Maryland’s 1115 HealthChoice Waiver Community Health Pilot Development PHASE Internship

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Agenda

• Introduction to MD Medicaid and 1115 HealthChoice Waiver
• Community Health Pilot Overview
• Assistance in Community Integration Services Pilot (ACIS)
• Evidence-Based Visiting for High Risk Pregnant Women and Children up to Age 2 Pilot (HVS)
• Process of Development of the Pilot Programs
• Policy and Practice Implications
• Next Steps
• Lessons Learned
• Acknowledgements
• References
§1115 HealthChoice Waiver

- Established in 1997, under §1115 of the Social Security Act
- Mandatory managed care program
- Covers over 80% of Maryland’s Medicaid population
- 2017 focuses on developing cost effective services that target the significant, complex health needs of individuals enrolled in Medicaid – effective from January 1, 2017 to December 31, 2021

What’s in the 2017 §1115 HealthChoice Waiver Renewal?

- Residential Treatment for Substance Use Disorders (Eff. Date: July 1, 2017)
- Limiting Medicaid Payment for Observation Stays in Hospitals to 48 Hours (Eff. Date: January 1, 2017)
- Dental Expansion for Former Foster Youth (Eff. Date: January 1, 2017)
- Increased Community Services Program (Eff. Date: January 1, 2017)
- Community Health Pilot programs (Eff. Date: July 1, 2017)
Community Health Pilot Overview

- Vision: empower communities to use innovative solutions to promote care integration for high risk high utilizers in the Medicaid community
- Pilot approach was modeled after California’s Whole Person Care Pilot
- Federal matching funds for community health pilots: assistance in community integration services (ACIS), and expanding evidence-based home visiting services for high-risk pregnant women and children up to age 2 (HVS)
- Pilots have a Local Health Department or Management Board act as a Lead Entity with the ability to fund 50% of Pilot costs with local dollars through an intergovernmental transfer (IGT)
- The Pilot programs were requested by local stakeholders interested in home visiting and housing issues
- Lead Entities will coordinate with local organizations (Participating Entities) to deliver services
- 4 ½ year pilot programs
Assistance in Community Integration Services Pilot (ACIS)  
(formally known as Limited Housing Supports Pilot)

- Goal: to identify high-risk, high-utilizing Medicaid beneficiaries at risk of institutionalization and assess unmet need to:
  - Improve health outcomes
  - Promote appropriate use of health services
  - Reduce unnecessary utilization of emergency departments
- Target populations must meet certain health and housing vulnerability criteria
- Shift from original proposal
- $2.4 million annually in federal financial participation
- Not allowed to be used for room and board
Evidence-Based Home Visiting for High Risk Pregnant Women and Children up to Age 2 Pilot (HVS)

- Goal: to expand home visiting programs across MD to improve maternal, newborn, and child health outcomes and promote appropriate use of health services to reduce unnecessary utilization of emergency departments
- Targeted at high risk pregnant women and mothers with children under age 2
- $5.4 million annually in federal financial participation
- Must align with at least one of two evidence-based models: Nurse Family Partnership (NFP) or Healthy Families America (HFA)
Evidence-Based Home Visiting

Healthy Families America (HFA)

• Evidence-based model serving over 100,000 families across North America
• Visits are available prenatally to age 5 *(the HVS pilot will only serve children up to age 2)*
• Fosters healthy childhood development
• Provides at-risk mothers necessary resources and skills to care for an infant/child
• Improves maternal and child health
• Reduces child abuse and neglect

Nurse Family Partnership (NFP)

• Registered nurses are home visitors for high risk mothers in poverty prenatally to age 2
• Fosters healthy childhood development
• Provides at-risk mothers necessary resources and skills to care for an infant/child
• Improves maternal and child health
• Reduces child abuse and neglect
Presence of NFP and HFA home visiting programs

Home Visiting in Maryland
Funding Flow for Home Visiting Services Pilot

Lead Entity contributes local share of pilot project funding

Intergovernmental Transfer (IGT)

DHMH draws down matching federal funds

Using both local and federal dollars, DHMH disburses pilot project funds to Lead Entity

Payment

Lead Entity receives pilot project funding (Next arrow: Choose one or the other)

Lead Entity provides services “in-house;” accounts for direct service expenditures on Budget form 4542

Lead Entity pays Participating Entity retrospectively for services delivered
Process of Development of the Home Visiting Pilot

- Created the application, letter of intent (LOI), budget and financial documents, supporting documents
- Tools for communicating with local stakeholders
  - Local health department meetings, local health officer and staff meetings, FAQs, informational documents (one-pagers, summaries, etc.)
- Worked with CMS to finalize STCs and post approval protocols
- Collaborated with internal DHMH stakeholders and subject matter experts
Timeline for Home Visiting Pilot

January
HealthChoice Waiver Renewal approved by CMS

February - April
Development of application, funding specifications, supporting documents, evaluation mechanisms

May
Release Letter of Intent

June
Release of request for applications and FAQs

July
DHMH reviews applications

August/Sept.
Matching fund awards made and Pilots begin
Next Steps...

- Review applications and make award payments
- Monitor and evaluate Pilot progression over the next 4 ½ years
- Based on the final evaluation, determine whether home-visiting or supportive housing services should be included in the Medicaid managed care program
Policy & Practice Implications

The pilots are designed to answer the following questions:

• Does providing Medicaid funding for home visiting services or supportive housing services improve the health outcomes for high risk beneficiaries?
• Is it cost-effective to include home visiting programs and supportive housing in the managed care package?
• What is the most effective way to facilitate improved coordination between local health departments, DHMH, and Maryland MCOs?
• Could these programs be a model for other states?
• What are other innovative ways to tackle social determinants of health through Medicaid programs in general?
Lessons Learned from PHASE

- Connecting research to policy
  - Evidence-based programs ➔ Medicaid policy

- Collaboration
  - This project relied on many departments and organizations from across DHMH and local stakeholders

- Flexibility
  - Timelines change, deadlines change

- Teamwork
  - Needed many different skill sets to develop the programs
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Questions


