



Medicaid and Home Visiting

Best Practices from States

By Rachel Herzfeldt-Kamprath, Maura Calsyn, and Thomas Huelskoetter

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Introduction and summary

Children's experiences before age 5 have dramatic and lasting impacts throughout their lives. During this period, children develop critical foundational capabilities in cognition, language and literacy, emotional growth, and reasoning.¹ When young children deal with poverty and other toxic stressors, it has a detrimental impact on both their short- and long-term development and leads to lifelong health disparities across socio-economic groups.² In the United States, about one in four infants and toddlers grow up in homes experiencing poverty.³ Almost one in four children are exposed to at least one adverse childhood experience—such as income insecurity, the incarceration of a parent, neighborhood violence, or family mental illness—before they start school.⁴ These experiences have profound effects on a child's development.

For this reason, interventions that help families provide a nurturing, healthy environment are absolutely critical. Evidence-based home visiting programs that engage parents and provide parental coaching and guidance while helping them access other professionals and social services are among the most effective social programs at alleviating the stress of poverty.

The benefits of these programs range from improved school readiness to enhanced maternal and child health. Similarly, some programs have reduced the hospitalization rate among participating mothers and children. Others have effectively decreased the need for safety net programs such as the Supplemental Nutrition Assistance Program, or SNAP, and lowered rates of interaction with the juvenile justice system. In turn, the success of home visiting programs ultimately saves money for states and the federal government by lowering costs for programs such as Medicaid.

In 2010, the federal government established the Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, program, which represents the largest source of federal investment in home visiting. States have used this funding to identify high-risk target populations and expand evidence-based home visiting programs. While the MIECHV program is a critical federal investment, additional funds are needed to reach all the families who would benefit from these services.

In 2015, the program reached only 145,500 parents and children, a small portion of the eligible population.⁵

To supplement MIECHV funding, states are leveraging other funding sources to serve more families in need, including philanthropic funds, state funding, and other federal sources such as Temporary Assistance for Needy Families, or TANF, and Medicaid. Of these sources, Medicaid offers a significant opportunity for increased funding. A number of states already finance part of their home visiting programs using Medicaid, but it remains a greatly underused option to support home visiting.

This report highlights strategies that have worked in states where Medicaid supports home visiting, discusses barriers and challenges to leveraging Medicaid funding for these services, and outlines state and federal policy options for streamlining the accessibility of Medicaid funds to support home visiting. Findings presented in this report are based on existing state resources, published information on Medicaid and home visiting, and conversations with national organizations, as well as a series of interviews with 19 practitioners and home visiting administrative staff members in nine states.

This report finds that, while states have been able to support home visiting using Medicaid funding, Medicaid coverage and payment rates fail to cover the full cost of services, and administrative challenges inhibit broader access. To address these challenges, states and the federal government should take a number of actions to streamline efforts around accessing Medicaid for home visiting. Specifically, states should:

- Integrate payment for home visiting services into managed care financing
- Conduct feasibility studies to explore gaps in funding and opportunities to bolster Medicaid support for home visiting
- Obtain buy-in from key stakeholders such as relevant agency administrators, lawmakers, service providers, and the advocacy community
- Develop cross-agency collaborations
- Improve the accuracy of reimbursement rates by rebasing rates more frequently and by providing training and technical assistance to home visitors

It is also critical that the federal government offer more specific support to states working to increase Medicaid support for home visiting services. To this end, the federal government should:

- Issue home visiting-specific waiver templates for states wishing to expand services
- Provide technical assistance to states on billing and bundled payment rates for services
- Clarify the relationship between the MIECHV grant program and Medicaid funding
- Ensure that MIECHV is extended for a longer-term authorization at a higher amount

Investments in evidence-based home visiting programs are investments in America's future economic prosperity. Ensuring that more of the nation's most vulnerable families can access the resources that they need to thrive can prevent costly negative outcomes and save taxpayer dollars down the road. States and the federal government should prioritize expanding access to these critical services.

Methodology

To gather the data and information presented in this report, the authors identified a variety of states where Medicaid is currently being used to support an array of home visiting programs. In order to present diverse findings, the criteria for selection included but were not limited to the home visiting programs supported with Medicaid, the Medicaid authorities utilized, geography, and whether or not the state had been featured in prior research. After target states were identified, the authors conducted a series of phone interviews with state-level administrators and stakeholders involved in implementing these financing efforts. (see Appendix) To supplement the data collected through the interviews, the authors reviewed available supporting documents, program information, and Medicaid state plan information to gain a clear understanding of how states are

able to target Medicaid funds toward home visiting programs. All information provided in this report comes from the aforementioned interviews, unless otherwise indicated in the Endnotes.

In total, nine target states were identified and included in this analysis: California; Colorado; Michigan; Minnesota; New York; Oregon; South Carolina; Washington; and Wisconsin. Home visiting models captured in the research include those from state-based programs in Oregon, Washington, and Michigan, as well as national models such as Healthy Families America and Nurse-Family Partnership. Interviews were conducted from March 2016 through August 2016 using a tailored set of interview questions for each conversation.

Background on home visiting

Home visiting programs vary in scope and practice but generally connect the parents of young children to nurses, social workers, and other professionals who provide coaching and guidance on how to support healthy development during the early years of a child's life. Home visitors deliver services designed to promote healthy child development and positive parenting, including screenings for developmental benchmarks, maternal health, and child safety. Common case management activities among home visiting programs include assessing a family's needs, developing a care plan, providing service referrals, monitoring developmental progress, and conducting follow-up activities as needed. Finally, most home visiting programs offer parent-support activities and coaching, which can include counseling services and referrals along with services that work with parents to develop skills around stress management, nutrition, child discipline, and nurturing interactions.

Through these activities, home visitors develop supportive relationships with the parents that they serve, allowing them to help parents develop the skills and practices to support children's healthy physical, social, and emotional growth. Home visiting services have existed in the United States since the late 19th century, but in recent decades, research has identified specific models that produce significant positive outcomes for the families and children who participate.⁶ In an effort to expand the most effective of these programs, the federal government created the Maternal, Infant, and Early Childhood Home Visiting program. MIECHV is a federal grant program administered by the Health Resources and Services Administration, or HRSA, of the U.S. Department of Health and Human Services, or HHS. States, tribal communities, and territories receive grant funds to implement one or more of the home visiting models that meet HHS' evidence-based criteria or evaluate promising practices.

Evidence-based home visiting models provide a specific set of home visiting services that are consistent across every location where the services are offered. Models often include a research-based curriculum, a targeted population, and services for a specific duration and dosage. Home visiting models can vary in their goals and approach, as well as in who they serve and for how long. Across the country, MIECHV grantees conduct needs assessments to identify at-risk communities, then select the eligible evidence-based home visiting models that best support their target populations.

Examples of evidence-based home visiting models

Two examples of evidence-based home visiting models that states are currently implementing are Healthy Families America, or HFA, and Nurse-Family Partnership, or NFP. Prevent Child Abuse America, a national nonprofit dedicated to addressing child abuse, developed HFA and designed the program to provide home visiting services to families facing challenges such as single parenthood, economic hardship, or risk of child abuse and neglect.⁷ Families enroll during pregnancy or during the newborn period and receive weekly home visits from a trained professional for at least the first six months of the child's life, with visits continuing at decreasing frequency until the child's third birthday or in some situations until age 5.⁸ To use the HFA model, prospective local agencies must apply to the HFA national office, which provides ongoing training and technical support and oversees a national accreditation process to ensure model fidelity.

NFP targets low-income, first-time mothers and their children with in-home support services delivered by a registered nurse. NFP's goals

are to improve maternal health, child health and development, and the economic stability of families. First-time mothers receive regular home visits during their pregnancy until their child is 2 years old. NFP's national office contracts with local agencies to implement the NFP home visiting model. The national office educates nurses, collects and analyzes data on each visit as part of a national performance management and quality improvement system, and provides monitoring and technical support to ensure fidelity in implementation, while the local agencies provide services directly to families.

Other home visiting models may focus on supporting families with children who are older, working with specific demographic groups such as immigrant communities, or targeting the development of early learning skills.⁹ It is important that a wide variety of home visiting models qualify for MIECHV funding so that states can select the models that will most effectively address the needs of their target communities.

Determining effective home visiting programs

To determine which home visiting programs would qualify for MIECHV funds, HHS conducted a comprehensive review of available academic literature and evaluations of home visiting programs to identify evidence-based home visiting models. HHS considered a program's impact on eight general outcome areas: child development and school readiness; family economic self-sufficiency; child health; maternal health; positive parenting; reduction in abuse and neglect; reduction in juvenile justice system participation; and referrals and linkages to other social services.¹⁰

HHS deems home visiting models evidence based if they demonstrate favorable and statistically significant impacts in two outcome areas or through multiple rigorous evaluation studies.¹¹ Evaluations or impact studies are considered rigorous if they utilize random control trials or quasi-experimental designs.¹² Today, HHS has identified 17 evidence-based models that support positive outcomes across an array of social indicators.¹³ (see Table 1)

These evidence-based home visiting programs are associated with a variety of positive outcomes for parents and children. Many are linked to improved educational outcomes and academic performance. For example, some models support higher GPAs, reading, and math scores among participating children.¹⁴ Others result in increased participation in school-based gifted programs or reduced need for special education.¹⁵ Parenting practices, too, are improved by participation in home visiting. Parents who participated in some programs were more likely to read to their children daily and have children's books in the house.¹⁶ Researchers also found improved home safety and decreased rates of harsh parenting practices such as physical and verbal aggression and corporal punishment.¹⁷

Positive health outcomes associated with home visiting are among the strongest benefits of the programs. Specific health outcomes for children include a reduction in instances of low birth weight, preterm births, and hospitalization during infancy.¹⁸ Studies have also linked participation in some home visiting models to an increase in the number of well-child visits, reducing the number of emergency room visits and overnight stays in the hospital.¹⁹ Home visiting also leads to increased rates of breastfeeding, which is a proven boon for infants, and improved child nutrition. Babies whose mothers participate in the programs are less likely to be born preterm or to have low birth weights, and mothers and children participating in the programs have fewer emergency room visits.²⁰

Additionally, home visiting can improve the health of participating mothers by reducing rates of maternal depression, improving nutrition and diet during pregnancy, and lowering reported rates of parental stress.²¹ Participation may also reduce drug and alcohol use among new mothers and pregnant women and increase use of prenatal health care, which reduces complications such as pregnancy-induced hypertension.²² Mothers participating in the program—especially adolescent mothers—are less likely than those who do not participate to become pregnant again soon after the birth of their first child.²³

TABLE 1
Evidence of the effectiveness of MIECHV-eligible home visiting models

	Outcome domains							
	Child development and school readiness	Child health	Family economic self-sufficiency	Linkages and referrals	Maternal health	Positive parenting practices	Reductions in child maltreatment	Reductions in juvenile delinquency, family violence, and crime
Child First	✓	N/A	N/A	✓	✓	N/A	✓	N/A
Family Connects	N/A	✓	N/A	✓	✓	✓	N/A	N/A
Early Head Start-Home Visiting	✓	✗	✓	✓	✗	✓	✓	N/A
Early Intervention Program for Adolescent Mothers	N/A	✓	✓	N/A	✗	✗	N/A	N/A
Early Start (New Zealand)	✓	✓	✗	N/A	✗	✓	✓	✓
Family Check-Up For Children	✓	N/A	N/A	N/A	✓	✓	N/A	N/A
Family Spirit	✓	N/A	N/A	N/A	✓	✓	N/A	N/A
Health Access Nurturing Development Services Program	N/A	✓	✓	N/A	✓	N/A	✓	N/A
Healthy Beginnings	✓	✓	N/A	N/A	✓	✓	N/A	N/A
Healthy Families America	✓	✓	✓	✓	✓	✓	✓	✓
Home Instruction for Parents of Preschool Youngsters	✓	N/A	N/A	N/A	N/A	✓	N/A	N/A
Maternal Early Childhood Sustained Home-Visiting Program	N/A	✓	N/A	N/A	✓	✓	N/A	N/A
Minding the Baby	N/A	✓	N/A	N/A	✓	✗	✗	N/A
Nurse Family Partnership	✓	✓	✓	✗	✓	✓	✓	✓
Parents as Teachers	✓	✗	✓	N/A	✗	✓	✓	N/A
Play and Learning Strategies Infant	✓	N/A	N/A	N/A	N/A	✓	N/A	N/A
SafeCare Augmented	N/A	N/A	✗	✓	✗	N/A	✓	✗

Note: "Yes" means that positive impacts were confirmed on either primary or secondary outcome measures; "no" means that no effect was measured statistically significant for this domain; and "N/A" means that outcomes were not measured for this domain.

Source: U.S. Department of Health and Human Services, "Home Visiting Evidence of Effectiveness: Outcomes," available at <http://homvee.acf.hhs.gov/outcomes.aspx> (last accessed December 2016).

Cost savings from home visiting

Home visiting programs produce health care cost savings by improving child and maternal health. Funding home visiting is a critical investment in prevention. By making an upfront investment to identify and head-off risk factors for children and their families—before they cause long-term problems—home visiting programs can produce significant cost savings over a participant’s life.

More specifically, the positive health outcomes associated with participation in home visiting are linked to significant health care savings for states and the federal government by reducing Medicaid expenses and other health care costs. For example, some home visiting services are able to reduce the rate of neonatal intensive care unit, or NICU, care among participants.²⁴ Studies have found that Medicaid pays up to \$20,000, on average, for a birth that results in NICU care.²⁵ Comparatively, Medicaid pays up to \$13,000, on average, for a routine birth.²⁶ This means home visiting programs that prevent NICU care end up saving the public thousands of dollars. If fully scaled, home visiting services could have a dramatic impact on reducing overall medical costs in the United States.

In addition to the reductions in health care costs, home visiting is associated with federal and state savings in other social service sectors. These savings result from a decreased need for food and income assistance programs, fewer placements in foster care, lower rates of contact with the juvenile justice system, decreased need for special education or grade repetition between kindergarten and 12th grade, and lower rates of child abuse and neglect.²⁷ Broadly, the benefits of home visiting outweigh the costs of providing these services. In fact, for every dollar spent, there is a return of up to \$5.70 in savings and benefits.²⁸

Funding sources for home visiting programs

Funding for home visiting is limited and comes from a variety of sources. The Maternal, Infant, and Early Childhood Home Visiting program is the single largest source of federal funding dedicated to home visiting. In some states, MIECHV is the most significant or only source of investment in home visiting. In other states,

home visiting has long been a priority, with dedicated state and private funding sources. In these states, a patchwork of funding from various federal, state, local, and private sources comprises the total investment in home visiting efforts.

The MIECHV grant program provides funding to support evidence-based home visiting programs. MIECHV grantees—states, tribes, territories, and nonprofit implementing agencies—receive a formula-based grant every year and can apply for additional competitive grant funds to scale innovative efforts. Seventy-five percent of MIECHV funds must support evidence-based home visiting models that serve either high-risk communities or specific target populations, such as high-poverty communities or underserved rural populations. Up to 25 percent can go toward implementing and evaluating promising practices—or home visiting programs that have not yet completed a rigorous evaluation to prove outcomes.²⁹

Given that MIECHV funds are relatively new and are limited, states also draw from a number of other sources. Before MIECHV funding began in 2010, states relied on alternative funding sources—both public and private—and these continue today. In a number of states, such as California, tobacco tax revenue or tobacco lawsuit settlement funds support home visiting.³⁰ States also rely on philanthropic support to implement and expand home visiting services. For example, Washington’s Department of Early Learning works with Thrive Washington, a state-based nonprofit, to administer the Home Visiting Services Account, which has funded home visiting programs by leveraging private funding to match state dollars.³¹

Some states also allocate resources from other federal programs—including Temporary Assistance for Needy Families, Maternal and Child Health Block Grant funds, and the Early Intervention Partnerships Program—to help support home visiting programs.³² Yet funding from other federal programs is often relatively low and disparate across the country. In 2015, less than 0.1 percent of TANF funds were used to support home visiting programs in only six states.³³

Considering that some home visiting programs have substantial positive health outcomes for low-income families, many states have turned to Medicaid as a funding source. While home visiting is not a specifically covered service under Medicaid, Medicaid-enrolled providers can seek reimbursement from Medicaid for components of home visiting programs in specific situations. For example, programs that incorporate case management services or that refer patients to Medicaid for enrollment may be able to receive Medicaid reimbursement

for these activities. Unfortunately, this approach creates added administrative burdens for home visitors and state administrative staff. For example, they must carefully allocate the time spent on different parts of a home visit to make sure that they only bill Medicaid for allowed services.

Despite these barriers, a number of states have used Medicaid funding to support their home visiting programs. These states recognize that home visiting services complement Medicaid, as home visiting programs 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. Therefore, these states see Medicaid funding as an important supplemental funding source to bolster their home visiting systems.

The sections below detail how nine states have navigated Medicaid's administrative complexities and piecemeal coverage to support home visiting. These examples not only provide a guide for states that have yet to tap into this funding source but also illustrate the need for policymakers to create a more streamlined approach for states that wish to use Medicaid funding to support home visiting services.

How states use Medicaid to support home visiting

Medicaid is a joint federal-state program that provides health coverage to groups of low-income adults, children, women who are pregnant, and certain individuals with disabilities.* As the primary health care program for low-income pregnant women and children, it makes sense that states would seek Medicaid funding for services provided by their home visiting programs because home visiting programs successfully promote positive health and well-being outcomes among these vulnerable populations.

In some states, Medicaid helps fund national home visiting models—or component services provided by national home visiting models—such as Nurse-Family Partnership and Healthy Families America. In other states, Medicaid funds state-specific home visiting programs, which in some places were developed through state Medicaid programs. Regardless of how these programs were developed, home visiting remains a natural complement to Medicaid. These effective interventions help counteract the ongoing effects of poverty and stress throughout a child’s life and are as critical to improving health and economic opportunity for participants as other Medicaid-covered services.

Medicaid overview

The federal government contributes a percentage of the states’ Medicaid program expenditures for services covered under each state’s unique Medicaid state plan. That percentage is called the Federal Medical Assistance Percentage, or FMAP, and it is based on the state’s relative wealth.³⁴

* 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, and currently, 19 states have not expanded eligibility to these low-income adults. See Kaiser Family Foundation, “Current Status of State Medicaid Expansion Decisions,” January 1, 2017, available at <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>.

Federal law sets general requirements for the Medicaid program, but within those parameters, states have a significant amount of flexibility to design their Medicaid programs to meet their specific needs.³⁵ For example, federal law requires states to cover a number of mandatory services, such as inpatient hospital services and physician services, but the Medicaid statute also gives states flexibility to cover other optional services, including case management.³⁶

The Medicaid law also gives a large amount of deference to state professional standards and licensure requirements.³⁷ For many home visiting models, this flexibility is important because some models rely on social workers or other nonmedical professionals to provide services during home visits. Because the Medicaid program only pays for services furnished by qualified Medicaid providers, states must designate nonmedical professionals as qualified providers of home visiting services. Guidance from the U.S. Department of Health and Human Services describes this flexibility:

*In many areas of health care, it is clear what type of provider can perform certain services (e.g., surgery, prescribing medications). However, where a licensing category does not exist or does not fit for the purposes of providing a particular service within the Medicaid program, the state can define the requirements for background, training, level of education, etc. Through this process, the state can create its own type of paraprofessional provider solely for delivery of services within the Medicaid program. In reviewing state Medicaid State Plans, CMS [the Centers for Medicare & Medicaid Services] pays particular attention to these unique types of providers and their associated requirements.*³⁸

States also have flexibility to set the amount of Medicaid payments to health care providers, as long as the payment amount meets federal requirements. The payment amount, according to the guidance, must be high enough “to enlist enough providers so that care and services are available ... at least to the extent that such care and services are available to the general population in the geographic area.”³⁹ Federal law also places upper limits on provider payments.⁴⁰ Generally, states consider the cost of providing the service, as well as comparisons to what both private insurers and Medicare pay for a service.⁴¹

States may pay for covered services under fee-for-service arrangements or through managed care organizations, or MCOs.⁴² Under a fee-for-service arrangement, states pay a provider directly, and the payment corresponds to a discrete service, such as a single primary care visit. States may also choose to contract with MCOs. Under these arrangements, states usually pay the MCOs a set per-member per-month capitation payment for providing care to Medicaid enrollees.⁴³ About 70 percent of Medicaid enrollees receive their care through these managed care arrangements.⁴⁴

These specifics are included in each state's state plan, which may be amended by submitting state plan amendments, or SPAs, to the Centers for Medicare & Medicaid Services. CMS then reviews and approves the SPAs to make sure they meet federal requirements.

Federal law also allows states to claim federal reimbursement for 50 percent of the costs of activities that are necessary for the “proper and efficient administration” of their Medicaid programs.⁴⁵ Administrative activities include assisting an individual, who has not yet been determined to be eligible for Medicaid, to apply for or obtain coverage, as well as outreach activities to inform or persuade individuals to enroll in Medicaid.⁴⁶ The federal match for administrative services is the same for every state.⁴⁷ It is generally 50 percent, though some administrative tasks qualify for higher match rates, including activities that require medically trained personnel.⁴⁸

Funding for discrete components of home visiting models

Although home visiting is not a covered benefit under Medicaid, various component services of home visiting models are Medicaid-covered services. For that reason, many states that use Medicaid to support home visiting models have done so by including in their state plans those discrete Medicaid-covered services when provided through home visiting programs.

In early 2016, CMS and the Health Resources and Services Administration, the agency within HHS that administers the Maternal, Infant, and Early Childhood Home Visiting program, issued guidance that identified the various funding sources that states can use to cover the costs of services provided as part of a home visiting program.⁴⁹ Similarly, in 2012, The Pew Charitable Trusts and the National Academy for State Health Policy, or NASHP, published a report that provided examples from states utilizing various Medicaid authorities to finance home visiting.⁵⁰

The CMS-HRSA guidance document and the Pew-NASHP report also listed many Medicaid benefit categories that include services that may be furnished as part of a home visiting program: case management services; other licensed practitioner services; preventive services; rehabilitation services; therapy services; early and periodic screening, diagnostic and treatment services; extended services to pregnant women, health homes, and home health services.⁵¹ A number of the services listed in the guidance and report—including early and periodic screening, diagnostic, and treatment services; home health services; therapy services; rehabilitative services; and health homes—are not used by any of the states interviewed for the purposes of this report.⁵²

Among the states for which the authors conducted interviews with stakeholders—including state Medicaid officials and state and local home visiting program administrators—targeted case management, or TCM, services are the most commonly billed services by home visiting programs. For example, approximately 15 percent of Healthy Families America sites across the country currently utilize Medicaid. Nurse-Family Partnership operates in 42 states, and implementing agencies in 26 states are able to receive some funding for NFP through Medicaid.⁵³ In the majority of these states, NFP programs receive funding as a TCM service.⁵⁴ In general, case management services include services that help eligible individuals gain access to and coordinate medical, social, educational, and other services.⁵⁵ Case management services also include comprehensive assessments of eligible individuals, development of a specific care plan, referrals, and monitoring.⁵⁶ Alternatively, TCM services generally include assessments to evaluate an individual’s medical and social needs, case plan management to access and coordinate services to target the areas of need, and ongoing monitoring and service coordination.⁵⁷ In addition, TCM services are only offered to specific groups of Medicaid enrollees or to Medicaid enrollees who live in specific areas of a state.⁵⁸

In addition to billing for discrete medical and case management services, states may also receive federal funding to help pay for administrative services that are part of home visiting programs. These funds are available only for the parts of the home visiting program that relate to the administration of the Medicaid program. For example, these funds may not be used to pay for the time that home visitors take to help recipients access non-Medicaid services.⁵⁹ Yet there are benefits to using this bucket of Medicaid funds. Administrative claiming is not service-based; therefore, home visiting programs do not need to bill for distinct activities. Instead, the home visiting provider generally apportions its administrative costs and receives a payment based on the amount of services that are related to administration of the Medicaid program.⁶⁰

The examples below are illustrative in demonstrating how different states have used Medicaid to finance portions of home visiting services. The information presented below was gleaned from interviews with state administrators. (see Methodology text box above)

Wisconsin: Prenatal care coordination and TCM

Through Wisconsin’s MIECHV grant, the state operates four home visiting models—Early Head Start, HFA, NFP, and Parents as Teachers. HFA and NFP also receive Medicaid funding through prenatal care coordination, or PNCC, services and TCM services.

Wisconsin home visiting programs bill Medicaid for two categories of case management services—TCM services and PNCC services. PNCC services are provided to high-risk pregnant and postpartum women until their babies are 2 months old. These services include outreach; an initial assessment; care plan development; ongoing care coordination and monitoring; and health education and nutrition counseling services for enrollees with identified needs in this area.⁶¹

A range of public and private providers offer PNCC services from “qualified professionals” able to support the needs of eligible pregnant women.⁶² For instance, Wisconsin requires that all PNCC providers have staff who can provide health and nutrition education. PNCC providers include community-based health organizations, social services agencies, county or city public health agencies, and physicians’ offices. In addition, Medicaid-certified PNCC providers may subcontract with agencies not certified by the state’s Medicaid agency for PNCC services. The services are typically provided in a client’s home by registered nurses. Two of the home visiting programs offered in Wisconsin—HFA and NFP—meet these criteria and are thus able to receive payment for furnishing 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. However, Medicaid does not pay for the time that nurses spend during the visit on diagnostic or treatment services, except for health education and nutrition counseling.

Once a child is 2 months old, he or she is eligible for additional home visiting services up to age 5. Certified home visitors then bill Medicaid for the TCM portion of these home visiting services. TCM providers are generally public entities such as counties, tribes, or municipalities, but those providers may, in turn, contract with private providers, such as home visiting programs, to offer the services. Individual case managers must have knowledge of the local service delivery area and meet training and experience requirements.⁶³

One example of how this works in the field is the nonprofit human services organization Family Services of Northeast Wisconsin, or simply Family Services, which provides a range of services to at-risk children and families, including four home visiting programs. Family Services has been an HFA provider for 20 years. The organization contracts with the county to provide home visiting services using the HFA model, and it pieces together funding to pay for services provided under the model through both PNCC and TCM services.

Family Services is a licensed PNCC service provider, and during the period of time that each mother and infant qualifies for PNCC services, the organization receives \$896, or roughly \$40 per hour, in Medicaid funding as a Medicaid subcontractor. Once the child ages out of PNCC eligibility, Family Services bills the Medicaid program for the TCM services it provides. TCM services are provided to families separately using the Healthy Families model. TCM is not part of the HFA model. Medicaid reimburses the program at about 50 percent, and the precise payment amount is set annually—again, at about \$40 per hour. Given these complexities with billing the Medicaid program, Family Services spends a significant amount of time training staff on how to document and bill their time. Home visitors are responsible for tracking their individual time and recording what is billable to Medicaid, and supervisors review these materials once per month before they are submitted to the state.

California: TCM and administrative claiming

The California Home Visiting Program, or CHVP, is part of the state's Department of Public Health's Maternal, Child, and Adolescent Health, or MCAH, Program. The state created CHVP following MIECHV's enactment as part of the Affordable Care Act, or ACA.⁶⁴ There are currently 25 sites in 24 counties throughout the state that provide home visiting services to at-risk pregnant women and infants using either the NFP or HFA models.⁶⁵ California's Medicaid program, Medi-Cal, contributes funding to both programs by paying for either the TCM services or the administrative services components of the models, depending on the specific model.

California supports NFP through its TCM program. The program pays for the federal share of costs for case management services provided to specific groups of high-risk Medi-Cal enrollees—including women, infants, and children—that encompass the NFP target population.⁶⁶

In California, TCM is an optional benefit that is largely administered at the county or local level. Under the TCM program, the state contracts with counties and other local governmental agencies opting to offer the TCM benefit and reimburses them for the federal share of the costs for providing Medicaid-covered services.⁶⁷ County and local governments may, in turn, contract with providers and community-based organizations to provide these services to Medi-Cal recipients, and the payments then flow to those organizations.⁶⁸ The state provides guidance about billing, but coordination of TCM services is largely at the county level.

A number of county health departments in California are NFP-implementing agencies. When nurse home visitors provide TCM services as part of an NFP home visit in counties offering the TCM benefit, the state can draw down federal matching funds for the expenditures related to the TCM portion of the NFP home visits. Medi-Cal's reimbursement for TCM is also higher than in many other states; rates for these services are updated regularly based on cost reports and perpetual time studies, which require home visitors to account for the actual time and effort spent on TCM-related home visiting activities in an online tracking system. The state then looks at the amount of time spent on TCM services and calculates an overall payment for these services. NFP notes that these efforts can lead to significantly higher reimbursements than those paid in other states where the costs of TCM activities for Medicaid beneficiaries are not monitored on a frequent and periodic basis to set payment rates.

Medi-Cal supports other home visiting models as well. For instance, Solano County offers prenatal programs and services for children ages 0 through 5, including NFP; HFA; the Adolescent Family Life Program; and the Black Infant Health Program, a case management program.⁶⁹ The county receives Medi-Cal support for both NFP and HFA. Initially, Solano County worked with four different providers to offer services under the HFA model, but due to recent budget cuts, the county now contracts with just two groups—the California Hispanic Commission and Planned Parenthood. Each group employs one home visitor and subcontracts to add two additional home visitors.

Under the California state plan, Medi-Cal only pays for TCM services when the home visitors meet specific professional requirements. Solano County HFA home visitors are nondegreed, well-trained professionals. HFA instead receives Medicaid funding through the Federal Medicaid Title XIX funds, which are part of California's Federal Financial Participation, or FFP, Medicaid program. This funding stream offers federal matching funds for activities that involve connecting

clients to Medi-Cal services and insurance coverage. For example, time that home visitors spend on case management or care coordination can be paid for by the Medi-Cal program, as long as the home visitor is enrolling a client in Medi-Cal or coordinating care with a Medi-Cal provider. Solano HFA is part of the MCAH continuum of care and is particularly critical for the county; because of the model's broader inclusion criteria, mothers who might not meet the enrollment requirements for other programs can receive home visiting services through HFA.

Solano County does not bill the Medicaid program for discrete administrative services performed by home visitors. Instead, the state transfers federal Medicaid matching funds to the county for HFA services each quarter, based on the results of time studies that track the portion of time that home visitors spend on eligible FFP activities. Unlike the perpetual time studies that the state uses to set TCM rates, the state calculates quarterly payments under the FFP program based on one-month time studies; home visitors track their time for a month, and the state uses these data to calculate the quarterly payment.

There are two categories of providers whose time qualifies for federal matching funds under the program: Skilled professional medical personnel—providers who have higher educational levels and professional training and include nurses, doctors, and social workers—receive a 75 percent federal matching rate for their services, while all other personnel are considered nonskilled professional medical personnel and have a matching rate of 50 percent for their time.⁷⁰ For nonskilled medical personnel, Medicaid funding is split in half.

As a result of these variations, the amount of Medi-Cal funding Solano County receives varies from month to month. The county estimates that annually, this funding source provides about 25 percent of the MCAH budget, though at times this funding number can be closer to 45 percent of the overall budget for home visiting programs.⁷¹

Colorado: TCM

Colorado has four active home visiting programs that receive MIECHV funding, but only the state's NFP program receives Medicaid funding. Colorado's NFP program serves families that are living below 200 percent of the federal poverty level and who are first-time parents. NFP clients generally enroll during pregnancy, and services are offered until the child turns 2 years old. Since some women will be eligible for Colorado's NFP program who are not eligible for Medicaid, only about 75 percent of cases qualify for Medicaid reimbursement.⁷²

NFP in Colorado serves clients in every county in the state and is partially supported through funding for Medicaid-covered TCM services, though Colorado uses tobacco settlement funding to cover most of the program's expenses.

Colorado's Medicaid state plan includes TCM services for the state's nurse home visiting program that can be billed to Medicaid.⁷³ Specifically, Medicaid can be billed for TCM services when nurse home visitors conduct a needs assessment for the mother and/or the child; when they work with families to develop a care plan to obtain necessary services; when they refer families to medical providers outside their organization; and when they conduct follow-up monitoring to track progress toward the goals identified in the care plan.

Colorado's NFP program utilizes registered nurses who use their professional education, knowledge, and skills to deliver comprehensive services to families. Frequently after a nurse home visitor conducts a needs assessment and prescribes an intervention, he or she is able to provide the intervention. Since the nurse provides the intervention instead of referring to an external provider, the service provided is not billable to Medicaid via TCM. As a result, there are many services provided during a typical NFP visit that could be billable to Medicaid if they were referred to an outside provider. But they do not qualify for Medicaid reimbursement, since the nurse home visitor provides the intervention. As a result, Colorado expects Medicaid to cover less than 1 percent of home visiting costs via TCM, and the state has hired an outside expert consultant to find a solution to maximize Medicaid billing for NFP in Colorado.⁷⁴

All Colorado state-funded home visiting program sites are required to maximize Medicaid billing. Medicaid reimburses TCM services in a monthly payment to service providers for each family receiving visits.

Funding for state-specific, Medicaid-based home visiting programs

In some states, Medicaid offices have long realized the benefits of providing services to families in their homes. Therefore, offices developed their own home visiting programs. These programs generally originated in and continue to be operated by state Medicaid agencies and typically include services that were already covered, or could be covered, by Medicaid.

Washington: First Steps

Washington state's Medicaid agency, the Washington State Health Care Authority, administers the First Steps Program, created in 1989 under the Maternity Care Access Act.⁷⁵ After the legislation was enacted, the state worked with CMS to develop an approved benefit package of enhanced maternal and infant health services, which closely resembles services provided by home visiting programs.

Within the First Steps Program, eligible clients can receive full medical coverage through the state's Medicaid program—Washington Apple Health⁷⁶—as well as childbirth education and access to interpretive services and transportation.⁷⁷ First Steps' extended services include:

- **Maternity Support Services, or MSS:** Enhanced preventive health and education services and brief interventions to eligible pregnant clients as early in pregnancy as possible through 60 days postpartum, based on the client's individual risks and needs
- **Infant Case Management, or ICM:** Case management and care coordination services in the infant's first year to improve the infant's and family's welfare by providing information and assistance for necessary medical, social, educational, and other services⁷⁸

State-approved providers deliver services through an interdisciplinary team approach to address a broad range of risk factors. First Steps team members must include a Washington State Department of Health licensed or credentialed nurse, nutritionist, and behavioral health specialist. Community health representatives are optional team members. First Steps teams can be found within community clinics, federally qualified health centers, local health departments, hospitals, nonprofit organizations, and private clinics.⁷⁹ Reimbursement for MSS and ICM services is authorized in Washington's Medicaid state plan. Unlike in other states, Washington's plan also reimburses for MSS services provided by community health workers under the direct supervision of a nurse, nutritionist, or behavioral health specialist.

Until 2009, all Medicaid-covered pregnant women were eligible for 15 hours of maternity support services.⁸⁰ After the recession, budget cuts led to the development of a screening tool to identify women as high, moderate, or low risk, with high-risk women being eligible for 7.5 hours of service. A woman's risk is determined by assessing for nutrition concerns, socio-economic status, maternal

health issues, maternal age, drug use and addiction, domestic violence, mental health issues, and maternal developmental disabilities.⁸¹ To be considered high risk, women must experience multiple or key risk factors particularly determinant of poor health outcomes.

Prior to the cutbacks, about 75 percent of Medicaid-enrolled pregnant women were enrolled in First Steps. In 2014, there were around 42,000 Medicaid births, with just fewer than 23,000 mothers receiving MSS and just fewer than 9,700 receiving ICM.⁸² Additionally, many providers stopped offering MSS and ICM services due to the decreased hours of service coupled with the requirement to target services toward high-risk women on Medicaid rather than to any Medicaid-eligible pregnant woman. Based on the targeted risk assessment requirement, some providers operate in areas where most of the women population does not meet the criteria to be considered high risk. For these providers, it no longer makes sense for the state to offer MSS and ICM services. One offset for the budget reductions includes the ability of government entities, such as local health departments, to receive partial reimbursement for outreach activities such as helping individuals apply for Medicaid services through Medicaid administrative claiming.

In addition to Medicaid-funded MSS and ICM services, which can be delivered in an office, clinic, or home setting, Washington funds a portfolio of home visiting models through its Home Visiting Services Account, which leverages public and private dollars to support evidence-based home visiting models such as NFP and Parents as Teachers, as well as other research-based and promising practice home visiting models.⁸³ Funds come from the MIECHV program as well as other sources, including philanthropy and state appropriations. Washington is currently exploring how best to leverage Medicaid as an additional source of financing to support home visiting models in the state.

Michigan: Maternal Infant Health Program

Michigan's Maternal Infant Health Program, or MIHP, is the state's largest home visiting program for Medicaid-eligible pregnant women and infants. MIHP is unique in that the entire home visiting program—rather than only specific components—is part of Michigan's state plan. Michigan is currently the only state with this structure for covering home visiting services.

MIHP grew out of two previous programs—Maternal Support Services and Infant Support Services. Established in 1987, Maternal Support Services was Michigan's first Medicaid-specific program to reduce infant mortality and morbidity among

pregnant and infant Medicaid beneficiaries. It addressed logistical and other barriers, such as lack of transportation, that prevented pregnant Medicaid beneficiaries from receiving prenatal care.⁸⁴ The state built on this program when it added the Infant Support Services, or ISS, program a few years later to promote healthy development throughout infancy.⁸⁵ Both programs were generally home-based, and teams included registered nurses, licensed social workers, and registered dietitians. Providers had flexibility in determining how specific services were delivered, which created wide variation across the program.⁸⁶

In 2004, the state consolidated Maternal Support Services and ISS and renamed the new program the Maternal Infant Health Program. All pregnant and infant Medicaid beneficiaries are eligible to participate in the program. The redesign also introduced substantive changes to the program, including the use of a standardized validated risk screener as well as a greater focus on evidence-based interventions tied to the level of beneficiary risk. A centralized database was created, allowing program staff and Michigan State University researchers to track outcomes and quality. In 2009, researchers began to analyze data on the MIHP model utilizing a quasi-experimental design structured to meet the federal requirements for an evidence-based home visiting model, and the research continues and has expanded annually. Research demonstrates that MIHP has a positive impact on birth outcomes and infant mortality and has established MIHP as an evidence-based program.⁸⁷

Similar to other home visiting programs, MIHP provides care coordination and health education services, including childbirth and parenting education classes by registered nurses and licensed social workers. The MIHP provider may be located in a private business, practitioner's office, hospital-based health clinic, federally qualified health center, or local or regional public health department.⁸⁸

In addition to the registered nurse and social worker, the MIHP team may also include a registered dietitian; International Board Certified Lactation Consultant, or IBCLC; and an infant mental health specialist. Qualifications for each MIHP staff member are specified in Michigan's Medicaid program. MIHP providers are responsible for ensuring that all MIHP staff members meet the state's registration or licensure requirements. Specifically, qualified staff must have one of the following credentials with the corresponding qualifications:

- **Nurse:** Current Michigan licensure as a registered nurse and at least one year of experience providing community health, pediatric, or maternal/infant nursing services
- **Social worker:** Current Michigan licensure as a social worker and at least one year of experience providing social work services to families⁸⁹

- **Infant mental health specialist:** Licensure by the state of Michigan; a degree as a psychologist, master social worker, or professional counselor; infant mental health endorsement by the Michigan Association for Infant Mental Health at Level II or Level III; and at least one year of experience in an infant mental health program
- **International Board Certified Lactation Consultant:** Possession of current Michigan licensure as a registered nurse or licensed social worker, credentialing by the International Board of Lactation Consultant Examiners, and a valid and current IBCLC certification
- **Registered dietitian:** A master's degree in public health with an emphasis on nutrition; a master's degree in human nutrition; a bachelor's degree and registration as a dietitian; or a bachelor's degree and registered dietitian eligible, with examination pending in six months or less and at least one year of experience providing community health, pediatric, and/or maternal/infant nutrition services

Because registered dietitians are not licensed by the state of Michigan, a physician order is needed before a dietitian may provide services.⁹⁰ Michigan's Population Health agency has staff at the state level who train and certify providers, support the provider enrollment process, and manage quality improvement and oversight.

MIHP agencies secure a National Provider Identifier, enroll as a Medicaid provider, and become certified by the Michigan Department of Health and Human Services. The agency is then able to bill Medicaid for MIHP services.⁹¹ The state provides education and support for providers around how to properly bill for home visiting services. Medicaid is the sole funding source that pays for MIHP services, though providers have noted that the reimbursement does not cover the full costs of services and that they must rely on other funds to offset the full cost of providing services. For example, local health departments may have additional funds in their budgets that they can use to supplement these payments, and they may also be able to draw down additional Medicaid funds, such as funds for administrative services, during the cost settlement process.

As of January 1, 2017, MIHP services administered to beneficiaries enrolled in the Medicaid Health Plan, or MHP, are administered and reimbursed by the MHP. As part of this transition, the MHP is required to refer all pregnant women to a Maternal Infant Health Program or equivalent evidence-based home visiting program or to document women's refusal to receive these services. By January 1, each MIHP provider needs to have a contract with one or more MHPs to receive reimbursement for in-network services provided to MHP enrollees. The state hopes this approach will more closely integrate MIHP and other home visiting services with other social services that assist low-income families.

Oregon: Public health nurse home visiting

Oregon supports 3 programs in 13 of 36 counties in the state through funding from the Maternal, Infant, and Early Childhood Home Visiting Program: Early Head Start; Health Families America; and Nurse-Family Partnership. Additionally, the Oregon Health Authority operates a public health nurse home visiting program that supports four home visiting models—NFP, along with three state specific programs, Maternity Case Management, or MCM; Babies First!; and CaCoon. Oregon has been successful in directing Medicaid funds, primarily through targeted case management, toward these four public health nurse home visiting programs.

MCM is a public health program designed to support positive health outcomes for women and their babies and to ensure that mothers have access to prenatal health care.⁹² Women who have risk factors for poor pregnancy outcomes are eligible for MCM services. Under the program, home visits to women who are enrolled in the Oregon Health Plan may be billed to Medicaid.⁹³ The home visits are conducted by MCM case managers who are either nurses, social workers, or other professionals trained to address a variety of health, social, economic, and dietary problems that high-risk pregnant women may face. MCM services are a specific benefit set forth in Oregon's state plan and are paid for on a fee-for-service basis. However, Medicaid payments for MCM total only about \$25 per visit, which is far below the actual cost of an entire home visit.⁹⁴

The other two Oregon-specific programs, Babies First! and CaCoon, are both public health nurse home visiting programs that receive TCM funding. Babies First! provides home visiting services to families with babies and young children up to age 5 to help ensure healthy growth and development.⁹⁵ CaCoon targets services toward families with a child with a disability or a chronic health condition from birth through age 21.⁹⁶ Both programs are evidence-informed home visiting models, and CaCoon, which is supported through Oregon Health & Science University, is identified as a promising practice—or a home visiting program that the Health Resources and Services Administration has found to have some research to support its effectiveness but that has not yet undergone or completed rigorous evaluation in order to be considered evidence based. MCM, Babies First!, and NFP are coordinated by three nurse consultants working at the state level, who work with local health departments to implement and support the programs.

In Oregon, the target population for TCM is at-risk children, so services provided to children through nurse home visits can be billed in part to Medicaid. For example, both Babies First! and CaCoon receive TCM funding to cover the costs of providing needs assessments; referral to other medical, social, and educational services; monitoring; and reassessments during a home visit. Although TCM funding is limited to specific components of home visits, providers are able to obtain a significant amount of funding—\$355 per eligible visit—inclusive of the required state match.⁹⁷

One of the key challenges of access to Medicaid funding identified by Oregon practitioners is that counties often have a hard time directing funding resources toward the state match in order to draw down federal Medicaid funds. Oregon requires local providers to pony up this match upfront before providers receive federal matching funds. Additionally, when states receive reimbursement funds, the amount they are reimbursed does not cover the full costs of providing home visiting services. In particular, fee-for-service reimbursement per visit for prenatal care is low, and since TCM is targeted toward providing services to children, it cannot be used to provide prenatal services. Moving forward, Oregon hopes to expand TCM to cover nurse home visiting services starting in the prenatal period.

In addition to the nurse home visiting services provided through public health, Oregon offers HFA and Early Head Start as evidence-based models supported by the state's Early Learning Division with federal and state general funds, as well as some Medicaid Administrative Claiming funding.

Use of waivers to fund home visiting efforts

A number of states also cover and pay for home visiting services by using waivers and demonstration projects.⁹⁸ Waivers allow states to adopt Medicaid policies that differ from the usual federal Medicaid requirements. As a result, waivers require a more rigorous, lengthy submission and approval process than state plan amendments. States applying for waivers must show that their proposal is cost-effective or budget-neutral, and waivers are generally approved for limited periods of time.

There are three general categories of Medicaid waivers and demonstrations, each named for a section of the federal Social Security Act:

- **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 benefit package to all beneficiaries throughout the state.⁹⁹
- **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.¹⁰⁰
- **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.¹⁰¹

States have used waivers to support home visiting services in a variety of ways. Waivers allow states to access funding to establish new home visiting programs, expand home visiting services to additional or targeted populations, pay for home visiting services, and weave together private and public funding sources to expand the reach of existing programs. Including home visiting as part of a waiver differs from the more common approach that many states, including California and Oregon, have taken, to keep home visiting services outside the scope of the managed care structures established by their Section 1115 waivers.

While waivers represent an opportunity for states to create more flexibility within their Medicaid programs to direct funding toward services such as home visiting, the process for designing and approving a waiver requires time and effort. To be successful in securing a waiver to fund home visiting programs, states need a champion for this effort—someone who is invested in seeing the process through and who understands home visiting as a priority for the state. Moreover, Medicaid agencies face competing demands, and efforts to develop a waiver for home visiting services may not be a state priority. For instance, some Medicaid programs have had little time to focus on expanding home visiting services, given their efforts to take advantage of some of the new payment and delivery system reform options in the ACA. In interviews, NFP officials described this as “opportunity fatigue” for Medicaid programs. Where waivers have been successful, states have engaged broad stakeholders in the process and dedicated time and resources to the effort. Let’s examine more closely the waiver experiences in South Carolina and New York.

South Carolina

In 2016, South Carolina launched a new pay for success, or PFS, initiative that leverages Medicaid funding along with philanthropic and state funding to support the expansion of home visiting services. PFS financing is a relatively new approach to scaling effective social interventions by engaging private-sector or philanthropic funders to provide upfront funds, while government entities pay back the upfront investment as cost savings that result from improved social outcomes are realized.

In 2013, a national nonprofit organization based in South Carolina called the Institute for Child Success published a feasibility study exploring how the state could develop a PFS financing project to expand home visiting.¹⁰² As part of that study, the institute found that South Carolina had already implemented successful home visiting programs and that MIECHV funding supported the expansion of five home visiting models—HFA, NFP, Parents as Teachers, HealthySteps, and Family Check-Up. However, funding constraints have kept programs from being able to fully scale and provide services to all eligible children and families in the state. The study found that NFP was well-established in the state, though at that time, it was only able to reach about 5 percent of eligible families. The feasibility study suggested leveraging public and private funds through a PFS financing arrangement. Moreover, NFP's evidence base and documented cost-effectiveness research made the model a good fit for the financing project.

After publication of the feasibility study, the South Carolina Department of Health and Human Services, or SCDHHS, convened stakeholders to develop a PFS project. Participating stakeholders included the governor's office; The Duke Endowment; BlueCross BlueShield of South Carolina; legislative staff; the Harvard Kennedy School Government Performance Lab; and Social Finance, a national nonprofit organization.

South Carolina considered ways that current Medicaid spending could support the PFS effort. Because of the newness of PFS financing, stakeholders in South Carolina engaged the Centers for Medicare & Medicaid Services early in the process to explore which funding path would be most appropriate for the effort. In working with CMS, SCDHHS identified the Section 1915(b) waiver as the most appropriate waiver to pursue to expand billing for home visiting services under the PFS project.

Initially, South Carolina policymakers considered utilizing a 1115 waiver, which allows states to implement more comprehensive reforms, but realized they had existing authority to cover home visiting services. South Carolina’s Medicaid state plan allows for new mothers to receive two home visits following their baby’s birth. So instead of a 1115 waiver, SCDHHS developed a 1915(b) waiver application to cover a portion of the expanded number of NFP home visits provided under the PFS project. The remaining costs of each home visit—approximately half—would be covered by philanthropic funds upfront and be repaid by SCDHHS only if NFP reached four previously negotiated success outcomes: reduced preterm births; reduced child hospitalizations and emergency department usage; increased health birth spacing; and increased services to high-poverty ZIP codes.¹⁰³ The 1915(b) waiver was designed to cover a portion of the cost of expanding home visiting services to reach 3,200 South Carolina families who meet NFP’s eligibility requirements over a five-year period. The waiver also expanded the scope and duration of allowable services for mothers in the PFS project so the NFP model could be implemented.

South Carolina worked with CMS to determine a payment amount per home visit, but that payment per home visit does not cover the full cost of providing an NFP home visit. Instead, Medicaid covers a portion of the cost of a home visit, while philanthropic contributions to the PFS initiative cover the remaining cost. South Carolina negotiated a “bundled payment”¹⁰⁴ per visit with the federal government that provides a set payment during the pilot program, rather than reimbursing for specific activities. Under the new waiver, Medicaid will pay for a maximum of 40 visits at \$176 per visit.¹⁰⁵

The PFS project will be a six-year effort, during which the Abdul Latif Jameel Poverty Action Lab, a research center based at the Massachusetts Institute of Technology, will conduct a rigorous evaluation to determine if NFP improves outcomes, including reducing child injury and preterm births for mothers and their children as a result of the services. In total, the PFS effort will mobilize \$30 million—\$17 million in philanthropic investment and \$13 million through the 1915(b) waiver—to expand home visiting.¹⁰⁶ If the project proves to be successful, South Carolina will issue up to \$7.5 million in success payments that will go toward sustaining NFP home visiting services in the state after the project concludes.¹⁰⁷

New York

New York's MIECHV initiative funds both NFP and HFA in 14 high-risk counties identified by the state following a home visiting needs assessment. That needs assessment considered a range of risk indicators along with the availability of existing home visiting services.¹⁰⁸ In addition to MIECHV funding, New York's Medicaid program supports NFP through two funding streams.

New York's Medicaid system operates under a broad Section 1115 waiver. The waiver's Delivery System Reform Incentive Payment, or DSRIP, program, is one part of the waiver. The DSRIP program provides federal funding to implement changes to the state's safety net health care system in order to reduce avoidable hospital use and increase primary and preventive care. Under the waiver, hospitals, community-based organizations, and other providers must form integrated delivery networks, called Performing Provider Systems, or PPS, as a condition for receiving DSRIP funding.¹⁰⁹ Each PPS then has flexibility to use DSRIP funds to implement specific programs selected by the state as eligible for DSRIP funding. The NFP home visiting model is one of the state-approved, DSRIP-eligible programs.

New York's initial 1115 waiver amendment submission proposed to expand NFP as preventive services through set-aside funds. As the waiver's content evolved through negotiations with CMS, New York identified NFP as a DSRIP-eligible service that PPS could elect to offer to help reduce avoidable hospitalizations among the maternal and child health population. Following community planning meetings, three PPS opted to include NFP in their DSRIP programs. For example, NFP in the Bronx is participating in the DSRIP program partnering with the Bronx-Lebanon Hospital Center.¹¹⁰ In Chautauqua County, NFP is funded through the DSRIP program through a partnership with Catholic Health System,¹¹¹ and NFP will be expanding in the Finger Lakes region in collaboration with the Finger Lakes PPS. DSRIP funds will be used by the PPS to support the infrastructure to expand NFP to these areas.

New York also allows NFP providers to bill for the TCM portion of home visits. However, these payments only cover a small portion of the cost of providing a home visit. In addition to only covering the portion of the visit attributable to TCM activities, the reimbursement rates are quite low in most of the state, ranging from about \$10.25 to \$21.15 per visit.¹¹² The rates are low in large part because the state has not reconsidered the costs of home visits in a number of years.

Interaction with managed care organizations

Even in states that contract with MCOs to provide care to Medicaid enrollees, home visiting services typically remain a distinct benefit that is provided outside the MCO networks, reimbursed on a fee-for-service basis, and not included in the per-enrollee capitation payments. For example, Medi-Cal is the largest Medicaid managed care program in the nation, with more than three-quarters of all Medi-Cal beneficiaries, approximately 10 million individuals, enrolled in plans.¹¹³ Yet California's home visiting services remain outside the MCO framework.

Minnesota is one example of a state that has taken steps to start to integrate home visiting into its Medicaid managed care program. More than two-thirds of Minnesota's Medicaid population, close to 800,000 individuals,¹¹⁴ is enrolled in managed care plans, and the state managed care contracts require that plans' networks include public health agencies that implement home visiting programs, including NFP, HFA, and Family Spirit. Because the managed care plans available in each county can vary from year to year, public health agencies may need to enter into new contracts, learn new systems, and interact with new MCO staff. This can create administrative complexity for public health agencies.

Under the contracts between the MCOs and the local public health agencies, MCOs reimburse the public health agencies for specific, Medicaid-covered services provided as part of the home visiting program. These payments can vary based on the individual contracts the public health agency has with the MCOs and the specific services provided. Home visit costs are greater than the level of reimbursement provided by the MCOs. The cost of a single home visit, which is usually provided by a licensed public health nurse, can average between \$200 and \$250. Reimbursement provided by MCOs does not cover the full cost of a home visit and related services such as case management and follow-up on referrals. The Minnesota Department of Health is working to provide training to public health agencies on how to maximize allowable reimbursement for home visiting.

As mentioned above, Michigan is also transitioning Maternal Infant Health Program services provided to Medicaid Health Plan enrollees from fee for service to managed care. Beginning January 1, coverage for MIHP services, Michigan's home visiting program, will be included in the capitation amount that the state pays to MCOs for care of Medicaid enrollees.

Additional Medicaid considerations for states

In addition to deciding which specific funding mechanisms within Medicaid to use to support home visiting, states must also consider which home visiting programs and which home visitors will qualify as eligible Medicaid providers. States must also identify funding sources to cover their share of the Medicaid funding.

Ensuring home visitors are eligible Medicaid providers

Frequently, home visiting programs utilize nonmedical professionals or paraprofessionals as home visitors. These individuals can be social workers or other licensed professionals. If a state wishes to seek Medicaid payment for services that these individuals provide, it must make sure that these providers meet the requirements of the state plan. If a state wants to support home visiting by using Medicaid funds to pay for a portion of a home visit, the state must make sure that the requirements listed for those services in the state plan are consistent with the background, experience, and licensure of the home visitors.

States must consider two levels of provider-related issues when expanding Medicaid support for home visiting.¹¹⁵ First, the Medicaid provider is the entity that has a direct relationship with the state.¹¹⁶ In the home visiting context, this is many times the local or county health department. This entity receives Medicaid payments directly from the state. As with much of the Medicaid program, the state has a great deal of flexibility to define the requirements to be a Medicaid-eligible provider. The Medicaid provider may, in turn, employ or subcontract with other entities or individuals who provide the actual hands-on care to the Medicaid patient.¹¹⁷ These so-called rendering providers are the actual home visitors—the nurses, other professionals, paraprofessionals, or team of individuals who provide home visiting services. A rendering provider may also be the Medicaid provider with the direct link to the state, but this is generally not the case in the home visiting context.

States wishing to expand Medicaid support for home visiting must consider both of these levels—which entities should be the Medicaid provider and what requirements the state should place on home visitors seeking Medicaid reimbursement. States have taken different approaches to this issue. A number of states include Medicaid provider requirements in their state plans. For example, the California state plan lists requirements for TCM providers. These TCM providers are not limited to nurse home visitors; NFP nurses also meet these criteria. Other states have chosen to include community health professionals and social workers as eligible providers.

In Washington, credentials for First Steps providers are more directly written into the state plan. Since 1990, the state plan has included maternity support services delivered by a provider approved by the Washington State Department of Health.¹¹⁸ Similarly, the state plan includes infant case management services and specifies that individuals delivering these services must work with a case management agency and meet licensure requirements established by the state Department of Health.¹¹⁹ This way, the state can ensure that a multidisciplinary team provides comprehensive services to support the health of children and families.

Similarly, Oregon's state plan specifies that Babies First! and CaCoon providers must be public health authorities with the ability to link to statewide data systems.¹²⁰ Home visitors delivering case management services must be employed by a local county health department or an agency that contracts with health departments, be a registered nurse with one or more years of experience, and adhere to the policies and procedures of the state Title V Maternal and Child Health Services Block Grant Program and Medicaid.¹²¹ Under the state plan, nurses can delegate work to licensed community health workers, and it is up to counties to hire people with the appropriate credentials as established by the state.¹²²

Sources of state shares of Medicaid payments

A state's decision to cover home visiting services or discrete components of home visiting services as part of its Medicaid program is only the first step. The state must then decide how it will pay for the nonfederal portion of Medicaid expenditures for this care. At least 40 percent of the nonfederal portion must be financed by the state, while up to 60 percent may come from local governments and other sources.¹²³

A 2014 Government Accountability Office study found that 69 percent of Medicaid's nonfederal funding came from state general revenues, 16 percent came from local governments, 10 percent came from health care-related taxes, and 5 percent came from other sources.¹²⁴ Local governments and local government providers can fund the state share of Medicaid payments through intergovernmental transfers, or IGTs, or certified public expenditures, or CPEs.¹²⁵ IGTs are transfers of public funds between different government entities. They may transfer money between one level of government and another, such as from county or local governments to states, or within the same level of government, such as from the state public health department to the state Medicaid agency.¹²⁶ CPEs are local expenditures that the state claims as part of its share of Medicaid payments; the local government certifies its Medicaid expenditures, and then the state claims the federal Medicaid matching funds.¹²⁷

Just as coverage of home visiting services varies from state to state, there are differences in how states and localities fund the nonfederal portion of Medicaid reimbursements for home visiting. And even within states, there can be variations. For example, California's TCM program—which funds NFP in the state—relies on CPEs by participating counties to draw down federal funds. The state then transfers the federal share to counties to help offset those expenses.

California takes a different approach in financing the HFA program in various counties. The state has used the First 5 California program as the source of its nonfederal share of payments for HFA. First 5 California distributes tobacco tax revenues for early childhood development programs; however, as tobacco sales continue to decline in the state, revenues from this source are also down, requiring new funding approaches. For example, Solano County will start to receive a portion of its funding for HFA using IGTs from the Partnership HealthPlan, which is a joint public-private Medi-Cal plan. This requires Solano County to transfer funds to the California Department of Health Care Services. The department then uses the funds to draw down federal matching funds. Those federal matching funds are then transferred to the Partnership HealthPlan, which in turn sends funding to the county.¹²⁸

States looking for additional money to fund the nonfederal portion of Medicaid payments for home visiting should consider adopting a soda tax, following the lead of Berkeley, California, and Philadelphia, Pennsylvania.¹²⁹ Using this source of revenue to support home visiting would accomplish two public health goals. First, taxing drinks that contribute to high rates of obesity and diabetes reduces soda consumption and improves individuals' health. Second, added funding will allow states to expand home visiting programs that improve maternal and infant health.

Challenges with Medicaid funding

Conversations with administrators, practitioners, and state officials revealed a number of challenges that states face when financing home visiting services with Medicaid funds. These challenges generally fall into three buckets—coverage, payment related, and administrative.

One of the most significant challenges that practitioners raised in interviews concerned the reimbursement per visit, which typically does not cover the full cost of providing home visiting services. In fact, it often falls significantly short of the actual costs of providing these comprehensive services. Currently, none of Medicaid's funding authorities cover every component of a home visit. For example, Medicaid does not typically provide coverage for job counseling or parent education and coaching activities. It is possible that states could cover additional services through a waiver, but, as discussed above, this approach has its own additional challenges.

Medicaid funding in states is also limited, and directing that money to be provided for home visiting services can be politically challenging. In most states, the Medicaid budget is already stretched, so it is difficult to expand the program to cover additional services. Moreover, Medicaid financing is only able to cover the Medicaid-eligible population. While this population likely has significant overlap with individuals in need of home visiting, the reach of the Maternal, Infant, and Early Childhood Home Visiting program and home visiting in general is broader than the Medicaid population. For example, adolescent mothers might have non-Medicaid health insurance but may still qualify for and benefit significantly from home visiting programs. Ensuring that at-risk families have access to home visiting services even if they are not covered by Medicaid is critical.

These coverage and payment limitations also contribute to the administrative challenges home visiting programs face. Medicaid billing is extraordinarily complex, and home visitors must account for each specific task during a home visit. County employees and other home visiting providers note that they spend a significant amount of time and effort on establishing billing procedures, training personnel, and ensuring accuracy and compliance.

There are also additional administrative complexities and challenges because some states house home visiting programs in an education or human services department separate from the state Medicaid agencies. In such states, home visiting administrators may be less familiar with Medicaid's financing authorities, and practitioners must work to develop collaborative relationships across agencies to explore Medicaid as a funding option. However, doing so can take significant time and effort. State administrators interviewed in this report frequently stated that having the political will and broad stakeholder support for such an effort is necessary for success.

Variation in state Medicaid plans can present additional challenges to states seeking to expand home visiting programs by leveraging Medicaid funding. First, state plans vary in defining who may provide services eligible for Medicaid payment. Without inclusive criteria, many home visiting models that employ social workers or other certified professionals to conduct home visits rather than nurses or medically trained staff may be disqualified from being Medicaid providers. Additionally, in some states such as New York and Colorado, even nurses are not able to bill independently, and a physician's order is required to provide services.¹³⁰ Second, the services that are covered by Medicaid vary by state, especially the optional benefits that states select for inclusion in their state plan. Third, the process for amending state plans and state licensure criteria also depends on individual states, so it might be difficult to modify or change these requirements.

Recommendations

As a result of these challenges, Medicaid continues to be an underutilized resource for funding home visiting services across the country. To better leverage this financing option, states and the federal government should consider the following recommendations.

State recommendations

For states that are interested in pursuing Medicaid financing for their home visiting programs, there are a number of steps they can take based on effective practices in other states.

Conduct a feasibility study

States interested in exploring funding opportunities through Medicaid should start by conducting a feasibility study. This process allows states to assess what home visiting services are offered in the state and if any of the services included in home visiting are currently, or could be, covered through their Medicaid state plans. States should use this process to evaluate how expanding Medicaid funding for home visiting services can help reach additional populations not currently served. A feasibility study should consider different ways to increase Medicaid coverage and funding, either through state plan amendments or a waiver.

In South Carolina, for example, the Institute for Child Success conducted an initial feasibility study that looked at how to structure a pay-for-success financing initiative to expand home visiting services in the state. The study considered how home visiting outcomes affect Medicaid costs, what services were currently covered in the state plan, and what additional funding sources would allow the state to expand services. This process jump-started conversations in the state around using Medicaid to support the effort.

Obtain early buy-in from key stakeholders

The interviewees in states that have had success in obtaining Medicaid funding frequently cited the importance of having a broad coalition of supporters participating in the effort to leverage Medicaid. In Colorado, the advocacy community began conversations with key stakeholders—including the Centers for Medicare & Medicaid Services, the state’s Medicaid agency, and nurse home visitors, who directly participated in the policy process. Broad inclusion of these different stakeholders was critical in understanding which services were likely billable under Medicaid. Colorado policymakers also had buy-in from the state legislature, which allowed the process to move forward smoothly.

Ensure cross-agency collaboration

In states where Medicaid currently supports home visiting, stakeholders should work to establish cross-agency collaboration. This is particularly critical in states where home visiting administrators and Medicaid directors are in different state departments. In Michigan, the Maternal Infant Health Program was a joint venture of the state’s Department of Public Health and the Medicaid office from the onset. This allowed both offices to draw on policy expertise and knowledge of program options to leverage the appropriate Medicaid funding authority. The public health office knew that there were many layers of Medicaid that could support home visiting but that it was a complicated funding source, so both agencies worked with others in the state who had Medicaid expertise.

States interested in exploring or expanding Medicaid financing for home visiting programs should identify lead administrators from both the state Medicaid agency and the office responsible for providing home visiting services or MIECHV implementation. Leads should be responsible for coordinating with each other and initiating stakeholder conversations. In many states, direction from the governor’s office will be essential to moving these efforts forward.

Work directly with CMS

Interviewees also identified the need to engage CMS early and throughout the process of submitting a state plan amendment or waiver request to expand Medicaid coverage for home visiting. The state of South Carolina worked directly

with CMS when developing its initial waiver. CMS reviewed various iterations of the waiver and provided feedback around how to cover the services and populations the state was targeting for the PFS initiative.

Integrate home visiting into managed care financing

Most states contract with managed care organizations to provide care to Medicaid enrollees. These states should consider ways to better integrate home visiting programs into their managed care contracts, including adding payment for these services into the Medicaid capitation payment to plans. Additionally, CMS should provide specific guidance around opportunities to include payment for home visiting services in Medicaid managed care.

Improve accuracy of reimbursement rates

Reimbursement rates vary depending on a state's rate-setting process. In Colorado, Medicaid reimbursement covers less than 1 percent of the cost of a home visit, but in California, Medi-Cal pays much more because it revises rates frequently based on cost and time studies. Even in states with lower reimbursement rates, capturing all this time will help improve funding for these programs. For this reason, states should ensure that home visitors understand Medicaid billing processes and can accurately track and report the time they spend providing those services eligible for reimbursement. States should offer training and technical support to home visitors who are able to provide Medicaid services on a regular basis and should rebase rates frequently.

Increase funding for home visiting by adopting a soda tax

States should tax sweetened beverages, which contribute to obesity and diabetes, and use these revenues to expand the reach of their home visiting programs. These funds can pay for the nonfederal portion of Medicaid expenditures for home visiting services, which the federal government then matches.

Federal recommendations

Similarly, there are a number of steps that the federal government should take to make it easier for states to utilize Medicaid to expand home visiting programs.

Encourage and simplify the use of waivers for home visiting

CMS should provide states with more specific, concrete guidance on how to use Medicaid waivers to expand home visiting funding. This information should be easily accessible and found on a home visiting specific webpage on the official Medicaid website.¹³¹

CMS should issue both a home visiting-specific Section 1915(b) waiver template, as well as detailed, specific home visiting instructions and examples of how states may add home visiting to a broader Section 1115 waiver request. As part of the Section 1115 waiver instructions, CMS should detail how states may use the Delivery System Reform Incentive Payment program to bolster integration of in-state home visiting programs with the evolving health care system, using specific examples from New York's waiver experience. This information should include details about home visiting-specific data collection and reporting requirements, as well as how CMS will assess the performance of home visiting programs and their impacts on clinical and population health.

Although the focus of this report is Medicaid payment for home visiting services, as part of these efforts, CMS should also consider how home visiting could be part of the new Section 1332 waivers that were included in the Affordable Care Act. It's uncertain what precise changes Congress and the new administration will make to either Section 1332 waivers or to the Medicaid program more generally. But as of today, states may use Section 1332 waivers to modify some of the ACA's private health insurance requirements, as long as the waiver offers coverage that is at least as comprehensive and affordable as the ACA and covers the same residents.¹³² To fund these changes, states may use the federal funding currently used for premium tax credits and cost-sharing reductions for lower- and moderate-income marketplace enrollees with incomes from just above the federal poverty level to 400 percent of the poverty level.¹³³ States may also apply for 1332 and 1115 waivers at the same time to further transform and integrate their health care systems.

States may wish to include home visiting in both waiver proposals for two reasons. First, pregnant women or mothers who meet home visiting criteria may have marketplace coverage if their incomes are too high to qualify for Medicaid. Second, for individuals whose incomes are right around the cutoff point for Medicaid coverage, even slight changes to their incomes may shift them from one source of coverage to another. Setting consistent rules about coverage and payment for these services can lessen administrative challenges when individuals move in and out of the Medicaid program.

Guidance on billing and bundled payment rates

One of the key challenges that states face when accessing Medicaid funds is that coverage and reimbursement rates fail to cover the full costs of a home visit. First, the payment rates in some states are very low. Second, many of the services and activities delivered during a home visit are not currently Medicaid-covered services. Third, states frequently mentioned that complicated billing processes and procedures can be difficult for home visitors to navigate. It can be challenging for home visitors to identify and track all of the time they spend during a visit on services that Medicaid can be billed for, which means that total payment is lower than it could be.

CMS should issue materials that reflect best practices around billing. Further, CMS should work with states to approve new bundled payments for home visits so that home visitors can focus on service provision rather than time tracking while they are working with children and families.

Clarify the relationship between MIECHV-funded home visiting and Medicaid

While states are currently able to direct Medicaid funding toward home visiting services, CMS and the Health Resources and Services Administration should specifically address the coordination of MIECHV and Medicaid benefits and provide guidance for states seeking to expand Medicaid funding for home visiting services. Many states are uncertain about how these funding sources can interact and whether they can be used together in the same way as Medicaid and Title V Maternal and Child Health Block Grant, or MCHBG, funds. Medicaid is typically considered a payer of last resort when other sources of funding are available to cover medical costs for Medicaid enrollees. This means that if other sources of funding are available to cover medical costs incurred by a Medicaid enrollee,

those funds must be used before Medicaid funds.¹³⁴ Certain prenatal and pediatric services are considered to be exceptions, including Title V MCHBG programs and early intervention services. Because of this exception, Medicaid funds can be used to cover Medicaid eligible services, while Title V funds cover other wraparound services that do not qualify for Medicaid funding or services for people who are not eligible for Medicaid.¹³⁵ While MIECHV is authorized under Title V, it is authorized under a section of Title V separate from the other MCHBG programs. State officials remain uncertain if MIECHV and Medicaid funds can be used in the same complimentary way. CMS and HRSA should clarify this interaction and consider whether changes are necessary to ensure that the two funding sources can act in an efficient and complimentary way.

Protect and expand MIECHV

While Medicaid funds are an important funding source for home visiting, federal lawmakers must reauthorize and expand MIECHV funds. Medicaid still plays a complementary role to MIECHV, which remains the federal government's largest investment in evidence-based home visiting.¹³⁶ Not all MIECHV-funded services are covered by Medicaid, and not all families participating in MIECHV home visiting are Medicaid enrollees. Therefore, it is important for lawmakers to ensure that MIECHV continues beyond fiscal year 2017, when the current authorization is slated to expire.¹³⁷ Further, reauthorization legislation must extend MIECHV financing on a longer-term basis, and at higher rates, so that services can be fully scaled to all families and children who want and need support through home visiting. Since the original authorization expired, MIECHV funding has only been extended in one- or two-year increments. Program operation is complicated by these short-term funding extensions; programs cannot expand without consistent, reliable funding. MIECHV funds should be extended for at least five years. Moreover, Congress should double MIECHV funds—increasing the annual amount from \$400 million to \$800 million—to ensure that states can expand the reach of these services.

Conclusion

Home visiting programs are a natural complement to any state’s Medicaid program. For participating families, evidence-based home visiting can improve outcomes ranging from health and well-being to school readiness and academic achievement. While the federal government has invested in expanding these programs through the MIECHV grant program, states struggle to reach all eligible children and families. Innovative funding solutions are required to fully scale these services, and leveraging Medicaid funds is currently an underutilized strategy.

As detailed in this report, home visiting programs are a critical investment in America’s future economic prosperity. Supporting our most vulnerable families so that they can lead healthy lives and access the resources that they need to thrive can prevent costly negative outcomes and save taxpayer dollars down the road. While Medicaid in its current form is not seen as a viable option for fully scaling home visiting services, it can provide important supplemental funds to increase access to home visiting programs across the country. It is incumbent on state and federal policymakers to explore innovative financing opportunities to extend the reach of these effective programs. Leveraging Medicaid to support the expansion of evidence-based home visiting programs should be an easy choice for lawmakers.

Appendix

In researching and writing this report, the authors conducted a series of telephone interviews between March and August 2016 with the following state administrators:

California: Nazlin Huerta, health services manager, Solano County Public Health Division—Maternal Child & Adolescent Health—Healthy Families America & Black Infant Health Program

Colorado: *Participated in interviews:* Michelle Neal, Nurse-Family Partnership program director, Invest in Kids; Julie Becker, home visiting program director, Colorado Office of Early Childhood; Jennifer Orlando, nurse home visitor program manager, Colorado Office of Early Childhood. *Provided a review of earlier drafts:* Allison Mosqueda, nurse consultant, Nurse-Family Partnership, Invest in Kids; Lisa Hill, executive director, Invest in Kids.

Michigan: Brenda Fink, director, Division of Family and Community Health, Michigan Department of Health and Human Services

Minnesota: Genie Potosky, grants and policy specialist, Family Home Visiting Section, Community and Family Health Division, Minnesota Department of Health

New York: Amy Jesaitis, director, Maternal and Infant Health Home Visiting Programs, New York State Department of Health; Fran Mazzariello, former contract manager for Nurse-Family Partnership programs, Maternal and Infant Health Home Visiting Programs, New York State Department of Health

Oregon: Lari Peterson, public health home visiting manager, Public Health Division, Oregon Health Authority; Cate Wilcox, maternal and child health section manager, Public Health Division, Oregon Health Authority

South Carolina: *Participated in interviews:* Erica Brown, former fellow, Harvard Kennedy School Government Performance Lab; Joe Waters, executive vice president, Institute for Child Success. *Reviewed drafts:* Sarah Allin, fellow, Harvard Kennedy School Government Performance Lab; William Camp, program coordinator II, South Carolina Department of Health and Human Services

Washington: Laura Alfani, home visiting project manager, Washington Department of Early Learning; Todd Slettvet, community services section manager, Washington State Health Care Authority; Stacey Bushaw, family health care services unit supervisor, Washington State Health Care Authority; Heather Weiher, First Steps program manager, Washington State Health Care Authority; Shannon Blood, early learning and home visiting program manager, Washington State Health Care Authority

Wisconsin: Julie Ferral, program manager, Healthy Families Program, Family Services of Northeast Wisconsin; Rich Hunkins, director of support systems and services, Family Services of Northeast Wisconsin

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