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Maternal, Infant, and Early Childhood Home Visiting Program

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is the primary federal program that focuses exclusively on home visiting. The program seeks to strengthen and improve home visiting services to families residing in at-risk communities, while also improving coordination of supportive services in these communities. Home visits are made by social workers and other professionals to the homes of families with young children, who participate on a voluntary basis. Visitors provide services such as parenting education, developmental screenings, and referrals to community supports.

Overview

The MIECHV program is jointly administered by the U.S. Department of Health and Human Services' (HHS) Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF). The Patient Protection and Affordable Care Act (ACA; P.L. 111-148) established MIECHV under Section 511 of the Social Security Act and appropriated mandatory funding for the program from FY2011 through FY2014. Authorization of the program has been extended multiple times, most recently by the Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123) from FY2018 through FY2022.

Grantees

MIECHV provides funding directly to the 50 states, District of Columbia, the territories, and tribal entities. Generally, the state's/territory's public health department or social service department is the lead agency that administers the funds. Under the law, HHS may make grants to nonprofit organizations to carry out a home visiting program in a state that did not apply, or receive approval, for a grant as of FY2012. Nonprofit organizations operate MIECHV-funded home visiting programs in three states (FL, ND, and WY). As of FY2017, the program provided funding to 29 tribes.

Requirements

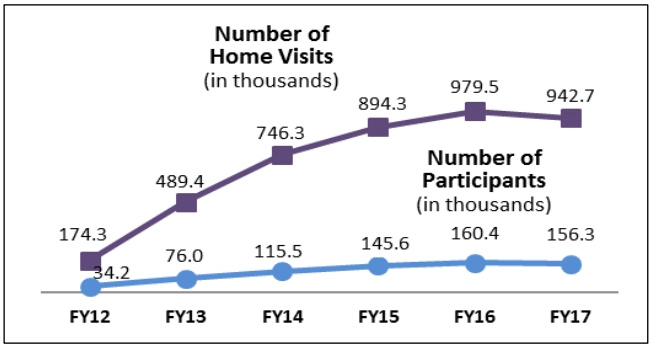
The law specifies a variety of requirements for grantees (or jurisdictions) receiving MIECHV funds. These jurisdictions were required to conduct a needs assessment by September 20, 2010, to identify communities with concentrations of poor infant and maternal health and mortality, poverty, and other risk factors. They had to submit the results of the assessments to HHS and explain how they intended to address the identified needs. BBA 2018 directs jurisdictions to update this assessment by September 30, 2020.

Jurisdictions must also submit an application for funding to HHS that includes several items, such as how they will serve high-risk populations as identified by the jurisdiction. Jurisdictions must also meet other requirements, such as using MIECHV funding to supplement, and not supplant, other federal funding for home visiting services.

Participants

Under the program, jurisdictions provide home visiting services to eligible families who participate voluntarily. An eligible family includes (1) a pregnant woman and father-to-be, if available; (2) a parent or primary caregiver of a child; or (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. Jurisdictions must prioritize eligible families who have certain risk factors, such as low-income families and families with a history of child abuse and neglect. As shown in **Figure 1**, the number of participants (i.e., parents, other caregivers, and children) served and the number of home visits provided more than quadrupled from FY2012 to FY2017.

Figure 1. MIECHV Participants and Home Visits, FY2012-FY2017



Source: HHS, HRSA, *FY2019 Congressional Budget Justifications.*

Funding

The statute provided for mandatory funding, which has increased from an initial $100 million in FY2010 to $400 million annually in each of FY2013 through FY2022. Funds were subject to sequestration in FY2013, FY2014, and FY2017. HHS must reserve 3% of the annual appropriation for tribal entities, and another 3% for technical assistance, research, and evaluation. MIECHV funding may be expended by the grant recipient through the end of the second succeeding fiscal year after the award. The law does not specify how the funds are to be awarded.

In practice, HHS distributes MIECHV funds by both formula and competitive grants to states and territories. The formula grants have made up between 29% and 86% of obligated funds in each year from FY2010-FY2017 (86% in FY2017). Funding under the formula grants has been distributed based in part on the relative share of children under age five in families at or below the federal poverty line in each state (including Puerto Rico, effective as of FY2018); however, uniform poverty data are generally not available for the territories, which each receive $1 million annually. Tribal entities separately receive competitive program funding.

Home Visiting Models

Jurisdictions may use no less than 75% of MIECHV funding to implement a home visiting model that has shown sufficient evidence of effectiveness based on criteria established by HHS. The remaining 25% of funds may be used to implement models that have promise of effectiveness (grantees must rigorously evaluate such models). 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 meet the criteria. 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, states and territories implemented 10 of the 18 models (**Table 1**).

Table 1. Home Visiting Models Used, FY2017

Model Determined by HHS to Be Evidence-Based	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, August 2018.

Benchmarks

The MIECHV statute requires grantees to demonstrate improvements among eligible families in what the law refers to as six "benchmark areas." These six benchmark areas are desired outcomes for participants and relate to health, child abuse, crime and safety, economic self-sufficiency, academic readiness, and community referrals. These outcome domains are similar, but not identical, to the outcome categories used in the HomVEE review. The law requires jurisdictions to show that they are making improvements in at least four out of six benchmark areas three years after the law is implemented. As of FY2017, HHS uses 19 items to measure the performance of each jurisdiction. 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.

Research and Evaluation

The MIECHV law requires HHS to conduct an evaluation of the home visiting program. With input from an HHS-appointed advisory panel, ACF (in partnership with HRSA) is conducting an evaluation of the program known as the Mother and Infant Home Visiting Program Evaluation (MIHOPE). The evaluation is examining how home visiting services are provided to more than 4,000 families across 12 states who are randomly assigned to receive services. It is also looking at the effects of the program on family outcomes, and analyzing program costs and cost effectiveness. The 2018 implementation study reported that families participated in the home visiting program for an average of eight months. In general, families and home visitors commonly discussed mental health, positive parenting behavior, child preventative care, child development, and economic self-sufficiency.

In a required report to Congress, HHS provided preliminary information about how states planned to use MIECHV funds to implement the four models (EHS-HV, HFA, NFP, and PAT) studied in MIHOPE. The report showed that states chose communities with high poverty and other risk factors for MIECHV funds. Nearly 70% of enrolled families included a pregnant mother and that the average age of mothers generally was 23, among other findings. HHS anticipates that final reports on the evaluation will be available in late 2018.

Technical Assistance

The law directs HHS to provide technical assistance (TA) to grantees, specifically with regard to home visiting activities, and to support any grantee that is required to implement an improvement plan because it failed to improve in the benchmark areas. Jurisdictions receive TA from federal staff, developers of home visiting models, and TA providers contracted with HHS.

Reauthorization Activity

Following a hearing in March 2017 by the House Ways and Means Subcommittee on Human Resources, the full committee marked up legislation (H.R. 2824) to reauthorize the MIECHV program. A major feature of H.R. 2824 was a proposal that jurisdictions provide matching funds as a condition for receiving MIECHV funding. The House passed H.R. 2824 in September 2017. That same month, a reauthorization bill (S. 1829) was introduced in the Senate. It did not include the matching requirement.

BBA 2018, enacted on February 9, 2018, 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. Under BBA 2018, jurisdictions may also begin using up to 25% of their MIECHV grants for a pay-for-outcomes initiative to support home visiting approaches that result in cost savings.

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