Maryland HealthChoice Waiver - Community Health Pilots
Frequently Asked Questions and Answers for the
Home Visiting Services (HVS) Pilot – Round 2

This document is a compilation of frequently asked questions (FAQs) and responses regarding the Maryland Department of Health's (MDH) HealthChoice Waiver initiative: Home Visiting Services (HVS) Pilots. This document is a living document and will be updated as additional questions are received.

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A. General FAQs

1. Overview, Timeline, and Contact Information

a. What are the Maryland Department of Health's HealthChoice Waiver Community Health Pilots?

MDH Response: As part of the State of Maryland's HealthChoice §1115 Waiver, the Maryland Department of Health (MDH) is facilitating federal matching funds for two pilot programs: (1) Assistance in Community Integration Services (ACIS), for Medicaid enrollees who are high-risk, high-utilizing and either transitioning to the community from institutionalization or at high-risk of institutional placement; and (2) Home Visiting Services (HVS), which offers evidence-based home visiting to high-risk pregnant women and children up to age 2 years.

There is widespread evidence that socioeconomic factors significantly impact health outcomes. Social determinants of health have a particularly strong effect on vulnerable individuals, including the populations served under Maryland's Medicaid program. Coordinating health and social services and addressing social determinants of health through a "whole-person" strategy has shown promise as a way to enhance health outcomes and lower costs. The Pilots are opportunities for communities to be able to clearly demonstrate if, in fact, providing expanded HVS and ACIS to the Maryland Medicaid population is a sustainable model that improves health

outcomes and reduces healthcare costs among the target populations.

b. Is there a specific email address for Community Health Pilot questions and comments?

MDH Response: Yes, you may direct your questions and comments to MDH.healthchoicerenewal@maryland.gov

c. If Lead Entities opted not apply for the first round of Year 01 participation in the Community Health Pilots, may they apply later instead?

MDH Response: Yes; at this time MDH is offering a second round of competition for ACIS and HVS Pilots. New applicant organizations that are qualified to be Lead Entities (see RFA), as well as those Lead Entities in good standing that are already participating in Round 1 and aspire to expand yet again the number of beneficiaries to be served, are eligible to apply.

d. Where can I learn more about the content of the approved programs?

MDH Response: Please refer to the MDH Community Health Pilots website at https://mmcp.health.maryland.gov/Pages/HealthChoice-Community-Health-Pilots.aspx.

Please also refer to the official websites of the approved evidence-based programs for the HVS Pilot:
Healthy Families America (Healthy Families America)
Nurse Family Partnership (Nurse Family Partnership)

e. What are the key deadlines for launching Round 2 of the Home Visiting Services (HVS) Pilot?

MDH Response: The anticipated timeline is as follows:

Deliverable/Activity	**Date**
Release Letter of Intent request for Community Health Pilots	December 4, 2017
Letters of Intent due from Lead Entities to MDH	December 22, 2017
HVS Pilot Application Published by MDH, FAQs released	January 22, 2018
HVS Pilot Application Process Webinar and Review of FAQs	January 31, 2018 1:00pm-2:30pm
HVS Pilot Applications due to MDH	March 26, 2018

Meetings with applicants (clarification & modification discussions)	Early April 2018
HVS Pilot Award Notifications (expected)	Late April/Early May 2018

2. Lead and Participating Entities

a. Who may apply to be a Lead Entity for the Pilots?

MDH Response: Please see the HVS RFA for more detailed information. MDH will accept applications for the Pilots from local health departments, local management boards, a consortium of entities serving a county or region consisting of more than one county or city, a federally recognized tribe, or a tribal health program under a Public Law 93-638 contracted with the federal Indian Health Services. Applicant organizations will act as the Lead Entities during the planning, implementation and evaluation of the project. Lead Entities will need to participate in the financing of the non-federal portion of medical assistance expenditures. Each Lead Entity must be able to provide the non-federal share of payment through an intergovernmental transfer (IGT). Lead Entities will also serve a critical role in providing leadership and coordinating with key community partners, such as Participating Entities, to deliver the programs.

b. Are Departments of Aging, Social Services, or Local Management Boards eligible to be Lead Entities?

MDH Response: Each Lead Entity must be a local government entity, be able to provide the non-federal share of payment to MDH through an intergovernmental transfer (IGT), and manage required fiscal and contractual reporting. Lead Entities will provide leadership and coordination with key community partners to deliver the programs and be responsible for managing the Pilot relationship with MDH.

c. Could you be more specific as to what is meant by coordination with MCOs?

MDH Response: A major goal for the Pilots is to increase access to and coordination of care for the most vulnerable Medicaid beneficiaries. The Pilots are required to have key community partners (Participating Entities) participate in the Pilot. These Participating Entities must have prior experience serving the target population within the targeted geographic area. These Participating Entities should include, but are not necessarily be limited to, Medicaid managed care organizations (MCOs).

MDH recommends that the Lead Entity establish and sustain appropriate linkages and ongoing communications with each MCO in operation within the targeted geographic area. Include in the application a description of how care coordination in partnership with each MCO is to be

implemented and monitored at organizational and provider levels.

d. Can you tell us more about what you are contemplating in regards to coordination with Administrative Care Coordination Units (ACCUs)?

MDH Response: Maryland Medicaid provides administrative grants to each of the 24 local health departments (LHDs) to operate the Administrative Care Coordination-Ombudsman Program (ACC). The primary purpose of the ACC program is to assist Medicaid/HealthChoice beneficiaries to access and appropriately utilize their health care benefits through the provision of care coordination, education, Ombudsman and Medicaid administrative activities. The ACCU program provides administrative services, not direct clinical services or targeted case management.

If applicable, Lead Entities should include a description in their application regarding how they will coordinate with ACCUs in the context of the HVS Pilot work without duplicating or supplanting the ACCU's functions and services. The roles of an ACCU and those of a Lead Entity overseeing the expansion of home visiting services should be separate and distinct.

e. Will funding be distributed as grant funding to Lead Entities?

MDH Response: No. Community Health Pilot funding differs from a typical grant funding process and is not grant funding. Applicants' funding assumptions will be derived from a "per home visit services rate" developed and proposed by the Lead Entity. The amount to be funded will be predicated upon the volume (i.e., number of units) of Pilot-eligible direct services rendered at an agreed-upon unit rate, up to a pre-negotiated amount of eligible total Pilot funding. Pilots must have a lead local governmental entity with the ability to fund fifty percent (50%) of total pilot costs through an intergovernmental transfer (IGT) to MDH. Once MDH receives the IGT from the local entity, the IGT will then be matched with federal dollars. This combined sum will then be disbursed to the Lead Entity to pay for home visiting services rendered.

f. Do you anticipate the Lead Entities having to provide an annual independent financial audit to verify the source of the local funding?

MDH Response: All non-federal entities that expend $500,000 or more of federal awards in a year are required to obtain an annual audit in accordance with the Single Audit Act Amendments of 1996, OMB Circular A-133, the OMB Circular Compliance Supplement and Government Auditing Standards. A single audit is intended to provide a cost-effective audit for non-federal entities in that one audit is conducted in lieu of multiple audits of individual programs. Additionally, the Centers for Medicare and Medicaid Services (CMS) has program monitoring and reporting requirements for the HealthChoice §1115 Waiver as defined in the Pilot Special Terms and Conditions. Lead entities that receive less than $500,000 in federal funds per year may choose to initiate an independent (i.e., external) audit in addition to meeting their own internal auditing standards and requirements. Pilots must report to MDH in accordance with the requirements

contained in the Special Terms and Conditions. Each approved Pilot's reporting requirements will be comprehensively defined in its inter-agency and data sharing agreements with MDH.

g. Does the State expect a particular approach to referring individuals to these programs or do the applicants have leeway to propose their own?

MDH Response: Each Lead Entity is to define its own referral-making and referral-receiving policies and procedures. In the Request for Application, MDH asks the application team to describe the Lead and Participating Entities' processes for identifying and prioritizing eligible participants, in addition to defining referral mechanisms and methods. For example, if a physician affiliated with an MCO makes a referral for home visiting services, how will the Lead or Participating Entity receive and respond to such a referral?

h. Is a Home Health Agency considered a Lead or Participating Entity?

MDH Response: A Home Health Agency would not be considered for a Lead Entity. Please reference Section A.2.a for the requirements for a Lead Entity. A Home Health Agency could be considered as a Participating Entity depending on the role it may play. For the HVS Pilot, if a Lead Entity is considering a Home Health Agency as a direct service provider, the Home Health Agency must be HFA or NFP accredited.

i. Are only the Lead Entities required to complete the Letter of Intent?

MDH Response: Yes, only the Lead Entities are invited to complete the Letter of Intent (LOI), which is optional but recommended.

j. Can you provide an example of Lead Entities besides the Local Health Department?

MDH Response: In addition to Local Health Departments, other Lead Entities may be Local Management Boards, a consortium of entities serving a county or region consisting of more than one county or city, a federally recognized tribe, or a tribal health program under a Public Law 93-638 contracted with the federal Indian Health Services.

k. What are the expectations for demonstrating execution of the partnerships with other entities for purposes of administering the Pilots?

MDH Response: The Lead Entity is required to include a letter of commitment from each of the Participating Entities in its application. Each letter of commitment must indicate the role that the Participating Entity will serve throughout the planning, implementation, and evaluation of the Community Health Pilot, along with the Participating Entity's capacity to perform proposed responsibilities. If and when the application is approved and funded, the Lead Entity will be responsible for executing all necessary contracts and data use agreements with each

Participating Entity.

3. Finance

a. What is the possibility of new funding after the 4.5 year Pilot period? Will Pilots need a financial sustainability plan for the post-Pilot years?

MDH Response: The availability of funding beyond this waiver renewal period is currently unknown. An applicant for the Pilot funds must explain how such funding will align with the applicant's long term programmatic goals. This will include addressing the needs of the Pilot target population through expanded service delivery, and the proposed methods of program and financial sustainability. The results of the Pilot evaluation will inform Maryland Medicaid's programmatic decisions regarding future waiver renewal applications.

b. Will MDH be limiting the number of awards made (e.g., to two, three, four consortia)?

MDH Response: MDH does not anticipate putting any a priori limits on the number of awards to be made as a result of the Round 2 competition. At this time, MDH does not yet know how many eligible entities will apply, the proposed funding amounts applicant organizations will be able to provide as the required non-federal share, and other relevant information needed to make such a determination.

c. Is the local match an In-Kind or Cash Match?

MDH Response: The local matching funds must be a cash match comprised of an electronic transfer of funds to MDH. MDH prefers a one-time, up-front, lump-sum payment of the required local match. However, if a Lead Entity is not able to make a lump-sum payment at the beginning of the contract, the Lead Entity may make quarterly payments of the required local match, with the first quarter payment due at the onset of the contract, and the second, third and final quarterly payments due no later than the beginning of Months 4, 7 and 10 of the first one-year contract.

d. Which line items of the MDH 4542 Budget Request Form should be used in the context of the proposed project budget? Which costs are (im)permissible?

Our guidance here aligns with the structure and contents of the MDH 4542 Budget Request Form.

Costs associated with the *initial* training of newly hired, transferred or contractual staff are <u>not</u> permissible. However, costs associated with the *ongoing* training of individuals delivering home visiting services <u>are</u> permissible.

Direct personnel expenses incurred during the delivery of *expanded* home visiting services are

permissible. Direct personnel expenses in support of staff employed by the Lead Entity should be indicated on line items 0111(Salaries), 0121 (FICA), 0131 (Retirement), 0141 (Health Insurance), 0161 (Unemployment Insurance), 0162 (Workmen's Compensation), and 0171 (Overtime Earnings, if any). Direct personnel expenses in support of staff employed by or under contract with a Participating Entity should be indicated on line item 0881 (Purchase of Care).

The following line item costs are permissible if they are solely related to the delivery of Pilot services: office supplies (0965), educational supplies (0919), advertising (0801), postage (0301), printing (0873), and language translation (0816) expenses, dues and memberships (related to evidence-based program accreditation), in-state travel (0405) (i.e., reimbursement of local mileage), and cellular telephone purchase/use (0304).

Flat-rate indirect expenses (e.g. 10% flat indirect rate) and expenses such as rent (1334) and utilities (0604, 0613, 0615, 0701) are impermissible costs.

This is not an all-inclusive list of permissible and impermissible line items. Any specific questions regarding which costs are or are not permissible should be submitted to MDH prior to application submission.

e. Will MDH be providing a template for invoicing under the Pilot?

MDH Response: Yes, MDH will provide a template for invoicing to each approved Lead Entity.

4. Evaluation

a. Will MDH contract with outside entities (e.g., local universities) to conduct Pilot program evaluation?

MDH Response: Yes, MDH anticipates working with its evaluation partner, The Hilltop Institute at the University of Maryland, Baltimore County (UMBC), and may partner with other evaluation entities that are yet to be determined. MDH also expects that Pilots will conduct self-monitoring, evaluate their activities and performance, and report the results of such evaluations to MDH.

b. Will there need to be data use agreements between the awardees, the MCOs, Hilltop, and MDH? Will these need to be in place prior to implementation?

MDH Response: Yes; final approval of any application will be subject to the Lead Entity's mandatory agreement to the forthcoming inter-agency and data use agreements, which will govern the Lead Entity's assurances to provide the required data elements, as well as the exchange and utilization of the data involved in the Community Health Pilot.

B. FAQs Specific to Evidence-Based Home Visiting Services (HVS) Pilot Program

1. Target Population

a. Who would be eligible for home visiting services in this program?

MDH Response: The intent of the HVS Pilot funding opportunity is to expand evidence-based home visiting services to Medicaid eligible high-risk pregnant women and children up to age 2. To participate in the HVS Pilot, the recipient must be an enrolled Medicaid beneficiary. The HVS Pilot service delivery process must align with at least one of two evidence-based models that focus on the health of pregnant women and children up to age 2: Healthy Families America (HFA) and Nurse Family Partnership (NFP).

As provided in the HVS Pilot RFA, HVS Pilot applicants could establish primary or secondary target groups of Medicaid beneficiaries, as a way to prioritize the highest risk sub-populations identified as being the most urgently in need of Pilot services :

Primary Risk Factors	Secondary Risk Factors
● Adolescent ≤ 15 years ● Late Registration > 20 wks into pregnancy ● Abuse/Violence ● Alcohol/Drug Use (may target by substance) ● Less than 1 year since last delivery ● History of fetal/infant death ● Non-compliance	• Disability (intellectual /physical / developmental) • Less than 12th grade education or no GED • Lack of social/emotional support • Housing/environmental concerns • Smoking/tobacco use

b. If the HVS Pilot is limited to Medicaid eligible groups, how will eligibility for undocumented postnatal women with Medicaid eligible children be determined?

MDH Response: The HVS Pilot is designed to provide evidence-based home visiting services for high-risk Medicaid enrolled pregnant women and children up to age two. Undocumented pregnant women are ineligible to enroll in Medicaid, and services other than labor and delivery cannot be paid by Medicaid. Thus, they are not eligible to participate in the HVS Pilot. Children enrolled as Medicaid beneficiaries are eligible to receive HVS Pilot services. HVS Pilot applicants must follow the program model's guidelines. For HFA, enrollment must occur before the child turns 3 months old. For NFP, enrollment must occur before the 28th week of pregnancy. A child must be enrolled by these cut-off points in order to receive HVS Pilot services.

c. Will the Lead Entity and its chosen local partners be required to identify which specific Medicaid beneficiaries have received HVS funds through the Community Health Pilot?

MDH Response: Yes; Lead Entities must accomplish this by providing either (1) a Medicaid

identification number; (2) a combination of the beneficiary's first and last name, birthdate, and Social Security number; or (3) optimally both (1) and (2). Prior to providing each unit of pilot-eligible service, a beneficiary's Medicaid eligibility must be verified through the Maryland Medicaid Eligibility Verification System (EVS). An authorized representative of the Lead Entity will be required to log the EVS verification date and number in a month-by-month digital record of pilot-eligible home visiting services. This record is subject to auditing by MDH, the Hilltop Institute at UMBC, and federal partners.

d. Are HVS Pilot payments limited to Medicaid beneficiaries (at initial enrollment and for the duration of their enrollment), even if these beneficiaries lose Medicaid eligibility?

MDH Response: Pilot payments are limited to Medicaid beneficiaries for as long as they are actively enrolled in Maryland Medicaid. When a pregnant mother initially enrolls in the HVS Pilot, the mother must already have been enrolled in Medicaid. This mother will be Medicaid eligible for up to 60 days after she gives birth. However, if the mother loses Medicaid eligibility but the index child continues to be enrolled in Medicaid, the child is considered the Medicaid beneficiary being served. If that child is eligible for Medicaid, both the mother and the index child may continue to participate in the home visiting services pilot program.

e. Can a family enroll after a pregnancy has concluded if there are still children under the age of 2 in the family?

MDH Response: HVS Pilot applicants must follow the program model's guidelines. For HFA, enrollment must occur before the child turns 3 months old. For NFP, enrollment must occur before the 28th week of pregnancy a child must be enrolled by these cut-off points in order to receive HVS Pilot services.

f. If beneficiaries are currently enrolled in an evidence-based home visiting program, such as HFA, can they partake in the HVS Pilot at the onset of the Pilot's implementation or do beneficiaries need to be newly enrolled once the HVS Pilot begins?

MDH Response: Current participants in evidence-based or other HVS are not eligible to be enrolled in the HVS Pilot. The HVS Pilot opportunity is intended to *expand* services to additional clients who are Medicaid beneficiaries. The act of moving a currently enrolled HFA client to the newly expanded HVS Pilot program would be considered supplanting and is not allowable under Federal rules.

g. For section 5.1 in the application can you clarify what is considered a beneficiary? Does this number include individuals, families as a whole, or should primary care givers be separate from the targeted children served?

MDH Response: If enrolled in the HVS Pilot prenatally, the pregnant woman serves as the primary

beneficiary of Home Visiting Services. Following the birth of her child, the child becomes the "index child" and the primary beneficiary of home visiting services. The State will require Lead Entities selected for Pilot participation to utilize a data reporting template that will include additional specifications regarding data elements and reporting.

2. Services

a. Would work outside of the typical Healthy Families America (HFA) model have to be covered by another non-federal funding source? For example, for a Healthy Families - MIECHV program, a team may consist of a support worker with a public health nurse. Under this model, Medicaid funding could cover the HFA support worker, but would the Lead Entity have to cover the public health nurse with non-federal funding?

MDH Response: Pilot funding is only available for direct services delivery and will be based on a "per home visit services rate," which is to be developed and proposed by the Lead Entity. HVS Pilot funded services must align with at least one of two evidence-based models that focus on the health of pregnant women: HFA or NFP. MDH is not permitted to fund HVS that are offered outside of an HFA- or NFP-accredited program, or are not currently compliant with HFA- or NFP-accreditation standards. Pilot programs should maintain fidelity to the selected evidence-based model, including with regard to the model's staffing requirements. Any additional services or staffing plans which are not compliant with the HFA or NFP model may not be funded using HVS Pilot award funds.

b. How can applicants get in touch with an HVS provider in their area, or find out about HVS activities in their jurisdiction, including those related to MIECHV?

MDH Response: A list of currently HFA accredited programs by jurisdiction is noted below in Section 2. or upon request to mdh.healthchoicerenewal@maryland.gov.

c. Is the HVS Pilot an opportunity to enhance and expand upon home visiting services?

MDH Response: Yes; the HVS Pilot is an opportunity to expand upon home visiting services. In fact, *expansion* of existing home visiting services is an essential requirement for pilot funding eligibility. The HVS Pilot was developed in response to local jurisdictions' requests for a funding path to *expand* evidence-based home visiting services to Medicaid eligible high-risk pregnant women and children. The HVS Pilot is an opportunity for communities to demonstrate if, in fact, providing *expanded* evidence-based HVS using Medicaid resources is a sustainable model that improves health outcomes and reduces healthcare costs among the target populations.

d. Is there a list of Local Health Departments that are planning to apply with which applicants may collaborate?

MDH Response: The HVS Pilot is being offered as a competitive funding opportunity and MDH is unable to supply the names of the interested entities at this time. Nevertheless, in order to facilitate collaboration, MDH has included below the jurisdictions that currently operate an HFA or NFP program. MDH recommends that entities interested in collaborating should reach out to the Local Health Officer in the appropriate jurisdiction. MDH will provide a public announcement of Pilot awardees after applications have been approved, and Lead Entities have been notified of their receipt of an award.

Current Evidence-based Home Visiting Programs (HFA and NFP*) in Maryland by Jurisdiction

Jurisdiction	Agency	Current Status
Allegany	Health Department	Accredited
Baltimore County	Health Department	Accredited
Baltimore City*	Family League	Accredited
Calvert County	Public Schools	Accredited
Charles County	Center for Children	Accredited
Dorchester	Health Department	Accredited
Frederick	Mental Health Association	Accredited
Garrett	Health Department	Accredited
Harford	Health Department	Accredited
Howard	Howard General Hospital	Accredited
Lower Shore (Somerset)	Eastern Psych Association	Accredited
Mid Shore	Health Department	Accredited
Montgomery	Family Services	Accredited
Prince	Dept. Family Services	2 Sites

George's		Accredited; 1 site Affiliated
Washington	Health Department	Accredited
Wicomico	Health Department	Accredited

e. When MDH says "services not otherwise covered," how might that work with developmental and maternal depression screening? Can those be part of a HVS payment, per visit rate?

MDH Response: Some types of screening, such as a developmental screening and a maternal depression screening, are inherent components of the HFA and NFP evidence-based models of practice, as defined by HFA and NFP standards. Pilot funding is available for direct services delivery only at a negotiated "per home visit services rate." This rate is based upon the cost of delivering a *unit* of home visiting service, not a specific screening that is a component of this *unit* of service. If the type of developmental and maternal depression screenings falls within HFA and NFP "*Description of Services*" outlined in STC 29: Attachment D, such services may be included in the "per home visit services rate." However, it is not permissible to bill separately for each screening or for any other specific component of a *unit* of home visiting service.

f. How do HFA and NFP compare to the Residential Services Agencies?

MDH Response: HFA and NFP are not related to Residential Service Agencies, and have different objectives. Maryland describes Residential Services Agencies as **"**An agency that provides supportive home care services, for example, assistance with ADL's and/or housekeeping services, some nursing services, and may provide one or more home care service such as provision of oxygen or medical equipment such as wheelchairs, walkers and hospital beds."

According to the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), evidence-based home visiting services such as HFA and NFP support pregnant women and families with young children by assisting them in accessing services and acquiring the necessary skills to raise children who are physically, socially, and emotionally healthy and ready to learn. These programs improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development.

g. What happens next if home visiting services need to continue after the child turns two and ages out of the pilot program?

MDH Response: MDH would expect the Lead Entity to coordinate with the family and Participating Entities, such as the beneficiary's MCO, to identify the family's specific needs and transition the family to other programs or services within the jurisdiction that could support the

family's need. For example, if the Lead Entity has access to MIECHV funding, it may be feasible to fund the continuation of home visiting services using such funding. Please contact MDH's MCH team for more information on this option.

h. Is care coordination considered a direct provision of service?

MDH Response: If the type of care coordination this question poses falls within HFA and NFP *Description of Services* outlined in STC 29: Attachment D, such care coordination services are to be included in the "per home visit services rate."

i. Please provide examples of other services that might be considered to be funded. For instance, would supportive services, such as nutrition counseling, that fall outside of the HFA model be funded?

MDH Response: Only services outlined in HFA and NFP *Description of Services* STC 29: Attachment D are eligible for Pilot funding.

j. Can applicants reach out to accredited providers outside the county? For example, local procurement regulations may require contracts to be competitively bid. If an applicant is limited to the one provider listed in the applicant's county, the applicant needs to have this in writing from MDH in order to execute a sole source contract.

MDH Response: Lead Entities should follow local procurement rules and policies.

k. The letter of intent instructions specify that services may be provided to children up to age two years. However, HFA national accreditation requires services until age three years. Will the HVS Pilot program be limited to serving children under age two?

MDH Response: Yes; the HVS Pilot program will be limited to serving children under age two years.

l. Our understanding is that the MDH MIECHV Program will allow its staff to be supervised by staff funded by another source, as long as data is shared with the MIECHV Program. Will the HVS Pilot Program similarly allow its Pilot funded staff to be supervised by staff funded by another source?

MDH Response: Yes; this will be permitted. A description of how this proposed arrangement would work should be included in the submitted HVS Pilot application's staffing plan section.

3. Finance

a. Given that federal funds are involved, do federal policies and procedures apply, such as MDH

MIECHV?

MDH Response: Yes; Medicaid, as well as other program integrity federal rules and regulations, apply.

b. Will HVS Pilot funding be limited to the counties currently using eligible evidence-based home visiting programs?

MDH Response: The competition for home visiting services pilot funding is open to any county that is interested in participating and can produce the non-federal portion of funding for HVS service delivery as a cash transfer to MDH. The intention of the HVS pilot is to expand HVS service delivery through HFA or NFP programs. This may be accomplished either through 1) expanding existing HVS programs, 2) leveraging non-Pilot funds for start-up costs of a new HFA or NFP program and then using HVS Pilot funds along with the required match to pay for HVS service delivery through either a governmental entity or a contracted HFA or NFP program, or 3) entering into a partnership with one or more counties with existing HVS programs. Given the time, effort, and cost of initiating a new HFA or NFP accredited program, a qualifying Lead Entity is advised to consider partnering or contracting with HFA or NFP programs that are already in operation.

c. Can Community Health Pilot funds be used to supplement or offset the cost of designing one of the evidence-based programs (i.e., Health Families America; Nurse Family Partnership)?

MDH Response: No, Pilot funding is available for direct services delivery only and based on a "per home visit services rate" proposed by the Lead Entity. There is no start-up funding available in this Pilot demonstration. MDH is facilitating this matching federal funding opportunity in response to local programs who have expressed the need for expansion of evidence-based HVS. Funds are not available to build infrastructure or address start-up costs, such as program licenses and training. Lead Entities may have other resources that could be used to build capacity to start-up the program of their choice (HFA or NFP).

d. Is it permissible to assign already existing staff to provide HVS to eligible Medicaid beneficiaries participating in the Community Health Pilot waiver program?

MDH Response: Pilot funding is only available to support the *expansion* of home visiting services. If the financial support of pre-existing home visiting staff is already being matched with another source of federal funds, such as MIECHV funds, then duplicative assignment of these same staff to pilot funding is not permissible. Pilot funding may not be used to supplant, "double dip" or to replace existing services.

e. Are there any circumstances in which "braiding" of existing funded may be permitted? For example, may Maryland MIECHV and pilot funds be braided?

Yes, braiding of funds may be permitted when used in the following context, to address certain limitations of Medicaid HVS funding. While there is no single dedicated funding source available for home visiting services, selected federal funding streams can be paired with state and local funds to support a full package of services for pregnant women, families, infants, and young children.

Some local entities applying for the HVS Pilot may require additional resources beyond what are permissible for Medicaid to fund to expand their home visiting services. Lead Entities may use Medicaid Pilot payments in tandem with additional funding sources available through other federal, state or privately funded programs, provided these funds are not already being used as a match for another program. Prior to pairing pilot funds with other pre-existing funds, any change in a prior fund allocation must be approved by the grant manager(s) for these pre-existing funds, and these pre-existing sources of funding must be described in the HVS Pilot application.

Pairing of funds takes place when two or more sources of funds are spent for a single programmatic purpose in such a way that each source of funding can still be accounted for separately. Pairing is not combining two or more sources of funding in such a way that it would be difficult or impossible to tell which source was allocated for which program purpose. Pairing of funds does not result in any changes to the award terms and conditions that accompany each source of funding.

Federal Medicaid matching HVS Pilot funds may only be used for costs associated with the provision of direct home visiting services (per unit cost). Lead Entities may also be allowed to use a portion of their allocated MIECHV funds to pay for training costs, necessary for either of the two evidence-based maternal and child health programs aligned with the HVS Pilot (HFA and NFP). Any MIECHV funds that the Lead Entity may request are not eligible to be used by the Lead Entity to meet the local funding Medicaid match requirement, and their purpose must be approved at the discretion of MDH Office of Community Health Services prior to this funding application. These separate funds may not be factored into the proposed rate (per unit cost) as part of this application. MIECHV reporting requirements for staff supported through training will be implemented.

Further guidance may be found here: CMS/HRSA Coverage of Maternal, Infant, and Early Childhood Home Visiting Services Joint Information Bulletin, March 2, 2016 (https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf

f. If funds are braided, may such funds be counted toward meeting the local cash match requirement?

MDH Response: No; use of existing federal funds to achieve a match in order to obtain additional federal funds is not allowed. However, pairing or braiding of local funds and philanthropic grants or gifts is allowed.

g. Can the Pilot funding be applied to existing Healthy Families America accredited programs? If so, can existing local funding for an HFA program be used to satisfy the match requirement for the HFA program if the program enrollment is either expanded or not expanded under the proposal? In other words, is there a local funding supplantation prohibition?

MDH Response: Supplantation of existing funds and services is prohibited. Pilot funding is strictly for *expansion* of HFA or NFP accredited programs to Medicaid eligible families. Current local funding for HFA or NFP home visiting services programs may only be used to satisfy the local match requirement if it will result in a service *expansion* to increase the number of families served. In addition, existing local funding can be used to achieve the local match requirement, as long as it is from a permissible source.

h. How long will it take for payment to be disbursed back to the Lead Entity after the Lead Entity has submitted its request for payment?

MDH Response: Payment is expected to be disbursed on a quarterly basis for home visiting services rendered. This is a Pilot with new funding parameters and processes which have been set up to account for systems limitations, Pilot Lead Entities will have to manually claim for services from MDH. Lead Entities will be paid on a quarterly basis and will be required to provide the local funding match via an inter-governmental transfer (IGT) at the start of the Pilot, and will then receive complete payment for home visiting services rendered.

i. Can modifications be made to the cost of project in the second year of implementation? For example, if a site provides more billable visits than initially estimated, can that be adjusted in the second year?

MDH Response: Once the Year 1 project budget for the Lead Entity is approved, this Year 1 budget may not be increased at any time during Year 1. However, MDH expects that there may be adjustments to the proposed project budget for Year 2 based on Year 1 experience. The magnitude of any adjustments will be based upon justified projected expenditures. It will also be based on availability of Lead Entity funding to meet the local match requirement as well as the amount of federal matching funds that remains available. Proposed adjustments to the project budget for Year 2 will be considered in the context of MDH's review of the Year 1 annual report; the proposed Year 2 work plan, Year 2 unit rate, Year 2 operating budget, and Year 2 budget justification; and the proposed sources of the Year 2 local match.

j. Can a portion of local funds be private, non-profit philanthropic dollars from a foundation?

MDH Response: This may be permissible, as long as any and all restrictions that accompany the philanthropic grant are fully upheld, the money is otherwise unencumbered, and the funding sources are from an allowable matching fund source. In the case of a restricted grant, whether or not it may be applied to support expansion of home visiting services depends on the terms of the

restrictions that come with the award. In contrast, non-restricted philanthropic funding is usually a grant made to the general operating fund of the Lead Entity without any limitations, such as restrictions in regard to the specific program or population to be served. Use of non-restricted philanthropic funding is typically permissible. MDH reserves the right to evaluate funding sources at any stage of the Pilot, whether during the review of the application for funding or at a later point in time when project-relevant philanthropic funding is received and reported to the MDH by the Lead Entity.

k. If a program is being reimbursed by number of home visits, what should Lead Entities do if they have family that is on Level X where the Lead Entity still needs to engage families for approximately three months and often no home visit has taken place? Would programs still be reimbursed?

MDH Response: Pilot funding is for direct services delivery only and based on a "per home visit services rate" for Medicaid eligible high-risk pregnant women and children up to age 2. Services to this population that are within the parameters of the HFA and NFP "*Description of Services*" outlined in STC 29: Attachment D are eligible for reimbursement at a "per home visit services rate." Reasonable expenses related to outreach and client follow-up are allowable expenses and may be included in the per home visit rate. Any operational costs driven by programmatic alignment with HFA-defined standards, including costs associated with limitations to caseload size and number of visits completed, should be factored into the proposed home visiting services rate.

l. What kind of per visit rate are you expecting to see in the proposals?

MDH Response: The per visit rate is based on the cost of successfully completing a home visit. MDH defines a completed home visit for Medicaid HVS Pilot billing purposes as using HV tools, policy and practices during a face-to-face interaction that is delivered by a trained Home Visitor either where a Medicaid eligible index child is present along with at least one guardian, or with a pregnant woman with Medicaid coverage. Average time spent is one hour and the visit is documented.
As described in the following excerpt from STC 29: Attachment D (Appendix B), allowable components that make up a home visiting services rate (per unit cost):

"...The unit cost that will be based on such things as, estimated salary costs, travel cost, reporting costs, and other reasonable and necessary expenditures divided by the number of expected number of visits. The expected number of visits will be based on the model, the number of beneficiaries to be served, and the number of home visitors. MDH will evaluate the reasonableness of the unit cost and total payment. MDH anticipates that the initial quarterly payments will be prospective, and thereafter retrospective based on the Lead Entity's actual HVS services rendered. In turn, MDH anticipates that the HVS provider will invoice the Lead Entity monthly or quarterly for home visits provided to a specific Medicaid beneficiary based on the Lead Entity and HVS provider's contractually agreed upon payment schedule. Lead Entities are expected to submit a budget proposal and narrative that reflects average expected evidence-

based home visiting frequency and intensity, taking into account the potential for variations, that is, accommodating for those few cases that may require more intense visits."

MDH recognizes that developing a per home visit rate may be challenging given that many existing evidenced-based home visiting programs are not currently structured using a per-visit unit cost. Following release of the HVS RFA, additional individualized technical assistance will be offered to interested entities on home visiting rate development, upon request. HVS Pilot applicants should email mdh.healthchoicerenewal@mdh.gov to request individualized technical assistance.

A discussion of cost and rate development methodologies for evidence-based HVS programs may be found in the Mathematica Policy Research study "Cost of Early Childhood Home Visiting: An Analysis of Programs Implemented in the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative." Additional resources that may be useful for HVS rate development will be posted on the MDH website and shared with interested entities as they become available.

MDH must review and approve any proposed unit rate before it goes into effect.

m. Is the per visit fee to be established for each application or will it be applied state-wide?

MDH Response: The per home visit rate is to be established by each Lead Entity in negotiation with MDH. Please refer to 3k. above for details.

n. In future years, will funding be available for jurisdictions who want to start an evidence-based program in lieu of a vendor?

MDH Response: No; HVS Pilot funding, now and in the future, is available for direct services delivery only and based on a "per home visit services rate" for HFA or NFP that is to be developed and proposed by the Lead Entity. Funds are not available to build infrastructure or to address start-up costs, such as initial accreditation fees and *initial* staff training. Any additional services which are outside of the scope of HFA or NFP direct service delivery may not be funded using Pilot award funds. Lead Entities may have other resources that could be used to build capacity to stand-up the program of their choice (HFA or NFP).

o. What is the total funding available and the annual funding available for the HVS Pilot?

MDH Response: CMS approved the Pilots for a 5-year waiver renewal period. The HVS Pilots have an effective date of July 1, 2018. They will run over a 4.5 year period through December 31, 2021. For the HVS Pilot – Round 2, up to $2.5 million in matching federal funds are available annually. When combined with the local non-federal share, HVS Pilot expenditures may total up to $5.1 million annually.

p. Can the time for required training of new staff be included in the rate calculation?

MDH Response: No; the costs associated with required training of new staff may not be included in the rate calculation.

Medicaid Pilot funds are not available for HVS Pilots to build infrastructure or address start-up costs, such as initial accreditation fees and *initial* staff training. The Lead Entity should develop its funding request based on a per home visit rate (per unit cost). As described in the following excerpt from STC 29: Attachment D (Appendix B), allowable components that make up a home visiting services rate (per unit cost):

"...The unit cost that will be based on such things as estimated salary costs, travel cost, reporting costs, and other reasonable and necessary expenditures divided by the number of expected number of visits. The expected number of visits will be based on the model, the number of beneficiaries to be served, and the number of home visitors. MDH will evaluate the reasonableness of the unit cost and total payment. MDH anticipates that the initial quarterly payments will be prospective, and thereafter retrospective based on the Lead Entity's actual HVS services rendered. In turn, MDH anticipates that the HVS provider will invoice the Lead Entity monthly or quarterly for home visits provided to a specific Medicaid beneficiary based on the Lead Entity and HVS provider's contractually agreed upon payment schedule. Lead Entities are expected to submit a budget proposal and narrative that reflects average expected evidence-based home visiting frequency and intensity, taking into account the potential for variations, that is, accommodating for those few cases that may require more intense visits."

4. Evaluation

a. Will program data need to be entered into "ETO" or other data systems, such as the MDH MIECHV program, in addition to PIMS, as is required by HFA?

MDH Response: Lead Entities will be required to provide MDH with specific program and individual level data. This may be in the form of a data extract from an existing data system or the creation of a spreadsheet. MDH expects that HVS Pilot awardees will already have in place, or will contract for, a Performance Management System with the capabilities for data collection, record keeping, data sharing, data analysis, reporting and demonstrating quality improvement, in accordance with HVS Pilot reporting requirements, as outlined in the STC: Attachment D, RFA, and any other applicable MDH guidance. In the submitted application for funding, HVS Pilot applicants must indicate which system(s) they are using. Medicaid and Public Health staff is collaborating to seek future alignment opportunities with existing data systems and the HVS Pilot requirements.

b. What goals/outcomes/targets does MDH expect for the HVS Pilots?

MDH Response: The goal of the HVS Pilot is to create opportunities for communities to be able to demonstrate if, in fact, providing *expanded* HVS services within certain high-risk Medicaid

populations in Maryland is a sustainable model that improves health outcomes and reduces healthcare costs among the target populations. Pilots will be required to report measures and outcomes as outlined in the RFA.

c. Will the data requirements for HVS be comparable to or different from the MIECHV data requirements?

MDH Response: To the extent feasible, MDH has made attempts to align data requirements for the HVS Pilot with those for the MIECHV program. Currently, 21 out of 24 Maryland county and city health departments (including Baltimore City) offer evidence- based home visiting services through the Federal Home Visiting Program (MIECHV) administered by HRSA. MIECHV has established multiple data collection elements of which MDH has adopted a subset for the purposes of HVS Pilot funding and evaluation. The decision for modifying data collection elements for the HVS Pilots is based on several factors. Primarily, the HVS Pilots are designed to demonstrate evidence-based HVS value specific to the Medicaid program, to make certain all Medicaid funding and reporting requirements can be met, and to align with goals of the CMS Maternal and Infant Health Initiative and CMS's Child Core Set Measures.

d. How will you integrate the counties that do not currently receive MIECHV funds and are not in that data system?

MDH Response: This opportunity is open to any qualified lead entity in any county interested in participating and can produce the non-federal portion of funding for HVS service delivery. All evaluation elements required for HVS Pilot compliance and reporting are available within PIMS, Healthy Families America's data reporting system, and Efforts to Outcomes (ETO)/Insight, the Nurse Family Partnership data reporting system.

Counties that do not currently receive MIECHV funding may use HFA or NFP data collection systems to provide HVS Pilot required data to the Maryland Department of Health (MDH).