NEWBORN HOME VISITING PILOT PROGRAM

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Washington State Department of CHILDREN, YOUTH & FAMILIES

CONTENTS

Goals and Introduction

Engrossed Substitute House Bill 1109 was signed into law on May 21, 2019, by Governor Jay Inslee. In Section 225 is a budget proviso and request for a report to identify different methods for funding a brief, universally-offered and voluntary newborn home visiting model. The Department of Children, Youth and Families (DCYF) was asked to specifically look at the feasibility of leveraging other types of funds, including Medicaid and Title IV-E to offer this model. DCYF chose to also look into the feasibility of private, local governmental and private insurance funding.

> (bb) $379,000 of the general fund — state appropriation for fiscal year 2020 and $871,000 of the general fund — state appropriation for fiscal year 2021 are provided solely for the department of children, youth, and families to contract with a county-wide nonprofit organization with early childhood expertise in Pierce county for a pilot project to prevent child abuse and neglect using nationally recognized models. Of the amounts provided: (i) $323,000 of the general fund—state appropriation for fiscal year 2020 and $333,000 of the general fund — state appropriation for fiscal year 2021 are provided solely for the nonprofit organization to convene stakeholders to implement a countywide resource and referral linkage system for families of children who are prenatal through age five. (ii) $56,000 of the general fund — state appropriation for fiscal year 2020 and $539,000 of the general fund — state appropriation for fiscal year 2021 are provided solely for the nonprofit organization to offer a voluntary brief newborn home visiting program. The program must meet the diverse needs of Pierce county residents and, therefore, it must be flexible, culturally appropriate, and culturally responsive. The department, in collaboration with the nonprofit organization, must examine the feasibility of leveraging federal and other fund sources, including federal Title IV-E and Medicaid funds, for home visiting provided through the pilot. The department must report its findings to the governor and appropriate legislative committees by December 1, 2019.

Based on the legislative criteria of using a nationally recognized model that offers a voluntary, brief home visiting program, only one model explicitly meets this definition – Family Connects. Family Connects is a brief, universally-offered and voluntary home visiting model made available to all families with newborns residing within a defined service area. The model aims to support families' efforts to enhance maternal and child health and well-being and reduce rates of child abuse and neglect. It consists of one to three home visits by nurses, typically when the infant is 2-12 weeks old, and follow-up contact with families and community agencies to confirm families' successful linkages with community resources.

During the initial home visit, a nurse conducts a physical health assessment of the mother and newborn, screens families for potential risk factors associated with mother's and infant's health and well-being and may offer direct assistance (such as guidance on infant feeding and sleeping). Based on the global assessment of family needs, when a family expresses multiple needs the nurse connects them to community resources such as traditional, targeted and intensive home visiting; a medical home; social support services such as the Women, Infants, and Children (WIC) Nutrition plan or Supplemental Nutrition Assistance Program (SNAP); or an active resource and referral system such as a Help Me Grow network for ongoing miscellaneous needs, developmental screens or assistance for older children in the home. Program staff collaborate with local agencies that serve families with children from birth to age 5 years.

The model began as a pilot under the name Durham Connects and is replicated under the name Family Connects. Dissemination of the Family Connects model is a collaborative endeavor between the Duke Center for Child & Family Policy (CCFP) and the Center for Child & Family Health (CCFH). CCFP oversees ongoing research/evaluation, model innovation and technical assistance related to early childhood policy in communities considering enhancements to their early childhood system of care. CCFH serves as the national training and quality assurance center for the model. Collectively, under the name "Family Connects International," staff from both CCFH and CCFP serve as faculty and consultants for Family Connects implementation initiatives across the county.

Definitions/Glossary

The Department of Children, Youth & Families (DCYF): The Washington State agency charged with administering the funds and monitoring the progress of this pilot. DCYF is an agency focused on the well-being of children, youth and families. DCYF is in charge of child welfare services and early learning programming.

Department of Health (DOH): The Washington State agency charged with administering programs and services that help prevent illness and injury, promote healthy places to live and work, provide information to help people make good health decisions and ensure the state is prepared for emergencies.

Family First Prevention Services Act: The Family First Prevention Services Act (FFPSA) was signed into law on Feb. 9, 2018, with a goal to enhance public child welfare agencies while creating new opportunities for states to receive federal reimbursements for services that aide in preventing children from entering foster care and improve the well-being of children already in the system.

First 5 FUNdamentals: The implementing non-profit agency for this pilot in Pierce County. Their mission is to mobilize and inspire communities to achieve their collective goals for children and families.

Home Visiting Services Account (HVSA): Established by the legislature in 2010 (RCW 43.216.130), Washington pioneered a unique way to administer home visiting services with a private-public partnership. This partnership brings together state, federal and private dollars to support the portfolio of high-quality proven and promising programs. DCYF oversees the management of all grants, contracts, reports and data collection. The private-public partnership entity leads in supporting existing programs with coaching, community capacity building and implementation supports for programs to offer the highest quality services.

Model/Program: These terms are used interchangeably throughout and intended to mean a program that is implemented with articulated design and standards and that can be evaluated according to those designs and standards.

MIECHV: The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program facilitates collaboration and partnership at the federal, state and community levels to improve the health of at-risk children through evidence-based home visiting programs. The home visiting programs reach pregnant women, expectant fathers and parents and caregivers of children under the age of 5. It is administered by the Health Resources and Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF). To be eligible for MIECHV funding, a program must be listed on the HomVEE (Home Visiting Evidence of Effectiveness) list.

Traditional Intensive, Home Visiting: Services offered in the home, over an extended amount of time to a specific priority population. Two model examples are Nurse-Family Partnership (NFP) and Parents As Teachers (PAT). NFP is offered to pregnant, low-income, first-time mothers and their children through age 2. PAT is offered to populations based on HVSA priorities and specific communities, and can serve families prenatally and with children through kindergarten entry.

The Washington Health Care Authority (HCA): The Washington State agency administering and monitoring Apple Health (Medicaid) and the Public Employees Benefits Board (PEBB) Program, and, beginning in 2020, the School Employees Benefits Board (SEBB) Program.

Within Reach: A Seattle-based non-profit that is the National Affiliate for Help Me Grow. Their mission is to strive to create healthy, equitable and vibrant communities in Washington where all families have the opportunity to thrive.

Program Explanation

Family Connects

Family Connects® is an evidence-based, universally offered and community-wide outreach/"light touch" home visiting program for all families of newborns regardless of income or socioeconomic status. The model assists in earlier assessment of family need and increases child well-being by bridging the gap between family needs and community resources. A Family Connects® nurse visitor will connect with every family of a newborn (mother, father, foster parents, kinship caregiver and other family structures with a newborn) in their home. Family Connects® is shown to improve family well-being, including reducing emergency medical care for infants and improving parent behavior and the quality of child care selection.

The program provides between one and three nurse home visits to every family with a newborn beginning at about three weeks of age, regardless of income or demographic risk. Using a tested screening tool, the nurse measures newborn and maternal health and assesses strengths and needs to link the family to community resources. In some cases, Family Connects® recommends eligible families enroll in long-term programs, such as Early Head Start, Nurse-Family Partnership (NFP) and others.

Additionally, in Pierce County as in other areas where it is active, the nurse will connect all interested families with the Help Me Grow referral network. Nurses regularly address maternal and infant health concerns, home safety issues, breastfeeding, depression and mental health needs, substance use, interpersonal violence and relationship issues, child care access, parenting education, family planning, financial concerns, social support and more through assessment.

Universal reach addresses community norms related to help-seeking or accessing services by normalizing that all families need help at some time, especially when they have a new baby. All families with a newborn are vulnerable; targeting demographic risk does not address all families with vulnerabilities and needs. The cost for implementation of Family Connects® is $600 - $800 per birth in a service area. With an expansion in the number of children and families receiving early light touch home visiting and assessment services, an increased need is anticipated for referral to case management services, early intervention, more intensive home visiting models and more support in the early learning system. These referrals, under this model, would be provided via the Help Me Grow referral system.

Help Me Grow

Help Me Grow (HMG) is a model that works to promote collaboration across child-serving sectors in order to build a more efficient and effective system that promotes the optimal healthy development of young children. HMG is not a standalone program, but rather a model that utilizes and builds on existing resources in order to develop and enhance a comprehensive approach to early childhood system-building in any given community. Successful implementation of the HMG model requires communities to identify existing resources, think creatively about how to make the most of existing opportunities and build a coalition to work collaboratively toward a shared agenda. The success of an HMG system relies on the implementation of four core components:

- Child health care provider outreach – provides office-based training to support early detection and intervention and the use of the HMG call center.
- A coordinated access point – serves as a warm line and the hub to link children and their families to community-based resources, services and supports while providing seamless care coordination.
- Family and community outreach – promotes HMG, facilitates provider networking and bolsters children's healthy development through families.
- Ongoing data collection and analysis – helps identify gaps in and barriers to the system, and continuous quality improvement processes refine all aspects of the system.

Many different entities in Washington are working together to grow a robust statewide HMG system which will establish coordinated access points and databases, feedback loops and community organization to enable children and families to access the services that they need to be healthy, successful and ready to participate in both the preschool and K-12

systems. The HMG system is being co-created by local communities to ensure that it meets the distinct needs of each region, along with DCYF and DOH to ensure that there is equity across the state (especially racially, ethnically and geographically) and that data and resources can be supported by strong and consistent infrastructure.

HMG is a clear and simple referral system to coordinate services for families who may need more assistance as identified in the Family Connects® system as well as through other referral pathways that will be created and enhanced for older children. The HMG referral system will weave services together within and across communities, assuring that there is "no wrong door" for families needing referrals and access to services, starting even before birth.

The Current State of Affairs

Background and Context

Within Reach launched Help Me Grow Washington in 2010. They operate as the statewide affiliate to the National HMG system and also maintain the statewide access point, Parent Help 123. There are currently three sub-affiliates across the state that are working on standing up local structures for navigation to support families that will be associated with the statewide system. King County has begun work on a system as a sub-affiliate through the Seattle-King County Public Health Department and the Best Starts for Kids program. Central Washington is working with Within Reach to become a sub-affiliate. They have been working in Yakima County for nine years and through an expansion opportunity provided by Project HOPE through DOH, they have expanded to include Kittitas County as well.

Beginning in the summer of 2018, staff from DCYF and the Governor's office began work on the creation of a comprehensive statewide Birth to Age Five plan that would build on a previously funded legislative pilot in Pierce County. The initial year of funding allowed First 5 FUNdamentals in Pierce County to do a year of community planning, community engagement and goal setting to create a locally designed sub-affiliate to the Statewide Help Me Grow network. Pierce County was chosen to address their higher than average out-of-home foster care placements and they felt the resource and referral network would be an opportunity to connect families to resources that they need. Community leaders in Pierce County found as a part of their community planning process that Family Connects would be a value add to their Help Me Grow system as is documented in their Implementation Plan. It would allow them to be able to reach families early in their developmental stages to help reduce child abuse and neglect.

The Pierce County Help Me Grow pilot received continued funding for an additional two years through budget proviso. They were also given money to begin planning the Family Connects integration. In their second year, they will begin implementation of the Help Me Grow System while doing further research to support a Family Connects model in their

community. In the third year, Pierce County will be fully operational in their Help Me Grow system and should begin implementation of a Family Connects model in a defined population within their region.

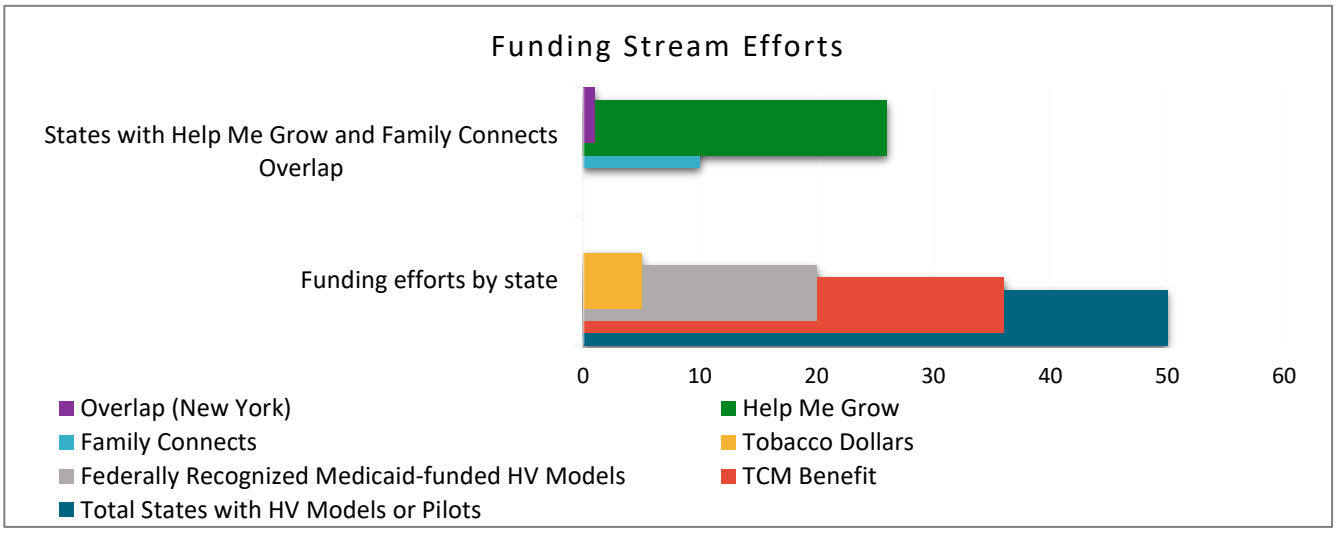
Statewide and Local Planning Efforts

While the legislature provided funding for a pilot in one county, Pierce County, there are currently several interagency groups and several funding sources exploring funding approaches and developing a phased-in implementation plan for an HMG system statewide. Nationally, there are several sites where HMG and Family Connects are being researched, planned and implemented. The national centers are currently collaborating to make this process easier. Family Connects and HMG serve as referral partners for other programs and services within the community. This includes development

of feedback loops between the programs, scheduling appointments and identifying capacity and infrastructure strengths and challenges. HMG and Family Connects are strategic partners in local community advisory boards that are set up as part of program implementation. The participation of both programs provides community partners with valuable information regarding aggregate client data as well as community resource assets and barriers.

There are also several sites across the country where Family Connects International staff are providing consultation related to an ideal program installation. When HMG is operational or in the planning phase within these locations, local Family Connects staff actively engage with these HMG implementers to ensure effective and efficient collaboration between the two programs. Generally, this results in coordinated and communicative business practices that allow for model fidelity for both programs while creating processes that promote efficiency.

Often, through this local exploration work, it is determined that both Family Connects and HMG execute comparable practices for completing the work or stakeholder engagement and referral management. This symmetry instills confidence regarding the process of collecting service provider data which all programs can access in order to make data-driven decisions for policy as well as infrastructure and capacity needs within an agecy and also the community.



Prior Financial Planning for Expansion of Home Visiting Through Medicaid

As a result of ESSHB 2779, in 2018, HCA and DCYF were required to collaborate to identify opportunities to leverage Medicaid funding for long-term home visiting services and provide recommendations building upon the research and strategies in the August 2017 Washington State Home Visiting and Medicaid Financing Strategies report. HCA and DCYF worked to identify sustainable Medicaid funding for intensive/long-term early childhood home visiting services, and to improve coordination across the health and early learning sectors. There were two top choices based on agency criteria from the previous cross-agency work and stakeholder criteria from a series of statewide workshops.

First, develop a Medicaid home visiting state plan amendment for case management. Under this option, HCA would work with DCYF to develop a proposed State Plan Amendment to reimburse targeted case management services to assist families in accessing medical, social, education or other services during home visits. These services could include screening, assessments, referrals and care plan development provided by DCYF home visiting programs funded through the Home Visiting Services Account (HVSA). The second choice was to contract with managed care organizations for discrete home visiting services. Under this option, HCA would work with Managed Care Organizations (MCOs) to support contracting with DCYF for home visiting services funded through HVSA programs that provide clinical, behavioral health and case management services.

While these financing options are specific to long-term home visiting, initial conversation and planning have begun between DCYF and HCA to determine the applicability of these options for Family Connects and/or HMG. Therefore, a

key strategy in sustainable Medicaid funding requires further alignment across HCA and DCYF to better leverage, maximize and ensure the non-duplication of limited resources for both brief and long-term home visiting programs.

Funding Options For Implementing Family Connects Across Washington

The chart below shows the estimated costs to implement a Family Connects model in each county in Washington, based on the number of Medicaid births. It is worth noting that the Best Starts for Kids initiative in King County is exploring implementation of a Family Connects model. Also of note is is that both Chelan and Whitman counties have no maternity support service providers operating within those counties, despite having birthing centers.

County	# Birthing Facilities	2016 Births	2015 Medicaid Birth Rate (HCA)+	% Non-Medicaid Births	Est. Family Connects Costs for Entire Birth Population ($900/birth)
Adams	1	478	93.7%	6.3%	$430,200
Benton	3	4,787	72.2%	27.8%	$4,308,300
Chelan	3	1,497	78.2%	21.8%	$1,347,300
Clallam	2	535	71.9%	28.1%	$481,500
Clark	2	5,619	53.6%	46.4%	$5,057,100
Cowlitz	1	840	78.7%	21.3%	$756,000
Grant	2	1,098	76.4%	23.6%	$988,200
Grays Harbor	1	472	79.7%	20.3%	$424,800
Island	3	510	51.6%	48.4%	$459,000
Jefferson	1	100	58.9%	41.1%	$90,000
King	18	30,460	42.1%	57.9%	$27,414,000
Kitsap	2	2,729	52.7%	47.3%	$2,456,100
Kittitas	1	312	54.7%	45.3%	$280,800
Lewis	1	728	72.1%	27.9%	$655,200
Mason	1	302	86.7%	13.3%	$271,800
Okanogan	3	418	86.3%	13.7%	$376,200
Pend Oreille	1	65	85.4%	14.6%	$58,500
Pierce	7	12,005	58.3%	41.7%	$10,804,500
Skagit	3	1,631	61.8%	38.2%	$1,467,900
Snohomish	4	6,321	50.5%	49.5%	$5,688,900
Spokane	5	6,896	61.3%	38.7%	$6,206,400
Stevens	1	231	68.1%	31.9%	$207,900
Thurston	3	3,058	54.5%	45.5%	$2,752,200
Walla Walla	2	775	69.0%	31.0%	$697,500
Whatcom	3	2,195	42.8%	57.2%	$1,975,500
Whitman	2	464	42.3%	57.7%	$417,600
Yakima	3	3716	88.3%	11.7%	$3,344,400
Washington	**79**	**90,310**	**66.4%**	**33.6%**	**$79,417,800**

Medicaid

Medicaid is a federal and state program that helps with medical costs for individualse with limited income and resources. The federal Centers for Medicare & Medicaid Services (CMS) is responsible for approving each state's Medicaid State Plan, including waivers, and monitoring state compliance with federal Medicaid regulations. In Washington State, Medicaid is called Apple Health and is provided free or at low cost on a sliding scale to eligible persons based on their income.

There are regulatory limits to what Medicaid will reimburse, and there are limits to which home visiting services meet Medicaid requirements for reimbursement. Federal regulations currently do not authorize proprietary home visiting models in their entirety, although some medically necessary home-based services may be allowed. In a 2016 joint bulletin, CMS and Health Resources & Services Administration (HRSA) encouraged states to look for ways to pair Medicaid, state dollars and private resources to create and fund a home visiting benefit package.

Proprietary Home Visiting Models	Home-Based Medicaid Services
Comprehensive package of services to directly support pregnant women and families in raising physically, socially and emotionally healthy children ready to learn.	Distinct medical services provided to patients in the home environment. The service is delivered in response to a specific diagnosed health care need.
Home visiting programs must meet specific model fidelity elements. Fidelity requirements vary by model. Changes to the home visiting model must be approved by the developer.	Services must be medically necessary and approved by CMS. Mandatory and optional services are described in each state's Medicaid plan. Changes to a Medicaid state plan require CMS review and approval.
Model developers set provider requirements which generally address education and model-specific training, and may include a medical credential or license.	States set and monitor medical provider licensing and credentialing rules. Only specific medical providers are federally allowed to bill for medical services.
Comprehensive services are typically funded "at-cost" based on a set budget determined by the number of enrollment slots a home visiting program can reasonably serve over a specific period of time. Home visiting programs contract with funders for monthly reimbursement based on the number of slots served.	Distinct medical services are typically reimbursed by Medicaid at less than cost and must have an assigned diagnosis and billing code. Services may be reimbursed under a fee-for-service arrangement or as part of a capitated rate. Non-billing providers must work under Medicaid billing providers to receive reimbursement.

The bulletin notes that the majority of evidence-based home visiting programs deliver services such as screening, case management, family support, counseling and skills training for pregnant women and parents with young children. While there is no distinct Medicaid state plan benefit called home visiting, states may cover many of the individual component services of home visiting programs through existing Medicaid coverage authorities.

The CMS and HRSA bulletin leaves the door open to states braiding multiple funding streams that could include Medicaid-coverable services as well as additional services funded by other Federal and state streams:

In designing a home visiting program, state agencies should work together to develop an appropriate package of services to be provided to their beneficiaries. This package may consist of Medicaid-coverable services in tandem with additional services available through other federal, state or privately funded programs. Each federal, state, and private funding stream is governed by its own rules such as: determining which women and families are eligible for home visiting services, which services are offered, which providers may deliver services, and the length and intensity of home visits.

Medicaid has the potential to fund specific discrete services within Family Connects for the Medicaid enrolled population. Medicaid currently insures approximately 50 percent of the population in Washington, however, this varies across the state by region. In a universally-offered voluntary program such as Family Connects, the maximum number of

families that could have portions of their home visits paid for by Medicaid would be whatever percentage of families are covered by Medicaid in that community.

Medicaid's reimbursement structure relies on:

- Federal CMS approval of the specific health benefit or services through the Medicaid state plan and/or Medicaid waivers;
- Funds to provide the required state match, which are typically provided through general state fund allocation, as well as other sources such as local government contributions, intergovernmental transfers, certified public expenditures or health care-related taxes.
- Services being provided by approved providers working under the supervision of Medicaid-allowed billing providers. Examples: maternal depression screen, infant hearing screen or breastfeeding support.

States that access Medicaid to help support home visiting services report 2 to 40 percent of specific home visiting services as reimbursable. The amount varies by model, state plan, allocated matching state funds and administrative processes. The larger reimbursement generally includes home visiting services that are more clinical in nature. States also tend to use more than one Medicaid Authority in order to more fully maximize reimbursement potential.

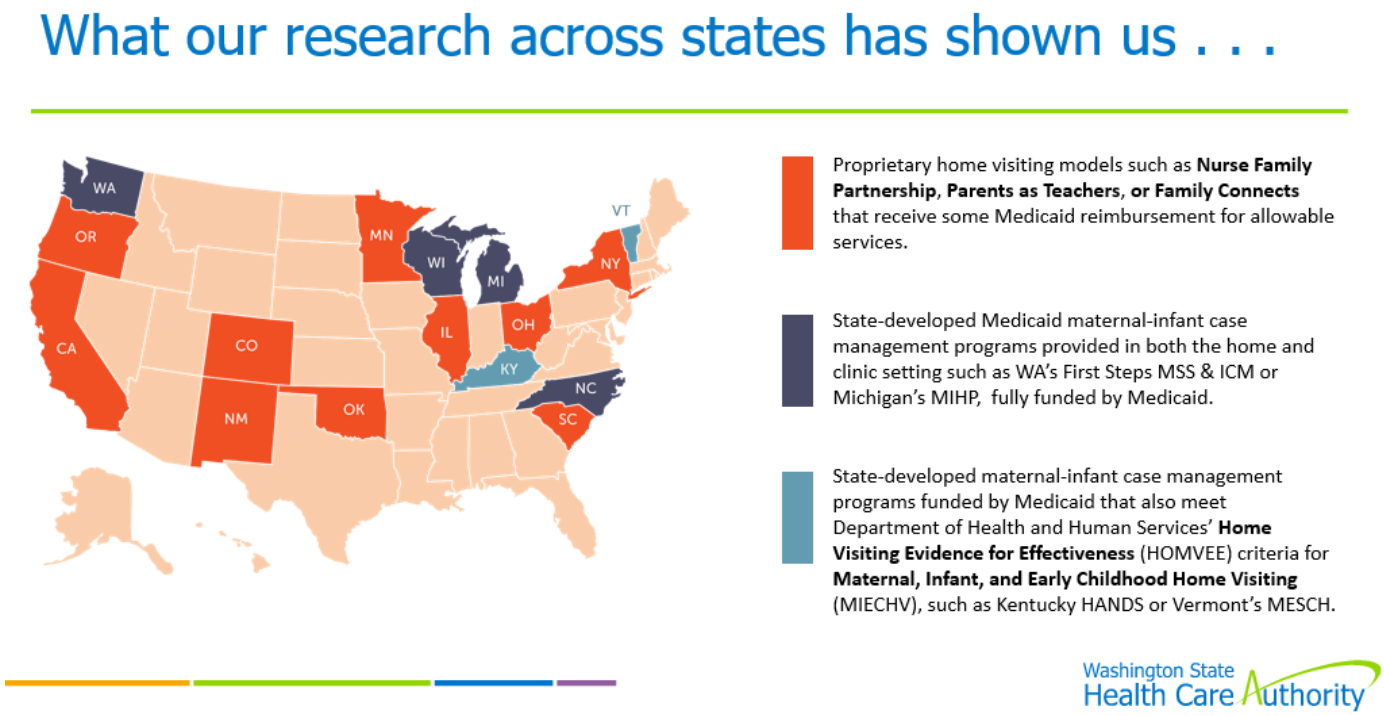
Medicaid reimbursement typically flows through a fee-for-service billing process, as part of the managed care capitated rate, or through administrative claiming contracts.

Managed Care	Fee for Service (FFS)	Medicaid Administrative Claiming
• HCA contracts with MCOs who in turn subcontract with community service providers. • MCOs must provide services within a set per-member-per-month (PMPM) fee. • MCOs can provide additional services or incentives outside of what is minimally required within the PMPM. • MCOs are not required to follow FFS rules for paying providers, although plans must make payments sufficient to ensure appropriate access for enrollees.	• Qualified providers contract directly with HCA under the Core Provider Agreement. • Providers bill HCA through Provider One for rendered services. • Providers are paid based on an established rate per unit of service. • Federally, rates can be based on a variety of measures: costs of providing the service, a review of what commercial payers pay in the private market and a percentage of what Medicare pays for equivalent services. https://www.medicaid.gov/medicaid/financing-and-reimbursement/index.html	• Governmental entities contract with HCA to receive partial reimbursement for specific Medicaid administrative activities performed by staff. • Eligible activities can include outreach, application assistance, referring clients to services and Medicaid program development. • Governmental entities must develop a cost allocation plan for CMS review and approval. • Reimbursement is based on random moment time study results, the percent of Medicaid individuals served and the federal financial participation rate.

The most common funding structure to bill Medicaid for care coordination type work is the optional Targeted Case Management (TCM) benefit. Washington is currently working on what type of plan will be needed to adapt the current TCM structure to this type of model or if there will need to be a approval from CMS for a state plan amendment that will allow for expansion of TCM billing to include evidence-based home visiting models with community-based providers who are already embedded in high-risk communities addressing social determinants of health.

There are approximately 20 states across the country currently accessing some level of Medicaid funding for home visiting services. This varies from statewide scale to state demonstration sites to local programs using existing state plan provisions without a state-led policy design. Most states are using a state plan amendment for the TCM benefit. Medicaid funding via TCM is anticipated to be part of the Oregon statewide rollout – the first cohort of communities are in the planning phase. A few other home visiting models do bill TCM such as Nurse-Family Partnership (NFP) and Parents as Teachers (PAT). There are currently two Family Connects programs in North Carolina billing Medicaid using the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program for services. This benefit applies to services offered as

part of the preventative health care benefit for children age 20 and younger to detect physical and behavioral health problems. Generally, Medicaid defines case management as services to help eligible individuals gain access to medical, educational, social or other benefits. There must be an assessment, development of a care plan, referral to services and monitoring activity. TCM are services targeted to a sub-group (e.g., postpartum women in the first 90 days postpartum). The service could target a specific geography, model or provider (such as a health department). It is matched at the Federal Medical Assistance Percentage (FMAP) rate.



Medicaid in Washington

In Washington, Medicaid Apple Health offers an optional voluntary extended service for pregnant women which is called Maternity Support Services (MSS). Infant Case Management (ICM) is a benefit that along with MSS are known by their umbrella program name First Steps. There has been expressed concern that Family Connects is a duplicative service of MSS and/or ICM.

First Steps MSS serves Medicaid pregnant clients through 60 days postpartum. The purpose of MSS is to improve and promote healthy birth outcomes through a multidisciplinary team that includes a registered nurse, certified dietitian and a behavioral health specialist, and may include a community health worker.

ICM serves Medicaid infants and their parents from day 61 to the infant's first birthday. The purpose of ICM is to improve the welfare of infants at higher risk of problems by providing their parent(s) with assistance to access medical, social, educational and environmental services delivered by an infant case manager. Many similar services are offered to mothers under MSS and ICM as in Family Connects. Services such as health screenings and education services, basic nutritional counseling, referral to community services and registered nursing services are covered in both programs. As is visible in the data below from the HCA website, not all of the Medicaid eligible infants and mothers are being reached by First Steps practitioners.

2016 Data	Statewide	Non-Medicaid	Medicaid
All WA Births	88,194	44,815	43,379
First Time Births	35,138 (39.8%)	20,794 (46.4%)	14,344 (33.1%)
Clients Who Received MSS	-	-	21,319 (49.3%)
Preterm Births (All Live, <37 Weeks)	7,169 (8.1%)	3,222 (7.1%)	3,947 (9.1%)
Low Birth Rate	4,289 (5%)	1,816 (4.1%)	2,473 (5.8%)
Infants Served With ICM	-	-	9,428 (21.7%)

Currently, an eligible provider can enroll with HCA to provide ICM services and bill at the rate of $20 per 15-minute unit of service for a maximum of 20 units per Medicaid enrolled child. Each state identifies what services they will offer and how much they will allow for reimbursement for these services in their CMS-approved State Plan. Some states are working through how to combine their TCM services for new mothers and infants with home visiting programs such as Family Connects. Those families who are not eligible for First Steps services, as well as many of those who might not have access to MSS/ICM services, may benefit from Family Connects.

At least eight counties and two tribes are not currently served by MSS/ICM and could benefit from a program such as Family Connects. In Oregon, the counties that are instituting Family Connects have made a commitment to blend/braid their funding streams behind the scenes so that families receive services at the point of service without any prior knowledge of who or how the service is being paid for. The families however still receive the same services.

To enable a program such as Family Connects to operate in a coordinated way with MSS/ICM in Washington, it will require HCA and DCYF to determine what services are authorized and what services are offered to participating families. The agencies will also need to decide if the current structure of the two systems should be combined or if there is benefit to keeping them as separate.

Additionally, the two agencies will need to work with local communities as they complete their planning processes to identify where and if there are MSS/ICM providers who could also be Family Connects providers or who work in agencies where the services could be integrated. A state plan amendment (SPA) would most likely be required for MSS/ICM providers to be able to bill for Family Connects. The SPA would need to address certain requirements in the current MSS model such as the interdisciplinary team that is not part of the Family Connects model; the number of units available to postpartum patients is not suffient to cover one Family Connects visit, let alone several if needed; and the timeline for services for patients now is 60 days postpartum while Family Connects can be up to 6 months.

For the 50 percent of the population that is not eligible for Medicaid services, the agency would need to be able to fund the same services to achieve the benefits of a universally offered program. In addition, approximately 50 percent of eligible Medicaid births currently access at least one of the First Steps services. Local providers have reported that there can be a stigma associated with participating in a program that is only offered to Medicaid patients. To utilize a common set of services will involve an increase in families accessing the First Step services as well.

Providing a program such as Family Connects to all families regardless of socio-economic status and insurance coverage will reduce stigma for all and increase the number of families at all levels who receive assistance and detection of any concerns earlier.

	Maternity Support Services (MSS) and Infant Case Management (ICM): Enhanced prevention education and brief intervention components of Washington State's First Steps program	***Family Connects***
Funding Authority And Structure	Medicaid Authority: Medicaid State Plan 3.1-A (20): Extended Services for Pregnant Women Through Sixty Days Postpartum; and, 3.1.-A Supplement (1-C): Infant Case Management Services Case Management services: 42 CFR 440.169 (a) *Case management services* means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with § 441.18 of this chapter. (b*) Targeted case management services* means case management services furnished without regard to the requirements of § 431.50(b) of this chapter (related to statewide provision of services) and § 440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan. Maternity Care Access Act of 1989 RCW 74.09.760 - 74.09.920 Maternity Related Services WAC 182-533-0300 through -0390 First Steps/MSS & ICM Billing Guide Carve-Out Program reimbursed through a fee-for-service process, which requires billing for discrete, federally approved services per 15-minute unit.	Similar to other proprietary models, Family Connects, International requires interested partner organizations to enter into a replication agreement with them. "Communities seeking to launch Family Connects need to have several components in place in order to replicate the model and must adhere to the evidence-based protocols derived from the evaluation studies of the Family Connects model in Durham, N.C., to be certified as a Family Connects program." Family Connects is on the HOMVEE list as eligible model for MIECHV funding. Depending on an individual state's Medicaid plan, Family Connects specific staff and component services may meet Medicaid requirements for reimbursement. Family Connects partners may include local non-profits, health departments, hospital systems, state-wide early childhood, education or health systems, physician groups and/or universities.
Purpose and Goals	Maternity Support Services (MSS) delivers enhanced preventive health and education services and brief interventions to eligible pregnant clients. Services are provided as early in a pregnancy as possible, based on the client's individual risks and needs. Goals of MSS include: • Increasing: Early access and ongoing use of prenatal and newborn care Screening for Postpartum mood disorder Initiation and duration of breastfeeding Family planning knowledge • Decreasing: Maternal morbidity and mortality Low birth-weight babies Premature births Infant morbidity and mortality rates Health disparities The number of unintended pregnancies The number of repeat pregnancies within two years of delivery (Healthy birth spacing intervals) Tobacco, nicotine, alcohol, marijuana, and drug use during pregnancy Pediatric exposure to second-hand smoke Goals of ICM are to improve infant health outcomes by: • Increasing referrals to well child visits and developmental screenings, as needed • Screening for Postpartum mood disorder	http:www.familyconnects.org/faq Family Connects is a community-wide nurse home visiting program for parents of newborns, regardless of income or socioeconomic status. Our mission is to increase child well-being by bridging the gap between parent needs and community resources. The primary goal of Family Connects is to integrate with existing community services and complement that which is already being done. Family Connects can reinforce local support systems for parents and offer another way to engage families at a critical juncture.

	• Reduce the number of repeat pregnancies within two years of delivery • Reduce pediatric exposure to second-hand smoke	
Target Population and Eligibility	Pregnant or post-partum women and infants up to age one who are eligible for and enrolled in Apple Health (Medicaid).	The program is designed for universal community coverage, with the goal of at least 70 to 80 percent of eligible families participating. All families with newborns in a coverage area are eligible, whether the area is a region, state, city, or neighborhood.
Providers	*MSS Interdisciplinary team* with an: • RN – Currently licensed registered nurse under WAC 246-840; • BHS – Currently credentialed or licensed behavioral health specialist under WAC 246-809, 246-810, and 246-924; • RD – Currently registered with the Commission on Dietetic Registration and certified under WAC 246-822. • In addition, a community health representative (CHR) can offer services under the direct supervision of the qualified MSS provider. *Individual ICM providers* must: • Be part of an MSS team at the RN, BHS or RD level; or • Have a BA or higher in social service field plus at least one year full-time social service work experience; or • Have an AA in social service field plus at least two years full-time social service work experience and work under the direct supervision of an MSS-team member or a supervisor with a BA or higher in the social service field.	Staff include: • Nurse home visitors • Nurse supervisor • Data manager • Program support coordinator • Community alignment specialist; and • Must incorporate consultation or support from the local department of social services; and • Consultation from a mental health professional encouraged. With recommendation that: • RN HNs and program support coordinators hold a bachelor's degree • Nurse supervisors and program directors hold a master's degree • Database managers hold an associate's or bachelor's degree. Nurse supervisors meet with nurse home visitors weekly for case review and supervision. Supervisors also observe a visit with each home visitor quarterly to monitor nurses' fidelity to the model protocol and consistency in assessing family risk. The National Service Office recommends a ratio of one supervisors to four to eight home visitors.
Caseload Maximum	There is not a caseload limit per nurse for MSS and ICM services. Per CMS regulations, services are to be available statewide.	The National Service Office recommends nurse caseloads of six to eight new cases per week, depending on the community's birth rate. Nurses also keep space in their schedules to conduct follow-up visits or calls with families visited in the past weeks, as needed.
Specific Services	First Steps provides: *Maternity Support Services* (MSS): • In-person screening and assessment for risk factors • Pregnancy/infant health education and health messages • Patient-centered interventions • Brief counseling • Referral to resources • Case management and care coordination • Group services • Telemedicine *Infant Case Management* (ICM): • In-person screening and assessment to identify risk factors • Case management and care coordination • Referrals and advocacy • Telemedicine	Family Connects Critical Components – the initial home visit at three weeks of age can be followed up by one or more visits or phone calls to complete the assessments and ensure linkage to local services and resources. The goal of the follow-up is to support the family, but not to become "case management." • Health and psychosocial assessments of newborn, mother and family including a systematic assessment, called the Family Support Matrix, of family strengths, risks and needs. • Supportive guidance, such as: o Placing baby on their back to sleep o Benefits of tummy time o Respond to parent queries and observe areas of possible difficulties in adjusting to having a newborn, such as breastfeeding, support for the "baby blues" and other issues • Nurse actively connects and links the family with community services

		• Documenting the home visit(s) and contacts with families and community referrals
Screening and Assessment Tools	Prenatal Screening Guide Prenatal Screening Tool Postnatal Screening Guide Postnatal Screening Tool ICM Screening Tool Agency approval required for alternate MSS or ICM screening tool. The screening guides are listed as samples on the website and are not required. Agencies can use any type of screening they choose, however they have to fill out the chosen screening tool and keep it in the client files.	The nurse home visit includes a systematic assessment, called the Family Support Matrix, of family strengths, risks and needs – assesses 12 risk factors across four domains: • Support for health care • Support for caring for the infant • Support for safe environments • Support for parents Additionally, parents complete three standardized screening tools to screen for depression: • Edinburgh Postpartum Depression Scale • Intimate partner violence (Conflict-Tactics Scale) • Substance use (CAGE Adapted to Include Drugs or CAGE-AID) The screening tools are completed by the mother on laptops or tablets and scored instantaneously for discussion during the home visit.
Service Location	Office, clinic, hospital, client home, other	Hospital, client home, other community setting
Duration and Intensity	Total service units are determined based on the level of assessed risk for MSS and ICM. A maximum of 7.5 hours (30 fifteen-minute units) of MSS and 5 hours (20 fifteen-minute units) of ICM for high-risk clients – with no limitation extension requests (LER) or access to other types of childbirth education classes (CBE). • *MSS* provides the services as early in the pregnancy as possible through 60 days postpartum and continues through the end of the month in which the 60th day post-pregnancy occurs. • *ICM* provides services from the end of the MSS eligibility period and continues through the last day of the month of the infant's first birthday.	Family Connects is a manualized intervention that provides one to three home visits from a registered nurse to all families with newborns living in a defined service area. During the initial home visit, the nurse conducts a physical health assessment of mother and newborn, provides supportive guidance on topics that are common to all families (such as infant feeding and safe sleeping practices), and conducts a systematic assessment of family risks and needs. • One to three home visits by a registered nurse approximately 2 to 12 weeks after the child's birth • Follow-up contacts with families and community agencies to confirm families' successful linkages with community resources • The initial home visit typically lasts 1.2 to 2 hours • 30% of families receive more than one visit based on their needs and continued interest in the program • 38% of families receive at least one follow-up telephone contact

Additional Information	See Health Care Authority's First Steps web pages and the First Steps flyer to learn more about MSS, ICM, group and childbirth education services.
	
	Under WAC 182-533-0327 (3) the MSS-interdisciplinary team requirement is waived for Tribal & Indian Health Programs, ad counties with under 55 Medicaid-paid births per year. MSS services may be provided as long as they have least one of the following provider types:
	• Licensed registered nurse under WAC 246-840; or
	• Credentialed or licensed behavioral health specialist under WAC 246-809, 246-810, and 246-924; or
	• Registered dietician with the Commission on Dietetic Registration and certified under WAC 246-822
	• In addition, a community health representative (CHR) can offer services under the direct supervision of the qualified MSS provider.
		Family Connects sites:
		http://www.familyconnects.org/other-dissemination-sites
		
		The goals of Family Connects are to:
		• Connect with families in their home after the birth of a newborn and
		  o Share in the joy of a new baby,
		  o Assess unique family risks,
		  o Respond to immediate needs for support and guidance.
		• Offer supportive guidance to families about newborn care
		• Link families to community services
		• Help new parents connect with their infant

Individual Program Cost	Each fifteen-minute MSS unit is reimbursed at $25/unit for group services and must be a minimum of 60 minutes. These services cannot be provided in the home and there must be a minimum of 3 clients and a maximum of 12 MSS clients attending a group service. and Home-based services are reimbursed at $35/unit. Each fifteen-minute ICM unit is reimbursed at $20/unit regardless of service location. As a baseline for comparison: $1,450 for up to 12.5 hours (50 units) of home-based services, starting as early in the pregnancy as possible, continuing through the infant's first birthday with no limitation extension requests (LER) or childbirth education classes (CBE) which are billed with a separate provider requirement and it's own billing code. This cost would increase with limitation extensions and childbirth education classes.	Family Connects costs approximately $900 per birth, including oversight, family recruitment, staff salaries and benefits, local travel reimbursement, and materials. Costs vary by community based on local wages, extent of travel, population size, existing data systems, and other factors. (HOMEVEE, 2019) Family Connects sites to have upfront costs for training and certification that vary by community size. There is also an annual fee for data collection and costs for ongoing certification. http://www.familyconnects.org/faq
		Created by Shannon Blood, Washington Health Care Authority

Title IV-E

Title IV-E is a federal open-ended entitlement funding stream that seeks to decrease out-of-home placement of children in the child welfare system through increased investments in prevention services. It is also known by its most recent authorizing legislation, the Family First Prevention Services Act (FFPSA). The funding cycle is 12 months and uses an FMAP of 50 percent. This means that while the entitlement is potentially open-ended, there is a required state match of 50 percent, just like Medicaid.

Additionally, the programs that can be funded through this mechanism must be listed both in the federally approved annual state plan submitted by DCYF to the ACF and also on the federal Title IV-E Prevention Services Clearinghouse. There are currently only 15 programs listed in this clearinghouse and all of them address either mental health treatment, in-home parenting or substance abuse and prevention – not all meet the evidentiary standard set forth by FFSPA legislation in Washington for approval for claiming. Two of the traditional, long-term home visiting models that are prevalent in Washington – NFP and PAT – are on the list. The definitions for the clearinghouse are the same as the California Evidence-Based Clearinghouse for Child Welfare. While Family Connects is not yet on either list, it is on the Home Visiting Evidence for Effectiveness (HOMVEE) list as meeting the U.S. Health and Human Services criteria for an evidence-based model. It is expected that there could be a programmatic review of Family Connects and that it might be added in the future to the Title IV-E clearinghouse. States have the option to request that a program be reviewed to be added to the approved list. Each state also has the option to define the at-risk population.

Washington has submitted a state plan which will focus the prevention work being funded through Title IV-E primarily on the candidacy group of children with imminent risk of entry or re-entry into the foster care system. Some of the other groups that will be eligible will be families that have had screened-in child welfare calls who have chosen to participate in voluntary services, and several specialized groups of pregnant women and children under the age of 18 who have been discharged from the juvenile rehabilitation system.

Candidacy in the proposed state plan for Title IV-E at this time does include segments of the population who would be eligible to participate in Family Connects were it offered in their area. Substance abusing pregnant women with screened out child welfare calls who are not otherwise involved in traditional intensive home visiting programs would be eligible for Family Connects. Other eligible populations would include foster care youth who are themselves pregnant, youth involved with adoptions where there are problems if they are also pregnant or if the youth is discharged from the juvenile rehabilitation system if they are pregnant.

Despite the candidacy possibilities, because Family Connects is not yet listed in the Title IV-E Prevention Services Clearinghouse, it is not a program that can be funded with this mechanism at this time. Washington will follow the progress of whether or not it gets added to the federally-approved programs list. DCYF can also investigate whether the Washington State Institute for Public Policy should instigate a review to request Family Connects be added to the approved list of evidence-based programming if it appears that Family Connects is a program that communities across Washington want to utilize. At that point, it could be added to the state plan and become a program that can be funded partially through Title IV-E. However, this funding could still only fund a portion of the Family Connects visits for the population that meets the candidacy criteria listed above.

Private Insurance

Commercial coverage (individual and group health plans) in Washington State must provide meaningful essential coverage, and specifically for the individual and small group health plans, must cover the essential health benefit categories established by the Affordable Care Act. The specifics of the services under each category are based on the state's selected base-benchmark plan and any state specified mandated benefits. While no official stakeholdering has happened with the Office of Insurance Commissioner (OIC) or any of the commercial insurance plans, based on a quick scan of potential services available and potentially Medicaid eligible services, staff from OIC identified the following range of services as having parallels under the essential health benefits:

- Maternity & Newborn Services category: The services classified to the Maternity & Newborn Services category of benefits are generally stated, and include prenatal and postnatal care and services, including screening. *WAC 284-43-5640 (4)*
- Mental Health and Substance Use Disorder Treatment/Services, Including Behavioral Health: Coverage must be offered for any condition included in the Diagnostic and Statistical Manual of Mental Disorders (DSM), but does not include counseling in the absence of illness, other than family counseling for a child or adolescent with a covered diagnosis. Coverage of V- codes 302 – 302.9 in the DSM-IV is required for children age 5 and under, related to parent-child relational problems or neglect or abuse of a child. *WAC 284-43-5640 (5)*
- Prescription drugs or treatments for tobacco cessation are covered under the Prescription Drug Services category. *WAC 284-43-5640 (6)*
- The Preventive and Wellness Services category includes A&B recommendations of the U.S. Preventive Services Task Force, services, screening and tests contained in the HRSA Bright Futures guidelines, and any services, screening and supplies recommended by HRSA under its women's preventive and wellness services guidelines. *WAC 284-43-5640 (9)*
- Home-based medical services and palliative care are covered, up to 130 visits per year, but would be covered by most health plans for medically necessary care, delivered as part of the Ambulatory Services Essential Health Benefit Category. *WAC 284-43-5640 (1)*

There are not currently any home visiting services paid for through commercial insurance coverage, so any investigation with health plans and OIC would be a long-term and non-universal solution for funding Family Connects. Just as with Medicaid, private commercial insurance only covers a portion of the population and would only pay for their covered population.

Other Funding Sources

There are several national philanthropic organizations that have expressed interest in funding both Family Connects and Help Me Grow. The consistent message from each of them is that with the commitment from the state to support the infrastructure needed to operate a system of this type, they would be interested in expanding reach, spread and the scale of the work.

In Pierce County, First 5 FUNdamentals and their partners have worked to leverage their local government and philanthropic funding to operate their HMG system. Pierce County estimates that approximately 50 percent of their operating budget will come from private funding and local government dollars for their local program.

Washington's Plan for Implementation

The Family Connects portion of the pilot in Pierce County has begun investigation this year about what an implementation plan will look like specifically for their region. The funding provided by the budget proviso allows them in the first year to complete six months of implementation planning and then serve approximately 375 families. There are seven birthing locations in the county and approximately 12,000 children born annually. The work of the first planning year will be to decide in large part how, where and by whom these families will receive their Family Connects visits.

The staff at Family Connects International are working with Pierce County to design a program that will meet the cultural, regional and logistical needs of the local area. DCYF will work with Pierce County to ensure that the model being developed ensures fidelity to the evidence base of the national model and is appropriately flexible and culturally responsive. The pilot in Pierce County will inform the work across the rest of the state with the knowledge that each region has different needs and populations and the implementation plan will be adapted to fit each region as appropriate.

Successful implementation of Family Connects will look somewhat different across the state, however, there will be some consistent needs for outreach, workforce development and funding. Regions are going to have to work collaboratively with local partners ensure that both the funding needs of the program are met as well as providing a quality and seamless product for families.

Areas that have a high Medicaid birth rate will likely be good demonstration sites for where to begin to build braided funding streams to pay for the services that families need using Medicaid strategies. Conversely, areas with low Medicaid birthrates will have a higher burden to attract other funding sources such as philanthropy and state funding.

Nationally, some programs that are operating a Family Connects system are doing so on a very small scale: one birthing hospital/town/city/county. However, other programs are rolling out at a large scale such as the entire state of Oregon and the city of Chicago. Operating at a smaller level gives programs more flexibility with their funding, as is evident by the successful funding in Pierce County, but also does not allow for any economy of scale that could be accomplished through a statewide infrastructure that would support local efforts.

Both HMG and Family Connects must be co-designed with the local community and the state to ensure that the system is both a needed and a desired service, and also that unintentional inequities are not created between regions. Additionally, the increase in the number of nurses that will be needed to operate this system will require working upstream to entice students to follow this training path.

Conclusion

Washington will benefit from a well-integrated and well planned HMG and Family Connects system. The Family Connects nurse visitors would be one of the first touchpoints for many families into the supports and services that are available for all families in Washington. The introduction of a statewide Family Connects system will allow families a point of entry into common services available for families with young children: early learning, quality child care, traditional intensive home visiting and early intervention much earlier and more quickly when needed.

This is where the HMG system will come into play. However, without an expansion of services that are currently provided in communities across the state, there will be a gap in capacity for the increased number of children and families who need further assistance. A network of services must be created, enhanced or expanded to connect families to enable them to be successful. This will need to include further investment in housing, energy assistance, food security, traditional-intensive home visiting services, early intervention, quality child care and preschools among other local resources that may be specific to each community.

NEWBORN HOME VISITING

Upon the birth of children, all families encounter new situations and many encounter unforeseen challenges to family stability. Addressing family supports and some of the new conditions that families are confronted with in a family with young children can help them enhance the relationships they are able to create with their children, avoid many struggles and ultimately avoid child welfare involvement. There are approximately 5,000 children under the age of 5 in foster care in Washington – this represents about 50 percent of the total children in care.

Factors in the child's first three years of life disproportionately affect what happens at age 5 for the child and the family. DCYF and local communities must address potential challenges to healthy development leading to kindergarten readiness by reaching a broader segment of the population earlier: through an understanding of current realities, increased outreach and referral, expansion of current programs and addressing the additional needs of children assessed, identified, referred and served.

DCYF must collaborate with communities and families to address their unique risks and needs, respond to immediate family needs for support and guidance and connect them to community services well matched to their needs and preferences based on identified vulnerabilities to create confidence and the support needed for child and parent health, mental health, child development and overall well-being for the family.

Community connections and case management are key components in any child's path to school readiness. Additionally, the earlier a child is identified for any health or social-emotional concerns, developmental delays or family challenges, the easier and more quickly the child's family can be referred on and connected to further services. The ongoing support of the family will allow them to navigate the medical, educational and social services that will help move them closer to school readiness: both preschool and K-12. All of these services can be accomplished through the implementation of Family Connects and HMG.

There are not currently any available options for funding portions of the Family Connects system through Medicaid, private insurance and Title IV-E, however they may be available in the future. While none of them are available today, one of the State's immediate planning efforts will need to be to work with HCA to identify how Medicaid can be used efficiently and effectively to serve the population.

There is not currently anyone with the capacity to dedicate to Family Connects and a position will be needed at DCYF to specialize in this model if the expansion is expected. DCYF will also need to revisit their Title IV-E state plan annually to see if Family Connects is added to the list of approved evidence-based programs to be eligible for funding. If it is approved, DCYF should revisit if Family Connects should be added to the state plan for approval by the federal government.

Local funding should also be identified in each community to assist in funding local services. This is not an option only for the state but also for local communities. The state, upon confirmation from the legislature of future funding, should begin to work with philanthropic organizations to expand and extend the reach of any allocated dollars.

Success in the creation of an integrated, statewide system of Family Connects and HMG will look like the seamless offering of free and brief home visiting services to all newborn families in Washington regardless of perceived risk level and the availability of resources and referrals for all those who need them. Funding should allow for different behind-the-scenes billing options based on the situation of families and communities and should never impact the quality, quantity or availability of services to them.