, as well as benefits offered under broader Medicaid 1115 waivers, which give states flexibility to test innovations and offer services that Medicaid usually does not cover.[31] (see Appendix A for more details on current Medicaid options to fund home visiting services)

These state plan options—even when adopted in conjunction with each other—are insufficient to fund fully the entire range of important home visiting services and the entire duration of interventions.[32] States may use existing waivers to help fund these programs, but these too are of limited use. They are short term; states must demonstrate cost effectiveness over a five-year period, as well as address other similar administrative requirements; and the waiver submission process requires significant state resources. Since waivers are typically only approved for three to five years, they cannot take into account the cost savings that are achieved or that begin to accrue after this time frame.

Financing challenges

Despite the variety of funding opportunities that exist, no single funding stream provides sufficient financing for home visiting programs. Additionally, even using all available funding sources is not enough to scale these programs fully to serve every eligible family. The most recent data show that only one in five families who live below the federal poverty level receive at least one home visit, let alone enroll in an evidence-based program with proven long-term outcomes.[33]

The administrative burden associated with blending multiple funding sources is another barrier. States and communities have pointed to the fact that blending various funding streams can become quite onerous, especially when it requires multiple tracking and reporting requirements and different timelines for each funding source.[34] For example, MIECHV grantees are required to track and report on progress toward key social constructs, and MIECHV program administrators have raised as a key challenge the infrastructure and expertise needed to meet the grant requirements efficiently.[35] Similarly, properly billing home visiting services to Medicaid requires a significant amount of precise information and data management.

Even if states were to leverage opportunities through Medicaid more effectively, funding would continue to fall short of potential demand. Currently, state and federal Medicaid funding shortfalls limit what services are covered and the amount of payment for them. For example, NFP finds that the average Medicaid reimbursement rate for services provided during a single visit in states that partially fund home visiting through Medicaid covers less than half the actual per-visit cost of $361.[36]

States are also obligated to balance their budgets on a yearly or biannual basis. So while home visiting services present an opportunity to save states money in the long run, these savings are not reflected in their budgets when they allocate new money to expand or initiate home visiting programs. Including the upfront costs of expanding home visiting services in a state budget without being able to factor in the long-term cost savings creates a significant challenge for balancing a one- or two-year budget. This is an important barrier that the federal government, which can consider costs and savings over a longer window, can help states overcome.

These financing challenges create significant disincentives for states to expand home visiting services and inhibit the implementation of programs that would actually save money down the road. This is particularly true for Medicaid, a program that would see significant cost savings in the future if participation in home visiting services were more widespread and if states had the ability to put up enough funding for their share of Medicaid costs for scaled home visiting. Since the federal government can take a long-term approach in its budgeting process, a more streamlined and reliable upfront funding source should be provided through Medicaid to scale home visiting services fully.

Proposed Medicaid home visiting state plan option

Evidence-based home visiting services are among the most effective and rigorously evaluated government programs available.[37] Ensuring that every eligible mother and child has the opportunity to enroll in these programs would not only change the individual lives of program participants but also would reduce government spending for years to come. In order to scale effective and evidence-based home visiting services fully, policymakers should amend the Medicaid statute to add a new home visiting option for states. This proposal would create a stable funding source for home visiting programs and reduce the administrative burden for states that wish to offer this important benefit. The federal government also should provide upfront funding to encourage and enable states to implement scaled home visiting. This proposal would entail no cost to the federal government or states over 10 years; it would actually result in net savings.

While multiple home visiting models have shown evidence of effectiveness, only Nurse-Family Partnership currently meets the threshold needed for this proposal to be cost neutral over a 10-year period. Other home visiting programs are likely to produce similar outcomes and demonstrate cost neutrality using robust studies in the coming years and also should be included as options in this proposal. This report uses NFP as an example to describe how this proposal could work, given that it is the only home visiting model that would be eligible at present.

Medicaid funding for scaled home visiting

The federal government should create a streamlined and consolidated funding source through Medicaid by creating a home visiting option that would explicitly cover evidence-based and cost-effective home visiting programs. The costs of providing home visiting services would be split between states and the federal government based on the regular Federal Medical Assistance Percentage rates.

Full funding of home visiting through Medicaid would eliminate the barriers and accompanying challenges that states face in accessing disparate funding sources. It also would allow home visiting services to be expanded to all eligible children and families.

The savings from scaling evidence-based home visiting also would outweigh the costs of providing the services. CAP modeling based on Ted Miller's research on the NFP program shows that if all states implemented this proposal and enrolled all eligible children and mothers over 10 years, states would see $2.4 billion in net savings, and the federal government would gain $816 million.

TABLE 1

Estimated costs and savings from scaled home visiting through Medicaid over 10 years

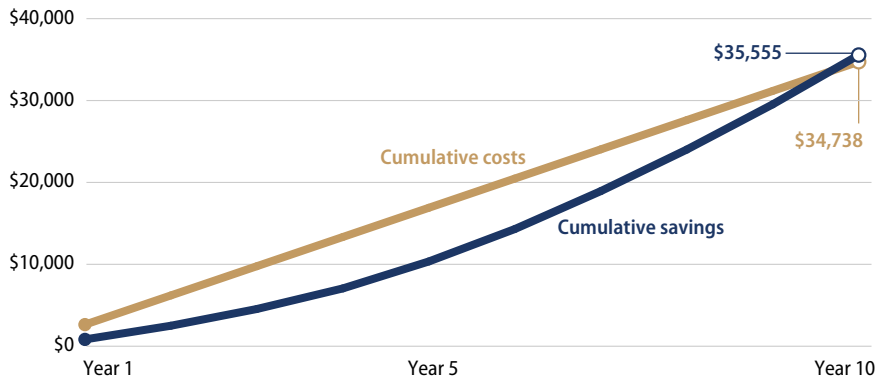
	Costs	Savings	Net savings
States	-$24,822,322,046	$27,203,951,320	$2,381,629,274
Federal government	-$34,738,382,769	$35,554,546,108	$816,163,338

Source: CAP analysis based on Ted Miller, "Cost Savings of Nurse-Family Partnership in the United States" (Calverton, MD: Pacific Institute for Research and Evaluation, 2014). See Appendix B for more details.

FIGURE 2

Savings would cover the costs of scaling cost-effective home visiting services

Estimated cumulative federal costs and savings of nationally scaled home visiting services over 10 years, in millions of U.S. dollars



Source: CAP analysis based on Ted Miller, "Cost Savings of Nurse-Family Partnership in the United States" (Calverton, MD: Pacific Institute for Research and Evaluation, 2014). See Appendix B for more details.

5-year federal loan to facilitate scaled home visiting

Additionally, the federal government should provide states with an initial five-year loan that would enable them to scale home visiting services while always maintaining cost neutrality for the programs. This loan would solve the timing issue for states of upfront costs and offsetting savings that accumulate later.

Timing of Medicaid loan disbursement and repayment

Table 2 shows the total state and federal costs and savings over a 10-year period if states enrolled every eligible family in the NFP program.* Because the costs for each birth are frontloaded and savings then accrue over many years, the costs to the federal government and the states will be greater than the savings in the first five years of scaled home visiting. After the first five years, the savings outweigh the costs, and states and the federal government have cumulative net savings at the end of 10 years.

The federal government should use its 10-year savings to provide the states with a loan to cover the difference between the state costs and state savings in the first five years of scaled home visiting. In Years 5 through 10, states would gradually repay the federal government while still retaining some savings. At the end of 10 years, the states and federal government would have the same net savings as in the absence of the loan, but the flexible Medicaid funding would enable the states to never spend more on home visiting than the amount of savings they receive back. This loan is essentially the same as an enhanced FMAP rate for home visiting services for the first five years and then a decreased rate for the next five: States would pay less and then more than they normally would under regular FMAP rates.

Steps to implement these proposals

Federal legislation is necessary to add evidence-based home visiting services as an optional Medicaid benefit. This legislation also would authorize the five-year federal loan to states. This legislation would be cost neutral to the federal government over 10 years and would even achieve savings, as already outlined and shown in Table 2.

* See Appendix C for costs and savings by state.

The secretary of Health and Human Services would certify the home visiting programs that meet the evidence threshold for effectiveness on outcomes and cost neutrality. As mentioned above, NFP is the only home visiting program that currently meets this standard. HHS also should work with other home visiting models, particularly those being evaluated as a result of funding from the Maternal, Infant, and Early Childhood Home Visiting program, to conduct the same level of evaluation and produce the same level of evidence. States could then choose to implement any eligible model, avoiding the need for states to piece together separate sources of funding or to apply for waivers.

Instead, states would submit state plan amendments to the Centers for Medicare & Medicaid Services to add one of the approved programs as a benefit of their Medicaid programs for first-time pregnant women who meet the certified program's requirements. In this way, home visiting would be permanently available to all eligible Medicaid beneficiaries in a state. States would indicate on their SPAs that they wish to receive the five-year federal loan.

These proposals would ensure that there is no downside for states to scale home visiting: There would be complete and steady funding, the services would pay for themselves, and the lives of thousands of vulnerable children and families would improve.

TABLE 2

Estimated costs and savings from scaled home visiting services over 10 years

In millions of U.S. dollars

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
With current federal medical assistance percentage rates											
State costs	-$1,886	-$2,548	-$2,548	-$2,548	-$2,548	-$2,548	-$2,548	-$2,548	-$2,548	-$2,548	-$24,822
Federal costs	-$2,639	-$3,567	-$3,567	-$3,567	-$3,567	-$3,567	-$3,567	-$3,567	-$3,567	-$3,567	-$34,738
State savings	$651	$1,332	$1,565	$2,003	$2,469	$2,899	$3,406	$3,894	$4,303	$4,681	$27,204
Federal savings	$833	$1,670	$2,043	$2,512	$3,291	$3,955	$4,632	$5,072	$5,523	$6,022	$35,555
State net savings	-$1,235	-$1,217	-$983	-$545	-$79	$351	$858	$1,345	$1,755	$2,132	$2,382
Federal net savings	-$1,806	-$1,896	-$1,523	-$1,055	-$275	$389	$1,065	$1,506	$1,956	$2,455	$816
With federal loan											
Federal loan	$1,235	$1,217	$983	$545	$79	$-	$-	$-	$-	$-	$4,059
State repayment of loan	$-	$-	$-	$-	$-	$203	$609	$812	$1,218	$1,218	$4,059
State net savings	$-	$-	$-	$-	$-	$148	$249	$533	$537	$915	$2,382
Federal net savings	-$3,041	-$3,113	-$2,507	-$1,600	-$354	$592	$1,674	$2,318	$3,174	$3,673	$816

Source: CAP analysis based on Ted Miller, "Cost Savings of Nurse-Family Partnership in the United States" (Calverton, MD: Pacific Institute for Research and Evaluation, 2014). See Appendix B for more details.

Efficient use of government funding

Using this structure to allow states to access Medicaid funding for home visiting would remove red tape and promote government efficiency. Redirecting funds toward prevention rather than treatment does not cost the government any additional funding. Rather, it diverts funds that would have been spent in the future toward preventive services earlier in a child's life. Similar approaches have received strong bipartisan support in the past. Florida received a waiver in 2006 to front-load child welfare spending on preventive services rather than pay for expensive out-of-home placements down the road. (see text box) The waiver was supported by then-Gov. Jeb Bush (R) and approved by the George W. Bush administration.

Florida's Title IV-E child welfare demonstration project

In Medicaid and other sectors of the federal government, waivers similar to the proposed Medicaid funding for home visiting have been employed to fund preventive services that have evidence of future cost savings. For instance, child welfare demonstration waivers allow states more flexibility in the timing and allowable use of their Title IV-E funds, which traditionally are restricted to the support of safe and stable out-of-home care for children until the children are safely returned home, placed permanently with adoptive families, or placed in other planned arrangements for permanency.[38]

Florida received a waiver in 2006 that provided flexible funding to reduce child abuse and neglect and reduce entrants into the child welfare system. The core assumption was that if child welfare agencies received the funds that they would normally get to support children in the system upfront in a lump sum, they could allocate that money toward services that would prevent out-of-home placement and improve child well-being, permanency, and child safety. Additionally, the cost of increased services would be offset by the savings realized by decreased foster care expenditures later down the road.[39]

As a result of the waiver, Florida reduced out-of-home placements of children; improved the timeliness of achieving permanency; significantly decreased rates of child maltreatment; improved placement stability; significantly shifted costs from spending for out-of-home care and front-end services; and achieved an 18 percent decrease in expenditures on out-of-home care.[40]

Outcomes of scaled home visiting

Scaling home visiting would magnify the positive results that home visiting programs are already achieving. For example, scaling the NFP program to all eligible pregnant women over just a 10-year period would prevent an estimated:[41]

- 20,000 infant deaths
- 400,000 preterm births
- 1,680,000 child maltreatment incidents
- 1,450,000 intimate partner violence incidents
- 1,450,000 youth arrests
- 1,640,000 cases of youth substance abuse

Appendix C breaks out the positive outcomes for each state. The research on the NFP program also has found evidence of other positive outcomes, including reduced smoking during pregnancy, reduced childhood injuries, improved language development, increased breastfeeding, and higher rates of immunizations.[42]

Conclusion

A new Medicaid state option for home visiting services would use federal funds more efficiently to achieve better outcomes for vulnerable children and their families. Rather than spending money in the future on expensive health care services, special education, and the criminal justice system, the federal government and states should be diverting those funds toward services and programs that prevent their necessity. Evidence-based home visiting programs that have undergone rigorous evaluations have proven their ability to reduce the need for expensive services. Participation in home visiting improves outcomes for both mothers and young children, resulting in significant cost savings in Medicaid and in other areas of government. Families that participate are more economically self-sufficient, improve their educational outcomes, and have higher rates of employment.[43]

Every child deserves the best possible start in life. Home visiting services support families in making this possible and have proven that they pay for themselves. Although these programs are being expanded across the country, they still fall far short of reaching every eligible family. Creating a new option for state Medicaid programs that redirects funding toward effective preventive services would allow states and communities the opportunity to scale their services to all eligible families. Spending limited resources efficiently so that all children have a great start in life should be an easy decision.

Appendix A: Select Medicaid funding options

Select mandatory and optional Medicaid benefits[44]

Early and Periodic Screening, Diagnostic and Treatment services

EPSDT provides comprehensive child and pediatric care for eligible children through age 20 with the goal of identifying developmental problems before they become more complex and costly to correct. The services and benefits covered under EPSDT include periodic screening, diagnostic services when screening identifies a need, and treatment of conditions identified during screening.

Targeted case management

Targeted case management, or TCM, services, are case management services that are targeted toward specific populations or geographic regions within a state. TCM services include comprehensive assessments and periodic reassessments, development of a specific care plan for participating individuals, referral and support for accessing other necessary services, and follow-up to ensure that individuals are implementing their care plans.

Pregnancy and pregnancy-related services and enhanced prenatal services

Services can include risk assessment, care coordination and case management, health and nutrition education, home visits, psychosocial counseling, smoking cessation, substance abuse treatment, infant care education, breastfeeding support, and child birth education. The Centers for Medicare & Medicaid Services allows states to design the components and delivery methods to enhance prenatal services, which allows for a significant amount of flexibility.

Preventive services

General preventive services include services that prevent disease, disability, and other health conditions that diminish overall health, as well as services that promote good physical and mental health.

Home health services

Home health services can include home visits by nurses to women who are pregnant or postpartum and their infants. These visits include assessments, nursing care and treatment, counseling, referral, and communication with the patient's physician.

Administrative case management and administrative claiming[45]

Administrative claiming allows states to draw on Federal Financial Participation, or FFP, matching funds for states to spend on home visiting services that are considered to be necessary and proper for the efficient administration of state Medicaid programs. These activities could include outreach, determining eligibility for services, authorization for services, EPSDT administration, case management, and third-party liability activities.

Waivers

There are three general categories of Medicaid waivers and demonstrations, each named for a section of the federal Social Security Act.[46] They are as follows:

- **Section 1915(b) waivers,** or Freedom of Choice waivers, allow states to waive Medicaid provisions that guarantee beneficiaries the right to choose their providers and require states to provide the same benefits to beneficiaries throughout the state. States generally use these waivers to enroll individuals in managed care plans. Under this approach, states contract with managed care organizations to provide Medicaid recipients with a defined set of services. States are able to identify services that promote health beyond traditional medical services within their managed care system. States have been able to include home visiting services in their managed care contracts or in the services provided by managed care organizations.

- **Section 1915(c) waivers,** or Home and Community-Based Services waivers, allow states to provide these services instead of institutional care for specific groups of Medicaid enrollees.

- **Section 1115 demonstration projects** offer states the greatest level of flexibility. They are generally statewide and allow states to waive a wide range of federal requirements in order to test a wide variety of payment and delivery system reforms, as well as offer a broader set of services to enrollees.

Appendix B: Methodology

CAP calculated the following figures cited in this report: the number of births eligible for the Nurse-Family Partnership program per year; state-by-state and federal costs and savings by year for scaled home visiting with full Medicaid funding; and the outcomes that result from scaled home visiting.

NFP's eligibility criteria are high-risk, first-time, and low-income mothers, so to calculate the number of births eligible for the program per year, we used Medicaid-eligible first-time births. To determine the number of first-time, Medicaid-financed births, we used the number of Medicaid-financed births in 2010[47]—the most recent year for which data are available—and the percentage of Medicaid-financed births that were first-time births.* According to NFP, approximately 40 percent of all Medicaid-financed births are first-time births.[48] We assumed that the number of births eligible for the NFP program was the same each year over the 10-year period of the proposal, as the national birth and fertility rates recently increased slightly from 2013 to 2014 but declined in years previous to 2013.[49]

According to NFP, $8,580 is the average cost per birth enrolled in the program; 30 percent of the costs occur prenatally, 40 percent occur in the first year after birth, and the remaining 26 percent occur in the second year.[50] We used this information and each state's 2016 Federal Medical Assistance Percentage to determine the federal government's share and the state's share of the costs of providing the NFP program to all eligible families.[51]

We then determined the federal government's and the states' total savings—Medicaid and other savings—using research from Ted Miller of the Pacific Institute for Research and Evaluation. This research provides conservative and

* Future state decisions on Medicaid expansion may alter slightly the number of pregnant women eligible for Medicaid and the NFP program. As of October 2014, however, most states—including many that have not expanded Medicaid—already had income thresholds for Medicaid for pregnant women that were higher than the income threshold for Medicaid expansion. See Centers for Medicare & Medicaid Services, "State Medicaid and CHIP Income Eligibility Standards," available at http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-eligibility-levels-table.pdf (last accessed August 2015).

rigorously tested estimates from six randomized controlled trials of the yearly savings that result from the birth of a child whose mother received NFP services from prenatal to 215 months after the birth of the child. Our per-birth federal and state savings differ slightly from Miller's research because we used the average of 2016 FMAP rates to calculate Medicaid savings for the state and federal governments, while his research used a different average FMAP rate. For the purposes of this analysis, we assumed that all eligible mothers would enroll in the NFP program each year of the 10-year period to show the greatest potential savings from a home visiting program when it is fully at scale.

We also used Miller's research on the outcomes of the NFP program to calculate the outcomes that result from scaled home visiting.[52] His research on outcomes was for 177,517 NFP clients enrolled from 1996 to 2013, so we extrapolated these data to our 10-year estimated number of NFP clients of 7,127,112.

Appendix C: Additional tables

TABLE A1

Average costs and savings per birth in the Nurse-Family Partnership program

Participation year	State Medicaid costs	Federal Medicaid costs	Total state savings	Total federal savings	Net total state savings	Net total federal savings	Cumulative net total state savings	Cumulative net total federal savings
Year 1	-$2,588	-$3,761	$895	$1,188	-$1,693	-$2,574	-$1,693	-$2,574
Year 2	-$909	-$1,322	$938	$1,191	$29	-$131	-$1,664	-$2,704
Year 3			$323	$528	$323	$528	-$1,340	-$2,177
Year 4			$608	$664	$608	$664	-$732	-$1,513
Year 5			$646	$1,102	$646	$1,102	-$86	-$411
Year 6			$598	$937	$598	$937	$512	$526
Year 7			$706	$954	$706	$954	$1,218	$1,480
Year 8			$679	$623	$679	$623	$1,897	$2,103
Year 9			$570	$637	$570	$637	$2,468	$2,739
Year 10			$524	$706	$524	$706	$2,992	$3,445
Year 11			$510	$832	$510	$832	$3,502	$4,277
Year 12			$510	$656	$510	$656	$4,013	$4,932
Year 13			$579	$472	$579	$472	$4,592	$5,404
Year 14			$645	$370	$645	$370	$5,237	$5,774
Year 15			$629	$371	$629	$371	$5,866	$6,145
Year 16			$665	$327	$665	$327	$6,531	$6,472
Year 17			$519	$163	$519	$163	$7,050	$6,635
Year 18			$398	$148	$398	$148	$7,448	$6,783

Source: CAP analysis based on Ted Miller, "Cost Savings of Nurse-Family Partnership in the United States" (Calverton, MD: Pacific Institute for Research and Evaluation, 2014). See Appendix B for more details.

TABLE A2

Estimated costs and savings from scaled home visiting services through Medicaid over 10 years, by state

	Number of eligible births per year*	10-year costs	10-year savings	10-year net savings
Alabama	12,599	-$317,240,296	$396,017,602	$78,777,306
Alaska	2,421	-$101,168,874	$104,178,183	$3,009,309
Arizona	18,557	-$481,991,859	$593,577,198	$111,585,339
Arkansas	10,264	-$257,316,252	$321,826,468	$64,510,216
California	97,093	-$4,056,983,811	$4,177,660,452	$120,676,641
Colorado	9,772	-$402,455,789	$416,375,868	$13,920,079
Connecticut	4,708	-$196,721,897	$202,573,470	$5,851,573
Delaware	743	-$28,054,468	$29,883,222	$1,828,755
District of Columbia	2,487	-$62,355,994	$77,988,892	$15,632,898
Florida	41,888	-$1,376,778,144	$1,541,526,970	$164,748,826
Georgia	22,404	-$607,545,426	$734,520,991	$126,975,564
Hawaii	1,820	-$70,009,937	$74,099,184	$4,089,247
Idaho	3,582	-$86,081,972	$109,713,266	$23,631,294
Illinois	34,391	-$1,411,443,534	$1,461,905,349	$50,461,815
Indiana	15,628	-$436,221,664	$521,054,576	$84,832,912
Iowa	6,233	-$234,860,332	$250,322,781	$15,462,449
Kansas	5,264	-$193,720,880	$208,172,342	$14,451,462
Kentucky	9,438	-$234,083,988	$294,163,929	$60,079,941
Louisiana	17,270	-$545,400,428	$620,029,445	$74,629,017
Maine	3,266	-$101,874,906	$116,365,307	$14,490,400
Maryland	7,653	-$319,769,187	$329,280,852	$9,511,665
Massachusetts	7,794	-$325,669,172	$335,356,335	$9,687,163
Michigan	20,778	-$597,310,389	$704,855,313	$107,544,924
Minnesota	11,993	-$501,131,065	$516,037,413	$14,906,348
Mississippi	10,346	-$223,319,339	$299,221,786	$75,902,447
Missouri	12,964	-$397,833,490	$457,354,089	$59,520,600
Montana	1,690	-$49,092,225	$57,686,280	$8,594,054
Nebraska	3,228	-$131,751,457	$136,707,604	$4,956,147
Nevada	6,295	-$184,486,226	$216,004,802	$31,518,576
New Hampshire	1,538	-$64,264,715	$66,176,295	$1,911,580

	Number of eligible births per year*	10-year costs	10-year savings	10-year net savings
New Jersey	11,400	-$476,327,726	$490,496,289	$14,168,563
New Mexico	5,933	-$146,905,347	$184,748,455	$37,843,107
New York	44,458	-$1,857,643,033	$1,912,899,384	$55,256,351
North Carolina	26,310	-$742,283,028	$882,709,003	$140,425,975
North Dakota	1,038	-$43,355,701	$44,645,334	$1,289,633
Ohio	21,256	-$666,662,997	$759,910,122	$93,247,125
Oklahoma	13,250	-$431,954,570	$485,136,371	$53,181,800
Oregon	8,185	-$243,651,705	$283,500,651	$39,848,945
Pennsylvania	18,104	-$726,058,369	$757,734,308	$31,675,939
Rhode Island	2,057	-$85,220,648	$87,994,842	$2,774,194
South Carolina	11,661	-$281,830,361	$358,300,217	$76,469,855
South Dakota	1,698	-$68,649,477	$71,448,508	$2,799,031
Tennessee	16,281	-$475,532,097	$557,545,974	$82,013,877
Texas	74,856	-$2,681,799,742	$2,909,401,645	$227,601,903
Utah	6,364	-$158,283,862	$198,671,385	$40,387,523
Vermont	1,160	-$44,704,876	$47,288,130	$2,583,254
Virginia	12,250	-$511,878,064	$527,104,086	$15,226,022
Washington	13,418	-$560,665,763	$577,342,995	$16,677,232
West Virginia	4,230	-$101,029,647	$129,131,031	$28,101,384
Wisconsin	13,539	-$472,610,889	$517,532,114	$44,921,225
Wyoming	1,157	-$48,336,425	$49,774,212	$1,437,787
Total	**712,711**	**-$24,822,322,046**	**$27,203,951,320**	**$2,381,629,274**

* 7,127,110 total births over the 10-year period

Source: CAP analysis based on Ted Miller, "Cost Savings of Nurse-Family Partnership in the United States" (Calverton, MD: Pacific Institute for Research and Evaluation, 2014). See Appendix B for more details.

TABLE A3

Estimated number of outcomes prevented by scaling the Nurse-Family Partnership over 10 years, by state

	Infant deaths	Preterm births	Child maltreatment incidents	Intimate partner violence incidents	Youth arrests	Cases of youth substance abuse
Alabama	355	7,097	29,809	25,551	25,551	29,100
Alaska	68	1,364	5,728	4,910	4,910	5,592
Arizona	523	10,454	43,906	37,634	37,634	42,860
Arkansas	289	5,782	24,283	20,814	20,814	23,705
California	2,735	54,695	229,719	196,902	196,902	224,249
Colorado	275	5,505	23,121	19,818	19,818	22,571
Connecticut	133	2,652	11,139	9,548	9,548	10,874
Delaware	21	419	1,758	1,507	1,507	1,717
District of Columbia	70	1,401	5,885	5,044	5,044	5,745
Florida	1,180	23,597	99,107	84,949	84,949	96,747
Georgia	631	12,621	53,006	45,434	45,434	51,744
Hawaii	51	1,025	4,307	3,692	3,692	4,204
Idaho	101	2,018	8,474	7,263	7,263	8,272
Illinois	969	19,373	81,369	69,744	69,744	79,431
Indiana	440	8,804	36,976	31,694	31,694	36,096
Iowa	176	3,511	14,747	12,640	12,640	14,396
Kansas	148	2,965	12,454	10,674	10,674	12,157
Kentucky	266	5,316	22,329	19,139	19,139	21,797
Louisiana	486	9,729	40,860	35,023	35,023	39,887
Maine	92	1,840	7,726	6,623	6,623	7,542
Maryland	216	4,311	18,106	15,520	15,520	17,675
Massachusetts	220	4,391	18,440	15,806	15,806	18,001
Michigan	585	11,705	49,159	42,136	42,136	47,989
Minnesota	338	6,756	28,376	24,322	24,322	27,700
Mississippi	291	5,828	24,477	20,981	20,981	23,895
Missouri	365	7,303	30,673	26,291	26,291	29,943
Montana	48	952	3,998	3,427	3,427	3,903
Nebraska	91	1,818	7,637	6,546	6,546	7,456
Nevada	177	3,546	14,893	12,766	12,766	14,539
New Hampshire	43	866	3,639	3,119	3,119	3,552

	Infant deaths	Preterm births	Child maltreatment incidents	Intimate partner violence incidents	Youth arrests	Cases of youth substance abuse
New Jersey	321	6,422	26,971	23,118	23,118	26,329
New Mexico	167	3,342	14,037	12,032	12,032	13,703
New York	1,252	25,044	105,185	90,159	90,159	102,681
North Carolina	741	14,821	62,249	53,356	53,356	60,767
North Dakota	29	585	2,455	2,104	2,104	2,396
Ohio	599	11,974	50,291	43,107	43,107	49,094
Oklahoma	373	7,464	31,349	26,871	26,871	30,603
Oregon	231	4,611	19,366	16,599	16,599	18,905
Pennsylvania	510	10,198	42,834	36,714	36,714	41,814
Rhode Island	58	1,159	4,866	4,171	4,171	4,750
South Carolina	328	6,569	27,590	23,649	23,649	26,933
South Dakota	48	956	4,016	3,443	3,443	3,921
Tennessee	459	9,172	38,521	33,018	33,018	37,604
Texas	2,108	42,168	177,107	151,806	151,806	172,890
Utah	179	3,585	15,058	12,907	12,907	14,699
Vermont	33	654	2,745	2,353	2,353	2,680
Virginia	345	6,901	28,984	24,844	24,844	28,294
Washington	378	7,559	31,747	27,211	27,211	30,991
West Virginia	119	2,383	10,008	8,578	8,578	9,770
Wisconsin	381	7,627	32,033	27,457	27,457	31,271
Wyoming	33	652	2,737	2,346	2,346	2,672
Total	**20,074**	**401,489**	**1,686,254**	**1,445,360**	**1,445,360**	**1,646,105**

Source: CAP analysis based on Ted Miller, "Projected Outcomes of Nurse-Family Partnership Home Visitation During 1996–2013, USA," Prevention Science 16 (6) (2015): 765–777. See Appendix B for more details.

About the authors

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