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Joint Informational Bulletin

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SUBJECT: Coverage of Maternal, Infant, and Early Childhood Home Visiting Services

The Center for Medicaid & CHIP Services (CMCS) and the Health Resources and Services Administration (HRSA) have been working collaboratively to inform states about resources available to help them meet the needs of pregnant women and families with young children, specifically with respect to home visiting services. Home visiting services support these individuals by assisting them in accessing services and learning the necessary skills to raise children who are physically, socially, and emotionally healthy and ready to learn.

HRSA's Maternal, Infant, and Early Childhood Home Visiting Program the Federal Home Visiting Program) aims to develop and implement evidence-based home visiting programs using models that are proven to improve child health and be cost effective. These programs improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Many goals of the Federal Home Visiting Program align with the CMCS Maternal and Infant Health Initiative[1], which focuses on improvement efforts in two areas: increasing the rate and content of postpartum visits; and 2) increasing the rate of pregnancies that are intended through increased use of effective contraception.

This Bulletin is intended to assist states in designing a benefit package to provide home visiting services for pregnant women and families with young children. We encourage state agencies such as Medicaid, Maternal and Child Health programs, and others to use this information to improve access and service delivery for beneficiaries.

BACKGROUND

[1] CMCS, Maternal and Infant Health Initiative, July 17, 2014 http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-18-2014.pdf (last accessed June 3, 2015)

The Affordable Care Act [2] created the first nationwide Maternal, Infant, and Early Childhood Home Visiting Program, which allocated Federal grants to states, tribal organizations, and non-profit organizations to support evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. The total number of counties being served by the Federal Home Visiting Program has more than doubled since the start of the program, reaching families in 825 counties as of July 2015, which represents 26 percent of all U.S. counties. The Federal Home Visiting Program targets communities with the highest need, serving families in approximately one-third of counties with high rates in 2014 of infant mortality, children living in poverty, low-weight births, and teen births. States receive Federal Home Visiting Program funding to provide home visiting services with fidelity to evidence-based models, selecting the model that best suits the specific needs of their communities. States often contract with local implementing agencies to provide these home visiting services.

The Federal Home Visiting Program builds upon decades of scientific research showing that home visits by a nurse, social worker, early childhood educator, or other trained personnel during early parenting improve the lives of children and families by preventing child abuse and neglect, supporting positive parenting, improving maternal and child health, and promoting child development and school readiness. [3] A randomized controlled trial of nurse home visiting in North Carolina showed a 50 percent reduction in hospital emergency department visits and hospital overnight stays in the first 12 months of life.[4] The positive impact continues well into adolescence and early adulthood, as children served in these programs were shown statistically to be less likely to report use of cigarettes, alcohol and marijuana, and less likely to have mental health internalizing disorders, such as anxiety and depression.[5] Among 19-year old girls born to high-risk mothers, home visiting during their mother's pregnancy and their first two years of life reduced their lifetime risk of arrest or conviction by more than 80 percent, teen pregnancy by 65 percent, and led to reduced enrollment in Medicaid by 60 percent.[6]

The Federal Home Visiting Program serves vulnerable pregnant mothers and parents, and promotes optimal infant and child physical and mental health development. Less than 50 percent of young children with developmental or behavioral disabilities—such as autism, attention-

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[2] Patient Protection and Affordable Care Act [P.L. 111-148 §2001].
[3] Washington State Institute of Public Policy. Benefit-Cost Results. Available at: http://www.wsipp.wa.gov/BenefitCost
[4] Dodge, KA, Goodman, WB, Murphy, RA, O"Donnell, K, Sato, J (2013), "Randomized controlled trail of universal postnatal nurse home visiting: impact on emergency care." Pediatrics, 132(S2):S140-146, November 2013.
[5] Kitzman, H. J., et al. (2010). "Enduring effects of prenatal and infancy home visiting by nurses on children: follow-up of a randomized trial among children at age 12 years." Arch Pediatr Adolescent Med **164**(5): 412-418.
[6] Eckenrode J, Campa M, Luckey DW, Henderson CR Jr, Cole R, Kitzman H, Anson E, Sidora-Arcoleo K, Powers J, Olds D. "Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial". Arch Pediatr Adolesc Med. 2010 Jan;164(1):9-15.

deficit/hyperactivity disorder, or delays in language—are identified before they start school.[7] Early identification has been shown to improve the developmental trajectories of children with such delays or a developmental disability. In 2015, 17 Home Visiting Program grantees (AK, AL, AZ, CA, CO, CT, ID, IL, LA, NE, NH, NM, NV, NY, OK, TN, and UT) reported developmental/behavioral screening rates of at least 75 percent, more than twice the national average of 31 percent in 2011-2012.[8,9]

Research also shows that evidence-based home visiting can provide a positive return on investment to society through savings in public expenditures on emergency room visits, child protective services and special education, as well as increased tax revenues from parents' earnings.[10,11] Given that Medicaid finances 40% of all births in the U.S.[12], Medicaid can provide a critical role in identifying and supporting mothers and infants at this critical stage, which can affect the child's future growth and development.

Common Services in a Home Visiting Model

While there is some variation across evidence-based home visiting models (e.g., some programs serve expecting mothers while others serve families after the birth of a child), all programs share some common characteristics. In home visiting programs, trained personnel bring support and evidence-based prevention and health promotion activities to expectant parents or families with young children while building strong, positive relationships with families during visits in the home.

The majority of evidenced-based home visiting programs deliver services such as screening, case management, family support, counseling, and skills training for pregnant women and parents with young children. The following are typical component services of a home visiting program.

Screening: Home visiting services include best practice guidelines and standards for screening services. These include infant/child developmental and behavioral screening/re-screening using

[7] U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), Part C Child Count, 1997–2006, from http://www.ideadata.org/PartCChildCount.asp (Accessed October 23, 2015).
[8] Child and Adolescent Health Measurement Initiative. Data Resource Center. http://www.childhealthdata.org. (Accessed October 23, 2015).
[9] American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental and Behavioral Pediatrics, Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs. (2006). "Identifying Infants and Young Children with Developmental Disorder in the Medical Home: An Algorithm for Developmental Surveillance and Screening." [Published correction appears in *Pediatrics*. 2006; 118(4):1808–1809]. *Pediatrics.* 118(1): 405–420.
[10] U.S. Department of Health and Human Services, Administration for Children and Families, "Home Visiting Evidence of Effectiveness (HomVEE)." Available at: http://homvee.acf.hhs.gov/.
[11] Karoly, L, et al. (2005). "Early Childhood Interventions: Proven Results, Future Promise." RAND Corporation. Santa Monica, California. Available at: http://www.rand.org/pubs/monographs/MG341.html
[12] Medicaid.gov at: http://www.medicaid.gov/medicaid-chip-program-information/by-population/pregnant-women/pregnant-women.html

standardized instruments to help prevent and identify potential physical, mental, developmental, dental, hearing, and vision problems. Screenings for pregnant mothers and parents help identify services needed to prevent, assess and treat maternal problems such as depression, trauma, intimate partner violence, and mental health and substance use disorders.

Case Management: Case Management services generally include activities such as conducting a history and assessment, developing a care plan, providing referrals and scheduling treatment services, monitoring, and follow-up activities. The care plan identifies specific activities that link the individual with medical, social, educational providers or other programs and services.

Family Support, Counseling and Parent/Caregiver Skills Training: Family support services aid the parent/primary care giver with knowledge and skills to address specific infant/young child medical, behavioral, and/or developmental treatment needs. Skills training may involve topics such as stress management, child discipline and limit setting, and anger management. Counseling given to pregnant mothers and parents develops problem-solving skills and coping mechanisms, and promotes healthy behaviors such as nutritious eating and weight management, smoking cessation, oral hygiene, etc.

FINANCING APPROACHES

While there is no single dedicated funding source available for home visiting services, federal funding streams can be paired with state and local funds to support a full package of services for pregnant women, families, infants, and young children. States select and implement different home visiting models that may include services eligible for Medicaid coverage and provided by evidenced-based programs. The following section describes how components of home visiting programs can be funded or reimbursed by federal sources from HRSA and Medicaid.

HRSA

The Federal Home Visiting Program is administered by HRSA, in partnership with the Administration for Children and Families (ACF), and oversees grants to states, territories, and tribal entities to implement voluntary, home visiting services with fidelity to evidence-based models, with the option to use up to 25 percent of available funding on other promising approaches with rigorous evaluation.

There are a number of home visiting models which have met the rigorous criteria for effectiveness and are considered evidence-based.

The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is a comprehensive national evaluation of the Federal Home Visiting Program mandated by law. It includes an analysis of the state needs assessments, a random assignment impact study, an implementation study, and a cost analysis. The study includes 4,229 families in 87 local home visiting program

sites across 12 states. Participating sites are using one of four models that meet HHS' evidence-based criteria and were chosen by at least 10 states for their Federal Home Visiting Programs: Early Head Start–Home Based Option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. The February 2015 MIHOPE Report to Congress included an analysis of state needs assessments and baseline characteristics of families, staff, sites, and models (http://www.acf.hhs.gov/programs/opre/resource/the-mother-and-infant-home-visiting-program-evaluation-early-findings-on-the-maternal-infant-and-early-childhood-home-visiting). For instance, the study found that participants face risks of adverse outcomes for themselves and their children, with 34% of the women having symptoms of depression, 33% reporting binge drinking or using illegal drugs in the three months before entering the study, and 10% having been a victim of physical intimate partner violence in the past year. The report also found that, prior to the creation of MIECHV, home visiting programs were an important resource throughout the country, but many communities did not use evidence-based models or had unmet home visiting needs. In response, states planned to spend Federal Home Visiting program funds in communities that, compared with states' overall averages, had higher rates of poverty, poor birth outcomes, and child maltreatment. States' plans also pointed to an increase in use of evidence-based models, with funds used to support a combination of national models.

To learn more about evidence-based home visiting models, visit the *Home Visiting Evidence of Effectiveness (HomVEE)* website referenced under Resources.

MEDICAID

Medicaid coverage authorities offer states the flexibility to provide services in the home, which may improve care and service delivery for eligible pregnant women, parents, and young children. However, home visiting programs may include some component services, which do not meet Medicaid requirements, and may require support through other funding options. The following section describes the component services of a home visiting program that may be coverable through Medicaid.

State Plan Authorities

While there is no distinct Medicaid state plan benefit called home visiting, states may cover many of the individual component services of home visiting programs through existing Medicaid coverage authorities. Submission of a Medicaid state plan amendment may be necessary to ensure federal financial participation (FFP) is available for these services and they must fit within the Medicaid definition of coverable services.

In creating a home visiting program using state plan authority, states should consider the following requirements:

Comparability: A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees. For example, if a state wants to provide home visiting services to address the needs of pregnant women, it would have to make the same services available to all pregnant women who need the services.

Freedom of choice: Medicaid beneficiaries must be permitted to choose a health care provider from any qualified provider who undertakes to provide the services (for example, nurses who are enrolled as providers in the Medicaid program and visit beneficiaries' homes to provide covered services).

State-wideness: Services provided under the state plan must be available statewide to all eligible individuals.

Examples of Medicaid benefit categories that include services that may be furnished as part of a home visiting program include:

Case Management Services

Case management services, defined at 42 CFR 440.169 and 42 CFR 441.18, include services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Case management services must include all of the following: comprehensive assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring activities. Under this benefit, states may target case management services to a specific group of individuals, such as pregnant women and infants, or to individuals who reside in specified areas of the state (or both). Direct services, such as counseling during the course of a home visit, are not covered under the case management benefit. However, the state may cover direct services under a different service category, as described below. The state has flexibility to define qualifications for practitioners to deliver these services, which can include specialized qualifications for case management services for individuals with intellectual disabilities or with chronic mental illness (or other conditions as appropriate) and does not have to meet comparability or state-wideness requirements. Use of this benefit in a home visiting program requires the case manager to provide all required elements of the benefit, which may include those common case management activities described in the previous section ("Common Services in a Home Visiting Model").

Other Licensed Practitioner Services

Other Licensed Practitioner services, defined at 42 CFR 440.60, are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." States may elect under the state plan to cover services furnished by providers who are state licensed practitioners. For example, this benefit could be used to cover counseling and licensed clinical social worker services provided by a licensed

practitioner. A state plan amendment may not be necessary if such practitioners are currently listed in the approved state plan.

Preventive Services

Preventive services, defined at 42 CFR 440.130(c), are services recommended by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health efficiency.

Preventive services must involve direct patient care and be for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury, or other impairments to an individual's physical or mental health.

As of January 1, 2014, preventive services may be furnished by non-licensed practitioners who meet qualifications set by the state. Some common home visiting services include counseling and screening services that may be furnished by non-licensed providers.

Rehabilitative Services

Medicaid's rehabilitative services benefit (42 CFR 440.130(d)) may meet a range of treatment needs and includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. The state can define the practitioners of this benefit. Services such as family therapy and counseling in the home may be authorized under this benefit, if they meet the required elements, including the restorative nature of the service.

Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist.

Home Health Services

Home health services are a mandatory benefit under Medicaid. To be covered, home health services must be ordered by a physician according to a written plan of care. In accordance with federal regulations at 42 CFR 440.70, the three mandatory component services are: nursing services, home health aide services, and medical supplies, equipment and appliances. The

optional components are: physical therapy, occupational therapy, speech pathology, and audiology services.

In addition to the above benefits, the state may elect to cover services in the home aimed exclusively to pregnant women or children under the following authorities:

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

The Medicaid program's benefit for children and adolescents provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under age 21. This benefit entitles individuals under age 21 to any medically necessary service that fits within any category of services described in section 1905(a) of the Act, whether or not otherwise covered under the state plan. EPSDT allows a state to target services to children, including those provided in the home.

Extended Services to Pregnant Women

Extended services to treat pregnancy-related conditions and other medical conditions, which may complicate pregnancy, may be covered under the Medicaid state plan, as defined at 42 CFR 440.250(p). Pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care up to 60 days after the birth of the child, and family planning services. This state plan authority would allow states to target home visiting services to pregnant and postpartum women to help ensure the delivery of prenatal and postpartum services.

Health Homes

This authority allows states to implement Health Homes for Medicaid beneficiaries with chronic conditions. Health homes are based on the chronic condition and not the type of beneficiary, i.e. pregnant women and children. Health Homes are intended to integrate primary care, behavioral health, and long-term services and supports. Health Home services include: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services.

Other Relevant Medicaid Authorities

Depending on how a state determines the design and scope of their home visiting program, Medicaid authorities described in this section may be used in concert with state plan benefits to achieve desired program goals. These authorities can be used in a variety of ways such as changing the delivery system and incorporating services beyond those coverable in the traditional coverage authorities. Waiver authorities must be budget neutral.

Managed Care under sections 1903(m) and 1932 of the Act

Consistent with sections 1903(m) and 1932 of the Act, states may deliver Medicaid-covered services through managed care plans. States must continue to assure access to the full set of state plan services, including EPSDT and generally must provide beneficiaries with a choice of at least two managed care plans. Contracts providing for capitation rates are subject to CMS approval, capitation rates must be actuarially sound, and network adequacy is reviewed.

Section 1915(b) of the Act - Freedom of Choice Waiver

Under section 1915(b) of the Act (1915(b) waiver), CMS may grant a waiver to permit states to restrict beneficiary free choice of provider, to create defined provider networks, which could be part of a managed care service delivery system. When using this authority, states may use the savings accrued through the use of a managed care delivery system to provide additional services or restrict the number of providers who can provide specific Medicaid services.

South Carolina received approval under this authority to implement a five year home visiting pilot to target pregnant women and children. Effective January 1, 2016, the South Carolina Enhanced Prenatal and Postpartum Home Visitation Pilot Project provides enhanced prenatal, postpartum, and infant care services using the Nurse-Family Partnership model. Due to the scope and design of the program, waivers of the following were required: Statewideness, Comparability of Services, and Freedom of Choice. The pilot is expected to generate Medicaid savings through improved birth outcomes, create long-term social and economic benefits resulting from increased birth spacing, and improved health outcomes for mother and child.

Section 1915(c) of the Act - Home and Community-Based Waiver Services

States may request a waiver to provide beneficiaries who would otherwise need to receive care in an institution, long-term care services and supports in community settings. States may not restrict freedom of choice under this waiver but may request waivers such as comparability and state-wideness, enabling them to limit the services to subgroups of Medicaid beneficiaries and to an area within the state. They may also limit participation to a specific number of beneficiaries. States may combine this type of waiver with a section 1915(b) waiver to waive freedom of choice.

Section 1115 of the Act - Research and Demonstration Waiver (section 1115 demonstrations)

Section 1115 of the Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that further the objectives of the Medicaid and Children's Health Insurance Program (CHIP). These demonstrations give states additional flexibility to design and improve their programs and to demonstrate and evaluate policy approaches to further the

objectives of the Medicaid Program. Many section 1115 demonstrations include services for children and youth.

FITTING IT ALL TOGETHER

In designing a home visiting program, state agencies should work together to develop an appropriate package of services to be provided to their beneficiaries. This package may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs.

Each federal, state, and private funding stream is governed by its own rules such as: determining which women and families are eligible for home visiting services, which services are offered, which providers may deliver services, and the length and intensity of home visits. The Federal Home Visiting Program's components and staffing requirements vary across models. States select Federal Home Visiting Program evidence-based models based on their communities' needs. As states consider implementing a home visiting program that, at least in part, relies on Medicaid, CMS and HRSA are available to provide additional technical assistance.

ADDITIONAL RESOURCES

Home Visiting Evidence of Effectiveness (HomVEE)
HomVEE provides an assessment of the evidence of effectiveness for home visiting program models that target families with pregnant women and children from birth to kindergarten entry (that is, up through age 5). Find this at: http://homvee.acf.hhs.gov/default.aspx (last accessed September 9, 2015)

For a national overview of the Federal Home Visiting Program, see: *The Maternal, Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed* (PDF - 137 KB) for national program data and information at: http://mchb.hrsa.gov/programs/homevisiting/programbrief.pdf (last accessed September 9, 2015)

To see how the Federal Home Visiting Program is helping at-risk families in each state, including home visits made, parents, children and communities served, and evidence-based models used, go to *Home Visiting State Fact Sheets* at: http://mchb.hrsa.gov/programs/homevisiting/states/index.html . (last accessed September 9, 2015)

The Mother and Infant Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program - A Report to Congress presents the first findings from the Mother and Infant Home Visiting Program Evaluation (MIHOPE), the legislatively mandated national evaluation of the Maternal, Infant, and Early Childhood Home Visiting program.
http://www.acf.hhs.gov/programs/opre/resource/the-mother-and-infant-home-visiting-program-evaluation-early-findings-on-the-maternal-infant-and-early-childhood-home-visiting (last accessed September 9, 2015)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf (last accessed July 20, 2015)
http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf (last accessed June 2, 2015)

Birth to Five: Watch Me Thrive!, is a coordinated federal effort which aims to encourage developmental and behavioral screening and support for children, families, and the providers

caring for infants and children up to age 5.
https://www.acf.hhs.gov/sites/default/files/ecd/screening_compendium_march2014.pdf
(last accessed July 20, 2015)

Supporting Early Childhood Mental Health Consultation, is a compilation of federal funding sources put together that includes discussions with Infant-Early Childhood Mental Health experts, advocates, technical assistance providers and state administrators that is being prepared by federal staff from The Office of the Assistant Secretary for Planning and Evaluation (ASPE), SAMHSA, and ACF. Resources in this compilation may be able to be paired with state and local funds to support mental health consultation in state home visiting programs for infants, young children and their families.
https://www.acf.hhs.gov/sites/default/files/ecd/supporting_early_childhood_mental_health_consultation.pdf (last accessed June 2, 2015)

Pathways for Covering Mental Health and Substance Use Disorder Services, a CMS resource document for states, describes a variety of federal authorities and service-delivery approaches to assist states with the flexibility to consider transforming their systems and improve coverage for individuals with mental health or substance use disorders. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/pathways-2-9-15.pdf (last accessed July 21, 2015)

Clarifying Guidance on Peer Support Services Policy, released by CMS (May, 2013) provides information regarding the use of peer to peer services in Medicaid. All requirements of SMDL #07-011 (August 15, 2007) must be met for peer support services to be reimbursable under the Medicaid program.
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf
(last accessed April 29, 2015)
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf
(last accessed July 20, 2015)