COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 16, 2021

MEMORANDUM

TO: The Honorable Janet D. Howell
Chair, Senate Finance Committee

The Honorable Luke E. Torian
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Vice Chair, House Appropriations Committee

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services

SUBJECT: Medicaid Home Visiting Workgroup Report

This report is submitted in compliance with the Virginia Acts of the Assembly – Item 313.EEEEEE., which states:

EEEEEE. The Department of Medical Assistance Services (DMAS) shall convene a workgroup and make recommendations on a Medicaid home-visiting benefit to support members' health, access to care and health equity. The workgroup shall include representatives from DMAS, Managed Care Organizations, the Virginia Department of Health, the Department of Health Professions, licensed and unlicensed providers of maternal and child health services, Early Impact Virginia, stakeholder groups, and community organizations. The workgroup shall: (i) analyze federal and state regulations and funding mechanisms impacting establishment of a Medicaid home visiting benefit; (ii) review home visiting strategies and benefits implemented in other state Medicaid programs; (iii) analyze and make recommendations on appropriate services and rates to be included in a Medicaid home visiting benefit; and (iv) project estimated costs over the next five years. The department shall report on the results and recommendations of the workgroup to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by December 1, 2021.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KK/REC
Enclosure
Pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Medicaid Home Visiting Workgroup Report

A Report to the Virginia General Assembly

December 1, 2021

Report Mandate:

The 2021 Appropriation Act, Item 313.EEEEEE. The Department of Medical Assistance Services (DMAS) shall convene a workgroup and make recommendations on a Medicaid home-visiting benefit to support members' health, access to care and health equity. The workgroup shall include representatives from DMAS, Managed Care Organizations, the Virginia Department of Health, the Department of Health Professions, licensed and unlicensed providers of maternal and child health services, Early Impact Virginia, stakeholder groups, and community organizations. The workgroup shall: (i) analyze federal and state regulations and funding mechanisms impacting establishment of a Medicaid home visiting benefit; (ii) review home visiting strategies and benefits implemented in other state Medicaid programs; (iii) analyze and make recommendations on appropriate services and rates to be included in a Medicaid home visiting benefit; and (iv) project estimated costs over the next five years. The department shall report on the results and recommendations of the workgroup to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees by December 1, 2021.

About DMAS and Medicaid

DMAS's mission is to improve the health and well-being of Virginians through access to high-quality health care coverage.

DMAS administers Virginia's Medicaid and CHIP programs for more than 1.8 million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 500,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives a dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90 percent for

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Government Human Services Consulting

Medicaid Home Visiting Workgroup Report

To the Chairs of the House Appropriations and Senate Finance and Appropriations Committees

Commonwealth of Virginia

November 1, 2021

Contents

Section 1

Executive Summary

Home visiting programs are focused, individualized, and culturally competent services for expectant parents, young children and their families. They utilize a research-based strategy, provided within homes and connected communities, dedicated to improving birth outcomes, family self-sufficiency, and children's early potential.

Virginia has a robust network of home visiting models and providers, with over 72 local programs serving communities across the Commonwealth. These home visiting programs represent eight models: Early Head Start Home-Based Option, Family Spirit®, Healthy Families America®, Health Start/Loving Steps, Nurse-Family Partnership®, Parents as Teachers®, Resource Mothers, and Comprehensive Health Investment Project of Virginia. Each model is designed to meet the specific needs of the people who use them and provide the resources and skills required to raise children who are physically, socially, and emotionally healthy.

The Department of Medical Assistance Services (DMAS), as directed by the General Assembly, established a workgroup to assess home visiting models to determine which to recommend for a Medicaid home-visiting benefit to support member's health, access to care and health equity. Over several months, the workgroup reviewed home visiting strategies and benefits in other state Medicaid programs and corresponding federal and state regulations. In addition, the workgroup reviewed funding mechanisms for existing home visiting programs in Virginia and funding approaches utilized across the nation.

In line with nationwide practice, home visiting models that meet the US Department of Health and Human Services (HHS) criteria as evidence-based early childhood home visiting service delivery models that also align with payment methodologies supported by Medicaid are recommended to be included in a Virginia Medicaid home visiting benefit. These HHS evidence-based models have demonstrated outcomes which support the DMAS mission to improve the health and well-being of Virginians through access to high-quality health care coverage:

- Nurse-Family Partnership®
- Family Spirit®
- Healthy Families America®
- Early Head Start Home-based Option

While each model has demonstrated outcomes in maternal and/or child health they use different theoretical approaches and services to target their intended population. Due to the differences in requirements across models, individual reimbursement rates have been developed for each of the recommended home visiting models. Virginia's current home visiting providers' data were utilized to develop rate assumptions. For purposes of consistency, rate development across all models uses the same salary and administration cost percentage. Variation in the rate is driven by staff role requirements, staff ratios, and number of required visits. As such, the per-visit recommended rate by program is:

- Nurse-Family Partnership®: $310.18/visit and 24 annual visits per family
- Family Spirit®: $295.14/visit and 16 annual visits per family
- Healthy Families America®: $305.56/visit and 36 annual visits per family
- Early Head Start Home-Based Option: $132.76/visit and 68 annual visits per family

The cost estimate over a five-year period for home visiting in Virginia is $131,458,937. The five-year estimate anticipates that the four recommended home visiting models will provide services for Medicaid reimbursement to a maximum of 3,328 families annually by year five, in accordance with the requirements of their model. Currently, home visiting programs serve approximately 2,178 Medicaid eligible families in the Commonwealth each year. While Medicaid funding will expand home visiting for pregnant women and young children in Virginia, it will take time for existing programs to enhance their staffing and administration to meet the increased demand. In addition to the existing Medicaid families currently being served through alternative funding sources, within the first five years it is expected that Medicaid funding for home visiting in Virginia will allow service delivery to an additional 1,150 families.

It is important to note that there are approximately 38,000 Medicaid supported births each year in the Commonwealth. Current home visiting capacity can only meet the needs of an estimated 11% of those who may qualify. It is therefore recommended that DMAS initially target the populations to be served by a Medicaid home visiting benefit to ensure the most at-risk families receive this important service.

Section 2
Background

Home Visiting Context

Home visiting programs are focused, individualized, and culturally competent services for expectant parents, young children and their families provided within safe homes and connected communities. While awareness and expectations of home visiting have grown in recent decades, the origins of home visiting can be connected to the public health movement in the 1800s. Since that time, home visiting has developed into a variety of comprehensive models designed for specific populations with targeted outcomes. The underlying goals of these programs are to help families strengthen attachment and encourage optimal development of their children, promote health and safety, and reduce the risk of child maltreatment.

Home visiting programs are based on curricula that support healthy pregnancy and delivery, strong child development, and positive parenting. Common activities include: assessing family needs; developing a care plan; providing education; making service referrals; monitoring developmental progress; providing screenings for developmental benchmarks, maternal health, and child safety; and conducting follow-up. Most home visiting programs also offer parent support activities and coaching, which can include counseling services and referrals along with services to help parents develop skills around stress management, nutrition, child discipline, and nurturing interactions. Each home visiting model is designed to meet the specific needs of the people who use them and provide the resources and skills required to raise children who are physically, socially, and emotionally healthy.

Home visiting staff are varied, and include nurses, social workers, and other providers (often peers) trained in the specific model they support and generally executed by providers based in the community they serve. This connects families to their home visiting provider and facilitates the development of a bond and trust, which is crucial to successful outcomes for home visiting.

In Virginia, home visiting has been identified as a component of the Commonwealth's approach to improving maternal health. Since 2019, Virginia has had a statewide Plan for Home Visiting intended to guide the development of a comprehensive framework for coordination of home visiting program services within the early childhood system to ensure quality service delivery and sustainable growth. In 2021, expanded access to home visiting was referenced in Virginia's Maternal Health Strategic Plan as a community-based strategy to improve availability and access to wrap around services that support pregnant and postpartum women and their families. Against this policy-level backdrop, Virginia has a solid operational network of home visiting models and providers, with nearly 10,000 families partnered with providers in 123 communities across the Commonwealth[1]. This network is currently comprised of eight home visiting models financed through federal, state, and private funds: Early Head Start Home-Based Option, Family Spirit®, Healthy Families America®,

[1] https://earlyimpactva.org/wp-content/uploads/2021/01/Early-Impact-Virginia-Annual-Report-2020.pdf

Healthy Start/Loving Steps, Nurse-Family Partnership®, Parents as Teachers, Resource Mothers, and Child Health Investment Project of Virginia.

Home visiting in Virginia is a public-private partnership. The majority of funding comes from the public sector:

- Federal support includes funding through Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Temporary Assistance for Needy Families (TANF), Head Start and Early Head Start and Child Abuse Prevention
- State support includes state matched funding to federal grants and general fund grants
- Local support may include grants and in-kind support from local Health Districts, agencies and communities

The MIECHV program, administered by the Virginia Department of Health (VDH), provides financial support, intake services, and training for 21 local agencies in Virginia utilizing three models: Parents as Teachers, Healthy Families America®, and Nurse Family Partnership®. VDH also provides grant funding, contract administration, and program management for Resource Mothers. Early Head Start Home-Based Option is funded through federal and state education grants. Family Spirit®, Child Health Investment Project of Virginia, Healthy Families America®, Nurse-Family Partnership®, and Early Head Start Home-Based Option, in addition to federal and state funds, may also have some reimbursement for Medicaid eligible services by local managed care organizations (MCOs). Across all home visiting programs, in 2019, approximately 63% of funding came from federal funds, 22% from localities, 2% from state funds, and 14% from private, third-party, or other sources.[2]

While all eight programs are actively striving to meet the needs of Virginia families, a Medicaid home visiting benefit could provide the opportunity to expand these important services to more families.

General Assembly Mandate

Per 2021 Reconvened Special Session I Acts of Assembly Chapter 552 (Item 313.EEEEEE), the Department of Medical Assistance Services (DMAS) established a workgroup to make recommendations on a Medicaid home visiting benefit to support member's health, access to care, and health equity. The workgroup had representatives from DMAS, Managed Care Organizations, the Virginia Department of Health, the Department of Health Professions, the Department of Social Services, licensed and unlicensed providers of mother and child health services, Early Impact Virginia, stakeholder groups, and community organizations. A list of workgroup members is in Appendix 1. Between August 2021 and October 2021, the workgroup met five times to:

1. Analyze federal and state regulations and funding mechanisms impacting establishment of a Medicaid home visiting benefit.
2. Review home visiting strategies and benefits implemented in other state Medicaid programs.

[2] Early Impact Virginia, SFY 2019-2020 HV Program Funding

3. Analyze and make recommendation on appropriate services and rates to be include in a Medicaid home visiting benefit.
4. Project estimated costs over the next five years.

Stakeholders participated in workgroup meetings through presentations, vigorous discussion, and thoughtful feedback. Information was shared by Early Impact Virginia, Virginia MIECHV, VDH, and each home visiting model. Additionally, ad hoc small group meetings were scheduled with stakeholders to discuss proposals in more detail. Small group meeting outputs were shared with the larger workgroup to ensure the information was consistent and available to all.

Section 3
Environmental Scan

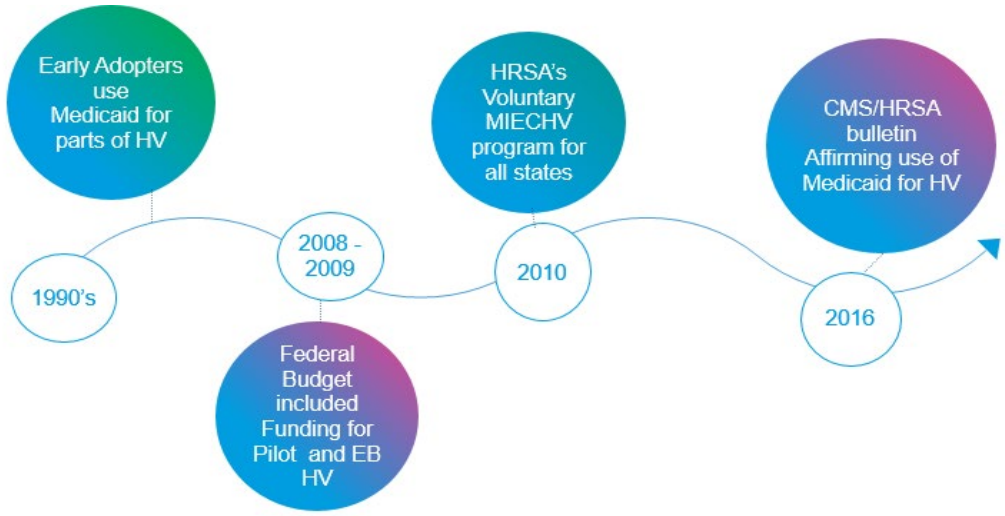
The review of home visiting strategies and benefits implemented in other state Medicaid programs explored state and federal home visiting structures and resources. This environmental scan included a broad look at home visiting models, payment methodologies, and available Medicaid authorities. The final analysis focused on Maternal, Infant, and Early Childhood Home Visiting (MIECHV) models, home visiting models that have met the US Department of Health and Human Services (HHS) criteria as evidence-based early childhood home visiting service delivery models, and payment methodologies supported by Medicaid.

Evidence-Based Home Visiting Models

All 50 states have implemented one or more of the 19 home visiting models considered to be 'evidence-based'. "Evidence-Based Home Visiting" is defined as models established as evidence-based by HHS and eligible for funding from MIECHV. MIECHV provides funds to states, territories, and tribal entities for implementation and ongoing support of MIECHV service delivery models that adhere to federally established evidence-based criteria of effectiveness. These criteria are established by HHS, which launched the "Home Visiting Evidence of Effectiveness" (HomVEE) process for annual review and reporting of models that meet the criteria.

HHS evidence-based home visiting programs have demonstrated positive impact on reducing the incidence of child abuse and neglect, improvement in birth outcomes such as decreased pre-term births and low-birthweight babies, improved school readiness for children and increased high school graduation rates for mothers participating in the program.

Since its inception, private, state and federal monies have been used to support home visiting initiatives. In recent decades, states have looked to expand the reach of their home visiting programs by leveraging Medicaid funding. The graphic below reflects the initiation of state Medicaid funding for home visiting by Oklahoma and Kentucky in the 1990s through to the issuance of the 2016 Centers for Medicare & Medicaid Services (CMS)/Health Resources and Services Administration (HRSA) bulletin affirming use of Medicaid funding for home visiting.



As the timeline indicates, access to targeted federal funding for home visiting has been available nationwide since 2010 under the authority of MIECHV. As noted earlier, the longstanding MIECHV program has developed a centralized framework for evaluation and identification of home visiting models that meet the HHS criteria for evidence-based early childhood home visiting service delivery models. These models are required to demonstrate and report on improvement in four of six established benchmark areas:

- Maternal, newborn and child health
- Child injuries, maltreatment, and reduction of emergency department visits
- School readiness and achievement
- Crime or domestic violence
- Family economic self-sufficiency
- Coordination and referrals for other community resources and supports

The HHS criteria for evidence-based models also require models to meet at least one of the following stipulations:

- One or more impact studies finds statistically significant favorable impacts in two or more of the eight outcome domains.
- Two or more impact studies, using non-overlapping study samples, find one or more statistically significant favorable impacts in the same domain.
- If the findings are based on randomized controlled trial(s) only the impact must be sustained for at least one year.

MIECHV-supported home visiting programs are additionally reviewed annually by HomVEE. The review includes:

- A thorough research/literature review.
- Rating of the quality of impact studies.

- Assessment of effectiveness.
- Identification of implementation requirements and support.

Of the 19 models designated as HHS evidence-based, five models are currently practiced in Virginia:

Model	Available in Virginia
Attachment and Biobehavioral Catch-Up (ABC) -Infant	
Child First	
Early Head Start Home-Based Option	Yes
Early Intervention Program for Adolescent Mothers	
Early Start (New Zealand)	
Family Check-Up® For Children	
Family Connects	
Family Spirit®	Yes
Health Access Nurturing Development Services (HANDS) Program	
Healthy Beginnings	
Healthy Families America (HFA)®	Yes
Home Instruction for Parents of Preschool Youngsters (HIPPY)®	
Maternal Early Childhood Sustained Home-Visiting Program (MECSH)	
Maternal Infant Health Program (MIHP)	
Minding the Baby® Home Visiting (MTB-HV)	
Nurse-Family Partnership (NFP)®	Yes
Parents as Teachers (PAT)®	Yes
Play and Learning Strategies (PALS) Infant	
SafeCare Augmented	

Medicaid Funding

As highlighted in the Background section, home visiting in Virginia is currently supported by a mix of public and private sector funding from the federal, state and local levels. The diversified funding portfolio that currently support the home visiting landscape in Virginia includes funding from:

- MIECHV
- Title V Maternal Child Health Block Grant
- Project Launch

- Families First Prevention Services Act (FFPSA)
- Temporary Assistance to Needy Families (TANF)
- Early Head Start (EHS)
- Matching, general revenue, and other funds

Medicaid reimbursement for home visiting is not expected to replace current sources of funding, but could expand access to home visiting services through a stable funding stream that allows for measured, manageable growth. Since federal law lacks explicit direction on how Medicaid funds can be braided with MIECHV and other funds to supplement and expand services, states, in consultation with CMS, have developed procedures for home visiting programs to prevent duplication of payments for services and to ensure separate accounting for the different funding streams. Typically, states use MIECHV grant funds to pay for operating the program (e.g., travel, personnel time, operating costs, building), while using Medicaid funds only for reimbursement of direct services provided to Medicaid members (e.g., home visit with client).

The table below reflects states that have implemented one or more of the five HHS evidence-based models currently available in Virginia. The black X denotes that a model is practiced in the state, the green **X** denotes that the model is practiced in that state and uses Medicaid for some of the funding for the selected model.

STATE	Early Head Start Home-based option	Family Spirit®	Healthy Families America®	Nurse-Family Partnership®	Parents as Teachers®
CA	X	X	**X**	**X**	X
CO	X		X	**X**	X
IL	X	X	X	****X**	X
MD	X	X	****X**	****X**	X
MI	X		X	**X**	X
MN	X	**X**	**X**	**X**	X
NH	X		**X**		
NM	X	X		****X**	****X**
NY	X		****X**	****X**	X
NC	X		X	****X**	X
OH	X		****X**	****X**	X
OK	X	X	X	**X**	**X**
OR	**X**	X	**X**	**X**	**X**
RI	X		**X**	**X**	X
SC	X		X	**X**	X
SD	X	X		****X**	X

STATE	Early Head Start Home-based option	Family Spirit®	Healthy Families America®	Nurse-Family Partnership®	Parents as Teachers®
WI	X	X	X	X	X

X = non-Medicaid funding
X = Combination of Medicaid and other funding
** = Pilot/demonstration/not statewide

SOURCE: NHVRC 2021 YEARBOOK

A 2016 CMS Informational Bulletin affirmed states ability to cover many of the individual component services of home visiting programs through existing Medicaid state plan amendment (SPA) coverage authorities. With limited exceptions, any new service being considered for coverage under Medicaid needs to fit within the definition of a statutorily defined service. However, there is no single Medicaid state plan service called Home Visiting. The 2016 CMS Information Bulletin described several authorities under which Medicaid funding can be accessed including as a State Plan benefit, under a 1915(b) or (c) waiver, and under Managed Care. While some states are using demonstration waivers to design and cover home visiting – as noted in the Table above – most states have submitted SPAs to do so. Several State Plan benefit categories include services that may be furnished as part of a home visiting program, including:

- Case Management Services: Services that assist eligible individuals to gain access to needed medical, social, educational, and other services.
- Other Licensed Practitioner: Defined as, “medical or remedial care or other services, other than physicians’ services, provided by licensed practitioners within the scope of practices as defined under state law.”
- Preventive Services: Defined as 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.
- Rehabilitative Services: Services that 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.
- Therapy Services: Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit. Optional services include: physical therapy, occupational therapy, speech pathology, and audiology services.
- Home Health Services: Mandatory Benefit that must be ordered by a physician according to a written plan of care. Mandatory components include: nursing services, home health aide services, and durable medical equipment.

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: 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). 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 Home: Allows states to implement Health Homes for beneficiaries with chronic conditions and 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.

Section 4

Recommended Benefit Design

The recommendation for Benefit Design is a result of an iterative process that incorporated review of the home visiting landscape in Virginia, evaluation of the environmental scan and stakeholder feedback. Current funding of home visiting, the desired timeline for implementation, and infrastructure requirements for oversight and monitoring also informed the recommendation. Two options for the benefit design and rate-setting were considered:

Option 1 – HHS evidence-based programs with demonstrated impacts to maternal or child health	Option 2 – All existing Virginia home visiting programs
• **Healthy Families America®** • **Nurse Family Partnership®** • **Early Head Start Home Based Option** • **Family Spirit®**	• **Healthy Families America®** • **Nurse Family Partnership®** • **Early Head Start Home Based Option** • **Family Spirit®** • **Parents as Teachers** • **Child Health Investment Project** • **Resource Mothers** • **Healthy Start/Loving Steps**

Option 1 was identified as the benefit design that is most feasible for timely implementation and leverages existing home visiting infrastructure (oversight and monitoring). HHS evidence-based models provide the required information to outline provider certification. They are also associated with a national organization that provides training, technical assistance and support, which may include performance standards, reporting requirements, data analysis, and other review processes. Additionally, they have ongoing minimum education requirements and pre-service training for staff. This support ensures local implementing agencies meet fidelity guidelines. It also ensures that the model detail needed to develop rates is easily accessible and consistent across providers for each model.

The current estimated capacity for the four home visiting programs included in Option 1 is 4,356. Of the estimated 4,356 families, the home visiting providers within the workgroup estimated that half, or 2,178 members, are eligible for Medicaid.

Option 2 would require development of provider certification and oversight/monitoring criteria. As such, it may also require that DMAS or another party add more staff to provide oversight and monitoring. To develop rates for the non-HHS evidence-based models, more information on criteria for the models would be required. In particular, provider type, visit cadence and amount per family, visit length, target population, and target outcomes. Lastly, depending on approach to implementation, DMAS may have additional costs compared to Option 1 to support the state role in administration.

The current estimated capacity for the seven home visiting programs included in Option 2 is 7,248. Of the estimated 7,248 families, the home visiting providers within the workgroup estimated that half, or 3,624 members, are eligible for Medicaid.

Both options would require additional administrative DMAS resources to implement. Under Option 1, required resources include three additional full-time staff members to aid in program development and coordinate/implement an operationalization plan, and one-time costs to refine rate development and engage a national home visiting consultant to provide technical assistance. Option 2 would require additional costs beyond those of Option 1 to support development of provider certification and oversight/monitoring criteria and a mechanism to conduct ongoing oversight and monitoring.

Evidence-Based Home Visiting Models

The evaluation and selection of home visiting models to include in the rate setting process prioritized models that meet the HHS criteria for evidence-based home visiting (as previously noted there are 19 models with this designation). HomVEE determination of evidence-based practice is used as the standard because the process is consistent and applies rigorous standards across identified domains, allowing for cross program comparison.

Additionally, HomVEE has reviewed published research and identified which models have demonstrated favorable outcomes across eight identified domains:

- Maternal Health
- Child Health
- Child Development & School Readiness
- Family Economic self-sufficiency
- Linkages and Referral
- Positive Parenting Practices
- Reductions in Child Maltreatment
- Reductions in Juvenile Delinquency, Family Violence, and Crime

Models are not required to show favorable outcomes in all eight domains in order to be deemed evidence-based. As such, the workgroup reviewed those models with consideration of MIECHV expectations, to ensure the model(s) selection can:

1. Meet the needs of the identified at-risk communities and/or any specific target populations.
2. Provide the best opportunity to achieve meaningful outcomes in benchmark areas and measures.
3. Be implemented effectively with fidelity to the model in Virginia based on available resources and support from the national model developer.

It was noted that the model(s) selected should also be well-matched to the needs of the state's early childhood system. **The mission of DMAS is improving the health and**

well-being of Virginians through access to high-quality health care coverage. As such, the recommended benefit design includes only those home visiting models that have demonstrated favorable outcomes in the Maternal and/or Child Health domains, as determined by HomVEE: Early Head Start Home-Based Option, Family Spirit®, Healthy Families America® and Nurse-Family Partnership®.

Early Head Start Home-Based Option[3]
Provides individualized services to pregnant women, infants, and toddlers to promote the school readiness of young children from low-income families. The model is administered by the Office of Head Start in HHS' Administration for Children and Families. Early Head Start promotes the school readiness of low-income children from birth to three years old by enhancing their cognitive, social, and emotional development.
Favorable Impact: Maternal Health As well as: Child Development and School Readiness, Family Economic self-sufficiency, Linkages and Referral, and Positive Parenting Practices

Family Spirit® [2]
An evidence-based, culturally tailored home visiting program of the Johns Hopkins Center for American Indian Health. The model promotes optimal health and well-being for parents and their children. It combines the use of paraprofessionals from the community as home visitors and a culturally focused, strengths-based curriculum as a core strategy to support young families. Parents gain knowledge and skills to promote healthy development and positive lifestyles for themselves and their children.
Favorable Impact: Maternal Health As well as: Child Development and School Readiness and Positive Parenting Practices

Healthy Families America® [2]
Healthy Families America® seeks to build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth. Additionally, the model aims to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors.
Favorable Impact: Maternal Health and Child Health As well as: Child Development & School Readiness, Family Economic self-sufficiency, Linkages and Referral, Positive Parenting Practices, Reductions in Child Maltreatment and Reductions in Juvenile Delinquency, Family Violence, and Crime.

Nurse-Family Partnership® [2]
Nurse-Family Partnership® seeks to improve participants' lives in three key areas: pregnancy outcomes (by helping women improve prenatal health), child health and development (by helping parents provide sensitive and competent caregiving), and parents'

[3] https://homvee.acf.hhs.gov/

Nurse-Family Partnership ® [2]
life trajectories (by helping them develop a vision for their future, plan subsequent pregnancies, continue their education, and find work).
Favorable Impact: Maternal Health and Child Health As well as: Child Development & School Readiness, Family Economic self-sufficiency, Positive Parenting Practices, Reductions in Child Maltreatment and Reductions in Juvenile Delinquency, Family Violence, and Crime.

Medicaid Funding

As previously noted the comprehensive review of options available for Medicaid funding for home visiting included consideration of authorities and benefit design. Based on this review, it is recommended that Virginia authorize the use of targeted case management for selected home visiting models under the Medicaid State Plan. The use of targeted case management is the approach most commonly seen in other states for Medicaid home visiting funding and allows Virginia to target a geography or group of Medicaid eligible individuals. Virginia already uses the targeted case management benefit for other services, and, in a limited way, for some components of home visiting. Therefore, planning and development should be able to build upon the current benefit and billing structure, which could allow for timelier implementation.

The environmental scan and workgroup activities identified several considerations that should be reviewed prior to implementation of a Virginia Medicaid home visiting program:

- DMAS development of the targeted case management (TCM) home visiting Medicaid benefit would need to ensure that it adheres to federal Medicaid requirements, including coordination with other services using TCM. This includes review of existing billing structure, rates and codes. Once the TCM benefit structure is outlined, DMAS billing systems would need to be updated to include any modifications to the existing TCM billing structure.
- DMAS identification of provider requirements and enrollment processes for Medicaid billing. Once established, each home visiting provider that is seeking reimbursement through Medicaid would need to follow the enrollment process before being able to bill Home Visiting services to Medicaid.
- Increased demand for services may require additional support to increase capacity and workforce development from DMAS. Support could include: hiring additional DMAS support staff to manage Home Visiting provider requests, or ongoing monitoring of the home visiting program.
- Home visiting providers may need to develop relationships between managed care organizations.
- Significant interagency coordination between DMAS and VDH and collaboration with home visiting agencies will need to be supported to ensure appropriate implementation, braiding of funds, and oversight.

This report recommends possible approaches and target populations for a Virginia Medicaid home visiting benefit. Following legislative guidance and budget details for a Virginia

Medicaid home visiting benefit, DMAS will reengage stakeholders to determine implementation details. It is estimated that an implementation phase would need approximately one year to appropriately address the considerations listed above. Incorporation of these considerations can help with the thoughtful and comprehensive development of the design and implementation of a Virginia Medicaid Home Visiting Benefit.

Section 5

Recommended Reimbursement Rates: Including Analysis of Rate Development

Recommended Reimbursement Rates

All HomVEE HHS evidence-based home visiting models must follow strict staffing and implementation requirements as designated for their model. These include specific controls for services, visit cadence and length, staff education and experience, supervision requirements, and staff ratio. As such, each model has varying staffing and visit frequency conditions to achieve optimal results. Due to the differences across models, individual reimbursement rates have been developed for each of the recommended home visiting models. Additionally, rates were developed based on costs to provide direct services, as opposed to costs to operate the program, in adherence with federal government guidance on how Medicaid funds should be utilized. This practice was incorporated into the rate development and recommendation for this report.

The home visiting models included in the recommended benefit design would be tied to the following per-visit reimbursement rates:

Models included in Option 1:

- Nurse-Family Partnership®: $310.18/visit and 24 annual visits per family
- Family Spirit®: $295.14/visit and 16 annual visits per family
- Healthy Families America®: $305.56/visit and 36 annual visits per family
- Early Head Start Home-Based Option: $132.76/visit and 68 annual visits per family

Additional Models included in Option 2:

- Parents as Teachers: $164.35/visit and 18 annual visits per family
- Child Health Investment Project: $164.35/visit and 18 annual visits per family (assumption that Child Health Investment Project adheres to Parent as Teachers model requirements)
- Healthy Start/Loving Steps : $164.35/visit and 18 annual visits per family (assumption that Healthy Start/Loving Steps adheres to Parent as Teachers model requirements)
- Resource Mothers: $174.85/visit and 16 annual visits per family

Annual visits per family in accordance with model fidelity were utilized to estimate the total Medicaid capacity of the home visiting provider. The estimate assumes that a provider is working at full capacity to serve its share of Medicaid families. If a provider has fewer visits

annually per family then required by their model, it is assumed their free capacity will be utilized to serve a higher number of families.

Additional details on the inputs and assumptions built into these rates are provided in Appendix 4.

Analysis of Appropriate Rates

Several criteria informed the analyses of appropriate reimbursement rates for each home visiting model. These criteria included:

- Market data on home visiting services in Virginia: A survey of workgroup participants collected data on current home visiting providers in Virginia. 53 surveys were collected for eight different home visiting models. Data were collected and validated against health care industry cost standards to be considered in the rate development process. The data collected included:
  - Staffing structure
  - Salaries and Fringe Benefit costs per position
  - Program Operating costs, including: travel, rent, office expenses, program supplies, and client support materials per family
  - Initial Training Costs
  - Recurring Certification Costs
  - Unlisted costs related to operating a home visiting program
  - Capacity limits
- Benefit package structure and reimbursement rates for home visiting services in other Medicaid programs, described in prior sections of the report.
- Prescribed requirements for staffing structure and minimum visit requirements for each home visiting model to align with MIECHV best practices.

Considerations on Recommended Benefit Design and Reimbursement Rates

While DMAS' goal is to provide home visiting services for all Medicaid eligible families who could benefit, existing capacity restricts the number of families that can be served initially by home visiting funded through Medicaid. In 2019, Virginia's Medicaid program covered approximately 38,000 births, with 28,600 under Managed Care and 8,600 under Fee-for-Service. While Medicaid funding can support the expansion of existing home visiting providers programs to serve a greater population of Medicaid members, it will take time for providers to increase their staffing to meet this increased demand. In order to target the highest need population first, the Home Visiting workgroup discussed specific populations to possibly prioritize initially. Possible areas of prioritization include:

Maternal health:

- Medicaid eligible mothers with pre-natal and post-natal depression and other mental health conditions
- Medicaid eligible mothers who are 21 and younger
- Medicaid eligible mothers with chronic health conditions
- Medicaid eligible mothers with a history of or current substance use disorder (SUD)

Child health:

- Medicaid eligible children admitted to NICU

Specific geographies:

- Medicaid eligible mothers and children living in zip codes with the least resources and highest need

Section 6

Five Year Estimated Costs

Option 1: HHS Evidence-Based Programs with Demonstrated Impacts to Maternal or Child Health — Detailed Rates

Within the first five years of the home visiting program, the number of Medicaid families served annually is expected to increase from an estimated 2,178 to 3,328. The table below summarizes the estimated five-year budget impact for services delivered to Medicaid members by home visiting models included within Option 1. Families served is built on provider capacity and model requirements for visit cadence. Note that these estimated dollar impacts reflect medical costs of delivering services and do not include administrative costs that would be incurred by DMAS to implement a home visiting benefit (e.g., three additional personnel, engagement of a national home visiting consultant and a consultant to continue rate development and forecasting efforts, and indirect costs to cover administrative functions such as undertaking informational systems changes).

Total 5 Year Budget Impact		
Year	**Families Served**	**Dollar Impact**
Year 1	2,178	$21,683,417
Year 2	2,287	$22,767,588
Year 3	2,538	$25,272,022
Year 4	2,874	$28,607,929
Year 5	3,328	$33,127,982
Total	**13,204**	**$131,458,937**

The present model factors in ramp-up challenges and projects a 5% growth of Medicaid families served from year one to year two. As home visiting providers establish relationships with the MCOs and provider referral networks in year three and beyond, the growth of Medicaid families served is projected to increase by approximately 10% - 16%.

While the home visiting models have demonstrated positive outcomes on maternal and child health, recognizable savings would not be realized immediately and have not been accounted for in the five year budget estimate. HHS is exploring research to better support the impact of home visiting and the return on investment.

Appendix E provides further detail on the estimated budget impact by model for Option 1.

Option 2: All Existing Virginia Home Visiting Programs; Estimated Rates and Expenses

As noted above, Option 2 would require development of provider certification and oversight/monitoring criteria.

In addition to the rates developed for the models included in Option 1, rates were developed for Parents-as-Teachers (PAT), Child Health Investment Project (CHIP), Resource Mothers, and Healthy Starts/Loving Steps based on market data. The assumption for these estimated rates is CHIP and Health Starts/Loving Steps adhere to the PAT model requirements.

With the inclusion of PAT, CHIP, Healthy Starts/Loving Steps, and Resource Mothers, Medicaid families served during the first five years of the home visiting program is expected to increase from an annual rate of 3,624 to an annual rate of 5,537. This increase would have an estimated five-year budget impact of $157,127,722. Appendix F provides further detail on the estimated budget impact by model for Option 2.

Section 7
Conclusion

A Medicaid home visiting benefit could greatly enhance members' health, access to care and health equity. HHS evidence-based home visiting have demonstrated positive impacts on maternal and newborn health, family economic self-sufficiency, school readiness and achievement, as well as reductions in child injuries, abuse, neglect, and domestic violence. It is for this reason that four HHS evidence-based home visiting models are recommended as the Medicaid home-visiting benefit in Virginia. The per-visit suggested rate by model is:

- Nurse-Family Partnership®: $310.18/visit and 24 annual visits per family
- Family Spirit®: $295.14/visit and 16 annual visits per family
- Healthy Families America®: $305.56/visit and 36 annual visits per family
- Early Head Start Home-Based Option: $132.76/visit and 68 annual visits per family

With consideration of current capacity and challenges to increase staffing to meet increased demand, the fiveyear estimate considers an achievable growth rate over the five-year projection. In this framework, it is estimated that families served will increase from 2,178 in year one to 3,328 in year five. The five year costs estimate for the medical costs of delivering home visiting services in Virginia is $131,458,937.

Successful implementation will also require that DMAS have the resources necessary for benefit design and administration. These resources, including staffing and time, will be needed to ensure that the benefit design leverages and builds upon existing frameworks, avoids duplication, minimizes program and provider burden and meets the goal for supporting member's health, access to care, and health equity.

Appendix A
Workgroup Members

Workgroup Members:
Active Visiting Programs
• Laurel Aparicio, Director, Early Impact Virginia • Dawn Ault, Executive Director, Virginia Head Start Association • Reagan Eshleman, Director, Health Families Virginia (Families Forward Virginia) • Jaime Fuquay, Government Affairs Manager South, Nurse-Family Partnership • Mylinda Moore, Director, CHIP of Virginia (Families Forward Virginia) • Sheri Parcell, Director, Parents as Teachers (Families Forward Virginia)
Department of Health
• Andelicia Neville, Early Childhood Unit Supervisor-Healthy Start • Brendan Rivenbark, Senior Policy Analyst • Consuelo Staton, Director, Resource Mothers
Community Organizations
• Stephanie Spencer, Executive Director, Urban Baby Beginnings (represents unlicensed providers) • Michon Blowe, Director, Heart in Home
Managed Care Organizations
• John Muraca, Executive Director, United Healthcare • Jennie Reynolds, President, Anthem • Randy Ricker, President, Optima
Department of Social Services
• Gena Berger, Chief Deputy Commissioner, • Elizabeth Lee (Alternate)
Department of Health Professionals
• Jay Douglas, Executive Director, Board of Nursing
Representative of Licensed providers
• Elizabeth Wolf, Pediatrician
Department of Medical Assistance Services
• Chethan Bachireddy, Chief Medical Officer • Cheryl Roberts, Deputy of Programs and Operations

Appendix B
Meeting Attendees

Department of Medical Assistance Services
Tina Weatherford, DMAS
Chethan Bachireddy, DMAS
Cheryl Roberts, DMAS
Adrienne Fegans, DMAS
Kimberly Moulden, DMAS
Cartier Smith, DMAS
Andrew Mitchell, DMAS

United Health Care
Shane Ashby, UHC
John Muraca, UHC

Early Impact VA
Laurel Aparicio, Early Impact VA
Jacque Hale, Early Impact VA

Virgina Department of Health
Andelicia Neville, VDH
Conseulo Staton, VDH
Robin Buskey, VDH
Kathy Lewis, VDH
Kelly Dodson, VDH

Families Forward Virginia
Mylinda Moore, Families Forward VA
Reagan Eshleman, Families Forward VA
Sheri Parcell, PAT, Families Forward VA
Michelle Powell, Families Forward VA
Jamia Crockett, Families Forward VA

Head Start Virginia
Dawn Ault, Head Start VA
Melissa Palombi, Head Start VA

Department of Social Services
Gena Berger, DSS
Jessica Liston, DSS

Office of the Governor
Rachel Becker, Office of the Governor
Vanessa Walker Harris, Office of the Governor

Children Health Investment Program
Trish O'Brien, CHIP SHR

Robin Haldiman, CHIP RV
Jon Nafziger, CHIP

Chesterfield County Mental Health Support Services
Melissa Ackley, LCSW - Chesterfield County Mental Health Support Services
Ashley Rogers, Chesterfield/Colonial Heights County Mental Health Support Services

Others
Jennie Reynolds, Anthem
Brenden Rivenbark, AVDH
Jay Douglas, DHP
Elizabeth Wolf, VCU Health
Stephanie Spencer, Urban Baby Beginnings
Carla Javier, CDR
Taundwa Jeffries, DOE
Kay Johnson, Johnson GCI
Doug Gray, VAHP
Jaime Fuquay, NFP
Randy Ricker, Sentara
Sherry Win, Piedmont CSB
Debbie Bullis, Sentara
Lisa Forrester
Melodie Jennings, HFRA
Olivia Brown
Michon Blowe, Heart in Home
Nicole Lawter
Williams Mullen
Isha Barrie, NVFS
Brook Porter, HNNCSB
Ashley Graham, HumanKind

Appendix C

Overview of Workgroup Meetings

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Agenda

Virginia Home Visiting Workgroup: Kick off and Approach Overview

Zoom

August 12, 2021

3:00–4:30 pm ET

Time	Topic	Lead
3:00 pm	Welcome/introductions	Shannon Kojasoy/All
3:10 pm	Overview on workgroup meeting plan and process • Review plan and timeline • Approach to rate development • Outreach to workgroup members/data requests	Shannon Kojasoy/ Elizabeth Zagami
3:30 pm	Overview of Home Visiting • Models • Non-Medicaid funding sources and approaches • Medicaid funding	Kay Johnson
4:00 pm	Open Discussion • Questions/feedback on today's agenda • Requests for information for future meetings • Recommended agenda topics/focus areas to include in future discussions •	Shannon Kojasoy/All
4:25 pm	Next Steps • Data request • Next meeting: August 26 — Analyze and make recommendations on appropriate services to be include in Medicaid Home Visiting benefit	Shannon Kojasoy
4:30 pm	Meeting Adjourn	

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Agenda

Virginia Home Visiting Workgroup: Medicaid funding requirements and authorities

Zoom

August 26, 2021

3:00–4:30 pm ET

Time	Topic	Lead
3:00 pm	Workgroup Overview: guiding principles	Shannon Kojasoy
3:05	Welcome	Cheryl Roberts
3:10	Home Visiting Vs. Care Coordination	Liz Collins
3:25	Virginia Home Visiting Structure	Laurel Aparicio
3:40	Medicaid Basic Funding Overview	Shannon Kojasoy
3:45	Medicaid Authorities Overview	Debbie Anderson
4:00	Open Discussion • Questions/feedback on today's agenda • Requests for information for future meetings • Recommended agenda topics/focus areas to include in future discussions	Shannon Kojasoy/All
4:25	Next Steps • Next meeting September 9: Review and recommend Home visiting Models to be included in 'projected estimated costs'	Shannon Kojasoy
4:30 pm	Meeting Adjourn	

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Agenda

Virginia Home Visiting Workgroup: MIECHV Evidence-Based Models, Rates

Zoom

September 16, 2021

3:00–4:30 pm ET

Time	Topic	Lead
3:00 pm	Workgroup Overview: guiding principles	Shannon Kojasoy
3.05	Welcome	Cheryl Roberts/Chethan Bachireddy
3:10	MIECHV Evidence Based Models • Review models provided in VA • Assess outcomes of models	Liz Collins
3:25	Considerations for Model Selection • Selection of models • Discussion	Shannon Kojasoy
3:40	5 year estimate and rate development • Staffing ratios and case loads • Current distribution and other considerations • Home Visiting Provider Questionnaire Surveys	Lizzy Zagami
4:00	Open Discussion	Shannon Kojasoy/All
4:25	Next Steps • Next meeting October 6: Rate approach and estimates	Shannon Kojasoy
4:30 pm	Meeting Adjourn	

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Agenda

Virginia Home Visiting Workgroup: MIECHV Evidence-Based Models, Rates

Zoom

October 6, 2021

3:00–4:30 pm ET

Time	Topic	Lead
3:00 pm	Welcome	Dr. Chethan Bachireddy/Cheryl Roberts
3:05	Workgroup Overview: guiding principles • Summary of feedback and key themes	Shannon Kojasoy
3:15	MIECHV in VA	Andelicia Neville
3:20	Small Breakout Rooms and Report Out • What populations should be prioritized for Medicaid funding for home visiting? • Should other populations be phased in over the next 5 years?	All
3:45	National Overview of Home Visiting Funding	Liz Collins
3:55	Overview of Model Options for 5 year Estimate	Shannon Kojasoy
4:00	Rate development • Fiscal assumptions • Formula	Lizzy Zagami
4:20	Budget Proposal Update	
4:25	Next Steps • Next meeting October 13: Provider considerations	Shannon Kojasoy
4:30 pm	Meeting Adjourn	

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Agenda

Virginia Home Visiting Workgroup: Provider Considerations and 5 Year Estimate

Zoom

October 13, 2021

10:00–11:30 am ET

Time	Topic	Lead
10:00	Workgroup Overview: guiding principles • Summary of feedback key themes	Shannon Kojasoy
10:10	Medicaid Providers Overview	Debbie Anderson
10:20	MIECHV and VDH overview	Andelicia Neville and Consuelo Staton
10:30	HFA, NFP, PAT, CHIP, and Family Spirit Panel • Questions and discussion	Melodie Jennings, Stephanie Spencer, Kim Smith, Meredith Taylor, and Mylinda Moore
10:55	5 year estimates • Targeted populations/first come first serve	Lizzy Zagami
11:15	Report Framework • Overview • Timeline for feedback	Shannon Kojasoy
11:25 am	Closing	Dr. Chethan Bachireddy
11:30 am	Meeting Adjourn	

Appendix D

Rate Development Inputs and Assumptions

All models will use the same salary and admin cost percentage in the rate development. Variation in the rate will be driven by:

- Staff role requirements
- Staff ratios
- Number of required visits

Salary and Administrative Cost Assumptions

Description	Models Impacted	Assumptions
Home Visitors - Nurses	NFP	$96,000
Home Visitors - High School Degree	FS, HFA, EHS	$50,000
Supervisors - Nurses	NFP	$115,200
Supervisors	FS, HFA	$85,000
Family Resource Staff	HFA	$50,000
Program Manager	HFA	$85,000
Education Manager	EHS	$60,000
Child and Family Services Manager	EHS	$60,000
Administrative Support	All	$50,000
Admin Cost Percentage	**All**	**20%**

Visit Assumptions

	Description	NFP	FS	HFA	EHS (HBO)	RM	PAT/ CHIP
A	Home Visitors per Team	8	8	3	8	7	12
B	Required Families per Home Visitor	25.0	22.5	25.0	12.0	30.0	33.0
C	Estimated Visits per Home Visitor	38.13	22.50	56.25	51.00	52.20	50.00
D	Required Monthly Visits per Family	2.03	1.33	3.00	5.67	1.74	1.5
E	Vacancy Rate	25%	25%	25%	25%	25%	25%
F	Estimated Actual Visits	1.53	1.00	2.25	4.25	1.31	1.13
G	**Total Visits Per Month (A * B * F)**	**305.0**	**180.0**	**168.8**	**408.0**	**274.1**	**450.0**

Option 1 – Proposed Rates

Model	Per Visit Rate
NFP	$310.18
FS	$295.14
HFA	$305.56
EHS (HBO)	$132.76

Option 2 – Proposed Rates

Model	Per Visit Rate
NFP	$310.18
FS	$295.14
HFA	$305.56
EHS (HBO)	$132.76
RM	$174.85
PAT/CHIP	$164.35

Appendix E
Five Year Estimated Cost

Option 1: HHS evidence-based programs with demonstrated impacts to maternal or child health:

- Healthy Families America®
- Nurse Family Partnership®
- Early Head Start Home Based Option
- Family Spirit®

Year	Dollar Impact
Year 1	$21,683,417
Year 2	$22,767,588
Year 3	$25,272,022
Year 4	$28,607,929
Year 5	$33,127,982
Total	**$131,458,937**

	Year 1		Year 2		Year 3	
Model	**Estimated Members Served**	**Dollar Impact**	**Estimated Members Served**	**Dollar Impact**	**Estimated Members Served**	**Dollar Impact**
NFP	200	$1,513,667	210	$1,589,350	233	$1,764,179
FS	100	$472,222	105	$495,833	117	$550,375
HFA	1,391	$15,301,000	1,461	$16,066,050	1,621	$17,833,316
EHS (HBO)	487	$4,396,528	511	$4,616,354	568	$5,124,153
Total	**2,178**	**$21,683,417**	**2,287**	**$22,767,588**	**2,538**	**$25,272,022**

	Year 4		Year 5		Total	
Model	**Estimated Members Served**	**Dollar Impact**	**Estimated Members Served**	**Dollar Impact**	**Estimated Members Served**	**Dollar Impact**
NFP	264	$1,997,050	306	$2,312,584	1,213	$9,176,829
FS	132	$623,025	153	$721,462	606	$2,862,917
HFA	1,835	$20,187,313	2,125	$23,376,909	8,433	$92,764,587
EHS (HBO)	643	$5,800,541	744	$6,717,027	2,953	$26,654,603
Total	**2,874**	**$28,607,929**	**3,328**	**$33,127,982**	**13,204**	**$131,458,937**

Option 2: All existing Virginia home visiting programs:

- Nurse Family Partnership®
- Family Spirit®
- Healthy Families America®
- Early Head Start Home Based Option
- Resource Mothers
- Parents as Teachers
- Child Health Investment Project
- Healthy Start/Loving Steps

Year	Dollar Impact
Year 1	$25,917,339
Year 2	$27,213,206
Year 3	$30,206,659
Year 4	$34,193,938
Year 5	$39,596,580
Total	**$157,127,722**

	Year 1		Year 2		Year 3	
Model	**Estimated Members Served**	**Dollar Impact**	**Estimated Members Served**	**Dollar Impact**	**Estimated Members Served**	**Dollar Impact**
NFP	200	$1,513,667	210	$1,589,350	233	$1,764,179
FS	100	$472,222	105	$495,833	117	$550,375
HFA	1,391	$15,301,000	1,461	$16,066,050	1,621	$17,833,316
EHS (HBO)	487	$4,396,528	511	$4,616,354	568	$5,124,153
RM	199	$544,881	209	$572,125	232	$635,059
CHIP	685	$2,026,458	719	$2,127,781	798	$2,361,837
PAT	332	$982,167	349	$1,031,275	387	$1,144,715
HS/LS	230	$680,417	242	$714,438	268	$793,026
Total	**3,624**	**$25,917,339**	**3,805**	**$27,213,206**	**4,224**	**$30,206,659**

	Year 4		Year 5		Total	
Model	**Estimated Members Served**	**Dollar Impact**	**Estimated Members Served**	**Dollar Impact**	**Estimated Members Served**	**Dollar Impact**
NFP	306	$2,312,584	1,213	$9,176,829	1,213	$9,176,829
FS	153	$721,462	606	$2,862,917	606	$2,862,917
HFA	2,125	$23,376,909	8,433	$92,764,587	8,433	$92,764,587
EHS (HBO)	744	$6,717,027	2,953	$26,654,603	2,953	$26,654,603
RM	304	$832,471	1,206	$3,303,422	1,206	$3,303,422
CHIP	1,047	$3,096,028	4,153	$12,285,705	4,153	$12,285,705
PAT	507	$1,500,557	2,013	$5,954,531	2,013	$5,954,531
HS/LS	303	$897,705	351	$1,039,542	1,394	$4,125,127
Total	**4,781**	**$34,193,938**	**5,537**	**$39,596,580**	**21,971**	**$157,127,722**

Appendix F
Comments from Workgroup Members on the Recommendation

Feedback from United Healthcare Community Plan of Virginia:

- We agree home visiting services should be coordinated through the MCOs. This will ensure coordination with existing benefits, facilitate a smooth implementation, and safeguard program integrity.
- We appreciate the wide range of home visiting programs and fully support taking advantage of existing programs in the Commonwealth. Given the need to demonstrate program efficacy to the Virginia General Assembly, we recommend limiting the benefit to programs that meet HHS criteria for evidence of effectiveness. Once the benefit is established, this limitation can be reevaluated.
- We support a pilot program that is either limited to a certain population (e.g., pregnant teens) or geographic region. This will allow the provider community, the MCOs and DMAS to develop a strong program foundation before making it more widely available. This limitation will also address potential provider access issues and allow providers to develop capacity overtime. This slower rollout seems even more pressing given the current labor market shortages.
- We believe there should be established criteria for those eligible to receive services. This will ensure the benefit is reserved for those most in need.
- DMAS should be sensitive to any potential overlap with the new Doula benefit. It is important DMAS does not unintentionally undermine the Doula provider community after encouraging them to make the investment to serve Medicaid recipients.
- Lastly, once we get clarity on the scope and coverage populations for this benefit, we are happy to provide some actuarial modeling to assist in estimating the cost of the program.

Feedback from Urban Baby Beginnings:

- To address health disparities and ensure that communities are involved in the process of defining what home visiting looks like in their specific areas, they must be at the table. Though HRSA defines high-risk priority areas based off of programs and access, it is important to evaluate risk by individual. The findings of the Medicaid Medical Review Team report and are:
  - Between 1999 and 2012, 427 women with a total of 848 chronic diseases died from a psychiatric advance directive (PAD) in Virginia.
  - The most prevalent chronic diseases were endocrine disorders, including obesity (43.8%), chronic mental illness (35.8%), and chronic substance abuse (29.6%).

  - The number of chronic diseases present in each case of PAD ranged from 1 to 7 with a median of 2 chronic diseases.
  - Overall, most women with a chronic disease died a natural death. Only women with chronic substance abuse had a higher percentage of non-natural deaths.
  - Over 62% of women with at least one chronic condition died six weeks or more, post-birth.
  - 36% of women with known chronic substance abuse had substance misuse or abuse identified as a risk in their medical record during their prenatal care.
  - Over 50% of women with cardiovascular diseases, endocrine disorders, hematologic malignancy and/or pulmonary disease were obese.
  - Only 34% of women with a chronic disease were seeing a provider to manage their chronic disease prior to pregnancy. Of those women who were seeing a provider prior to pregnancy, 72.4% continued to see that provider throughout the duration of their pregnancy.
  - Just over 25% of women with a chronic disease received a referral to a specialist for management of their chronic disease(s) during pregnancy. Among those who received a referral, 84% completed the referral.
  - Among women with at least one chronic disease, 44% had at least one provider-related factor 1, such as a failure to refer or seek consultation, contribute to their death

- As a result, pregnancy and OB history must be a factor in whether an individual is approved for longer term supports. From a baby perspective, I support the assessment for pregnancy and infants but would like to add families with low English proficiency and teens.
- Last I wanted to address the funding. The cost summary is appropriate based on our expertise and current structure. The only difference is Family Spirit® program sees families 2-4 times a month depending on gestation and age of the baby based on their curriculum requirements.

Feedback from Early Impact Virginia with input from members of the Alliance for Early Childhood Home Visiting:

- Estimated Members Served – The 20% growth projections are certainly feasible, but confirmation of the assumptions would be needed to compare these estimates with current service data.
- Estimated Dollar Impact – The calculations of estimated dollar impact are accurate. Based on what was shared in the work group, the chart below reflects the total number of

visits members would receive annually, per model.

Model	Rate	Members Served	Total # of Visits/Member Served
NFP	310.80	200	24
Family Spirit	295.14	100	16
Healthy Families	305.56	1,391	36
Early Head Start	132.76	487	68

- The significant difference in the rate, members served, and total number of visits for Early Head Start Home-Based underscores the issue of not having a reliable way of ensuring complete data are reported by all 14 programs. In addition to being incomplete, the ability to carve out home visiting service data and costs from classroom based services and costs varies by organization, as they are not required to disaggregate that information by the Administration of Children and Families at the Federal level.
- Of the populations to prioritize, there are two which overlap directly with other services already in place in Virginia that serve those with special health care needs and substance use, and receive Medicaid reimbursement.
  - **History of or current substance use disorder (SUD**) The Department of Behavioral Health and Developmental Services (DBHDS) administers and monitors ten Project Link programs throughout the state. Project Link provides intensive case management, linkage to MAT, primary care, pediatricians and coordinates services for women and children who have a history, current use or who are at risk of using substances. Project Link prevents gaps and barriers to treatment and is funded by the substance abuse block grant.
  - **Admitted to NICU, and medically fragile** – Also administered by the Department of Behavioral Health and Developmental Services (DBHDS), The Infant & Toddler Connection of Virginia is Virginia's early intervention system for infants and toddlers (age 0-36 months) with disabilities and their families. Any infant or toddler in Virginia who isn't developing as expected or who has a medical condition that can delay typical development is eligible to receive early intervention supports and services under Part C of the Individuals with Disabilities Education Act.
- While home visiting programs can, and have, worked with families enrolled in multiple services, using these categories to define the priority population would be duplicative and confusing for families and local programs.
- Home visiting is a prevention strategy, first and foremost. Applying that philosophy to the selection of priority populations will be critical to ensuring the successful uptake of the benefit.
- Using a broader approach based on geography would be true to the prevention focus of home visiting. With a deliberate focus on census tracts, this approach accomplishes several things:
  - Targets services at the micro level to address pockets of poverty in more affluent counties, and racial inequities at the neighborhood/community level.

- Creates a mechanism to scale growth and implementation, while specifically addressing health disparities; and Response to Growth Estimates and Priority Populations 4.
- Builds on the existing Virginia Home Visiting Needs Assessment, which only identified target areas at the locality level. HRSA, one of the audiences for the needs assessment, allows for sub-county data to be used to identify targeted funding zones. Any efforts to understand and assess need at the census tract level can also be applied to the methodology of the next Home Visiting Needs Assessment (2023).
- Characteristics and risk factors by family or community – like mothers 21 and younger, first birth, and high rates of infant mortality or child abuse and neglect can also be analyzed at the census tract level to target home visiting, again with a focus on prevention.
- Using zip codes is not recommended, as they span multiple localities, and are not used by any current funder, state administration, or model to define service areas.

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