Medicaid Reimbursement for Doula and Home Visiting Services: Recommendations of the Sustainability Subcommittee of the Home Visiting Task Force

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I. Overview

As the designated advisory body for the Maternal Infant and Early Childhood Home Visiting (MIECHV) program, and standing committee of the Early Learning Council, the Home Visiting Task Force (HVTF) represents a unique private-public partnership dedicated to strengthening and advancing cohesion within the statewide home visiting field. In line with the vision of the HVTF, and its explicit commitment to securing additional stability for the state system through a diversification of funding,[1] the Sustainability Subcommittee of the HVTF was reconvened in early 2020 with the charge of exploring the viability of alternate federal funding streams for home visiting. The central focus of the Subcommittee—exploring pathways to expand the reach of home visiting services— aligns with the January 2020 announcement by Governor Pritzker of his office's commitment to growing home visiting capacity to serve an additional 12,500 families by 2025.[2] However, in light of the impact of the COVID-19 pandemic on the state's economy, and the potential for budget shortfalls**, the need to build a cohesive systemwide approach to funding home visiting and doula services that maximizes state investments and untapped federal dollars is more is more urgent than ever.**

Building on prior work of the Subcommittee in its earlier configurations, including developing a draft State Plan Amendment in 2014, Medicaid reimbursement for home visiting and doula services emerged a top priority in the Subcommittee for increasing the service reach and sustainability of the Illinois home visiting system. Nationally, at least 24 states allow for Medicaid reimbursement of home visiting services, representing over two decades of leveraging federal funding to finance and grow home visiting.[3] Though more limited than home visiting, two states, Minnesota and Oregon, have operational structures allowing for the statewide reimbursement of doula services by Medicaid, and legislative efforts are pending in a number of other states. Following national and Illinois-specific research showing that doula and home visiting services result in myriad of short- and longer-term positive health outcomes for children and their families, recent attention to Illinois' maternal morbidity crisis has also focused on Medicaid reimbursement for doula and home visiting. In the 2018 Illinois maternal Morbidity

[1] State Home Visiting Vision and Priorities; Drafted by the Home Visiting Task Force and affirmed by the major funders of home visiting and the Illinois Early Learning Council in 2019

[2] Walker Burke, C. (2020, January 22). Pritzker lays out his next steps in rebuilding Illinois' early education system. Chalkbeat. Retrieved September 30, 2020, from https://chicago.chalkbeat.org/2020/1/22/21121818/pritzker-lays-out-his-next-steps-in-rebuilding-illinois-early-education-system

[3] Johnson, K., Medicaid Financing for Home Visiting: The State of States' Approaches. Johnson Consulting, Inc. 2019. https://ccf.georgetown.edu/wp-content/uploads/2019/01/Medicaid-and-Home-Visiting.pdf

and Mortality Report, the Department of Public Health recommended that the state expand doula and home visiting services during pregnancy and the postpartum period to improve maternal and infant health outcomes. In the 101st General Assembly Session, policy leadership at Nurse Family Partnership, Start Early (prior the Ounce of Prevention Fund), and EverThrive Illinois worked with State Representatives LaToya Greenwood and Robyn Gabel to advance legislation enabling Medicaid reimbursement for doula and home visiting services (House Amendments 1 and 2 to HB4). Advocates also continued discussions in the upper chamber with Senator Cristina Castro, who carried a maternal mortality omnibus bill during the Spring 2019 legislative session. This legislative language was also included in the Health Pillar of the Illinois Legislative Black Caucus package of bills introduced in the January 2021 lame duck session. Two similar bills with the language passed the chamber but neither received the concurrence vote needed to pass. The bills have been refiled in the 102nd General Assembly, and a standalone bill with the language pertaining to Medicaid reimbursement for home visiting and doula services will also be filed. These legislative actions represent significant progress toward leveraging additional federal funds to supplement, not supplant, existing funding for home visiting and doula services.

As a key strategy employed nationally to draw additional federal dollars down to support infant and maternal health interventions, Medicaid reimbursement for home visiting and doula services fits squarely within the Subcommittee's broader goal of building a systemwide framework that prioritizes connecting families to appropriate services and leveraging the upstream blending of state and federal funding streams. Representing research and exploratory conversations of the Subcommittee, the following document outlines key priorities for Medicaid reimbursement of home visiting and doula services, and offers supplemental evidence on the reasons why Medicaid dollars represent an appropriate, promising route to expanding services for high-quality supports for expectant and new families. Several key implementation questions that must be addressed to ensure that Medicaid reimbursement mechanisms are effective, efficient, and responsive to the needs of the provider community and the families they serve are also outlined by the Subcommittee in this document. As interest in both legislative and administrative pathways advancing Medicaid reimbursement continues, the Sustainability Subcommittee is committed to working with the Department of Healthcare and Family Services (HFS) to solidify the details of implementation including shoring up remaining questions outlined below.

II. Subcommittee Recommendations for Medicaid Reimbursement

The Sustainability Subcommittee of the Home Visiting Task Force recommends that Illinois Department of Healthcare and Family Services add home visiting and doula services to the array of reimbursable services under the state's Medicaid plan. Specific guardrails for the implementation of Medicaid reimbursement are as follows:

1. *Ensure reimbursement of <u>both</u> doula and home visiting services by Medicaid to strengthen the continuum of support for families*

The Subcommittee believes establishing reimbursement of both doula and home visiting services is crucial to increasing the health outcomes of families and children served by Medicaid. Numerous examples exist of successful reimbursement of home visiting services by Medicaid, whereas only Minnesota and Oregon also have fully operational doula reimbursement programs. However, even with

fewer examples from other states to draw upon, Illinois has a long-established a system of public funding for both of these services and views both as critically important to family and child well-being.

For decades, doula and home visiting services have served as an important part the landscape of supports for pregnant and new parents in Illinois and are backed by a robust body of evidence. Studies have shown that people who receive doula services, which consist of education, empowerment, and support to pregnant and birthing parents from the prenatal period to several weeks postpartum provided by a trained professional, are more likely to have spontaneous vaginal births and less likely to have any pain medication, epidurals, negative feelings about childbirth, vacuum or forceps-assisted births, and Cesareans.[4] Prenatal doula visits, which may encourage timely participation in prenatal care and positive health-behaviors, as well as reducing maternal stress, may also be associated with reductions in pre-term births. [5] Home visiting services, an evidence-based prevention strategy used to support pregnant and new parents to promote infant and child health and development, are likewise associated with positive health outcomes. National and Illinois-specific research studies show that high-quality evidence-based home visiting programs result in myriad of short- and longer-term positive outcomes for children and their families. These health outcomes include improved birth outcomes; increased rates of breastfeeding and immunization, increased uptake of well-child visits and developmental screenings; and reductions in avoidable hospitalizations and child injury, which translate to savings in healthcare spending.

Given the demonstrated impacts of both of these services on maternal and infant health, and noting that 72% of pregnancy related deaths were deemed preventable by review committee, the 2018 IDPH report on maternal mortality and morbidity recommended that the state expand doula and home visiting services during pregnancy and the postpartum period to improve maternal and infant health outcomes. Data from the Illinois Birth Three Institute show that family retention in home visiting programs increases when engagement begins prenatally with a doula. Additionally, though **programs billing for Medicaid reimbursement should not be required to provide both doula and home visiting services,** co-located (or coordinated) services can ease the transition from the perinatal period into early childhood, strengthening family and child health outcomes across the developmental trajectory.

2. Balance Reimbursement Rates with Ideal Uptake and Regularly Update Rates with Provider Input

As demonstrated by the implementation of Medicaid reimbursement for home visiting and doula services in other states, robust reimbursement rates are crucial to ensure provider participation. In Minnesota, where reimbursement rates originally established in the Medicaid State Plan Amendment were set too low, not one[6] but two[7] legislative increases were required to bring rates up to a level sufficient to incent doulas to serve with Medicaid enrolled clients. To avoid similar and potentially cumbersome legislative obstacles, **reimbursement rates should be established and regularly updated by the Department of Healthcare and Family Services.** A regular review of rates is necessary to ensure that they are do not stagnate below cost-of-living increases and instead remain high enough for it to be cost-effective for providers to bill for reimbursement and navigate the Medicaid bureaucracies. Rather than setting rates through legislation, which can be a cumbersome process, the Illinois General

[4] Hodnett, Ellen D., et al. "Continuous support for women during childbirth." *Cochrane database of systematic reviews* 7 (2013).
[5] Gruber, Kenneth J., Susan H. Cupito, and Christina F. Dobson. "Impact of doulas on healthy birth outcomes." *The Journal of perinatal education* 22.1 (2013): 49-58.
[6] https://www.revisor.mn.gov/bills/bill.php?b=Senate&f=SF3656&ssn=0&y=2017
[7] https://www.house.leg.state.mn.us/SessionDaily/Story/13995

Assembly should require HFS to review and adjust provider rates on a routine basis, no less than every four years, depending on feedback from program experts.

Not all home visiting program model component services meet CMS requirements for Medicaid funding, meaning that Medicaid will not pay for the fully burdened cost of a home visiting program. [8] Medicaid does not pay for the full cost of operating a home visiting program but can pay for the direct service portion of a visit. Elements like training, data management, supervision, though essential to the administration of programs, are not covered. However, federal funds can be paired with state and local funds to support a full package of services for pregnant women, families, infants, and young children. [9] In a sample from other states where Medicaid finances home visiting, average coverage ranges between 15-20% and 100% coverage of the home visit. **The Department of Healthcare and Family Services should aim for at least 30% coverage of visits to maintain sustainable funding**. Illinois should also consider ways to better integrate home visiting programs into managed care contracts, including adding payment for these services into the Medicaid capitation payment to plans.[10]

Under a reimbursement mechanism wherein individual providers contract with Managed Care Organizations who then draw down Medicaid funding, following the addition of doula and home visiting services to the state's Medicaid State Plan Amendment, **reimbursement rates should still be set statewide by the Department of Healthcare and Family Services.** Requiring individual providers to negotiate reimbursement rates with MCOs would cause fragmentation across the home visiting and doula provider landscape and could disincentive qualified providers from expanding services to a greater number of Medicaid reimbursement.

Doula services currently exist across a continuum of intensity, influenced by a myriad of factors including family needs and preferences, and provider setting and offerings. As an example, Chicago Volunteer Doulas, who support low-income families and those who meet other vulnerable community criteria, offer a package of services that mirrors the service intensity of private-pay doulas including 1-2 prenatal visits, 1-2 postpartum visits, and the provision of continuous emotional support during labor and delivery. Taking this range of intensity into consideration, the **Sustainability Subcommittee would advocate for a reimbursement or billing scheme that assigns discrete rates for each component of doula supports** including prenatal visits, the provision of continuous support during labor and delivery, and post-partum follow-up visits. As opposed to a using global doula package for reimbursement, this strategy should incent greater number of private doula providers to serve Medicaid beneficiaries at the service-intensity level appropriate for and preferred by families.

3. Allow for supplemental services based on social determinants of health and other risk factors

According to best-practice recommendations by the Illinois Birth to Three Institute, doula services embedded in a home visiting program should include 8-10 prenatal visits; 5-7 postpartum visits; and the provision of continuous emotional support during labor and delivery. Visits are typically 60-90 minutes, beginning prenatally and continuing at least four weeks postpartum. However, considering the deep disparities in maternal health outcomes in Illinois, the Subcommittee recognizes that that this duration may be insufficient to address inequities in the social determinants of health that impact maternal and infant well-being. In determining the quantity and quality of doula services provided, the **Department of Healthcare and Family Services (HFS) should consider instances in which a family may benefit from**

[8] CMS guidance, https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf
[9] CMS guidance, https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf
[10] General Assembly 2018 Perinatal Report Illinois Department of Healthcare and Family Services Division of Medical Programs, 2017. https://www.illinois.gov/hfs/SiteCollectionDocuments/HFSPerinatalReportfinalcompleted282018.pdf

doula services beyond the early postpartum period based on social determinants of health and other risk factors.

Though a large share of families would likely benefit from a standard service duration, **Medicaid reimbursement should allow for families, per the advice of a physician, doula, or other health expert, to receive doula support for up to one year postpartum, an extension of the usual model.** However, to ensure access to doulas is not limited, physician approval or recommendation should not be required for a family seeking doula services. Because many families may be unfamiliar with the scope or availability of doula services, the **Department of Healthcare and Family Services (HFS) along with the Department of Public Health (DPH)** should invest in public awareness and educational resources, collaborating with existing public and private partners to ensure service saturation among the Medicaid eligible population.

It is also critically important to consider the needs of undocumented and mixed-status families, and the need to expand access to doula and home visiting services for this community. Recognizing that minimum income and other eligibility criteria for Medicaid, such as citizenship or residency requirements are set by the federal government, but that states may opt to cover additional people beyond these federal minimums using only state funds, the Subcommittee would emphasize the **importance of extending state funded-Medicaid coverage for pregnant people from 60 days postpartum to 12 months postpartum including undocumented immigrants.**

4. Invest in billing supports and other infrastructure to enable provider participation

The Subcommittee has heard concerns from home visiting programs that, without adequate support for billing from the Department of Healthcare and Family Services or another intermediary organization, partial reimbursement for a visit would not justify the administrative cost necessary to bill Medicaid. Smaller, community-based programs that may lack the back-end administrative capacity of larger providers should not be excluded from potential Medicaid funding. **The Department of Healthcare and Family Services should invest in statewide billing infrastructure to maximize the number of providers able to serve Medicaid clients.**

Facilitating billing mechanisms through state-funded infrastructure and other supports is critically important to ensure equitable access to Medicaid financed home visiting and doula services. While some home visiting providers are well-poised to leverage Medicaid for these services, smaller home visiting and/or doula organizations or small doula practices (particularly those operating in and most connected to BIPoC communities) should have the opportunity to access these funds and have access to the needed infrastructure or back-office supports to do so. A centralized billing provider/organization could be established to serve as the intermediary between the local programs and the Medicaid agency to enable smaller providers to still bill Medicaid. Additionally, as a complement to investments in statewide billing infrastructure, the state may need to engage the Illinois Collaboration on Youth Medicaid Technical Assistance Center (ICOY MCAT), which works to help all Illinois providers thrive in a Medicaid Managed Care billing environment. A pilot project with ICOY leading up to full-scale implementation of Medicaid reimbursement could examine the unique needs of home visiting and doula providers to ensure systems are in place to allow providers of varying sizes and capacities to engage in value-based payment arrangements.

5. Prioritize accessibility in provider qualification requirements and reimbursement structures

Determining the conditions under which home visiting and doula services should be considered Medicaid-reimbursable is critically important and requires careful consideration of the core competencies necessary of providers. In some states, overly stringent requirements for providers, for example requiring that doulas be certified by a national training organization like DONA, has limited the

pool of providers able to successfully bill for Medicaid reimbursement. To balance between the need to vet the skills and knowledge of providers, while also ensuring that the process is accessible to providers, the **Department of Healthcare and Family Services should collaborate with private and public home visiting and doula program experts, including relevant bodies under the Illinois Early Learning Council.** From an equity perspective, provider qualifications and reimbursement processes should seek to mitigate examine potential barriers to BIPoC providers and seek to maximize access to enable a diverse provider-base to work in historically underserved communities.

III. Considerations for Next Steps & Remaining Questions

The following questions regarding the implementation of Medicaid reimbursement remain after discussions within the Subcommittee.

1. *Outline data collection and sharing requirements for partnership with Managed Care Organizations*

In 2019, with support from the Maternal, Infant and Early Childhood Home Visiting Program team (MIECHV) at the Governor's Office of Early Childhood Development (GOECD), a partnership began between two home visiting programs in DeKalb County and in the East St. Louis area and Meridian Health Plan to improve outcomes for families with high risk factors. The partnership between the MCO and home visiting program aims to: 1) reduce member/family confusion around health systems navigation; 2) improve communication around preventative health messages; 3) create new opportunities for information-sharing to provide the best care for the member/family; and 4) remove siloes to improve quality of care for the member/family. Project activities include sharing assessments completed by home visitors with the MCO, connecting via cross-silo "huddles" to strategizing around redetermination and other healthcare access issues for the population of shared participants, ensuring home visitors and care coordinators are sharing information about obstacles and needs that members are facing, and more. Though allowing MCOs to use administrative dollars to launch small scale partnerships is works to test innovations and build relationships across the health and home visiting fields, contracting with programs creates a line of sight into the services and client outcomes that is bidirectional. Therefore, leveraging larger MCO-HV contracts with set payment structures should be the focus for scale and maximum impact.

Among other successes, the pilot project has demonstrated that home visiting is not duplicative of care coordination activities done by MCOs. Additionally, the pilot has explored intentional coordination services and tracking of outcomes across home visiting programs and MCO Care coordinators, operationalized through cross-silo huddles. These strategies, which have the potential to improve the participant experience across Medicaid and home visiting, should be explored further explored with the aim of building out a continuum of engagement building from less-intensive data sharing agreements to the type of partnerships modeled by the pilot arrangement. As flagged by HFS representatives on the Sustainability Subcommittee, questions remain about how to structure Medicaid reimbursement in a managed care environment, including the minimum level of data collection and reporting that would be necessary for home visiting and doula programs to bill MCOs. Additional questions about how MCOs would contract with home visiting and doula programs remain, including standard contract language, how MCOs would ensure their members can access the most appropriate doula and home visiting programs to their unique needs, and potential outcome reporting requirements. Further discussion with MCO leaders, members of the Illinois Association of Medicaid Health Plans, and Medicaid program experts will focus on solidifying these and other details.

2. *Determine the role of standalone doulas under a reimbursement mechanism*

For home visitors and doulas working within established community agencies, including those that already bill Medicaid, it may be simpler and equally effective for HFS to enroll the community-based organizations (CBOs) in the state's Medicaid reimbursement system, rather than requiring individual providers to contract with Managed Care Organizations or bill Medicaid. However, questions remain as to how reimbursement structures should best support providers working outside of state funded CBOs, hospitals, Federally Qualified Health Centers, and other similar agencies already linked to Medicaid. This is particularly relevant to the doula workforce, where the participation of private doulas may be necessary to meaningfully expand access to perinatal support services for Medicaid beneficiaries. Additionally, based on feedback from obtained from members of the doula provider community in New York based on their experience with individual claiming under Medicaid, the Subcommittee recognizes may be an overly complicated lift for individual, standalone providers to bill Medicaid on their own. While the above recommendations do advocate for the creation of systemwide, backend billing supports for providers, HFS and the provider community will have to determine whether it would be feasible for standalone individual practitioners to bill Medicaid or if a partnership with other CBOs who could contract with MCOs on a larger scale would be a more realistic mechanism.

3. *Clarify the applicability of the Public Charge Rule in future Medicaid coverage of doula and home visiting services*

As of September 30th, 2020, the final Public Charge Rule is being implemented in all 50 states, despite the roller coaster of litigation across the country that resulted in the rule being blocked for a brief period.[11] Though the new Biden Administration is likely to rescind the Public Charge Rule, the timing of that final action is unknown and the Subcommittee will need to continue to monitor the implications and immigration laws to ensure that accessing doula and home visiting services under Medicaid would not jeopardize the immigration status of any beneficiaries. Noting the "chilling effect" among undocumented and mixed-status families seen in the uptake of other public benefits *not* included under the Public Charge Rule, it may be necessary for HFS or other stakeholders to invest in messaging to ensure communities are aware of the availability of doula and home visiting services under Medicaid, once it has been determined they are not subject to the Public Charge Rule.

4. *Clarify the interplay between Title IV-E and Medicaid funding for home visiting*

At the September meeting of the Sustainability Subcommittee, representatives of the Department of Children and Family Services provided an overview of the plan to expand home visiting under Family First Prevention Services Act. As clarified by DCFS, Title IV-E for home visiting under the FFPSA plan must be considered the funder of last resort, meaning that MIECHV, Medicaid, or any other options for federal funding sources must be exhausted before the Department can bill services for Title IV-E claiming. It is likely that at least a portion of families participating in home visiting services under the Department's FFPSA plan will be Medicaid eligible, raising the need to clarify how federal funding can be aligned upstream to ensure seamless access for families while also maximizing federal contributions to the state home visiting services.

IV. Conclusion

Medicaid reimbursement for home visiting and doula services is a key policy priority of the Home Visiting Task Force, and the Sustainability Subcommittee is therefore seeking action from the Early Learning Council to elevate these recommendations to the appropriate bodies to ensure that efforts and

[11] https://www.uscis.gov/news/public-charge-fact-sheet

energy to secure Medicaid reimbursement persist. Furthermore, the Subcommittee hopes to guide the design and implementation of Medicaid reimbursement through specific recommendations to the Department of Healthcare and Family Services to ensure the mechanisms are effective, efficient, and responsive to the needs of the provider community and the families they serve. Beyond submitting these recommendations to the ELC, the Sustainability Subcommittee remains committed to supporting the state in additional planning, vetting and stakeholder engagement, communication with the field, and implementation of changes to the Illinois home visiting system.