MEDICAID FINANCING OPTIONS FOR HOME VISITING

LOCAL PROVIDER CHALLENGES, PERSPECTIVES AND RECOMMENDATIONS

OCTOBER 2018

Washington State Health Care Authority

WASHINGTON STATE Department of Children, Youth, and Families

EXECUTIVE SUMMARY

- **Home Visiting Matters – Needs Support**. HVSA-funded home visiting services improves the lives of families and reduces the need for intervention and other higher cost public services, yet the delivery of services is compromised by inadequate and unstable funding, and by multiple funder administrative requirements that are absorbed by providers.
- **Washington State Legislature Directs Collaborative Action and Research**. The Washington State Health Care Authority and Department of Children, Youth and Families have been working together for the past several years to adequately and sustainably fund home visiting services via Medicaid. Based on this work, the Washington State Legislature directed them to continue collaborating, gather stakeholder input, and produce recommendations for Medicaid financing. Under this direction, the agencies and their contractor, The Athena Group, explored the options with local providers around the state.
- **Major Provider Recommendation: *Dream Big, Take Time…and Keep Working with Us!*** HVSA-funded home visiting providers preferred longer-term options that were explored with them, and they were very interested in being involved in working out administrative and process details with state agencies. HCA and DCYF were able to hone in on a recommendation to pursue both Managed Care Integration and a Targeted Case Management State Plan Amendment to support a more robust approach to funding allowable home visiting services with Medicaid. More work needs to be done with both agencies and home visiting providers to fully develop these concepts before submitting detailed proposals to the legislature, and adequate funding is needed to support on-going collaboration between DCYF and HCA and with local providers.

MEAGAN PICARD, PRINCIPAL,
OBO WA STATE HEALTHCARE AUTHORITY &
DEPT. OF CHILDREN, YOUTH AND FAMILIES

THE Athena GROUP

WHY HOME VISITING MATTERS

Home visiting programs are showing that they are making an impact and have the potential for much more when fully funded and able to serve all eligible families. Return-on-investment ranges from $1.75 to $5.70 for every dollar spent from future savings due to reduced need for child protective services, improved school readiness for children, reduced K-12 special education, reduced involvement in the criminal justice system, improvement in birth outcomes such as decreased pre-term births and low-birthweight babies, and improved education and employment outcomes for parents.

Given the relationship-based nature of home visiting work, these outcomes have a ripple-effect, affecting multiple generations of families. One home visitor that participated in September 2018 workshops on Medicaid financing for home visiting noted, "...home visiting positively affects many generations in a family..."

Research has also shown that home visiting reduces spending on government programs. It reduces the need for interventions like child welfare calls to CPS and law enforcement calls for domestic violence. Increased economic self-sufficiency of families also decreases the need for financial and other government financial subsidies, and improved child readiness for school reduces the need for special education supports in schools.

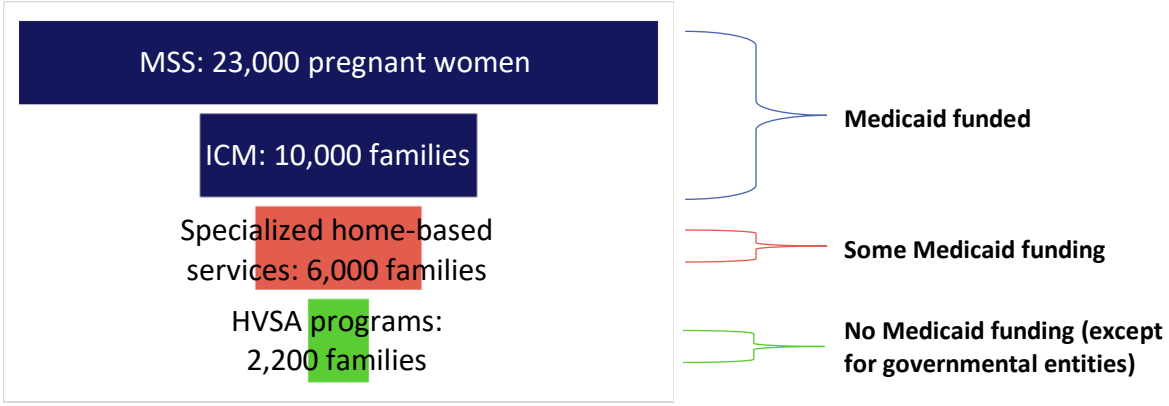
HOME VISITING IN WASHINGTON STATE – LEGISLATIVE MANDATE AND RESPONSE

The Home Visiting Services Account was established as a coordination mechanism for funding proprietary home visiting services. These services are a small part of a larger home visiting system in Washington State.

As shown in Figure 1 on the next page, HVSA programs serve approximately 2,200 families, largely without any funding from Medicaid (except those governmental agencies that are accessing Medicaid Administrative Claiming). In contrast, about 23,000 pregnant women per year receive Maternal Support Services (MSS), and approximately 10,000 families receive Infant Case Management (ICM) services.[1] Another 6,000 families received more specialized home-based interventions to address a family's involvement in the child welfare system or in substance abuse recovery.

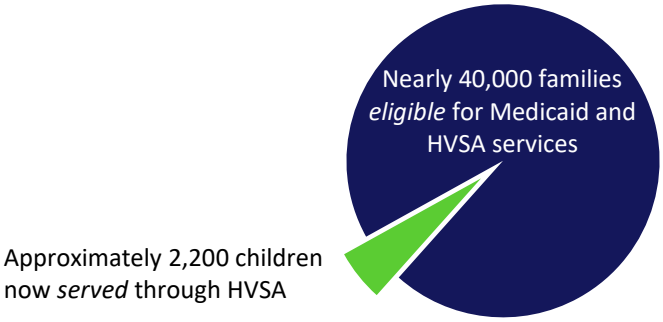
[1] Some families receive both MSS and ICM services, so some duplication exists in these numbers.

Figure 1: Medicaid Funding for Home Visiting Landscape in Washington State



Out of approximately 80,000 births per year in Washington State, half are paid for by Medicaid. Out of those Medicaid-paid births, about one-half of pregnant women choose to receive Washington's Medicaid-funded First Steps/MSS services which can be delivered in the clinic or the home. These services are designed to improve pregnancy and birth outcomes but end after the 60-days post-partum mark. By comparison, HVSA-funded home visiting programs can serve pregnant women and families for an extended duration of time. Families served by home visiting programs typically also meet the income requirements to qualify for Medicaid. There are clear opportunities to improve coordination, referrals and alignment between these programs to more fully serve families who may be experiencing the added challenges of teen parenting, single parenthood or the lack of social and financial supports. (See Figure 2.)

Figure 2: WA Opportunity Expanding Reach of HVSA Services via Medicaid



STATE AGENCY WORK AND LEGISLATIVE DIRECTION

Early spring in 2015, the Washington State Health Care Authority (HCA) and the Department of Early Learning (now the Department of Children, Youth and Families (DCYF)) entered into a contract to jointly fund an FTE to focus efforts on:

- Exploring and recommending sustainable Medicaid financing strategies for early childhood home visiting and
- Identifying opportunities to effectively connect, coordinate, and leverage Medicaid, home visiting and early learning sectors.

The results of that work were shared in a comprehensive report in August 2017, the *Washington State Home Visiting & Medicaid Financing Strategies Recommendations Report*, which explores the health and early learning landscape in Washington and proposed financing options and alignment strategies (https://www.hca.wa.gov/assets/program/home-visiting-medicaid-financing-strategies.pdf).

Leadership from both agencies met in early October 2017, prioritized the strategies and determined that the next step was for HCA to develop an implementation plan. As the implementation plan was being developed, the Washington State Legislature passed E2SHB 2779 Children's Mental Health (excerpt shown on next page), directing HCA and DCYF to work together to build upon the research and strategies developed in the August 2017 report and present to the legislature a set of actionable recommendations to leverage Medicaid funding for home visiting services on December 1, 2018.

The Medicaid system is complex and challenging to fully understand and implement. While much work has already been done within the partner agencies, additional preliminary steps were deemed necessary to develop shared understanding among state agency partners about the Medicaid financing options and how each option may impact local home visiting providers. Beginning July 2018, HCA contracted with The Athena Group to facilitate a process with HCA and DCYF staff to address these needs, determine local provider preferences among the previously prioritized Medicaid financing options, and identify state agency alignment needs to support effective and efficient implementation.

Engrossed 2nd Substitute - E2SHB 2779 http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/2779-S2.SL.pdf https://fortress.wa.gov/FNSPublicSearch/GetPDF?packageID=52456	
NEW SECTION. Sec. 4. A new section is added to chapter 74.09 RCW to read as follows: (1) The authority shall collaborate with the department of children, youth, and families to identify opportunities to leverage medicaid funding for home visiting services. (2) The authority must provide a set of recommendations relevant to subsection (1) of this section to the legislature by December 1, 2018, that builds upon the research and strategies developed in the Washington state home visiting and medicaid financing strategies report submitted by the authority to the department of early learning in August 2017.	***NEW SECTION. Sec. 5.*** (1) By November 1, 2018, the department of children, youth, and families must: (a) Develop a common set of definitions to clarify differences between evidence-based, research-based, and promising practices home visiting programs and discrete services provided in the home; (b) Develop a strategy to expand home visiting programs statewide; and (c) Collaborate with the health care authority to maximize medicaid and other federal resources in implementing current home visiting programs and the statewide strategy developed under this section. (2) This section expires December 30, 2018.

GOALS AND STEPS TAKEN IN RESPONSE TO ESSB 2779, SUMMER-FALL 2018

- **Goal 1: Develop a shared understanding of the options.** Staff from the two agencies, along with DCYF's private sector partner in administering the HVSA, Thrive Washington, met twice in July, then again in August, to review the Medicaid financing options as developed in 2017 and presented in the *Washington State Home Visiting & Medicaid Financing Strategies Recommendations Report*. The partners developed shared understanding of the options, refined them and planned stakeholder workshops.
- **Goal 2: Determine local provider preferences.** The agencies met again in late September to review the results of seven stakeholder workshops and identify which Medicaid financing strategies they recommend pursuing.
- **Goal 3: Identify HCA-DCYF alignment needs.** Over two meetings in October, the agencies identified steps to take together to advance these Medicaid financing strategies and prepare for implementation.
- **Goal 4: Report to agency leadership and the legislature.** The agencies presented their recommendations to HCA and DCYF executive leadership on November 5, 2018 and prepared a written report to the Washington State Legislature based on the results of all of these activities.

Results of each of these steps in the process are provided in this report, beginning in the next section.

Figure 3: 2018 Medicaid Financing for Home Visiting Project at a Glance

STAKEHOLDER OUTREACH AND PARTICIPATION

In September 2018, The Athena Group designed, convened and facilitated a series of seven workshops around Washington State for home visitors, supervisors and administrative/billing staff. Programs administered through the Home Visiting Services Account (HVSA) were the primary audience, though other stakeholders joined as well, including tribal and other home-based service providers. Across all workshops, 74 participants (see details in Appendix B) worked to understand the Medicaid financing options, how each option would affect them, and then identify their preferences.

HVSA HOME VISITING PROGRAMS

1. Nurse-Family Partnership
2. Parents as Teachers
3. Parent-Child Home Program
4. Steps to Effective, Enjoyable Parenting
5. Outreach Doula
6. Early Head Start – Home Based
7. Family Spirit
8. Parent-Child Psychotherapy

HOME VISITING CHALLENGES - LOCAL PERSPECTIVES ON MEDICAID FINANCING OPTIONS

Together with The Athena Group, HCA, DCYF and Thrive Washington presented four basic Medicaid financing options, two of which included both short-term and long-term variations (effectively six options), to workshop participants for their consideration. To understand the impacts of these options, it is first important to understand the current context.

CURRENT CONDITIONS FOR LOCAL PROVIDERS, FAMILIES

Trauma seems to be at the core of the home visiting world. Unserved families are experiencing trauma without the support of home visitors, though services are often provided on a triage basis, providing services first to people with the highest need (and likely those experiencing the greatest trauma). There are also impacts to home visitors, who experience secondary trauma

from their work with them. Home visitors, their supervisors and administrative staff are often in a state of overwhelm due to:

- High caseloads,
- Awareness of unmet needs of unserved families,
- Having to work multiple jobs to pay their own bills due to low pay in this industry,
- Job insecurity due to unstable funding, and
- Burdensome reporting and administrative requirements from multiple funders – an added responsibility for home visitors due to inadequate funding to support additional administrative staff.

All of this has led to high turnover rates among staff which significantly impacts the families served by those providers. Those who continue in this line of work – and even those who try but cannot make it work in their own lives – do so because they care about the families they serve and know that their services and programs make a difference in ways few other programs can.

IMPACTS OF MEDICAID FINANCING OPTIONS

The challenges briefly discussed above can be organized into four basic categories:

- Trauma
- Heavy reporting requirements
- High caseloads
- Inadequate and unstable funding

Can Medicaid help with these conditions and help to expand the reach of these services for greater impact in WA communities?

The experience of **trauma** among populations is directly addressed by the work that home visitors do with families through these programs. Trauma among staff is addressed by supervisors and support programs received from Thrive Washington and Department of Children, Youth and Families. While Medicaid financing does not have a direct role in addressing secondary trauma, it may play a role indirectly when considering the potential impact of administrative and reporting requirements.

Reporting requirements are important for understanding how well these programs are working, and Medicaid funds are unlikely to change this reality, nor is it necessarily desirable to do so. However, if Medicaid reimbursement for allowable clinical or administrative services can be accessed without significantly increasing reporting or administrative burden, it may allow

appropriate cost shifting, freeing up funds to hire more home visitors to **reduce caseloads**, making work life more sustainable, and/or to **serve more families**. Most clearly, Medicaid may offer a more ***stable*** **source of funding**.

The potential impact of Medicaid financing depends on the *requirements* – data to report, manner in which data are required to be reported, and required provider credentials – compared with *benefits* available, including the specific services eligible for reimbursement and level of reimbursement allowed.

The table below (Figure 4) shows the requirements, benefits and implementation timeline associated with each of the six Medicaid financing options explored, according to current law and any new legislative actions needed.

Figure 4: Medicaid Financing Options – Requirements, Benefits and Estimated Implementation Timelines

Options (Medicaid Authority)	Requirements	Benefits	Estimated Implementation Timeline
Medicaid Administrative Claiming (1903(w)(6)(A) of Social Security Act) *Currently, eligible entities can contract with HCA to access Medicaid reimbursement under the Medicaid Administrative Claiming program*	• Must be governmental or quasi-governmental entity (or contract with one) • Cost allocation plan must be approved by CMS (HCA currently uses random moment in time studies for its MAC program)	• Funding based on % of time spent on Medicaid enrollment, training, planning, and coordination activities with eligible or enrolled Medicaid population	6 months-1 year

(Figure 4 continued on next page)

Options (Medicaid Authority)	Requirements	Benefits	Estimated Implementation Timeline
Targeted Case Management - Shorter Term (Case Management Services, 42 CFR 440.169) *Currently, eligible entities can contract with HCA as Infant Case Management providers and bill fee-for-service through Provider One*	• State plan for ICM provider requirements includes a minimum of an Associate's degree plus experience and supervision by an MSS provider or a person with a bachelor's degree • Bill for time spent on allowable case management activities	• $20 reimbursement for 15-minute units of case management services provided in the home setting • Up to 20 units of services allowed during the eligibility period (based on risk assessment) • Providers may request additional units of service	6 months-1 year
Targeted Case Management - Longer Term (Case Management Services, 42 CFR 440.169) *With legislative approval and allocated match, HCA can develop a Medicaid State Plan Amendment to support more comprehensive set of case management services*	• HCA works with DCYF to develop SPA with baseline provider requirements, specific case management services, and reimbursement rates and process • CMS approval of SPA • WA state legislative approval and GSF Medicaid match	• Potential to describe home visiting specific provider types and models • Potential to set adequate reimbursement rate • Case management services can be spelled out more specifically to home visiting services	Up to 5 years
Managed Care Integration – Shorter Term (1932(a)(1) (A) of Social Security Act) *Currently, any community-based provider can negotiate with Managed Care Organizations to provide services as part of the MCO provider network*	• Providers must be professional health care providers, per state and federal requirements, except when delivering some incentive-based services • Reporting requirements and reimbursement is negotiated directly between MCOs and interested providers	• Coverage for clinical and case management services, as well as incentive-based services, within current per member per month benefit levels offered by each MCO	1+ years

(Figure 4 continued on next page)

Options (Medicaid Authority)	Requirements	Benefits	Estimated Implementation Timeline
Managed Care Integration – Longer Term (1932(a)(1)(A) of Social Security Act) *With legislative approval and allocated match, HCA can work with DCYF and the MCOs to include home visiting services as part of the benefit package*	• WA state legislative approval and GSF Medicaid match to increase monthly capitated rate to include allowable home visiting services • Home visiting provider requirements and services can be negotiated and defined in the MCO contracts	• Coverage for clinical and case management services, as well as incentive-based services, within current per member per month benefit levels offered by each MCO • Potential to include coverage for home visiting services as part of the MCO benefit package	Up to 5 years
1915B Waiver (1915 of Social Security Act) *With legislative approval and allocated match, HCA can develop a Medicaid waiver to support more comprehensive set of home visiting services*	• Requirements of waiver may be tailored to specific service areas, provider types and home visiting models • CMS approval of waiver • WA state legislative approval and GSF Medicaid match • Must be renewed (and may be modified) every 2-3 years with CMS	• Benefits vary based on specific programs, geographic regions, and/or target populations to be served, as designated in the waiver	Up to 5 years to identify and allocate both GSF funds for Medicaid match as well as funds for non-Medicaid covered home visiting services components

To determine the impacts of each of these options, it was necessary to detail the specific services that each of the home visiting programs provide, along with the amount of time staff spend on each of these services. Workshop hosts and participants worked together to develop these lists (see Appendix C for results), and though not comprehensive, these discussions helped to refine thinking about impacts.

Based on generalized input from HVSA providers, Figure 5 (on next page) shows the relative potential of each of these options to expand home visiting services, producing positive outcomes for more families as well as increasing positive impacts on Washington State systems, and to address the basic challenges that have prevented such expansion to date, as previously identified.

Figure 5: Relative Potential Impact of Options on Current Conditions

Key: Negative impacts — Limited positive impacts — Strong positive impacts

Options	Current Conditions to Address with Medicaid Funds			
	Number of Unserved Families	Number of Providers with High Caseloads	Reporting Requirements Workload	Funding Stability
Medicaid Administrative Claiming				
Targeted Case Management - Shorter Term				
Targeted Case Management - Longer Term				
Managed Care Integration – Shorter Term				
Managed Care Integration – Longer Term				
1915B Waiver				

Overall, HVSA providers determined that the benefits of the shorter-term options (Medicaid Administrative Claiming and shorter-term managed care integration and targeted case management) do not sufficiently outweigh the burdens that come with the requirements and do not make enough of a positive impact to be worthwhile. For instance, many participants noted that the $20 reimbursement for 15 minutes of Infant Case Management services does not cover the administrative costs, travel time and follow-up. As one home visitor said, "We have to consider how far in the hole each unit of service puts us."

The longer-term options were strongly preferred due to the opportunity to develop them in ways that would minimize burden and maximize benefits across all HVSA programs. However, it was extremely difficult for workshop participants to identify a clear preference among them. Across the state, they consistently suggested that more work needs to be done to build out the longer-term options, and they want the state to take the time needed, while continuing to work with them, to get Medicaid financing right.

Dream Big, Take Time…Work with Us!
--prevailing message from HVSA Programs

As a result of workshop discussions, **clear and consistent criteria emerged to guide decision-making**:

1) Promote high level of coordination. As one home visitor said, "Public health strategies are found to be most effective when we use an “all, some, few” approach. Currently, we are using a

"some, few" approach to parental support during pregnancy and early childhood and our service to the "some" has grown very scant. Maternity Support Services, with appropriate attention and investment, could effectively be the vehicle for "all" and "some" among Medicaid-eligible or enrolled pregnant women, and the evidence-based home visiting programs could be reserved for the more intensive "few". When universal approaches are employed, not only are we more likely to find the few that have the most urgent needs, but we also de-stigmatize services."

Another potential mechanism for coordinating services is through braiding funds – a foundation for which has already been established through the HVSA. However, it is important to be mindful of additional burdens place on providers by funders, which is the next criterion discussed and among most important to HVSA providers.

2) Limits or, if possible, reduces staff burden. Local providers need help to manage current levels of service, as they are currently constrained by administrative requirements. The additional burdens on staff workload limits the impact they can make. These responsibilities are not just hard on them; it affects the level of service, and therefore the benefits, that may be accomplished from home visiting.

"If we only receive 70% of the funding, we need to deliver our services then it is unreasonable to expect the fidelity of the model can be delivered at 100%."
--home visitor

3) Promotes sustainability. Programs don't want to go through multiple changes over time. Improvements that can't be sustained wreak more havoc than they do good.

4) Increases continuity of care for families. Reduction in the sources of overwhelm, such as high caseloads and insufficient administrative staffing, may reduce staff turnover, which increases and improves continuity of care.

5) Enhances effectiveness by covering services for children and their families up to age 5. Home visitors were consistently in agreement that their work will have greater, more sustained impact on families – and Washington State and local government systems as a result – when families receive this additional continuum of support for their children to age five.

6) Reaches more families while retaining model fidelity. Home visiting programs recognize the need to expand; staff see the need in their communities, and many have wait lists for their services. However, they have stressed that Washington State must first get the balance right within existing service levels to ensure model fidelity, then expand to more families.

7) Provides flexibility to meet varying needs. Finally, home visiting programs urged that funding plans and any related policies enable flexibility to account for variations in rural/urban and cultural factors. With mindfulness around these factors and the ability to address them, programs can provide services in ways that achieve more equitable outcomes.

RECOMMENDATIONS

Based on input from local providers, The Athena Group recommended that HCA and DCYF take the following steps collaboratively:

1. Identify the long-term Medicaid financing option(s) that would:

   - Be least burdensome and most feasible to administer in a sustainable way at both state and local levels,
   - Increase continuity of care,
   - Promote greater coordination, and
   - Allow some degree of flexibility for cultural and other adaptations (if possible to determine at this point).

2. Sketch out what the selected option(s) could look like to allow providers to fully evaluate impacts to services, staff and how the preferred option(s) would work.

3. Re-engage providers (and possibly others) to build out details of the approach, including:

   - Expanding services to age 5;
   - Considering whether other challenges programs face beyond funding stability could be addressed in the process, such as sources of funding for travel time or integrating potential high impact efficiencies like a strategy to streamline reporting to the extent that it is in state control; and
   - Building the package around a plan for a single point of entry.

4. Seek funding necessary to support these steps, which The Athena Group recommends, are needed prior to full execution of the legislative mandate in ESSB 2779.

CONCLUSION

The Athena Group recognizes that the Washington State Legislature would prefer to see legislation in 2019 that defines a Medicaid financing package for home visiting and provides plan

details. However, local provider input indicates that the above recommended next steps are necessary first. The Athena Group believes that these steps:

- Are highly responsive to local providers;
- Demonstrate that home visiting is valued;
- Acknowledge that current conditions are unsustainable; and
- Move Washington State toward improving operating conditions and enhancing impact on Washington families, communities and systems.

As of October 2018, these steps are already underway. Agency staff teams have collaborated in reviewing the long-term options, and they have identified a Medicaid financing strategy that combines Managed Care Integration and a State Plan Amendment to support a more robust approach to financing home visiting services with Medicaid, per the criteria identified by local HVSA-funded providers, and that will maximize Medicaid funds for home visiting.

Additional details on this recommended approach are provided in Appendix E. In order to carry out this approach, the agencies will need to continue to work closely and align their legislative activities, ideally with additional staff (as recommended) to enable better coordination.

APPENDIX A: HVSA HOME VISITING PROGRAMS

Each in their own way, the HVSA-administered home visiting models help young families set a foundation for success, from health of pregnant moms to helping parents help their kids get ready for starting Kindergarten.

HVSA VALUES AND PHILOSOPHY

The HVSA was intended to provide a mechanism for establishing a coordinated system of home visiting in Washington State. Therefore, all of these programs are guided by a **common philosophy and set of values**, key aspects of the impact these programs are having. These are shown in the call-out to the right.

HVSA CORE VALUES AND PHILOSOPHY

No one size fits all! WA offers evidence-based, research-based, and promising practice home visiting.

Services are: voluntary, family-focused, strengths-based, culturally relevant, trauma informed

Program support matters! Reflective supervision, on-going training, data informed, continuous quality improvement

Build capacity through: community choice, sustainable funding

OVERVIEW OF PROGRAMS

Following are brief descriptions of each of these model programs.

Nurse-Family Partnership: Community health program that serves low-income women pregnant with their first child. Each vulnerable new mom is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits. It is a life-transforming partnership, for the mom and her child.

Parent-Child Home Program: Early learning modeling program in which "Early Learning Specialists focus on building meaningful relationships with the families and support parents in realizing their role as their children's first and most important teacher.

Steps to Effective and Enjoyable Parenting: Through home visits and group sessions, STEEP facilitators work alongside parents to help them understand their child's development. Parents learn to respond sensitively and predictably to their child's needs and to make decisions that ensure a safe and supportive environment for the whole family.

Parents as Teachers: Delivers parent education primarily through personal visits and group meetings. We equip parents with knowledge and resources to prepare their children, from prenatal through kindergarten, for a stronger start in life and greater success in school.

Outreach Doula: Connects expectant and new parents to outreach doulas who are from their community and who are specially trained to provide support during the sensitive first months of pregnancy through a child's second birthday.

Early Head Start – Home Based: Designed to support and strengthen parents' or expectant parents' skills and abilities to nurture healthy development of children.

Family Spirit: Designed to promote mothers' parenting skills, while assisting them in developing coping and problem-solving skills to overcome individual and environmental stressors. The model also incorporates traditional tribal teachings throughout the curriculum.

Child-Parent Psychotherapy: Intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder.

APPENDIX B: STAKEHOLDER WORKSHOP PARTICIPATION, SEPTEMBER 2018

There are 36 organizations currently providing at least one of the eight home visiting models administered through the HVSA. A total of [19] (50%) organizations participated in the workshops, with one to three staff members participating from each organization. Additionally, 34 stakeholders from other home visiting programs and other interested parties participated. Following are participation details by workshop site.

Workshop Location	Spokane	Tukwila	Sequim	Lacey	Burlington	Vancouver	Yakima
Total # Participants[2]	9	18	4	19	7	14	10
NFP	3	5	2	7	2	4	4
PAT	4	4	1	5	1	3	1
Tribal HV		1				2	3
Doula		1					
CPP		1		1			
Other community service provider		4			2	2	
MSS/ICM	1	1	2	1	1	3	4
Other Interested	1	2		3		2	
Thrive Representative	1	2	1	1	1		1
DCYF Representative		1		1			

[2] Some participants provide multiple types of home visiting services, so total number of participants does not equal sum of programs identified in table.

APPENDIX C: LIST OF SPECIFIC SERVICES PROVIDED BY HVSA-FUNDED PROGRAMS

The following list of specific services provided by HVSA-funded programs was generated by workshop participants. It should be considered a starting point for identifying which services may be funded with Medicaid dollars. It requires more work to both expand and refine the list, which may be done in the next phase of efforts to acquire Medicaid funding for home visiting.

	Home Visiting Models						
Discrete Services	**NFP**	**PAT**	**ESIT/ CPP/ PFR/ MSS/ ICM**	**EHS Home based**	**PCHP**	**CPP**	**Doula**
Assessments/Screenings							
Physical health assessment - child and/or mother	X			X	X		
Mental health/post partum depression /depression assessment	X			X	X		X
Assess safety and adequacy of environment / CPP safety check	X		X				
Family systems assessment and relations	X	X					
Assess parent/child attachment	X						
Assess parenting practices / PICCOLO (parent interactions with children)	X	X			X		X
Intimate partner violence screening	X						X
ACES screening	X						

	Home Visiting Models						
Discrete Services	**NFP**	**PAT**	**ESIT/ CPP/ PFR/ MSS/ ICM**	**EHS Home based**	**PCHP**	**CPP**	**Doula**
Developmental screening / developmental assessment (ASQ3, SE2) / SPED assessment	X	X	X	X		X	X
Substance use screening	X						
Oral health screening	X			X	X		
Immunization/vaccine hesitance	X						
SBIRT: intentional interviewing, chemical dependency screening	X						
Futures assessment		X					
Edinburgh		X		X			
Family resources checklist		X					
IT home (observation)		X					
Milestones (observation every visit)		X					
COP intake assess			X				
Prenatal screening			X				
TS Gold assessment				X			
Hearing/vision screening				X	X		
Deca				X			

	Home Visiting Models						
Discrete Services	**NFP**	**PAT**	**ESIT/ CPP/ PFR/ MSS/ ICM**	**EHS Home based**	**PCHP**	**CPP**	**Doula**
Well child checks/assessment				X			X
Assess housing, food, social services, education, legal, transportation					X		
Not specified						X	
PHQ-9 asessessment						X	
Parent stress index assessment						X	
Child maltreatment assessment							X
Language/literacy assessment							X
1 PV screening at intake							X
Breastfeeding assessment							X
Case management							
Refer to healthcare	X			X			
Safety plan and referral	X						
Goal-setting and follow-up (financial, housing, education, mental health, health, nutrition, parent education)	X			X	X		

	Home Visiting Models						
Discrete Services	**NFP**	**PAT**	**ESIT/ CPP/ PFR/ MSS/ ICM**	**EHS Home based**	**PCHP**	**CPP**	**Doula**
Family planning	X						
Other referrals/case management based on screenings/assessments	X	X	X		X	X	X
Housing	X						
Outreach to providers and community: employment, education, housing stability	X	X					
Case staffing: communication with different team members (interdisciplinary team)							
Arrange interpreters/translation	X	X		X	X		
Mental health referrals				X			
Disabilities: coordination, referrals, transition support, contracts/mous				X			
Connect families to insurance /check financials and eligibility				X		X	

	Home Visiting Models						
Discrete Services	**NFP**	**PAT**	**ESIT/ CPP/ PFR/ MSS/ ICM**	**EHS Home based**	**PCHP**	**CPP**	**Doula**
Collateral info gathering: social worker, child care worker, PCP, other providers						X	
Other direct services							
Parent/caregiver health education	X						
Other support based on screenings/assessments	X						
Lactation support	X						
Tobacco cessation support	X						
Child development activity		X					
Intake with new referrals	X	X	X	X	X	X	
Psych education, mental health consults				X			
Immunizations				X			
Parent/child interaction and support					X		
Support during labor and birth							X
Breastfeeding initiation support							X
Promoting first relationships (PFR curriculum)							X

	Home Visiting Models						
Discrete Services	**NFP**	**PAT**	**ESIT/ CPP/ PFR/ MSS/ ICM**	**EHS Home based**	**PCHP**	**CPP**	**Doula**
Other indirect services							
Data collection every 6 months after enrollment and post-partum	X	X					
Charting/documentation and data entry	X	X	X	X	X	X	
Scheduling and rescheduling visits	X	X	X	X	X		
Interdisciplinary staff meetings (mental health, chemical dependency)	X						
Planning and materials preparation	X	X				X	
Travel	X	X	X	X	X	X	X

APPENDIX D: QUOTES FROM LOCAL IMPLEMENTING AGENCIES

Home visiting providers want policymakers to remember a few key things. Most shared that they want to see the state invest in comprehensive and sustainable funding, which will strengthen the impact potential when combined with expanding who can be served. They said:

Invest: comprehensive and sustainable funding

"Continue to invest in prevention and early intervention"

"Fully fund home visiting services for our kids and families."

"We need sustainable funding in order to make long-term changes."

"Think sustainability - create something that will broadly support home visiting."

"Commit to the sustainability and don't undo it later."

"Comprehensive program funding"

"[LIA] requires support from WA state departments and legislature to continue its work to maintain the health and safety of all families in [our] County."

Expand/strengthen impact potential

"Please prioritize services for families with children under 5. Let's create a support network to these families."

"Prenatal to K for greatest impact"

“Let's improve the health and wellness of our youngest community members! Healthy children will sustain healthy communities!”

Improve current conditions first

"Allocate funding for a statewide data management system to support program changes (reporting and billing)!"

APPENDIX E: HCA-DCYF STAFF RECOMMENDED APPROACH TO MEDICAID FINANCING

Medicaid Financing for HVSA-Funded Programs

Summary for HCA and DCYF Executive Leadership, Dec. 17, 2018

Local HVSA-funded programs and other stakeholders reviewed shorter- and longer-term options for accessing Medicaid funds. They preferred the longer-term options because these options best address key criteria they identified (shown on right), and they want DCYF and HCA to take the time needed to get the details right and to continue to work with them to do so. Based on this input and consideration for state agency administrative workload, HCA and DCYF staff recommend pursuing **two Medicaid financing strategies including conducting cross-agency fiscal analyses,** seeking **funding in 2019**, and determining next steps for **managed care contracting and a State Plan Amendment in 2020**.

Stakeholder-developed Criteria for Planning

HVSA-funded programs want Medicaid financing plans to:

- Promote high levels of coordination
- Promote sustainability
- Increase care continuity
- Expand services to families with kids up to 5 years old
- Serve more families
- Enable flexibility for rural/urban, cultural variations

Preferred Options: MCO + TCM

	Managed Care Plan Integration[3]	Targeted Case Management
Recommendations	Pursue contracts between DCYF and Apple Health managed care organizations (MCOs) for allowable services provided by HVSA-funded home visiting programs.	Develop a State Plan Amendment to reimburse targeted case management services provided by HVSA-funded home visiting programs.
Models Included	All HVSA-funded models; but some models may provide more allowable services by qualified providers than other models.	All HVSA-funded models; some models may provide more or fewer allowable case management services.

[3] See infographic of managed care integration recommendation following recommended next steps and leadership questions.

Funding Considerations	May increase in use of behavioral health and/or clinical services, as well as case management, which would require an increased per member/per month capitated rate.	• 50/50 FMAP • FQHC eligible • Reimbursement for case management services only • Undocumented persons require state funding only
Alignment Considerations	• Cross-agency fiscal analysis needed • Cross-agency policy and program coordination • Continued engagement with HVSA-funded programs	• Cross-agency fiscal analysis needed • Cross-agency policy and program coordination • Continued engagement with HVSA-funded programs

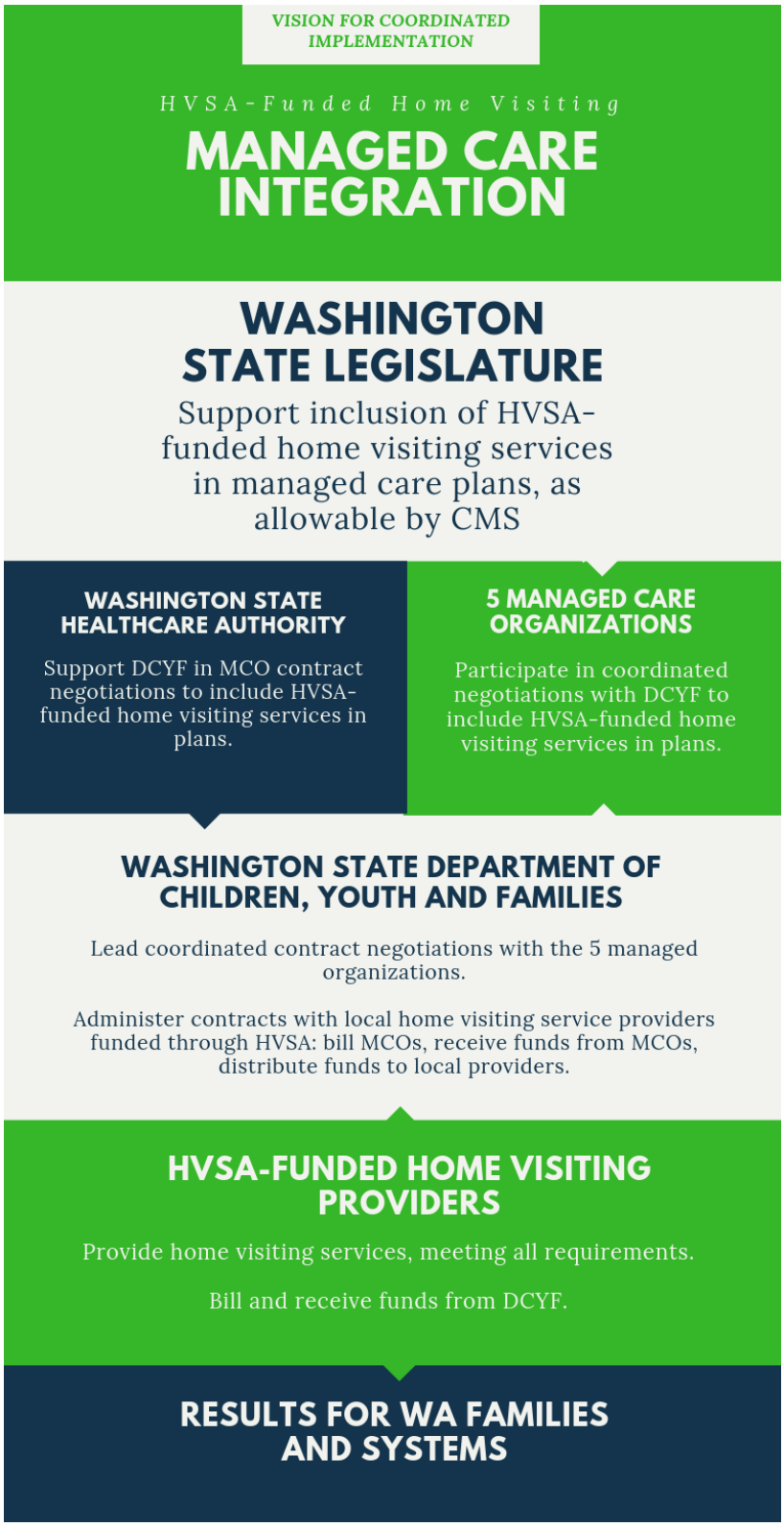
Recommended Next Steps

1. DCYF and HCA: Ensure sufficient staffing to complete next steps
2. DCYF and HCA: Develop coordinated funding proposal for 2019 legislative session
   a. HCA: ensure resources are available to complete a fiscal analysis that determines state and federal financial participation as well as administrative workload (add FTE if needed)
   b. DCYF: ensure resources are available to complete fiscal analysis (add FTE if needed)
3. DCYF and HCA collaborate to develop proposed MCO contracting and State Plan Amendment details
4. DCYF continue to involve HVSA-funded program providers in developing Medicaid financing proposals

Leadership Questions/Requests[4]

1. Which Medicaid authority do you want to pursue?
   a. MCO reimbursement for allowable services?
   b. TCM SPA?
   c. Both?
2. Will you assign staff in both HCA and DCYF to complete the next steps listed above? Some or all?
3. What fiscal impacts should cross-agency fiscal staff project/complete before the legislative session?

[4] Discussion on these questions with DCYF and HCA Executive Leadership Teams scheduled to occur on December 17, 2018.


VISION FOR COORDINATED IMPLEMENTATION
HVSA-Funded Home Visiting
MANAGED CARE INTEGRATION
WASHINGTON STATE LEGISLATURE
Support inclusion of HVSA-funded home visiting services in managed care plans, as allowable by CMS
WASHINGTON STATE HEALTHCARE AUTHORITY
Support DCYF in MCO contract negotiations to include HVSA-funded home visiting services in plans.
5 MANAGED CARE ORGANIZATIONS
Participate in coordinated negotiations with DCYF to include HVSA-funded home visiting services in plans.
WASHINGTON STATE DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES
Lead coordinated contract negotiations with the 5 managed organizations.
Administer contracts with local home visiting service providers funded through HVSA: bill MCOs, receive funds from MCOs, distribute funds to local providers.
HVSA-FUNDED HOME VISITING PROVIDERS
Provide home visiting services, meeting all requirements.
Bill and receive funds from DCYF.
RESULTS FOR WA FAMILIES AND SYSTEMS