



State Checklist for Expanding Medicaid to Cover Home Visiting

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Evidence-based home visiting programs improve outcomes for children and families and reduce spending on health care. States across the country have leveraged Medicaid funds to finance and expand home visiting programs. This checklist identifies key steps that a state can take to support home visiting using Medicaid.

Step 1: Initial outreach and stakeholder engagement

Establish a state working group

The state should convene a working group to explore opportunities around Medicaid financing for home visiting. Gubernatorial staff should convene the working group with key officials from the state's Medicaid agency and the office responsible for providing home visiting services or Maternal, Infant, and Early Childhood Home Visiting, or MIECHV, implementation. This group will be responsible for coordinating with each other and initiating stakeholder participation. The Medicaid agency will be responsible for most of the technical work and contact with the federal Centers for Medicare & Medicaid Services, or CMS.

Reach out to key legislators

Buy-in and support from state policymakers is critical for efforts to finance home visiting services with Medicaid. Medicaid funds are often limited in states, and directing resources toward home visiting programs may require political support. In some states, Medicaid changes may require legislative approval. Especially in these states, the state working group and stakeholders should gauge the interest of key legislators and understand any questions and concerns they may have.

Convene stakeholders

The state working group should convene a broad group of stakeholders—including home visiting programs, providers and home visitors, advocacy organizations, and Medicaid managed care plans—to discuss the effort to expand funding for home visiting services.



This document summarizes key strategies for leveraging Medicaid to finance home visiting as outlined in the CAP report “Medicaid and Home Visiting: Best Practices from States.”

Stakeholders should share their experiences with billing Medicaid, the challenges they face, the services they bill, and the amount of reimbursement they receive. If home visitors in the state have no prior experience with Medicaid, the working group should discuss services delivered during a home visit to identify overlap with Medicaid-covered services. State leaders should establish key contacts with different organizations as the working group moves forward.

Start an ongoing conversation with CMS

The state should reach out to CMS early in the process about the state's work and goals for funding home visiting services. The initial contact can inform the agency that the state is studying how it can maximize Medicaid funding for home visiting and inquire about other states that might offer their perspectives. As the process moves forward, the state will continually need to seek guidance and technical advice from CMS.

Step 2: Conduct a feasibility study

Assess the landscape of the state's home visiting programs

The state working group should examine the current home visiting landscape and identify what services are offered through home visits, what federal or state support they already receive, and the credentials and certifications of home visitors who provide these services. For programs currently receiving Medicaid funds, the working group should gather additional information, including what services are paid by Medicaid, what their portion of their budget is from Medicaid, and how the state funds its portion of these payments.

Review licensing requirements for home visitors

A state interested in leveraging Medicaid to finance home visiting must ensure that home visitors can be Medicaid providers. To determine this, the state should review the current credentials and licensing requirements for home visitors that are currently, or could be, funded through the Medicaid state plan. The working group should compare this information with the provider requirements detailed in the existing Medicaid state plan for possible coverage without changes to the plan. If home visitors do not qualify as providers, the state should explore how to include home visitors as Medicaid providers through changes to its state plan.

A state wishing to expand Medicaid support for home visiting must consider two issues: which entities should be Medicaid providers and what requirements the state should place on home visitors seeking Medicaid reimbursement. States have taken different approaches to this issue. A number of state plans include Medicaid provider requirements that could include home visitors. For example, the California state plan lists requirements for targeted case management, or TCM, providers. These are not limited to nurse home visitors, but Nurse-Family Partnership, or NFP, nurses meet these criteria.¹ Other states have chosen to include community health professionals and social workers as eligible providers.²

Review currently covered services in the existing Medicaid state plan

During the planning process, the state should examine which services are currently included in its Medicaid state plan. The working group can consider if home visiting programs may already bill Medicaid for covered services listed in the state plan that are delivered during a home visit. For example, if targeted case management services are already included in the state plan, the state may be able to use this existing authority to cover certain aspects of home visits.

Assess gaps and list options for amending the state plan

The working group should next consider if there are parts of the state plan that limit the extent to which Medicaid can help support home visiting programs and whether or not the state plan can be modified easily. For example, if the state covers targeted case management services when offered by registered nurses but not when provided by social workers, the working group could recommend minor modifications to the state plan. If there are optional benefits that home visitors could provide, the working group could recommend a state plan amendment to add those benefits.

Consider what additional changes could be made through a waiver

In addition to assessing gaps that can be addressed through a state plan amendment, the working group should also consider how the state could use a waiver to enact more sweeping changes to the Medicaid program and integrate home visiting services with other Medicaid benefits. The working group should assess if a waiver will allow the state to expand home visiting to reach additional populations that currently lack these services.

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, to expand home visiting services to additional or targeted populations, to pay for home visiting services, and to weave together private and public funding sources to expand the reach of existing programs. There are three general categories of Medicaid waivers and demonstrations that states can consider: Section 1915(b) waivers, Section 1915(c) waivers, and Section 1115 demonstration projects.

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.³ 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 payment and delivery system reforms, as well as offer a broader set of services to enrollees.⁴

Consider the feasibility of partnering with state managed care organizations

Most states contract with managed care organizations, or MCOs, to provide care to many of their 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.

Step 3: Determine the specifics of the proposal and submit to CMS

Submit a state plan amendment

Based on its assessment, if the state working group decides that a state plan amendment would allow it to cover certain home visiting services under Medicaid, the state should move forward with the standard procedures for state plan amendment, or SPA, processing through CMS. The state should communicate its goals and intentions with CMS early to ensure mutual understanding and a smooth process.

Submit a waiver application

If a state decides that a SPA cannot achieve its goals, it should work with CMS to clarify the goals and intentions for covering home visiting services under a waiver. Once a state decides to pursue a waiver, it will be able to shape its contents using the feasibility study process. The state should work directly with CMS throughout the process to ensure a shared understanding of the goals of the waiver, as well as limits to the waiver authority.

Determine the budget implications of different payment rates

The state must consider the budget implications of different Medicaid payment rates. Payment for the same service can be very different depending on how the state determines rates. For example, Colorado reimbursement for a home visit is only about \$40 per visit,⁵ but California's Medicaid program pays much more.⁶ In addition to the payment amounts, the working group should evaluate if home visiting agencies are capturing all their time spent on services that Medicaid can pay for. One option might be to bundle payments for home visiting services, which could simplify the billing process for administrators and home visitors. Even in states with lower reimbursement rates, capturing all of this time or bundling payments would help increase funding for these programs.

Identify sources of funding for the state share of Medicaid matching funds

Finally, the state must 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.⁷ The state can utilize general revenue funds, dedicated taxes, intergovernmental transfers, certified public expenditures, or other sources of funding. One option to explore is adopting a soda or sugary beverage tax and using these revenues to expand the reach of home visiting programs. Sweetened beverages contribute to obesity and diabetes—public health concerns that home visiting programs can help address or prevent.⁸ These funds can pay for the nonfederal portion of Medicaid expenditures for home visiting services, which is then matched by the federal government.

Step 4: Implement and provide ongoing program support for home visitors

Conduct outreach to potential families who are eligible for home visiting services

To ensure that home visiting services reach those who would benefit the most, the state should make a concerted effort to promote these programs among eligible families. The state and health care institutions should also specifically target Medicaid enrollees and inform them of available home visiting services.

Conduct outreach and training to home visiting programs

The state must publicize these changes and start providing training so that home visitors understand Medicaid billing processes and can accurately track and report the time they spend providing services that are eligible for reimbursement. The state needs to offer billing guidance and other support materials to home visitors who are less familiar with or new to Medicaid billing. It should also offer ongoing training and technical support to home visitors who are able to provide Medicaid services on a regular basis.

Convene working group periodically

The state should continue to bring together the working group to assess how well the changes to the state's Medicaid program are helping to expand the reach of home visiting services. The working group can also identify any challenges and implementation issues and offer additional recommendations to address any such complications.

Endnotes

- 1 California Department of Health Care Services, "California State Plan," available at <http://www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx> (last accessed January 2017).
- 2 Health Resources and Services Administration, "Coverage of Maternal Infant, and Early Childhood Home Visiting Services," available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf> (last accessed January 2017).
- 3 Medicaid.gov, "Authorities," available at <https://www.medicaid.gov/medicaid/managed-care/authorities/index.html> (last accessed January 2017).
- 4 Medicaid.gov, "About Section 1115 Demonstrations," available at <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html> (last accessed January 2017).
- 5 Michelle Neal, Julie Becker, and Jennifer Orlando, phone interview with authors, March 21, 2016.
- 6 Nazlin Huerta, phone interview with authors, April 8, 2016.
- 7 MACPAC, "Medicaid's share of state budgets," available at <https://www.macpac.gov/subtopic/medicaids-share-of-state-budgets/> (last accessed January 2017).
- 8 Administration for Children & Families, "Child Health," available at <http://homvee.acf.hhs.gov/Outcome/2/Child-Health/2/1> (last accessed January 2017).