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Maternal, Infant, and 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 indicators of risk. 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 FY2017, the MIECHV program supported 156,297 individual parents and children involved in 942,676 home visits.

The Patient Protection and Affordable Care Act (ACA, as amended; 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). The ACA, and amendments to the act, have directly appropriated mandatory funding for the program. Most recently, the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) provided $400 million annually through FY2022.

The law is silent about how funds are to be distributed under the program, except to require that HHS reserve 3% of the annual appropriation for Indian tribal entities and another 3% for training, technical assistance, and evaluations. BBA 2018 directs HHS to use the most accurate data available for eligible jurisdictions if funding is awarded on the basis of relative population or poverty considerations. In practice, HHS has distributed MIECHV funding based on a formula that accounts for poverty and based on a competitive award process. States, territories, and tribes must carry out their home visiting programs as specified in the law. Among other requirements, these jurisdictions had to carry out a needs assessment by September 20, 2010, 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. BBA 2018 directs jurisdictions to update this assessment by October 1, 2020. Under the program, these jurisdictions are required to achieve gains in four of six "benchmark" (outcome) areas pertaining to family well-being and coordination of community resources.

The law requires that 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 FY2017, jurisdictions had implemented 10 of the 18 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.

Contents

Introduction 1
Overview of Home Visiting 2
What is Home Visiting? 2
Research on Home Visiting 2
Overview of the MIECHV Program 3
Eligible Families 4
Funding 5
Formula Funding 5
Competitive Funding 7
Funding Levels 7
Coordination in the Community and at the Federal Level 10
Coordination within Jurisdictions 10
Federal Coordination 10
Administration 11
Requirements for Grantees 11
Overview 11
Needs Assessment 12
Coordination with Other Assessments 12
Initial Needs Assessment 13
Update to Needs Assessment 14
How Jurisdictions Demonstrate Improvement 14
Demonstrating Improvements After Three Years 16
Demonstrating Continuous Improvements 17
Additional Requirements 18
Home Visiting Models 19
Home Visiting Evidence of Effectiveness (HomVEE) 20
Eighteen Models Found to be Evidence-Based as of June 2017 20
Selected Characteristics of the Models 21
Use of Models 22
Option to Fund Home Visiting Services on a Pay-for-Outcome Basis 22
Technical Assistance 23
Research and Evaluation 24
National Evaluation of MIECHV: MIHOPE 24
MIHOPE-Strong Start Evaluation 26
Grantee-Led Evaluations 27
Other Research and Evaluation Activities 28
Recent Congressional and Executive Branch Action 28

Figures

Figure 1. Overview of the MIECHV Program 4

Tables

Table 1. Factors for Allocating Funding Under the Formula Grant 6
Table 2. Obligated Funding for the MIECHV Program, by Type of Award, FY2010-FY2017 8
Table 3. MIECHV Benchmark Areas (Outcomes) and Constructs 15
Table 4. Evidence-Based Models Used by States/Territories with Funding Under the MIECHV Program in FY2017 22

Table B-1. MIECHV Formula Funding by State and Territory, FY2017-FY2018 35
Table C-1. Relevant Dates for the MIECHV Program 37
Table D-1. Selected Characteristics of Home Visiting Models That Meet HHS Criteria for Being Evidence-Based Under the MIECHV Program 39
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 45
Table D-3. Home Visiting Models Adopted by States and Territories Under the MIECHV Program, as of FY2017 47

Appendixes

Appendix A. Legislative History of Home Visiting 31
Appendix B. MIECHV Formula Funding by State and Territory 35
Appendix C. Timeline for the MIECHV Program 37
Appendix D. Home Visiting Models Used Under the MIECHV Program 39

Contacts

Author Information 51
Acknowledgments 51

Introduction

Early childhood 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 visit the homes of families who participate on a voluntary basis. The federal government has long supported early childhood 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 budget request for a national home visiting program and a home visitation pilot program carried out in 15 states that had been initiated by the George W. Bush Administration. Congress considered proposals to establish home visiting programs as part of health care reform in 2010 and in prior years.

HHS provides MIECHV funding to states, territories, and tribal entities for home visiting services in at-risk communities, as identified by these jurisdictions.[2] MIECHV prioritizes certain populations, including low-income families, young mothers, or individuals who have a history of substance abuse, among other risk factors. Families participate on a voluntary basis. In FY2017, the MIECHV program served 156,297 individual parents and children who participated in 942,676 home visits.[3] Jurisdictions that carry out home visiting programs under the program must adhere to specific requirements. 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 on participants' outcomes.

This report begins with an overview of the MIECHV program and home visiting generally, and discusses federal efforts to increase and support home visiting services. It goes on to describe the program, including 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 within 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

[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. For a summary overview of the MIECHV program, see CRS In Focus IF10595, *Maternal and Infant Early Childhood Home Visiting Program*.

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

[3] The number of participants over time is 34,180 in FY2012; 75,970 in FY2013; 115,545 in FY2014; 145,561 in FY2015; and 160,374 in FY2016. Home visits over time are as follows: 174,257 in FY2012; 489,363 in FY2013; 746,303 in FY2014; 894,347 in FY2015; and 979,121 in FY2016. Of households served in FY2017, approximately 20% had a history of child abuse, 15% included pregnant teens, and 12% reported substance abuse. U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), *HRSA's Maternal, Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed* (hereinafter, HHS, HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed*). The FY2017 figures do not include data from Puerto Rico and the U.S. Virgin Islands due to reporting delays resulting from hurricanes Irma and Maria. See HHS, HRSA, *FY 2019 Justification of Estimates for Appropriations Committees*, p. 205.

models adopted by jurisdictions, and features of selected home visiting models that meet HHS criteria for being effective.

Overview of Home Visiting

What is Home Visiting?

Home visiting is a holistic strategy that involves social, health, and/or educational services for parents and their children from birth to entry into kindergarten. In practice, it generally entails visits to the homes of families on a regular basis (e.g., weekly or monthly) over an extended period (e.g., six months or longer). For some home visiting models, the number of visits becomes more infrequent over time. 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.

To a large extent, parents shape their children's earliest experiences. Home visiting programs seek to help parents better understand the development of their children. For example, home visitors can help parents facilitate learning opportunities through playing games, talking to their children frequently, and reading to them. Home visitors can also provide information to parents about child health, such as the value of well-child visits, car seat safety, and brushing teeth. Home visiting can directly help parents identify outside supports, such as referrals for health insurance and substance abuse resources. The programs can help achieve positive benefits for children, parents, and possibly their communities.[4]

For many years, greater attention has been focused on early childhood home visitation as a way to improve child and family outcomes. In recent decades, 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]

Research on Home Visiting

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 the desired outcomes, those effects have not necessarily been studied and/or achieved across more than one study or program

[4] Jill S. Cannon et al., *Investing Early: Taking Stock of Outcomes and Economic Returns from Early Childhood Programs*, RAND Corporation, 2017. (Hereinafter, Jill S. Cannon et al., *Investing Early: Taking Stock of Outcomes and Economic Returns from Early Childhood Programs*.)

[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); and Jill S. Cannon et al., *Investing Early: Taking Stock of Outcomes and Economic Returns from Early Childhood Programs*.

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 implementation as part of a range of strategies intended to enhance and improve early childhood development.[6]

Overview of the MIECHV Program

The Patient Protection and Affordable Care Act (ACA, as amended; P.L. 11-148) established the MIECHV program under Section 511 of the Social Security Act.[7] (See **Appendix A** for a history of federal home visiting efforts.) The program—jointly administered by the U.S. Department of Health and Human Services' (HHS's) Health Resources and Services Administration (HRSA) and 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 referring families to services outside of the program. States, territories, and Indian tribes determine which communities are at risk by conducting needs assessments.

The MIECHV law requires that jurisdictions administer programs that are evidence-based. Specifically, jurisdictions must use no less than 75% of their program funds to implement home visiting models that HHS has determined as effective, ensure that services are carried out with fidelity to these program models, and demonstrate improvements in outcomes for participating families.

MIECHV funding is mandatory, meaning that the authorizing law funds the program directly (as opposed to the funding provided through appropriations law). Annual funding levels have been between $100 million and $400 million. The most recent reauthorization of the program, the Bipartisan Budget Act of 2018 (BBA 2018; P.L. 115-123) extended funding through FY2022. With limited exceptions, jurisdictions have two full fiscal years to expend these funds.[8]

The law includes several requirements related to eligible families, funding program administration, and research and evaluation. **Figure 1** summarizes the major components of the program.[9]

[6] For further information, see CRS Report R40705, *Home Visitation for Families with Young Children*; HHS, Administration for Children and Families (ACF), Office of Planning, Research and Evaluation (OPRE), *Evidence of the Long-term Effects of Home Visiting Programs: Laying the Groundwork for Long-Term Following in the Maternal, Infant, and Early Childhood Home Visiting Program Evaluation (MIHOPE)*, OPRE Report 2017-73, September 2017, pp. 3-5; and HHS, ACF, OPRE, *Home Visiting Evidence of Effectiveness Review: Executive Summary*, OPRE Report 2017-58, August 2017.

[7] All statutory references to law are to Section 511 of the Social Security Act unless otherwise noted.

[8] BBA 2018 enables jurisdictions to use up to 25% of their MIECHV funding for a "pay-for-outcomes" initiative to test whether visiting initiatives lead to improved outcomes and result in savings. These jurisdictions can expend the funds up to 10 years after they first become available.

[9] 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 Program: State Fact Sheets," http://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-state-fact-sheets.

Figure 1. Overview of the MIECHV Program

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

Eligible Families

Under the MIECHV 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-to-be, if available; (2) a parent or primary caregiver of a child, including grandparents or

other relatives of the child, and foster parents, who is 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.[10] 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 the needs assessment conducted by the jurisdiction and accounting for other factors (staffing, community resources, and other requirements) that are necessary to operate at least one approved home visiting model in those communities;
- 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.[11]

Funding

Funding for the MIECHV program has increased over time from $100 million to $400 million annually. The authorizing law requires that 3% of the annual funding is to be reserved for Indian tribal entities, and another 3% is to be reserved for selected technical assistance, research, and evaluation. MIECHV funding may be expended by the jurisdiction through the end of the second succeeding fiscal year after the award.

The law does not specify how the funds are to be awarded, though the most recent reauthorization of the program under BBA 2018 included language that directs HHS to use the most accurate data available for eligible jurisdictions if funding is awarded on the basis of relative population or poverty considerations.[12] In practice, HHS has distributed MIECHV funds by both formula and competitive grants to states and other jurisdictions.

Formula Funding

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. HHS has noted that the funds are intended to

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

[11] Section 511(d)(4).

[12] Section 511(j)(4). HHS awarded FY2017 funds before this requirement went into effect in February 2018.

both address the need for services and to reward jurisdictions for improved outcomes.[13] **Table 1** uses funding for FY2018 as an example of how formula funds are to be awarded.[14] Funds are allocated, in part, based on a "need funding" factor that accounts for the relative share of children in poverty, with certain adjustments. Most of the funds will be allocated based on a "base funding" factor that accounts for the amount of competitive funding each jurisdiction receives. Awards are adjusted using "guard rails" to ensure no award varies by greater than ±7.5% from the prior-year formula ceiling amount.

Table 1. Factors for Allocating Funding Under the Formula Grant

Uses FY2018 Funding as an Example

Factor	Description
Need Funding	Approximately one-third of funding 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 based on the Census Bureau's Small Area Income Poverty Estimates (SAIPE). SAIPE data are not available for the territories, and four territories (American Samoa, Guam, Mariana Islands, and the U.S. Virgin Islands) each received the minimum funding of $1.2 million. In FY2018, Puerto Rico Community Survey (PRCS) data were used for the first time to determine need funding for Puerto Rico. Award amounts were reduced by the proportion of each jurisdiction's FY2014 de-obligation amount to the total FY2014 award, and deductions were redistributed across awardees based on relative child poverty. For example, a state awarded $5 million in FY2014 that did not expend $500,000 would have de-obligated 10% of funds. Each state or territory receives a minimum of $12 million regardless of its de-obligation history.
Base Funding	About two-thirds of the formula funds for FY2018 were distributed according to "base funding" amounts. This is based on each jurisdiction's base funding portion of their FY2017 formula funding amounts, which was derived primarily (two-thirds of the funding) from the proportion of the jurisdiction's competitive awards in FY2013, FY2014, and FY2015 out of the total competitive funds awarded across those fiscal years. This proportion was then applied to the total base funding amount available in FY2018. For example, if $600 million was awarded in total competitive awards 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 the total base funding amount available in FY2018.
Guard Rails	The total amount of funding was adjusted, where appropriate, to ensure that funding for any jurisdiction did not fluctuate by more than ±7.5% from the award for the prior year.

Source: HHS, HRSA, *Maternal, Infant and Early Childhood Home Visiting Program–Formula," Funding Opportunity Announcement Fiscal Year 2018,* HRSA-18-091, April 27, 2018; and CRS correspondence with HHS, HRSA and ACF, in August 2018.

[13] HHS, HRSA, *Maternal, Infant and Early Childhood Home Visiting Program–Formula, Funding Opportunity Announcement Fiscal Year 2016, Frequently Asked Questions*, version 1, December 4, 2015. See also, HHS, HRSA, *FY 2017 Formula Grant Work Plan and Budget Update (WPBU)*, p. 8, May 4, 2017; and HHS, HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program – Formula, Notice of Funding Opportunity FY 2018,* HRSA-18-091, April 27, 2018 (hereinafter, HHS, HRSA, *FY 2018 Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program – Formula, Notice of Funding Opportunity FY 2018*.)

[14] In April 2018, HHS issued the formula funding announcement for FY2018. The announcement notes that up to $362 million is available to jurisdictions that receive MIECHV formula funding. HHS expects that up to $351 million of these funds will be available for home visiting services and up to $11 million will be available for jurisdictions to update what is known as the statewide needs assessment. The needs assessment is to identify at-risk populations and the capacity for each jurisdiction to provide substance use disorder treatment and counseling in need. HHS, HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program – Formula, Notice of Funding Opportunity FY 2018.*

Competitive Funding

In some years, HHS has awarded competitive funding to jurisdictions based on the strength of their program or their effort to develop a strong program. Most recently, HHS awarded competitive funding in FY2017 (using carryover funding from prior years). These "innovation grants" focused on bolstering selective aspects of home visiting (e.g., recruitment, engagement, and retention of eligible families). In the past, competitive funds were provided for "development grants" focused on building the capacity of the workforce, data infrastructure, and care coordination and referral systems; and/or to build upon their efforts already underway and expand services to more families and communities under grants known as "expansion grants."

Funding Levels

Funding levels for the program have been enacted by the authorizing law, and amendments to that law, as follows:

- The ACA 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).[15]
- The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) extended the $400 million made available under P.L. 113-93 through 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. P.L. 114-10 also provided $400 million for each of FY2016 and FY2017 under the program.[16]
- BBA 2018 extended funding of $400 million for the program for each of FY2017 through FY2022.

Table 2 summarizes the obligated funding for the program from FY2010 through FY2017. The total funding for each year does not equal the mandatory level established in the law due to sequestration (in FY2013, FY2014, and FY2017). In addition, some funds were not obligated for each of FY2011 through FY2017.

[15] 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.

[16] 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.

Table 2. Obligated Funding for the MIECHV Program, by Type of Award, FY2010-FY2017

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

	Formula Grants			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 (34.3%)	$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 (30.1%)	$7.5 (2.0%)	*$117.0*	$211.3 (58.1%)	$11.5 (3.0%)	*$222.8*	$18.2 (5.0%)	$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*
FY2017	$317.0 (85.5%)	$13.5 (3.4%)	*$330.5*	$0 (0%)	$12.0 (3.2%)	*$12.0*	$18.0 (4.9%)	$10.2 (2.8%)	*$370.7*

Source: CRS correspondence with HHS, HRSA and ACF, October 2016 and November 2018.

Notes: Dollars are displayed in millions and rounded to the nearest tenth. Total funding for FY2011 through FY2017 does not equal the mandatory level established by the ACA, as amended, due to sequestration in FY2013, FY2014, and FY2017 and because some funds were not obligated in each of FY2011-FY2018. The program was

funded at $400 million in both FY2013 and FY2014; however, this funding was subject to sequestration, which reduced the actual funding available to the amounts shown. Also, the FY2017 amount of $400 million was reduced to $372.4 million due to sequestration. Funding levels are as of each fiscal year and exclude funds that were not obligated or carryover funding from unobligated balances in previous fiscal years. All funds that are not obligated are carried over to be available for obligation in subsequent years. For example, carryover funding was used in FY2017 from prior years for formula grants and competitive grants known as Home Visiting Innovation Awards.

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 in the Community and at the Federal Level

Coordination within Jurisdictions

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 an initial needs assessment that was coordinated with needs assessments under other federal programs, including those pertaining to child abuse, early childhood education, and domestic violence. Jurisdictions are required to update the needs assessment by October 1, 2020.[17] Jurisdictions must also establish and demonstrate improvements in coordinating with other community resources and supports.[18]

Federal Coordination

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).[19] 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 known as "MIHOPE."

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.[20]

As of February 2020, HRSA and ACF must designate data exchange standards to ensure that a state agency operating a home visiting program can exchange data with another state agency under federal law. Additionally, HRSA and ACF must designate data exchange standards to govern federal reporting and data exchanges that are required under federal law. These standards are to be developed in consultation with a working group established by the Office of Management and Budget (OMB) and must consider the perspectives of states.[21]

[17] Section 511(b).

[18] Section 511(d)(1)(A)(vi).

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

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

[21] Section 511(h)

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 lead 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 13 of these jurisdictions (Alaska, Delaware, Guam, Idaho, Kentucky, Maine, Michigan, Montana, Nebraska, Nevada, New Hampshire, North Carolina, and West Virginia) the department of health also includes the state social service agency. In addition, 13 states administer the program through other departments with a social service focus (Alabama, Colorado, Connecticut, Illinois, Kentucky, Mississippi, New Mexico, Oregon, Pennsylvania, Texas, Vermont, Washington, and Wisconsin). South Carolina operates its program through a nonprofit 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.[22]

Three states (Florida, North Dakota, and Wyoming) have declined funding for the program, and, as permitted under law, nonprofits have applied and have operated the program in these states in selected years: Florida Association of Healthy Start Coalitions (Florida); Prevent Child Abuse (North Dakota); and Parents as Teachers National Center (Wyoming).[23] The nonprofit organizations receive funding that otherwise would have been awarded to the states 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.

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. Under BBA 2018, jurisdictions must update their needs assessment. Further, the law requires jurisdictions to establish, subject to HHS approval, quantifiable and measurable benchmarks for demonstrating improvements in six indicators for

[22] This is based on a CRS review of HHS, HRSA, "Maternal, Infant, and Early Childhood Home Visiting Program FY 2017 Formula Funding Awards."

[23] 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 states in FY2013. Oklahoma received nonprofit formula funding for FY2014. CRS correspondence with HHS, HRSA, June 2016.

eligible families in the program. Jurisdictions must also meet requirements related to serving families, among other requirements.

Needs Assessment

The MIECHV law requires states to conduct a statewide needs assessment for the MIECHV program.[24] The law separately requires that tribes and nonprofit organizations carry out needs assessments similarly to the assessment required for all states.[25] The statewide needs assessments have 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.[26]

Coordination with Other Assessments

In carrying out the needs assessment, jurisdictions must 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

[24] Section 511(b).

[25] 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)*.")

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

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).[27] HHS guidance issued in August 2010 also specified that the assessment should be 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.[28]

Initial Needs Assessment

As a condition of receiving funds under the Maternal and Child Health Services Block Grant for FY2011,[29] each jurisdiction was required to submit the needs assessment by September 20, 2010 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.)[30] 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, a more

[27] Section 511(b)(2). In order to receive Maternal and Child Health Services Block Grant funding, states must submit to the HHS Secretary 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 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).

[28] 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*.)

[29] Section 511(b)(1) references Section 502 of the Social Security Act, which addresses allotments to states and federal set-asides for the Maternal and Child Health Services Block Grant program. For further information about the program, see CRS Report R44929, *Maternal and Child Health Services Block Grant: Background and Funding*. 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, 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.

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

detailed needs assessment for the targeted communities, and a specific plan for home visiting services tailored to address those needs.[31]

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 (or jurisdiction) as a whole. States and territories had the option of targeting all at-risk communities or sub-communities 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.[32]

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.[33]

Update to Needs Assessment

With enactment of BBA 2018, jurisdictions (including tribal grantees and nonprofit organizations that operate home visiting programs in three states) must review and update their prior assessments. As with the initial assessment, the updated assessments must be coordinated with the statewide needs assessment required under the Maternal and Child Health Services Block Grant, but they may be conducted separately. The assessment must be reviewed and updated by the jurisdiction no later than October 1, 2020. In guidance, HHS has directed jurisdictions to begin activities related to the needs assessment update no earlier than January 2019 and to complete the assessment between early 2019 and October 1, 2020. The guidance notes that further information about the needs assessment is forthcoming.[34]

How Jurisdictions Demonstrate Improvement

The MIECHV law 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").[35] These six benchmark areas are desired outcomes for participants; for each of those outcomes, a state or

[31] HHS, HRSA and ACF, *Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program*, August 19, 2010. (Hereinafter, 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*.)

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

[33] 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.

[34] HHS, HRSA, *Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program – Formula, Notice of Funding Opportunity FY 2018*, pp. 55-57.

[35] 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. 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).*

jurisdiction operating a MIECHV program must establish a baseline to begin measuring performance (see **Table 3**). Jurisdictions were required to demonstrate improvements against these baselines within three years of the law's enactment.[36] In addition, BBA 2018 directs jurisdictions to demonstrate improvements by the end of FY2020 (September 30, 2020) and every three years thereafter.[37]

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. Under this prior system, 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, the revised data collection efforts are intended to make it easier for data to be aggregated nationally.[38]

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	(9) Visits for children to emergency department; (10) visits for mother to emergency department; (11) information/training on prevention of child injuries; (12) child injuries; (13) reported suspected maltreatment; (14) reported substantiated maltreatment; and (15) first-time victims of maltreatment.	(7) Safe sleep; (8) child injury; and (9) child maltreatment.
Improvements in school readiness and child academic achievement	(16) Parent support for child learning and development; (17) parent knowledge of child development; (18) parenting behaviors/parent-child relationship; (19) parent emotional well-being/parenting stress; (20) child communication, language, and emerging literacy; (21) child cognitive skills; (22) child positive approaches to learning; (23) child social behavior/emotional well-being; and (24) child physical health and development.	(10) Parent-child interaction; (11) early language and literacy skills; (12) developmental screening; and (13) behavioral concerns.

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

[37] Section 511(d)(1). HHS is in the process of developing guidance to jurisdictions about submitting benchmark data, and does not have a definitive date for issuing this guidance. CRS correspondence with HHS, HRSA and ACF, in August 2018.

[38] HHS, ACF and HRSA, *The Maternal, Infant, and Early Childhood Home Visiting Program, Form 2 Performance Indicators and Systems Outcomes Toolkit*, August 2016 and updated in November 2017.

Benchmark Areas (Outcomes)	37 Constructs (Used in Original Accountability System FY2010-FY2016)	19 Constructs (Used for Revised Accountability System as of FY2017)
Reduction in crime or domestic violence	(25) Screening for domestic violence; (26) referrals for domestic violence services; (27) domestic violence-safety plans; (28) arrests; and (29) convictions.	(14) Intimate partner violence screening.
Improvements in family economic self-sufficiency	(30) Income and benefits; (31) employment or education; and (32) health insurance status.	(15) Primary caregiver education; and (16) continuity of insurance coverage.
Improvements in the coordination and referrals for other community resources and supports	(33) Identification for necessary services; (34) referrals for necessary services; (35) receipt for necessary services; (36) number of memorandums of understanding (MOU) with community agencies; and (37) information sharing.	(17) Intimate partner violence referrals; (18) completed developmental referrals; and (19) 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; HHS, ACF and HRSA, *The Maternal, Infant, and Early Childhood Home Visiting Program, Performance Measurement Toolkit*, May 2016; and HHS, ACF and HRSA, *The Maternal, Infant, and Early Childhood Home Visiting Program, Form 2 Performance Indicators and Systems Outcomes Toolkit,* August 2016 and updated in November 2017.

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.

This data collection effort is focused on grantee performance over time rather than on the impacts of the program.[39] As discussed in a subsequent section, HHS is assessing the effects of MIECHV programs through a separate evaluation effort.

Demonstrating Improvements After Three Years

The law required jurisdictions to show that they were making improvements in at least four of six benchmark areas three years after the law was implemented. The law also separately required jurisdictions to submit a report to HHS no later than December 31, 2015, about whether improvements were made in each of the benchmark areas. [40]

By October 30, 2014, all states and territories operating a MIECHV program submitted reports to demonstrate their performance against the benchmarks for the first three years of the program.

[39] 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.

[40] Section 511(d)(1)(B)(i) and Section 511(d)(1)(C). The law also directs jurisdictions submit to HHS, not later than 30 days after the end of the third year in which the jurisdictions operate their home visiting programs, a report demonstrating improvement in at least four of the benchmark areas. See Section 511(d)(1)(B(i). The law does not direct reporting after the fifth year. In addition, the law separately required a report to Congress by December 15, 2015, that included information about the extent to which jurisdictions had demonstrated improvements in each of the benchmark areas. HHS submitted two reports to Congress that included information that was available at the time, which included results after the first three years of the program.

The tribal entities that were awarded funding under the first cohort of the tribal grants were required to submit their reports by December 31, 2014, and they did so. The three nonprofit organizations that operate programs in Florida, North Dakota, and Wyoming and were awarded funding after September 2011 were required to submit reports on the three-year benchmarks by October 30, 2016, and they did so.[41]

Report to Congress on Benchmark Areas

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 determined appropriate. A report on tribal grantees was submitted to Congress in November 2015 and a report on state grantees was submitted in March 2016.

Source: Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*, HHS, ACF, OPRE, OPRE Report 2015-88, 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.

If a jurisdiction fails to demonstrate improvements in at least half of the constructs in four of the benchmark (outcome) areas, it has to develop and implement a plan to make improvements in each of the applicable areas, subject to approval by HHS. HHS provides technical assistance to the grantee in developing and implementing the plan. As directed by statute, HHS convened an advisory panel made up of staff from HHS and the Department of Education to make recommendations about this technical assistance.[42] 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.[43] To date, one grantee (from the first cohort of tribal grantees) was not awarded funds due to performance and compliance concerns. No jurisdictions are currently on improvement plans.[44]

Demonstrating Continuous Improvements

Jurisdictions must continue to track improvements in the benchmark areas. They must report to HHS about the benchmarks at least 30 days after the end of FY2020 and every three years thereafter. They must demonstrate that their program results in improvements for eligible families in at least four of the benchmark areas that *are applicable to the home visiting models used by the jurisdiction*. (Some models may not focus their activities on each of the benchmark areas.) This is distinct from the reporting on the benchmark areas for the initial three years, which did not specifically reference the benchmark areas that are applicable to the models. Further, jurisdictions must demonstrate improvements in the benchmark areas based on comparing enrolled families to families that did not receive services under a home visiting program. This varies from the initial

[41] CRS correspondence with HHS, HRSA and ACF, in August 2018.

[42] 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*.) See also, Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*, HHS, ACF, OPRE, OPRE Report 2015-88, November 2015 (hereinafter, Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress*.)

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

[44] CRS correspondence with HHS, HRSA and ACF, in August 2018.

reporting on benchmark data, which was based on improvements over time among enrolled families only.

As with the benchmark reporting requirement for the initial three years of the program, jurisdictions that do not show improvement within each subsequent three-year period must develop and implement a plan to improve outcomes that are subject to approval by the HHS Secretary. The improvement plan must include the same provisions that had been required as part of the initial reporting on benchmark data. HHS must continue providing technical assistance to the eligible entity in developing and implementing the improvement plan (but the law does not address the ongoing role of the advisory panel). HHS may opt to terminate the jurisdiction's grant if improvements are not made after a period specified by HHS, and provide remaining funds to nonprofit organizations to operate the home visiting program in that jurisdiction.

Additional Requirements

The law also specifies other requirements for jurisdictions carrying out MIECHV programs. 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.[45]

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.[46]

Jurisdictions may use MIECHV funding to supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.[47] 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.

[45] Section 511(d)(2). Other requirements are outlined at Section 511(e) related to grant applications submitted to HHS.

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

[47] Section 511(f).

Home Visiting Models

Jurisdictions must use at least 75% of their total funding (regardless of whether they are formula or competitive 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;
- 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).[48] 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 outcome domain.[49]

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.

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[48] Section 511(d)(3)(iii). HHS, HRSA and ACF, "Maternal, Infant, and Early Childhood Home Visiting Program," 75 *Federal Register*, July 23, 2010. HHS 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.

[49] 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).

Jurisdictions 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 led by the jurisdiction.[50] HHS has further explained that a promising approach is one that meets the standards 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.[51]

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 five.[52]

HomVEE prioritizes the home visiting models for further study based on a point system. Points are assigned to models based on the number and design of their impact studies (with three points for each randomized control trial (RCT) and two points for each quasi-experimental designed study) and their sample size of their 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.[53]

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

As of June 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.[54] The HomVEE project also reviewed home visiting models to examine specific

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

[51] 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*.

[52] This review involves searching research databases of studies published since 1979, and a more focused search on prioritized program models published since 1989. The search is updated on an annual basis (approximately) to identify new literature.

[53] 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 and (2) whether the impacts were measured at least one year after program services ended, among other features.

[54] Emily Sama-Miller et al., *Home Visiting Evidence of Effectiveness Review: Executive Summary*, HHS, ACF, OPRE,

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.[55]

Selected Characteristics of the Models

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. Some key characteristics of the models are as follows:

- 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 nonprofit and community-based organizations; hospitals, health clinics, or physicians; 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.

Further, each model requires preplacement training on the model, and the majority of the models (14 models) require ongoing training, as opposed to having voluntary ongoing training (4 models).[56] 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.[57] See **Table**

OPRE Report 2017-58, August 2017; and HHS, ACF, "Home Visiting Evidence of Effectiveness (HomVEE), Models," at http://homvee.acf.hhs.gov/programs.aspx. Two additional models meet the criteria but are not implemented: Oklahoma's Community-Based Family Resource and Support Program (per HHS, "implementation support is not currently available for the model as reviewed") and Healthy Steps (per HHS, "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)."

[55] Andrea Mraz Esposito et al., *Assessing the Research on Home Visiting Models Implemented in Tribal Communities, Part 1: Evidence of Effectiveness*, HHS, ACF, OPRE, OPRE Report 2017-60a, updated August 2017. This report, along with a companion report, discusses considerations for developing and replicating home visiting programs for tribal communities. See also, Andrea Mraz Esposito et al., *Assessing the Research on Home Visiting Models Implemented in Tribal Communities, Part 2: Lessons Learned about Implementation and Evaluation*, HHS, ACF, OPRE, OPRE Report 2017-60b, updated August 2017.

[56] Section 511(d)(3)(B)(ii) 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.

[57] 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.

D-1 and **Table D-2** for further detail on the characteristics of the 18 models designated as effective.

Use of Models

Table 4 summarizes information on the number of jurisdictions implementing each evidence-based model in FY2017. In addition, three jurisdictions (Arkansas, Kansas, and Tennessee) used a portion of their funds to implement a home visiting model in FY2017 that was promising, but not yet determined to be effective.[58] Specifically, these states used 25% or less of their FY2017 formula grant allocation for this purpose.

Table 4. Evidence-Based Models Used by States/Territories with Funding Under the MIECHV Program in FY2017

There were 18 possible models, of which 10 were implemented

Evidence-Based Model	Number of States/Territories Using Model
Nurse-Family Partnership (NFP)	38
Healthy Families America (HFA)	37
Parents as Teachers (PAT)	35
Early Head Start-Home Visiting (EHS-HV)	15
Home Instruction for Parents of Preschool Youngsters (HIPPY)	5
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, August 2018. 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 includes the home visiting model(s) adopted as of FY2017 by each state or territory, as well as three states (Florida, North Dakota, and Wyoming) in which a nonprofit administers the MIECHV program.

Option to Fund Home Visiting Services on a Pay-for-Outcome Basis

The most recent law to reauthorize the MIECHV program, BBA 2018, added new language to enable a jurisdiction to use up to 25% of its MIECHV grants for a "pay-for-outcome" (sometimes referred to in policy literature as "pay-for-success") initiative that satisfies the requirements for providing evidence-based home visiting services. Funding for pay-for-outcomes initiatives may be expended by the eligible entity for up to 10 years after the funds are made available.

"Pay-for-outcome" initiative is defined as a performance-based grant, contract, or cooperative agreement awarded by a jurisdiction in which a commitment is made to pay for improved

[58] CRS correspondence with HHS, HRSA and ACF, in August 2018.

outcomes that result in social benefit and direct cost savings or cost avoidance to the public sector. Such an initiative is to include

- a feasibility study that describes how the proposed intervention is based on evidence of effectiveness;
- a rigorous third-party evaluation that uses experimental or quasi-experimental design, or other research methodologies, that allow for the strongest possible causal inferences to determine whether the initiative has met its proposed outcomes;
- an annual, publicly available report on the progress of the initiative; and
- a requirement that payments are made to the recipient of a grant, contract, or cooperative agreement only when agreed-upon outcomes are achieved, except that this requirement does not apply to payments for the third-party evaluation.

HHS has provided some preliminary guidance to states advising that FY2018 formula funds are not to be used for pay-for-outcome initiatives; however, jurisdictions that plan to use future funding for this purpose must submit a letter of intent with a description of any past or current activities that would support pay-for-outcome initiatives, such as a feasibility study, third party evaluation, and outcome payments. This preliminary guidance noted that further guidance is forthcoming.[59]

Technical Assistance

The law directs the HHS Secretary to provide technical assistance (TA) to grantees, specifically with regard to administering programs or activities that are funded by the MIECHV program.[60] 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.[61] Jurisdictions receive TA from federal staff, developers of home visiting models, and TA providers contracted with HHS.[62] Multiple HHS-contracted providers assist grantees.

HRSA provides assistance to grantees through the MIECHV Home Visiting-Improvement Action Center (HV-ImpACT), which is operated under a contract with the Education Development Center, a national nonprofit organization that provides support to states and territories in implementing and improving their programs. HV-ImpACT provides training and technical assistance that focuses on administering high-quality programs, strengthening coordination of early childhood systems, and improving program outcomes.[63] ACF provides similar types of technical assistance to Tribal MIECHV grantees via Programmatic Assistance for Tribal Home Visiting (PATH), operated by Zero to Three, a national nonprofit organization.[64]

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[59] HHS, HRSA, *Maternal, Infant and Early Childhood Home Visiting Program–Formula, Notice of Funding Opportunity FY 2018*, p. 12 and p. 22.

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

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

[62] 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*, pp. 51-56.

[63] HHS, HRSA, "Home Visiting Program – Technical Assistance," https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-technical-assistance.

[64] HHS, ACF, Office of Early Childhood Development, "Tribal Home Visiting Technical Assistance Providers,"

ACF also provides assistance to grantees through the Design Options for Maternal, Infant, and Early Childhood Home Visiting Evaluation (DOHVE) Technical Assistance Team. James Bell Associates operates the DOHVE Technical Assistance Team. DOHVE provides technical assistance to jurisdictions on their research and evaluation efforts. For example, they assist jurisdictions with developing meaningful plans to evaluate home visiting programs and disseminate findings, building capacity to analyze returns on investments in home visiting, integrating home visiting data into other early childhood data systems, and coordinating state and tribal home visiting efforts.[65] Tribal entities receive technical assistance on these same topics via the Tribal Evaluation Institute (TEI). James Bell Associates operates TEI.[66]

Under a contract with the Education Development Center, HRSA funds the Quality Measures Center for Program Assessment and Technical Assistance. This center delivers TA to assist jurisdictions in collecting high-quality and accurate performance data for federal reporting purposes and using data to improve their home visiting practices.[67]

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.[68] In practice, these activities include developing studies of home visiting models and sharing research and best practices. 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.

National Evaluation of MIECHV: MIHOPE

The HHS Secretary was required to 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. HHS appointed the panel in 2013. As specified in the law, the evaluation must include an

- analysis of the results of the statewide needs assessments and state actions in response to the assessments;
- 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);

https://www.acf.hhs.gov/ecd/home-visiting/tribal-home-visiting/technical-assistance

[65] HHS, ACF, OPRE, "Design Options for Home Visiting 2, 2016-2021," https://www.acf.hhs.gov/opre/research/project/design-options-for-home-visiting-2 and James Bell Associates, "Design Options for Home Visiting Evaluation: Project Overview," https://www.jbassoc.com/project/design-options-home-visiting-evaluation-dohve/.

[66] HHS, ACF, OPRE, "Tribal Evaluation Institute, 2010-2016 & 2015-2018, Project Overview," https://www.acf.hhs.gov/opre/research/project/tribal-home-visiting-evaluation-institute-2011-2015; and Tribal Evaluation Institute, "About TEI, What We Do," http://www.tribaleval.org/what-we-do/.

[67] Education Development Center, "Quality Measures Center for Program Assessment and Technical Assistance," https://www.edc.org/quality-measures%E2%84%A2-center-program-assessment-and-technical-assistance.

[68] Section 511(h(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
- 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.[69]

The evaluation, known as the Mother and Infant Home Visiting Program Evaluation (MIHOPE), is examining programs that use the four most common evidence-based home visiting models: Early Head Start-Home Visiting (EHS), Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). [70] The MIHOPE study includes 4,229 families in 88 local home visiting programs across 12 states who were randomly assigned to receive home visiting services or to a control group that was referred to non-home visiting services available in the community.[71] The evaluation is generally 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, the social policy research organization, is conducting the evaluation, along with partner organizations.

MIHOPE researchers collected information from families when the mother was pregnant or the child was no more than six months, and again when the child was 15 months old and between the ages of 2 ½ and 3 ½ years.[72] HHS published a report on the implementation study, and additional reports are forthcoming.[73]

[69] Section 511(g).

[70] HHS, ACF and HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Plans for the 2015 Report to Congress*, September 12, 2013 (hereinafter, HHS, ACF and HRSA, *Maternal, Infant, and Early Childhood Home Visiting Program Evaluation: Plans for the 2015 Report to Congress*); and 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*, HHS, ACF, OPRE, OPRE Report 2015-11, January 2015 (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*).

[71] Females were at least 15 years old and were either pregnant or had a child no more than six months old when they entered the study. Charles Michalopoulos et al., *Evidence on the Long-Term Effects of Home Visiting Programs: Laying the Groundwork for Long-Term Follow-Up in the Mother and Infant Home Visiting Program Evaluation (MIHOPE)*, HHS, ACF, OPRE, OPRE Report 2017-73, September 2017 (hereinafter, Charles Michalopoulos et al., *Evidence on the Long-Term Effects of Home Visiting Programs: Laying the Groundwork for Long-Term Follow-Up in the Mother and Infant Home Visiting Program Evaluation (MIHOPE)*).

[72] Charles Michalopoulos et al., *Evidence on the Long-Term Effects of Home Visiting Programs: Laying the Groundwork for Long-Term Follow-Up in the Mother and Infant Home Visiting Program Evaluation (MIHOPE).* This brief synthesizes findings from past studies on the four home visiting models that are involved in the MIHOPE evaluation. The findings focus on the along-term outcomes (for families with children up to the age of 21) who participated in the models' programs, as well as on the cost-benefit analyses of the four models. Generally, these studies have found positive effects in many of the outcome areas that are the focus of the MIHOPE study. The studies have positive findings with regard to cost-effectiveness.

[73] HHS, ACF, "MIHOPE, Mother and Infant Home Visiting Program Evaluation Continues," March 2018.

Report to Congress on the National Evaluation

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 presented initial findings.

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 reported using MIECHV funds to expand at least two of the four evidence-based models in five or more eligible local programs. The study was continuing to recruit families when the report was published, and therefore it discussed characteristics of about one-third of families who eventually enrolled.

Nearly 70% of the mothers in the study were pregnant at the time they enrolled, with an average age of 23. Women in the study exhibited healthy behaviors 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, home visitors reported that they were generally well-trained and -supported in working with families.

Source: 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.

The implementation study reported that families participated in the home visiting program for an average of eight months in the year following their first visit, and about half of all families were participating at the time of the child's first birthday.[74] Families with more challenges and barriers participated in home visiting programs for shorter periods compared with average families in the study. Families in programs implementing EHS or NFP stayed in the program longer. About half of all families received at least one referral for public assistance or health insurance, including public health insurance programs. On average, families and home visitors discussed five topics in each visit; the most common topics discussed were mental health, positive parenting behavior, child preventative care, child development, and economic self-sufficiency. Home visitors described their role as providing consistent and stable support to empower mothers in their role as their child's first teacher. Some home visitors reported that they had challenges identifying and addressing a mother's poor mental health, substance abuse, and intimate partner violence.

In 2016, HHS awarded a separate contract to MDRC to design a follow-up study of MIHOPE participants. This evaluation is known as MIHOPE-LT (long term), and is designed to track outcomes of families in the study when their children are in kindergarten, third grade, early adolescence, and late adolescence. The evaluation is to include a cost-benefit analysis to examine whether benefits to families outweigh the costs of the four home visiting models.

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,

[74] Anne Duggan et al., *Implementation of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation*, HHS, ACF, OPRE, OPRE Report 2018-76A, October 2018.

delivery, and over the course of the child's first year of life. One of those interventions is home visiting.[75]

The MIHOPE-Strong Start evaluation seeks to determine whether home visiting services can impact health outcomes for disadvantaged pregnant women. The evaluation enrolled approximately 3,000 families from Healthy Families America and Nurse-Family Partnership sites in 66 local home visiting programs in 17 states. Families were randomly assigned to a home visiting group or to a non-home visiting control group. Participants include pregnant women who have Medicaid or CHIP (Children's Health Insurance Program) and are interested in and eligible for home visiting services, along with their children. The evaluation includes an implementation study and an impact analysis of the outcomes in three areas: (1) birth outcomes, (2) maternal prenatal health and health care use, and (3) infant health and health care use. The evaluation is also intended to provide information relevant to CMS 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.[76]

HHS has published a report that provides an overview of how the 17 states involved in the MIHOPE evaluation are working to promote prenatal and positive birth outcomes. The report discusses the major stakeholders and partners involved in supporting these outcomes, through such efforts as providing funding, administering and expanding programs, supporting system-building efforts, linking services to families, and conducting training and professional development. The report also identified that the states use multiple sources to fund home visiting and other resources to support positive prenatal and birth outcomes.[77] Additional reports for MIHOPE-Strong Start are forthcoming.

Grantee-Led Evaluations

As noted, jurisdictions conduct evaluations of home visiting programs if they are implementing promising models. They also have the option to conduct evaluations of models that HHS has determined to be evidence-based, particularly for enhancements to these models. Plans for these evaluations must first be approved by HHS. Between 2011 and 2015, 48 jurisdictions developed grantee-led evaluations for promising approaches and evidence-based models. 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 to develop the home visiting workforce; (3) how to collaborate with community partners and coordinate services; (4)

[75] HHS, Centers for Medicare and Medicaid, *Strong Start for Mothers and Newborns Initiative; Enhanced Prenatal Care Models.*

[76] MDRC is conducting the evaluation along with partner organizations. HHS has issued annual reports for each year of the study, as follows: Jill H. Filene et al., *The Mother and Infant Home Visiting Program Evaluation-Strong Start: First Annual Report*; 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*, 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*, HHS, ACF, OPRE, 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*, HHS, ACF, OPRE, OPRE Report 2015-63, June 2015.

[77] Mariel Sparr et al., *Promoting Prenatal Health and Positive Birth Outcomes: A Snapshot of State Efforts*, HHS, ACF, OPRE, OPRE Report 2017-65, December 2017.

how programs are enhancing home visiting; and (5) the effectiveness of promising approaches in home visiting.[78]

Other Research and Evaluation Activities

HHS supports efforts to learn more about selected aspects of home visiting, such as mapping the career trajectories of home visitors and investigating how home visiting programs can support families in substance abuse prevention, treatment, and recovery.[79] In addition, HRSA and ACF support collaborative efforts that focus on certain research topics:

- HRSA contracts with Johns Hopkins University to operate the Home Visiting Applied Research Collaborative (HARC). The center provides funding to researchers to strengthen home visiting practices. It also partners with other academic institutions, research firms, and home visiting experts to design and build HARC's research agenda.[80]
- HRSA provides funding to the Education Development Center to operate the Home Visiting Collaborative Improvement and Innovation Network (HV-CoIIN 2.0). This network convenes teams from states and local home visiting agencies to focus on improving home visiting interventions that were found to be effective in the earlier collaborative network known as HV-CoIIN 1.0. These issues include screenings for maternal depression, access to treatment, reducing symptoms, early detection, and linkages to services for children at developmental risk. HV-CoIIN 2.0 will also build capacity to improve in other areas, such as screening and referrals for intimate partner violence.[81]
- ACF provides MIECHV funding to the Tribal Early Childhood Research Center (TRC). The center 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 early childhood development and early childhood programs for American Indian and Alaska Native children and families. The TRC is located at the University of Colorado Denver's School of Public Health.[82]

Recent Congressional and Executive Branch Action

Since 2014, Congress has held oversight hearings on the MIECHV program and considered legislation to extend funding for and reauthorize it. The program was reauthorized through FY2022 under the Bipartisan Budget Act of 2018 in February 2018.

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[78] Susan Zaid and Lance Till, *Overview of Grantee-Led Evaluations: The Maternal, Infant, and Early Childhood Home Visiting Program*, HHS, ACF, OPRE, OPRE Report 2016-78, October 2016; and Susan Zaid, *Profiles of Grantee-Led Evaluations-The Maternal, Infant, and Early Childhood Home Visiting Program: Fiscal Years 2011-2015*, HHS, ACF, OPRE, OPRE Report 2016-79, October 2016.

[79] For further information about these other efforts, see National Home Visiting Resource Center, *Home Visiting Research and Evaluation Supported by the Maternal, Infant, and Early Childhood Home Visiting Program*, May 2018.

[80] Home Visiting Applied Research Collaborative, "What We Do," https://www.hvresearch.org/about/.

[81] CRS correspondence with HHS, HRSA and ACF, in August 2018.

[82] HHS, ACF, "Tribal Early Childhood Research Center (TRC), 2016-2020; and University of Colorado, Colorado School of Public Health, Centers for American Indian and Alaska Native Health, "Tribal Early Childhood Research Center."

- 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.[83] 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, President Obama 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 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 visiting program, and two researchers.[84] 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.[85] Witnesses generally discussed the benefits of home visiting.

As mentioned, the Protecting Access to Medicare Act of 2014 (P.L. 113-93) was signed into law on April 1, 2014, and 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).[86] P.L. 114-10 also provided $400 million for each of FY2016 and FY2017 under the program.

On June 8, 2017, the Increasing Opportunity through Evidence-Based Home Visiting Act (H.R. 2824) was introduced and referred to the House Ways and Means Committee and the House Energy and Commerce Committee. The bill sought to reauthorize, and make substantive changes to, the MIECHV program. At a September 13, 2017, markup, the Ways and Means Committee considered amendments to H.R. 2824. The committee reported the bill, as amended.[87] On

[83] 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).

[84] 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).

[85] 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.

[86] 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.

[87] See, U.S. Congress, House Committee on Ways and Means, *Markup of Legislation to Improve Medicare Programs and Policies, Expand Evidence-Based Welfare Solutions*, 115th Cong., 1st sess., September 13, 2017. For the text of H.R. 2824 as ordered to be reported amended, see House Committee Rules Print 115-33; and U.S. Congress, House Committee on Ways and Means, *W&M Passed: Legislation to Extend Evidence-Based Solutions that Help Low-Income*

September 26, 2017, the House passed H.R. 2824 with additional amendments. On September 19, 2017, the Strong Families Act of 2017 (S. 1829) was introduced, and included several of the same provisions in H.R. 2824. The Bipartisan Budget Act of 2018 (H.R. 1892), enacted on February 9, 2018 as P.L. 115-123, incorporated all of S. 1829 and a provision in H.R. 2824 that directs HHS to use the most accurate relative federal population and poverty data if HHS awards funds based on these factors.[88]

Families, 115th Cong., 1st sess., September 14, 2017.

[88] For further information, see CRS Report R45136, *Bipartisan Budget Act of 2018 (P.L. 115-123): CHIP, Public Health, Home Visiting, and Medicaid Provisions in Division E*.

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. Some home visiting proposals reflected government-wide efforts beginning in the George W. Bush Administration and extending into the Obama Administration to expand social programs that work and eliminate those that do not.[89]

Education Begins At Home Act

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.[90] One of these similar 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.[91] 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."[92] 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.

Home Visiting and Domestic Violence Program

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

[89] Ron Haskins and Greg Margolis, *Show Me the Evidence: Obama's Fight for Rigor and Results in Social Policy*, Brookings Institution Press, Washington, DC, 2014.

[90] 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.

[91] 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).

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

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.

Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment

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 or expansion of such models.[93] 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.[94]

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.[95]

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

[94] 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.

[95] Kimberly Boller et al., *Making Replication Work: Building Infrastructure to Implement, Scale-up, and Sustain Evidence-Based Early Childhood Home Visiting Programs with Fidelity*, HHS, ACF, Children's Bureau, January 2014. (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*.)

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 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 reach an estimated 450,000 new families at a cost of $1.8 billion over a 10-year period.[96]

Home Visiting as Part of Health Care Reform

At the same time that Congress was considering whether to fund the Obama Administration's initiative,[97] 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.[98]

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.[99]

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

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

[97] 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.

[98] 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).

[99] 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.

to sustain services beyond the EBHV funding period or to expand services. However, some grantees were using models that did not meet HHS criteria under the MIECHV program for being effective and therefore were ineligible for funding.[100]

[100] 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 Formula Funding by State and Territory

Table B-1. MIECHV Formula Funding by State and Territory, FY2017-FY2018

State/Territory	FY2017 Award Amount	FY2018 Award Amount
Alabama	$6,593,481	$6,928,995
Alaska	$1,703,815	$1,952,247
Arizona	$10,846,596	$11,410,696
Arkansas	$7,107,244	$7,784,751
California	$22,024,005	$21,384,282
Colorado	$7,773,398	$8,143,045
Connecticut	$9,028,358	$9,765,192
Delaware	$3,635,840	$4,005,571
District of Columbia	$1,629,009	$1,878,267
Florida	$10,850,099	$10,236,342
Georgia	$7,478,707	$7,559,892
Hawaii	$3,510,137	$3,878,058
Idaho	$2,935,942	$3,254,217
Illinois	$8,618,833	$8,744,850
Indiana	$10,434,596	$10,911,705
Iowa	$5,640,587	$6,096,921
Kansas	$4,795,514	$5,119,126
Kentucky	$7,019,433	$7,548,849
Louisiana	$9,339,739	$10,304,719
Maine	$5,944,280	$6,458,030
Maryland	$7,450,938	$7,925,829
Massachusetts	$6,801,586	$7,212,800
Michigan	$7,907,266	$7,799,696
Minnesota	$8,582,548	$9,243,786
Mississippi	$3,053,417	$3,024,410
Missouri	$3,956,703	$3,906,090
Montana	$4,281,362	$4,680,084
Nebraska	$1,264,086	$1,509,215
Nevada	$1,870,244	$2,174,954
New Hampshire	$2,958,820	$3,294,207
New Jersey	$10,496,911	$10,969,325
New Mexico	$3,542,370	$3,742,370

State/Territory	FY2017 Award Amount	FY2018 Award Amount
New York	$9,160,198	$9,212,347
North Carolina	$3,262,788	$3,590,686
North Dakota	$1,068,291	$1,207,045
Ohio	$7,492,473	$7,547,944
Oklahoma	$6,326,830	$7,001,342
Oregon	$8,386,641	$8,793,254
Pennsylvania	$11,704,276	$12,282,659
Rhode Island	$7,124,318	$7,718,082
South Carolina	$8,321,216	$8,495,768
South Dakota	$1,010,338	$1,210,687
Tennessee	$9,855,815	$10,366,741
Texas	$17,095,280	$18,577,426
Utah	$3,147,317	$3,423,566
Vermont	$1,360,253	$1,587,515
Virginia	$7,587,164	$7,860,627
Washington	$10,002,922	$10,463,215
West Virginia	$5,762,816	$6,231,476
Wisconsin	$8,584,677	$9,076,894
Wyoming	$1,630,522	$1,708,233
American Samoa[a]	$1	$1,200,000
Guam	$992,000	$1,200,000
Northern Mariana Islands	$992,000	$1,200,000
Puerto Rico	$992,000	$1,266,400
U.S. Virgin Islands	$1,392,000	$1,200,000
Total	$342,328,000	$361,270,428

Source: Congressional Research Service (CRS) based on data provided by HHS, HRSA, October 2016, February 2017, and November 2018.

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. The formula awards include formula funds that are allocated to states; territories; and three nonprofit organizations that operate home visiting programs in three states (Florida, North Dakota, and Wyoming) that have declined formula funding. FY2017 funding includes $330.5 million from FY2017 appropriations and $11.8 million in carryover funding from prior years, for a total of $342.3 million.

a. According to HHS, American Samoa received $1 in FY2017 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 it would continue to be eligible for FY2018 formula funds. Based on CRS correspondence with HHS, HRSA in November 2018.

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. A report on tribal grantees was submitted in November 2015.[b]
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]
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 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. These findings were incorporated into a brief published in 2018.[c]
September 30, 2020	This is the last day that jurisdictions can expend funds appropriated for FY2018.

Source: Section 511 of the Social Security Act and CRS correspondence with HHS, HRSA in 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. According to HHS, final reports on MIHOPE will be available in 2018. See, HHS, ACF, "MIHOPE, Mother and Infant Home Visiting Program Evaluation Continues," March 2018.

b. Kate Lyon et al., *Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress,* HHS, ACF, OPRE, 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.

c. HHS, HRSA and ACF, *The Maternal, Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed,* 2018.

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[a]							
	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	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[a]							
	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	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.[b]	X			30 case load points[c]		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[a]							
	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	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)[d]	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 is 6 months old.	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[a]							
	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	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[a]							
	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	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.[e]	X	X		60 visits per month[f]			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,* at 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," HHS, ACF, Office of Policy Research and Evaluation (OPRE), OPRE Report 2017-58, August 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. 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. The spaces left blank indicate that a study or studies of a model did not measure the outcome domain or had an unfavorable effect in the category.

b. 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.

c. 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.

d. 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.

e. 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.

f. 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 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			
Healthy Families America (HFA)					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 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)
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,* at 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 2017-58, August 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, at 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 FY2017

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			X				
Arkansas	X	X	X		X					
California	X	X								
Colorado	X		X		X					
Connecticut	X		X	X				X		
Delaware	X	X	X	X						
District of Columbia		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						
Kansas		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
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								
Oklahoma	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
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		X					
Utah			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								
Northern Mariana Islands		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
Puerto Rico		X								
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, August 2018.

Note: Three jurisdictions (Arkansas, Kansas, and West Virginia) are using a portion of their funds to implement a home visiting model in FY2017 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.," at https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-state-fact-sheets.

Author Information

Adrienne L. Fernandes-Alcantara
Specialist in Social Policy

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