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CC: Jay Smithjay.smith@scdhhs.gov
Date: 10/11/2013 9:35:00 AM
Subject: SIB Federal Funding Options Update
Attachments: SC_Fed NFP CBA.xlsx

Hi John & Christian,
Jay and I have been meeting with Vicki and the MCO team to review our options for federal funding. The important takeaways are below, followed by what I believe to be 2 options to consider as we move forward (keeping in mind, we may get additional ideas from the RFI responses). If you have any questions, please let me know. We have a call scheduled with Jeff on Wednesday where we can discuss in further detail. I've been focusing solely on NFP for simplicity but I get the sense that other home visiting programs would work in the same manner.

Current Medicaid support to NFP
NFP is not currently considered a Medicaid service. DHHS will begin supporting NFP through an incentive payment to the MCOs in November (max. $2,000 per client). This incentive was put in place as a way to support NFP while they find a sustainable funding source. It was never intended to fully cover the cost of services. The MCO team explained that this incentive happened "under CMS' radar", since NFP isn't really an incentive, it is more of a service. The team seemed very concerned that if we try to increase the amount of this incentive in order to fully cover the cost of services, it may raise a red flag with CMS and they could re-visit the initial incentive. Additionally, there is no guarantee that the MCOs are passing the incentive funds back to NFP (as I understand), so it doesn't seem like a reliable method of getting the principal back to investors.

Amending MCO contracts to provide NFP
Since NFP is not considered a Medicaid service, the MCOs are not required to provide it for their clients (hence the incentive). The MCOs could choose to contract with NFP and cover services for their clients but they are unlikely to do so as they believe NFP is only a good investment for very high-risk clients, the investment is immediate while benefits are long-term, and clients often switch MCOs (so they would be investing in something that would ultimately benefit another plan). In order to ensure that NFP is covered by the MCOs, we first would need to file a SPA to have NFP become a covered service under FFS and then renegotiate MCO contracts/capitation rates to reflect NFP coverage. In this case, NFP would become covered for ALL clients, and not just the target population of the SIB. The question of whether NFP should be a covered service is what we are trying to figure out, and what the SIB pilot project can help determine. Thus, jumping to covering NFP for all would negate the point of doing the SIB. Unfortunately, since the FMAP is so high, it seems more cost-effective to go right to this step (having NFP be a covered service) if the state cannot get any federal support for the SIB (see the attached summary cost-benefit of NFP in SC).

Getting a federal match for the service costs by passing the funds through the MCOs does not seem feasible under the previous options. New structural options are:

1.) Pilot Funding from CMS to Split SIB costs
The easiest solution would be to get CMS / Federal HHS to grant pilot funding for the SIB. The money could be used to cover service costs + return and we wouldn't have to go through the MCOs. Christian, I think this is what your letter to CMS (that Tony needs to sign) is requesting? Jeff can offer additional insight on the likelihood of securing federal support this way.

Alternatively, Vicki suggested that we connect with the Q-TIP team, as there may be flexible CHIPRA funds that could be used for this. I need to explore further.

2.) No SIB - NFP Becomes Medicaid Service for a limited population and philanthropy covers success payments
The state makes NFP a covered service through "targeted case management" and pays 80% service costs. This would

allow the state to limit receipt of services to a certain demographic population or eligibility category within Medicaid (i.e. placing a cap on the number of recipients for now). The state would carry out the evaluation and the foundations would make success payments (remaining 20% of service costs), which could be tied to serving the highest-risk population. If the evaluation shows positive results, the state could then expand NFP to all clients by removing the cap and making NFP a covered Medicaid service for all eligible mothers.

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