October 2023

Implementing Medicaid Reimbursement for Home Visiting in Missouri

Center for Advancing Health Services, Policy & Economics Research

INSTITUTE FOR PUBLIC HEALTH | INSTITUTE FOR CLINICAL & TRANSLATIONAL SCIENCES | DEPARTMENT OF MEDICINE

WASHINGTON UNIVERSITY IN ST. LOUIS

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EXECUTIVE SUMMARY

Ranking 42nd in the nation on maternal mortality, 31st for low birth weight, and 33rd for infant mortality, Missouri faces challenges across many maternal and infant health measures.[1] Across the U.S., many states have turned to home visiting as a way to combat poor maternal and infant health outcomes. In fact, many states now offer Medicaid reimbursement for home visiting services, expanding the pool of funding sources for home visiting and making the services accessible to a larger proportion of the population.

"Home visiting" refers to a set of programs that provide individualized, culturally competent, and holistic services to expectant parents, young children, and their families including assessments, case management, screenings, referrals, parent and safety education, and mental health, nutrition, and lactation support. Medicaid reimbursement for home visiting allows home visiting agencies to serve more families and amplify the impact they can have on health outcomes. To implement Medicaid reimbursement for home visiting, Missouri must consider several factors, including Medicaid benefit category, eligible services, populations, and providers, payment systems, and how Medicaid funds will be braided with current sources of funding.

KEY TAKEAWAYS

- Home visiting has been proven to improve health outcomes for both mothers and babies, decrease instances of domestic violence, child maltreatment, and substance abuse; it has been shown to be cost-effective, yielding a positive a return on investment.
- To implement Medicaid reimbursement for home visiting, several factors must be considered, including Medicaid benefit category, eligible services, populations, and providers, payment systems, and how Medicaid funds will be braided with current sources of funding.
- Collaboration and communication with home visiting stakeholders, including home visiting agencies and employees, are vital to constructing a Medicaid reimbursement approach that is efficient, effective, and accessible to use by agencies and employees.

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GOALS FOR MEDICAID-REIMBURSED HOME VISITING

- Decrease the number of preventable maternal deaths
- Increase the proportion of women receiving prenatal care in the first trimester
- Open new avenues for culturally competent care to reduce racial disparities in maternal health
- Increase access to prenatal and postpartum care in geographically disadvantaged, low-income, and historically marginalized communities
- Improve accessibility to high quality and holistic home visiting services

HOME VISITING

WHAT IS HOME VISITING?

Home visiting is a collection of services that are offered in the home to address the needs of at-risk families or those in low-resourced areas. Services are tailored to a family's individual needs and are provided on a regular basis over a period of months or more.

MODEL VS. AGENCY

Home visiting agencies are entities like nonprofits, health departments, and schools that facilitate and administer home visiting services. Home visiting models are specific frameworks with unique goals and a specific approach to home visiting that a particular home visiting agency follows. This is similar to how different schools (home visiting agencies) might use different curricula (home visiting models).

VARIATION IN MODELS

Each home visiting model is constructed differently with unique goals and methods to achieving those goals. For example, Healthy Families America focuses on reducing child maltreatment, improving parent-child interactions, and promoting children's school readiness, while models like the Maternal Early Childhood Sustained Home Visiting Program, the Maternal Infant Health Program, and Nurse-Family Partnership prioritize prenatal care and improving maternal and infant health outcomes.[2]

HomVEE

Home Visiting Evidence of Effectiveness, or HomVEE, was launched by the Department of Health and Human Services to conduct reviews on early childhood home visiting models. The purpose of HomVEE is to provide an assessment of the evidence of effectiveness for home visiting models and provide summaries, reports, and databases of research manuscripts that are available to the public. The research database houses over 2000 research articles that can be filtered by model, outcomes, and quality rating.[3] It is important to note that just because a home visiting model isn't approved by HomVEE doesn't mean that it does not provide benefits. It simply means that there is not enough formal evidence to prove its effectiveness, or it is still in the process of being approved.

EVIDENCE OF EFFECTIVENESS

Many studies have been conducted to examine the outcomes of home visiting. The research indicates that home visiting can have a positive impact on maternal and child health, child development, school readiness, family economic self-sufficiency, parenting practices, and health-seeking behaviors. Some models have a stronger emphasis on health outcomes and focus resources on improving maternal, infant, and child health including during pregnancy and postpartum.[4] Table 1 shows that among 18 HomVEE models, 14 have shown favorable outcomes in maternal health, child health, or both. To say that maternal or child health is a primary outcome indicates that the primary focus of the study was to examine maternal health. To say that maternal or child health is a secondary outcome means that the primary focus of the study wasn't on health outcomes, yet the research found that the model has favorable health outcomes.

Table 1. Favorable Effects on Health Outcome Domains Among 18 Home Visiting Models that Meet Federal Criteria for Evidence-Based Home Visiting

Model	Maternal Health	Child Health
Attachment and Biobehavioral Cath-up (ABC)	Not measured	Yes (primary)
ChildFirst®	Yes (primary, secondary)	Not measured
Head Start Home-Based Option (EHS-HBO)	No	No
Early Intervention Program for Adolescent Mothers (EIP)	No	Yes (primary)
Early Start (New Zealand)	No	Yes (primary, secondary)
Family Check-Up®	Yes (secondary)	
Family Connects®	Yes (secondary)	Yes (primary, secondary)
Family Spirit®	Yes (primary, secondary)	
Health Access Nurturing Development Services (HANDS)	Yes (primary)	Yes (primary)
Health Beginnings	Yes (secondary)	Yes (primary, secondary)
Health Families America®	Yes (secondary)	Yes (primary, secondary)
Home Instruction for Parents of Preschool Youngsters (HIPPY)®	Not measured	Not measured
Maternal Early Childhood Sustained Home Visiting Program (MECSH)	Yes (secondary)	Yes (secondary)
Minding the Baby®	Yes (primary)	Yes (primary)
Nurse Family Partnership (NFP)®	Yes (primary, secondary)	Yes (primary, secondary)
Parents as Teachers (PAT)®	No	No
Play and Learning Strategies (PALS) Infant	Not measured	Not measured
SafeCare Augmented®	Not measured	Not measured

COST

The Home Visiting Evidence of Effectiveness Review (HomVEE) maintains a database of research studies that examined the effectiveness and outcomes of home visiting. The database houses over 2000 manuscripts that can be filtered by model, outcome, or quality.[5]

According to the 2022 MIHOPE report, home visiting costs between $1,304 and $5,788 per year for the middle half of the families served, depending on how many visits are made, the home visitor's compensation, the program type, and their resource allocation.[6] The report shows that some models, like Nurse-Family Partnership and Early Head Start - Home-based option, consistently cost more than other models like Health Families America and Parents as Teachers. Table 2 reports average cost by type of agency (panel A) and by model (panel B).

Five key elements drive the cost of home visiting programs:

- Target population and age at enrollment
- Program intensity and duration
- Home visitor training
- Supervision of home visitors
- Home visitor qualifications.

Table 2A. Estimated Home Visiting Cost Per Family Per Year by Type of Implementing Agency

Types of Local Implementing Agency	Average Program Costs Per Family Per Year
Health Department	$5,608
Community-Based Nonprofits	$3,347
School Districts	$1,781
Other Types of Agencies	$3,704

Table 2B. Estimated Home Visiting Cost Per Family Per Year by Home Visiting Model

Model	Average Program Costs Per Family Per Year
Nurse-Family Partnership	$5,351
Early Head Start—Home-based Option	$4,808
Health Families America	$3,238
Parents as Teachers	$2,568

FUNDING

As of May 2023, twenty-one states cover home visiting through Medicaid in some capacity.[7]

Home visiting in Missouri is currently being funded by a variety of federal and private sources including MIECHV funds, the Children's Trust Fund of Missouri, the Missouri Department of Elementary & Secondary Education, and several philanthropic organizations.[8]

COST EFFECTIVENESS

According to economists, a successful and well-designed home visiting program can return up to $5.70 per taxpayer dollar invested. This return is possible because home visiting programs have been shown to reduce future costs of poor health and academic failure that a family might experience in the future if they are not enrolled in a home visiting program during pregnancy and postpartum.[9]

MIECHV

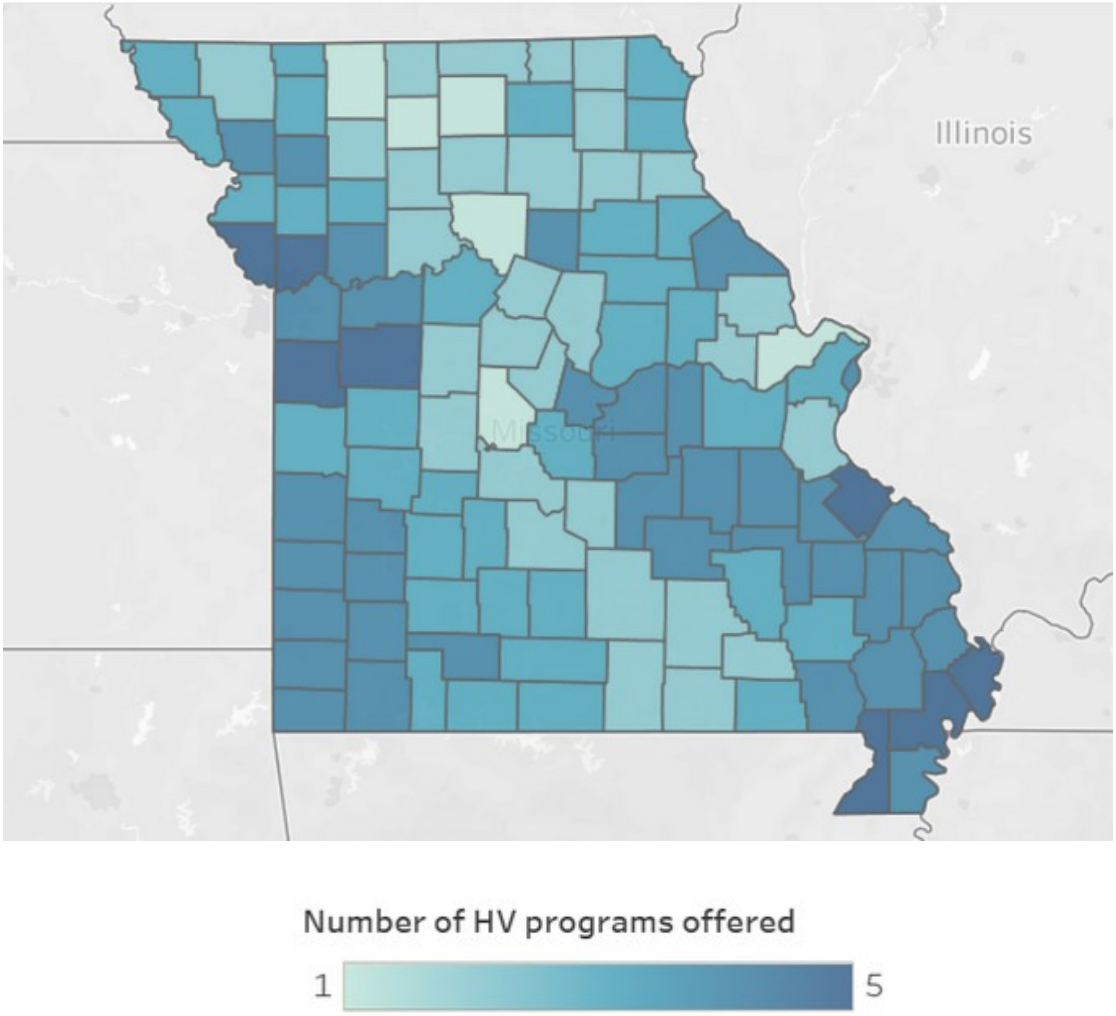
The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is a federal program administered by the Health Resources and Services Administration (HRSA). It was implemented in 2010 to address barriers that pregnant women and parents with young children might face to achieving positive health outcomes during pregnancy, postpartum, and early childhood.[10] As of the 2023 fiscal year, there are 23 home visiting models that are approved for MIECHV funds. Each of the models has met the evidence-based criteria defined by HHS. Each year, MIECHV awards $400 million to states to help pay for their evidence-based programs.[11]

MIECHV was authorized by Congress in 2010, which has allowed the expansion of evidence-based home visiting programs across the United States, specifically those who serve families in areas that have been identified as "high risk."[12] The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is a longitudinal study of the effects of MIECHV-funded home visiting on family and child outcomes. The study exists to examine a broach range of outcomes of home visiting programs, detail the services provided to families and how they vary depending on the family, home visiting agency, stakeholders, etc., identify the financial costs of operating the programs, and analyze the needs assessments provided by states in their initial MIECHV applications.[13]

HOME VISITING IN MISSOURI

Missouri utilizes 8-9 different home visiting models that are administered by a number of agencies across the state.[14] Included are widely recognized models like Parents as Teachers, Healthy Families America, and Nurse-Family Partnership. Other than Parents as Teachers, which is offered in each county in Missouri, the models are typically offered in a small number of Missouri counties. This has resulted in a disparity of access, where people in populated counties in the Kansas City and St. Louis metropolitan areas have access to three, four, or five different home visiting programs, while people in rural counties in some other parts of the state only have access to one or two home visiting programs as shown in Figure 1.

Figure 1. Home Visiting Models Offered by Missouri County



INSIGHTS FROM Q & A SESSIONS

PURPOSE

Q&A sessions facilitated by the Office of Childhood at the Missouri Department of Elementary and Secondary Education were held with home visiting stakeholders in April 2023, with a follow-up in July 2023. Stakeholders included home visitors, home visiting agency representatives, and state agencies. The goal of the April sessions was to gain multiple perspectives on the climate of home visiting in Missouri, to understand challenges faced, and to define the priorities of home visiting agencies and workers. There were four main takeaways from the sessions.

SERVICES

Stakeholders reported that various home visiting models are being used by a number of home visiting agencies in Missouri, meaning that there is a wide variety of services being offered. Many home visiting services are focused on health, e.g. providing screenings, assessments, mental health support, substance abuse support, physical therapy, occupational therapy, and preparation for delivery. Other services focus on education and can have secondary impacts on health. These services include parent education, safety education, nutrition support, lactation consulting, and referrals to additional services. Some home visiting agencies that follow models like Parents as Teachers may focus more on educational services while agencies that follow models like Nurses for Newborns or Nurse-Family Partnership might focus on a select number of health services.

PROVIDERS

Because home visiting agencies in Missouri offer a variety of services, they have to employ a number of different specialists. Community health workers, nurses, social workers, parent educators, dieticians, lactation consultants, mental health workers, physical therapists, occupational therapists, and doulas all come together to serve families and fulfill the goals of their model. Not every agency employs every type of worker mentioned, instead agencies that follow the Parents as Teachers model might employ primarily community health workers and parent educators, while agencies that follow the Nurse-Family Partnership model might employ primarily nurses.

REFERRALS

Agencies have different systems for tracking referrals, and there is no centralized database among agencies. Therefore, knowing definitively where referrals come from and the most popular sources of referrals throughout the state is challenging. Based on discussion during the stakeholder sessions, families are referred to home visiting services through a variety of mechanisms. Stakeholders shared that some of the most common sources of referrals are medical entities such as pediatrician offices, local health departments, hospitals, NICUs, and OB clinics. Another large source of referrals is schools and educators.

MANAGED CARE ORGANIZATIONS

Historically, home visiting agencies and MCOs have not had strong relationships. Because home visiting services aren't currently Medicaid-reimbursed, and there is no contractual agreement between MCOs and home visiting agencies, there is little motive for robust partnerships. Some data cited during the session indicated that a couple of MCOs have made a handful of referrals to home visiting agencies, but there remains a significant potential for a more formal relationship and thus a larger flow of referrals. Additionally, home visiting stakeholders stated that it would be beneficial for them to be more educated on Medicaid plan benefits in order to better equip their clients with resources and services.

MEDICAID POLICY OPTIONS

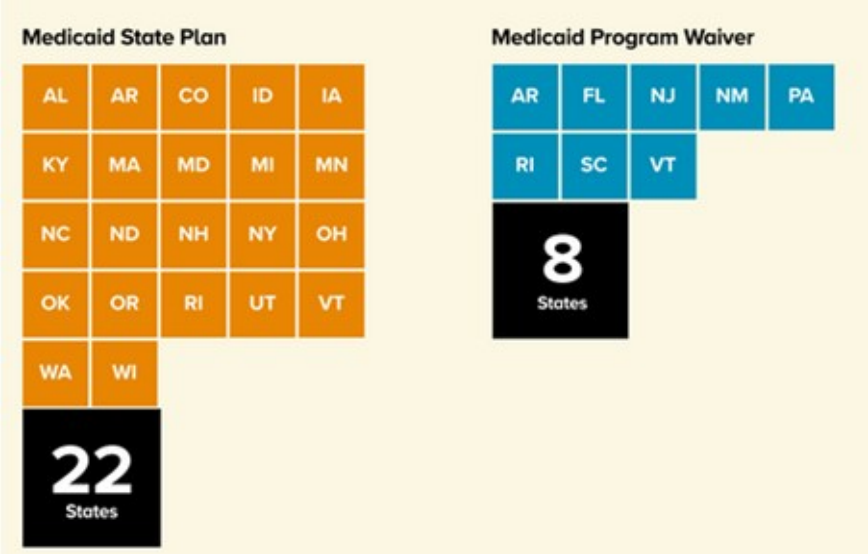
BENEFIT CATEGORY

At the federal level, Medicaid does not have a designated benefit category for home visiting; thus, states must either justify including home visiting services under existing benefit categories in their state plan or submit a program waiver. The most common approach is to place home visiting services under an existing category such as Targeted Case Management (TCM). TCM allows states the flexibility to provide case management services to specific populations who might be at higher risk based on geographic area or medical condition. Other states categorize home visiting services under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) in conjunction with other state plan categories like Extended Services for Pregnant Women, Preventative Services, or Other Licensed Practitioner Services.[15]

If states don't want to define their services in a way that fits under an existing category, they can submit a Medicaid program waiver. This will "waive" certain federal Medicaid requirements that otherwise limit the state's freedom to make decisions about who is eligible to receive services and which services they can be offered. A program waiver is a common approach for states who wish to pilot a new home visiting program or implement a program that is designed specifically for that state and its needs. Figure 2 summarizes this information.

Figure 2. Federal Authorities and Medicaid Benefit Categories Used to Support Home Visiting

Source: Veronnica Thompson, A. H. (2023, May 1). Medicaid reimbursement for home visiting: Findings from a 50-state analysis. NASHP. https://nashp.org/state-medicaid-reimbursement-for-home-visiting-findings-from-a-50-state-analysis/



ELIGIBLE SERVICES

It is important for states to identify which home visiting models they want to support with Medicaid. Almost half of the states only reimburse for a HomVEE-approved model like Nurse Family Partnership, Parents as Teachers, or Healthy Families America.[16] However, states are not required to reimburse for only HomVEE-approved models. It is possible to reimburse for both HomVEE and non-HomVEE-approved models, as do Pennsylvania, Arkansas, and Vermont. This choice recognizes that just because a model isn't approved by HomVEE doesn't mean that it does not provide benefits for the communities it serves.

ELIGIBLE MODELS

Home visiting programs deliver a comprehensive set of services to families, but the most common services include screenings, assessments, health education, development of a care plan, and referrals to services. Additional services might be offered by certain models, like stress management, intimate partner violence screening, substance abuse counseling, and tobacco use screening and cessation education. Deciding which specific home visiting services will be reimbursed by Medicaid is important to avoid duplicating services that may already be covered by Medicaid in another manner or through another authority.

ELIGIBLE POPULATIONS

All states wishing to use Medicaid to finance home visiting must provide specific eligibility criteria for the populations they want to serve. Most states offer home visiting services to mothers from the prenatal period up to 12-24 months after postpartum and to infants from 72 hours after discharge up to age 21. Some states have additional eligibility criteria based on risk factors, geographic location, income, and number of pregnancies.

PROVIDERS

Missouri must clearly define what makes a provider qualified to administer Medicaid-reimbursed home visiting services. There are two general avenues to take when defining provider qualifications. The first is to qualify by the model being used, and the second is to qualify by the individual provider serving the Medicaid participant or family. Qualifying by model means that any provider who has completed training and is approved by a certain home visiting model can be reimbursed by Medicaid for their services. The alternative route is to provide a set of qualifications that each type of provider (e.g. nurse, social worker, community health worker). For example, in Minnesota, home visiting services must be delivered by a Public Health Nurse who has completed a baccalaureate degree, registered with the state of Minnesota, completed specific course work, and paid a small fee.[17] Appropriate compensation rates must be defined based on the provider type, qualifications, the model they work for, and working conditions. For example, a Master's level nurse should be compensated more than a community health worker who holds a 2-year certificate. Additional expenses like drive time and gas compensation should be considered.

PAYMENT SYSTEM

There are several billing and payment mechanisms that states use to implement Medicaid-financed home visiting. The most common approaches are fee-for-service (FFS) and per member per month (PMPM), also known as a global or capitation rate. Using a FFS system, states reimburse providers for each service they provide. More than half the states using Medicaid to finance home visits utilize a FFS structure, including Colorado, Kentucky, Minnesota, New Mexico, Oregon, and Wisconsin. With capitation payments, risk-based payments are made to managed care organizations for a defined set of benefits on an average PMPM basis. A handful of states, including Michigan, Vermont, Arkansas, and Pennsylvania combine FFS and PMPM payment strategies to finance home visiting.[18] Choosing a payment strategy may be dependent on which benefit category a state chooses to use for home visiting, as well as their target population, participation of managed care organizations, and scope of services offered.

CONCLUSION

Home visiting has the potential to make a positive impact on the landscape of infant and maternal health in Missouri. The variety of frameworks available make it possible to customize services to meet a family's need and set them on a pathway to success in the future. Missouri has the opportunity to craft its own unique approach to reimbursing home visiting services through Medicaid, to make the intervention more accessible to more families across the state. Collaboration between MO HealthNet, home visiting agencies, and other home visiting and Medicaid stakeholders is necessary to address each consideration in this report and invest the time to craft the most effective approach with the greatest impact.

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AUTHORS

Celeste Sangster
BA Candidate at the University of North Carolina at Chapel Hill
IPH Summer Program Scholar

Abigail Barker, PhD
Washington University in St. Louis

ACKNOWLEDGEMENTS

This policy paper was produced with the support of the Cora Faith Walker Foundation and the Washington University in St. Louis Institute for Public Health

The views and opinions expressed in this white paper are those of the authors and do not reflect the official policy or position of Washington University.