01/24/2018: Report has been attached, please see below.

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

November 1, 2017

SENT VIA ELECTRONIC MAIL

The Honorable Nelson Dollar, Chair
Joint Legislative Oversight Committee on
Medicaid and NC Health Choice
North Carolina General Assembly
Room 307B, Legislative Office Building
Raleigh, NC 27603

The Honorable Ralph Hise, Chair
Joint Legislative Oversight Committee on
Medicaid and NC Health Choice
North Carolina General Assembly
Room 312, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight Committee on
Medicaid and NC Health Choice
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

Session Law 2017-57, Section 11H.14.(b), requires that the Department of Health and Human Services, Division of Medical Assistance, submits to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division, a report containing a copy of the plan to provide Medicaid and NC Health Choice coverage for home visits for pregnant women and families with young children either statewide or through a pilot program.

On behalf of Secretary Cohen, the Department of Health and Human Services is notifying you that this report will be delayed as the Department continues to work to develop a cohesive and comprehensive plan.

Should you have any questions, please contact Dave Richard, Deputy Secretary for Medical Assistance, at Dave.Richard@dhhs.nc.gov or 919-855-4100.

Sincerely,

for MKC

Mandy Cohen, MD, MPH
Secretary

cc: Dave Richard, Rod Davis, Mark Benton, Christen Linke Young, Marjorie Donaldson, Susan Perry-Manning, LT McCrimmon, Denise Thomas, Joyce Jones, Pam Kilpatrick, reports@ncleg.net, Kolt Ulm, Leah Burns, Lisa Wilks, Theresa Matula, Ben Popkin

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AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

November 1, 2017

SENT VIA ELECTRONIC MAIL

Mr. Mark Trogdon, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh, NC 27603-5925

Dear Director Trogdon:

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Plan to Implement Coverage for Home Visits for Pregnant Women and Families with Young Children

Session Law 2017-57, Section 11H.14.(a)

Report to the

Joint Legislative Oversight Committee on Medicaid and NC Health Choice

and the

Fiscal Research Division

by

North Carolina Department of Health and Human Services

January 24, 2018

Legislative Reporting Requirement

Session Law 2017-57, Section 11H.14. (a) states:

> It is the intent of the General Assembly to provide Medicaid and NC Health Choice coverage for evidence-based home visits for pregnant women and families with young children designed to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness that are consistent with the model used by Nurse-Family Partnership. No later than July 1, 2018, the Department of Health and Human Services, Division of Medical Assistance (Department), shall begin providing Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program.
>
> The Department shall develop a plan to implement changes necessary to provide Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program; however, consistent with G.S. 108A-54(e)(4), the Department is not authorized to make any changes to eligibility for the Medicaid or NC Health Choice programs. The plan shall detail the design and scope of coverage for the home visits for pregnant women and families with young children and include the identification of any State Plan Amendments or waivers that may be necessary to submit to the Centers for Medicare and Medicaid Services.

Session Law 2017-57, Section 11H.14.(b) states:

> No later than November 1, 2017, the Department shall submit to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division a report containing the following information:
>
> (1) As required by subsection (a) of this section, a copy of the plan to provide, no later than July 1, 2018, Medicaid and NC Health Choice coverage for home visits statewide or through a pilot program.
>
> (2) A detailed description of the coverage to be provided, including the proposed service definition, the home visit schedule, the scope of the covered service, and the anticipated reimbursement rate to be paid.
>
> (3) An analysis of the total fiscal impact of adding Medicaid and NC Health Choice coverage for the home visits for pregnant women and families with young children. This shall include an outline of both costs and savings to the Medicaid and NC Health Choice programs, as well as any savings to other programs provided by the State.
>
> (4) A description of how the Department intends to leverage any private funding that may be currently utilized to provide coverage for evidence-based home visits for pregnant women and families with young children.

(5) Whether the Department intends to add this coverage pursuant to its authority under G.S. 108A-54(e) or whether additional appropriations are required.

(6) Any plans to include pay-for-success initiatives as part of the Medicaid and NC Health Choice funding for the covered service.

(7) An anticipated time line for the implementation of the Department's plan and the submission of any necessary State Plan Amendments or waivers to the Centers for Medicare and Medicaid Services.

Executive Summary

Plan for Pilots of Coverage for Home Visits for Pregnant Women and Families with Young Children

The North Carolina Department of Health and Human Services has a longstanding collaboration among its Divisions and community providers across the state to deliver maternal and child health services. When the 2017 Appropriations Act was enacted, the Division of Medical Assistance convened a team to begin planning how to address the requirements of Section 11H.14. This report describes the proposed plan for conducting Pilot Projects on coverage for home visiting services within targeted areas of the state that are consistent with the model used by Nurse-Family Partnership. Collaborators include: the Division of Public Health's Women's and Children's Health Section; Community Care of North Carolina (CCNC); the Division of Medical Assistance; the Division of Child Development and Early Education; and service providers.

The Pilot Project on home visits, as proposed, will operate for a period of one year during SFY2019, in advance of the state's Medicaid Managed Care transition in SFY2020. DHHS recommends a Pilot Program to compare coverage for home visits for first pregnancies to risk-based coverage for all pregnancies (providing home visits to the highest risk women). The first pilot project will implement coverage for home visiting in one county which presently has home visiting services funded by private grants. The second pilot project will implement coverage for home visiting in one county which does not presently have home visiting by enhancing the existing Medicaid Pregnancy Care Management and Care Coordination for Children. Any home visit program implemented in North Carolina will be in addition to NC's foundation of evidence-based, risk-driven maternity care and case management and early childhood pediatric care and risk-based case management. Once Medicaid Prepaid Health Plans (PHPs) are implemented, home visit programs will be in addition to the PHP's maternal and child programs. Upon completion of the pilots, DHHS will provide an assessment of the feasibility of maintaining or expanding coverage for home visiting services.

ACRONYMS FOUND IN THIS DOCUMENT

ACRONYM	DEFINITION
CC4C	Care Coordination for Children

CCNC	Community Care of North Carolina
CDSA	Children's Developmental Services Agencies
CMIS	Case Management Information System
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance
DMCN	Disease Management Coordination Network
DPH	Division of Public Health
FFS	Fee-For-Service
HC	Health Check
HV	Home Visiting
IC	Informatics Center
LME/MCO	Local Management Entities/Managed Care Organizations
LSP	Life Skills Progression
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
MOA	Memorandum of Agreement
NCHC	NC Health Choice
NFP	Nurse-Family Partnership
OBCM	Pregnancy Care Management
PMH	Pregnancy Medical Home
PMPM	Per Member Per Month

1) Background

a) Federal Home Visiting Programs

Home visiting, as defined by the Health Resources and Services Administration (HRSA), U.S. DHHS, is an evidence-based program that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women and families with children ages birth to five years. Home visiting targets numerous outcomes, including: improved maternal and child health; prevention of child injuries, child abuse, or maltreatment; reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; improvements in coordination and referrals for other community resources and supports; and improvements in parenting skills related to child development.

b) Home Visiting Programs in North Carolina

North Carolina has a history of access to home visits to support maternal and child health. As national home visiting models have evolved, the NC Division of Public Health (DPH) has kept pace and participated in Maternal, Infant, and Early Childhood Home Visiting (MIECHV) development and programs. The following evidence-based home visiting programs are currently implemented in North Carolina:

- Nurse-Family Partnership;
- Healthy Families America;
- Parents as Teachers;
- Child First;
- Early Head Start Home Visiting; and
- Family Connects.

The map in Attachment B shows the distribution of evidence-based home visiting models across the State, and Attachment C includes a description of each program.

<u>The NC Home Visiting Consortium</u>

Since 2014, the Division of Public Health has been convening the NC Home Visiting Consortium as a means of bringing together state sponsoring agencies, funders, and model developers for coordinating MIECHV home visiting services as part of a system of care for young children. The Consortium meets quarterly and addresses expansion of home visiting services in North Carolina, coordination of services when more than one model is implemented in each service area, and updates on State and federal legislation. State agencies and funders represented include the NC Division of Public Health, North Carolina Partnership for Children, Prevent Child Abuse North Carolina, Blue Cross and Blue Shield Foundation of North Carolina, the Winer Foundation, the Duke Endowment, and the Kate B. Reynolds Charitable Trust. Model developers include Nurse-Family Partnership, Healthy Families America, Parents as Teachers, Early Head Start Home Visiting, Family Connects, and Child First.

c) North Carolina Context for Service Delivery

Since 2011, the Divisions of Public Health and Medical Assistance have collaborated on the Pregnancy Medical Home (PMH) model, which focuses on the prevention of preterm birth and low birth weight. PMH provides prenatal care and community-based care coordination to most pregnant Medicaid beneficiaries in the state.[1] It also includes the Pregnancy Care Management (OBCM) Program, which serves women based on their level of need during pregnancy and the postpartum period. NC Medicaid covers more than 55% of NC births.[2] In SFY2015, Medicaid covered more than 66,000 births.

All PMH practices use a standardized, comprehensive risk assessment tool (See Attachment E) for pregnant Medicaid beneficiaries. Risk screening data, combined with other data sources, are used to calculate a Maternal-Infant Impactability Score (MIIS) from 0 to 1,000 for each pregnant Medicaid beneficiary. Higher MIIS scores reflect the potential for Pregnancy Care Managers to impact the birth outcomes by reducing the risk of low birth weight (LBW). One in four women in the "high impactability" priority group (MIIS score $\geq$ 500) have a risk of having a LBW infant, and have been shown to benefit the most from OBCM services when they receive intensive, *face-to-face*, pregnancy care management with at least 10 interactions with the care manager during pregnancy.

Following birth, the care of the child is assumed by pediatric care providers (pediatricians and family physicians). At-risk children and their families receive care management services through Care Coordination for Children (CC4C). Care Coordination for Children consists of a set of evidence-based interventions and activities that address the health of the birth-to-age five population with the goal of promoting wellness, improving health outcomes, improving the quality of care, and promoting cost-effective care for the targeted population.[1]

In preparation for developing a pilot, the DHHS team compared the characteristics and content of the existing home visiting programs (See Attachment C). The team also prepared a direct comparison of OBCM and CC4C visit topics, content, and Medicaid coverage with those of the Nurse-Family Partnership, which is the most visit intensive home visiting program in NC (See Attachment D). The collaborating Divisions developed the following criteria for a pilot home visit model:

- Integrate with the existing MCH infrastructure for the Medicaid population;
- Continue the existing relationships with obstetric and pediatric providers;
- Screen the entire pregnant population to establish the risk for LBW;
- Target the highest risk women;
- Avoid duplication of services;
- Reduce Cost; and
- Improve maternal and child outcomes.

[1] Source: North Carolina Community Care Network Quarterly Report SFY2017 Quarter 3 Pregnancy Medical Home (PMH) and Pregnancy Care Management.

[2] Source: State Center for Health Statistics, NC Department of Health and Human Services http://www.schs.state.nc.us/schs/births/matched/2015/medicaid.html.

2) Pilot Program Design

As a result of the insight gained from studying national models and considering current NC services, the DHHS interdisciplinary team is proposing to implement two pilot projects. The first, County Pilot A, will implement Medicaid coverage for the nurse visits of the NFP model for all first-time mothers and their infants. The second, County Pilot B, will implement coverage for home visits for all pregnant women at high risk and their infants, as an enhancement to existing OBCM and CC4C services. The second model will minimize duplication of services and support continuity of care with obstetric and pediatric providers.

For County Pilot A, the home visits covered for the NFP model will be provided according to the evidence-based model which includes multiple home visits for the woman in her first pregnancy and her infant.

County Pilot A Design Elements:

The first segment during the pregnancy includes visits every other week during the pregnancy to address health behavior issues such as the effects of alcohol and smoking on fetal growth, nutrition and exercise, and other risk factors for preterm birth. The second segment includes home visits every two weeks postpartum until the baby reaches 21 months of age, then monthly visits until the child is 2 years of age. During these visits, the nurse focuses on topics such as parent or infant and toddler nutrition, health, growth and development and environmental safety. NFP model fidelity is maintained for intake for eligibility, standardized assessment, plan of care, and some visiting schedule. Staff ratios, reporting requirements, and other program details are specified for the model.

In County Pilot A, the NFP project is currently in place with staffing of one NFP nurse supervisor, one administrative staff, and four nurse home visitors with the expectation of serving 100 clients. This is a timely opportunity for piloting Medicaid coverage for the nurse home visits, since the remainder of program funding is in place via private and state funding and financial data are available to DPH.

For County Pilot B, the team recommends the following design elements and program enhancements:

County Pilot B Design Elements:

a) Leverage the existing service delivery of PMH, OBCM, and CC4C and existing relationships with obstetric and pediatric practices, Children's Developmental Services Agencies (CDSAs), the Departments of Social Services, and LME/MCO providers of behavioral and substance use services.
b) Include all pregnancies, not just first pregnancies.
c) Base the home visiting interventions on beneficiary Maternal-Infant Impactability Scores, and target the women with MIIS scores >500.
d) Build an enhanced NC model based on the elements of successful home visiting established by MIECHV programs, using the existing NC programs for the Medicaid

population as the foundation. Start with existing OBCM services; add enhanced home visiting; transition to CC4C with enhanced home visiting during the postpartum period and the infant's first year of life; and continue CC4C services through age 5 for at-risk children.

County Pilot B Enhancements to Existing Programs

The risk-based home visiting pilot will include:

a) Transitioning from phone or office to face-to-face interventions, including structured home visits;
b) Staff training;
c) Engaging a multi-disciplinary team for each family;
d) Augmenting social determinants of health screening and interventions (transportation, food, etc.);
e) Using the Life Skills Progression Tool (See Attachment F) for intake and ongoing assessment of families of infants and young children; and
f) Using the MIECHV Centralized Intake and Referral Tool (See Attachment G)

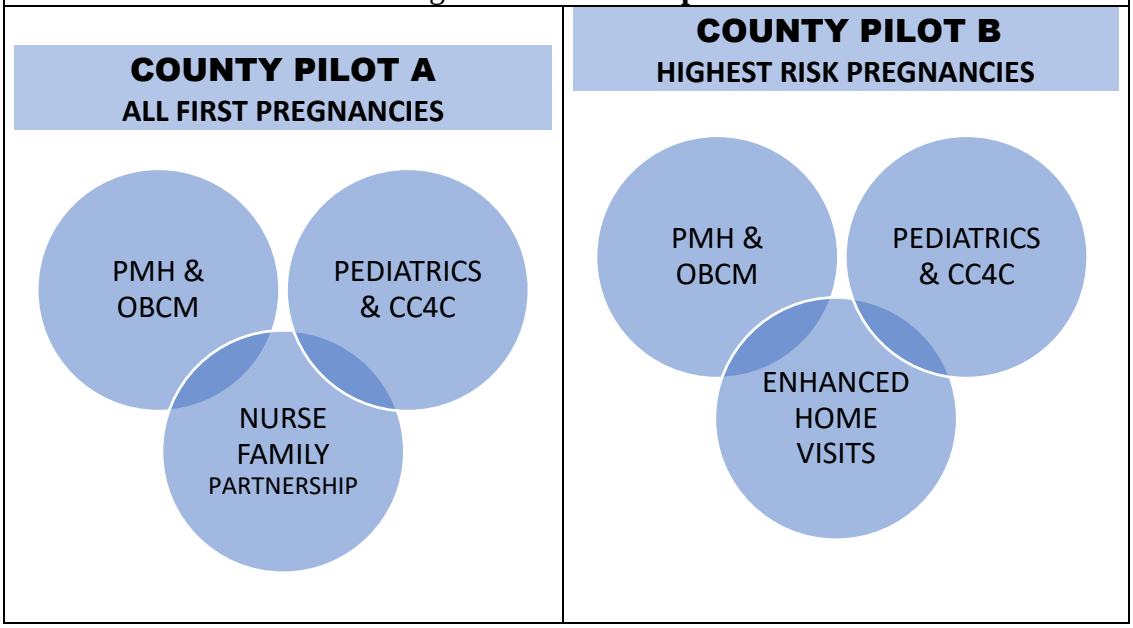
The MIECHV Centralized Intake and Referral Tool was developed as an integral part of the NC Medicaid State Plan for Home Visiting. Participating families will be able to find resources based on their specific pregnancy and early childhood needs and referrals will be generated to the agencies that fit their needs.

The County Pilot B will incorporate two existing Medicaid home-based nurse visits—the Home Visit for Postnatal Assessment and Follow-Up Care and the Home Visit for Newborn Care and Assessment—into a more comprehensive, coordinated, intensive home visiting program for the target population. Care managers will also work with patients in the medical setting. If patients miss one or more medical visits, additional home visits will be conducted to assess for and address barriers that are affecting the patient's ability to receive appropriate obstetric and pediatric care. The Pilot elements are all consistent with the MIECHV evidence base for successful home visiting models; some are newly implemented innovations.

3) Pilot Plan

DHHS's Divisions of Medical Assistance and Public Health will implement two one-year pilots, as described above. The limited duration is due to anticipated implementation of managed care contracts in July 2019. County Pilot A has an existing NFP project, along with PMH, OBCM, and CC4C. In this county, home visits for first time mothers and their infants will be covered by Medicaid. County Pilot B has PMH, OBCM, and CC4C but no current MIECHV home visiting programs. In this county, the target population will be all pregnant women with Medicaid coverage who are at high risk of having a low birth weight infant, based on a Maternal-Infant Impactability Score of 500 or greater. (See Diagram 1) The service definition for home visits and schedule of home visits for both pilots are described below under Section 4, *Coverage.* The home visiting details for County Pilot B are in Attachment F.

Diagram 1: **Pilot Comparisons**



4) Pilot Coverage Plan

a) Service Definition

The goal of home visits for pregnant women and families with young children is provision of services that will improve maternal outcomes and overall child health. A nurse or social worker in the role of Care Manager will provide one-on-one education and support beginning in early pregnancy and throughout, facilitating a crucial supportive bond between mothers and Care Managers. Care Managers will provide support, education, counseling on health behavior and self-management, and community referrals.

Care Managers will also conduct a thorough assessment and develop a care plan to address any medical or psychosocial issues identified. Home visits during early pregnancy will allow barriers and health risks in the home to be addressed early in the prenatal period. Health risks may include food insecurity, tobacco use, and substance abuse. The home setting will also allow the Care Manager to assess and identify needs of the pregnant woman's family, including other children who may be in the home.

After the delivery, Care Managers will facilitate post-partum follow up, including the woman's choice of family planning methods. They will provide support regarding infant and toddler nutrition, health, growth, development, and environmental safety. They will also provide guidance to new parents about building and fostering social support networks. Care Managers will assist the families by helping parents set goals related to future pregnancies, continued education, or employment. In addition, Care Managers will help parents set realistic goals for education and work, and identify strategies for attaining those goals.

b) Schedule of Visits

The NFP model used in County Pilot A, includes the visit schedule listed below. Visit total is at least 58 visits, depending on when women enroll.

NFP Nurse Visit Schedule for All First Pregnancies:

1. Weekly visits in the first month of enrollment
2. Every other week until the child is born
3. Weekly for the first six weeks after the child is born
4. Every other week through the child's first birthday
5. Every other week until the child is 21 months
6. Monthly until the child is 2 years old

A total of 58 visits should occur if the mother is enrolled by the 28th week of pregnancy and graduates the program when the child turns 2 years of age, per the NFP model. If the mother is enrolled prior to the 28th week, additional every-other-week visits would be delivered. These visits are in addition to risk-based OBCM visits, well child visits, and CC4C visits for children at risk.

For County Pilot B, which targets all pregnancies at high risk, Table 1 outlines the proposed visiting schedule for a participating mother and her child. In addition to the Existing Well-Child Care schedule (no color), Existing Home Visiting (HV) Services (blue) and Enhanced HV Services (pink) will be provided.

Table 1: Pilot B Home and Well-Child Visits Periodicity Schedule

Billing Code	Service		Number of Visits
		Entry to Prenatal care (no later than 24 weeks - Birth 40 weeks)	
99600	Enhanced HV Services	Two of the required 10 face-to-face visits during pregnancy with the pregnancy care manager must occur in the home. Additional home visits will be performed as needed for patients who miss one or more medical prenatal appointments.	2
		Postpartum Period/Months 1 & 2	
99501	Existing HV Services	Home Visit for Postnatal Assessment and Follow-up Care (P-code 99501) – maternal health; assessment of mother and infant	1
99502	Existing HV Services	Home Visit for Newborn Care and Assessment (P-code 99502) -child health; assessment of mother and infant	1
99600	Enhanced HV Services	Postpartum home visit by pregnancy care manager	1
	Well-Child Care Visit *	2 to 5 days	1

	Well-Child Care Visit *	4th week Care Management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
99600	Enhanced HV Services	6th week	1
Billing Code	**Service**		**Number of Visits**
	Well-Child Care Visit *	8th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
		3rd month - 12th month	
99600	Enhanced HV Services	10th week	1
99600	Enhanced HV Services	14th week	1
	Well-Child Care Visit *	16th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
99600	Enhanced HV Services	18th week	1
99600	Enhanced HV Services	22th week	1
	Well-Child Care Visit*	24th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
99600	Enhanced HV Services	26th week	1

99600	Enhanced HV Services	30th week	1
99600	Enhanced HV Services	34th week	1
Billing Code	**Service**		**Number of Visits**
	Well-Child Care Visit *	36th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1
99600	Enhanced HV Services	38th week	1
99600	Enhanced HV Services	42nd week	1
99600	Enhanced HV Services	46th week	1
	Well-Child Care Visit *	48th week- Care management encounter in conjunction with pediatric visit; if family does not attend well child visit, CC4C care manager must make home visit to re-engage family in care.	1

c) Reimbursement Rates – The home visits for both pilots will be billed individually as fee-for-service claims for services provided prenatally, during the immediate postpartum period, and through the end of the infant's first year of life. Reimbursement will be made with an unlisted CPT code 99600 (which will be billed per home visit). This will allow Medicaid to track expenses for the pilot directly. The enhanced visit reimbursement rate will be $83.72 per visit.

5) Fiscal Analysis Plan

County Pilot A

The chart below shows costs for reimbursement of nurse home visits only, not total program cost. For County Pilot A (NFP model) the following costs are presently covered by private funding but will shift to State appropriations in 2018. In the future, if this model were

implemented statewide, the salaries of nurse consultants could be considered for inclusion in the Division of Medical Assistance Interagency Memorandum of Agreement with the Division of Public Health. Private funding or State appropriations would be needed for costs not coverable by Medicaid.

1) Two NFP State Nurse Consultants = Approximately $200,000
2) Service Fees Paid to NFP National Service Office = $75,000
3) Travel for NFP State Nurse Consultants (NFP Required Education) = $5,320
4) Local Travel for NFP State Nurse Consultants = $13,356

Note that the total visits for both pilots are less than the length of the pregnancy plus the first year of life for the infant, because the one-year pilot will end before the infants first year one of life is completed.

COUNTY PILOT A	**One County Pilot-NFP Model**
Projected Number of First Pregnancies Per Year:	100
Fee For Service:	
CPT Code 99600 – Unlisted Home Visit Service or Procedure (Cost/Visit):	$ 83.72
Number of Visits Prenatal (28-40 Weeks):	8
Number of Visits Postpartum (Months 1 through 9):	22
Total Number of Home Visits (1 Yr. Pilot) Per Pregnancy	**30**
Total Cost Per Pregnancy	**$ 2,511.60**
(Costs are for visits only, not total program costs.)	
Fiscal Impact (State dollars)–NFP Model (1 County, 1 yr. Pilot):	**$ 251,160.00**

County Pilot B

COUNTY PILOT B	**Hybrid Model- Enhanced Visits Analysis**
Projected Number of High Risk Pregnancies Per Year:	100
Fee for Service:	
CPT Code 99600 – Unlisted Home Visit Service or Procedure (Cost/Visit):	$83.72
Number of Prenatal Home Visits	2
Number of Postpartum Home Visits (Months 1 through 9):	9
Total Number of Enhanced Visits per Participant (1 Yr. Pilot)	**11**
Total Cost Per Pregnancy	**$920.92**
State Dollar Fiscal Impact – Enhanced Visits for High Risk Pregnancies (1 Yr. Pilot)	**$92,092.00**

- The pilots will be funded with State dollars only; no additional appropriations are required at this time. No waiver or State Plan Amendment will be required.

- Pay for success will not be implemented in the pilots. However, if the pilots lead to statewide implementation, transition to a per member per month capitated reimbursement would be appropriate and could be implemented with withholds or some form of pay for performance.

Preliminary Analysis of Cost of Statewide Home Visit Program

The legislation also requests an estimate of providing Medicaid and NC Health Choice coverage for home visits statewide. Using cost estimates provided by Nurse-Family Partnership for implementation of their model for home visits for all first-time mothers and data on the number of first time mothers cared for in Pregnancy Medical Home (about 17,000), DHHS estimates the total cost of the NFP model to be between $197,049,996 and $321,363,200 for each 2.25 year cycle of mothers and their infants. (See Table 2) With each annual group of approximately 17,000 first time mothers, *the cycle will begin again, so in the second year, cost would be doubled*.

Table 2: Statewide Implementation Financial Estimate for NFP Model

	Year 1	Year 2	Year 3 (13 Weeks)	Total (2.25 Years)
Lower Cost Range:				
# of First Pregnancies	17,012	17,012	17,012	17,012
# of Home Visits	30	25	3	58
NFP Avg. Cost Per Child	$ 11,583	$ 11,583	$ 11,583	
Weighted Cost Per Pregnancy	$ 5,991	$ 4,993	$ 599	$ 11,583
Total Impact	**$ 101,922,412**	**$ 84,935,343**	**$ 10,192,241**	**$ 197,049,996**
Higher Cost Range:				
# of First Pregnancies	17,012	17,012	17,012	17,012
# of Home Visits	30	25	3	58
NFP Avg. Cost Per Child	$ 13,600	$ 13,600	$ 13,600	
Weighted Cost Per Pregnancy	$ 7,034.48	$ 5,862.07	$ 703.45	$ 13,600
Total Impact	**$ 119,670,621**	**$ 99,725,517**	**$ 11,967,062**	**$ 231,363,200**
Assumptions:				
Year 1 = 28 Weeks Prenatal through Month 9 Postpartum				
Year 2 = Month 10 through Month 21 (Postpartum)				
Year 3 = Month 22 through Month 24 (Postpartum)				
Data Sources:				
1. $11,583 NFP Avg. Cost Per Child: Data Source: NC DHHS/DPH. This is the average cost per participant at NC NFP sites. The cost varies based on market rates for personnel and cost of living in various counties. The total is based on cost over the 2.25 years that a mother/child are enrolled in the program.				
2. $13,600 NFP Avg. Cost Per Child: Data Source: Coalition for Evidence-Based Policy. Top Tier Evidence: Nurse Family Partnership, 2015				

Workforce Impact of Statewide Home Visit Program

Looking at the program from the perspective of workforce, NFP's model calls for a ratio of one RN to 25 pregnant women and one master's RN supervisor for every eight RNs. With a projection of approximately 17,000 first time mothers per year, 680 RNs would be needed to implement the model statewide. In addition, 85 master's prepared RN supervisors would be needed. The same number would be needed in the second year to visit the next cohort of first time mothers and their infants.

6) Recommendations for Pilot Assessment

DHHS and the collaborating agencies will establish a monitoring team to oversee the Pilot Projects. The team will assure appropriate training, data collection, tracking, and communications with county, project, and State staff. The monitoring team will meet monthly July through September 2018, then quarterly during the duration of the pilot projects. The team, with assistance from DHHS/DMA analytic staff, will prepare an assessment of the pilots for coverage of home visits and will make recommendations regarding ongoing coverage.

TABLE 2: PROJECT TIME LINE

August 2017	• Review evidence-based model(s) & legislation • Select services and correlate with legislative components • Identify geographic area and target population(s) • Facilitate discussions with key collaborating Divisions and agencies to create service definitions • Finalize the scope of the Pilot Projects
September 2017	• Engage pilot counties to discuss readiness and operational needs.
October 2017	• Revise Pilot Project Plan • Develop tracking and clear comparison for Pilot Project based on divisions and departmental feedback • Identify site liaisons
November 2017	• Conduct informational sessions with interested agencies, programs, and subject matter experts • Revise plan based on feedback from Legislature and stakeholders
December 2017 -February 2018	• Develop and deploy Communications Plan • Finalize Pilot Project Plan, key collaborators, strategies and owners • Begin development of processes for startup, implementation, monitoring and reporting • Identify any system or operation modifications for payment
February - March 2018	• Incorporate system or operational changes • Present overview of pilot to participating county staff • Work with CCNC for processes and documentation needs • Develop the intensive home visiting model and program standards and expectations • Assess training and professional development needs
April 2018	• Engage fiscal staff from each site to clarify appropriate billing. • Finalize OBCM, CC4C, LHD, DPH, CCNC and DMA oversight for tracking and evaluation
May 2018	• Establish Pilot Project status tools for county and state (DMA, DPH, CCNC) updates. • Review timelines and plan kick-off meeting for pilot. • Confirm contacts and discuss communication and participation • Complete any system operation or Project planning details.
June 2018 **June 2018 (continued)**	• Local staff training • Prepare for startup by conducting site visits and conference calls with all staff and providers • Content: - Overview - Roles and documentation - Communications - Contact persons at state level for troubleshooting

ATTACHMENTS

A. Session Law 2017-57, Section 11H.14.

B. North Carolina Evidence-Based Home Visiting Map

C. North Carolina Evidence-Based Home Visiting Models

D. Comparison of NFP Visit Content, Current Medicaid Coverage, and Care Entities

E. Pregnancy Medical Home Risk Screening Tool

F. Life Skills Progression

G. NC MIECHV Centralized Intake and Referral System