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Maternal and Infant Early Childhood Home Visiting (MIECHV) Program: Background and Funding

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Summary

The federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program supports home visiting services for families with young children who reside in communities that have concentrations of poor child health and other risk indicators. Home visits are conducted by nurses, mental health clinicians, social workers, or paraprofessionals with specialized training. Generally, they visit the homes of eligible families on a regular basis (e.g., weekly or monthly) over an extended period (e.g., six months or longer) to provide support to caregivers and children, such as guidance on creating a positive home environment and referrals to community resources. Families participate on a voluntary basis. Research on the efficacy of home visiting has shown that some models can help improve selected child and family outcomes, such as reducing child abuse. In FY2015, the MIECHV program supported 145,561 individual parents and children and conducted 912,119 home visits.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) established the MIECHV program under Section 511 of the Social Security Act in March 2010. The program is jointly administered by the U.S. Department of Health and Human Services' (HHS's) Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). Congress directly appropriated five years of mandatory funding for the program in the MIECHV authorizing statute: $100 million for FY2010; $250 million for FY2011; $350 million for FY2012; and $400 million for each of FY2013 and FY2014. (The funds in FY2013, FY2014, and FY2017 were subject to sequestration.) The statute has twice been amended (by P.L. 113-93 and P.L. 114-10) to appropriate $400 million for each of FY2015, FY2016, and FY2017. MIECHV funding is provided primarily to states and territories to administer home visiting programs, and funds are awarded on both a formula and a competitive basis. The law requires that HHS reserve 3% of the annual appropriation for Indian tribal entities, and funding is provided to tribes on a competitive basis to carry out home visiting services. Another 3% is to be reserved for training, technical assistance, and evaluations.

States, territories, and tribes must carry out their home visiting programs as specified in the law. Among other requirements, jurisdictions had to conduct needs assessments to identify communities with concentrations of poor infant health and other negative outcomes for children and families; the availability and use of home visiting services; and the capacity for providing substance abuse treatment and counseling in the jurisdiction. Under the program, these jurisdictions are required to achieve gains in four of six "benchmark" (or outcome) areas pertaining to family well-being and coordination of community resources.

The majority of annual funding (a minimum of 75%) for jurisdictions that administer home visiting programs must be used to support a program model that has shown sufficient evidence of effectiveness. The remaining 25% of funds may be used to implement models that have promise of effectiveness. HHS has established criteria for determining whether home visiting models are effective and reviews home visiting models on an ongoing basis via the Home Visiting Evidence of Effectiveness (HomVEE) project. The project has determined that 18 models are evidence-based. Generally, these models have shown impacts in one or more outcomes in maternal and child health; early childhood social, emotional, and cognitive development; family/parent functioning; and links to other resources. In FY2016, jurisdictions had implemented 10 of the 17 models using MIECHV funding: Child First, Early Head Start-Home Visiting (EHS-HV), Family Check-Up (FCU), Family Spirit, Health Access Nurturing Development Services (HANDS) Program, Healthy Families America (HFA), Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse-Family Partnership (NFP), Parents as Teachers (PAT), and SafeCare Augmented.

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Introduction

Home visiting is a strategy for delivering services to improve health, well-being, and education outcomes for vulnerable families with young children. Nurses, social workers, and other professionals provide support in the homes of families who participate on a voluntary basis. The federal government has long supported programs in which home visiting is a major component or is otherwise permitted. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is the primary federal program that focuses exclusively on home visiting.[1] The program was implemented in March 2010, following the Obama Administration's FY2010 budget request for a national home visiting program and a home visitation pilot program carried out in 15 states that had been initiated in FY2008 by the Bush Administration.

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) established MIECHV under Section 511 of the Social Security Act.[2] The program—jointly administered by the U.S. Department of Health and Human Services' (HHS's) Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF)—seeks to strengthen and improve home visiting services and support to families residing in at-risk communities, while also improving coordination of supportive services in these communities. States, territories, and Indian tribes ("jurisdictions")[3] determine which communities are at risk by conducting needs assessments. The MIECHV statute requires that jurisdictions must administer programs that are evidence-based.[4] Specifically, jurisdictions must use no less than 75% of their program funds to implement home visiting models that HHS has determined are effective; ensure that services are carried out with fidelity to these program models; and demonstrate improvements in outcomes for participating families. Congress appropriated $400 million in FY2017 to support the MIECHV program, and jurisdictions have until September 30, 2019, to expend these funds.

This report begins with an overview of home visiting generally and discusses federal efforts to increase and support home visiting services. It goes on to describe the MIECHV program, which encompasses information about its administration, coordination, and funding. Following this is an outline of MIECHV requirements for states and other jurisdictions, including information on the types of home visiting models that have been implemented across jurisdictions. The report concludes with information about efforts to research, evaluate, and provide technical assistance on the MIECHV program. **Appendix A** includes federal legislative history on home visiting; **Appendix B** includes funding levels by state for the MIECHV program in selected years; **Appendix C** includes a timeline of relevant dates for the program; and **Appendix D** provides information about home visiting models adopted by jurisdictions, and features of selected home visiting models that meet HHS criteria for being effective.

[1] The New Parent Support Program, operated by the Department of Defense, also has a primary focus on home visiting; however, it is available only to military families.

[2] All statutory references to law are to the Social Security Act unless otherwise noted.

[3] The law describes these as "grantees" or "eligible entities." This report primarily uses the term "jurisdictions."

[4] The Obama Administration has focused on implementing evidence-based social policy initiatives, including the MIECHV program. For further information, see Ron Haskins and Greg Margolis, "The Maternal, Infant, and Early Childhood Home Visiting Initiative," in *Show Me the Evidence: Obama's Fight for Rigor and Results in Social Policy* (Washington, DC: Brookings Institution Press, 2014).

Overview of Home Visiting

Home visiting is a comprehensive strategy that involves social, health, and/or educational services for parents and their young children. For many years, greater attention has focused on early childhood home visitation as a way to improve child and family outcomes. In the past decade, this trend appears to be driven in some part by newer research on how the human brain develops and, specifically, the significance of prenatal and early childhood environments to later life.[5] To a large extent, parents shape their children's earliest experiences. Home visiting programs seek to help parents understand their own child's development. Proponents see these programs as an opportunity to enhance parents' role in ensuring their children's physical well-being and positive social-emotional growth, and supporting their early education. In turn, the programs can help achieve positive benefits for children, parents, and possibly their communities.

At least since the 1960s, a variety of early childhood home visiting models have undergone many assessments and evaluations intended to test how effectively they achieve their goals. Looking at findings across multiple home visiting studies, researchers conclude that home visiting can provide benefits to children and their parents, including preventing potential child abuse and neglect, enhancing cognitive development, improving parenting attitudes and parenting behaviors (e.g., discipline strategies), and increasing maternal education. They caution, however, that while visiting programs can lead to improvements, the difference is small between observed outcomes for families that received home visits versus those who did not. Further, while one or more individual studies may have shown positive effects with regard to many other desired outcomes, those effects have not necessarily been studied and/or achieved across more than one study or program site. Nonetheless, some models or aspects of models have been shown to be particularly effective. Overall, while researchers have cautioned that home visiting is not a panacea, they have generally encouraged its use as part of a range of strategies intended to enhance and improve early childhood.[6]

Overview of MIECHV

The MIECHV law does not define "early childhood home visiting." In practice, this generally entails visits to the homes of families with children until the age of kindergarten entry (e.g., under age five or six) on a regular basis (e.g., weekly or monthly) over an extended period (e.g., six months or longer). Depending on the program model, visits may be conducted by nurses, mental health clinicians, social workers, or paraprofessionals who have received specialized training. These visitors provide services such as parenting education, and they refer families to other services in the community.

HHS provides MIECHV funding to states, territories, and tribal entities for home visiting services in at-risk communities, as identified by these jurisdictions. MIECHV prioritizes certain eligible

[5] National Research Council and Institute of Medicine, *From Neurons in to Neighborhoods: The Science of Early Childhood Development*, ed. Jack P. Shonkoff and Deborah A. Phillips (National Academy Press, 2000).

[6] For further information, see Office of the President, *The Economics of Early Childhood Investments*, Invest in US: The White House Summit on Early Childhood Education, December 2014; CRS Report R40705, *Home Visitation for Families with Young Children*, by Emilie Stoltzfus and Karen E. Lynch; and U.S. Department of Health and Human Services (HHS), Administration for Children, Youth and Families, Administration for Children and Families (ACF), Office of Planning, Research, and Evaluation (OPRE), *Home Visiting Evidence of Effectiveness Review: Executive Summary*, OPRE Report #2016-72, September 2016, http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2016_B508.pdf.

families who are low-income, including young mothers, or have history of substance abuse, among other risk factors. Families participate on a voluntary basis. In FY2015, the MIECHV program served 145,561 individual parents and children and provided 912,119 home visits.[7] Jurisdictions that carry out home visiting programs under MIECHV must adhere to specific requirements in the law and guidance. For example, they must use most of their program funding to implement one or more home visiting models that have been identified by HHS to be effective. Separately, HHS provides training and technical assistance to jurisdictions and is carrying out research activities to evaluate the impacts of the program. **Figure 1** summarizes the major components of the program.[8]

Eligible Families

Under the program, jurisdictions provide home visiting services to eligible families who volunteer to participate. An eligible family includes (1) a woman who is pregnant, and the father of the child if he is available; (2) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth to entry into kindergarten; and (3) a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child from birth to entry into kindergarten.[9] Jurisdictions must give priority to serving eligible families who meet any of the following criteria:

- reside in communities that are in need of home visiting services, as identified in a needs assessment conducted by the jurisdiction;
- are low-income;
- include a pregnant woman under the age of 21;
- have a history of child abuse or neglect or have had interactions with child welfare services;
- have a history of substance abuse or need substance abuse treatment;
- have users of tobacco products in the home;
- have children with low student achievement;
- have children with developmental delays or disabilities; or
- individuals who are serving, or formerly served, in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.[10]

[7] HHS, HRSA, *Maternal Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed*, no date, http://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview (hereinafter, HHS, HRSA, *Maternal Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed*). This is up from 34,180 participants in FY2012; 75,970 participants in FY2013; and 115,545 participants in FY2014; and 174,257 home visits in FY2012; 489,363 home visits in FY2013; and 746,303 home visits in FY2014.

[8] For information about each state's and territory's home visiting program, see HHS, HRSA, *HRSA's Maternal Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed*; and an interactive map that includes information about their programs. Both the brief and map are available at HHS, HRSA, "Home Visiting Helps At-Risk Families Across the U.S.," http://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-state-fact-sheets.

[9] Section 511(k)(2).

[10] Section 11(d)(4).

Figure 1. Overview of the MIECHV Program

PURPOSES

(1) Strengthen and improve home visiting services and activities, (2) **improve coordination** of services for at-risk communities, and (3) **identify and provide comprehensive services to improve outcomes** for families residing in these communities.

ELIGIBLE ENTITIES (JURISDICTIONS)

Any of the 50 states and the District of Columbia; Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and America Samoa; and an Indian tribe, tribal organizations, or urban Indian organization. In addition, HHS may make grants to non-profit organizations to carry out a home visiting program in a state that has not applied for or been approved for a grant as of the beginning of FY2012.

ELIGIBLE FAMILIES

(1) A woman who is pregnant, and the father of the child if he is available; (2) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the parent's primary caregiver from birth to entry into kindergarten; and (3) a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child from birth to entry into kindergarten.

FUNDING

Between **$100 million to $400 million for each of FY2010-FY2017,** of which 3% is to be reserved for Indian tribal entities and another 3% is to be reserved for training, technical assistance, and research. In practice, HHS distributes MIECHV funds by both **formula** and **competitive** grants to eligible entities. HHS separately awards competitive grants to tribal entities under the **Tribal MIECHV program**.

SELECTED REQUIREMENTS OF ELIGIBLE ENTITIES

(1) Conduct **statewide needs assessment** to identify communities with concentrations of poverty, poor infant health and mortality, and other negative outcomes for children and families to gauge the availability and use of home visiting services; (2) establish, subject to HHS approval, **quantifiable and measurable benchmarks for demonstrating improvements in four out of six child, parent, and family indicators**; and (3) spend no less than **75% of their funds to conduct a home visiting program using a model(s) that HHS deems to be evidence-based**, among other requirements.

RESEARCH AND EVALUATION

HHS supports the **Home Visiting Evidence of Effectiveness (HomeVee)** review that determines whether home visiting models are evidence based. In addition, HHS provides MIECHV funding for the **Tribal Early Childhood Research Center**, which seeks to help translate research findings applicable to American Indian and Alaska Native children and families.

HHS is also carrying out a random assignment evaluation **(MIHOPE)** of four home visiting models to examine the effects on home visiting services for family outcomes in parent health and well-being, parenting, and child health and development. The **MIHOPE-Strong Start** evaluation also involves random assignment, and is examining the effects of home visiting services on birth, prenatal health, and infant health outcomes.

Source: Congressional Research Service (CRS), based on Section 511 of the Social Security Act.

Funding

The Affordable Care Act directly appropriated five years of funding for the MIECHV program: $100 million for FY2010, $250 million for FY2011, $350 million for FY2012, and $400 million for each of FY2013 and FY2014. The Protecting Access to Medicare Act of 2014 (P.L. 113-93) provided $400 million for the program for the first half of FY2015 (October 1, 2014, through March 31, 2015).[11]

The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10), which was signed into law on April 16, 2015, extended the $400 million made available under P.L. 113-93 through

[11] Section 511(j). See, HHS, HRSA, *Justification of Estimates for Appropriations Committees*, *FY2016*, p. 272; and HHS, HRSA, *Justification of Estimates for Appropriations Committees*, *FY2018*, p. 180.

all of FY2015 (October 1, 2014, through September 30, 2015). In other words, the law allowed HHS to obligate FY2015 funds through the end of FY2015 but otherwise did not change the level of funding for FY2015.[12] P.L. 114-10 also provided $400 million for each of FY2016 and FY2017 under the program.[13]

The law requires that 3% of the annual appropriation is to be reserved for Indian tribal entities, and another 3% is to be reserved for technical assistance (related to corrective action on benchmark areas, discussed subsequently), research, and evaluation. MIECHV funding may be expended by the recipient through the end of the second succeeding fiscal year after the award.

The law does not specify how the funds are to be awarded. In practice, HHS distributes MIECHV funds by both formula and competitive grants to states and other jurisdictions. Formula funding is available annually for home visiting in the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa. The factors for allocating funds under the formula component have changed, effective with funding awarded with the FY2016 appropriation. The major distinction is that a sizable share of FY2016 funds was allocated based on a jurisdiction's average competitive award grants; however, funding for each jurisdiction could not be less than 10% of their average formula and competitive grant funding. See **Table 1** for further information. According to HHS, home visiting programs are better established, and the new formula will "provide funding stability and predictability" for states and territories. HHS has noted that the funds are intended to address need and reward states and territories for quality and ultimately, improved outcomes. HHS plans to maintain the same criteria for awarding funds in the future.[14] **Table B-1** in **Appendix B** shows FY2015 and FY2016 formula and competitive funding by state, and indicates the difference in total funding between these two years for each jurisdiction. As of the date of this report, FY2017 funds had not been fully obligated.

[12] Under P.L. 113-93, HHS had until March 31, 2015, to obligate all FY2015 funding. HHS reported that all funds had been obligated by this date. States and territories have more than two years to expend these funds, which will be available through September 30, 2017 (the end of FY2017).

[13] The Balanced Budget and Emergency Deficit Control Act of 1985 was amended by the Budget Control Act of 2011 (BCA, P.L. 112-25) to provide a budget process mechanism that would reduce mandatory spending and further reduce discretionary spending over an extended period. For mandatory spending, the reductions are to occur to nonexempt accounts through sequestration in each of FY2013-FY2025. (As originally enacted in the BCA, mandatory sequestration was scheduled to run through FY2021, but this period has subsequently been extended to FY2025 by P.L. 113-67, P.L. 113-82, and P.L. 114-74.) MIECHV funding has been subject to sequestration in years in which there was an appropriation at the time of the sequester order, including FY2013, FY2014, and FY2017, resulting in operating levels of $379.6 million, $371.2 million, and $372.4 million, respectively.

[14] HHS, HRSA, "Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Fiscal Year (FY) 2016 Formula Funding Opportunity Announcement (FOA)," HRSA-16-172, frequently asked questions, version 1, most recently updated December 4, 2015.

Table 1. Factors for Allocating Funding Under the Formula Grant, by Year

Year	Factors
FY2010-FY2015	**Need Funding:** Funds were distributed based on the relative share of children under age five in families at or below 100% of the federal poverty line in each state. The poverty data were derived from the Census Bureau's Small Area Income Poverty Estimates (SAIPE). SAIPE data are not available for the territories, and the territories generally received a minimum level of funding (i.e., $500,000 each in FY2010 and $1 million per year from FY2011 through FY2015). In FY2011, HHS proportionally modified funding to ensure that each jurisdiction received at least 120% of its FY2010 allocation. In FY2012 and FY2013, HHS proportionally modified funding to ensure that each jurisdiction received no less than the amount they received in the previous fiscal year.
FY2016	HHS awarded $344.7 million, of which $125 million (36.3%) was allocated based on the base need factor and $216 million (62.6%) was allocated based on the structured stability factor, described below. The remaining $3.7 million (1.1%) was allocated to account for funding adjustments. **Base Need:** 36.3% was distributed based on the share of children under age five in families at or below 100% of the federal poverty line in each state. The data are derived from SAIPE. The calculated amount is reduced by the proportion of the FY2012 de-obligation amount to the total FY2012 award. Each state or territory received a minimum of $1 million. For example, a state awarded $5 million in FY2012 that did not expend $500,000 would have de-obligated 10% of funds. Therefore, the state's expected funding for FY2016 would be reduced by 10%. **Structured Stability:** 62.6% was distributed based on the average of the state's or territory's competitive awards in FY2013, FY2014, and FY2015 as a proportion of total competitive funds awarded across those fiscal years. This proportion was then applied to $216 million to determine the structured stability factor. For example, if $600 million was awarded in total across those three fiscal years, and a state received a total of $20 million in competitive awards across those fiscal years, the state's proportion would be 3.3%. The 3.3% is applied to $216 million for a total of $7.2 million. **Funding Adjustment:** 1.1% of the total amount of funding available was adjusted to ensure that, where necessary, a jurisdiction receives no less than 10% from the average total funding amount (combined formula and competitive) of FY2013, FY2014, and FY2015. According to HHS, no jurisdiction's total grant award varied by more than 10% of its average funding awards over the past three years.

Source: HHS, HRSA, "Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Formula Grant Program Limited Competition," HRSA-14-1081, April 11, 2014; HHS, HRSA, "Maternal, Infant and Early Childhood Home Visiting Program–Formula," Funding Opportunity Announcement HRSA-16-172, November 16, 2015; and CRS correspondence with HHS, HRSA in October 2016.

Notes: In each of FY2010 through FY2012, MIECHV funding was provided to support 17 grantees under a previous home visiting program, Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV). See **Appendix A** for more detail about the program.

Three states (Florida, North Dakota, and Wyoming)[15] have declined funding for the program, and, as permitted under law, three nonprofits have successfully applied and have operated the program

[15] North Dakota was awarded funds in FY2010 to conduct its needs assessment. The state subsequently withdrew from the program and did not submit an updated state plan for FY2010 formula funding to implement services. A nonprofit organization began implementing the program in FY2012. Florida and Wyoming operated as state agency grant recipients in FY2010 and FY2011. After receiving the FY2011 awards, both states withdrew from the program and were required to return FY2011 funds to HRSA. Nonprofit organizations began implementing the program in these (continued...)

in these states selected years: Florida Association of Healthy Start Coalitions (Florida); Prevent Child Abuse (North Dakota); and Parents as Teachers National Center (Wyoming).[16] The nonprofit organizations receive funding that would have otherwise been awarded to the states (based on the formula factors) in which they operate. To be eligible to operate home visiting programs under MIECHV, nonprofits must have an established record of providing early childhood home visiting programs or initiatives in one or more states.

HHS also awards competitive funding to states based on the strength of their program or their effort to develop a strong program. This funding has been provided for "development grants" focused on building the capacity of the workforce, data infrastructure, and care coordination and referral systems; and to build upon their efforts already underway and expand services to more families and communities under grants known as "expansion grants." (Since FY2014, HHS has not distinguished between development and expansion grants, since each jurisdiction has developed a program.)

Table 2 summarizes obligated funding for the program from FY2010 through FY2016 (FY2017 funding is not included in the table because funds have not been fully obligated). Formula grants to jurisdictions made up about half to more than three-quarters of funds in FY2010, FY2011, and FY2016. The competitive grants made up the majority of funds in FY2012, FY2013, and FY2014.[17]

(...continued)

states in FY2013. In addition, Oklahoma received nonprofit formula funding for FY2014. CRS correspondence with HHS, HRSA, June 2016.

[16] HHS, HRSA, *Division of Home Visiting and Early Childhood Systems, Contact Information of MIECHV State Leads*, updated April 2015. Oklahoma received nonprofit formula funding for FY2014. The nonprofit organization Parents as Teachers National Center no longer operates the program.

[17] For a list of most grantees in each of these years, see HHS, HRSA, *MIECHV Grants and Grantees*, http://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview.

Table 2. Obligated Funding for the MIECHV Program, by Type of Award, FY2010-FY2016

Dollars in millions, percentages based on total obligated funding for a given year

				Competitive Grants					
Year	**Formula Grants to States and Territories (a)**	**Formula Grants to Nonprofit Organizations (b)**	***Total Formula Grants (c=a+b)***	**Competitive Grants to States and Territories (d)**	**Competitive Grants to Tribal Entities (e)**	***Total Competitive Grants (f=d+e)***	**Technical Assistance, Evaluation, and Research and Other Evaluation Activities (g)**	**Federal Administration and Grant Review (h)**	***Total Obligated Funding (i=c+f+g+h)***
FY2010	$91.8 (92.0%)	$0 (0.0%)	*$91.8*	$0 (0.0%)	$3.0 (3.0%)	*$3.0*	$2.8 (2.8%)	$2.4 (2.4%)	*$100.0*
FY2011	$124.0 (49.6%)	$0 (0.0%)	*$124.0*	$100.0 (40.0%)	$7.5 (3.0%)	*$107.5*	$12.7 (5.1%)	$5.7 (2.3%)	*$249.9*
FY2012	$118.0 (33.7%)	$1.0 (0.3%)	*$119.0*	$190.0 (55.3%)	$10.5 (3.0%)	*$200.5*	$17.4 (5.0%)	$6.8 (1.9%)	*$343.7*
FY2013	$109.5 (28.8%)	$7.5 (2.0%)	*$117.0*	$211.3 (58.1%)	$11.5 (3.0%)	*$222.8*	$18.2 (4.8%)	$5.9 (1.6%)	*$363.9*
FY2014	$106.7 (28.7%)	$9.3 (2.5%)	*$116.0*	$217.7 (58.6%)	$12.0 (3.0%)	*$229.7*	$18.0 (4.8%)	$6.8 (1.8%)	*$370.5*
FY2015	$116.6 (29.4%)	$8.4 (2.1%)	*$125.0*	$235.9 (59.5%)	$12.0 (3.0%)	*$247.9*	$16.7 (4.2%)	$6.8 (1.7%)	*$396.4*
FY2016	$331.1 (86.4%)	$13.6 (3.5%)	*$344.7*	$0 (0.0%)	$12.0 (3.1%)	*$12.0*	$16.8 (4.4%)	$9.6 (2.5%)	*$383.1*

Source: CRS correspondence with HHS, HRSA and HHS, ACF, October 2016; and HHS, HRSA, "Home Visiting Grants & Grantees," https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview.

Notes: Dollars are displayed in millions and rounded to nearest tenth; obligations are as of each fiscal year. This does not include unobligated funding or carryover funding (from unobligated balances and deobligations from previous fiscal years). Congress appropriated $400 million for this program in both FY2013 and FY2014; however, this funding was subject to sequestration, which reduced the actual funding available to the amounts shown. In addition, figures do not add to obligated totals for FY2011 through FY2014 because of funds that were unobligated in each of those years: FY2011 ($0.1 million was unobligated, or 0.1%; total funding would otherwise be $250 million); FY2012 ($6.3 million was unobligated, or 1.8%; total funding would otherwise be $343.7 million); FY2013 ($15.7 million was unobligated, or 4.1%; total

funding would otherwise be $379.6 million); FY2014 ($0.7 million was unobligated, or 0.2%; total funding would otherwise be $371.2 million); FY2015 ($3.6 million was unobligated, or 0.9%; total funding would otherwise be $400 million); and FY2016 ($16.9 million was unobligated, or 4.2%; total funding would have otherwise been $400 million). All unobligated funding is carried over to the next fiscal year to be available for obligation.

Competitive funding to states and territories was allocated for development grants to further develop the program and expansion grants to expand the program. These grants were awarded from FY2011 through FY2013 as follows: FY2011 ($33.7 million for development; $66.3 million for expansion); FY2012 ($46.7 million for development; $143.3 million for expansion); and FY2013 ($7.4 million for development and $203.9 for expansion). As of FY2014, HHS no longer distinguished between the two types of competitive grants because each state has developed a home visiting program.

The law requires that 3% is to be reserved for corrective action technical assistance (Section 511(d)(1)(B)(iii)), evaluation (Section 511(g)), and research and other evaluation activities (Section 511(h)(3)). Funding for general technical assistance to grantees (Section 511(c)(4)) is included in the column for technical assistance. This funding is not subject to the 3% set-aside provision.

Coordination

The MIECHV law includes several provisions that seek to ensure holistic services to families and promote coordination between agencies. For example, the law states that grants for home visiting programs are intended to improve specific family outcomes across a number of domains concerning health, emotional and physical well-being, and education. Related to this, jurisdictions carrying out MIECHV programs were required to conduct a needs assessment that was coordinated with needs assessments and planning processes under other federal programs, including those pertaining to child abuse, early childhood education, and domestic violence. Jurisdictions must also establish and demonstrate improvements in coordinating with other community resources and supports, among other areas.

In addition, the law requires coordination at the federal level between HRSA (specifically, the Maternal and Child Health Bureau) and ACF in (1) reviewing and analyzing the statewide needs assessments; (2) awarding MIECHV funds and overseeing the grants; (3) carrying out an evaluation of the program and an accompanying report; and (4) establishing advisory panels (as required in the law to review and make recommendations on the evaluation for the program and for providing assistance to jurisdictions that have not met expectations for performance). In practice, HRSA administers funding for the states and territories, and ACF administers funds for the tribes. ACF, in collaboration with HRSA, is overseeing the random assignment evaluation of the program.

The law also specifies that HRSA and ACF must coordinate and collaborate on research with other federal agencies that have responsibility for administering or evaluating programs for eligible MIECHV families. Such agencies include the HHS Office for Planning and Evaluation (OPRE), the Centers for Disease Control and Prevention (CDC), the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health (NIH), the Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the Department of Education's Institute of Education Sciences.[18]

Administration

HHS formula and competitive grant funding for states and territories is allocated to a lead agency in each state that successfully applies for the MIECHV program. Jurisdictions are required to effectively implement home visiting models (or a single home visiting model) in the state's at-risk community or communities, as identified by the jurisdiction via its needs assessment.

States and territories can determine which state agency or agencies will administer the MIECHV program. The public health department is the lead agency that administers home visiting funds in most states, the District of Columbia, and the five territories. In 11 of these jurisdictions (Arkansas, Delaware, Guam, Idaho, Maine, Montana, Nebraska, Nevada, New Hampshire, Texas, and West Virginia) the department of health also includes the state social service agency. Eight states administer the program through other departments with a social service focus (Alabama, Colorado, Georgia, Illinois, Mississippi, Pennsylvania, Texas, and Wisconsin). Specifically, Alabama, Georgia, and Wisconsin administer the programs through agencies or governmental entities that focus on children and families or early childhood. Alaska and Oregon each have two lead health and social service agencies. South Carolina operates its program through a nonprofit

[18] Section 511(h)(1).

organization, the Children's Trust Fund of South Carolina, which is authorized under state law and overseen by the state Office of Executive Policy and Programs.

In the three states that declined to participate, funds that would have otherwise been awarded to the state agency go instead to an eligible nonprofit organization that must carry out the MIECHV program in a community or communities identified in the statewide needs assessment. The nonprofit organizations that operate MIECHV programs in these states are the Florida Association of Healthy Start Coalitions; Prevent Child Abuse (North Dakota); and Parents as Teachers National Center (Wyoming).[19]

Requirements for Grantees

Overview

The law specifies a variety of requirements for jurisdictions receiving MIECHV funds. These jurisdictions were required to conduct an initial needs assessment to identify communities with concentrations of poor infant health and mortality, poverty, and other negative outcomes. They had to submit the results of the assessments to HHS and explain how the jurisdiction intended to address the needs of the assessment. Jurisdictions must also submit an application for funding to HHS that includes several items, such as a description of the populations to be served under the program and how they will serve high-risk populations as identified by the jurisdiction. Further, the law requires jurisdictions to establish, subject to HHS approval, quantifiable and measurable benchmarks for demonstrating improvements in six indicators for eligible families in the program. Jurisdictions must also meet other requirements, such as using MIECHV funding to supplement, and not supplant, other federal funding for home visiting services.[20]

Needs Assessment

As a condition of receiving funds under the Maternal and Child Health (MCH) Services Block Grant for FY2011,[21] "states" were required to conduct a statewide needs assessment for the MIECHV program.[22] The MIECHV law separately requires that tribes and nonprofit

[19] HHS, HRSA, *Division of Home Visiting and Early Childhood Systems, Contact Information of MIECHV State Leads*, updated April 2015. Oklahoma received nonprofit formula funding for FY2014. The nonprofit organization, Parents as Teachers National Center, no longer operates the program.

[20] Section 511(h)(2) specifies that the requirements for tribal entities must, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are states, and must include that tribal entities conduct a needs assessment and establish quantifiable benchmarks to measure program performance.

[21] Section 511(b)(1) references Section 502 of the Social Security Act, which addresses allotments to states and federal set-asides for the MCH Services Block Grant program. For further information about the program, see CRS Report R42428, *The Maternal and Child Health Services Block Grant: Background and Funding*, by Carmen Solomon-Fears. In addition, the law specifies that certain requirements under the Maternal and Child Health Services Block Grant apply to the MIECHV program. This includes provisions relating to prohibitions on payments to excluded individuals and entities (Section 504(b)(6)); use of funds for the purchase of technical assistance (Section 504(c)); limitations on administrative expenditures (Section 504(d)); reports and audits, but as determined appropriate for the MIECHV program (Section 504(d)); criminal penalty for false statements (Section 507); nondiscrimination (Section 508); and administration of title and state programs (Section 509(a)). All references are to the Social Security Act.

[22] Section 511(b).

organizations carry out needs assessments similarly to the assessment required for all states.[23] The statewide needs assessments had three purposes:

1. Identify communities with concentrations of
    - premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health;
    - poverty;
    - crime;
    - domestic violence;
    - high school dropouts;
    - substance abuse;
    - unemployment; or
    - child maltreatment.
2. Determine the quality and capacity of existing programs or initiatives for early childhood home visitation in the jurisdiction, including
    - the number and types of individuals and families who are receiving services under such programs or initiatives;
    - gaps in early childhood home visitation in the jurisdiction; and
    - the extent to which such programs and initiatives are meeting the needs of eligible families.
3. Determine the state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.[24]

In carrying out the needs assessment, jurisdictions were required to coordinate with, and take into account, other appropriate needs assessments conducted by the state, as determined by the HHS Secretary, including similar assessments already required under law: (1) the needs assessment for the Maternal and Child Health Services Block Grant (both the most recent completed assessment and any assessments in progress); (2) the community strategic planning and needs assessment under the Head Start program; and (3) the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect and other family resource services under the Child Abuse Prevention and Treatment Act (CAPTA).[25] HHS guidance issued in August 2010 also specified that the assessment should be

[23] Section 511(h)(2). See also, HHS, ACF, Office of Child Care, "Tribal Maternal, Infant, and Early Childhood Home Visiting Program, Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs (Phase 2 Implementation Plan)," September 17, 2012. (Hereinafter HHS, ACF, Office of Child Care, "Tribal Maternal, Infant, and Early Childhood Home Visiting Program, Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs (Phase 2 Implementation Plan).")

[24] Section 511(b)(1).

[25] Section 511(b)(2). In order to receive MCH block grant funds, states must submit to the Secretary of the Department of Health and Human Services (HHS) an application that includes a statewide needs assessment (to be conducted once every five years) and a plan for meeting the needs identified in the needs assessment. The needs assessment must identify statewide health status goals (consistent with national health objectives); the need for preventive and primary care services for pregnant women, mothers, infants, and children; and services for children with special health care needs. The plan to address the needs assessment must include a description of how and where block grant funds will be used within the state to address those needs. See Section 505(a) of the Social Security Act. In applying to expand Head (continued...)

coordinated with the state advisory council established under the Head Start Act (for children from birth to school entry); the state's child care agency; the state's education agency; the state's agencies administering federal funds to prevent and respond to domestic violence (under the Family Violence Prevention and Services Act [FVPSA] and STOP grants authorized under the Violence Against Women Act [VAWA]); and the state child welfare agency (if this agency is not also administering programs under CAPTA). In addition, the guidance encouraged coordination with the state Individuals with Disabilities Act (IDEA) agency.[26]

Each jurisdiction was required to submit the needs assessment by September 20, 2010, as a condition of receiving MCH Block Grant funds for FY2011, regardless of whether it intended to apply for a grant to provide home visiting services. The 50 states, the District of Columbia, and the territories submitted the assessment and subsequently received a portion of their FY2010 MIECHV funds if they applied for them. (The three states that did not ultimately apply for MIECHV funds, and whose MIECHV programs are now operated by nonprofit organizations, also submitted an assessment.)[27] Jurisdictions that applied for a MIECHV grant (which included the remainder of the FY2010 funds) had to subsequently submit an updated state plan in 2011 that included a final designation of the at-risk communities, provided a more detailed needs assessment for the targeted communities, and provided a specific plan for home visiting services tailored to address those needs.[28]

As part of the needs assessment, HHS directed states and territories to describe their understanding of the term "community" based on the unique structure and makeup of the state or territory. For example, "community" could be composed of zip codes, neighborhoods, or census tracts (in urban areas) or counties (for rural areas). HHS defined "at risk community" as a community for which indicators, in comparison to statewide indicators, demonstrate that the community is at greater risk than the state as a whole. States and territories had the option of targeting all at-risk communities or subcommunities or neighborhoods deemed to be at greatest risk, if data on these smaller units were available. Jurisdictions were required to provide a justification for each such community identified, using the most recent and/or relevant data available on each of the risk factors (defined further in the guidance), for both the entire jurisdiction and each community defined as at risk.[29]

(...continued)

Start programs, the HHS Secretary is to take into account the extent to which an applicant has undertaken a community-wide strategic planning and needs assessment involving other entities, including community organizations and federal, state, and local public agencies that provide services to children and families. See Section 640(g)(1)(C) of the Head Start Act. As a condition of receiving CAPTA funds, states must submit an application to the HHS Secretary that includes a description of the inventory of current unmet needs and available programs and activities to prevent child abuse and neglect, and other family services operating in the state. See Section 204(3) of CAPTA (Section 511(b)(2) of the Social Security incorrectly references Section 205(3) of CAPTA).

[26] HHS, HRSA, "Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Statewide Needs Assessment," August 19, 2010. (Hereinafter, HHS, HRSA, "Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Statewide Needs Assessment.")

[27] In addition, a nonprofit organization administered Oklahoma's home visiting program until FY2015.

[28] HHS, HRSA, "Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program," February 8, 2011.

[29] HHS, HRSA, "Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Statewide Needs Assessment."

Tribal grantees are required to conduct a needs assessment of the tribal community and to develop a plan to address those needs. The assessment is to be conducted within the first year of receiving funding under the program.[30]

Application for Funding

Jurisdictions applying for MIECHV funding must submit an application with multiple requirements, including the following:[31]

- a description of the populations to be served by the jurisdiction, including specific information regarding how the jurisdiction will serve high-risk populations (e.g., eligible families who reside in communities in need of home visiting services, as identified in the statewide needs assessment; are low income; include pregnant women under age 21; and have a history of child abuse or neglect or have had interactions with child welfare services, among others);
- an assurance that the jurisdiction will give priority to serving low-income eligible families and eligible families who reside in at-risk communities identified in the statewide needs assessment;
- the home visiting model or model(s) that the jurisdiction will use under the program and the basis for the selection of the model or models (based on the requirements in the law for selecting such model(s));
- a statement identifying how the service delivery model(s) used and the populations to be served are consistent with the results of the statewide needs assessment;
- the quantifiable, measurable benchmarks established by the jurisdiction to demonstrate that the program contributes to improvements in family and other indicators (discussed in following section);
- an assurance that the jurisdiction will obtain and submit documentation from the organization or entity that developed the home visiting model(s) used under the program to verify that the program is implemented and services are delivered according to the model specifications;
- assurances that the jurisdiction will establish procedures that ensure (1) the participation of each eligible family in the program is voluntary and (2) services are provided to an eligible family in accordance with the individual assessment for that family;
- assurances that the jurisdiction will (1) submit annual reports to the HHS Secretary regarding the program and activities carried out under the program that include information and data required by the Secretary; (2) participate in, and cooperate with, data and information collection necessary for the required evaluation and other research and evaluation activities specified under the law;
- a description of other programs in the jurisdiction that include home visitation services, including, where applicable—other programs carried out under Title V of the Social Security Act with funding from the Maternal and Child Health

[30] HHS, ACF, "Tribal Maternal, Infant, and Early Childhood Home Visiting Program Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs," no date.

[31] Section 511(e).

Services Block Grant; programs funded under the Child Abuse Prevention and Treatment Act (CAPTA) community-based grants for the prevention of child abuse and neglect; and Early Head Start programs; and

- other information as required by the HHS Secretary.

Benchmark Areas

The MIECHV statute requires states and other jurisdictions that receive grant funds for home visiting programs to demonstrate improvements among eligible families in what the law refers to as six "benchmark areas" (HHS sometimes calls benchmark areas "outcomes").[32] These six benchmark areas are desired outcomes for participants; for each of those outcomes, a state or jurisdiction operating a MIECHV program must establish a baseline to begin measuring performance (see **Table 3**). The law requires jurisdictions to show that they are making improvements in at least four out of six of the benchmark areas three years after the law is implemented.[33]

HHS uses 19 items (described as "constructs") to measure the performance of each jurisdiction. Each benchmark area has between one and six constructs. This is a change from the performance accountability system that was in place through FY2016, when HHS used 37 constructs to measure performance. Prior to FY2017, jurisdictions were given flexibility in developing how they would measure performance for each construct. For example, all grantees had to measure prenatal care under the benchmark area for improved maternal and newborn health; however, grantees could focus on different aspects of performance, such as the onset of prenatal care or the adequacy of prenatal care. The revised performance measurement system requires grantees to measure performance under each construct in the same way. According to HHS, this is intended to make it easier for data to be aggregated nationally.[34]

[32] Section 511(d)(1) for states and territories, and Section 511(h)(2) for tribal entities and nonprofit organizations. These grantees are required to measure benchmarks in the same way; however, tribal grantees have an additional construct (regular visits to a primary health care provider or medical home). HHS, ACF, Office of Child Care, "Tribal Maternal, Infant, and Early Childhood Home Visiting Program, Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs (Phase 2 Implementation Plan)."

[33] Section 511(d)(1).

[34] HHS, ACF, and HRSA, *Performance Measurement Toolkit*, May 2016.

Table 3. MIECHV Benchmark Areas (Outcomes) and Constructs

Benchmark Areas (Outcomes)	37 Constructs (Used in Original Accountability System FY2010-FY2016)	19 Constructs (Used for Revised Accountability System as of FY2017)
Improved maternal and newborn health	(1) Prenatal care; (2) alcohol, tobacco, and illicit drugs; (3) preconception care; (4) inter-birth interval; (5) maternal depressive symptoms; (6) breastfeeding; (7) well-child visits; and (8) maternal and child health insurance status.	(1) Preterm birth; (2) breastfeeding; (3) depression screening; (4) well-child visit; (5) postpartum care; and (6) tobacco cessation referrals.
Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits	(1) Visits for children to emergency department; (2) visits for mother to emergency department; (3) information/training on prevention of child injuries; (4) child injuries; (5) reported suspected maltreatment; (6) reported substantiated maltreatment; and (7) first-time victims of maltreatment.	(1) Safe sleep; (2) child injury; and (3) maltreatment.
Improvements in school readiness and child academic achievement	(1) Parent support for child learning and development; (2) parent knowledge of child development; (3) parenting behaviors/parent-child relationship; (4) parent emotional well-being/parenting stress; (5) child communication, language, and emerging literacy; (6) child cognitive skills; (7) child positive approaches to learning; (8) child social behavior/emotional well-being; and (9) child physical health and development.	(1) Parent-child interaction; (2) early language and literacy skills; (3) developmental screening; and (4) behavioral concerns.
Reduction in crime or domestic violence	(1) Screening for domestic violence; (2) referrals for domestic violence services; (3) domestic violence-safety plans; (4) arrests; and (5) convictions.	(1) Intimate partner violence screening.
Improvements in family economic self-sufficiency	(1) Income and benefits; (2) employment or education; and (3) health insurance status.	(1) Primary caregiver education; and (2) continuity of insurance coverage.
Improvements in the coordination and referrals for other community resources and supports	(1) Identification for necessary services; (2) referrals for necessary services; (3) receipt for necessary services; (4) number of memorandums of understanding (MOU) with community agencies; and (5) information sharing.	(1) Intimate partner violence referrals; (2) completed developmental referrals; and (3) completed referrals for depression.

Source: CRS based on Section 511(d)(1) of the Social Security Act; HHS, ACF, and HRSA, *The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Summary of Benchmark Measures Selected by Grantees*, Design Options for Home Visiting Evaluation (DOHVE) – A DOHVE TA Resource Document, July 2014; and HHS, ACF, and HRSA, *Performance Measurement Toolkit*, May 2016.

Notes: Ten of the original constructs are not being used under the revised system: prenatal care, preconception care, inter-birth interval, maternal emergency department visits, suspected maltreatment, parent emotional well-being, intimate partner violence (IPV) safety plans, arrests, convictions, and income. Seven constructs were added: preterm birth, postpartum care, safe sleep, behavioral concerns, continuity of insurance, completed referrals for depression, and completed developmental referrals. Six constructs were revised: breastfeeding, depression, tobacco use, well-child visits, child emergency department visits, and education.

According to HHS and its technical assistance partners, the purpose of this data collection effort is to collect data about grantee performance over time rather than on the impacts of the program.[35] (As discussed in a subsequent section, HHS is assessing the effects of MIECHV programs with respect to each of the benchmark areas through a separate evaluation effort.)

By October 30, 2014, all states and territories operating a MIECHV program had submitted reports to demonstrate their performance against the benchmarks for the first three years of the program. The tribal entities awarded funding under the first cohort of the Tribal MIECHV grants were required to submit their reports by December 31, 2014. The three nonprofit organizations that operate programs in Florida, North Dakota, and Wyoming awarded funding after September 2011 were required to submit reports on the three-year benchmarks by October 30, 2016.[36]

If a jurisdiction fails to demonstrate improvements in at least half of the constructs in four of the benchmark (outcome) areas, it must develop and implement a plan to make improvements in each of the applicable areas, subject to approval by HHS. HHS must provide technical assistance to the grantee in developing and implementing the plan. As directed by statute, HHS has convened an advisory panel made up of staff from the Departments of Health and Human Services and Education to make recommendations about this technical assistance.[37] The law requires HHS to terminate a jurisdiction's MIECHV funding if, after a period of time specified by HHS, the jurisdiction has failed to demonstrate any improvements in outcomes, or if HHS determines that the jurisdiction has failed to submit the required report on performance in benchmark areas.[38]

Nine jurisdictions (including both states and territories) did not demonstrate improvement in at least four of six benchmark areas by the end of the third year of the program.[39] Each of these grantees has developed an improvement plan that was approved by HRSA. HRSA monitored how the plans were implemented, and provided individualized technical assistance, including intensive site visits, as needed. HRSA used FY2015 data to reassess whether jurisdictions had made improvements in the benchmark areas (using FY2014 data as the baseline) under which they previously did not show improvement. This reassessment indicated that eight of the nine jurisdictions demonstrated improvement in FY2015; therefore, their improvement plans were

[35] HHS, ACF and HRSA, *The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Summary of Benchmark Measures Selected by Grantees*, Design Options for Home Visiting Evaluation (DOHVE) – A DOHVE TA Resource Document, July 2014.

[36] CRS correspondence with HHS, HRSA and ACF, November and December 2014; and HHS, HRSA, *Justification of Estimates for Appropriations Committees, Fiscal Year 2017*, p. 258.

[37] HHS, ACF and HRSA, *Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress*, March 2016, p. 28. (Hereinafter, HHS, ACF and HRSA, *Demonstration Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress*.)

[38] Section 511(d)(1)(B).

[39] Section 511(h)(4) of the Social Security Act required the HHS Secretary to submit a report to Congress by December 31, 2015**,** regarding (1) the extent to which eligible entities receiving grants demonstrated improvements in each of the benchmark areas; (2) technical assistance provided to grantees, including the type of assistance provided; and (3) recommendations for such legislative or administrative action as the HHS Secretary determines appropriate. A report on tribal grantees was submitted in November 2015 and a report on state grantees was submitted in March 2016. See Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*, James Bell Associates, for HHS, ACF, Office of Planning Research and Evaluation, November 2015 (Hereinafter, Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*, James Bell Associates*)*; and HHS, ACF and HRSA, *Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress*.

concluded. HRSA continues to provide ongoing technical assistance in an effort to improve the program's implementation.[40]

Additional Requirements

The law also specifies other requirements for jurisdictions carrying out MIECHV programs. In addition to making improvements under the benchmark areas for eligible participating families overall, jurisdictions must also design their home visiting programs to assist individual families in the program. Jurisdictions are to conduct individualized assessments of the families and to make improvements in particular outcomes that are relevant to each participating family. Such desired individual family outcomes are nearly identical to the benchmark areas, except that the outcomes also include improvements in parenting skills and in cognitive, language, social-emotional, and physical developmental indicators.[41]

Jurisdictions must also ensure that the program

- adheres to a clear, consistent home visiting model that meets the requirements for being research-based (discussed further in the next section) and is linked to the benchmark areas and outcomes for individual families;
- employs well-trained and competent staff, as demonstrated by education or training (such as nurses, social workers, educators, and child development specialists) and provides ongoing and specific training on the home visiting model;
- maintains high-quality supervision to establish "home visitor competencies";
- demonstrates strong organizational capacity to implement the activities involved;
- establishes appropriate linkages and referral networks to other community resources and supports for eligible families; and
- monitors how the home visiting model is implemented to ensure that services are implemented with fidelity to the model.[42]

Jurisdictions may use MIECHV funding to supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.[43] Finally, as discussed in the next section, jurisdictions must spend most of their MIECHV funds on specified home visiting models that meet certain standards of effectiveness.

Home Visiting Models

Jurisdictions must use at least 75% of their funds within a given fiscal year to carry out home visiting models that are "evidence-based." As outlined in the statute, models are evidence-based if they

- have been in existence for at least three years;

[40] Among the first cohort of tribal grantees, 3 out of 13 did not demonstrate improvements. HHS, ACF and HRSA, *Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress*; and CRS correspondence with HHS, HRSA, June 2016.

[41] Section 511(d)(2).

[42] Section 511(d)(3)(B).

[43] Section 511(f).

- are associated with a national organization or institution of higher education that has comprehensive standards to ensure that services are high quality and that the program continuously makes improvements;
- are research-based and grounded in relevant empirically based knowledge; and
- have demonstrated significant positive outcomes in the benchmark areas and the desired individual family outcomes when evaluated using well-designed and rigorous quasi-experimental research designs or randomized controlled research design in which the evaluation results have been published in peer-reviewed journals.

In implementing the MIECHV program, HHS established criteria for determining which home visiting models have evidence of effectiveness after seeking public comment on the criteria (as required under the law).[44] The criteria expand on the requirements in the law about models that are linked to specified outcomes and demonstrate significant positive outcomes. The criteria are as follows:

- at least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of eight outcome domains; or
- at least two high- or moderate-quality impact studies of the model using nonoverlapping study samples find one or more favorable, statistically significant impacts in the same domain.[45]

In this context, impact studies evaluate whether the home visiting model results in favorable outcomes for participants generally. As specified by HHS (and in accordance with the MIECHV law), the outcome domains are generally consistent with the benchmark areas and individual family outcomes for the program: (1) maternal health; (2) child health; (3) child development and school readiness; (4) positive parenting practices; (5) family economic self-sufficiency; (6) reductions in child maltreatment; (7) reductions in juvenile delinquency, family violence, and crime; and (8) linkages and referrals.

Jurisdiction may use up to 25% of their formula and/or competitively awarded funds for administering home visiting models that conform to a promising and new approach for achieving improved outcomes under the benchmark areas and improved family outcomes. The law specifies that such a "promising" model must have been developed or identified by a national organization or institution of higher education and will be evaluated through a well-designed and rigorous process.[46] HHS has further explained that a promising approach is one that meets the standards

[44] Section 511(d)(3)(iii). HHS, HRSA and ACF, "Maternal, Infant, and Early Childhood Home Visiting Program," 75 *Federal Register*, July 23, 2010. HHS received approximately 140 comments and published the final criteria in HHS, HRSA and ACF, "Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program." The proposed and final criteria are the same.

[45] HHS has determined that "high-quality" studies are those that use randomized control trials (RCTs, or "randomized controlled research design") in which sample members are assigned to the program and comparison groups by chance. In addition, high-quality studies have low attrition of sample members and no reassignment of sample members after the original random assignment. Models evaluated with RCTs must demonstrate that one or more impacts in an outcome domain is sustained for at least one year after program enrollment, and one or more impacts in an outcome domain must be reported in a peer-reviewed journal. "Moderate-quality" studies are those that use quasi-experimental design with a comparison group, or random assignment design with high attrition or any reassignment of sample members. Quasi-experimental design refers to sample members who are selected for the program and comparison groups in a nonrandom way (e.g., families may self-select into groups).

[46] Section 511(d)(3)(A)(i)(II). The law does not specify a time frame for when the evaluation is to be evaluated.

outlined in the statute but for which there is little to no evidence of effectiveness; one with evidence that does not meet the criteria for an evidence-based model; or a modified version of an evidence-based model that includes significant alterations to core components.[47]

Home Visiting Evidence of Effectiveness (HomVEE)

In 2009, prior to implementation of ACA, HHS/ACF created the Home Visiting Evidence of Effectiveness (HomVEE) initiative to determine which home visiting models have shown evidence of effectiveness. The project has been incorporated into the MIECHV program. It annually (on a fiscal year basis) reviews the research literature on studies of models in which home visiting is the primary service strategy for pregnant women or families with children from birth to age 5.[48] HomVEE prioritizes the home visiting models for further study based on a point system. Points are assigned to models based on their number and design of impact studies (with three points for each randomized control trial [RCT] and two points for each quasi-experimental design) and their sample size of impact studies (with one point for each study with a sample size of 250 or more). In addition, HomVEE reviewers determine whether the program is currently in operation and if additional information on the model can be gleaned from websites and others sources.

Of those models that receive sufficient points for further review, HomVEE examines applicable impact studies with RCTs and quasi-experimental designs and assigns each study a rating of high, moderate, or low quality. After reviewing studies for a model, HomVEE evaluates the evidence across all studies that receive a high or moderate rating and measure outcomes in at least one of the eight domains. The reviewers additionally examine and report on other aspects of the evidence for each model, based on all high- and moderate-quality studies available. These other aspects include (1) the quality of the outcome measures, to determine if they were collected through direct observation or were self-reported using a standardized instrument; (2) whether the impacts were measured at least one year after program services ended; (3) whether the impacts were replicated and showed favorable, statistically significant impacts in the same outcome domain in at least two nonoverlapping study samples; (4) whether subgroup findings could be replicated in the same outcome domain in at least two studies using different samples; (5) whether some impacts were unfavorable or ambiguous; (6) the funding source for each study and whether any of the study authors were program model developers; and (7) the magnitude of the impacts.

Eighteen Models Found to be Evidence-Based as of April 2017

As of April 2017, the HomVEE review had identified 45 home visiting models as suitable for review and identified 18 of these models as having met the criteria for an evidence-based program.[49] As of FY2016, 10 of these models had been implemented by one or more

[47] HHS, HRSA and ACF, "Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program."

[48] This review involves searching research databases of studies published since 1989, and a more focused search on prioritized program models published since 1979. The search is updated annually to identify new literature.

[49] CRS review of HHS, ACF, Home Visiting Evidence of Effectiveness (HomVEE), *Model Reports,* http://homvee.acf.hhs.gov/programs.aspx, as of June 2017; and Emily Sama-Miller et al., "Home Visiting Evidence of Effectiveness Review: Executive Summary," Mathematica Policy Research Inc., for HHS, ACF, Office of Policy Research and Evaluation (OPRE), OPRE Report #2017-29, April 2017. See HHS, Health Resources and Services Administration (HRSA), Maternal and Child Health (MCH), "Home Visiting Models," https://homvee.acf.hhs.gov/models.aspx. Two additional models meet the criteria but are not implemented: Oklahoma's Community-Based Family (continued...)

jurisdictions. The HomVEE project also reviewed home visiting models to examine specific impacts for American Indian and Alaska Native populations. One model, Family Spirit, had such impacts and is one of the 18 models that meet the HHS criteria.[50]

HHS determined that each of the 18 models is effective in at least two of the eight areas that were included in the HHS criteria for evidence of effectiveness of home visiting models. Just over half of the models (11) target at-risk pregnant women, and all of them target parents and their young children. All but two models serve families with children under age one, and nearly all (14) serve children across multiple age ranges (birth to 23 months, 24 to 48 months, etc.). The models are implemented by a variety of entities that includes hospitals, health clinics, or physicians; nonprofit and community-based organizations; a state governmental agency (e.g., child welfare or health care agency); Head Start agencies; and other types of entities (e.g., preschool and criminal justice programs).

All but four of the models require home visitors to meet certain minimum educational requirements. Home visitors are typically registered nurses, mental health professionals, social workers, or paraprofessionals; four of the models use two of these types of workers. Each model requires preplacement training on the model, and the majority of the models (14 models) require ongoing training, as opposed to having voluntary training (4 models).[51] The caseload for home visitors varies, with a range of about 10 to 30 cases per worker (for 12 of the models); however, some models assign greater or fewer caseloads based on the needs of families. Many of the models call for weekly visits with the family for an initial period of time, and the visits often become less frequent over time. A few models specify a particular number of visits overall (ranging from 1 to 52 visits), and others provide a certain number of visits based on family needs. Four models provide additional types of interventions that include classes on preparing for motherhood and meetings with other program participants.[52] See **Table D-1** and **Table D-2** in **Appendix D** for further detail on the characteristics of the 18 models designated as effective.

Table 4 summarizes information on the number of jurisdictions implementing each evidence-based model in FY2016. In addition, five jurisdictions (Arkansas, Kansas, Tennessee, Virginia, and West Virginia) used a portion of their funds to implement a home visiting model in FY2016 that was promising, but not yet determined to be effective.[53] Specifically, these states are using 25% or less of their FY2016 formula grant allocation for this purpose.

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Resource and Support Program ("implementation support is not currently available for the model as reviewed") and Healthy Steps ("HHS has determined that home visiting is not the primary service delivery strategy and the model does not meet current requirements for MIECHV program implementation)."

[50] Andrea Mraz Esposito, "Assessing the Evidence of Effectiveness of Home Visiting Models Implemented in Tribal Communities," Mathematica, for HHS, ACF, Office of Policy Research and Evaluation (OPRE), September 2014.

[51] Section 511(d)(3)(B)(ii) of the Social Security Act requires that MIECHV-funded programs employ well-trained and competent staff, as demonstrated by education or training. Such staff can include nurses, social workers, educators, child development specialists, or other well-trained and competent professionals. The program should also provide ongoing and specific training on the model delivered.

[52] This is based on CRS review of the HomVEE website, which provides background about each model. This level of detail varies across models, and in some cases information is not available or is limited.

[53] CRS correspondence with HHS, HRSA, and ACF, June 2016.

Table 4. Evidence-Based Models Used by States/Territories with Funding Under the MIECHV Program in FY2016

There were 17 possible models, of which 10 were implemented

Evidence-Based Model	Number of States/Territories Using Model
Nurse-Family Partnership (NFP)	39
Healthy Families America (HFA)	36
Parents as Teachers (PAT)	35
Early Head Start-Home Visiting (EHS-HV)	15
Home Instruction for Parents of Preschool Youngsters (HIPPY)	6
Family Spirit	4
SafeCare Augmented	2
Family Check-Up (FCU)	1
Child First	1
Health Access Nurturing Development Services (HANDS) Program	1

Source: CRS correspondence with HHS, HRSA, and ACF, October 2016. Additional evidence-based home visiting models are Family Connects (also referred to as Durham Connects), Early Intervention Program for Adolescent Mothers (EIP), Early Start (New Zealand), Healthy Beginnings, Maternal Early Childhood Sustained Home-Visiting Program (MECSH), Minding the Baby, and Play and Learning Strategies (PALS) Infant.

Note: Table D-3 in **Appendix D** includes the home visiting model(s) adopted as of FY2016 by each state or territory, as well as three states (Florida, North Dakota, and Wyoming) in which a nonprofit administers the MIECHV program.

Technical Assistance, Research, and Evaluation

Technical Assistance

The law directs the Secretary to provide technical assistance (TA) to grantees, specifically with regard to administering programs or activities that are funded by the MIECHV program.[54] In addition, HHS is to provide technical assistance to any jurisdiction that is required to implement an improvement plan because it failed to improve in the benchmark (or outcome) areas.[55] Jurisdictions receive TA from federal staff, developers of home visiting models, and TA providers contracted with HHS.[56]

Multiple HHS-contracted providers assist grantees. The MIECHV Technical Assistance Coordinating Center (TACC) is operated under a contract with HRSA by Zero to Three, a national nonprofit organization that provides support to states and territories in implementing and improving their programs. TACC provides TA in partnership with other entities—the Association of Maternal & Child Health Programs (AMCHP), Chapin Hall Center for Children at the

[54] Section 511(c)(4).

[55] Section 511(d)(1)(B)(iii).

[56] HHS, ACF and HRSA, *Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress*, pp. 27-28; and Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*, James Bell Associates, pp. 51-56.

University of Chicago, and Walter R. McDonald and Associates. TACC delivers training and technical assistance to grantees on topics such as developing the state infrastructure to support MIECHV; supporting efforts to linking MIECHV with existing childhood and health systems; implementing TA in the jurisdiction, including capacity building among local sites in the jurisdiction; and focusing on program participants, such as family engagement. TACC provides assistance via webinars, an e-newsletter, on-site forums, and an online portal designed for the exchange of information. In addition, TACC hosts regional forums on multiple topics for grantees.[57] ACF provides similar types of technical assistance to Tribal MIECHV grantees via Programmatic Assistance for Tribal Home Visiting (PATH), operated by Walter R. McDonald and Associates in partnership with other organizations.[58]

HHS also provides assistance to grantees through the Design Options for Maternal, Infant, and Early Childhood Home Visiting Evaluation (DOHVE) Technical Assistance Team. This team works in collaboration with TACC to assist grantees in strengthening their evaluation of promising programs; developing data and reporting on the federal benchmarks; and implementing continuous quality improvement (CQI) initiatives in which grantees evaluate their own programs and identify areas for improvement.[59] MDRC, in partnership with James Bell Associates and other organizations, operate the DOHVE Technical Assistance Team.[60] Tribal entities receive technical assistance on these same topics via the Tribal Home Visiting Evaluation Institute (TEI). James Bell Associates operates TEI in partnership with the University of Colorado School of Public Health, Johns Hopkins University Center for American Indian Health, Michigan Public Health Institute, and MDRC.[61]

Research and Evaluation

The law directs the HHS Secretary to carry out a continuous program of research and evaluation activities to increase knowledge about home visiting programs, using random assignment designs when feasible.[62] These activities include efforts to share research and best practices, and develop studies of home visiting models using randomized control trials.

In addition, HHS requires jurisdictions to conduct evaluations of home visiting programs if they are implementing promising models (as opposed to a model that HHS has determined is evidence-based) or receive competitive awards.

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[57] Valerie Lane, *MIECHV Technical Assistance Coordinating Center*, MIECHV Technical Assistance Coordinating Center, Zero to Three, http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Archive/2013/NovDec2013/Pages/Feature2.aspx.

[58] Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*, James Bell Associates, pp. 51-56; HHS, ACF, "Tribal MIECHV Technical Assistance," http://www.acf.hhs.gov/programs/ecd/home-visiting/tribal-home-visiting/technical-assistance; and HHS, HRSA, "Early Childhood Development Newsletter: Home Visiting," March 2015.

[59] HHS, ACF and HRSA, *Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress*.

[60] MDRC, *Design Options for Home Visiting Evaluation: Project Overview*, http://www.mdrc.org/project/design-options-home-visiting-evaluation#featured_content.

[61] Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*, James Bell Associates, pp. 51-56; HHS, ACF, *Tribal Home Visiting Evaluation Institute, 2011-2015* http://www.acf.hhs.gov/programs/opre/research/project/tribal-home-visiting-evaluation-institute-2011-2015; and HHS, HRSA, "Early Childhood Development Newsletter: Home Visiting," March 2015.

[62] Section 511(h(3).

Home Visiting Applied Research Collaborative

The Home Visiting Applied Research Collaborative (HARC) was established in 2012 under the MIECHV program. It includes a network of researchers and other home visiting stakeholders who have helped to define priorities for research on home visiting and develop and disseminate research that is consistent with these priorities. These priority areas include (1) strengthening and broadening home visiting effectiveness; (2) identifying core elements of home visiting; (3) promoting successful adoption of home visiting innovations; (4) promoting successful adaptation of home visiting innovations; (5) promoting fidelity in implementing home visiting innovations; (6) building a stable, competent home visiting workforce; (7) promoting family engagement in home visiting; (8) promoting home visiting coordination with other services for families; (9) promoting the sustainment of effective home visiting; and (10) building home visiting research infrastructure.[63] Based on these priority areas, HARC has conducted original research on topics that include family engagement, communication with primary care providers, and work with families connected to the military.[64]

Home Visiting Collaborative Improvement and Innovation Network (HVCoIIN)

As part of the Home Visiting Collaborative Improvement and Innovation Network, HRSA and Education Development, Inc. (a nonprofit organization) have convened teams from local home visiting agencies in 11 states and one nonprofit grantee for collaborative learning and sharing best practices in home visiting. The purpose of the initiative, which began in 2013, is to encourage grantees to use data for both accountability and to drive improvements in four program outcomes: (1) improve rates of initiation and extent of breastfeeding; (2) improve the screening and surveillance of developmental risk and delay; (3) improve the screening, referral, and provision of services for maternal depression; and (4) improve family engagement in home visits.[65] Within the first seven months of implementation, the initiative reported promising outcomes in each of these four areas.[66]

Tribal Early Childhood Research Center

Separate from the efforts to evaluate home visiting programs funded under MIECHV, HHS provides MIECHV funding to the Tribal Early Childhood Research Center (TRC), which also receives funding from the HHS-funded Head Start and Child Care programs. The TRC seeks to partner with American Indian and Alaska Native communities, programs, practitioners, and researchers to advance research into young children's development and early childhood programs and to facilitate the translation of research findings to inform early childhood practice with American Indian and Alaska Native children and families. The TRC is located at the University of Colorado's School of Public Health, and operates in partnership with Johns Hopkins University and Michigan State University.[67]

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[63] Home Visiting Research Network, *Home Visiting Research Agenda*, October 29, 2013.

[64] Home Visiting Research Network, "HARC Projects," http://www.hvrn.org/harc-projects.html.

[65] HHS, HRSA, "Home Visiting Collaborative Improvement and Innovation Network: About," http://hv-coiin.edc.org/about.

[66] HHS, HRSA, "Early Childhood Development Newsletter: Home Visiting," March 2015.

[67] University of Colorado, School of Public Health, Centers for American Indian and Alaska Native Health, *Tribal Early Childhood Research Center*, http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/ (continued...)

MIHOPE: National Evaluation of MIECHV

The HHS Secretary must appoint an independent advisory committee of experts in program evaluation and research, education, and early childhood development. The purpose of this panel is to review, and make recommendations, on the design and plan for a national evaluation of the MIECHV program. Based on these recommendations, the Secretary is to conduct an evaluation. The evaluation must include an (1) analysis of the results of the statewide needs assessments and state actions in response to the assessments; (2) an assessment of the effect of early childhood home visitation programs on child and parent outcomes, including with respect to the benchmark areas and the individual family outcomes (described previously); (3) an assessment of the effectiveness of home visiting programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and (4) an assessment of the potential for the activities carried out under home visiting programs, if scaled broadly, to improve health care practices, health care system quality, and efficiencies; eliminate health disparities; and reduce costs.[68]

HHS appointed the panel, and the evaluation is underway.[69] Known as the Mother and Infant Home Visiting Program Evaluation (MIHOPE), the evaluation is looking at programs that use four evidence-based home visiting models: Early Head Start-Home Visiting, Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). The MIHOPE study includes 4,229 families in 87 sites across 12 states who are randomly assigned to receive home visiting services.[70] The evaluation is designed to address the requirements outlined in the law and will include (1) an analysis of state needs assessments, (2) an implementation study of local program services, (3) an impact analysis of the effects of MIECHV on child and family outcomes, and (4) an economic analysis of program costs and cost effectiveness. MDRC is conducting the evaluation, along with Mathematica, James Bell Associates, Johns Hopkins University, University of Georgia, and Columbia University.

The MIECHV law directed the HHS Secretary to submit a report to Congress by March 31, 2015, on the results of the national evaluation. HHS issued a report to Congress in January 2015 that presents the first findings from the study.[71] This report provides an early look at implementation

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CAIANH/trc/Pages/TRC.aspx.

[68] Section 511(g).

[69] (1) HHS, ACF and HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Plans for the 2015 Report to Congress*, September 12, 2013, http://www.acf.hhs.gov/sites/default/files/opre/mihope_sac_materials_revised_0.pdf. (Hereinafter, HHS, ACF and HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Plans for the 2015 Report to Congress*.) (2) Charles Michalopoulos et al., *The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program, A Report to Congress*, for HHS, ACF, OPRE, OPRE Report 2015-11, January 2015, http://www.acf.hhs.gov/sites/default/files/opre/mihope_report_to_congress_final.pdf. (Hereinafter, Charles Michalopoulos et al., *The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program, A Report to Congress*). (3) MDRC, MIHOPE Newsletter, *MIHOPE Update*, May 2015. For a list of advisory committee members, see HHS, ACF, *Advisory Committee on the Maternal, Infant, and Early Childhood Home Visiting Program*: *Roster*, http://www.acf.hhs.gov/sites/default/files/opre/miechvpe_roster_september_2013.pdf.

[70] HHS, HRSA, *Maternal Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed.*

[71] Charles Michalopoulos et al., *The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Early*

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of MIECHV, including information on the needs identified by states and their plans for using MIECHV funds to meet those needs, a description of where the study is being conducted, information about families in the study, and a discussion of whether plans for local home visiting programs reflect the requirements. Families were being recruited for the study through calendar year 2014, and therefore information on the effectiveness and costs of home visiting programs are not available in the report.

As part of an initial analysis of state needs assessments, the study found that states generally proposed using MIECHV funds in counties with high rates of risk indicators and to implement the four models studied in MIHOPE. The states involved in the study are using MIECHV funds to expand at least two of the four evidence-based models and are each planning to support five or more eligible local programs. The study was continuing to recruit families when the report was published, and therefore the report discusses characteristics of about one-third of the families who will eventually be enrolled. Nearly 70% of the mothers in the study were pregnant at the time they enrolled, with an average age of 23 at enrollment. Women in the study exhibited healthy behavior and were in good health; however, more than a third reported using tobacco and almost 60% exhibited symptoms of anxiety or depression. Nearly all families in the study were receiving some government benefits. Consistent with the statute, all four of the MIHOPE models intend to serve families at risk of poor child outcomes and most prioritized the outcomes mentioned in the authorizing legislation. According to the study, MIECHV encouraged some local programs to broaden the outcomes they focused on. Home visitors reported that were generally well trained and supported in working with families to address outcomes.

HHS anticipates that final reports on impacts, implementation, and cost effectiveness will be available in 2018.[72]

MIHOPE-Strong Start Evaluation

In addition to the MIHOPE evaluation, the MIHOPE expansion evaluation (MIHOPE-Strong Start) is examining birth and health outcomes for mothers and infants through the Strong Start for Mothers and Newborns (Strong Start) initiative. Strong Start is carried out by the Centers for Medicare and Medicaid (CMS). The initiative is examining whether nonmedical prenatal interventions, when provided in addition to routine medical care, can improve health outcomes for pregnant women and newborns and decrease the cost of medical care during pregnancy, delivery, and over the course of the child's first year of life. One of those interventions is home visiting.[73]

The MIHOPE-Strong Start evaluation seeks to determine whether home visiting services can impact health outcomes for disadvantaged pregnant women. The evaluation has enrolled approximately 3,000 families from HFA and NFP sites in 67 local home visiting programs in 17 states. Families have been randomly assigned to a home visiting group (program group) or to a non-home visiting group (control group). Recipients include pregnant women who have Medicaid or CHIP (Children's Health Insurance Program) and are interested in and eligible for home visiting services. The evaluation will include an implementation study and an impact analysis of

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Findings on the Maternal, Infant, and Early Childhood Home Visiting Program, A Report to Congress.

[72] HHS, HRSA, *Maternal Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed.*

[73] HHS, Centers for Medicare and Medicaid, *Strong Start for Mothers and Newborns Initiative; Enhanced Prenatal Care Models*, http://innovation.cms.gov/initiatives/Strong-Start-Strategy-2/index.html.

the outcomes in three areas: (1) birth outcomes, (2) maternal prenatal health and health care use, and (3) infant health and health care use. It is also intended to provide information relevant to CMS actuaries on how participation in such programs might affect Medicaid costs. The evaluation was designed by CMS and ACF, is funded by CMS (without MIECHV funds), and is implemented in partnership with HRSA.[74]

Grantee-Led Evaluations

As noted, jurisdictions conduct evaluations of home visiting programs if they are implementing promising models or any model (promising or evidence-based) under a competitive MIECHV grant. Plans for these evaluations must first be approved by HHS. Between 2011 and 2015, 48 jurisdictions developed grantee-led evaluations. Based on an analysis by HHS, these grantee-led evaluations have helped to identify how programs are carried out, including (1) how to recruit, retain, and engage participants; (2) how and why home visiting workforce development is beneficial; (3) how to collaborate with community partners and coordinate services; (4) how programs are enhancing home visiting; and (5) the effectiveness of promising approaches in home visiting.[75]

Recent Congressional and Executive Branch Action

On January 9, 2014, the House Energy and Commerce Committee held a hearing on the extension of health care policies that included discussion of the MIECHV program.[76] Two witnesses from HHS testified about how the MIECHV program has been carried out and on the screening and use of evidence-based models selected by jurisdictions in the program. On April 1, 2014, the President signed into law the Protecting Access to Medicare Act of 2014 (P.L. 113-93), which extended funding for the MIECHV program through March 31, 2015 (the law also extended funding for other health care programs and policies). On April 2, 2014, the House Ways and Means Committee's Subcommittee on Human Resources held a hearing on the MIECHV program. Witnesses included a home visiting nurse and her client, an administrator of a home

[74] MDRC is conducting the evaluation, along with Mathematica, James Bell Associates, Johns Hopkins University, and New York University. HHS is issuing annual reports for each year of the study. According to HHS, a final report will provide detailed information about how the program was implemented and impact results for the full sample of enrolled families. The annual reports are as follows: Jill H. Filene et al., *The Mother and Infant Home Visiting Program Evaluation-Strong Start: First Annual Report*; for HHS, ACF, Office of Planning, Research and Evaluation (OPRE), OPRE Report 2013-54, December 2013; Helen Lee, Anne Warren, and Lakhpreet Gill, *Cheaper, Faster, Better: Are State Administrative Data the Answer? The Mother and Infant Home Visiting Program Evaluation-Strong Start, Second Annual Report*, MDRC, for HHS, ACF, OPRE, OPRE Report 2015-09, January 2015; and Helen Lee et al., *An Early Look at Families and Local Programs in the Mother and Infant Home Visiting Program Evaluation-Strong Start: Third Annual Report*, OPRE Report 2016-37, April 2016. See also a separate report on the design of the program: Charles Michalopoulos et al., *Design for the Mother and Infant Home Visiting Program Evaluation-Strong Start*, MDRC for HHS, ACF, OPRE, OPRE Report 2015-63, June 2015.

[75] Susan Zaid and Lance Till, *Overview of Grantee-Led Evaluations: The Maternal, Infant, and Early Childhood Home Visiting Program*, James Bell and Associates, for HHS, ACF, Office of Planning, Research, and Evaluation (OPRE), OPRE Report 2016-78, October 2016, http://www.acf.hhs.gov/opre/resource/grantee-led-evaluations-maternal-infant-early-childhood-home-visiting-program-overview-profiles?utm_source=MIHOPE+Newsletter&utm_campaign=102bde0abe-MIHOPE+EMAIL_CAMPAIGN_2016_11_29&utm_medium=email&utm_term=0_a9da9c609f-102bde0abe-42243149.

[76] U.S. Congress, House Committee on Energy and Commerce, *The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?*, 113th Cong., 2nd sess., January 9, 2014, H.Hrg. 113-111 (Washington: GPO, 2014).

visiting program, and two researchers.[77] They discussed how the program works in practice, both from the perspectives of program staff and the client. In addition, researchers discussed the current research on home visiting, including the efficacy of selected home visiting models. On March 15, 2017, the Subcommittee on Human Resources held another hearing that focused on reauthorization of the program, including testimony from staff and a client with a national home visiting model, a home visiting manager, and a state committee in Illinois that promotes home visiting services.[78] Witnesses generally discussed the benefits of home visiting.

As mentioned, Congress passed and the President enacted the Protecting Access to Medicare Act of 2014 (P.L. 113-93). The act, signed into law on April 1, 2014, provided funding of $400 million for the first half of FY2015 (October 1, 2014, through March 31, 2015). The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10), signed into law on April 16, 2015, extended the $400 million made available under P.L. 113-93 through all of FY2015 (October 1, 2014, through September 30, 2015).[79] P.L. 114-10 also provided $400 million for each of FY2016 and FY2017 under the program.

[77] U.S. Congress, House Committee on Ways and Means, Subcommittee on Human Resources, *The Maternal and Early Childhood Homevisiting Program*, 113th Cong., 2nd sess., April 2, 2014, H.Hrg. 109-59 (Washington: GPO, 2014).

[78] U.S. Congress, House Committee on Ways and Means, Subcommittee on Human Resources, *Hearing on the Reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program*, 115th Cong., 1st sess., March 15, 2017.

[79] In other words, the law allows HHS to obligate FY2015 funds through the end of FY2015 but otherwise does not change the level of funding for FY2015. Under P.L. 113-93, HHS had until March 31, 2015, to obligate all FY2015 funding. HHS reported that all funds had been obligated by this date.

Appendix A. Legislative History of Home Visiting

Federal Efforts to Establish a Home Visiting Program

Congressional and executive branch interest in early childhood home visiting programs predated the Affordable Care Act and implementation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Since 2004, Congress has considered home visiting legislation and held related hearings across multiple committees. Some of these efforts have supported selected home visiting models and/or particular aspects of home visiting, such as its role in promoting parent and child education, responding to domestic violence, and reducing child maltreatment.

The Education Begins at Home Act (S. 2412; 108th Congress), introduced in 2004, sought to authorize a stand-alone home visiting program, and would have directed the Departments of Education and Health and Human Services to collaboratively award grants to support home visiting. It would have also amended the Early Head Start program to establish standards for home visiting staff. The bill was not taken up; however, several similar bills were introduced in subsequent years.[80] One of these bills (the Education Begins At Home Act, H.R. 3628; 109th Congress) was the focus of a hearing by the House Education and the Workforce Committee.[81] At the hearing, Representative Osborne said that home visiting can "deliver parent education and family support services directly to parents with young children and aim to offer guidance to parents on how to support their children's development from birth through their enrollment in kindergarten."[82] Other witnesses, including representatives from two home visiting programs (Parents as Teachers and Nurse-Family Partnership), testified about the role of home visiting in improving multiple child and family outcomes in education, health, and other domains.

In 2006, the Violence Against Women and Department of Justice Reauthorization Act of 2005 (P.L. 109-162) was signed into law. It authorized $7.0 million each fiscal year for FY2007-FY2011 for the Department of Justice to develop and implement policies and procedures to help home visitors address the effect of domestic violence on pregnant women as well as young children and their parents. Congress did not appropriate funds for the program, and the Violence Against Women Reauthorization Act of 2013 (P.L. 113-4) repealed the authorizing language.

Congress subsequently funded a home visiting pilot program that had been proposed by the Bush Administration in the FY2008 budget request and had a child maltreatment focus. As part of the request, the Administration sought $10 million (as a set-aside within the discretionary activities account of the Child Abuse Prevention and Treatment Act, CAPTA) for competitive grants to expand, upgrade, or develop home visiting programs that have "proven effective models," and to support a national cross-site evaluation to examine factors associated with successful replication

[80] The Education Begins at Home Act appeared to draw inspiration from the Head Start Improvements for School Readiness Act (S. 1940), and was (re)introduced in the House and the Senate in the 109th Congress (S. 503 and H.R. 3628) and 110th Congress (S. 667 and H.R. 2343). Related legislation was also introduced around this same time: the Prevention of Childhood Obesity Act (S. 2894) in 2004; the Prevention of Childhood Obesity Act (S. 799) and the Head Start Improvements for School Readiness Act (S. 1107) in 2005; and the Balancing Act of 2007 (H.R. 2392) and the Healthy Children and Families Act of 2007 (S. 1052 and H.R. 3024) in 2007.

[81] U.S. Congress, House Committee on Education and the Workforce, *Perspectives on Early Childhood Home Visitation Programs*, 109th Cong., 2nd sess., September 27, 2006, H.Hrg. 109-59 (Washington: GPO, 2006). Two years later, in the 110th Congress, the committee marked up and reported a bill of the same name but with some differences (H.R. 2343; H.Rept. 110-818).

[82] Ibid, Statement of the Honorable Tom Osborne.

or expansion of such models.[83] To support this initiative, Congress provided $10 million in FY2008 and $13.5 million in FY2009 as a set-aside from the CAPTA discretionary activities account. Funding in years 3 through 5 of the initiative was provided under MIECHV.

This initiative—Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment (EBHV)—was carried out by ACF, which awarded cooperative agreements to 17 grantees (mostly private, nonprofit organizations; state or local agencies; or hospitals or medical centers) in 15 states. The goals of the initiative were to (1) support implementation with fidelity to home visiting program models; (2) help scale up home visiting models, by replicating the program in a new area, adapting the model for a new population, or increasing enrollment capacity in an existing service area; and (3) help sustain the home visiting model beyond the end of the grant period. EBHV funding was not used to cover the full cost of direct home visiting services; instead, grantees used other funding sources for such services. Grantees were expected to adopt home visiting models that, as defined by ACF, were evidence-based programs.[84]

Each grantee worked with one or more implementing agencies to deliver home visiting services to families or served as the agency and provided services directly. The implementing agencies used one or more of the following five models in carrying out home visiting services: Healthy Families America, Nurse-Family Partnership (NFP), Parents as Teachers (PAT), SafeCare, and Triple P. In addition to the cooperative agreements, ACF awarded funds to Mathematica Policy Research, Inc., and the Chapin Hall Center for Children to conduct a cross-site evaluation of the funded programs.

The evaluation found that the grantees generally adhered to standards that measured fidelity to a home visiting model; however, they often struggled to maintain caseloads and deliver services as intended. In addition, the grantees participated in activities to build infrastructure and partnerships. Such activities included strengthening fiscal capacity through partnering and fundraising, building community awareness or political support for programs, and evaluating and monitoring programs. The evaluation found that grantees with greater investment in these activities tended to achieve the initiative's goals.[85]

While the EBHV initiative was underway, the Obama Administration proposed a new capped entitlement program as part of its FY2010 budget request for grants to states, territories, and tribes to establish and expand evidence-based home visitation programs for low-income mothers and pregnant women. The program was intended to "create long-term positive impacts for children and their families, as well as generate long-term positive impacts for society as a whole." Under the proposal, the Administration sought to give priority to funding for home visiting models "that have been rigorously evaluated and shown to have positive effects on critical outcomes for families and children." The proposal also included provisions to ensure that states

[83] HHS, ACF, *Justification of Estimates for Appropriations Committees, Fiscal Year 2008*, pp. 115-116.

[84] Criteria for such evidence-based programs included the following: (1) there must be no evidence that the home visiting program would constitute a substantial risk of harm to participants; (2) the program must identify outcomes and describe activities that are related to those outcomes; and (3) the evaluation research supporting the efficacy of the program must be based on at least rigorous randomized controlled trials (RCTs) that were reported in published, peer-reviewed journals; and (4) meet other related criteria related to sustaining the effects of the program over time.

[85] Kimberly Boller et al., *Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity*, Mathematica Policy Research, for HHS, ACFY, ACF, Children's Bureau, January 2014, http://www.mathematica-mpr.com/~/media/publications/PDFs/earlychildhood/EBHV_makingreplication.pdf. (Hereinafter Kimberly Boller et al., *Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity*.)

and other jurisdictions would adhere to a proven program model and sought to direct some of this funding for technical assistance and program assessment and monitoring. The Administration requested $124 million for an initial year of the program and envisioned a "gradual growth" in the program so that it would, in 10 years (as of FY2019), reach an estimated 450,000 new families at a cost of $1.8 billion.[86]

Home Visiting as Part of Health Reform

At the same time that Congress was considering whether to fund the Obama Administration's initiative,[87] other home visiting proposals were moving forward in the House and the Senate. In June 2009, the House Ways and Means Subcommittee on Income Security and Family Support held a hearing on early childhood home visitation programs, related research, and a bill introduced by members of the subcommittee (H.R. 2667) to establish a home visiting program. Witnesses included researchers, an administrator of state-funded home visitation programs, a former participant and current home visitor, and a nurse consultant. The witnesses generally supported broader implementation of early childhood home visiting models with a proven record of positive outcomes for families based on rigorous research.[88]

In November 2009, the House passed the Affordable Health Care for America Act (H.R. 3962). The bill included two home visiting provisions. Section 1713 specified that the Medicaid program support home visits by trained nurses. This section appeared to draw from the Healthy Children and Families Act of 2007 (H.R. 3024/S. 1052). Section 1904 sought to provide a program for home visiting, to be funded at $750 million over five years (FY2010-FY2014). This section appears to have been drawn primarily from H.R. 2667, which had been introduced earlier in 2009. Separate health care reform efforts in the Senate culminated in the passage of the Patient Protection and Affordable Care Act (H.R. 3590) on December 24, 2009; the bill included the MIECHV program. H.R. 3590 was taken up by the House on March 21, 2010, and was signed into law on March 23, 2010, as P.L. 111-148.[89]

HHS first allocated funding for the MIECHV program in FY2010. As the MIECHV program was implemented, the EBHV grantees entered into subcontracts with the MIECHV lead agency in their states, and these states received additional funds from FY2010 through FY2012 to pass through to EBHV grantees. Some of the EBHV grantees received MIECHV funds to allow them to sustain services beyond the EBHV funding period or to expand services. However, some of the grantees were using models that did not meet HHS criteria under the MIECHV program for being effective and therefore were ineligible for funding.[90]

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[86] HHS, ACF, *Justification of Estimates for Appropriations Committees, Fiscal Year 2010*, p. 267.

[87] The FY2009 budget resolution in both the House (H.Con.Res. 85) and the Senate (S.Con.Res. 13, as amended by S.Amdt. 880) included reserve language for home visiting programs.

[88] U.S. Congress, House Committee on Ways and Means, Subcommittee on Income Security and Family Support, *Hearing on Proposals to Provide Federal Funding for Early Childhood Home Visitation Programs*, 111th Cong., 1st sess., June 9, 2009, H.Hrg. 111-24 (Washington: GPO, 2010).

[89] P.L. 111-148 was amended by the Health Care and Education Reconciliation Act (P.L. 111-152), but these amendments did not affect the MIECHV program.

[90] Kimberly Boller et al., *Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity.*

Appendix B. MIECHV Funding by State and Territory

Table B-1. MIECHV Formula and Competitive Grant Funding by State and Territory, FY2015-FY2016

State/Territory	FY2015 Formula	FY2015 Competitive	*Total FY2015*	Total FY2016 (Formula Only)
Alabama	$2,103,623	$0	*$2,103,623*	$6,646,654
Alaska	$1,000,000	$2,344,479	*$3,344,479*	$1,717,555
Arizona	$2,854,557	$8,809,435	*$11,663,992*	$10,934,069
Arkansas	$1,369,547	$7,801,146	*$9,170,693*	$7,136,908
California	$13,201,834	$9,400,000	*$22,601,834*	$22,201,618
Colorado	$1,501,443	$8,450,000	*$9,951,443*	$7,836,087
Connecticut	$1,000,000	$9,400,000	*$10,400,000*	$9,100,000
Delaware	$1,000,000	$0	*$1,000,000*	$3,665,161
District of Columbia	$1,000,000	$0	*$1,000,000*	$1,642,146
Florida	$6,402,965	$8,361,139	*$14,764,104*	$10,937,600
Georgia	$4,457,718	$9,310,630	*$13,768,348*	$7,539,019
Hawaii	$1,000,000	$8,430,783	*$9,430,783*	$3,538,445
Idaho	$1,000,000	$3,200,000	*$4,200,000*	$2,959,619
Illinois	$4,016,157	$9,399,351	*$13,415,508*	$8,688,340
Indiana	$2,427,180	$9,400,000	*$11,827,180*	$10,518,746
Iowa	$1,000,000	$0	*$1,000,000*	$5,686,076
Kansas	$1,056,142	$9,400,000	*$10,456,142*	$4,834,188
Kentucky	$1,862,016	$0	*$1,862,016*	$7,076,041
Louisiana	$2,155,095	$9,389,965	*$11,545,060*	$9,475,543

State/Territory	FY2015 Formula	FY2015 Competitive	*Total FY2015*	Total FY2016 (Formula Only)
Maine	$1,000,000	$0	*$1,000,000*	$5,992,218
Maryland	$1,354,131	$7,412,419	*$8,766,550*	$7,511,026
Massachusetts	$1,439,443	$0	*$1,439,443*	$6,856,437
Michigan	$3,508,188	$0	*$3,508,188*	$7,971,034
Minnesota	$1,348,637	$9,400,000	*$10,748,637*	$8,651,762
Mississippi	$1,707,789	$0	*$1,707,789*	$3,078,041
Missouri	$2,183,504	$0	*$2,183,504*	$3,988,612
Montana	$1,000,000	$0	*$1,000,000*	$4,315,889
Nebraska	$1,000,000	$0	*$1,000,000*	$1,274,280
Nevada	$1,126,895	$0	*$1,126,895*	$1,885,343
New Hampshire	$1,000,000	$3,775,229	*$4,775,229*	$2,982,681
New Jersey	$2,094,745	$9,400,000	*$11,494,745*	$10,581,564
New Mexico	$1,096,229	$3,000,877	*$4,097,106*	$3,570,937
New York	$6,296,241	$9,400,000	*$15,696,241*	$9,234,796
North Carolina	$3,916,661	$0	*$3,916,661*	$3,289,101
North Dakota	$1,000,000	$0	*$1,000,000*	$1,076,906
Ohio	$4,150,121	$8,457,000	*$12,607,121*	$7,552,896
Oklahoma	$1,620,074	$9,025,081	*$10,645,155*	$6,377,853
Oregon	$1,420,246	$9,399,810	*$10,820,056*	$8,454,283
Pennsylvania	$3,482,306	$9,400,000	*$12,882,306*	$11,798,665
Rhode Island	$1,000,000	$9,272,115	*$10,272,115*	$7,181,772
South Carolina	$2,001,954	$6,492,893	*$8,494,847*	$8,388,323

State/Territory	FY2015 Formula	FY2015 Competitive	*Total FY2015*	Total FY2016 (Formula Only)
South Dakota	$1,000,000	$0	*$1,000,000*	$1,018,486
Tennessee	$2,557,447	$9,374,047	*$11,931,494*	$9,935,297
Texas	$11,557,960	$9,400,000	*$20,957,960*	$17,233,145
Utah	$1,043,901	$0	*$1,043,901*	$3,172,699
Vermont	$1,000,000	$0	*$1,000,000*	$1,371,223
Virginia	$1,958,149	$6,244,950	*$8,203,099*	$7,648,351
Washington	$2,060,549	$9,398,651	*$11,459,200*	$10,083,591
West Virginia	$1,000,000	$9,400,000	*$10,400,000*	$5,809,290
Wisconsin	$1,666,553	$9,400,000	*$11,066,553*	$8,653,908
Wyoming	$1,000,000	$0	*$1,000,000*	$1,643,671
American Samoa	$1,000,000	$0	*$1,000,000*	$1,000,000
Guam	$1,000,000	$0	*$1,000,000*	$1,000,000
Northern Mariana Islands	$1,000,000	$0	*$1,000,000*	$1,000,000
Puerto Rico	$1,000,000	$0	*$1,000,000*	$1,000,000
U.S. Virgin Islands[a]	$1,000,000	$0	*$1,000,000*	$1
Total Funding	**$125,000,000**	**$260,750,000.00**	***$385,750,000***	**$344,717,896**

Source: Congressional Research Service (CRS) based on data provided by HHS, HRSA, October 2016 and February 2017.

Notes: The table displays grant obligations for states and territories only, and does not include obligations for tribal entities, research, evaluation, technical assistance, and federal administration. Obligations are as of the end of each fiscal year.

The formula awards include formula funds that are allocated to states; territories; and three nonprofit organizations that operate home visiting programs in states that have declined formula funding. North Dakota received regular formula funding for FY2010; declined this funding for FY2011; and received nonprofit formula funding for each of FY2012 through FY2016. Florida and Wyoming received regular formula funding for FY2010; declined this funding in FY2011 and FY2012; and received nonprofit formula funding for each of FY2013 through FY2016. After receiving the FY2011 awards, both states withdrew from participating in the program and were required to return the FY2011 funds. In addition, Oklahoma received nonprofit formula funding for FY2014. CRS correspondence with HHS, HRSA, June 2016.

The competitive awards include those for development grants and expansion grants to states and territories and grants to tribal entities. Development grants focus on building the capacity of the workforce, data infrastructure, and care coordination and referral systems. Expansion grant support efforts already underway and expand services to more families and communities. HHS separately awards competitive grants to tribal entities to operate home visiting programs under the Tribal MIECHV program.

a. According to HHS, the U.S. Virgin Islands received $1 in FY2016 because it did not meet the objectives of the program, including that it did not sufficiently spend down its funding on time. The $1 award was to ensure that USVI would continue to be eligible for FY2017 formula funds. (Source: CRS correspondence with HHS, HRSA in February 2017.)

Appendix C. Timeline for the MIECHV Program

Table C-1. Relevant Dates for the MIECHV Program

Date	Activity
March 23, 2010	The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) established the MIECHV program under Section 511 of the Social Security Act.
September 20, 2010	All states, the District of Columbia, and the five territories ("eligible entities") were required to submit statewide needs assessments as a condition of receiving funding under the Maternal and Child Health Block Grant for FY2011.
May-June 2010	Jurisdictions were required to submit final statewide needs assessments.
March 22, 2011	The HHS Secretary was required to appoint an independent advisory panel to review and make recommendations on the design of an evaluation that examines the statewide needs assessments, and effects of the home visiting programs on child and parent outcomes and the potential effects on broader health outcomes.
October 1, 2012	If an eligible entity had not applied or been approved for a MIECHV grant, the HHS Secretary could provide grants for the home visiting program in that jurisdiction to be conducted by a nonprofit organization with an established record of providing early childhood home visitation programs in one or more jurisdictions. (Such grants have since been awarded to three nonprofit organizations that operate MIECHV programs in Florida, North Dakota, and Wyoming. Oklahoma's MIECHV program was operated by a nonprofit organization in FY2014 only.)
October 30, 2014	Most states (including Oklahoma) and all territories were required to submit a report to HHS to demonstrate improved outcomes in four of six benchmark areas for the first three years of the program.
December 31, 2014	The first cohort of Tribal MIECHV grantees were required to submit a report to HHS demonstrating improved outcomes in four of six benchmark areas for the first three years of the program.
March 31, 2015	The law required HHS to submit a report to Congress on the results of the national evaluation. The evaluation was to include an (1) analysis of the results of the statewide needs assessments and state actions in response to the assessments; (2) assessment of the effect of early childhood home visitation programs on child and parent outcomes, including with respect to the benchmark areas and the individual family outcomes (described previously); (3) assessment of the effectiveness of home visiting programs on different populations, including the extent to which the ability of programs to improve participant outcomes varies across programs and populations; and (4) assessment of the potential for the activities carried out under home visiting programs, if scaled broadly, to improve health care practices, health care system quality, and efficiencies; eliminate health disparities; and reduce costs. Early results from the evaluation, known as the Mother and Infant Home Visiting Program Evaluation (MIHOPE), were submitted in January 2015.[a] According to HHS, final reports on MIHOPE will be available in 2018.
December 31, 2015	Most states and all territories were required to submit a final report to HHS demonstrating improved outcomes in four of six benchmark areas for the first years of the program. The law required HHS to submit a report to Congress by December 31, 2015, regarding (1) the extent to which eligible entities receiving grants demonstrated improvements in each of the benchmark areas; (2) technical assistance provided to grantees, including the type of assistance provided; and (3) recommendations for such legislative or administrative action as the HHS Secretary determines appropriate. A report on tribal grantees was submitted in November 2015 and a report on state grantees was submitted in March 2016.[b]

Date	Activity
October 30, 2016	The three nonprofit organizations that operate MIECHV programs in Florida, North Dakota, and Wyoming were required to submit a report to HHS to demonstrate improvements (if any) in six "benchmark" areas for the first three years of the program.
September 30, 2019	This is the last day that jurisdictions can expend funds appropriated for FY2017.

Source: Section 511 of the Social Security Act and CRS correspondence with HHS/HRSA, November and December 2014 and June 2016.

a. Charles Michalopoulos et al., *The Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program*, *A Report to Congress,* January 2015.

b. Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress,* James Bell Associates, for HHS, ACF, Office of Planning Research and Evaluation, November 2015; and HHS, ACF and HRSA, *Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program: A Report to Congress*, March 2016.

Appendix D. Home Visiting Models Used Under the MIECHV Program

Table D-1. Selected Characteristics of Home Visiting Models That Meet HHS Criteria for Being Evidence-Based Under the MIECHV Program

18 Models as of April 2017

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	Birth to 11 Months	12 to 23 Months	24 to 35 Months	36 to 47 Months	48+ Months	Program Intervention	Interventions Vary Based on Family Needs	Visits and Services Diminish in Frequency	Intervention May Be Longer	Number of Families (over specified period, if known) Per Home Visitor	Maternal Health	Child Health	Child Development and School Readiness	Positive Parenting Practices	Family Economic Self- Sufficiency	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, and Crime	Linkages and Referrals
Attachment and Biobehavioral Catch-Up (ABC)		X	X				Nine to ten weekly home visits.				19		X	X	X				
Child First		X	X	X	X	X	Weekly home visits for 6 to 12 months.		X	X	14-18	X		X			X		X
Early Head Start-Home Visiting (EHS-HV)	X	X	X	X			Weekly home visits and group socialization.	X			10-12			X	X	X			X
Early Intervention Program for Adolescent Mothers (EIP)	X	X					17 home visits (2 prenatal, 15 postpartum) at set intervals; and 4 "preparation for motherhood" classes.						X			X			

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	**Birth to 11 Months**	**12 to 23 Months**	**24 to 35 Months**	**36 to 47 Months**	**48+ Months**	**Program Intervention**	**Interventions Vary Based on Family Needs**	**Visits and Services Diminish in Frequency**	**Intervention May Be Longer**	**Number of Families (over specified period, if known) Per Home Visitor**	**Maternal Health**	**Child Health**	**Child Development and School Readiness**	**Positive Parenting Practices**	**Family Economic Self- Sufficiency**	**Reductions in Child Maltreatment**	**Reductions in Juvenile Delinquency, Family Violence, and Crime**	**Linkages and Referrals**
Early Start (New Zealand)	X	X	X	X	X	X	Up to 3 contact hours per week, including direct and indirect contact.[a]	X			30 case load points[b]		X	X	X		X		
Family Check-Up (FCU)				X	X	X	Not available				Not available	X		X	X				
Family Connects (also known as Durham Connects)		X					One home visit.	X		X	5-7 per week	X	X		X	X			X
Family Spirit		X	X	X			63 independent lessons in six domains taught during 52 home visits.	X	X		20-25	X		X	X				
Health Access Nurturing Development Services (HANDS) Program	X	X	X				A screening, followed by weekly visits.	X	X		20-30	X	X		X		X		

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	**Birth to 11 Months**	**12 to 23 Months**	**24 to 35 Months**	**36 to 47 Months**	**48+ Months**	**Program Intervention**	**Interventions Vary Based on Family Needs**	**Visits and Services Diminish in Frequency**	**Intervention May Be Longer**	**Number of Families (over specified period, if known) Per Home Visitor**	**Maternal Health**	**Child Health**	**Child Development and School Readiness**	**Positive Parenting Practices**	**Family Economic Self- Sufficiency**	**Reductions in Child Maltreatment**	**Reductions in Juvenile Delinquency, Family Violence, and Crime**	**Linkages and Referrals**
Healthy Beginnings (Australia, program is no longer active)[c]	X	X					8 home visits at set intervals.		X		50	X	X	X	X				
Healthy Families America (HFA)	X	X	X	X	X	X	At least one home visit per week until child age 6 months.	X	X	X	15-25	X	X	X	X	X	X	X	X
Home Instruction for Parents of Preschool Youngsters (HIPPY)					X	X	30 week curriculum for parents of 3-, 4-, and 5-year-olds. Curriculum differs by age group. Group meetings offered monthly.	X	X		10-25			X	X				
Maternal Early Childhood Sustained Home-Visiting Program (MECSH)	X	X	X				Minimum 25 home visits that begin during pregnancy.			X	30	X	X		X				

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	Birth to 11 Months	12 to 23 Months	24 to 35 Months	36 to 47 Months	48+ Months	Program Intervention	Interventions Vary Based on Family Needs	Visits and Services Diminish in Frequency	Intervention May Be Longer	Number of Families (over specified period, if known) Per Home Visitor	Maternal Health	Child Health	Child Development and School Readiness	Positive Parenting Practices	Family Economic Self- Sufficiency	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, and Crime	Linkages and Referrals
Minding the Baby	X	X	X				27-month program beginning in 3rd trimester of pregnancy, and involving 8-10 weekly visits during pregnancy, weekly visits until age 1, and biweekly visits until age 2.		X		24	X	X						
Nurse Family Partnership (NFP)	X	X	X				Weekly home visits for the first month; then every other week until the baby is born; weekly for first six weeks after birth; and biweekly until baby is 20 months. Last four visits are monthly until the child is 2 years old.		X		25	X	X	X	X	X	X	X	

	Target Population						Intensity				Caseload	Favorable Results in Outcome Domains							
	Pregnant Women	Birth to 11 Months	12 to 23 Months	24 to 35 Months	36 to 47 Months	48+ Months	Program Intervention	Interventions Vary Based on Family Needs	Visits and Services Diminish in Frequency	Intervention May Be Longer	Number of Families (over specified period, if known) Per Home Visitor	Maternal Health	Child Health	Child Development and School Readiness	Positive Parenting Practices	Family Economic Self- Sufficiency	Reductions in Child Maltreatment	Reductions in Juvenile Delinquency, Family Violence, and Crime	Linkages and Referrals
Parents as Teachers (PAT)	X	X	X	X	X	X	12 home visits annually. Group "connections" (meetings) also offered.[f]	X	X		60 visits per month[g]			X	X	X	X		
Play and Learning Strategies (PALS) Infants		X	X	X			11 to 13 weekly sessions, depending on child's age.	X			12-15			X	X				
SafeCare Augmented		X	X	X	X	X	Weekly or biweekly home visits.	X			10-12	X		X	X		X		X

Source: CRS review of HHS, ACF, Home Visiting Evidence of Effectiveness (HomVEE), *Model Reports,* http://homvee.acf.hhs.gov/programs.aspx, as of June 2017; and Emily Sama-Miller et al., "Home Visiting Evidence of Effectiveness Review: Executive Summary," Mathematica Policy Research Inc., for HHS, ACF, Office of Policy Research and Evaluation (OPRE), OPRE Report #2017-29, April 2017.

Notes: The Home Visiting Evidence of Effectiveness (HomVEE) review involves assessing the evidence of effectiveness for home visiting models that target families with pregnant women and children from birth to kindergarten entry (up to age five). HHS established the criteria for evidence of effectiveness, including that models meet at least one of the following: (1) at least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of eight outcome domains; (2) at least two high- or moderate-quality impact studies of the model using nonoverlapping study samples find one or more favorable, statistically significant impacts in the outcome domains. The outcome domains are included on the HomVEE website, which includes varying level of detail about the models. In some cases, information is not available or is limited. The spaces left blank indicate that information is not applicable. See, HHS, HRSA, https://homvee.acf.hhs.gov/models.aspx. Two additional models meet the criteria but are not included in the table. Healthy Steps does not meet current requirements for program implementation because home visiting is not the primary service delivery strategy, and Oklahoma's Community-Based Family Resource and Support Program has not met the criteria that relate to implementation of the model.

a. Early Start includes four levels of intensity, with level 1 being weekly contact and level 4 being a graduate of the program with up to one hour of contact per three months. Indirect contact can include paperwork that is completed by the family and visitor.

b. Home visitor caseloads are calculated by allocating case load points (CLP) to each family based on its service level. For example, a family enrolled in level one has an allocation of 2.75 CLP.

c. Healthy Beginnings was a demonstration project designed by researchers from Sydney and South Western Sydney Local Health Districts Health Promotion Service and the University of Sydney, in Australia. It was implemented from 2007 to 2010.

d. Health Steps includes three levels of intensity, with high-intensity involving a minimum of five home visits with additional home visits as needed and with low-intensity being two home visits.

e. The number of families that a Healthy Steps Specialist serves varies depending on the (1) intensity of the Healthy Steps intervention implemented, (2) characteristics and needs of the families being served, and (3) amount of administrative support provided. It is unclear which period of time home visitors have this caseload.

f. PAT affiliates are required to provide services for at least two years. Affiliates may choose to focus services primarily on pregnant women and families with children from birth to age 3; others may offer services from pregnancy to kindergarten.

g. The expectation for completing monthly visits is based on parent educators having two hours per visit for planning and travel, having time for other responsibilities such as recruitment activities, and have time for planning and participating in group connections.

Table D-2. Implementing Agencies and Home Visiting Staff Associated with Home Visiting Models That Meet HHS Criteria for Being Evidence-Based Under the MIECHV Program

18 Models as of April 2017

	Type of Implementing Agency				Required Training of Home Visiting Staff				Educational Requirements of Home Visiting Staff				
	Health Clinic, Hospital, or Physician	Nonprofit or Community Based Organization	Government Agency	Other	Preservice Optional	Preservice Required	In-Service Optional	In-Service Required	Minimum Education Requirement	Registered Nurses (RN) or Physician	Mental Health or Developmental Clinician	Social Workers	Paraprofessionals (e.g. Training in child development)
Attachment and Biobehavioral Catch-Up (ABC)		X				X		X	X				
Child First		X				X		X	X		X		X
Early Head Start-Home Visiting (EHS-HV)		X	X			X	X						X
Early Intervention Program for Adolescent Mothers (EIP)			X	X				X	X	X			
Early Start (New Zealand)		X				X		X	X	X		X	
Family Check-Up (FCU)				X		X		X	X		X		
Family Connects (also known as Durham Connects)						X		X		X		X	
Family Spirit	X			X		X	X		X				X
Health Access Nurturing Developing Services (HANDS) Program			X			X		X	X	X		X	X
Healthy Beginnings (Australia, program no longer active)[a]				X		X		X	X	X			

	Type of Implementing Agency				Required Training of Home Visiting Staff				Educational Requirements of Home Visiting Staff				
	Health Clinic, Hospital, or Physician	Nonprofit or Community Based Organization	Government Agency	Other	Preservice Optional	Preservice Required	In-Service Optional	In-Service Required	Minimum Education Requirement	Registered Nurses (RN) or Physician	Mental Health or Developmental Clinician	Social Workers	Paraprofessionals (e.g. Training in child development)
Healthy Families America (HFA)						X	X		X				
Home Instruction for Parents of Preschool Youngsters (HIPPY)	X	X	X	X		X	X					X	X
Maternal Early Childhood Sustained Home-Visiting Program (MECSH)	X					X		X	X	X			
Minding the Baby	X					X		X	X	X			
Nurse Family Partnership (NFP)		X				X		X	X	X			
Parents as Teachers (PAT)		X	X	X		X		X	X				X
Play and Learning Strategies (PALS) Infants		X		X		X		X	X				X
SafeCare Augmented	X	X	X			X		X					X

Source: CRS review of HHS, ACF, Home Visiting Evidence of Effectiveness (HomVEE), *Model Reports,* http://homvee.acf.hhs.gov/programs.aspx, as of June 2017; and Emily Sama-Miller et al., "Home Visiting Evidence of Effectiveness Review: Executive Summary," Mathematica Policy Research Inc., for HHS, ACF, Office of Policy Research and Evaluation (OPRE), OPRE Report #2017-29, April 2017.

Notes: The Home Visiting Evidence of Effectiveness (HomVEE) review involves assessing the evidence of effectiveness for home visiting models that target families with pregnant women and children from birth to kindergarten entry (up to age five). HHS established the criteria for evidence of effectiveness, including that models meet at least one of the following: (1) at least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of eight outcome domains; (2) at least two high- or moderate-quality impact studies of the model using nonoverlapping study samples find one or more favorable, statistically significant impacts in the outcome domains. The outcome domains are included on the HomVEE website, which includes varying level of detail about the models. In some cases, information is not available or is limited. The spaces left blank indicate that information is not applicable. See, HHS, HRSA, https://homvee.acf.hhs.gov/models.aspx. Two additional models meet the criteria but are not included in the table. Healthy Steps does not meet current requirements for program implementation because home visiting is not the primary service delivery strategy, and Oklahoma's Community-Based Family Resource and Support Program has not met the criteria that relate to implementation of the model.

a. Healthy Beginnings was a demonstration project designed by researchers from Sydney and South Western Sydney Local Health Districts Health Promotion Service and the University of Sydney, in Australia. It was implemented from 2007 to 2010.

Table D-3. Home Visiting Models Adopted by States and Territories Under the MIECHV Program, as of FY2016

10 Adopted Out of 17 Models (at the time) That Met HHS Criteria for Being Evidence-Based

State or Territory	Nurse-Family Partnership (NFP)	Healthy Families America (HFA)	Parents as Teachers (PAT)	Early Head Start-Home Visiting (EHS-HV)	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Family Spirit	SafeCare Augmented	Child First	Family Check-Up (FCU)	Health Access Nurturing Development Services (HANDS) Program
Alabama	X		X							
Alaska	X									
Arizona	X	X				X				
Arkansas	X	X	X		X					
California	X	X								
Colorado	X		X		X					
Connecticut	X		X	X				X		
Delaware	X	X	X							
District of Columbia		X	X		X					
Florida	X	X	X							
Georgia	X	X	X	X						
Hawaii		X	X		X					
Idaho	X		X	X						
Illinois		X	X	X						
Indiana	X	X								
Iowa	X	X	X	X						

State or Territory	Nurse-Family Partnership (NFP)	Healthy Families America (HFA)	Parents as Teachers (PAT)	Early Head Start-Home Visiting (EHS-HV)	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Family Spirit	SafeCare Augmented	Child First	Family Check-Up (FCU)	Health Access Nurturing Development Services (HANDS) Program
Kansas		X	X	X						
Kentucky										X
Louisiana	X		X							
Maine			X							
Maryland	X	X								
Massachusetts		X	X	X						
Michigan	X	X		X						
Minnesota	X	X				X				
Mississippi		X								
Missouri	X		X	X						
Montana	X		X			X	X			
Nebraska		X								
Nevada	X		X	X	X					
New Hampshire		X								
New Jersey	X	X	X							
New Mexico	X		X							
New York	X	X								
North Carolina	X	X								
North Dakota			X							
Ohio	X	X								

State or Territory	Nurse-Family Partnership (NFP)	Healthy Families America (HFA)	Parents as Teachers (PAT)	Early Head Start-Home Visiting (EHS-HV)	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Family Spirit	SafeCare Augmented	Child First	Family Check-Up (FCU)	Health Access Nurturing Development Services (HANDS) Program
Oklahoma	X		X				X			
Oregon	X	X		X						
Pennsylvania	X	X	X	X						
Rhode Island	X	X	X							
South Carolina	X	X	X						X	
South Dakota	X									
Tennessee	X	X	X							
Texas	X		X		X					
Utah	X		X							
Vermont	X									
Virginia	X	X	X							
Washington	X		X							
West Virginia		X	X	X						
Wisconsin	X	X	X	X		X				
Wyoming			X							
America Samoa		X								
Guam		X	X							
Northern Mariana Islands		X								
Puerto Rico		X								

State or Territory	Nurse-Family Partnership (NFP)	Healthy Families America (HFA)	Parents as Teachers (PAT)	Early Head Start-Home Visiting (EHS-HV)	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Family Spirit	SafeCare Augmented	Child First	Family Check-Up (FCU)	Health Access Nurturing Development Services (HANDS) Program
U.S. Virgin Islands	X	X								
Total	39	36	35	6	8	4	2	1	1	1

Source: CRS correspondence with HHS, HRSA and ACF, October 2016.

Note: Tribal grantees use PAT (13 grantees), Family Spirit (6 grantees), NFP (4 grantees), SafeCare Augmented (1 grantee), and HIPPY (1 grantee). In addition, 1 grantee uses the Parent-Child Assistance Program, which is considered to be a promising model but not yet determined to be effective. Three jurisdictions (Arkansas, Kansas, and West Virginia) are using a portion of their funds to implement a home visiting model in FY2016 that was promising, but not yet determined to be effective. For further information about each state's and territory's home visiting program, see HHS, HRSA, *Maternal Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed.;* and an interactive map that includes information about their programs. Both the brief and map are available at HHS, HRSA, "Home Visiting Helps At-Risk Families Across the U.S.," https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-state-fact-sheets.

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