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Maternal, Infant and Early Childhood Home Visiting in New York: *Funding Options and Opportunities*



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This report is one of several published by the Schuyler Center for Analysis and Advocacy (SCAA) to advance thinking in New York around expansion and promotion of maternal, infant and early childhood home visitation programs. This document explores a range of financing options employed in New York and other states, their relevance heightened by the recently unveiled Maternal, Infant and Early Childhood Home Visiting program at the federal level. This report does not include background on maternal, infant and early childhood home visitation in general. For additional background, please see preceding reports by SCAA, available at www.scaany.org.

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Maternal, Infant and Early Childhood Home Visiting in New York: Funding Options and Opportunities

Executive Summary

This report explores how New York and other states finance maternal, infant and early childhood home visiting programs and infrastructure. It looks at ways funding is combined or used to leverage additional money, and what new possibilities might emerge from states and the federal government.

Using this review of home visiting funding and financing, New York policymakers and advocates can explore strategies to blend and braid funding and coordinate and maximize available resources to increase, improve and expand services and build a system. A system of home visiting would involve collaboration across government, agencies and families for the purpose of creating efficiencies, improving access, and strengthening coordinated, community-based services and supports.

The information presented is a snapshot of what is occurring. Comparing states is difficult, since budget years do not align, states do not similarly budget, and federal grant funding is allocated to states at different times. Information sources sometimes span separate fiscal years, creating inconsistency in the reference points used. In addition, the Maternal, Infant and Early Childhood Home Visitation (MIECHV) program authorized under the Affordable Care Act (ACA) is rapidly changing the home visiting dynamic in many states. States are adding and expanding sites, exploring new models and seeking ways to achieve efficiencies through shared services. Research for this paper reveals that myriad funding sources support home visiting systems and services in the states. There is no magic formula.

Every state is different. Drawing conclusions about whether a particular financing approach taken by a state is better than another is challenging, though there are lessons to be learned. Financing mechanisms are adopted for many reasons, including state agency structure and historical funding streams. Some efforts reflect whether a state considers home visiting through a health, child welfare or other lens. Much seems to depend upon which agencies are involved and the degree of leadership from the Executive branch. This review does not reflect on the degree of advocacy and the political and fiscal climates of individual states. Each of these elements shapes how states set their budgeting priorities and affects the level and type of innovation.

State General Funds give states flexibility to pay for the entire array of services in a model, but that source relies on yearly state appropriations that may be insufficient to meet the needs of an entire state. Likewise, funding from federal block grants for child welfare or health may provide some pots of money for projects, but funding cuts in these programs have reduced the size of grant awards. A few states have experimented with Medicaid funding and Medicaid managed care, which show some promise as a stable revenue stream for those enrolled in the program. One drawback is that, as a health program, the full range of services provided by home visiting programs are not typically covered, requiring ancillary sources of revenue to complete the package of services provided by the model.

Bringing different types of funding streams into a particular program is another option being used by states. This method of “blending” and “braiding” funding can allow programs to operate a wide range of services, though it must be applied carefully. This strategy can also be used to build vital infrastructure such as data systems, staff training, and evaluation by combining resources already allocated for those purposes into a larger pool.

Reporting requirements, accountability standards, and outcome measures vary among funding sources and generally must be maintained when funding streams are combined. Political and turf issues may also arise when funding is moved from one agency or program to another. Finessing the bookkeeping, reporting and human aspects of blended and braided funding requires states to establish mechanisms that allow for sharing budgets and high level inter-agency negotiations.

The long view should be to use and create sustainable funding structures that can provide high quality home visiting to all eligible families in New York State. This will require New York to be proactive and innovative. While there are no off-the-shelf solutions, there are opportunities to engage state and federal regulators, national program models, advocates and individual program sites to explore new approaches.

Note: While “home visiting” for families and young children encompasses a variety of types of models and populations, it can also refer to other programs that provide health services. For the purposes of this paper, SCAA applies the term maternal, infant and early childhood home visiting, the standard language favored by the federal government in recent grant applications.

Introduction

Maternal, infant and early childhood home visiting has emerged across the nation as a promising way to engage new and expecting parents and young children with services that support the family and lead to positive outcomes and public cost savings in the short, medium, and long term. Home visiting programs are generally designed to improve pregnancy outcomes, parenting skills, and early childhood health and development. Numerous home visiting models operate in New York and the State provides fiscal and programmatic support to many of them. The programs vary with regard to vision, outcome measures, eligibility, practice model, financing and data collection. Some programs target intensive services to very high-risk populations, while others aim for a more universal reach. They vary by geography and most aim to respond to the particular needs of the communities in which they operate.

There is a growing consensus that maternal, infant and early childhood home visiting should be a critical component of a state's comprehensive early childhood system. In many states, there is a seismic shift occurring, a shift that is based on the understanding that public investment in children must *begin well before* kindergarten, that parental engagement matters, and that early investment pays off in terms of fiscal and human outcomes.

Prioritizing resources is essential. In New York and across the country, existing capacity does not meet demand. States are exploring improved efficiency and effectiveness by building and linking systems. System building includes developing ways of coordinating and aligning programs; measuring and paying for outcomes; and improving data collection, coordination and financing among and across home visiting and other early childhood programs.

This report examines funding options for maternal, infant and early childhood home visiting that New York State currently uses and might consider as policymakers look to build and strengthen home visitation in New York.

This paper does not include background on maternal, infant and early childhood home visitation in general. For additional background, please see preceding reports by SCAA, available at www.scaany.org.

In New York and Nationwide, Funding Comes from Diverse Sources

In 2010, states made \$1.4 billion available to home visiting programs, according to the Pew Center on the States. Of that, \$462 million was allocated to categorical funding streams narrowly defined by a state for the exclusive purpose of home visiting, while \$912 million in block grant-style funding was allocated to programs meeting a range of early childhood objectives that could include but were not solely limited to home visiting.¹ About 60% of state investment in 2010 supported one or more national program models, such as Healthy Families America, Nurse-Family Partnership™ (NFP), Parents as Teachers (PAT) and The Parent-Child Home Program, Inc. (PCHP).² Of the 40 states that reported appropriations to home visiting in fiscal year 2011, 27 increased funding, 6 maintained, and 7 decreased funding, for a 1% total increase.³

A review of home visiting programs by the Pew Center on the States reveals a mix of funding sources for maternal, infant and early childhood home visiting programs around the country. While State General Funds, Medicaid and Temporary Assistance for Needy Families (TANF) make up a significant portion of the money for home visiting, there are a variety of other funding mechanisms. The report shows that states use different sources to fund the same program model and often need multiple funding sources to pay for one program. In addition to nationally recognized, evidence-based models, many states have developed their own programs, sometimes over decades, that meet the needs of their populations and fit the structure of their health and human services system.⁴ A 2009 survey by the National Center on Children in Poverty reported that there was no correlation between the size of a state's population and the investment in home visiting.⁵

Precise Calculations Are Elusive

Calculating what New York spends on maternal, infant and early childhood home visiting services during a given year is complicated. One of the first problems is determining what programs should be considered for inclusion in the calculation since a variety of programs provide some level of home visitation. Additional limitations include the difficulty in identifying each local, private foundation and individual source of program

A Snapshot of Maternal, Infant and Early Childhood Home Visiting Program Funding in New York State

Program	Administration/ Oversight	Funding Sources	2010-11 Federal and State Program Funding	Notes
Building Healthy Children	Department of Health (federal grant program in Rochester)	Federal – HRSA	\$673,000 in federal money	Money is currently passed through the Department of Health in the Maternal, Infant and Early Childhood Home Visiting (MIECHV) award.
Community Health Workers	Department of Health	Federal, State	\$4,404,735 <ul style="list-style-type: none"> Federal Medicaid Match – \$2,080,462 Federal – MCHBG \$199,920 State General Fund – \$2,132,584 	
Early Head Start	Federal Administration for Children and Families, Office of Family Supportive Services Region II	Federal Administration for Children and Families	\$118,865,647 <ul style="list-style-type: none"> An additional \$23,773,127 in non-federal share 	62 grantees. The NYS Head Start Collaboration Office, housed at the Council on Children and Families, provides a link between Head Start/ Early Head Start programs and state early childhood initiatives.
Healthy Families New York	Office of Children and Family Services	State	\$23.3 million	36 sites
Healthy Start	Federal HRSA	Federal	\$4,855,613	5 grantees: Columbia/Downstate, Brooklyn, Northern Manhattan, Onondaga and Monroe counties.
Home Instruction for Parents of Pre-school Youngsters (HIPPY)	No state or federal infrastructure.	Public and private, local, state, national levels	None	One project in the Bronx.
Nurse-Family Partnership™	No state agency administration.	State, local – county private, including foundations	\$19 million <ul style="list-style-type: none"> TANF – (ended 12/11) \$7,000,000 COPS – (most ended 9/10) \$7,488,981 Medicaid – some Targeted Case Management Matching support from counties where there are programs to draw down other funds 	Programs in Monroe County, Onondaga County and all five boroughs in New York City. Monroe and Bronx counties targeted to receive portion of initial MIECHV federal grant funds for NYS.
Parents as Teachers (PAT)	None	Public and foundation	\$310,670 <ul style="list-style-type: none"> Public – \$221,832 Foundation – \$88,847 	PATs are independent. Programs may work in conjunction with other education or home visiting programs.
The Parent Child Home Program, Inc.	None	Public (county, state grants, libraries and school districts), foundation	\$3,500,000 <ul style="list-style-type: none"> Public – \$175,000 Foundation – \$3,325,000 	
Maternal, Infant and Early Childhood Home Visiting (MIECHV)	Department of Health	Federal, Affordable Care Act	\$4.1 million FY 2010 \$5.6 million FY 2011	Federal grant initiative to support state-selected evidence-based home visiting program model(s). Funds the expansion of evidence-based in Erie, Monroe and Bronx counties for HF & NFP.
Healthy Moms Healthy Babies	Department of Health	State	General Fund – \$1.9 million per year 2009-2011	Funds infrastructure development in selected counties.
County Health Departments	Department of Health	State – Article 6 funding for local public health agencies; Some Medicaid	<ul style="list-style-type: none"> Varies from county to county and not tracked by NYSDOH Some limited Medicaid 	Maternal and child health is a required service for county health departments although not all conduct home visits.

Note: Table does not illustrate expenditures related to supportive/ancillary services. A version of this table was developed by the New York State Department of Health for the MIECHV program application in 2010 and has been updated using various sources.

funding throughout the state and accounting for grant funding cycles that often span more than one year. The inability to quantify home visiting is not unique to New York. In one national survey, few states were able to report the annual budget for their home visiting programs and this was similar to the results of previous surveys.⁶

Funds Pay for Services and Infrastructure

One of the many reasons that maternal, infant and early childhood home visiting programs are effective is that they provide a coordinated and comprehensive set of services for families. However, this strength becomes a dilemma when funding sources pay only for discrete services—such as a medical exam, a referral to a domestic violence shelter or mental health counseling.

In New York, most funding of home visiting pays for direct service provision. In some cases, funding may also pay for the ancillary and “wraparound services,” such as mental health care, which ensures that each family receives the support they need to succeed.

Money to build home visiting infrastructure is more elusive, but around the state some small initiatives are starting to develop localized systems for maternal and child health that coordinate referrals as well as identify and fill gaps in services. This is the funding that is beginning to help build systems in local communities. Funding for some of these initiatives comes from federal (Building Healthy Children in Monroe County) and State (Healthy

Mom/Healthy Baby) grants. Additional money would be needed to finance technical assistance for communities to coordinate existing home visiting programs or facilitate the implementation of home visiting models appropriate to the community need.

Funding Sources and Opportunities

This section provides detail regarding the most common funding sources used to support maternal, infant and early childhood home visiting programs nationally. The examples illustrate existing and potential funding streams that New York can leverage to increase capacity and begin to build a system of home visiting.

General Fund Appropriations

Based on surveys of the states, General Fund dollars are the single most common funding source for home visiting programs.^{7,8} General Funds are used to match federal dollars in programs such as Medicaid and the Maternal and Child Health Block Grant. Other states appropriate General Funds to particular home visiting program areas such as education, health and child welfare.⁹ In New York, the General Fund supports the Healthy Families New York (HFNY) program and Community Health Worker Program.

Other State General Funds used for various home visiting programs include:

- ▶ Illinois appropriated almost \$21 million in 2011 with over \$10 million for the Healthy Families Illinois program.¹⁰

New York Invests in Healthy Mom/Healthy Baby Program to Build Capacity

Beginning in 2009, New York used a general fund appropriation of \$1.9 million over three years to create the Healthy Mom/Healthy Baby program. Designed to incentivize the development of systems of care in communities, the program is being implemented in six counties (Bronx, Erie, Monroe, Onondaga, Orange, and Westchester). The participating counties have high rates of low birth weight, adolescent pregnancies/births, and neonatal intensive care admissions for Medicaid clients.

Local health departments are funded to engage key stakeholders to develop a system of services for pregnant women and children. Some of the outcomes include the coordination of referrals between home visiting programs and services and the provision of home visiting services as needed. The program will serve to inform efforts to create additional community-based systems of care as well as the need for a state-level system of services. Healthy Mom/Healthy Baby is also assisting the Department of Health in creating a single, standardized risk assessment form.

- In Connecticut, just under \$12 million was appropriated in 2010 for several programs including Healthy Start and Family Resource Centers.¹¹
- Ohio's Help Me Grow program received \$36.5 million in general revenue funding in the State budget 2010-2011.¹²

A drawback of this type of revenue is that programs must go through the annual appropriations process and compete with other state priorities for funding. For example, budget cuts in Illinois forced some programs to drop nearly two-thirds of their home visit cases. While the funds were eventually restored, staff were concerned they would not be able to re-connect with the dropped families.¹³

The HFNY program experienced similar problems when the state failed to pass a timely budget in 2010, resulting in ten programs being shuttered for several months. The uncertainty in funding resulted in loss of connection with families and an exodus of valuable staff. It took months and, in some cases, years for programs to recover. The proposed elimination of funding from the 2010-2011 Executive Budget again caused HFNY sites to experience difficulties with recruitment and staffing as the uncertainty of continued funding loomed over the program for several months. Although the money was restored, the anxiety caused some sites to experience continued demoralization.

Medicaid Funding for Home Visiting

Medicaid is a joint program financed in New York by the state, federal, and local governments that provides medical care to low-income populations. Eligibility is determined by income and family size.

Medicaid finances almost half of the births in New York State (46.9%), giving it an important stake in the outcomes of mothers and babies. Medicaid pays for about 60% of births in New York City and about 34% of births in the rest of the state.¹⁴

All adults under 100% of the federal poverty level (FPL) are eligible for Medicaid in New York. In New York, pregnant women with income up to 200% of the FPL qualify for Medicaid. This enables them to receive pregnancy care and other health services, such as lab tests,

HIV tests, nutrition screenings, and other services for at least two months after delivery. Babies receive health care services for at least one year after birth. As of October 2011, all pregnant women in Medicaid residing in counties with mandatory managed care are required to choose a managed care plan at the point of application for presumptive eligibility.¹⁵

Medicaid seems a natural fit for maternal, infant and early childhood home visiting programs. These programs provide a comprehensive set of diverse services that can include medical components, such as coordination with a medical home, behavioral health assessments and health education as well as case management services. A proposal is pending in New York State that would allow Medicaid to cover the full scope of NFP services for eligible families.

Medicaid Targeted Case Management

The Comprehensive Medicaid Case Management program, also known as targeted case management (TCM), provides assistance to help beneficiaries gain access to needed medical, social, educational and other services. TCM includes four components: comprehensive assessment and periodic reassessment to determine an individual's needs for any medical, social, educational and other services; development of a specific care plan based on the information collected through the needs assessment; referral and related activities to help the individual obtain needed services; and follow-up activities to ensure that the care plan is implemented and assesses the individual's needs. TCM is an optional service that states may elect to cover but that must be approved by the Centers for Medicare and Medicaid Services (CMS) through a state plan amendment.¹⁶

New York currently allows Medicaid reimbursement for Nurse-Family Partnership (NFP) TCM services in Monroe County and in New York City through the First-time Mothers/Newborns (FTM/N) Program. This coverage was instituted in 2010 following federal approval of State Plan Amendment #09-57.¹⁷ FTM/N provides Medicaid coverage for TCM services for low-income, pregnant women who will be first-time mothers and for their newborn up to the child's second birthday. The mother must be eligible for Medicaid and must enroll in the program no later than 28 weeks of gestation. If a mother loses Medicaid eligibility her child can continue in the program.¹⁸

Medicaid Redesign Team Recommends Nurse-Family Partnership

In the context of a dramatic budget gap, Governor Cuomo created a Medicaid Redesign Team (MRT) in 2011 to fundamentally restructure the State's Medicaid program. The initial phase of the MRT process culminated in the adoption of over 200 initiatives designed to reduce the cost of Medicaid and improve service delivery. A recommendation advanced by the Basic Benefits Work Group and accepted in December 2011 by the MRT would allow Medicaid coverage for NFP home visits. Such coverage would be available to Medicaid eligible, first-time pregnant women and their children receiving nurse home visiting services through qualified NFP providers.

Section 1905(a) of the Social Security Act and 42 CFR 440.130 (c) allows for states to include optional preventive services in their state Medicaid programs. Proponents of this proposal suggest that the comprehensive set of services provided by NFP during a home visit may be construed to meet the definition of a preventive service under this section. Allowing programs to be reimbursed for all NFP services through this mechanism could achieve savings for the Medicaid program while making it easier for NFP programs to meet model fidelity.* Coverage can be accomplished in multiple ways, through a State Plan Amendment, through a waiver or through a benchmark plan.

This proposal may be financially beneficial to the state as well. Section 4106 of the ACA allows for increased reimbursement for preventive services by 1%, effective January 1, 2013. Services eligible for the enhancement must be rated A or B by the U.S. Preventive Services Task Force, be related to vaccinations or be a medical or remedial service recommended by a physician or other licensed practitioner for the maximum reduction of physical or cognitive disability.** Some argue that states can make the case that evidence-based maternal, infant and early childhood home visitation programs prevent negative health outcomes for certain populations and should be included as a preventive service.***

* *Preferred Coverage Options for Nurse-Family Partnership Evidence-Based Home Visitation*, Nurse-Family Partnership, Denver, Colorado; July 2011.

** Patient Protection and Affordable Care Act, P.L. 111-148 Section 4106(a).

*** *Medicaid Financing of Maternal and Early Childhood Home Visiting Programs: Options, Opportunities, and Challenges*, Presentation by Katherine Witgert, Program Manager, National Academy for State Health Policy, National Summit on Quality in Home Visiting Programs; Feb. 15, 2012.

The key services provided under FTM/N are:

- 1) Assessment of each mother to ascertain potential risk and need for medical, education, social and other services.
- 2) Development of a care plan for each mother with goal setting to ensure her active participation and engagement in the planned activities.
- 3) Referrals to help the mothers obtain needed services that may include prenatal care; improving diets; reducing use of cigarettes, alcohol and illegal substances; improving each child's health and development; and reducing quickly occurring and unintended pregnancies.
- 4) Monitoring to ensure the mother is accessing and receiving adequate services in accordance with the care plan and to determine if changes or further action steps are needed.¹⁹

While NFP program sites in New York City and Monroe County can now bill Medicaid, reimbursement is limited to coverage of only those services considered to be within the scope of TCM. Other services provided as part of a home visit, such as preventive screening, physical nursing assessments and health education and counseling are not eligible for Medicaid reimbursement. Coaching on breastfeeding, developmental assessments or education about the warning signs of postpartum depression cannot be billed under TCM.

The recommendations of the MRT to more comprehensively cover the scope of NFP services may have implications for the existing TCM program and for any future expansions of NFP home visiting to other counties. An MRT proposal passed in the 2011-12 State budget requires selected TCM programs (but not NFP) to become part of a *health home* by 2014 or be phased out. The *health home* is a model for providing coordinated

care for Medicaid enrollees with two or more chronic conditions or serious mental illness. However, since many pregnant women would not meet the eligibility criteria for these chronic health home services, integration of the NFP program into the health home model for persons with chronic illness may not be appropriate.

Other states are also using TCM to finance portions of their maternal, infant and early childhood home visiting programs.

- ▶ Oregon uses TCM for two home visiting programs. Babies First! provides public health nurse assessment, care plan, health education, case management and referrals to children ages 0-5 at risk for poor health and development outcomes. CaCoon serves children birth to 21-years-old identified with special health needs. Services include a variety of developmental and health assessments by a public health nurse, interventions, case management, health promotion, monitoring and referrals.²⁰
- ▶ The Kentucky Health Access Nurturing Development Services (HANDS) program is based on the Healthy Families America model. The program serves approximately 11,000 families across the state. A 2002 revised Medicaid State Plan allows the state to bill HANDS services under TCM using state tobacco dollars to leverage federal Medicaid funding.²¹

Home Health Services and Medicaid Managed Care

Medicaid pays for medically necessary home health services rendered to eligible persons by providers enrolled in Medicaid. This includes skilled nursing home health care visits to pregnant or postpartum women designed to: assess medical health status, obstetrical history, postpartum depression, current pregnancy-related problems, and psychosocial and environmental risk factors such as unstable emotional status, inadequate resources or parenting skills; and to provide skilled nursing care for identified conditions requiring treatment, counseling, referral, instructions or clinical monitoring. Home health care providers communicate findings, plans and patient needs to the mother or child's physician and/or case manager.²²

New York State amended the Public Health Law in 2010 to allow county health departments to bill for public health nursing visits using their licensed home care

Broome County's Experience with Medicaid Managed Care and Home Visiting

The Broome County Department of Health Maternal Child Health division, along with the Monroe Plan for Medical Care, one of the largest Medicaid HMOs in Central New York, began to explore options for collaboration of services in 2006. In 2007 a contract was signed, initiating the *Southern Tier Healthy Beginnings Perinatal Program*. The Monroe Plan for Medical Care agreed to reimburse the Broome County Health Department for part of the cost of a public health nurse to conduct home visits for high-risk perinatal members enrolled in the Monroe Plan.

Through this collaboration, a perinatal outreach program designed to assist pregnant women and adolescents in accessing comprehensive prenatal, postpartum and primary health care and specialty and ancillary services evolved. The program also identifies and intervenes to reduce psychosocial risks that could negatively impact pregnancy outcomes. The program will provide in-home supportive and information counseling, and linkages with health and human services providers in the Monroe Plan.

The Monroe Plan uses a risk assessment tool to identify which members are eligible for the home visiting program. County nurses and Plan outreach/case managers develop a plan of care. Home visits are assigned to the county maternal and child health nurse or the outreach/case manager as needed to provide direct care and education to reinforce the recommended health care. Crisis intervention is provided as needed.

services agencies (LHCSA). CMS approved this change to Medicaid State Plan Amendment 07-45, 2011. Under this new provision, county health departments can contract with Medicaid managed care plans if there are three or more managed care plans in that county. The contract allows counties to do public health nurse visits as a contractor and bill directly.

This change allows county health departments to play an important role in the provision of maternal, infant and early childhood home visiting in their capacity as health providers for low-income families in their county. With substantial evidence about improved pregnancy and other outcomes associated with home visiting, managed care organizations are taking notice.

Early and Periodic Screening, Diagnosis, and Treatment

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a mandatory set of services and benefits for all individuals under age 21 who are enrolled in Medicaid. States are required to provide screenings and all medically necessary diagnostic and treatment services regardless of whether the state covers the services for adults in Medicaid.²³ The EPSDT program in New York is also known as the Child Teen Health Program (CTHP).

Under federal program guidance, EPSDT can be used to pay for medically necessary home visits by a nurse for newborns. States have also used home visiting programs to provide outreach to Medicaid families to ensure children are receiving recommended health services.²⁴ It may be possible to bundle services to both children and mothers under age 21 but no state has worked with the Centers for Medicaid and Medicare Services (CMS) to pursue this as an option.²⁵

Federal Title V Maternal and Child Health Block Grant

Under the Federal Title V Maternal and Child Health Block Grant (MCHBG) block grant, states apply for and receive a formula grant each year based on the proportion of low-income children in a state compared to the total number of low-income children in the United States. States and jurisdictions must match every \$4 of federal MCHBG money they receive with at least \$3 of state and/or local money.²⁶

Among the goals of the MCH program are assuring access to quality care; reducing infant mortality; and providing and ensuring access to comprehensive prenatal and postnatal care to women (especially low-income and at-risk pregnant women). The program allows funding to be used for infrastructure, population-based, enabling, and direct services for the MCH population.

In New York, Title V money along with Medicaid and State General Fund money is used to support the Community Health Worker Program (CHWP). CHWP is a 20-year-old paraprofessional home visiting program developed by the New York State Department of Health (DOH). There are currently 23 sites in communities with high risk factors, such as infant mortality, preterm delivery, teen mothers and poverty. The program targets mothers with late or no prenatal care.

A number of other states are also using MCHBG funds as part of the funding mechanism for home visiting programs:

- ▶ The Massachusetts Early Intervention Partnerships Programs (EIPP) provides services in communities with some of the state's highest rates of infant mortality and morbidity. EIPP identifies maternal and infant risk and links families to services to prevent or reduce poor health and/or developmental outcomes. To be included in the program, pregnant and postpartum women and infants must have at least one characteristic that may affect their pregnancy, health or development. Assessments, services and referrals are individualized to families and provided by a multi-disciplinary MCH team.²⁷ The program currently operates in eight communities.²⁸
- ▶ Wyoming uses Title V and TANF funds to support Best Beginnings (BB) for Wyoming Babies. This perinatal program assists pregnant women in accessing care and services necessary to help assure a healthy pregnancy, through public health nurses in the 23 county public health offices throughout the state. Wyoming also offers NFP programs in 14 counties.²⁹
- ▶ Title V is one of the many different sources of funding for the Louisiana NFP program that operates in 52 of the state's parishes. The state was one of the earliest NFP implementers, starting in 1999.³⁰

Federal Maternal, Infant and Early Childhood Home Visiting Program

The Maternal, Infant and Early Childhood Home Visitation program contained in the Affordable Care Act will provide \$1.5 billion between 2010 and 2014, awarded to states through both formula and competitive grants. States are required to meet maintenance of effort (MOE) standards based on previous spending and not use new funds to supplant funds from other sources. States receive a formula award based on the number of young children in families at or below 100% of the FPL in the state as compared to the number of such children nationally. In New York, although the Department of Health is the lead agency, the State plan was developed with extensive collaboration with other state agencies and stakeholders. New York received formula awards of \$4.1 million in 2010 and \$5.6 million in 2011.

New York identified 14 communities with the highest need based on a comprehensive assessment conducted by DOH as part of the application process. The State plan will phase in funding initially to three communities (Bronx, Erie and Monroe counties) to enhance specific evidence-based home visiting programs (HFNY and NFP). These first projects, along with work already underway through the Healthy Mom/Healthy Baby program, will be used to inform subsequent communities about systems building, collaboration, shared resources, best practices and financing.

New York will continue the interagency workgroup established to support completion of the needs assessment and State plan. The group will be a resource to identify, prioritize and coordinate needs, strategies and resources related to MIECHV. The workgroup has identified three priorities for cross-sector coordination: mental health, substance abuse, and domestic violence. To support these efforts, some funding will be used for a new Perinatal Health Statewide Center of Excellence. The Center will provide a new state-level infrastructure to coordinate and facilitate the development, dissemination and implementation of evidence-based and promotions practices through training, technical assistance, research-to-practice information and resources and evaluation. The infrastructure is expected to help support further integration of home visiting with other perinatal and early childhood programs and systems.³¹

Examples of how other states will use MIECHV:

- ▶ Maine will expand its Family Home Visiting Program that uses the PAT and Touchpoints models. They expect to focus more on the highest-risk families, those families with substance abuse and/or mental health issues, and estimate serving 150 families per year with the available funding.³²
- ▶ North Carolina will primarily expand their use of HFA and NFP and project they will reach 420 families.³³
- ▶ The Illinois Home Visiting Task Force endorsed five evidence-based models already in widespread use in the state: Early Head Start (EHS), Healthy Families America, Healthy Steps for Young Children, NFP and PAT. The state selected nine counties for initial program funding.³⁴

- ▶ Pennsylvania identified five “county clusters” and expects to serve 556 families in these areas using NFP, HFA, PAT and EHS.³⁵

MIECHV also provides opportunities for states to compete for additional funding under two categories: development and expansion. New York unsuccessfully applied for a competitive grant in the 2011 round of funding, but remains eligible for additional rounds of funding slated for 2012 and 2013.

Social Services Funding for Home Visiting

Temporary Assistance for Needy Families

Temporary Assistance for Needy Families (TANF) is used by many states to help fund home visiting programs. TANF replaced the federal welfare program known as Aid to Families with Dependent Children (AFDC), the Job Opportunities and Basic Skills Training (JOBS) program and the Emergency Assistance (EA) reform legislation of 1996 (the Personal Responsibility and Work Opportunity Reconciliation Act [PWRORA] Public Law 104-193). The law ended federal entitlement to assistance and instead created TANF as a block grant that provides states with federal funds each year.³⁶

Because states are allowed to design and operate TANF, there is flexibility in using it to meet the goals of the program: helping families achieve self-sufficiency by assisting families so children can be cared for in their own homes; promoting job preparation and work; preventing out-of-wedlock pregnancies; and encouraging marriage and two-parent families.

States use TANF to fund Healthy Families, NFP and a number of state-specific programs. For example:

- ▶ The Minnesota Family Home Visiting Program directs approximately \$8 million in TANF dollars for local initiatives. The program was created by statute in 2001 to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The state provides oversight, guidance

and statewide evaluation of the locally-administered Family Home Visiting Program. Among the 91 local health departments there are 15 different curricula used, 9 documentation systems and at least 6 different funding sources. Twenty-eight local health departments use a nationally recognized family home visiting model while 63 use other types of programming.³⁷

- Michigan's Zero to Three Secondary Prevention Initiative is a statewide, evidence-based, community collaborative child abuse and neglect (CAN) prevention initiative charged with integrating a system of services for Michigan's expectant families and those with children age birth to three who have been identified as high-risk. The programs serve Michigan's most vulnerable populations that have multiple CAN risk factors, known to be a precursor to child abuse and neglect.

Grants are provided to school districts, public health and mental health agencies, hospitals, community action agencies, extension services, child abuse prevention councils and other non-profit organizations. State funding is through an inter-agency agreement among the Michigan Department of Human Services, Michigan Department of Community Health, and the Michigan Department of Education. It is administered by the Children's Trust Fund. Grantees are required to provide a 25% match, leverage community funds and use in-kind resources to cover program costs that exceed their appropriation.³⁸

Child Abuse Prevention Funds

There are two primary federal funding sources for child abuse prevention that states use for home visiting:

- The Community-based Child Abuse Prevention (CBCAP) grants are provided to states through the Administration for Children's Services (ACS) at the U.S. Department of Health and Human Services (HHS). This program provides funding to states to develop, operate, expand, and enhance community-based, prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect. The program was reauthorized, amended and renamed as part of the Child Abuse Prevention and Treatment Act (CAPTA) amendments in 2003.³⁹

- One of the core features of the CBCAP specifically includes using funds to support programs such as voluntary home visiting programs, parenting programs, family resource centers, respite and crisis care, parent mutual support and other family support programs. The program also places an emphasis on evidence-based and evidence-informed programs and practices.
- The Promoting Safe and Stable Families Program (PSSF), Title IV-B, Subpart 2 of the Social Security Act, aims to prevent child maltreatment, allows children to remain safely with their families, and ensures safe and timely permanency for children in foster care. Funding is allocated to states based on the number of child Supplemental Nutrition Assistant Program (SNAP) recipients. States must use the money for specific programs areas, including family support services.⁴⁰

States are using CBCAP and PSSF/Title IV-B funding to support national program models for home visiting and state-developed programs.

- Oklahoma uses CBCAP as partial funding for the Start Right home visiting/center-based program. Start Right teaches positive parenting skills and connect families to resources to reduce the risk of child abuse and neglect. The structure is based on HFA and utilizes PAT and other nationally-recognized, evidence-base curricula for delivery services.⁴¹
- Pennsylvania uses CBCAP funds as one of the sources for the Family Centers that use the PAT models. It uses PSSF funding for the PCHP.^{42,43}
- The Healthy Start and HFA model was supported in Tennessee with \$3 million in interdepartmental funds from the Department of Children's Services. Part of that was from PSSV/Title IV-B with a three to one federal-state dollar match.⁴⁴

Other Sources

Tobacco Settlement Money and Tobacco Taxes

Several states have used money from the 2000 Tobacco Master Settlement Agreement to fund home visiting programs directly or to establish health foundations or consortiums that provide grants for home visiting programs. Other states have dedicated funds from tobacco taxes to programs that assist children.

- Maine used tobacco settlement money to create the Fund for a Healthy Maine that now allocates over \$5 million a year to home visiting.
- In Colorado, tobacco money funds almost \$14 million of the budget for its NFP program. In addition, the state receives some Medicaid TCM reimbursement.⁴⁵
- The Arizona First Things First program that funds home visiting was created in 2006 through a ballot initiative that sets aside 80¢ from each pack of cigarettes sold in order to fund the expansion of education and health programs for children from birth through age five.⁴⁶
- In 1998, voters in California passed Proposition 10, adding a 50¢ tax to each pack of cigarettes sold to create First 5 California. Each county has its own commission that receives money to fund a variety of school readiness programs, including home visiting.⁴⁷

Private Philanthropy and Public Private Partnerships

Private philanthropy also helps support maternal, infant and early childhood home visiting programs.

- The State of Washington enacted a statute in 2010 creating the Home Visiting Services Account (HVSA), designed to leverage public dollars for home visiting by providing matching private dollars. Starting in July of 2011, state, federal and private funds are deposited to the account to support a range of evidence-based, research-based and promising home visiting programs. The goal is to maintain the annual public-private support at \$4.5 million, although the fund is looking to increase resources over the next three years.⁴⁸ Thrive by Five Washington administers the fund and matched the state investment with \$598,000 in private money for the fund in 2012.⁴⁹

Discussion

Maternal, infant and early childhood home visiting models are funded in varied ways by states, localities, private donors and the federal government; there is no off-the-shelf funding method that covers the array of services provided by all models and is reasonably scalable to cover all eligible families in a state. As states take steps

to better coordinate home visiting systems and services, an understanding of the funding landscape is critical.

A system of home visiting would involve collaboration across government, agencies and families for the purpose of creating efficiencies, improving access and strengthening coordinated, community-based services and supports.

While home visiting has a long history, states and communities are in the early stages of coordinating home visiting with a systems approach. Moving forward with improved coordination requires more structured decision-making than is now in place. To utilize funding most successfully and develop the mechanisms for new funding structures, New York must create a home visiting system that connects programs and State agencies in novel ways. This will entail designing accounting, personnel and evaluation processes while preserving the accountability that each program and agency has to its source of revenue. Such a system could allow an enhanced use of funding by merging or consolidating duplicative or similar services. State level systems can also develop synergy among program sites at the local level to achieve efficiencies and encourage coordination. Finally, larger systems-building activity can prepare the state for new opportunities and promote innovative thinking of new financing strategies.

Maternal, infant and early childhood home visiting stakeholders in New York continue to explore systems-related issues through the ongoing work of several groups: the New York State Home Visiting Workgroup convened by SCAA; the state's Early Childhood Advisory Council (ECAC); *Winning Beginning NY*, the state's early care and learning coalition; and through the application processes for federal MIECHV funds.

Still, New York lacks statewide guidance, oversight and evaluation; a comprehensive plan for development of a state home visiting infrastructure; and a unified set of outcomes for home visiting or a framework for program accountability. A unified plan has the potential to ensure that resources are utilized as efficiently as possible to maximize results. These components are necessary in order to most effectively project costs, measure long-term impacts and expand services to more families. Next steps should include developing shared outcomes and data systems to measure them; ensuring that policy and financing are aligned; improving strategies to coordinate across programs; and identifying and empowering a single entity to lead and coordinate home visiting endeavors.

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