



# Preserving the Children's Health Insurance Program and Other Safety-Net Programs

*March 2017*



BIPARTISAN POLICY CENTER

## **HEALTH PROJECT**

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, BPC's Health Project seeks to develop bipartisan policy recommendations that will improve health care quality, lower costs, and enhance health care coverage and delivery. The Health Project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care.

## **ACKNOWLEDGMENTS**

Support for this report was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the foundation.

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The report was produced in collaboration with a distinguished group of fellows and experts for the Health Project. BPC would like to thank Sheila Burke, Henry Claypool, Chris Jennings, Steve Lieberman, Anne Tumlinson, and Tim Westmoreland for providing substantial feedback, support, and direction.

# *Executive Summary*

As Congress debates legislation to repeal and replace the Affordable Care Act (ACA), a full range of stakeholders are attempting to predict the impact of these changes. Governors, state agencies, and state legislatures are working to finalize budgets for the upcoming fiscal year that, for most states, begins on July 1, 2017. Health care providers are trying to predict how changes will affect their revenues, and health insurers must set premiums within the next few months for services that will be covered in 2018. Finally, patients are hearing from some elected officials that they will lose coverage or access to certain services, while others are telling them that their coverage will be better and more affordable.

At the same time, funding for programs designed to improve coverage and access to care for vulnerable populations are set to expire on September 30, 2017. These include the Children's Health Insurance Program (CHIP), mandatory funding for community health centers and the National Health Service Corps, and the Maternal, Infant and Early-Childhood Home Visiting Program (MIECHV).

Without congressional action, mandatory funding for all four programs ceases at the end of Fiscal Year (FY) 2017. In addressing continued funding, policymakers must consider the implications of legislative timing, funding levels and duration of an extension, interactions with the ACA and Medicaid, and potential impacts on coverage for lower-income Americans.

This report highlights the importance of these bipartisan programs that serve vulnerable populations, recommends extending these programs at their current funding levels, and stresses the need for action early in the 115th Congress. Early action is needed to allow planning for FY2018, which for most states, begins July 1, 2017.

# *Summary of Recommendations*

## *Children's Health Insurance Program*

While the structure of private health insurance and the future of Medicaid expansions under the ACA are unclear, children should not be at risk of losing health insurance coverage, and states should have some level of certainty to plan for state FY2018. BPC recommends:

- Extending CHIP funding at current levels for four years through FY2021.
- Maintaining the 23 percent enhanced federal match rate for federal FY2018, which begins on October 1, 2017.
- Balancing the need for an enhanced match rate to help states pay for the cost, with the need to slow cost growth and the uncertainty as to the future of the ACA Medicaid expansion population, beginning in FY2019, phase down the 23 percent enhanced CHIP match rate to the greater of: 1) the states' historical enhanced match rate for the CHIP program; or 2) the enhanced rate for the ACA Medicaid expansion population.
- Extending the ACA's federal maintenance of effort (MOE) requirement for the duration of the four-year extension (through FY2021) to ensure continuity of coverage for children.
- Extending CHIP in a way that does not add to the federal deficit. While phasing down the match rate will offset a portion of the costs, Congress should also consider other options, including changes in the Medicaid drug rebate program to extend discounts paid by brand name pharmaceuticals to sole-source generics.

## *Community Health Centers*

Given the importance of maintaining access to care for both the insured and uninsured populations, extending funding of Community Health Centers at current total level of \$5.1 billion annually (including both mandatory and appropriated funding), through FY2021. BPC recognizes the importance of safety net providers, and acknowledges the potential need for additional funding to ensure continued and improved access to care.

## *National Health Service Corps*

Extending funding of NHSC at current levels of \$310 million per year through FY2021.

## *MIECHV Program*

Extending mandatory funding of MIECHV at current levels of \$400 million annually through FY2021. Early evidence shows MIECHV is meeting programmatic goals to assist vulnerable families through evidence-based local programs that target at-risk communities.<sup>1</sup> The program should continue to focus on evidence-based program models for early-childhood home visiting service delivery and robust program evaluation.

Note: Mandatory funding for Community Health Centers, the National Health Services Corps and the MIECHV program should be fully offset, and any additional discretionary funding should be allocated through the annual appropriations process within the total overall domestic discretionary spending cap.

### ***Long-Term Recommendations for Safety-Net Programs***

Congress should initiate a process to examine a longer-term solution to health coverage for vulnerable populations. These goals might factor in how CHIP, Community Health Centers, NHSC, and the MIECHV program fit into the new coverage landscape as Congress considers a repeal and replace of the ACA, the role of states versus the federal government, and how best to ensure benefit adequacy and affordability. This process should evaluate evidence based-approaches to improving quality and access to care, and highlight the importance of timing for governors and states as they prepare their budgets.

# Introduction

The Medicare and CHIP Reauthorization Act (MACRA) extended funding for several programs that serve vulnerable populations, including the Children’s Health Insurance Program (CHIP), Community Health Centers (CHC), the National Health Services Corps (NHSC), and the Maternal, Infant, and Early-Childhood Home Visiting program (MIECHV).<sup>a</sup> Each of these programs expire on September 30, 2017. This report highlights the importance of these bipartisan programs that serve vulnerable populations, recommends extending these programs at their current funding levels, and stresses the need for action early in the 115th Congress to allow planning for Fiscal Year (FY) 2018, which for most states, begins July 1, 2017.

## Children’s Health Insurance Program

CHIP was enacted as part of the Balanced Budget Act of 1997, and has been reauthorized four times over the last 20 years. The most recent authorization, MACRA, enacted in 2015, provided \$39.7 billion in total funding, and extended the program through September 30, 2017. In FY2015, 8.4 million children received health insurance coverage through CHIP.<sup>2</sup>

CHIP makes funding available to states to provide health insurance coverage to uninsured children residing in families with incomes below 200 percent of the federal poverty level (FPL), but whose family income exceeds the eligibility limits for Medicaid. Under CHIP, states may expand coverage through the state’s Medicaid program, through separate state programs, or through a combination of Medicaid and one or more separate programs. CHIP is administered by states under broad federal guidelines, and is jointly financed by states and the federal government. States have discretion to set higher income eligibility levels, up to 300 percent of the FPL, and receive the CHIP match rate.<sup>3</sup>

Unlike Medicaid, which is an individual entitlement, CHIP funding is provided to states as a block grant. Under CHIP, states receive annual allotments based on each state’s recent CHIP spending, and have two years to spend their allotments.<sup>b</sup> Unspent funds are available for redistribution to other states.

For detailed information on the legislative history and background, see BPC’s 2015 report, [\*The Role and Future of the Children’s Health Insurance Program\*](#).<sup>4</sup>

## Reauthorization Financing Issues

In reauthorizing CHIP, policymakers must determine the length of the authorization and the level of funding for each year. Federal policymakers must also decide whether to maintain the “enhanced” federal match rate and whether states must continue current-law levels of Medicaid and CHIP coverage—the maintenance of effort (MOE) requirement.

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<sup>a</sup> MACRA also repealed the sustainable growth rate methodology used to update Medicare payments to physicians with new, streamlined quality reporting structures and payment incentives focused on quality and value. This program rewards the delivery of high-quality patient care through either Advanced Alternative Payment Models (Advanced APMs) or the Merit-based Incentive Payment System (MIPS) for eligible clinicians or groups.

<sup>b</sup> Each allotment is based on each state’s recent CHIP spending increased by a growth factor.

## A. Enhanced Federal Match Rates

Under the Medicaid program, states receive federal matching dollars for CHIP expenditures. Medicaid matching, known as the federal medical assistance percentages (FMAP), varies by state and is based on a formula that accounts for state per-capita income.<sup>5</sup> When CHIP was enacted in 1997, the law provided for an “enhanced” federal medical assistance percentages (e-FMAP), which averaged about 15 percentage points higher than the states’ regular Medicaid FMAP for newly-eligible children.<sup>6</sup> The ACA further increased the CHIP e-FMAP for children. Since the health reform law expanded coverage to “newly eligible adults” and provided a match rate that was higher than the CHIP enhanced match, lawmakers sought to provide comparability by further increasing match rates under CHIP. While Medicaid matching rates averaged 71 percent prior to the passage of the ACA, the CHIP rate averaged 15 percentage points higher.<sup>c,7,8</sup> The ACA temporarily increased e-FMAP rates for states by 23 percentage points in CHIP, not to exceed 100 percent.<sup>9</sup> This “super” e-FMAP rate for CHIP is commonly referred to as the “23 percent bump,” and applies to CHIP expenditures made from October 1, 2015 through September 30, 2019, bringing the average federal match rate for CHIP to 93 percent.<sup>10</sup> Although current law authorizes the Health and Human Services (HHS) secretary to apply the higher rate through FY2019, MACRA provided funding only through FY2017. Unless funding is provided, states will receive the historical CHIP match rate, rather than the 23 percent enhanced rate, after FY2019.

## B. Maintenance of Effort

Since CHIP’s enactment in 1997, the number of uninsured children has decreased from 9.9 million to 3.5 million in 2015.<sup>11</sup> The ACA included an MOE requirement, which prohibited states from reducing Medicaid and CHIP coverage below levels in effect on the date of enactment of the ACA, March 23, 2010.<sup>12</sup> Under the terms of the MOE, states must maintain coverage through September 30, 2019 for children in Medicaid and CHIP, with some limited exceptions. While the purpose of the MOE was to provide stability in coverage in both Medicaid and CHIP until exchanges and Medicaid expansions were operational,<sup>13</sup> some governors have criticized the provision as limiting state flexibility and placing unnecessary financial burdens on states.<sup>14,15</sup> Centers for Medicare and Medicaid Services (CMS) issued guidance to the states on exceptions to the MOE in February 2011, including permitting a reduction in coverage associated with the expiration of a state waiver.<sup>16</sup> While a few states have proposed waivers of the MOE requirements, CMS has not approved any of these waivers to date.

## Children’s Health Benefits and Alternatives in the Health Insurance Marketplace

The ACA allows children enrolled in separate CHIP programs to transition to marketplace coverage if they could obtain comparable benefits and cost sharing.<sup>d,17</sup> However, on November 25, 2015 the HHS secretary released a review comparing CHIP to the second-lowest-cost silver plan in the largest rating area in each state, which found that marketplace benefits were not as comprehensive as CHIP and had higher cost-sharing.<sup>18,e,19</sup>

The Medicaid and CHIP Payment and Access Commission (MACPAC) also has cited concerns about transitioning children from

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<sup>c</sup> The e-FMAP for CHIP has ranged from 65 percent to 81 percent, compared to 50 percent to 73 percent for children in Medicaid.

<sup>d</sup> The HHS secretary must certify that plans in the exchange are “at least comparable” to CHIP program benefits and cost-sharing.

<sup>e</sup> Benefit packages in CHIP were determined by HHS to be “generally more comprehensive” for “pediatric services (such as dental, vision, and habilitation services)” and for children with special health care needs when compared to qualified health plans (QHPs). However, CHIP coverage of “core” benefits (such as physician services, laboratory, and radiological services) was found to be similar between CHIP and QHPs.



CHIP. In their June 2014 report to Congress, MACPAC found that children in the CHIP program would not have a “smooth transition to another source of coverage offering comparable benefits and cost sharing.”<sup>20</sup> The Commission found that the number of uninsured children would rise, and there would be increased out-of-pocket financial burden for children and their families who would need to purchase pediatric coverage outside of CHIP (either through the marketplace or employer-based coverage). The Commission concluded that plans available through the health insurance marketplaces were not ready to serve as an adequate alternative to CHIP, and reiterated this in its recommendation to extend CHIP funding for two years, as a part of its March 2015 report.

According to MACPAC’s 2016 analysis, CHIP requires less out-of-pocket spending, on average, than exchange coverage.<sup>21</sup> State-level estimates show that 5 to 7 percent of children in exchange coverage at 151 to 200 percent of FPL would have out-of-pocket spending greater than 5 percent of their family’s income.<sup>22</sup> This is greater than the cost-sharing ceiling requirement (5 percent of income) that separate CHIP programs and Medicaid must adhere to in order to make cost-sharing permissible under federal regulation. MACPAC also found that those with greater cost-sharing exposure in marketplace coverage were not limited to children with chronic health conditions, but also included otherwise-healthy children who had unexpected costly care due to an acute episode.<sup>23</sup> In its most recent report, MACPAC has recommended extending CHIP funding for five years, through FY2022, to provide a stable source of children’s coverage.<sup>24</sup>

Based on MACPAC’s analysis, out-of-pocket spending for pediatric coverage for subsidized coverage in the exchanges is over \$900 higher—nearly seven times as costly when compared to CHIP (Table 1).

**TABLE 1: Comparison of Out-of-Pocket Spending in Separate CHIP versus Marketplace Coverage**

Coverage Type	Effective Actuarial Value	Average Cost Sharing	Average Premiums	Total Out-of-Pocket Spending
Separate CHIP	98%	\$31	\$127	\$158
Second-lowest-cost silver marketplace plan	82%	\$266	\$806	\$1073

**Source:** MACPAC March 2016 Report to Congress.

Those children who would have the highest out-of-pocket spending in marketplace coverage are more likely to need treatment for mental health conditions, asthma, and trauma—raising concerns about the adequacy of benefits in marketplace coverage for common pediatric conditions.<sup>25</sup> An October 2016 analysis conducted by The Wakely Group concluded that if children moved from CHIP to the marketplace, children with special health care needs in some states could go from having zero cost-sharing in CHIP to over \$10,000 in annual out of pocket expenditures in the marketplace.<sup>26</sup> This analysis also evaluated benefit adequacy, and found that while the coverage of core benefits is comparable between CHIP and the marketplace plans, marketplace coverage offers fewer child-specific services than CHIP.<sup>27</sup>

## Considerations for the Future of CHIP

Congress remains deeply divided over the ACA, and the debate to repeal and replace the law will continue in the coming months. Even as policymakers map out the future of the private individual and small business health insurance markets, some exchanges have faced dramatic premium increases in certain areas, the exit of some insurance carriers, and risk-selection issues, while others have remained relatively stable.<sup>28,29</sup> Congress may also consider significant changes to the Medicaid program, either in the context of ACA replacement, or subsequent deficit reduction legislation.<sup>30</sup> For states operating a CHIP Medicaid expansion program, when federal funding is exhausted, states are required by the MOE to continue covering those children through Medicaid until September 30, 2019.<sup>f</sup> According to MACPAC, in the absence of separate CHIP programs, 36 percent of the children who would then be eligible for exchange coverage would become uninsured at the end of FY2019 when federal funding ends, primarily due to the prohibitive cost of coverage in the exchanges.<sup>31</sup>

BPC's recommendations recognize longstanding bipartisan support for CHIP, the partisan divide over the future of the ACA, concerns about the lack of comparable pediatric coverage options within the ACA marketplace, and the need to move quickly and clearly so that states have time to take the appropriate actions to avoid disruptions in coverage.

In passing MACRA, policymakers recognized that early reauthorization of CHIP is critical, as 46 states begin their fiscal years on July 1, and of the remaining four, New York has the earliest fiscal year with a start date of April 1.<sup>g,32</sup> In addition to differing dates for state fiscal years, 21 states are on two-year cycles or a biennial basis, and Kansas and Missouri use both. For more information regarding the implications of timing and state budget cycles with regards to federal CHIP legislation, please refer to [\*The Role and Future of the Children's Health Insurance Program\*](#).<sup>33</sup>

## CHIP Recommendations

1. Extend CHIP funding and authorization for four years.

Rationale: The private health insurance market and health insurance marketplaces under the ACA do not provide a comparable level of care for pediatric coverage when comparing affordability and benefits to CHIP. Children who would have the highest out-of-pocket spending in an alternative to CHIP are more likely to need treatment for mental health conditions, asthma, and trauma. Given the uncertainty around coverage and benefits of a new replacement program, the four-year extension ensures children's coverage remains stable, and provides states a longer timeline and assurance of funding as states establish budgets.

2. Extend CHIP funding for one year maintaining the current allotment formula, including the 23 percentage-point increase to the federal CHIP match rate authorized by the ACA. Beginning in FY2019, continue the program while implementing a phase-down of the federal funding bump. This phase-down should equal the greater of the following: the federal match in statute for states that expanded Medicaid under the ACA, or the historical enhanced FMAP for CHIP.

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<sup>f</sup> Under the Medicaid MOE for children, states are not permitted to limit Medicaid eligibility for CHIP Medicaid expansion children without the loss of all Medicaid federal matching funds.

<sup>g</sup> The Texas budget cycle begins September 1, and those of Alabama and Michigan begin October 1.

Rationale: The one-year extension of the enhanced match provides states with time to adjust for the phase-down of the 23 percent bump beginning in FY2019. The phase-down in subsequent years is recommended to offset costs associated with Recommendation 1, a four-year CHIP program extension. Any further program costs associated with Recommendation 1 must also be offset by identifying spending reductions or revenue increases (or a combination of the two). One possible offset could be found by extending the current-law Medicaid brand-name prescription drug rebate amount to sole-source generic drugs.

3. Extend the ACA's federal MOE requirement—under which currently states must maintain at least pre-ACA eligibility and enrollment standards for children in Medicaid and CHIP through September 30, 2019—for the duration of the four-year extension (through FY2021).

Rationale: BPC recognizes the extension of the MOE places a financial requirement on states that will increase as the enhanced matching is phased down (Recommendation 2). However, by continuing to require the MOE, continuity of coverage for children is assured, particularly as lawmakers consider the future of the ACA marketplaces and how to ensure stability and access.

# *Community Health Centers, National Health Service Corps and the Maternal, Infant and Early Childhood Home Visiting Program*

In addition to extending CHIP, MACRA extended funding for health centers, the National Health Service Corps (NHSC), and the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV).<sup>34,35,36</sup> Like CHIP, these programs play an important role in the safety net for lower-income, underinsured, or uninsured populations.

## *Community Health Centers*

Federal financial support for health centers dates back more than 50 years. Health centers are defined in section 330(k)(2) and Section 330(k)(3)(J) of the Public Health Service Act (PHSA) as serving “a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangement”:<sup>37</sup>

- Required primary health services (as defined in subsection (b)(1)); and
- As may be appropriate for particular centers, additional health services.

Health centers support the care system at the local, state and federal level, and are widely considered safety net providers to vulnerable populations. More specifically, health centers are:

- Located in high-need areas identified as having elevated poverty, higher-than-average infant mortality, and where few physicians practice;
- Open to all residents, regardless of insurance status or ability to pay; and
- Provide comprehensive primary and other health care services, including services that help their patients access care, such as transportation, translation, and case management.<sup>38</sup>

Ninety-two percent of the health center population is below 200 percent of the FPL.<sup>39</sup> Although the ACA decreased the nation’s uninsured population by half, health centers continue to serve as an access point by providing comprehensive primary care to approximately 24 million individuals in medically needy areas, as well as about 1 in 6 Medicaid enrollees.<sup>40,41</sup> And while they provide health care access to a large portion of the nation’s uninsured population (28 percent) they also serve many underinsured individuals.<sup>42</sup> Forty-seven percent of the health center population are Medicaid or CHIP beneficiaries, 9 percent are Medicare beneficiaries and 16 percent have private insurance.<sup>43</sup>

In addition to serving vulnerable populations, health centers provide benefits and services that might not otherwise be available: 81 percent of health centers offer mental health and/or substance abuse treatment, 77 percent offer oral health, and 40 percent have a pharmacy.<sup>44</sup> During public health crises, such as the recent spread of the Zika virus, the Flint water crises, and opioid epidemic, health centers are often frontline primary care.<sup>45</sup>

A recent study analyzing Medicaid claims data from 13 states for health center and non-health center patients demonstrated health centers save, on average, \$2,371 (or 24 percent) in total spending per Medicaid patient when compared to other providers.<sup>46</sup> These savings are attributed to lower utilization and spending across key drivers of health care costs, including:

- 22 percent fewer hospital visits;
- 33 percent lower spending on specialty care;
- 25 percent fewer hospital admissions; and
- 27 percent lower spending on inpatient care.

Overall, health centers have 24 percent lower spending per Medicaid patient when compared to non-health center sites.<sup>47</sup>

Health centers have enjoyed broad bipartisan support in recent decades. In March 2016, senators from both sides of the aisle drafted a letter to Chairman Blunt (R-MO) and Ranking Member Murray (D-WA) on the Subcommittee on Labor, Health and Human Services, Education and Related Agencies requesting the continued recognition and support of health centers during the FY2017 Appropriations process.<sup>48</sup> In the House of Representatives, a similar letter was sent to Chairman Cole (R-OK) and Ranking Member DeLauro (D-CT) of the Subcommittee on Labor, Health and Human Services, Education and Related Agencies, signed by both Republican and Democratic members of Congress.<sup>49</sup>

Health centers are financed through both discretionary funding as part of the appropriations process, and mandatory funding made available under the Community Health Center Fund (CHCF). This fund was established under the ACA in 2010, and consisted of \$11 billion over a five-year period for the operation and expansion of health centers as authorized in Section 330 of the Public Health Service Act. MACRA extended the CHCF for two years at \$3.6 billion annually for FY2016 and FY2017. For FY2016, health centers are funded with nearly \$1.54 billion in discretionary funds and \$3.6 billion in mandatory funds. Funds remain available until expended.

## **Recommendation**

- Given the importance of maintaining access to care for both insured and uninsured populations, extend funding of health centers at the current total level of \$5.1 billion annually (including both mandatory and appropriated funding), through FY2021. BPC recognizes the importance of safety net providers, and acknowledges the potential need for additional funding to ensure continued and improved access to care.

## ***National Health Service Corps***

The NHSC program was established in 1972 to strengthen the primary care workforce by incentivizing primary care providers to practice in the most vulnerable, high-needs areas of the United States.<sup>50</sup> The NHSC fund provides scholarships and loan repayments to certain health professionals in exchange for them providing care in a health professional shortage area for a period that varies based on the length of the scholarship or loan repayment.<sup>51</sup> In 2014, more than 9,000 providers were placed in areas designated as Health Professional Shortage Areas (HPSAs).<sup>52</sup> These health care professionals serve nearly 10 million people, however estimates suggest it would require an additional 18,100 providers to meet the existing need in all currently designated HPSAs.<sup>53</sup>

Prior to the American Recovery and Reinvestment Act of 2009 (ARRA), NHSC was funded through the annual appropriations process. ARRA expanded NHSC funding by establishing a \$300 million trust fund over the course of two fiscal years.<sup>54</sup> In 2011, the ACA allocated dedicated mandatory funding for the NHSC through the CHCF, authorized in Title III of the PHSA.<sup>55</sup> Specifically, the CHCF provided \$1.5 billion total for the NHSC from FY2011 through FY2015 annually as follows: \$290 million for FY2011; \$295 million for FY2012; \$300 million for FY2013; \$305 million for FY2014; and \$310 million for FY2015.<sup>56</sup> Separately, Congress removed all discretionary funding for the NHSC in 2011, leaving the program fully dependent on the CHCF since then.

MACRA extended this mandatory funding through FY2017, although it is estimated that this level of funding allows NHSC to fund less than 40 percent of applicants willing to serve. In the president's FY2016 Budget, the administration included an additional \$287.4 million in discretionary appropriations for NHSC to improve access to primary care providers.<sup>57</sup> The 2017 budget called for similar investments in NHSC, citing the importance of the program in combating the opioid epidemic and making primary care accessible to those who need it most.<sup>58</sup>

## Recommendation

- BPC recommends the continued funding of NHSC at current levels of \$310 million per year in mandatory funding within the CHCF for four years, through FY2021. The NHSC program is critical to supporting the workforce that serves low-income, vulnerable populations, and BPC leaders recognize an increase in funding above current levels might be necessary to provide critical primary care services to those who need it most.

## *The Maternal, Infant, and Early-Childhood Home-Visiting Program*

In 2010, the ACA (P.L.111-148) amended Title V of the Social Security Act (42 U.S.C. 701) to authorize the creation of the Maternal, Infant, and Early-Childhood Home-Visiting Program (MIECHV), which provides federal grants to support evidence-based home visiting programs for vulnerable families. These grants are intended to “strengthen and improve the programs and activities carried out under this title; improve coordination of services for at-risk communities; and identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.”<sup>59</sup> Commonly referred to as the “federal home visiting program,” grants are awarded as a partnership between the federal and state/local governments so that trained nurses, social workers, and other experts—such as child development specialists—can visit homes of expecting parents and/or families with young children. As part of the program, states are required to conduct needs assessments so that services can be properly targeted to at-risk families.<sup>60</sup> The ACA defined “at-risk” for the purposes of MIECHV as communities with concentrations of:

- Premature birth, low-birth weight infants;
- 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 rates of high-school drop-outs;

- Substance abuse;
- Unemployment; or
- Child maltreatment.

Per the National Conference of State Legislators, the goals of the MIECHV program include coordinating and improving existing home programs as well as expanding home visiting services to at-risk communities where existing services are currently limited.<sup>61</sup> As part of the federal-state partnership, states must display improvement in six benchmark areas, including:

- Improvements in maternal and newborn health;
- Childhood injury or maltreatment prevention and reduced emergency room visits;
- School readiness and achievement;
- Crime or domestic violence;
- Family self-sufficiency; and
- Coordination with community resources and support.

To determine the effectiveness of programs that receive MIECHV funding, HHS also created the Home Visiting Evidence of Effectiveness (HOMEVEE) review, which is tasked with completing literature reviews of home visiting effectiveness evidence, providing assessments of current home visiting programs that target at-risk families with pregnant women and young children, and reviewing the quality of the research evidence. The programs that receive MIECHV funding are those that meet the criteria defined by HHS HOMEVEE for evidence of effectiveness, meaning they show statistically significant impacts in outcome measures. Outcome measures include improvements in child development and school readiness, family economic self-sufficiency, maternal health, reductions in maltreatment, child health, linkages and referrals, positive parenting practices, reductions in juvenile delinquency, family violence, and crime.

In FY2015, states reported serving approximately 145,500 parents and children in all 50 states, the District of Columbia, and five territories through MIECHV.<sup>62</sup> This number has quadrupled since FY2012, and the number of home visits provided has increased five-fold.<sup>63</sup> Those individuals served by MIECHV live in both urban and rural areas: In FY2015, MIECHV funded services in 29 percent of all urban counties, and 23 percent of all rural counties.

In a report to Congress on the MIECHV program implementation, the HHS Office of Planning, Research, and Evaluation conducted a review of early findings. This evaluation found that MIECHV is being implemented through programs that have demonstrated effectiveness, and states are targeting counties with higher rates of poverty and premature birth to fulfill the program design goal of assisting disadvantaged communities. The evaluation found that:

- States used initial MIECHV funds primarily to expand the use of four evidence-based home visiting models as determined by HOMEVEE in at-risk communities. Programs have been shown to target those counties with high rates of poverty, child maltreatment, and premature birth;



- As intended, MIECHV-funded programs serve a group of mothers with many needs, including depression, victims of intimate violence, health problems that limit their activities, and lack of a high-school diploma; and
- MIECHV-funded programs are designed to help parents support the healthy development of infants and toddlers and overcome the problems low-income families face.<sup>64</sup>

More specifically, MIECHV has been successful in improved screening for critical health issues in vulnerable communities. In FY2015, 18 grantees reported screening rates of at least 75 percent for developmental delays in children, more than twice the national average of 31 percent in 2011-2012.<sup>h,65,66</sup> Evaluations from FY2015 also show greater rates of screening for intimate partner violence and maternal depression through the MIECHV program.<sup>67</sup> In FY2014, data showed 83 percent of grantees demonstrated improvement in at least four of the six benchmark areas outlined in the legislation. Those that did not show improvement received targeted technical assistance through MIECHV, and all but one of the nine grantees who received this assistance demonstrated improvement.<sup>68</sup>

Before 2010, it is estimated that states spent between \$500 and \$750 million annually on home visiting programs.<sup>69</sup> The ACA funded MIECHV at \$1.5 billion for five years in increasing amounts: \$100 million in fiscal year FY2010, \$250 million in FY2011, \$350 million in FY2012, \$400 million in FY2013, and \$400 million in FY2014. In 2014, The Protecting Access to Medicare Act provided an additional \$400 million to MIECHV through the middle of FY2015. As part of MACRA, the federal home visiting fund received \$400 million annually in funding through FY2017.<sup>70</sup>

## Recommendation

- BPC recommends the continued funding of MIECHV at current levels of \$400 million annually through FY2021 to target funding for evidence-based programs; specifically, for at-risk communities. Early evidence shows MIECHVI is meeting programmatic goals to assist vulnerable families through evidence-based local programs that target at-risk communities.<sup>71</sup> BPC leaders believe the program should continue with a focus on evidence-based success and continued program evaluation.

## *Long-Term Considerations for Programs That Serve Lower-Income Populations*

Congress should initiate a formal process to examine a longer-term solution to health coverage for vulnerable populations. Similar to the process in the recent Senate Chronic Care Working Group, Congress could request broad input, host public hearings/roundtables featuring diverse stakeholders, release policy options for public feedback, and then move forward with bipartisan legislation that achieves certain goals. These goals might factor into how CHIP, health centers, NHSC, and the MIECHV program fit into the new coverage landscape as Congress considers a repeal and replace of the ACA, the role of states versus the federal government, and how best to ensure benefit adequacy and affordability. This process should evaluate evidence-based approaches to improving quality and access to care, and highlight the importance of timing for governors and states as they prepare their budgets.

<sup>h</sup> Grantees include programs from the following states: AK, AL, AZ, CA, CO, CT, ID, IL, LA, NE, NH, NM, NV, NY, OK, SD, TN, and UT.



## *Conclusion*

The programs analyzed in this report serve vulnerable populations—children, lower-income individuals and families, and those in both rural and urban areas where finding affordable, accessible care remains difficult. Funding for each program ends on September 30, 2017. Historically, many of these programs have longstanding bipartisan support. Extending each program for four years will allow policymakers the time to examine the future of programs that serve these populations. BPC leaders support reauthorization of CHIP, health centers, MIECHV, and the NHSC. Due to state budget cycles, extension of funding early in 2017 is necessary to avoid disruptions in coverage for children and families, given the lack of alignment between state and federal fiscal years.

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