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Testimony Before the District of Columbia Council
Committee on Health
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Public Hearing:
B25-0321 – Home Visiting Services Reimbursement Act of 2023
B25-0419 – Childhood Continuous Coverage Act of 2023

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Introduction

Good morning, Chairperson Henderson and members of the Committee. My name is Leah Castelaz. I am a Policy Attorney at Children's Law Center and a resident of the District. Children's Law Center believes every child should grow up with a strong foundation of family, health and education and live in a world free from poverty, trauma, racism and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify regarding B25-0321 Home Visiting Services Reimbursement Act of 2023 ("Home Visiting Reimbursement Act") and B25-0419 Childhood Continuous Coverage Act of 2023 ("Continuous Coverage Act"). Children's Law Center supports both bills before the Committee today and commends the Council's focus on increasing supports for children ages 5 and under and their families. Many of the children we work with – children in the foster care system, children receiving special education services, and children accessing healthy housing – have faced multiple adverse childhood experiences resulting in complex trauma and need access to high-quality health services to achieve stability. Each year the Children's

Law Center works on a systemic level to increase access to health supports and services from pregnancy onward. Through our work we know that children thrive when they are met with the proper resources early on, can grow, and maintain strong relationships, and live in a healthy environment.

The early childhood years – generally considered to encompass ages zero to five – are a critical developmental period in a child's life. During these years, children's brains are rapidly developing. The environment and experiences of early childhood help form the foundations for learning, health, and behavior for the rest of a child's life.[1] Providing sufficient and adequate supports to children and their families during this period is vital for creating the best possible opportunities for brain development and future successes. Children's Law Center, therefore, has consistently supported investments in early childhood programs for many years.[2]

To this end, my testimony today will explain how the Continuous Coverage Act and the Home Visiting Reimbursement Act will support District families and improve the lives of children ages five and younger. My testimony will also discuss implementation considerations that both the Council and Executive Agencies should be aware of as they move forward the work of both bills.

Continuous Medicaid Eligibility Will Ensure DC Children Do Not Lose Healthcare Coverage During a Critical Period of Development

Current DC Medicaid law requires individuals and families to renew their Medicaid once a year in order to continue to receive healthcare coverage.[3] In 2020, however, the federal government paused the yearly Medicaid renewal procedure for all states, including DC, to ensure that people could continue to access healthcare during the pandemic.[4] Across the country, the Medicaid pause on renewals was praised as a benefit to individuals and families as it increased consistent healthcare access, reduced stress, and provided cost savings to the Medicaid agencies.[5] The proposed Continuous Coverage Act would make this pause permanent in DC for children ages zero to five, enabling them to maintain continuous Medicaid coverage without yearly redeterminations.[6]

Continuous Coverage Results in Greater Utilization of Medicaid Covered Services

Close to two-thirds of DC children rely on Medicaid for connection to and coverage of all medically necessary healthcare services.[7] The Continuous Coverage Act ensures children five and under covered by Medicaid have consistent access to health care, which is associated with better health, higher academic achievement, and more stable households.[8]

Requiring annual re-certification to maintain Medicaid coverage has historically resulted in children 'churning' on and off from public health insurance due to a variety of family circumstances outside of their control.[9] For these children, coming on and off Medicaid can result in unmet healthcare needs and delays in accessing critical health

services.[10] The American Academy of Pediatrics recommends that children visit the doctor at least 14 times before they turn 6 years old.[11] During those visits, children receive vaccinations, speech, hearing and vision tests, as well as critical health screenings.[12] Doctor visits are also a critical touchpoint for young children and families to receive behavioral health supports.[13] Continuous coverage means that youth will maintain appropriate insurance coverage to access Medicaid services that can meet both their physical and behavioral health needs.[14]

Continuous Coverage Provides Cost Savings for Medicaid Agencies

The disenrollment and reenrollment processes create administrative costs for Medicaid agencies.[15] Continuous coverage, therefore, is likely to reduce administrative costs for the Department of Healthcare Finance (DHCF). According to Medicaid, the average monthly cost for a child enrolled in Medicaid for 12 months was $107, compared to $163 for a child enrolled for only one month and $147 for a child enrolled for only six months.[16] The decrease in cost for a child that is consistently enrolled in Medicaid for twelve months illustrates that the longer a child remains enrolled, the less the monthly cost. Oregon, the first state to provide continuous enrollment for six years, reported a reduction in administrative costs since the Medicaid office no longer has to redetermine eligibility each year.[17] Additionally, Oregon believes it will see a reduction of medical costs over time, since children who stay on Medicaid will have consistent access to prevention and primary care services that can reduce the need for more expensive

treatments down the road.[18] Reducing the costs associated with Medicaid would result in savings that could then be used to increase or create new investments in services and supports for DC children and families.

Continuous Coverage Reduces Parental Stress

Yearly Medicaid renewal can create undue burdens on families through complex and onerous paperwork requirements, poor navigation tools, and confusing eligibility rules, all which contribute to parental stress. When a parent is stressed by the mounting obligations of renewal, Medicaid services may be dropped especially when there are other competing priorities.[19] Under continuous coverage, families do not have weigh maintaining health insurance against other concerns that need their attention.[20] Additionally, continuous coverage reduces parental stress by alleviating parental worry of financing any expected or unexpected healthcare needs for their children.[21] Continuous coverage eases family burdens by improving access to healthcare and removing onerous application processes.

To Ensure Effective Implementation of the Continuous Coverage Act the District Must Consider All Necessary Investments

Continuous coverage is good for children and families because it increases access to health care services, provides costs savings to the District, and reduces parental stress. Both the national narrative and outcomes in other jurisdictions support the implementation of continuous coverage.[22] For implementation to be successful in DC, however, continuous coverage must be understood within the context of our City's

operations and population. Below are four DC specific considerations to help support effective implementation of the Continuous Coverage Act:

1. **Individual-level data is needed to gauge required investment and impact of the Continuous Coverage Act.**

   Currently, the publicly available data from DHCF does not show the number of children who could be impacted by continuous coverage. It is therefore difficult for us to gauge the necessary investment and the true impact of the Continuous Coverage Act in the District. DHCF should share individual level data minimally with the Council. Individual level data would show how many children, on average, would have to be redetermined when continuous coverage expires on the month ahead of their sixth birth (e.g., based on current data there are 1,500 children on Medicaid who turn six in Calendar Year 2025 and would have to go through the redetermination process). Properly understanding the scale of continuous coverage, and ultimately redetermination of Medicaid coverage, is critical to understanding the investments necessary to support implementation.

2. **DHCF should learn from past experiences to inform implementation of continuous coverage.**

   The pause, for example, significantly reduced the communications DHCF had with Medicaid recipients. This in turn made it difficult to keep updated information including recipients' addresses, phone numbers, and emails. Therefore, DHCF should devise a way to keep recipient information up to-date

while still reducing administrative burden on families. This is one example of a lesson learned from the Medicaid pause. It would be helpful to hear more from DHCF on their other experiences with redetermination after the end of the Medicaid pause and how it will inform implementation of continuous coverage for children going forward.

3. **An evaluation of the impact of continuous coverage in the District should be part of implementation.**

   Other jurisdictions, for example, have reported cost savings from continuous coverage. Therefore, an evaluation of continuous coverage would be useful for the Council, Agency, and stakeholders to understand the anticipated cost savings in the District. Savings from continuous coverage could be used to support other programs for children and families. However, there must be consideration of the resources needed to evaluate continuous coverage including sufficient financial, technological, and personnel investments. Additionally, it must be considered which aspects of continuous coverage, aside from cost savings, need to be evaluated.

4. **The Council must exercise vigorous oversight to ensure proper investment and successful implementation of continuous coverage.**

   We ask the Council to provide support to the Agency throughout implementation, including addressing any workforce needs that come up under this additional

benefit. The Council should also utilize their oversight role to ensure children and families receive the full benefits of continuous coverage.

Medicaid Reimbursement for Home Visiting will Stabilize Funding for this Critical Program that Supports District Children and Families

Home Visiting Strengthens Parent-Child Relationships and Creates Positive Future Outcomes for Children

Creating a strong foundation in early childhood requires resources and supports not only for the child but also for their family and caregivers. The first few years of a child's life are typically full of rapid change and development for the child as well as stress and uncertainty for the parent or caregiver. This puts younger children at a higher risk of experiencing a strained parent- child relationship or some form of maltreatment.[23] Studies show that warm, responsive relationships in the first five years of life are critical for child development.[24] The reduction of stress is one way to allow parents and caregivers to nurture a relationship with their children in a way that positively impacts the child's development.[25]

Home visiting is a proven service delivery model for reducing parental stress and strengthening early relational health - the positive, nurturing connection between child and parent/caregiver that creates emotional wellbeing for both.[26] Home visiting programs connect expectant parents and parents of children five and under with a designated support person, like a nurse, social worker, or community health worker, often called a home visitor.[27] Home visitors regularly meet with families in the setting where they are

most comfortable – usually the home – to deliver various services and provide resources that support the physical and mental health of the parent and the child.[28]

There are several models of home visiting being implemented in the District, including Healthy Families America, Parents as Teachers, Nurse Family Partnership, Home Instruction for the Parents of Preschool Youngsters (HIPPY), Mothers Rising, and Father-Child Attachment Program.[29] While each model focuses on slightly different needs, there are common areas of emphasis for home visiting programs including maternal mental and physical health; child development; school readiness; child health; family safety; family economic security; and connections to other resources and services.[30] Home visitors decrease stress by breaking down barriers to resources, participating in goal setting and completion, and offering general support to caregivers who sometimes just need a listening ear. When a parent is less stressed, they are better able to meet the needs of their child, resulting in healthier outcomes for the family.

Medicaid Reimbursement for Home Visiting is an Essential Financing Component to Strengthening Home Visiting Programs

There are currently 17 home visiting programs in the District.[31] Each program receives funding through a variety of different funding mechanisms including private dollars, Federal Early Head Start and Head Start, Federal Community-Based Child Abuse prevention grant, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, Federal Family First Prevention Services Act, and local DC budget dollars.[32] Starting in Fiscal Year 2024, the funding is distributed amongst Child and Family Services

Agency (CFSA), the Department of Health (DC Health), and the Department of Health Care Finance (DHCF).[33]

Because of the variety of funding sources and authorities, home visiting programs across the District have been plagued by fluctuations in funding that lead to instability of the programs. Unstable funding leads DC home visiting programs to experience high workforce turnover, undermining the effectiveness of the program.[34] In order to improve physical, mental, and emotional health outcomes, home visitors must build trusting, long-term relationships with the families. As we have previously testified, stable and sufficient funding for home visiting is necessary to foster consistent, meaningful relationships between home visitor and participant.[35] Medicaid reimbursement for home visiting services is a crucial source of funding that the District is currently missing. We are glad to see the Council act on this issue and strongly support this bill.

The Proposed Legislation has Key Provisions that will Create Meaningful Access to Medicaid Reimbursement for Home Visiting

The Home Visiting Medicaid Reimbursement Act of 2023 requires DHCF to submit a State Plan Amendment (SPA) to the Center for Medicare and Medicaid Services (CMS) to establish reimbursement of eligible home visiting services.[36] The SPA, if accepted by CMS, would open the door for DC home visiting programs to draw down Medicaid dollars as an additional source of federal funding and help to sustain and expand services to reach more children and families.[37] The legislation is not overly prescriptive in how DHCF should approach the SPA but does require two critical pieces:

(1) the opportunity for home visiting programs that do not meet the U.S. Department of Health and Human Services (US DHHS) criteria for evidence of effectiveness to potentially become eligible for Medicaid through alternative routes; and (2) that DHCF shall consult with home visiting providers in the District to inform the SPA.[38] We look forward to working with DHCF and the Council on the implementation of home visiting Medicaid reimbursement to ensure meaningful utilization and impact of this legislation.

The proposed Home Visiting Reimburse Act is Not Overly Restrictive of Which Programs are Eligible

The legislation limits eligibility for reimbursement to evidence-based home visiting programs that meet the US DHHS criteria for evidence of effectiveness.[39] However, the legislation does leave open the possibility to expand to home visiting programs that meet substantially equivalent criteria for evidence of effectiveness as determined by a credible, independent academic or research organization.[40] This is a great addition as the US DHHS Home Visiting Evidence of Effectiveness (HomVEE) review can be extensive, burdensome, and long.[41] Allowing for alternative routes to gain evidence-based status opens the possibility that more programs could be covered by Medicaid. Under the proposed legislation, at least 12 of the 17 home visiting programs will be eligible for Medicaid reimbursement based solely on the US DHHS criteria for evidence-based home visiting programs. We, however, do believe more programs will be added after completion of academic research.

The Home Visiting Medicaid Reimbursement Act Accounts for Key Stakeholder Input to Inform Coverage of Home Visiting Services

There are several models of evidence-based home visiting.[42] Each model adheres to its own service package, staffing requirements, and defined set of protocols to meet the needs of the families it serves. This results in varying costs across model type. For example, one model may require registered nurses to deliver home visiting services while another may require an individual with a non-specified bachelor's degree. The difference in degree requirements often results in a difference of pay for the home visitor, which in turn results in different costs across the two models. Therefore, it would be difficult to set one rate for all home visiting services covered by local Medicaid programs. DHCF must take into consideration the varying costs of each qualifying program in the District to understand how it could create meaningful reimbursement that covers home visiting programs actual costs.

There are currently 28 states that allow for Medicaid reimbursement of home visiting services.[43] Amongst these states the structure for reimbursement varies including:

- The federal authority that allows states to implement a managed care delivery system (i.e. a state plan authority and waiver authority [either section 1915(a) and (b) or section 1115]);
- The eligibility of requirements for the families in the home visiting program (i.e., income levels, a parent that is expectant, a child that is of a certain age, etc.);

- The benefit duration (e.g., some states only cover home visiting services for children until their second birthday);
- The home visiting service providers that are qualified to deliver the models (e.g., nurses, community health workers, licensed professionals, etc.);
- The specific home visiting models that qualify for reimbursement (e.g., evidence-based home visiting programs determined by HomVEE like Nurse Family Partnership, Healthy Families America, and Parents As Teachers);
- The Medicaid reimbursement structure (i.e., does a state use Fee-For-Service, Per Member Per Month, or Certified Public Expenditure to reimburse home visiting programs); and
- The dollar amount of the reimbursement rate paid to programs.[44]

These variances in home visiting reimbursements across the country illustrates this cannot be a one size fits all approach.[45] While this may seem daunting, the multiple options for home visiting Medicaid reimbursement also provide the opportunity to ensure Medicaid reimbursement is developed and implemented in a way that truly meets the needs of DC home visiting programs. In determining reimbursement, DHCF must account for every associated cost for the home visiting program and work to cover as many pieces of home visiting as possible through Medicaid reimbursement.

Given the multiple ways to determine Medicaid reimbursement, we are glad the legislation requires DHCF "to consult with home visiting providers and other relevant

stakeholders to establish processes for billing and reimbursement of home visiting services."[46] Consultation was a hallmark of establishing the SPA for Medicaid reimbursement for doula services. The Children's Law Center had the opportunity to participate as a member of Maternal Health Advisory Group (MHAG) and found it an effective way to elicit input and feedback on the benefit from doulas, healthcare providers, and community stakeholders.[47] The MHAG, for example, was instrumental in ensuring that DC has one of the highest number of visits allowed under the reimbursement structure and ensuring visits were both prenatal and postpartum.[48] The MHAG continues to serve as a valuable resource for implementation of the doula benefit.

We are, therefore, hopeful that the consultation for Medicaid reimbursement prompts the same kind of engagement as the MHAG. Consultation can and should inform the rates for home visiting services in the District, but only if there is meaningful participation across all eligible or potentially eligible home visiting programs. This is an opportunity for DHCF to ensure Medicaid reimbursement is driven by home visitors to set sufficient reimbursement rates.

Home Visiting Requires Continued Local and Federal Investments to Maintain Funding for All Aspects of the Programs

DC home visiting programs' ability to draw down Medicaid dollars will allow for more consistent and stable funding. Medicaid reimbursement provides more stable funding as it specifically outlines which services can and cannot be reimbursed. This means programs will be able to account for certain home visiting services receiving

reimbursement; services like breastfeeding education, parenting skills, family planning, nutritional information, case management, referral to services, screening, and health promotion and counseling.[49] Medicaid does not pay for the full costs of operating a home visiting program, there will be certain aspects of a program that will not be able to draw down Medicaid reimbursement, including training of home visitors, data management, supervision, and related administrative activities.[50] The aspects of home visiting programs not covered by Medicaid can, however, be covered by sufficient investment of other funding streams such as local and federal dollars. For example, the administrative aspect of billing Medicaid can at times be burdensome, especially for community-based organizations that do not currently bill for services and may lack the experience or staff to properly bill. Home visiting programs across the District must be able to access funds other than Medicaid to support their administrative capacities.

Medicaid reimbursement for home visiting provides a path toward greater investment in an underinvested service delivery model. Through Medicaid reimbursement, there is an opportunity to increase funding that home visiting programs can draw down to move forward their valuable work. However, Medicaid reimbursement cannot be the only funding source for home visiting programs in the District. It must be skillfully braided with other funding sources like MIECHV and local dollars.

We, therefore, ask the Council to ensure that the current funding levels for home visiting remain stable. Continued local investment in home visiting is critical to ensure the non-reimbursable elements of home visiting continue to operate at full capacity. DC home visiting programs cannot afford to lose any of their current investment. We must build up these programs so they can continue to serve DC children and families in the earliest years of development.

Conclusion

Thank you for the opportunity to testify today. I welcome any questions the Committee may have.

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[1] Nadine Burke Harris, Toxic Childhood Stress: The Legacy of Early Trauma and How to Heal (2020).

[2] *See* Children's Law Center Policy Testimony, *available at:* https://childrenslawcenter.org/audience/policy-testimony/.

[3] Department of Health Care Finance, How to Renew Your Medical Coverage, *available at:* https://dhcf.dc.gov/service/how-renew-your-medical-coverage#:~:text=In%20order%20to%20continue%20to,Medicaid%20coverage%20once%20a%20year.

[4] Families First Coronavirus Response Act (FFCRA) required states to maintain enrollment of nearly all Medicaid enrollees during the COVID-19 public health emergency. *See* Medicaid.gov, *Unwinding and Returning to Regular Operations after COVID-19, available at*: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/index.html#:~:text=The%20Consolidated%20Appropriations%20Act%2C%202023,end%20on%20March%2031%2C%202023.

[5] Joan Alker, *Lessons from the Pandemic: Medicaid Works!,* Georgetown University McCourt School of Public Policy Center for Children and Families, December 7, 2022, *availabl*e at: https://ccf.georgetown.edu/2022/12/07/lessons-from-pandemic-medicaid-continuous-coverage-works/; Jennifer Tolbert and Meghana Ammula, *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision,* KKF, June 9, 2023, *available at*: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/; Farah Erzouki, *States Must Act to Preserve Medicaid Coverage as End of Continuous Coverage Requirement Nears,* Center on Budget and Policy Priorities, February 6, 2023, *available at*: https://www.cbpp.org/research/health/states-must-act-to-preserve-medicaid-coverage-as-end-of-continuous-coverag; Joan Alker and Tricia Brooks, *Millions of Children May Lose Medicaid: What Can Be Done to Help Prevent Them from Becoming Uninsured?,* Georgetown University Health Policy Institute Center for Children and Families, February 17, 2022, *available at*: https://ccf.georgetown.edu/wp-content/uploads/2022/02/Kids-PHE-FINAL-2-17.pdf.

[6] Edwin Park, et. al., *Consolidated Appropriations Act, 2023: Medicaid and CHIP Provisions Explained,* Georgetown University McCourt School of Public Policy Center for Children and Families, January 4, 2023, *available at*: https://ccf.georgetown.edu/2023/01/05/consolidated-appropriations-act-2023-medicaid-and-chip-provisions-explained/.

[7] As of March 2023, there 160,059 children (ages 0-20) living in the District and of that population, 101,478 were enrolled in Medicaid. *See* District of Columbia Department of Health Care Finance Monthly Enrollment Report - April 2023, Reflecting Period of March 2022-March 2023, *available at:* https://www.dchealthmatters.org/demographicdata?id=130951§ionId=942; https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/MCAC%20Enrollment%20Report%20-%20April%202023.pdf.

[8] "Research shows that Medicaid eligibility during childhood lowers the high school dropout rate, raises college enrollment, and increases four-year college attainment." *See* Jessica Schubel, *Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children,* Center on Budget and Policy Priorities, June 14, 2021, *available at*: https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and#:~:text=Research%20shows%20that%20Medicaid%20eligibility,increases%20four%2Dyear%20college%20attainment; https://news.virginia.edu/content/study-expanded-medicaid-kids-results-more-stable-households; https://ccf.georgetown.edu/2022/10/07/medicaid-and-chip-continuous-coverage-for-children/. *See also* Allison Barrett Carter, STUDY: EXPANDED MEDICAID FOR KIDS RESULTS IN MORE STABLE HOUSEHOLDS, UVAToday, March 1, 2022, *available at*: https://news.virginia.edu/content/study-expanded-medicaid-kids-results-more-stable-households; Cathy Hope, *Medicaid and CHIP Continuous Coverage for Children*, Georgetown University McCourt School of Public Policy Center for Children and Families, October 7, 2022, *available at*: https://ccf.georgetown.edu/2022/10/07/medicaid-and-chip-continuous-coverage-for-children/.

[9] Cathy Hope, *Medicaid and CHIP Continuous Coverage for Children,* Georgetown University McCourt School of Public Policy Center for Children and Families, October 7, 2022, *available at*: https://ccf.georgetown.edu/2022/10/07/medicaid-and-chip-continuous-coverage-for-children/.

[10] Aditi Vasan and Rebecka Rosenquist, *the Importance of Medicaid Continuous Enrollment Policies for Children and Families,* Children's Hospital of Philadelphia, June 7, 2023, *available at*: https://policylab.chop.edu/blog/importance-medicaid-continuous-enrollment-policies-children-and-families#:~:text=In%202018%2C%20for%20example%2C%2011.2,medical%20needs%20and%20unfilled%20prescriptions; Tricia Brooks and Allexa Gardner, *Continuous Coverage in Medicaid and Chip,* Georgetown University Health Policy Institute Center for Children and Families, July 2021, *available at*: https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf; Cathy Hope, *Medicaid and CHIP Continuous Coverage for Children*, Georgetown University McCourt School of Public Policy Center for Children and Families, October 7, 2022, *available at*: https://ccf.georgetown.edu/2022/10/07/medicaid-and-chip-continuous-coverage-for-children/.

[11] The Bright Futures/American Academy of Pediatrics (AAP), AAP Schedule for Well-Child Care Visitis, *available at*: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx.

[12] *Id.*

[13] For example, across the District HealthySteps, integrated behavioral health care in pediatric primary care, is in 10 sites and allows children and families to be connected with prevention and early intervention services. See Early Childhood Innovation Network, HealthySteps DC, *available at*: https://www.ecin.org/healthysteps.

[14] Health Affairs examined "children's Medicaid participation during 2019–21 and found that as of March 2021, states newly adopting continuous Medicaid coverage for children during the COVID-19 pandemic experienced a 4.62 percent relative increase in children's Medicaid participation compared to states with previous continuous eligibility policies." *See* Aditi Vasan, et. al., *Continuous Eligibility And Coverage Policies Expanded Children's Medicaid Enrollment*, Health Affairs Vol. 42., No. 6, June 2023, https://doi.org/10.1377/hlthaff.2022.01465. Additionally, it has been found that churning on and off Medicaid coverage can "limit access to care and lead to delays in getting needed care. Gaps in coverage can be especially problematic for young children who are recommended to receive frequent screenings and check-ups." Elizabeth Williams, et. al., *Implications of Continuous Eligibility Policies for Children's Medicaid Enrollment Churn,* KKF, December 21, 2022, *available at*: https://www.kff.org/medicaid/issue-brief/implications-of-continuous-eligibility-policies-for-childrens-medicaid-enrollment-churn/; Emma Daugherty and Cindy Mann, Oregon Leads the Way for States to Provide Continuous Coverage in Medicaid, Manatt, Phelps & Phillips, LLP, January 30, 2023, available at: https://www.jdsupra.com/legalnews/oregon-leads-the-way-for-states-to-8118990/; [14] Kelly Whitener and Matthew Snider, *Advancing Health Equity for Children and adults with a Critical Tool: Medicaid and Children's Health Insurance Program Continuous Coverage*, Georgetown University Health Policy Institute Center for Children and Families and UNIDOS US, *available at*: https://ccf.georgetown.edu/wp-content/uploads/2021/10/continuity-of-coverage-final.pdf.

[15] Jennifer Wagner and Judith Solomon, *Continuous Eligibility Keeps People Insured and Reduces Costs,* Center on Budget and Policy Priorities, May 4, 2021, *available at*: https://www.cbpp.org/research/health/continuous-eligibility-keeps-people-insured-and-reduces-cost.

[16] Kelly Whitener and Matthew Snider, *Advancing Health Equity for Children and adults with a Critical Tool: Medicaid and Children's Health Insurance Program Continuous Coverage*, Georgetown University Health Policy Institute Center for Children and Families and UNIDOS US, *available at*: https://ccf.georgetown.edu/wp-content/uploads/2021/10/continuity-of-coverage-final.pdf.

[17] Phil Galewitz, *Oregon will become 1st state in nation to allow children who enroll in Medicaid at birth to stay to age 6,* The Oregonian, March 17, 2023, *available at*: https://www.oregonlive.com/business/2023/03/oregon-will-become-1st-state-in-nation-to-allow-children-who-enroll-in-medicaid-at-birth-to-stay-to-age-6.html; Emma Daugherty and Cindy Mann, *Oregon Leads the Way for States to Provide Continuous Coverage in Medicaid,* Manatt, Phelps & Phillips, LLP, January 30, 2023, *available at*: https://www.jdsupra.com/legalnews/oregon-leads-the-way-for-states-to-8118990/.

[18] *Id.*

[19] Joan Alker and Tricia Brooks, *Millions of Children May Lose Medicaid: What Can Be Done to Help Prevent Them from Becoming Uninsured?,* Georgetown University Health Policy Institute Center for Children and Families, February 17, 2022, *available at*: https://ccf.georgetown.edu/wp-content/uploads/2022/02/Kids-PHE-FINAL-2-17.pdf; Rostad WL, Moreland AD, Valle LA, Chaffin MJ. Barriers to Participation in Parenting Programs: The Relationship between Parenting Stress, Perceived Barriers, and Program Completion. J Child Fam Stud. 2018 Apr;27(4):1264-1274. doi: 10.1007/s10826-017-0963-6. Epub 2017 Dec 22. PMID: 29456438; PMCID: PMC5812022.

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[37] The Home Visiting Reimbursement Act is structured similarly to the Maternal Health Resources And Access, which held that DHCF submit a SPA to create reimbursement for doula services in the District. D.C. Law 24-45. Fiscal Year 2022 Budget Support Act of 2021. Subtitle E. Maternal Health Resources and Access, sec. 672. Reimbursement for doula services. The SPA for doula services was accepted by CMS in October 2022. Doula Benefit, Provider Qualifications and Enrollment, Rates and Reimbursement Standards, Transmittal #22-34, September 30, 2023, *available at*: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Transmittal-22-34-Doula-Benefit-Provider-Qualifications-and-Enrollment-Rates-and-Reimbursement-Standards.pdf. The Home Visiting Reimbursement Act provides another path to leverage federal Medicaid dollars to provide a vital support for pregnant and postpartum people, children, and their families.

[38] B25-0321, Home Visiting Services Reimbursement Act of 2023, Sec. 2. Definitions. (a)(3)(D), lines 23-25, Sec. 3. Medicaid reimbursement for home visiting services. (b)(2)(A)(i-iii), lines 78-86.

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