MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM FORMULA AWARDS

FY 2022 NON-COMPETING CONTINUATION UPDATE (NCC UPDATE)

ACTIVITY CODE: X10

EHBs ONLY ISSUANCE: March 7, 2022

EHBs SUBMISSION DEADLINE: June 6, 2022

508 COMPLIANCE DISCLAIMER

Note: Persons using assistive technology may not be able to fully access information in this file. For assistance, please email or call one of the HRSA staff listed in the **HRSA Contacts** section.

Purpose

This notice of Non-Competing Continuation Update (NCC Update) provides instructions for completing applications for the Fiscal Year 2022 Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program – Formula Awards. This NCC Update is being used as a streamlined alternative to HRSA's traditional Notice of Funding Opportunity for this program (NOFO). The NCC Update solicits key updates from you, current MIECHV recipients, about grant-supported activities since the submission and approval of your FY 2021 MIECHV formula funding application, as well as your proposed plans for use of FY 2022 MIECHV Formula Awards.

The goals of the MIECHV Program are to:

(1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act;
(2) improve coordination of services within at-risk communities[1]; and
(3) identify and provide comprehensive services to improve outcomes for eligible families living in at-risk communities. HRSA administers this program in partnership with the Administration for Children and Families (ACF).

The HRSA Maternal and Child Health Bureau (MCHB) administers programs with focus areas in maternal and women's health, adolescent and young adult health, perinatal and infant health, child health, and children with special health care needs. To achieve its mission of improving the health and well-being of America's mothers, children, and families, MCHB is implementing a strategic plan that includes the following four goals:

Goal 1: *Assure access to high-quality and equitable health services to optimize health and well-being for all MCH populations*
Goal 2: *Achieve health equity for MCH populations*
Goal 3: *Strengthen public health capacity and workforce for MCH*
Goal 4: *Maximize impact through leadership, partnership, and stewardship*

The MIECHV program addresses MCHB's goals to *assure access to high-quality and equitable health services to optimize health and well-being for all MCH populations* and to *achieve health equity for MCH populations.* To learn more about MCHB and the bureau's strategic plan, visit https://mchb.hrsa.gov/about.

Assistance Listings (AL/CFDA) Number: 93.870

Statutory Authority

HRSA MIECHV Program - Formula Awards are authorized by 42 U.S.C. § 711(c) (Title V, § 511(c) of the Social Security Act) to support the provision of home visiting services to eligible families by states, nonprofit organizations serving states, and U.S. jurisdictions. The Bipartisan Budget Act of 2018 (Pub. L. 115-123) (BBA) extended appropriated funding for the MIECHV

[1] The phrase "at-risk communities" originates from MIECHV authorizing statute (Social Security Act, Title V, § 511); see Appendix F for additional detail. We use the term "communities" to reference areas served in the MIECHV program according to statutory requirements in this document.

Program through FY 2022. In addition to extending funding for the Program, the BBA includes new MIECHV provisions. Specifically, the BBA includes a requirement that states conduct an updated statewide needs assessment, authority for use of funds by recipients for a Pay for Outcomes (PFO) initiative (subject to certain conditions), a requirement that HRSA develop data exchange standards, and a requirement that recipients demonstrate improvements in benchmark measures. The Consolidated Appropriations Act, 2021 (P.L. 116-260) (CAA), includes authority for recipients to use MIECHV grant funds during the declared COVID-19 public health emergency period, to:

- Train home visitors in conducting virtual home visits (see Appendix F for a definition of virtual home visit) and in emergency preparedness and response planning for families;
- Acquire the technological means as needed to conduct and support a virtual home visit for families enrolled in the program; and
- Provide emergency supplies to families enrolled in the program, regardless of whether the provision of such supplies is within the scope of the approved program, such as diapers, formula, non-perishable food, water, hand soap, and hand sanitizer.

Eligibility Information

Eligible applicants include all currently funded MIECHV recipients (i.e., states; six jurisdictions including the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, the Commonwealth of the Northern Mariana Islands, and American Samoa; and nonprofit organizations currently funded in FY 2021 under the MIECHV Program.

In response to the COVID-19 public health emergency, MCHB continues to prioritize meeting emerging needs, including routine childhood vaccinations and well-child visits; funding telehealth expansion; and supporting vaccination, testing, contact tracing, and slowing the spread of the coronavirus. MCHB is committed to supporting states, jurisdictions, and tribes to provide services safely to MCH populations, and encourages them to follow appropriate CDC, state, and local health department guidance. Read more about MCHB's response to COVID-19 at https://mchb.hrsa.gov/coronavirus-frequently-asked-questions.

Current Funding

In FY 2022, up to $340 million is available for awards to the 56 eligible entities that currently receive FY 2021 MIECHV formula funding to continue to deliver coordinated, comprehensive, high-quality, and voluntary early childhood home visiting services to eligible families.[2]

The following formula is applied to FY 2022 funding available to states, nonprofit organizations, and territories:

- Need Funding–Approximately one-third of the grant allocation available under this funding opportunity will be distributed based on the proportion of children under age 5 living in poverty as calculated by the Census Bureau's Small Area Income and Poverty Estimates (SAIPE). 2020 SAIPE data will be used to the extent available, and these data may vary from previous year's SAIPE data. The Puerto Rico Community Survey (PRCS) data will be used as a proxy to determine need funding for Puerto Rico.

  There is a $1.0 million minimum need-based award for recipients.

[2] The FY 2022 appropriation was reduced due to sequestration pursuant to the Budget Control Act (BCA) of 2011, which contained specific procedures for reducing the federal budget deficit through FY 2021 and extended through FY 2027 under the Bipartisan Budget Act of 2018 (P.L. 115-123).

In typical years, the calculated amount is reduced by the proportion of the most recent year's de-obligated amount to that total year's award. Due to the ongoing impacts of the COVID-19 public health emergency that may have affected awardee's ability to fully expend FY 2018 grant funds, de-obligated funds will not be considered in the funding formula for FY 2022 award calculations.

- Base Funding–Approximately two-thirds of the grant allocation available under this funding opportunity is proportionally distributed based on each recipient's base funding portion of the FY 2021 formula grant award ceiling amounts.

- Guard Rails–In an effort to maintain stability, the total amount for which you may apply will be adjusted, where appropriate, to ensure that any available recipient funding does not fluctuate by more than 5 percent from the prior year award.

Submission Information
NCC Updates must be submitted through the HRSA Electronic Handbooks (EHBs). **The total size of all uploaded files may not exceed the equivalent of 50 pages when printed by HRSA**. The page limit includes the project and budget narratives, and required attachments. Standard OMB-approved forms, such as the SF-424, SF-424A, and Project Abstract Summary forms are NOT included in the page limit. Please note: Effective April 22, 2021, the abstract is no longer an attachment that counts in the page limit. The abstract is the standard form (SF) "Project_Abstract Summary."

Instructions on how to submit the NCC Update will be emailed to eligible entities with award ceiling amounts on/around March 7, 2022.

Outline of Required Sections

I. Project Narrative
   A. Progress to Date and Significant Changes to Program Activities since Beginning of the FY 2021 Formula Award (X10) Period of Performance (September 30, 2021 to present)
      1. Description of Progress to Date
      2. Description of Significant Changes
      3. Coordinated State Evaluation (CSE) Progress to Date
      4. FY 2019 Formula Funds Estimated Unobligated Balance
   B. Proposed Activities for the FY 2022 Formula Award (X10) Period of Performance (September 30, 2022 to September 29, 2024)
      1. Project Abstract Summary form
      2. Assurances and Proposed Program Activities for FY 2022 Formula Award (X10)
      3. Work Plan
         - Attachment 1: Work Plan Timeline
         - Attachment 2: MIECHV Communities, Local Implementing Agencies, and Caseload of Family Slots
      4. Budget
         - Budget Forms (SF-424A)
         - Budget Narrative
         - Attachment 3: Period of Availability Spreadsheet
         - Attachment 4: Maintenance of Effort Chart

II. Required Attachments (Attachments 1–6 count towards the 50-page limit)
   Attachment 1: Work Plan Timeline
   Attachment 2: MIECHV Communities, Local Implementing Agencies, and Caseload of Family Slots
   Attachment 3: Period of Availability Spreadsheet
   Attachment 4: Maintenance of Effort Chart
   Attachment 5: Current Organizational Chart
   Attachment 6: *(Only if applicable)* Model Developer Documentation for Enhancements
   Attachment 7: *(Only if applicable)* Indirect Cost Rate Agreement or Cost Allocation Plan
   Attachment 8: *(Only if applicable)* New or Revised MOUs or Letters of Agreement
   Attachments 9–14: Other Relevant Documents

Required Sections

All of the following are required for a complete NCC Update application package. You must upload a complete application into the HRSA EHBs to be considered for funding. *Note*: Please read instructions carefully and report only on the specific MIECHV award(s) and period of performance referenced in each section.

Project Narrative

A. Progress to Date and Significant Changes to Program Activities Since Beginning of the FY 2021 Formula Award (X10) Period of Performance (September 30, 2021 to present)

This section calls for a report of progress to date and significant changes to program activities since the beginning of the FY 2021 award period of performance (September 30, 2021), through the date of this NCC Update submission. The entire period of performance for these FY 2021 formula awards (X10) extends from September 30, 2021 to September 29, 2023.

In this section:

1. Provide a **description of progress** *specifically* on the goals and objectives proposed in your FY 2021 formula award work plan. Describe any barriers to progress and strategies/steps taken to resolve such challenges.

2. Provide a brief **description of any significant changes** in your implementation of the program during the stated time period, or clearly state if there have been no significant changes. Specifically identify any changes related to the following:
   - Goals, objectives, major activities, or budget, including those changes under the FY 2021 formula award that have occurred as a result of the COVID-19 public health emergency or HRSA-approved re-budgeting or program changes;
   - Model selection;
   - Model enhancements to a MIECHV-funded home visiting model that do not alter the core components of the model (which has been documented through submission of a letter of concurrence from the model developer);
   - Coordination with comprehensive statewide and local early childhood systems;
   - Caseload;
   - Staffing plans, including changes to key personnel and, if applicable, a discussion of any vacancies or difficulties in hiring or retaining staff;
   - Communities served, including changes made as a result of your approved 2020 MIECHV statewide needs assessment update; and
   - Changes to subrecipients or local implementation sites that perform all or part of the work of the grant, including changes to contracts with local implementing agencies (LIAs[3]), closing of existing LIAs, or establishment of new LIAs.

3. HRSA encourages recipients to continue their existing **coordinated state evaluations** (CSE). If you are conducting a CSE with your FY 2021 formula award, briefly summarize progress on your evaluation since the start of the FY 2021 formula award.

[3] Note: the term “local implementing agency” includes local sites operated by recipient staff.

Include a description of any challenges encountered in planning or conducting your evaluation.

4. If you had more than 25 percent deobligation of previously awarded FY 2019 MIECHV formula grant funds, state this and describe actions you will take to avoid deobligations of active formula grants (i.e., FY 2020 and FY 2021) within the respective periods of performance. Deobligated funds are those MIECHV grant funds that remain unobligated at the end of the period of performance, and are returned to the Federal Government. Otherwise, leave this section blank.

B. Proposed Activities for the FY 2022 Formula Award (X10) Period of Performance (September 30, 2022 to September 29, 2024)

This section provides instructions for submission of a project abstract, assurances of compliance with Program Expectations and Funding Restrictions (see Box 1), proposed activities, a work plan, and a budget for the FY 2022 period of performance.

1. Project Abstract Summary

Use the Standard OMB-approved Project Abstract Summary Form. Do not upload the abstract as an attachment or it may count toward the page limitation. See Section 4.1.ix of HRSA's *SF-424 Application Guide.*

Start with the information below and provide a summary of proposed activities for the FY 2022 formula award (X10) period of performance in the Project Abstract box of the Project Abstract Summary Form using 4,000 characters or less.

- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- Email Address
- Website Address, if applicable
- List all grant program funds requested in the application, if applicable

Because the abstract is often distributed to provide information to the public and Congress, prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served. If the application is funded, your project abstract information (as submitted) will be made available to public websites and/or databases including USAspending.gov.

Include the following sections:

a. Purpose: Provide a brief description (three-to-five-sentences) of the proposed project including the population and/or community needs to be addressed, the proposed services, and the population group(s) to be served.
b. Goal(s) And Objectives: Identify the major goal(s) and objectives for the project. Typically, you state the goal(s) in a sentence and present the objectives in a numbered list.
c. Methodology: Briefly describe the major methods and activities used to attain the goal(s) and objectives, including:
   i. Selected eligible evidence-based models and promising approaches implemented with MIECHV grant funds;

ii. Communities to be served, and any specific target population group(s) within those communities, based on the approved 2020 statewide needs assessment update;
iii. Proposed caseload of MIECHV family slots (associated with the maximum service capacity) for each federal fiscal year within the FY 2022 formula award period of performance;
iv. Current caseload of MIECHV family slots (associated with the maximum service capacity);
v. Key activities to ensure appropriate linkages and referral networks to other community resources and supports, including to high-quality, comprehensive statewide early childhood systems, to support eligible families served by the project.

2. Assurances and Proposed Program Activities for FY 2022 Formula Award (X10)
In this section:

a. Program expectations: Include a statement assuring compliance with *each* of the Program Expectations listed in Box 1 (see additional details in Appendix A). If you believe the program requirement does not apply to your program, please clearly make a statement to that effect, including justification/explanation. In any event, you must adhere with all statutory and relevant program requirements.

b. Voluntary services: Include a statement assuring that home visiting services offered through the MIECHV Program are provided on a voluntary basis to eligible families.

i. If applicable, describe any planned changes to how you will ensure enrollee participation is voluntary, with mention of any new or planned policies and procedures. Further explanation is not necessary if there are no planned changes.

Box 1: Assurances Required for Program Expectations

- Priority for Serving High-Risk Populations
- Enrollment
- Selection of Home Visiting Service Delivery Model(s)
- Fidelity to Home Visiting Service Delivery Model(s)
- Model Enhancements
- Early Childhood Systems Coordination and Collaboration
- Non-duplication with Tribal MIECHV Program
- High-Quality Supervision
- Subrecipient Monitoring
- Limit on Use of Funds to Support Direct Medical, Dental, Mental Health, or Legal Services

c. Plan overview: Provide an overview of your plans for the FY 2022 formula award (September 30, 2022 to September 29, 2024). **Clearly indicate[4] any significant changes** from your FY 2021 formula award and provide a brief justification/explanation for each change.

i. State the goal(s) and objectives for the period of performance. Typically, the goal(s) are stated in a sentence, and the objectives are presented in a numbered list. Objectives should support progress toward goals. Utilize the

[4] HRSA recommends the use of specific annotations (e.g., marking elements as “new”) or formatting (e.g., bold or italics) to indicate changes.

SMARTIE framework (specific, measurable, achievable, realistic, time-bound, inclusive, and equitable) framework[5], as feasible.

ii. Provide an overview of all major activities planned to achieve your goal(s) and objectives. (NOTE: Proposed activities must be in compliance with MIECHV statute and Program Expectations and Funding Restrictions detailed in Appendix A. Activities must not be duplicative with other federally funded projects.) Include a work plan timeline for completing these activities as Attachment 1 (see instructions below).

d. Discontinued communities: Identify any communities[6] that are currently being served with MIECHV formula award funds, for which you propose to *discontinue* services under the FY 2022 MIECHV formula award, or clearly state if you will not discontinue services to any communities. Describe your plans to notifiy the model developer(s) of your intent to discontinue services in these communities.

i. Explain why you decided to discontinue services in these communities, using information from your approved 2020 statewide needs assessment update or other information, and describe how you plan to support families to transition to other home visiting or early childhood services, as applicable.

e. New communities: Identify any communities that you do not currently serve with MIECHV formula award funds that you intend to *newly serve* with FY 2022 MIECHV formula award funds, or clearly state if you do not intend to serve new communities with FY 2022 formula award funds. (List all communities to be served under the FY 2022 MIECHV formula award in Attachment 2. Note that all communities served must be within areas identified as at-risk for poor maternal and child health outcomes in the approved 2020 statewide needs assessment update, as required under the MIECHV authorizing statute.[7]) If proposing new communities:

i. Explain why you propose to provide services in these new communities that are not currently being served with MIECHV formula award funds, and discuss factors that led you to prioritize these communities. Describe your plans to notifiy the model developer(s) of your intent to initiate services in these communities.

ii. Describe the community readiness and capacity to provide home visiting services within these communities, including:

- how you determined readiness (if applicable, please refer to Community Readiness: A Toolkit to Support Maternal, Infant, and Early Childhood Home Visiting Program Awardees in Assessing Community Capacity toolkit to support your response);
- any major barriers to providing home visiting services in the selected communities and plans to address those barriers; and
- how early childhood systems and community service infrastructure will be available to support the implementation of MIECHV home visiting.

---

[5] The Management Center. “SMARTIE Goal Worksheet.” Last updated: May 10, 2021. Available at: https://www.managementcenter.org/resources/smartie-goals-worksheet/

[6] The term “communities” is operationalized as counties, county equivalents, or sub-territory geographic units identified as at-risk in Table 7 of the approved 2020 statewide needs assessment update, or specific communities within these areas (including tribal communities). See Appendix F for additional details.

[7] Social Security Act, Title V, § 511(b).

- If you intend to serve tribal communities, describe relevant activities, including any coordination or collaboration with tribal representatives or ACF Tribal MIECHV Program recipients. (Note: These services must not be duplicative of, but rather coordinated with, any services provided by the Tribal MIECHV Program in these communities, if applicable.)

f. Subpopulations: Identify any subpopulations of eligible families that you intend to prioritize in your activities. This may be informed by specific community needs identified in your approved 2020 statewide needs assessment update. Describe the factors that led you to select these subpopulations.

g. Family engagement and leadership: Identify key activities that support parent or family engagement and leadership to ensure high-quality services within statewide or local early childhood systems. Include any efforts to engage diverse family and community representatives in leadership and advisory roles and to support their meaningful and equitable participation.

h. Social determinants of health and health equity: Identify key activities, including any coordination and collaboration with early childhood systems partners, to address inequality and disparities in outcomes for families. Recipients should identify specific social and structural determinants of health, such as institutional and personal bias, family access and linkage to nutrition, behavioral health (including infant and early childhood mental health and substance use), maternal health, early care and education, oral health, and family violence services, and other supports that address social determinants of health as highlighted in Appendix A.

  i. Identify key activities or strategies that will advance health equity for eligible families living in communities you intend to serve (see Appendix A for a definition and example strategies).

i. Model enhancements: If you propose any model enhancements implemented in the context of a MIECHV-funded home visiting model, provide a summary of the enhancement(s) to be implemented, including which LIAs will use the enhancement(s) and any training that has been or will be completed. Provide documentation of model developer concurrance as **Attachment 6.** Otherwise, clearly state that you are not implementing a model enhancement.

j. Recruitment and retention of staff: Briefly describe how you will plan for and address recruitment and retention of qualified staff at the recipient and local levels, including professional development activities and any efforts to address staffing vacancies or other staffing challenges (e.g., reassignments). In particular, highlight efforts to promote staff well-being, as well as to promote competitive compensation for staff, including wages and benefits.

  i. Describe any proposed changes to key staff at the recipient level beginning with the FY 2022 formula award period of performance.

  ii. Provide a current project organizational chart with position titles, names and vacancies noted, contractors, and other significant collaborators as **Attachment 5**. Include staff biographies and resumes for any new key staffing positions as one of the additional required attachments (**Attachments 8–14**) (for more information on key staffing positions, see the budget narrative instructions for personnel costs).

k. Partnership agreements: Describe any key changes to required or other high-priority partnerships (as described in Appendix A), or clearly state if there are no changes.

i. Provide an assurance that you have reviewed, and updated as appropriate, all written agreements with required partners within the last 3 years. If updated written agreements are needed, provide assurance that you will submit the required agreements to HRSA no later than October 30, 2022.

ii. Describe any challenges experienced related to maintaining required partnerships or written agreements and plans to address those challenges; otherwise state if you have not experienced challenges.

l. Project sustainability: Propose a plan for sustainability of key project methods and activities after the period of MIECHV funding ends.

i. Describe how your state is leveraging other funding sources, such as public insurance financing or braiding of funds across programs, to support evidence-based home visiting. Specifically, describe any alignment or braiding of funds with the following: Medicaid, the Title V Maternal and Child Health (MCH) Block Grant, Title IV-E Prevention Program funds as described in the Family First Prevention Services Act (FFPSA), the Preschool Development Grant Birth-through-Five (PDG B-5), and Early Childhood Comprehensive Systems (ECCS).

ii. Describe the extent to which activities related to implementation of the Title V MCH Block Grant, FFPSA, PDG B-5, or ECCS are coordinated with MIECHV in your state. If you are coordinating, describe any activities that are currently underway, either in planning or implementation, and describe any barriers to coordination.

m. Caseload method: Identify which caseload method (Home Visitor Personnel Cost Method or Enrollment Slot Method) you will utilize. (See Box 2 for more information about the approved caseload methods.) Please describe why you have chosen this approach. Note that you will use this method to propose a caseload of family slots in this NCC update **and** to define MIECHV families for the purposes of reporting to HRSA on performance reporting Forms 1, 2, and 4.

n. Pay for outcomes: If you intend to to implement a pay for outcomes (PFO)

Box 2: Identifying MIECHV Families

For the purposes of reporting to HRSA on performance reporting Forms 1, 2, and 4, a "MIECHV family" is defined as a family served during the reporting period by a trained home visitor implementing services with fidelity to the model and that is identified as a MIECHV family at enrollment. HRSA has identified two different methods to identify MIECHV families:

- ***Home Visitor Personnel Cost Method:*** Recipients designate families as MIECHV at enrollment based on the designation of the home visitor they are assigned. Using this methodology, recipients designate all families as MIECHV that are served by home visitors for whom at least 25 percent of his/her personnel costs (salary/wages including benefits) are paid for with MIECHV funding.
- ***Enrollment Slot Method:*** Recipients designate families as MIECHV families based on the slot to which they are assigned at enrollment. Using this methodology, recipients identify certain slots as MIECHV-funded and assign families to these slots at enrollment in accordance with the terms of the contractual agreement between the MIECHV state recipient and the LIA regardless of the percentage of the slot funded by MIECHV.

The Home Visitor Personnel Cost Method is consistent with the current definition of caseload of MIECHV family slots first identified in the 2016 MIECHV Formula Funding Opportunity Announcement (HRSA-16-172) and HRSA encourages recipients to use this method. After identifying a MIECHV family, the recipient tracks that family for the purposes of data collection using the same method through the tenure of family participation in the program.

initiative, describe any past or proposed activities that would support such an initiative, such as a feasibility study, third party evaluation, and outcome payments. Refer to Appendix A for additional instructions.

o. Evaluations: Provide a statement indicating whether you plan to conduct any of the following evaluations:

i. A new promising approach evaluation;
ii. A continuing promising approach evaluation;
iii. A continuation of an existing coordinated state evaluation (CSE) proposed under the FY 2021 formula award; and/or
iv. A new "implementation quality/fidelity" CSE. Recipients may apply to begin a new CSE within the existing "implementation quality/fidelity" peer network. Recipients who propose to conduct a new CSE in this existing topic area will receive technical assistance from the MIECHV Evaluation Coordinating Center. HRSA will also provide interested recipients with publicly available evaluation design templates for relevant implementation quality/fidelity research questions, which can be tailored and used to support the development of recipient evaluation plans (see Appendix A for further details).

If you plan to conduct any of the above, follow the instructions in Table 1 for each planned evaluation. Otherwise, clearly state if you do not propose to conduct any of these evaluations with the FY 2022 formula award, including if you will discontinue a previously approved CSE. Refer to Appendix A of HRSA-21-050 for complete information on HRSA's expectations for research and evaluation activities.

(Note: Only the above evaluation types are eligible for funding under FY 2022 formula award. New proposals will not be considered for the other three CSE topic areas.)

If you propose an evaluation, you must include a budget narrative and detailed line item breakdown as part of the overall budget for evaluation expenses. For details, see the evaluation budget instructions in the **Budget Narrative** section.

Table 1: Instructions for proposing an evaluation

If you propose:	Describe:
To begin implementation of a home visiting model that qualifies as a promising approach with FY 2022 formula funds and conduct a new promising approach evaluation Note: Recipients that propose to implement a promising approach are required to	• The purpose and the focus of the evaluation • How the evaluation design will meet requirements for an assessment of impact using an appropriate comparison condition **NOTE: Promising approaches must be evaluated through a well-designed and rigorous process. See Appendix A for a description of the Limit on Funds for Conducting and Evaluating a Promising Approach.**

If you propose:	Describe:
conduct a rigorous evaluation of that approach.[8]	
To continue an existing promising approach evaluation(s) Note: Recipients that propose to continue implementing a promising approach are required to continue evaluating that approach.	• The rationale for continuing the evaluation • Any enhancements or modifications to the existing evaluation
To continue an existing coordinated state evaluation from FY 2021 formula award	• Major evaluation activities that will be supported with the FY 2022 formula award • Any planned changes to your evaluation beginning in FY 2022 • A plan to address challenges encountered to date, if any
To begin implementation of an "implementation quality/ fidelity" CSE	• The rationale for selecting this topic area, including your needs and interest for conducting a CSE within this topic • Evaluation staff who will lead the CSE, and describe their relevant experience, training, skills, and knowledge, including materials published and previous evaluation work, that will allow them to achieve the goals and meet the requirements of the CSE • Organizational experience and capability to coordinate and support the planning and implementation of rigorous evaluation activities, including by identifying meaningful support and collaboration with key stakeholders in conducting evaluation • Capacity and capability to engage with federal and TA staff in collaborative evaluation development and engage with other recipients to develop shared evaluation design and measurement strategies through consensus processes • How you plan to disseminate lessons learned to applicable stakeholders, including home visiting participants, staff, model developers, MIECHV formula recipients, and the home visiting field broadly, including evaluation findings

[8] Social Security Act, Title V, § 511(d)(3)(A)(i)(II

3. **Work Plan**
   For this section, include the following as attachments:

a. **Attachment 1: Work Plan Timeline:** Provide a work plan timeline that includes: 1) a list of key activities to achieve each of the objectives proposed; 2) anticipated outputs; 3) responsible staff for each activity; and 4) timelines for completion. The work plan timeline must extend across the period of performance (September 30, 2022 through September 29, 2024) and include start and completion dates for activities.

b. **Attachment 2: MIECHV Communities, Local Implementing Agencies, and Caseload of Family Slots:** Provide a list of each LIA. For each LIA, identify the:

   i. County/ies, County Equivalent or Tribal entity(ies) the LIA will serve (in whole or in part; these should align with areas listed in Table 7 of your approved 2020 statewide needs assessment update);
   ii. Evidence-based model(s) and/or promising approach models the LIA will implement;
   iii. Number of families the LIA cumulatively served from 10/1/2020 through 9/30/2021;
   iv. Current caseload of MIECHV family slots (associated with the maximum service capacity) from 10/1/2021 through 9/30/2022 by model;
   v. Proposed caseload of MIECHV family slots (associated with the maximum service capacity) for Year 1 (10/1/2022 through 9/30/2023) by model;
   vi. Proposed caseload of MIECHV family slots (associated with the maximum service capacity) for Year 2 (10/1/2023 through 9/30/2024) by model; and
   vii. Estimated cost per family slot using proposed caseload from 10/1/2022 through 9/30/2024.

Base the proposed caseloads on your best estimates assuming stable formula funding from FY 2022 to FY 2024. You may request revisions to caseloads should there be changes in future funding.

Note: Caseloads reported in this attachment must align with numbers reported in the abstract.

***Box 4:* The MIECHV Program requires the following for a complete, non-PFO budget submission:**

- Budget Forms
  - SF-424A
- Budget Narrative
  - Personnel costs
  - Travel
  - Supplies
  - Contractual
  - Other
  - Administrative Expenditures
    - Description of Activities
    - Line Item Breakdown
    - Estimated Percentage of Budget
  - Recipient-Level Infrastructure Expenditures
    - Description of Activities
    - Line Item Breakdown
    - Estimated Percentage of Budget
  - Evaluation Costs (if applicable)
    - Description of Activities
    - Line Item Breakdown
- Attachment 3: Period of Availability Spreadsheet
- Attachment 4: Maintenance of Effort Chart

4. Budget

*If you are requesting MIECHV formula funds for the purpose of a PFO initiative, please disregard this section and refer to the budget instructions in Appendix E. The below instructions apply only if you are not proposing a PFO initiative.

Prior to completing this NCC Update, see Program Expectations and Funding Restrictions in Appendix A for complete descriptions of the following types of expenditures:

- Limit on Funds to Support Direct Medical, Dental, Mental Health, or Legal Services;
- Statutory Limit ("Cap") on Use of Funds for Administrative Expenditures;[9]
- Limit on Use of Funds for Recipient-Level Infrastructure Expenditures; and
- Statutory Limit on Funds for Conducting a Program (including Evaluating of the Program) Using a Promising Approach.[10]

NOTE: Please do not include prior year MIECHV formula funds or funds from other MIECHV awards (e.g., ARP X11 awards) in the SF-424A or the budget narrative.

Period of Availability

Funds awarded to you for a federal fiscal year under this NCC Update shall remain available for expenditure through the end of the second succeeding federal fiscal year after award. **The project/budget period is 2 years,** for the period of September 30, 2022 through September 29, 2024. You must demonstrate that home visiting services will be made available throughout the entire period of performance (the full period of availability). However, maintaining the same rate of expenditure or the same level of home visiting services throughout the full period of availability is not required. Reminder: grant funds that have not been obligated for expenditure by the recipient during the period of availability for use of such funds will be de-obligated. FY 2022 funds must be obligated by recipients no later than September 29, 2024, and such obligations must be liquidated by December 31, 2024.

COVID-19 Public Health Emergency Authorities

During the declared COVID-19 public health emergency period, recipients can choose to budget MIECHV funds to:

1. Train home visitors in conducting virtual home visits (see Appendix F for a definition of virtual home visit) and in emergency preparedness and response planning for families;
2. Acquire the technological means as needed to conduct and support a virtual home visit for families enrolled in the program; and
3. Provide emergency supplies to families enrolled in the program, regardless of whether the provision of such supplies is within the scope of the approved program, such as diapers, formula, non-perishable food, water, hand soap, and hand sanitizer.

P.L. 116-260 specifies that the additional authorities listed above are only available "during the COVID-19 public health emergency period" and therefore will be discontinued (and therefore no longer will represent allowable costs under this award) at the conclusion of the declared COVID-19 public health emergency. At that time, any

[9] Social Security Act, Title V, § 511(i)(2)(C).
[10] Social Security Act, Title V, § 511(d)(3)(A).

unobligated grant funds budgeted for activities related to the COVID-19 authorities described above must be re-budgeted for other allowable activities.

Key Requirements
Costs charged to the award must be reasonable, allowable, and allocable under this program. Documentation must be maintained to support all grant expenditures. Personnel charges must be based on actual, not budgeted labor. Promotional items and other expenditures which do not support the home visiting initiative are unallowable. Organizational membership in business, professional, or technical organizations or societies are generally allowable costs, if paid according to an established organizational policy consistently applied regardless of the source of funds. Costs of membership in any country club or social or dining club or organization are unallowable. Costs of membership in organizations whose purpose is lobbying are unallowable. Salaries and other expenditures charged to the grant must be for services that occurred during the grant's period of availability. It is the responsibility of the recipient to ensure that proper stewardship is exercised over federal funds. Costs must be necessary and reasonable, accorded consistent treatment, and allocable to the award[11] in accordance with the benefits received by the project. Further information regarding allowable costs is available from the Uniform Administrative Requirements (UAR) at 45 CFR part 75.

The recipient accounting systems must be capable of separating the MIECHV awards within a single grant by period of availability (i.e., must have a chart of accounts to prevent grant expenditures from being commingled with other grant periods of availability). Recipients are responsible for reviewing subrecipients' and local sites' budgets according to all applicable organizational policies and procedures and for ensuring adequate post award monitoring of activities and expenditures[12]. Recipients and subrecipients must maintain all documentation in accordance with the federal record retention policy which states documentation must be maintained for a minimum of 3 years after the submission of the final (accepted) Federal Financial Report.

Required Submissions

a. **Budget Forms**

Complete Application Form SF-424A Budget Information – Non-Construction Programs in the EHBs. **The project/budget period is 2 years.** Provide a line item budget narrative using the budget categories in the SF-424A for the period of September 30, 2022 through September 29, 2024. The narrative must explain the amounts requested for each detailed line item in the budget (e.g., personnel, fringe, travel, equipment, supplies, contractual, other, indirect charges, etc.).

For additional information on all the object class categories on the SF-424A and information to be included in the budget narrative, please refer to Section 4.1v. of the HRSA *SF-424 Application Guide*.

(1) **In Section A of the SF-424A budget form, you will use only row (1), column (e)** to provide the budget amount you will request for FY 2022 (see communication via HRSA's EHBs for the total amount you may request).

[11] See definition of "allocable costs" in Appendix F.
[12] Recipients must show they are meeting all MIECHV monitoring requirements, regardless of the type of relationship they have with their implementing agencies.

Please enter the amounts in the "New or Revised Budget" column, not the estimated unobligated funds column.

(2) **In Section B of the SF-424A budget form, you will use only column (1)** to provide object class category breakdown for the entire period of availability of FY 2022 funds. Do not separately report budget amounts for each year of the award period. Use of column (2) is reserved for PFO budgets only.

b. **Budget Narrative**

Provide a narrative explanation of the amounts requested for each line in the budget. The budget narrative should specifically describe how each item will support the achievement of proposed objectives. Provide a reasonable estimate of how you plan to break down costs within each budget line and a description of how you came to that estimate. Line item information must align with and explain the costs entered in the SF-424A and Period of Availability Spreadsheet as **Attachment 3** (discussed later).

Include the following in the Budget Narrative:

i. Personnel Costs: List each staff member to be supported by (1) MIECHV funds, the percent of effort each staff member spends on the MIECHV award, roles and area of responsibility, and (2) in-kind contributions. If personnel costs are supported by in-kind contributions, please indicate the percent of effort and the source of funds.

Please include:

- The full name of each staff member (or indicate a vacancy);
- Position title with description of role and responsibilities;
- Percentage of full-time equivalency (FTE) dedicated to this MIECHV award;[13]
- Annual/base salary;
- Federal amount requested; and
- If in-kind contributions, indicate percent of effort and funding source(s).

Personnel includes, at a minimum, the project director, primarily responsible for the oversight and/or the project coordinator, primarily responsible for the day-to-day management of the proposed program; staff responsible for quality improvement activities (including, but not limited to, providing continuous quality improvement support to LIAs); programmatic and fiscal staff responsible for monitoring program activities and use of funds; and staff responsible for data collection, quality, and reporting. This list must include the Project Director listed on the Notice of Award.

Note that if any of these positions are contractual and included in the Contractual Object Class category, you must have a formal written agreement with the contracted individual that specifies the nature of the relationship between the parties, even if that relationship does not involve a salary or other form of remuneration. If the individual is not an employee of your organization,

[13] Total percent of effort for each personnel funded under this award must not exceed a sum of 100 percent FTE on all Federallyfederally-funded projects.

HRSA will assess whether the arrangement will result in the organization being able to fulfill its responsibilities under the grant, if awarded.

NOTE: Final personnel charges must be based on actual, not budgeted labor.

ii. Travel: The budget should reflect the travel expenses associated with participating in meetings that address home visiting efforts, other proposed trainings or workshops, and monitoring visits to LIAs. You should list travel costs, including whether the travel costs are for local and long distance travel. You must budget for one All Grantee Meeting in the Washington, DC area for up to five people for 5 days. **Meeting attendance is a grant requirement.** If you are applying to continue your participation in a CSE or applying to begin implementation of an implementation quality/fidelity CSE, you must budget for two in-person peer network meetings in the Washington, DC area for up to two people for 2 days. **Meeting attendance is required for all recipients conducting a CSE**. Refer to page 30 of the HRSA *SF-424 Application Guide* for more information on providing a travel budget justification. If travel cannot be completed during the period of performance because of circumstances beyond the recipients' control, funds budgeted for travel may be rebudgeted.

iii. Supplies: Educational supplies may include pamphlets and educational videotapes—as well as model-specific supplies such as crib kits to promote safe sleep, tools to promote parent/child interaction, etc., that are essential in ensuring model fidelity. Clear justification for the purchase of basic medical supplies must be included.

iv. Contractual: You must ensure your organization has in place and follows an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts.

You must provide:

- A clear explanation of the purpose of each contract;
- How the costs were estimated;
- The specific contract deliverables;
- A breakdown of costs, including the level of effort for home visitor personnel, for example, full-time equivalent (you may provide a listing of each home visitor personnel); and
- Narrative justification that explains the need for each contractual agreement and how it relates to the overall project.

HRSA reserves the right to request a more detailed, line-item breakdown for each contract. Costs for contracts must be broken down in detail as described above. Reminder: you must notify potential subrecipients (e.g., LIAs) that entities receiving subawards must be registered in the System for Award Management (SAM.gov) and provide the recipient with their Unique Entity Identifier (UEI)[14], formerly known as the Dun and Bradstreet Data Universal Numbering System (DUNS) number. "Subaward" means an award provided by

[14] In April 2022, the DUNS number will be replaced by the UEI, a "new, non-proprietary identifier" requested in, and assigned by, the System for Award Management (SAM.gov). For more details, visit the following pages: Planned UEI Updates in Grant Application Forms and General Service Administration's UEI Update.

a pass-through entity to a subrecipient for the subrecipient to carry out part of a federal award received by the pass-through entity. It does not include payments to a contractor or payments to an individual that is a beneficiary of a federal program. A subaward may be provided through any form of legal agreement, including an agreement that the pass-through entity considers a contract. For more information on subawards and subrecipient monitoring, see Appendix A.

Consultant contractors can also be listed in this section. For each consultant, specify the scope of work for the consultant, the hourly rate, and the number of hours of expected effort.

(NOTE: Contracting and subcontracting are allowable under this program; however, subgranting is not allowable under this program. Recipients that intend to provide services through subrecipient LIAs must have a written plan in place for subrecipient monitoring and must actively monitor subrecipients. See Appendix A for a complete description of subrecipient monitoring.)

Timely Federal Funding Accountability and Transparency Act (FFATA) reporting is required by the federal grant recipient to the FFATA Subaward Reporting System (FSRS.gov). You must have policies and procedures in place to ensure compliance with FFATA. For more FFATA information, please see Section 6.d. Transparency Act Reporting Requirements of HRSA's *SF-424 Application Guide* and HRSA's FFATA page.

v. Other: Include all costs that do not fit into any other category and provide an explanation of each cost in this category (e.g., provider licenses, audit, etc.). In some cases, rent, utilities, and insurance fall under this category if they are not included in an approved indirect cost rate. You may include the cost of access accommodations as part of your project's budget, including sign language interpreters, plain language and health literacy print materials in alternate formats (including Braille, large print, etc.); and linguistic competence modifications (e.g., translation or interpretation services). The cost of purchasing consultative assistance from public or private entities, if the state determines that such assistance is required in developing, implementing, evaluating, and administering home visiting programs, is allowable if clearly justified. The cost of childcare for participating families may also be allowable if within the scope of an approved project or program or as incidental costs of a project or program if incurred to enable individuals to participate as subjects in research projects or to receive health services.

Additionally, include within the Budget Narrative as a separate breakout:

i. Administrative expenditures: A description of activities and detailed line-item breakdown of administrative expenditures,[15] as applicable, incurred through administering the MIECHV grant. Also, include the **estimated percentage** (at no more than 10 percent) of the FY 2022 MIECHV formula grant award planned to support these activities. (*For a complete definition and examples of administrative expenditures, see Appendix A.)*

[15] Social Security Act, Title V, § 511(i)(2)(C).

ii. Recipient-level infrastructure costs: A description of activities and detailed line item breakdown of recipient-level infrastructure costs, as applicable, to enable the delivery of home visiting services, including but not limited to administrative costs. Also, include the **estimated percentage** (at no more than 25 percent, including administrative costs as described above) of the FY 2022 MIECHV formula grant award planned to support those activities. Actual expenditures made under the award cannot exceed the 25 percent limitation. (*For a complete definition and examples of recipient-level infrastructure expenditures, see Appendix A.)*

   i. NOTE: To seek HRSA approval for spending more than 25 percent of the award amount on recipient-level infrastructure costs, you must provide written justification for this request (for example, providing explanation of an unusually high negotiated indirect cost rate that increases infrastructure costs). Include this justification within the Budget Narrative.

iii. Evaluation activities (as applicable)**:** If you propose any evaluation activities (as described above in the "Assurances and Proposed Program Activitivies" section of the Project Narrative), **you must include a budget narrative with justification and rationale for the proposed evaluation budget and detailed line item breakdown for evaluation expenses.** These include, but are not limited to costs associated with salary and benefits for staff working on the evaluation, contracts for external evaluators, data collection, travel, communication tools that share interim results with stakeholders, printing, supplies, equipment, etc.

   HRSA recommends a maximum funding ceiling of 10 percent of the total requested budget for evaluation activities. HRSA also recommends that a minimum of $100,000 be devoted to evaluation-related activities to ensure the appropriate level of quality and rigor.

c. **Attachment 3: Period of Availability Spreadsheet**

The purpose of this spreadsheet is to support verification that MIECHV formula funds will be budgeted to last through the full 2-year period of availability. Recipients are not required to budget FY 2022 formula funds in Year 1 of the period of performance.

Submit a spreadsheet, labeled as **Attachment 3 – Period of Availability Spreadsheet**, that includes the proposed budget by object class category (personnel, fringe, travel, etc.) for each individual fiscal year of the 2-year period of performance/period of availability (9/30/2022 to 9/29/2024), as well as an additional column that indicates how funds remaining from the previous FY 2021 MIECHV formula grant are proposed to be spent in Year 1 by object class category (e.g., personnel, fringe, travel).

For example:
FY 2021 MIECHV formula award (Year 1 of the FY 2022 period of performance) (for budgetary purposes: September 30, 2022 to September 29, 2023)
Column 1: Remaining funding from FY 2021 MIECHV formula grant to be spent in Year 1 of the FY 2022 period of performance

FY 2022 MIECHV grant - Year 1 (for budgetary purposes: September 30, 2022 to September 29, 2023)
Column 2: FY 2022 MIECHV grant Year 1 proposed spending
FY 2022 MIECHV grant - Year 2 (for budgetary purposes: September 30, 2023 to September 29, 2024)
Column 3: FY 2022 MIECHV grant Year 2 proposed spending

NOTE: The sum of expenditures for service delivery, recipient-level infrastructure, and administrative costs included in this Period of Availability Spreadsheet will **not** add up to the total grant award ceiling amount because certain recipient-level expenditures do not count against the 25 percent limit on recipient-level infrastructure expenditures, and so are not included in this spreadsheet. (See Appendix A for a list of recipient-level infrastructure expenditures that do not count against the 25 percent limit.)

d. **Attachment 4: Maintenance of Effort Chart**
Submit the following Maintenance of Effort (MOE) chart as **Attachment 4**. Refer to Appendix A for a description of the maintenance of effort statutory requirement. Also, include an explanation for any decreases in state funding.

NON-FEDERAL EXPENDITURES		
Two Fiscal Years Prior to Application – Actual (Corresponds to State FY 2020) Actual 2 years prior state FY non-federal (State General Funds) expended for the proposed project by the **recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. **Include prior state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** This number should equal the reported expenditures entered in the "FY Prior to Application (Actual)" column submitted as Attachment 4 in response to HRSA-21-050. (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) Amount: $______________	Fiscal Year Prior to Application - Actual (Corresponds to State FY 2021) Actual prior state FY non-federal (State General Funds) expended for the proposed project by **the recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. **Include prior state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** This number should equal the reported expenditures entered in the "Most Recently Completed Fiscal Year (Actual)" column submitted as Section V of the FY 2019 Formula Grant Final Report. (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) Amount: $______________	Current Fiscal Year of Application – Estimated (Corresponds to State FY 2022) Estimated current state FY non-federal (State General Funds) designated for the proposed project by the **recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. **Include current state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) Amount: $______________

Required Attachments
You may upload only the attachments listed below with the NCC Update submission (no more than 15 total attachments). Each attachment must contain the Project Title, Organization Name, and Primary Contact Name. You must ensure each attachment is correctly labeled and uploaded in the "Attachments" section in the EHBs as follows:

- Attachment 1: Work Plan Timeline
- Attachment 2: MIECHV Communities, Local Implementing Agencies, and Caseload of Family Slots
- Attachment 3: Period of Availability Spreadsheet
- Attachment 4: Maintenance of Effort Chart
- Attachment 5: Current Organizational Chart
- Attachment 6: *(Only if applicable)* Model Developer Documentation for Enhancements
- Attachment 7: *(Only if applicable)* Indirect Cost Rate Agreement or Cost Allocation Plan
- Attachment 8: *(Only if applicable)* New or Revised MOUs or Letters of Agreement
- Attachments 9–15: Other Relevant Documents

Administrative and National Policy Requirements

Accessibility Provisions and Non-Discrimination Requirements
Should you successfully compete for an award, recipients of federal financial assistance (FFA) from HHS must administer their programs in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes ensuring programs are accessible to persons with limited English proficiency and persons with disabilities. The HHS Office for Civil Rights (OCR) provides guidance on complying with civil rights laws enforced by HHS. See Providers of Health Care and Social Services and HHS Nondiscrimination Notice.

- Recipients of FFA must ensure that their programs are accessible to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see Fact Sheet on the Revised HHS LEP Guidance and Limited English Proficiency.

- For information on your specific legal obligations for serving qualified individuals with disabilities, including reasonable modifications and making services accessible to them, see Discrimination on the Basis of Disability.

- HHS-funded health and education programs must be administered in an environment free of sexual harassment. See Discrimination on the Basis of Sex.

- For guidance on administering your program in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see Conscience Protections for Health Care Providers and Religious Freedom.

Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under federal civil rights laws or call 1-800-368-1019 or TDD 1-800-537-7697.

The HRSA Office of Civil Rights, Diversity, and Inclusion (OCRDI) offers technical assistance, individual consultations, trainings, and plain language materials to supplement OCR guidance and assist HRSA recipients in meeting their civil rights obligations. Visit OCRDI's website to learn more about how federal civil rights laws and accessibility requirements apply to your programs, or contact OCRDI directly at HRSACivilRights@hrsa.gov.

HRSA Contacts

You are encouraged to request assistance, if needed, when submitting your NCC Update. Please contact your HRSA Project Officer to obtain additional information regarding overall program issues.

Rachel Herzfeldt-Kamprath
Policy Analyst
Division of Home Visiting and Early Childhood Systems
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Telephone: (301) 443-2524
Email: RHerzfeldt-Kamprath@hrsa.gov

You may obtain additional information regarding business, administrative, or fiscal issues related to this NCC Update by contacting your Grants Management Specialist.

Tya Renwick
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10SWH03
Rockville, MD 20857
Telephone: (301) 594-0227
Email: trenwick@hrsa.gov

Janene P. Dyson
Grants Management Specialist
Division of Grants Management Operations, OFAM
Health Resources and Services Administration
5600 Fishers Lane, Mailstop 10N190A
Rockville, MD 20857
Telephone: (301) 443-8325
Email: jdyson@hrsa.gov

You may need assistance when working online to submit information electronically through HRSA's EHBs. For assistance (i.e., technical system issues), contact the HRSA Contact Center, Monday through Friday, 7 a.m. to 8 p.m. ET:

HRSA Contact Center
Phone: (877) 464-4772 / (877) Go4-HRSA
TTY: (877) 897-9910
Website: http://www.hrsa.gov/about/contact/ehbhelp.aspx

APPENDIX A: Program Expectations and Funding Restrictions

Priority Population Recruitment and Enrollment 27
- Priority for Serving High-Risk Populations 27
- Enrollment 27

Implementing Evidence-Based Home Visiting Models 28
- Selection of Home Visiting Service Delivery Model(s) 28
- Fidelity to Home Visiting Service Delivery Model(s) 28
- Model Enhancements 29
- Eligible Evidence-Based Models 29

Systems Coordination 30
- Early Childhood Systems Coordination and Collaboration 30
- Written Agreements to Advance Coordination 31

Implementation Oversight 32
- High-Quality Supervision 32
- Subrecipient Monitoring 32
- HRSA Operational Site Visits 33
- Technical Assistance Engagement Expectations 33

Budgeting and Limitations of Use of Funds 34
- Maintenance of Effort/Non-Supplantation 34
- Limit on Use of Funds to Support Direct Medical, Dental, Mental Health, or Legal Services 34
- Limit ("Cap") on Use of Funds for Administrative Expenditures 34
- Limit on Use of Funds for Recipient-Level Infrastructure Expenditures 35
- Limit on Use of Funds for Conducting and Evaluating a Promising Approach 36
- Home Visiting Budget Assistance Tool (HV-BAT) 36

Health Equity 37

Data and Evaluation 38
- State Evaluation – Promising Approaches 38
- Coordinated State Evaluations (CSE) – Evaluations of Other Recipient Activities 39

Pay for Outcomes (PFO) 40

Performance Reporting and Continuous Quality Improvement 41
- Demonstration of Improvement 41
- Continuous Quality Improvement 42
- Performance Measurement Plan 42

Priority Population Recruitment and Enrollment

Priority for Serving High-Risk Populations

All communities served must be within areas identified as at-risk for poor maternal and child health outcomes in the MIECHV 2020 approved statewide needs assessment update, as required under the program's authorizing statute.

As required by the MIECHV statute,[16] recipients must give priority in providing services under the MIECHV Program to the following[17]:

- Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection 511(b)(1)(A), taking into account the staffing, community resources, and other requirements to operate at least one approved model of home visiting and demonstrate improvements for eligible families;
- Low-income eligible families;
- Eligible families with pregnant women who have not attained age 21;
- Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services;
- Eligible families that have a history of substance abuse or need substance abuse treatment;
- Eligible families that have users of tobacco products in the home;
- Eligible families that are or have children with low student achievement;
- Eligible families with children with developmental delays or disabilities; and
- Eligible families that include individuals who are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

Enrollment

As required by statute, recipients must implement home visiting programs primarily through one or more selected evidence-based service delivery models.[18] They must ensure fidelity to the model, which may include the development of policies and procedures to recruit, enroll, disengage, and re-enroll home visiting services participants. Enrollment policies should strive to balance continuity of services to eligible families over time with ensuring access to services for families who have not yet received services.

Recipients must develop and implement policies and procedures to avoid dual enrollment. Dual enrollment refers to home visiting participant enrollment and receipt of services through more than one MIECHV-supported home visiting model concurrently. Recipients implementing more than one MIECHV-supported home visiting model, particularly in the same community, must, with fidelity to the model, develop policies and procedures to screen and enroll eligible families in the model that best meets their needs. Avoiding dual enrollment maximizes the availability of limited resources for home visiting services for eligible families and prevents duplicative collection and reporting of benchmark data.

---

[16] Social Security Act, Title V, § 511(d)(4), as amended by the Bipartisan Budget Act of 2018, Title VI, § 50604, indicates the priority for serving high-risk populations.

[17] Reporting defintions for these priority populations can be found in Form 1 – Demographic Performance Measures.

[18] Social Security Act, Title V, § 511(d)(3).

Recipients may participate in or support the development of centralized intake systems (CIS) (see Appendix F for a definition of CIS) to reach and enroll eligible families, and avoid dual enrollment. CIS have the potential to improve families' enrollment experiences, strengthen or streamline service referral processes, and facilitate early childhood systems coordination and collaboration.

Implementing Evidence-Based Home Visiting Models

Selection of Home Visiting Service Delivery Model(s)
As noted above, the MIECHV statute reserves the majority of funding for the delivery of services through implementation of one or more evidence-based home visiting service delivery models.[19] Home visiting service delivery models meeting U.S. Department of Health and Human Services (HHS)-established criteria for evidence of effectiveness and eligible for implementation under MIECHV have been identified.[20] Per statute, recipients may expend no more than 25 percent of the grant awarded for a fiscal year for conducting and evaluating a program using a service delivery model that qualifies as a promising approach.[21] The MIECHV statute defines a home visiting service delivery model that qualifies as a promising approach; see Appendix F for the definition of a promising approach.[22]

When selecting a model or multiple models, recipients should ensure the selection can:
1) Meet the needs of the state's, territory's, or jurisdiction's communities identified as at-risk in the approved statewide needs assessment update and the state's, territory's, or jurisdiction's targeted priority populations named in statute;
2) Provide the best opportunity to accurately measure and achieve meaningful outcomes in MIECHV benchmark areas and performance measures;
3) Be implemented effectively with fidelity to the model in the state, territory, or jurisdiction based on available resources and support from the model developer; and
4) Be well matched for the needs of the state's, territory's, or jurisdiction's early childhood system.

Recipients may select multiple models for different communities to support a continuum of home visiting services that meet families' specific needs. Additionally, as families' goals and needs change over time, recipients may transition families with their consent from one model to another.

Fidelity to Home Visiting Service Delivery Model(s)
Recipients must have policies and procedures in place to ensure fidelity of implementation to the evidence-based home visiting service delivery model(s) they select (refer to Appendix F for a definition of fidelity). Policies and procedures should include review and submission of fidelity information to home visiting model developers. Any recipient implementing a home visiting service delivery model that qualifies as a promising approach must also implement the model with fidelity. Fidelity requirements include all aspects of initiating and implementing a home visiting model, including, but not limited to:

- Recruiting and retaining families;

---

[19] Social Security Act, Title V, § 511(d)(3)(A) identifies various specific criteria applicable to such evidence-based home visiting models.
[20] See below for a list of evidence-based home visiting models eligible for implementation under MIECHV that meet the HHS-established criteria for evidence of effectiveness.
[21] Social Security Act, Title V, § 511(d)(3)(A).
[22] Social Security Act, Title V, § 511(d)(3)(A)(i)(II).

- Providing initial and ongoing training, supervision, and professional development for staff;
- Establishing an information management system to track data related to fidelity and service delivery; and
- Developing a resource and referral network to support families' needs.

Changes to an evidence-based model that alter the core components related to program outcomes are not permissible, as they could impair fidelity and undermine the program's effectiveness.

Model Enhancements
For the purposes of the MIECHV Program, an acceptable enhancement of an evidence-based model is a variation to better meet the needs of MIECHV communities or certain eligible families that does not alter the model's core components, as defined by the model. Model enhancements may or may not have been developed by the national model developer, and enhancements may or may not have been tested with rigorous impact research. Prior to implementation, the model developer must determine that the model enhancement does not alter the core components related to program impacts, and HRSA must determine it to be aligned with MIECHV Program activities and expectations. Recipients that wish to adopt enhancements to a model must submit documentation of concurrence (**Attachment 6**) that the enhancement does not alter core components related to program impacts from the national model developer(s) and receive approval from HRSA.

Note: Temporary changes to the model made by the model developer due to an emergency are not model enhancements.

Eligible Evidence-Based Models
You may select one or more of the evidence-based service delivery models from the list below. (NOTE: Models are listed alphabetically.)

- Attachment and Biobehavioral Catch-Up (ABC) Intervention
- Child First
- Durham Connects/Family Connects
- Early Head Start – Home-Based Option
- Early Intervention Program for Adolescent Mothers
- Early Start (New Zealand)
- Family Check-Up for Children
- Family Spirit
- Health Access Nurturing Development Services (HANDS) Program
- Healthy Beginnings
- Healthy Families America
- Home Instruction for Parents of Preschool Youngsters
- Maternal Early Childhood Sustained Home Visiting Program
- Maternal Infant Health Program
- Minding the Baby
- Nurse-Family Partnership
- Parents as Teachers
- Play and Learning Strategies – Infant
- Promoting First Relationships—Home Visiting Intervention Model

- SafeCare Augmented

These models have met HHS criteria for evidence of effectiveness. HHS uses Home Visiting Evidence of Effectiveness (HomVEE) to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting program models that target families with pregnant women and children from birth to kindergarten.

NOTE: In addition to the HHS criteria for evidence of effectiveness, the statute specifies that a model selected by a eligible entity "conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high-quality service delivery and continuous program quality improvement," among other requirements.[23]

Systems Coordination

Early Childhood Systems Coordination and Collaboration
Per the MIECHV statute, recipients must ensure the provision of high-quality home visiting services to eligible families in at-risk communities by, in part, coordinating with comprehensive statewide early childhood systems to support the needs of those families.[24] To do this, recipients must establish appropriate linkages and referral networks to other community resources and supports.[25] Refer to Appendix F for a list of potential early childhood systems partners. Additional examples of effective systems coordination and collaboration strategies include working with state and local partners to: increase the availability of and access to a continuum of two-generation early childhood services; coordinate programs, services, and data collection and reporting systems to reduce gaps and inefficiencies; align activities and leverage partnerships to engage priority populations in services and improve shared outcomes; identify and facilitate meaningful changes in structural barriers to eliminate health disparities; and engage families and other community representatives as leaders and partners toward shared decision-making and improved health equity.

Examples of early childhood systems coordination and collaboration initiatives to improve family outcomes in the MIECHV benchmark areas are provided in the FY 2021 NOFO (HRSA-21-050).

Recipients should develop policies and procedures, in collaboration with other home visiting and early childhood partners, to ensure sustained services and smooth transitions across a continuum of home visiting and early childhood services for eligible families from pregnancy through kindergarten entry, in alignment with model fidelity requirements.

Other state and local advisory groups also serve an important function in guiding MIECHV project planning, implementation, and/or evaluation. Recipients must ensure involvement in project planning, implementation, and/or evaluation by at least one statewide early childhood systems advisory committee or coordinating entity (e.g., Early Childhood Advisory Council, Governor's Children's Cabinet, Individuals with Disabilities Education Act (IDEA) Part C

---

[23] Social Security Act, Title V, § 511(d)(3)(A).
[24] Social Security Act, Title V, § 511(b)(1)(B).
[25] Social Security Act, Title V, § 511(d)(3)(B).

Interagency Coordinating Council, State Advisory Council on Early Childhood Education and Care).

To strengthen coordination with comprehensive statewide early childhood systems and improve service delivery quality, HRSA encourages MIECHV recipients to engage in active, ongoing collaboration with the following representatives, including participation in any MIECHV advisory groups (if such a group exists), whenever feasible:

A. Representatives of aligned early childhood programs (including the Early Childhood Comprehensive Systems (ECCS) funding recipient, where applicable; see also Appendix F);
B. Tribal representatives; and
C. Individuals representing eligible families and communities served.

MIECHV recipients may also engage and provide support for representatives to participate equitably and meaningfully in these roles and ensure that advisory members represent the diversity of the populations being served.

If you intend to serve tribal communities, then these services must not be duplicative of, but rather coordinated with, any services provided by the Tribal MIECHV Program in these communities, if applicable.

Written Agreements to Advance Coordination

Recipients must ensure the involvement of representatives from key state agencies in project planning, implementation, and/or evaluation through the development and implementation of signed written agreements, such as letters of agreement (LOAs) or memoranda of understanding (MOUs). These agreements may address state and local partnerships to facilitate referrals, screening, follow-up, and service coordination, as well as systems and data coordination (e.g., data sharing and data exchange standards), as applicable to each partner's scope. Agreements with partners in the same organization as the recipient may be informal. To the extent possible, recipients should address expectations for coordination among local subrecipients of signing state agencies. HRSA also encourages alignment of agreements with relevant state-level early childhood action plans or stated goals of statewide early childhood systems entities.

Recipients must develop or maintain agreements with:

- The state's ECCS recipient, if there is one;
- The state's Maternal and Child Health Services (Title V) agency;
- The state's Public Health agency, if this agency is not also administering the state's Title V program;
- The state's agency for Title II of CAPTA;
- The state's child welfare agency (Title IV-E and IV-B), if this agency is not also administering Title II of CAPTA;
- The state's IDEA Part C and Part B Section 619 lead agency(ies); and
- The state's Elementary and Secondary Education Act Title I or state pre-kindergarten program.

Beginning in FY 2021, HRSA requires recipients to review, and update as appropriate, agreements at least every 3 years (i.e., those established and dated before October 1, 2019). Recipients must submit new or updated agreements in response to requests from HRSA. **(Note: HRSA intends for these agreements to outline the expectations of collaborators and**

support effective collaboration. These are not required to be legally binding documents.) If you have questions regarding your written agreements with partners, please reach out to your Project Officer.

In addition, HRSA encourages recipients to identify and collaborate with other high-priority partners, including including state Medicaid agencies and those implementing the Family First Prevention Services Act[26] and Preschool Development Grants. Recipients may wish to develop written agreements that clearly state the purpose of the collaboration, establish a shared vision and goals, and outline key roles of each partner to achieve shared goals.

Implementation Oversight

High-Quality Supervision
Recipients must maintain high-quality supervision[27] to establish home visitor competencies. HRSA encourages the use of reflective supervision or practices aligned with infant early childhood mental health consultation (IECMHC), consistent with model fidelity, for home visiting staff funded through the MIECHV grant as components of high-quality supervision. (Refer to Appendix F for a definition of reflective supervision and IECMHC.) Recipients and LIAs should develop and implement policies and procedures that ensure high-quality supervision in alignment with fidelity to the model(s) implemented.

Subrecipient Monitoring
Recipients must monitor subrecipient performance for compliance with federal requirements and performance expectations, including timely Federal Funding Accountability and Transparency Act (FFATA) reporting. (For additional information regarding Subrecipient Monitoring and Management, see UAR 45 CFR part 75 and the Subrecipient Monitoring Manual for MIECHV Award Recipients. This requirement applies to all subrecipients, including those that oversee LIAs (i.e., intermediaries). Timely FFATA reporting is required by the federal grant recipient to the FFATA Subaward Reporting System.) You must have policies and procedures in place to ensure compliance with FFATA. For more FFATA information, please see Section 6.d. Transparency Act Reporting Requirements of HRSA's *SF-424 Application Guide*.

Recipients must also execute subrecipient agreements that incorporate all of the elements of 45 CFR § 75.351–353 and, either expressly or by reference, the subrecipient monitoring plan developed by the recipient.

Recipients must effectively manage all subrecipients of MIECHV funding to ensure successful performance of the MIECHV Program and to ensure compliance with fiscal, administrative, and program requirements. This requirement also applies to recipients who utilize local recipient staff in lieu of subrecipients for program implementation. Monitoring activities must ensure subrecipients or local sites comply with applicable requirements outlined in the UAR, and MIECHV statutory and programmatic requirements.[28] Recipients must be able to determine if costs proposed and subsequently incurred by subrecipients or local sites are allowable/unallowable. Recipients must base their final determinations on allowability of costs on their documented organizational policies and procedures.

[26] P.L. 115-123, Division E, Title VII
[27] Social Security Act, Title V, § 511(d)(3)(B)(iii).
[28] Social Security Act, Title V, § 511(d).

Recipients must develop and execute a subrecipient monitoring plan that outlines MIECHV program requirements and performance expectations, and a process to assess implementation of these requirements by subrecipients or local sites. The subrecipient monitoring plan must include an evaluation of each subrecipient's or local site's risk of noncompliance, identify the person(s) responsible for each monitoring activity, and include timelines for completion for each monitoring activity. Recipients must design their subrecipient or local site monitoring activities to ensure that the subaward:

- Is used for authorized purposes;
- Is used for allowable, allocable, and reasonable costs;
- Is in compliance with federal statutes and regulations;
- Is in compliance with the terms and conditions of the subaward; and
- Achieves applicable performance goals.

Subrecipient monitoring plans must include provisions for:

- Review of financial and performance reports as required by the recipient in compliance with federal requirements;
- Performing site visits to review financial and program operations;
- Providing technical assistance, when needed;
- Follow-up procedures to ensure timely and appropriate action by the subrecipient on all deficiencies identified through required audits, site visits, or other procedures pertaining to the federal award; and
- Issuance of a management decision for audit findings (as applicable) pertaining to the federal award provided to the subrecipient as required by 45 CFR § 75.521.

HRSA Operational Site Visits

HRSA conducts operational site visits with MIECHV recipients approximately every 3 years to assess recipient compliance with MIECHV statutory and programmatic requirements. Pursuant to 45 CFR § 75.364, HRSA and its designees must have the right of access to any books, documents, papers, or other records that are pertinent to the awards in order to make audits, examinations, excerpts, transcripts, and copies of such documents. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. Timely access is defined as a recipient's response to all document requests and requests to meet with a recipient's personnel by the deadlines stated by HRSA or its designees.

Technical Assistance Engagement Expectations

The MIECHV Program's technical assistance (TA) system supports recipients' efforts to improve family outcomes and strengthen the proficiency of state and local early childhood systems leaders and practitioners.[29] For a description of what the TA system supports, please see the MIECHV Program Technical Assistance webpage.

MIECHV promotes the provision of TA through a relationship-based approach. As such, HRSA expects recipients to engage with TA providers to support improvement in high-quality implementation of home visiting in their state, territory, or jurisdiction. Recipients should regularly engage TA providers as partners to help achieve short-and long-term goals. At least once annually, recipients must work with their TA providers to assess their TA priorities and develop a plan to address those priorities. Recipients must also engage with their TA providers during the review of annual performance reports and CQI plans.

[29] Social Security Act, Title V, § 511(c)(5).

Budgeting and Limitations of Use of Funds

Maintenance of Effort/Non-Supplantation

You must supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.[30] You may demonstrate compliance by maintaining non-federal funding for evidence-based home visiting and home visiting initiatives, expended for activities proposed in this NCC Update, at a level that is not less than expenditures for such activities as of the most recently completed state fiscal year. **For the purposes of this NCC Update, non-federal funding is defined as state general funds, including in-kind, expended only by the recipient entity administering the MIECHV grant and not by other state agencies. In addition, for purposes of maintenance of effort/non-supplantation, home visiting is defined as an evidence-based program implemented in response to findings from the most current approved statewide needs assessment that includes home visiting as a primary service delivery strategy, and is offered on a voluntary basis to pregnant women or caregivers of children birth to kindergarten entry.** Nonprofit entity applicants must agree to take all steps reasonably available for this purpose and should provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement. The baseline for maintenance of effort is the state fiscal year prior to the fiscal year during which the application is submitted.

You are required to accurately report maintenance of effort in your application (insert detail as requested in Attachment 4). As a reminder, recipients may NOT consider any Title V funding used for evidence-based home visiting as part of the maintenance of effort demonstration. Recipients should only include state general funds expended by the recipient entity administering the MIECHV grant and not by other state agencies. Also, include an explanation for any decreases in state funding.

HRSA will consider any application that fails to satisfy the requirement to provide maintenance of effort information non-responsive and will not consider it for funding under this notice.

Limit on Use of Funds to Support Direct Medical, Dental, Mental Health, or Legal Services

The MIECHV Program generally does not fund the delivery or costs of direct medical, dental, mental health, or legal services; however, some limited direct services may be provided (typically by the home visitor) to the extent required to maintain fidelity to an evidence-based model approved for use under MIECHV. Recipients may coordinate with and refer eligible families to direct medical, dental, mental health, or legal services and providers covered by other sources of funding, for which non-MIECHV sources of funding (to the extent available and appropriate) may provide reimbursement.

Limit (“Cap”) on Use of Funds for Administrative Expenditures

Use of MIECHV grant funding is subject to a limit on administrative expenditures, as further described below, which tracks the restrictions of the Title V Maternal and Child Health Services Block grant program on such costs.[31] No more than 10 percent of the award amount may be used for administering the award. You must develop and implement a plan to determine and monitor administrative expenditures to ensure you do not exceed the 10 percent cap.

[30] Social Security Act, Title V, § 511(f).
[31] Social Security Act, Title V, § 511(i)(2)(C).

For purposes of this NCC Update, the term "administrative expenditures" refers to the costs of administering the MIECHV award incurred by the recipient. This 10 percent limit is not a cap on indirect costs (also known as "facilities and administration costs").

MIECHV administrative expenditures include, but may not be limited to, the following:
- Reporting costs (MCHB Administrative Forms in HRSA's EHBs, Home Visiting Information System, Federal Financial Report, and other reports required by HRSA as a condition of the award);
- Project-specific accounting and financial management;
- Payment Management System drawdowns and quarterly reporting;
- Time spent working with the HRSA Grants Management Specialist and HRSA Project Officer;
- Subrecipient or local site monitoring;
- Complying with FFATA subrecipient reporting requirements;
- Support of HRSA site visits;
- The portion of regional or national meetings dealing with MIECHV grants administration;
- Audit expenses; and
- Support of HHS Office of Inspector General (OIG) or Government Accountability Office (GAO) audits.

NOTE: This 10 percent federal cap on administrative expenditures does not flow down to subrecipients. This is not a cap on the negotiated indirect cost rate.

Limit on Use of Funds for Recipient-Level Infrastructure Expenditures
Without prior approval from HRSA, no more than 25 percent of the award amount may be spent on recipient-level infrastructure expenditures necessary to enable recipients to deliver MIECHV services. For purposes of this NCC Update, the term "recipient-level infrastructure expenditures" refers to recipient-level expenditures necessary to enable recipients to deliver MIECHV services, but does not include the costs of delivering such home visiting services. It includes costs related to programmatic activities, indirect costs, MIECHV administrative expenditures (with a 10 percent cap), and other items.

Recipient-level infrastructure expenditures necessary to enable delivery of MIECHV services subject to the 25 percent limit may include recipient-level personnel, contracts, supplies, travel, equipment, rental, printing, and other costs to support the following:
- Professional development and training for recipient-level staff;
- Model affiliation and accreditation fees;
- Continuous quality improvement and assurance activities, including development of CQI and related plans;
- Technical assistance provided by the recipient to the LIAs;
- Information technology including data systems (excluding costs incurred to update data management systems related to the HRSA redesign of the MIECHV program performance measurement system which took effect on October 1, 2016);
- Coordination with comprehensive statewide early childhood systems;
- Administrative expenditures (further subject to a 10 percent cap); and
- Indirect costs (also known as "facilities and administration costs") (i.e., costs incurred for common or joint objectives that cannot be identified specifically with a particular project, program, or organizational activity).[32]

[32] See the Uniform Administrative Requirements at 45 CFR part 75.

NOTE: The limit on recipient-level infrastructure expenditures has no bearing on the negotiated indirect cost rate.

The 25 percent limit on recipient-level infrastructure expenditures does NOT include costs incurred for:
- Coordinated State Evaluation (CSE) activities; or
- Update of data management systems related to the HRSA redesign of the MIECHV Program performance measurement system, which took effect in FY 2017, or related to measurement and data system redesign by model developer(s).

Service delivery expenditures that are NOT recipient-level infrastructure expenditures and therefore are not subject to the 25 percent limit may include:
- Contracts to LIAs;
- Professional development and training for LIA and other contractual staff (NOTE: these expenditures should not be budgeted for professional development and training that is duplicative in scope or content of the professional development and training provided by other sources, including LIAs and home visiting model developers);
- Assessment instruments/licenses;
- Participant incentives; and
- Participant recruitment.

Recipients must use reasonable efforts to ascertain what constitutes recipient-level infrastructure expenditures necessary to enable delivery of MIECHV services in accordance with program activities and expectations, to document their findings in this regard, and to maintain records that demonstrate that such expenditures do not exceed 25 percent of the award amount.

To obtain HRSA approval for spending more than 25 percent of the award amount on recipient-level infrastructure costs, including administrative costs, a recipient must provide written justification for this request. This justification should be included within the budget justification. Recipients should maximize efficiencies in infrastructure expenditures to increase the proportion of the award budgeted for home visiting services costs.

Limit on Use of Funds for Conducting and Evaluating a Promising Approach
Per statute, no more than 25 percent of the MIECHV grant award for a fiscal year may be expended for purposes of conducting and evaluating a program using a service delivery model that qualifies as a promising approach.[33] This 25 percent limit on expenditures pertains to the total funds awarded to the recipient for the fiscal year.

Home Visiting Budget Assistance Tool (HV-BAT)
The Home Visiting Budget Assistance Tool (HV-BAT) is an Excel-based instrument that collects information on standardized cost metrics from programs that deliver home visiting services. The HV-BAT is designed for use by MIECHV-funded LIAs and recipients to collect and report comprehensive home visiting program costs incurred by LIAs during a 12-month period. It may help MIECHV recipients and LIAs in several ways, including program monitoring, budget planning, economic evaluation, and leveraging innovative financing strategies (technical

[33] Social Security Act, Title V, § 511 (d)(3)(A)(ii).

assistance resources are available on the MIECHV Data, Evaluation, and Continuous Quality Improvement webpage).

Beginning with the FY 2021 period of performance, HRSA requires reporting of HV-BAT data for one-third of recipients each year, resulting in collection of data from all recipients over a 3-year time period. HRSA is requiring this data collection in order to:

- Support recipients in using empirical cost data to inform program planning, budgeting, and subrecipient monitoring;
- Conduct descriptive research assessing the variability of implementation costs across MIECHV-funded home visiting programs; and
- Inform future activities to support policy priorities related to public financing of home visiting services and PFO approaches.

HRSA has created three HV-BAT reporting cohorts to ensure that information collected each year represents the diversity in home visiting participant and recipient characteristics. Appendix C includes information about when recipients are required to report HV-BAT information. Additional resources to support recipients in utilizing the HV-BAT and cost data are available in technical assistance resources on the HRSA website at the MIECHV Data, Evaluation, and Continuous Quality Improvement webpage.

Prohibition on certain telecommunications and video surveillance services or equipment
Be aware of the requirements for HRSA recipients and subrecipients at 2 CFR § 200.216 regarding prohibition on certain telecommunications and video surveillance services or equipment. For details, see the HRSA Grants Policy Bulletin Number: 2021-01E.

Health Equity

In alignment with HRSA's strategic goal to achieve health equity and enhance population health, MCHB's strategic goal to achieve health equity for maternal and child health populations, and the Biden-Harris Administration's commitment to "pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality," HRSA recommends recipients implement home visiting program strategies that contribute to equitable programmatic improvements and reduce disparities in family outcomes in MIECHV benchmark areas.[34] As a way to promote and advance health equity, recipients should begin the development of health equity action plans. The health equity action plan should consider the role of home visiting services and coordination with comprehensive statewide and local early childhood systems in identifying and addressing the social and structural determinants of health in their project planning, implementation, and/or evaluation and to propose specific activities to further define, support, or evaluate those efforts.

Home visiting implementation strategies that may advance health equity include, but are not limited to:

- Collecting and analyzing program data to identify key health disparities and the root causes of inequity;

[34] Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, 86 FR 7009, at § 2(a) (Jan. 20, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.

- Recruiting and retaining a diverse workforce that can provide culturally and linguistically appropriate services, including members that are representative of communities served;
- Leveraging Continuous Quality Improvement (CQI) activities to identify, address, and mitigate systemic barriers;
- Engaging family and community representatives in advisory, and collaborative roles;
- Engaging diverse referral partners and other implementation partners, including those that support access to services that address social determinants of health;
- Providing leadership development opportunities and compensation for families and family representatives; and
- Promoting comprehensive, trauma-informed, and multi-generational approaches to service delivery and coordination.

HRSA encourages recipients to utilize a health equity action planning process to identify and consider a full range of implementation strategies and state or program policies that can advance health equity, address social and structural determinants of health, and reduce disparities in family outcomes in MIECHV benchmark areas. This includes sharing information and insights related to the needs and strengths of MIECHV-eligible populations with state and local decision-makers toward improving systems and services that impact them.

Data and Evaluation

Data Exchange Standards for Improved Data Interoperability
Section 50606 of the Bipartisan Budget Act of 2018 provides authority for HRSA to establish data exchange standards for improved interoperability in two categories of information: (1) data required to be submitted as part of federal data reporting, and (2) data required to be electronically exchanged between the MIECHV state agency and other agencies within the state by required by applicable federal law.[35]

HRSA encourages recipients to consider approaches and plans to facilitate improved data interoperability in their state, territory, or jurisdiction through activities such as data exchange standards creation or adoption, data sharing, or data coordination with other state agencies or early childhood programs. These plans may range in scope and content, depending on capacity and readiness, among other factors, and focus on state and/or local operations.

Note that no changes to existing MIECHV federal data reporting are required due to this new authority. In addition, HRSA is not issuing new requirements around the adoption of data exchange standards at this time.

More information on implementing data exchange standards is available on the HRSA the MIECHV Data, Evaluation, and Continuous Quality Improvement webpage.

State Evaluation – Promising Approaches
Recipients that propose to implement a home visiting model that qualifies as a promising approach are required to conduct a rigorous evaluation of that approach.[36] The purpose of such an evaluation is to contribute to the evidence that may help support meeting HHS' criteria of effectiveness for the promising approach. Recipients must evaluate all new or continuing promising approaches. Recipients must design such evaluations for an assessment of impact using an appropriate comparison condition and meet expectations of rigor outlined in Appendix

[35] Social Security Act, Title V, § 511(h)(5).
[36] Social Security Act, Title V, § 511(d)(3)(A)(i)(II).

A of HRSA-21-050. (Refer to Appendix F below for a definition of a promising approach.) Recipients may propose to continue an existing evaluation of a promising approach implemented through prior MIECHV awards in order to meet the requirements of this section. For new promising approach evaluations, an evaluation plan describing the technical details of the evaluation is due to HRSA no later than 120 days from the project start date. For continuing promising approach evaluations, a modified evaluation plan and timeline noting any significant changes to the evaluation is due to HRSA no later than 120 days from the project start date. Further guidance and TA will be available after HRSA issues the award.

Coordinated State Evaluations (CSE) – Evaluations of Other Recipient Activities
Recipients who implement evidence-based home visiting models are not required to conduct an evaluation of their home visiting program.

Beginning with the FY 2021 MIECHV Formula Award NOFO, HRSA moved to a coordinated evaluation approach for voluntary state-led evaluation. Recipients who were interested in conducting program evaluations were required to participate in CSE and were required to choose from one of four identified priority topic areas (family engagement and health equity, implementation quality/fidelity, maternal health, and workforce development) in coordination with other MIECHV recipients and with support from the HRSA-funded technical assistance center. HRSA is supporting two options in FY 2022 for recipients interested in conducting CSE:

1. Continuing CSE: During the FY 2021 period of performance, recipients were required to co-create evaluation plans with other MIECHV recipients in a peer network. Evaluation designs were permitted to extend beyond the period of performance for the FY 2021 formula award due to HRSA's expectation that subsequent formula awards, such as this FY 2022 formula award, would support continuing the state-led evaluations within the same peer networks established under the FY 2021 award.

   HRSA encourages recipients to continue their existing coordinated state evaluations. Recipients may continue coordinated state evaluation activities that were planned for and designed under the FY 2021 award with the FY 2022 formula award, within the same peer networks established under the FY 2021 formula award.

   An addendum to the FY2021 evaluation plan that describes planned evaluation activities and the associated budget supported under the FY 2022 formula award in more detail will be due to HRSA no later than 120 days after the project start date.

   OR

2. Joining the existing "Implementation quality/fidelity" CSE peer network: Recipients who did not elect to participate in CSE as part of their FY 2021 formula award application have the opportunity to propose a new "implementation quality/fidelity" evaluation with this award. To support recipients joining this existing peer network, HRSA will provide interested recipients with publicly available evaluation design reports for relevant implementation quality/fidelity research questions, which can be tailored and used to support the development of recipient evaluation plans. HRSA anticipates that the evaluation designs will extend beyond the period of performance for the FY 2022 MIECHV formula award. We anticipate that the FY 2023 formula awards, subject to the availability of funding, will support continuing evaluations within the same peer networks. Recipients proposing to join this CSE peer network in FY 2022 should expect to be involved in an ongoing coordinated effort in subsequent periods of performance, pending

availability of funding. More information about HRSA-provided evaluation design reports will be made available to recipients following publication of the NCC.

Recipients proposing a new "implementation quality/fidelity" CSE must submit an evaluation plan to HRSA no later than 120 days after the project start date.

For recipients participating in either CSE option described above, HRSA expects recipients to participate in regular peer network sessions facilitated by TA providers, as well as evaluation-focused monitoring calls with HRSA staff and TA providers at a minimum on a quarterly basis. HRSA expects recipients to include an update on the progress of the evaluation in their FY 2022 formula award final report. Further guidance and TA will be available after HRSA issues the award.

Pay for Outcomes (PFO)

The Bipartisan Budget Act of 2018 provides authority for recipients to use a portion of their MIECHV grant for outcomes or success payments (hereafter referred to as outcomes payments) related to a PFO initiative,[37] which is defined in statute as a performance-based grant, contract, cooperative agreement, or other agreement awarded by a public entity in which a commitment is made to pay for improved outcomes achieved as a result of the intervention that result in social benefit and direct cost savings or cost avoidance to the public sector. [38] As further described in statute, such an initiative shall include:

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

In accordance with statute, recipients may use up to 25 percent of the grant for outcomes payments related to a PFO initiative.[39] You may also choose to budget MIECHV funds apart from the 25 percent limit on outcomes payments to support other activities needed to implement a PFO initiative. MIECHV funds designated for implementing a PFO initiative may support costs associated with conducting a feasibility study; conducting a PFO evaluation; reporting costs associated with PFO; and costs associated with administration of the PFO initiative. However, in submitting such proposals, recipients must demonstrate, as required by statute, that **the PFO initiative will not result in a reduction of funding for home visiting services as delivered by the recipient**[40] as compared to the year prior to the initiation of the PFO initiative. For this purpose, the baseline is the fiscal year prior to the fiscal year during which the recipient submits the initial funding application related to the PFO initiative.

[37] Social Security Act, Title V, § 511(c)(3).
[38] Social Security Act, Title V, § 511(k)(4).
[39] Social Security Act, Title V, § 511(c)(3).
[40] Social Security Act, Title V, § 511(c)(3).

As part of a PFO initiative, the MIECHV statute requires the completion of a feasibility study that describes how the proposed intervention is based on evidence of effectiveness.[41] (Refer to Appendix D for further instructions on the PFO feasibility study.) Recipients must complete the PFO feasibility study prior to proposing to use MIECHV funds for PFO initiative outcomes payments and PFO evaluation. You can apply to use MIECHV formula funds to conduct a new PFO feasibility study beginning in the FY 2021 funding application and in subsequent funding years, subject to the availability of future funding. Alternately, you can use a feasibility study completed within the past 5 years to meet this requirement. According to statute, funds made available for a PFO initiative within a fiscal year will remain available for expenditure for up to 10 years after the funds are made available. HRSA encourages recipients to consider the amount of time and resources needed to complete a PFO initiative when submitting their proposals.

For recipients proposing to use FY 2022 funds for a PFO initiative that includes funding for outcomes payments and PFO evaluation, following preliminary approval of your FY 2022 funding application, you must submit a response to the PFO Supplemental Information Request ("PFO SIR"). This SIR Response is due no later than 120 days after the period of performance start date. **If you propose to budget MIECHV funds for only a feasibility study, you are not required to respond to the MIECHV PFO SIR**; please refer to Appendix D for detailed instructions for what should be included in a MIECHV PFO feasibility study.

NOTE: If you are interested in implementing a PFO initiative, carefully review the MIECHV PFO SIR prior to proposing to budget MIECHV funds to implement any activities associated with such an initiative.

Performance Reporting and Continuous Quality Improvement

Demonstration of Improvement
Section 50602 of the Bipartisan Budget Act of 2018 requires recipients to track and report information demonstrating that the program results in improvements for eligible families participating in the program in at least four out of the six benchmark areas specified in statute that the service delivery model or models selected by the recipient are intended to improve. Such a demonstration is required following FY 2020 and every 3 years thereafter.

Recipients are required to submit information to HRSA demonstrating that the program results in improvements for eligible families participating in the program in at least four benchmark areas using the MIECHV Annual Performance Report, Form 2 (Performance Indicators and Systems Outcome Measures). Recipients failing to demonstrate improvement in at least four of the benchmark areas, as compared to eligible families who do not receive services under an early childhood home visitation program, must develop and implement a plan to improve outcomes, subject to approval by HRSA. This Outcome Improvement Plan (OIP) should describe the specific, measureable, and time-oriented actions the recipient will take to improve performance on selected performance measures and address how the recipient proposes to comply with HRSA's monitoring and oversight of the plan's implementation.

If a recipient continues not to demonstrate improvement after the full implementation of an OIP and subsequent reassessment, or does not submit a required performance report, HRSA may assert all available remedies for noncompliance, including termination of the grant award.

[41] Social Security Act, Title V, § 511(k)(4)(A).

More guidance on the requirements and methodology associated with the Demonstration of Improvement and OIPs is available online in the the MIECHV Data, Evaluation, and Continuous Quality Improvement webpage.

Continuous Quality Improvement
Recipients are required to implement an approved CQI Plan that meets the requirements outlined in Appendix B of HRSA-21-050. A new or updated CQI plan will be required in early 2023 **and is not due with this FY 2022 NCC Update submission**. If there is a request by HRSA or the recipient to revise a previously approved CQI Plan due to a change in scope of activities, HRSA must approve the amended plan. HRSA recommends that recipients required to complete an OIP associated with the Demonstration of Improvement focus their CQI activities on making improvements in the identified target measures, as outlined in the HRSA-approved OIP.

Performance Measurement Plan
Recipients are required to continue to implement a Performance Measurement Plan approved by HRSA. If a revision is requested by HRSA or the recipient, the amended plan must be approved by HRSA. (See Appendix B below for more information about performance measurement.). New recipients must submit a Performance Measurement Plan to HRSA 90 days after the start of the period of performance. **A proposed plan is not required for submission with this application.**

APPENDIX B: Reporting

Award recipients must comply with Section 6 of HRSA's *SF-424 Application Guide* **and** the following reporting and review activities:

1. **DGIS Performance Reports.** Available through the Electronic Handbooks (EHBs), the Discretionary Grant Information System (DGIS) is where recipients will report annual performance data to HRSA. Award recipients are required to submit a DGIS Performance Report **annually**, corresponding to the start and end of each formula award (X10) period of performance, by the specified deadline. To prepare successful applicants for their reporting requirements, the listing of administrative forms and performance measures for this program are available at https://grants4.hrsa.gov/DGISReview/FormAssignmentList/x10.html. The type of report required is determined by the project year of the award's period of performance.

Type of Report	Reporting Period	Available Date	Report Due Date
a) New Competing Performance Report	September 30, 2022 – September 29, 2024 *(administrative data and performance measure projections, as applicable)*	Period of performance start date	120 days from the available date
c) Project Period End Performance Report	September 30, 2022 – September 29, 2024	Period of performance end date	90 days from the available date

The full OMB-approved reporting package is accessible at https://mchb.hrsa.gov/data-research-epidemiology/discretionary-grant-data-collection (OMB Number: 0915-0298 | Expiration Date: 06/30/2022).

2. **Integrity and Performance Reporting.** The NOA will contain a provision for integrity and performance reporting in FAPIIS, as required in 45 CFR part 75 Appendix XII.

The demographic, service utilization, and select clinical indicators performance report will include: an unduplicated count of enrollees; participant race and ethnicity; socioeconomic data; other demographics; number of households from priority populations; service utilization across all models; among other measures. **NOTE: all data regarding enrollees should include only those enrollees served by a trained home visitor implementing services with fidelity to the model for whom at least 25 percent of his/her personnel costs (salary/wages including benefits) are paid for with MIECHV funding (Home Visitor Personnel Cost Method), or identified as MIECHV based on the designation of the slot they are assigned at enrollment and in accordance with the terms of the contractual agreement between the MIECHV state recipient and the LIA (Enrollment Slot Method).**

The performance indicators and systems outcomes performance report includes data collected for the 19 constructs defined by HRSA within the six benchmark areas (plus two optional measures to collect data on substance use screening and referrals). The reported data for these

19 constructs will be used by HRSA to meet the requirements for required reporting for the purposes of the Demonstration of Improvement, as required by statute.[42] These constructs include: preterm birth, breastfeeding, depression screening, well-child visits, postpartum care, tobacco cessation referrals, safe sleep, child injury, child maltreatment, parent-child interaction, early language and literacy activities, developmental screening, behavioral concerns, intimate partner violence screening, primary caregiver education, continuity of insurance coverage, completed depression referrals, completed developmental referrals, and intimate partner violence referrals.Specific inclusion and eligibility criteria have been established for each measure. TA resources are available online on the Data, Evaluation & Continuous Quality Improvement webpage.

HRSA requires that recipients submit performance reports on a quarterly basis that include: the number of new and continuing households served; maximum service capacity; identification of LIAs, counties, and zip codes where households are served; family engagement and retention; and staffing. Recipients will submit these reports through the Home Visiting Information System (HVIS), accessed through EHBs. Reports will be due no later than 30 days after the end of each reporting period[43]: Quarterly reporting periods are defined as follows:

- Q1 – October 1–December 31;
- Q2 – January 1–March 31;
- Q3 – April 1–June 30; and
- Q4 – July 1–September 30.

MIECHV-supported LIAs that have been active for 1 year or longer should strive to maintain an active enrollment of at least 85 percent of their maximum service capacity. Quarterly performance reports will assist HRSA in tracking this information at the state level for grants oversight and monitoring purposes and to be better able to target TA resources, as necessary.

Administrative Forms

The DGIS reporting system will continue to be available through the EHBs. HRSA enhanced the DGIS and these improvements are available for recipient reporting. The agency will communicate with recipients and provide instructions on how to access the system for reporting. HRSA will also provide TA via webinars, written guidance, and one-on-one sessions with an expert, if needed.

Recipients must submit data for FY 2022 MIECHV Annual Performance Reporting Forms 1 and 2 by October 30, 2023. Recipients will provide demographic, service utilization, and select clinical indicators and performance indicators and systems outcomes measures into the HVIS accessed through the EHBs that represent activities occurring during the reporting period of

[42] Social Security Act, Title V, § 511(d)(1)(D) requires eligible entities to track and report information demonstrating that the program results in improvements for the eligible families participating in the program in at least four of the six statutorily defined benchmark areas, no later than 30 days after the end of fiscal year 2020 and every 3 years thereafter. A recipient that does not submit the MIECHV Annual Performance Report Form 2 by the statutory deadline of October 30, 2023 will be considered non-compliant with program requirements, which may impact MIECHV grant funding in subsequent funding years.

[43] The submission due date associated with Form 4 Quarterly Performance Reports is now 30 days from the last day of the reporting period. However, because this is a shorter submission period than what was previously allowable, HRSA has instituted a temporary 45-day submission period to help transition recipients to the shorter submission timeframe. HRSA will seek feedback to assess the effectiveness of this 45-day submission period and the feasibility of shortening the submission period to 30 days, and will provide written notice prior to making any additional changes.

October 1, 2022 through September 30, 2023. Subsequent annual performance reporting will be required using the same timeline. Note: Annual performance reports will be consolidated across X10 and X11 grants and should present an unduplicated count of enrollees.

Termination

Note that the OMB revisions to Guidance for Grants and Agreements termination provisions located at 2 CFR § 200.340 - Termination apply to all federal awards effective August 13, 2020. No additional termination provisions apply unless otherwise noted.

APPENDIX C: HV-Budget Assistance Tool (HV-BAT) Cohort Assignments

HRSA has created three HV-BAT reporting cohorts to ensure that information collected each year represents the diversity in home visiting participant and recipient characteristics. recipients are required to submit HV-BAT data in the year assigned to their cohort:

1. Recipients included in Cohort 1 are required to submit HV-BAT data during the first year of their FY 2021 award (by March 31, 2022);
2. Recipients in Cohort 2 are required to submit HV-BAT data during the first year of their FY 2022 award (by March 31, 2023); and
3. Recipients in Cohort 3 are required to submit HV-BAT data during the first year of their FY 2023 award (by March 31, 2024).

Cohort 1	Cohort 2	Cohort 3
Alabama	American Samoa	Alaska
Arizona	Arkansas	CMNI
California	Florida	Georgia
Colorado	Hawaii	Guam
Connecticut	Illinois	Iowa
DC	Kansas	Maryland
Delaware	Kentucky	Massachusetts
Idaho	Mississippi	Michigan
Indiana	Montana	Minnesota
Louisiana	Nevada	Missouri
Maine	New Hampshire	New Mexico
Nebraska	Oklahoma	North Dakota
New Jersey	South Dakota	Ohio
New York	USVI	Pennsylvania
North Carolina	Utah	Puerto Rico
Oregon	Vermont	Rhode Island
Tennessee	Virginia	South Carolina
Texas	Washington	Wyoming
Wisconsin	West Virginia	

APPENDIX D: Pay for Outcomes Feasibility Studies

A Pay for Outcomes (PFO) initiative must include a feasibility study, which describes how the proposed intervention is based on evidence of effectiveness. The feasibility study also serves as a tool to determine the viability of using a MIECHV PFO approach to meet the proposed outcome(s), while meeting all MIECHV statutory and program requirements.

The PFO feasibility study must be completed prior to proposing to use MIECHV funds for outcome payments related to a PFO initiative, and prior to the submission of response to the Pay for Outcomes Supplemental Information Request (PFO SIR). You may fulfill the PFO feasibility study requirement in one of two ways:

1. Complete a new MIECHV PFO feasibility study based on the PFO feasibility study instructions, below; or
2. Submit a feasibility study completed within the past 5 years that assessed the same intervention and target population you are proposing in the PFO SIR Response. This feasibility study, which may have been supported by non-MIECHV funding sources, can be supplemented with any additional information necessary to submit a complete response to the PFO SIR.

The following instructions are intended to inform and support the development of the feasibility study for those applicants that propose to use MIECHV funds for a PFO feasibility study.

PFO Initiative Funding
When conducting a feasibility study:

- Identify and consider what funding source will be used to fund any part of the PFO initiative, in addition to MIECHV funds. You should also consider and ensure that there is sufficient funding for the full term of service provision in the PFO initiative.
- PFO initiative funding sources identified in the feasibility study can include:
    - MIECHV funding;
    - Provider or local implementing agency (LIA) working capital;
    - Foundation funding; and/or
    - Investor funding.

Target Population
In your feasibility study, consider the target population for the PFO initiative:

- The unmet need for home visiting services that the PFO initiative will address, and the baseline outcome(s) that the PFO initiative seeks to improve;
- The communities the PFO initiative will serve (based on the findings from your approved 2020 statewide needs assessment update);
- The LIAs that might participate in the PFO initiative; and
- The size and demographic characteristics of the populations in communities in the geographic area that will be included in a PFO initiative.

Proposed Intervention and Providers
In your feasibility study, consider:

- The evidence-based home visiting model(s) that would be appropriate for implementation as part of a PFO initiative; and
- The entire landscape of potential providers that can serve the needs of the target population, and their experience in implementing evidence-based home visiting programs.

- You should further consider:
    - The provider's experience implementing the evidence-based home visiting model;
    - The provider's capacity to meet enrollment targets of the PFO initiative, and (if currently a MIECHV-funded LIA), their track record of performance and maintaining enrollment capacity percentage;
    - The range of referral pathways for recruitment of the target population in order to meet enrollment targets; and
    - The provider's capacity to collect and report program data and participate in the PFO evaluation.

Potential Outcome Measure(s) and Payment Schedule

The feasibility study should address the potential outcome measure(s) for the PFO initiative, including how they would be measured.[44] When determining outcome measure(s) for a MIECHV-funded PFO initiative, ensure that selected measure(s) would meet requirements outlined in Section 3: Outcome Measure(s) and Payments of the PFO SIR, which include (but are not limited to) required alignment with MIECHV benchmark areas and constructs.

- Consider the potential payment amounts for each outcome measure, the payment schedule associated with each, and how it would align with the evaluation reporting timeline.
- Ensure payment amounts are reflective of federal, state, and/or local cost savings, cost avoidance and/or social benefit, and that they are appropriate and reasonable relative to the outcome measure achieved.

Ability to Rigorously Evaluate and Meet the Requirements of a PFO Evaluation

The feasibility study should address your capacity to meet all of the requirements of a rigorous, third-party PFO evaluation as described in Section 4: Third-Party Evaluation of the PFO SIR. In particular, consider:

- The capacity and independence of third-party evaluators, as well as your experience engaging with third-party evaluators;
- The availability and quality of data to evaluate each outcome measure, including your experience and capacity to access administrative data;
- What, if any, data sharing agreements will be needed, and if these agreements already exist;
- The recipient's experience and capacity using data to evaluate, track, and monitor progress on the outcome measure(s) for the PFO initiative; and
- Whether the size of the target population is sufficient to be included in the PFO initiative.

PFO Initiative Duration

In your feasibility study, you should consider:

- The anticipated duration of the PFO initiative, including the length of service provision, and the last date that outcome payments are expected to be made;
- The amount of time needed to complete the evaluation, determine if outcome payments will be made, and obligate funds; and
- If the project, both the intervention and evaluation, can be completed within the 10-year PFO statutory period of availability.

[44] Refer to *Section 4: Selected Outcome Measure(s)* in the PFO SIR for detailed requirements.

Stakeholders and Partnerships
PFO initiatives require the involvement of many partners including LIAs, third-party evaluators, model developers, agencies that house administrative data sources, early childhood systems partners, home visitors, families, and others. They may also include investors and/or an intermediary organization. In the feasibility study, consider:

- The potential key stakeholders and partners for a PFO initiative, their level of interest/engagement, and any significant or known barriers to partnership;
- The agreements or memoranda of understanding (MOUs) that are, or would need, to be in place to implement a PFO initiative; and
- The opportunities and challenges associated with engaging home visiting service providers and families in a PFO initiative.

Determination of Feasibility
The final step of the feasibility study is to provide an overall assessment as to whether the PFO initiative is or is not determined to be feasible. In making this determination, consider:

- The primary benefits and assets associated with implementation of a PFO initiative, as identified through the feasibility study;
- The primary risks and challenges associated with implementation of a PFO initiative, as identified through the feasibility study; and
- If the PFO initiative is NOT determined to be feasible, consider what steps would be necessary to address the findings should this approach be pursued in the future.

APPENDIX E: Budget – Pay for Outcomes Budget Submission

The following instructions apply if you **ARE** requesting to use a portion of your MIECHV formula award for a PFO initiative.

*If you are **NOT** requesting MIECHV formula funds for the purpose of a PFO initiative, you should disregard this appendix. Instead, refer to and follow the budget instructions beginning on page 15.

Budget
Prior to completing this NCC Update, see Program Expectations and Funding Restrictions in Appendix A for complete descriptions of the following types of expenditures:

- Limit on Funds to Support Direct Medical, Dental, Mental Health, or Legal Services;
- Statutory Limit ("Cap") on Use of Funds for Administrative Expenditures;[45]
- Limit on Use of Funds for Recipient-Level Infrastructure Expenditures; and
- Statutory Limit on Funds for Conducting a Program (including Evaluating the Program) Using a Promising Approach;[46]

The MIECHV Program requires the following for a complete PFO budget submission:

- Budget Forms
  - SF-424A
- Budget Narrative – MIECHV Formula Award
- Budget Narrative – MIECHV Pay for Outcomes Initiative
- Budget Narrative Breakout Items
- Attachment 3: Period of Availability Spreadsheet
- Attachment 4: Maintenance of Effort Chart

NOTE: Please do not include prior year MIECHV formula funds or funds from other MIECHV awards (e.g., ARP X11 awards) in the SF-424A or the budget narrative.

Period of Availability
You may choose to budget a portion of your FY 2022 MIECHV award for a PFO initiative. **The MIECHV PFO project/ budget period is up to 10 years** for the period of September 30, 2022 through September 29, 2032. MIECHV PFO funds must be obligated no later than September 29, 2032, and must be liquidated by December 31, 2032.

COVID-19 Public Health Emergency Authorities
During the declared COVID-19 public health emergency period, recipients can choose to budget MIECHV funds to:

1. Train home visitors in conducting virtual home visits (see Appendix F for a definition of virtual home visit) and in emergency preparedness and response planning for families;
2. Acquire the technological means as needed to conduct and support a virtual home visit for families enrolled in the program; and
3. Provide emergency supplies to families enrolled in the program, regardless of whether the provision of such supplies is within the scope of the approved program, such as diapers, formula, non-perishable food, water, hand soap, and hand sanitizer.

P.L. 116-260 specifies that the additional authorities are only available "during the COVID-19 public health emergency period" and therefore will be discontinued (and therefore no longer will

[45] Social Security Act, Title V, § 511(i)(2)(C).
[46] Social Security Act, Title V, § 511(d)(3)(A).

represent allowable costs under this award) at the conclusion of the declared COVID-19 public health emergency. At that time, any unobligated grant funds budgeted for activities related to the COVID-19 authorities described above must be re-budgeted for other allowable activities.

Key Requirements
Costs charged to the award must be reasonable, allowable, and allocable under this program. Documentation must be maintained to support all grant expenditures. Personnel charges must be based on actual, not budgeted labor. Promotional items and other expenditures which do not support the home visiting initiative are unallowable. Organizational membership in business, professional, or technical organizations or societies are generally allowable costs, if paid according to an established organizational policy consistently applied regardless of the source of funds. Costs of membership in any country club or social or dining club or organization are unallowable. Costs of membership in organizations whose purpose is lobbying are unallowable. Salaries and other expenditures charged to the grant must be for services that occurred during the grant's period of availability. It is the responsibility of the recipient to ensure that proper stewardship is exercised over federal funds. Costs must be necessary and reasonable, accorded consistent treatment, and allocable[47] to the award in accordance with the benefits received by the project. Further information regarding allowable costs is available from the UAR at 45 CFR Part 75.

The recipient accounting systems must be capable of separating the MIECHV awards within a single grant by period of availability (i.e., must have a chart of accounts to prevent grant expenditures from being commingled with other grant periods of availability). Recipients are responsible for reviewing subrecipients' and local sites' budgets according to all applicable organizational policies and procedures and for ensuring adequate post award monitoring of activities and expenditures[48]. Recipients and subrecipients must maintain all documentation in accordance with the federal record retention policy which states documentation must be maintained for a minimum of 3 years after the submission of the final (accepted) Federal Financial Report.

Required Submissions

a. Budget Forms

Applicants proposing to implement a PFO initiative with FY 2022 MIECHV funds must complete one SF-424A budget form and **two separate budget justifications** – one for the typical MIECHV Formula Award and one for the PFO initiative. The total for the MIECHV Formula funds and the PFO initiative funds **cannot exceed the FY 2022 grant award ceiling amount**.

Complete one SF-424A Budget Information form in Grants.gov. **The MIECHV formula project/budget period is 2 years. The PFO initiative budget period is up to 10 years.** The two narratives/budget justifications must explain the amounts requested (one for the MIECHV formula funds, and the second for the PFO initiative). Each narrative must include an explanation for each detailed line-item in the budget (e.g., personnel, fringe, travel, equipment, supplies, contractual, other, indirect charges).

Recipients will be allowed to request prior approval to rebudget grant funds between the originally requested budget supporting the PFO initiative, and the MIECHV formula

[47] See glossary for definition of allocable costs.
[48] Recipients must show they are meeting all MIECHV monitoring requirements, regardless of the type of relationship they have with their implementing agencies.

budget, up to and within the first 12 months of the period of performance (by September 29, 2023). After that time, funds may no longer be rebudgeted between allocations. Please note that recipients rebudgeting between the PFO initiative and the MIECHV formula budgets are required to submit a formal prior approval request via the EHBs.

For additional information on all the object class categories on the SF-424A and information to be included in the budget narrative, please refer to Section 4.1v. of the HRSA SF-424 Application Guide.

(1) **In Section A of the SF-424A budget forms, you will use only row (1), column (e)** to provide the budget amount you will request for FY 2022 (see communication via HRSA's EHBs for the total amount you may request). Please enter the amounts in the "New or Revised Budget" column, not the estimated unobligated funds column.

(2) **In Section B of the SF-424A budget forms, you will use column (1)** to provide object class category breakdown for the MIECHV formula funds requested through the period of availability of FY 2022 funds, and column (2) to provide the object class category breakdown for the PFO initiative funds requested for use through 2032. The combined amount requested may not exceed the FY 2022 ceiling amount, and must not exceed the allowable percentages for each.

b. Budget Narrative – MIECHV Formula Award

Provide a narrative explanation of the amounts requested for each line in the budget. The budget narrative should specifically describe how each item will support the achievement of proposed objectives. Provide a reasonable estimate of how you plan to break down the costs within each budget line and a description of how you came to that estimate. Line-item information must align with and explain the costs entered in the SF-424A, Section A, Column 1, and the Period of Availability Spreadsheet as **Attachment 3** (discussed later).

Include the following in the Budget Narrative:

(1) Personnel Costs: List each staff member to be supported by (1) MIECHV funds, the percent of effort each staff member spends on the MIECHV award, roles and area of responsibility, and (2) in-kind contributions. If personnel costs are supported by in-kind contributions, please indicate the percent of effort and the source of funds.

Please include:

- The full name of each staff member (or indicate a vacancy);
- Position title with description of role and responsibilities;
- Percentage of full-time equivalency (FTE) dedicated to this MIECHV award[49];
- Annual/base salary;
- Federal amount requested; and
- If in-kind, indicate the percent of effort and funding source(s).

Personnel includes, at a minimum, the project director, primarily responsible for the oversight and/or the project coordinator, primarily responsible for the day-to-day management of the proposed program; staff responsible for quality improvement activities (including but not limited to providing continuous quality improvement support to LIAs); programmatic and fiscal staff responsible for monitoring program activities and

[49] Total percent of effort for each personnel funded under this award must not exceed a sum of 100 percent FTE on all Federallyfederally-funded projects.

use of funds; and staff responsible for data collection, quality, and reporting. This list must include the project director listed on the Notice of Award.

Note that if any of these positions are contractual and included in the Contractual Object Class category, you must have a formal written agreement with the contracted individual that specifies the nature of the relationship between the parties, even if that relationship does not involve a salary or other form of remuneration. If the individual is not an employee of your organization, HRSA will assess whether the arrangement will result in the organization being able to fulfill its responsibilities under the grant, if awarded.

NOTE: Final personnel charges must be based on actual, not budgeted labor.

(2) Travel: The budget should reflect the travel expenses associated with participating in meetings that address home visiting efforts, other proposed trainings or workshops, and monitoring visits to LIAs. You should list travel costs, including whether the travel costs are for local and long distance travel. You must budget for one All Grantee Meeting in the Washington, DC area for up to five people for five days. **Meeting attendance is a grant requirement.** If you are applying to continue your participation in a CSE or applying to begin implementation of an implementation quality/fidelity CSE, you must budget for two in-person peer network meetings in the Washington, DC area for up to two people for 2 days. **Meeting attendance is required for all recipients conducting a CSE**. Refer to page 30 of the HRSA *SF-424 Application Guide* for more information on providing a travel budget justification. If travel can not be completed during the period of performance because of circumstances beyond the recipients' control, funds budgeted for travel may be rebudgeted.

(3) Supplies: Educational supplies may include pamphlets and educational videotapes—as well as model-specific supplies such as crib kits to promote safe sleep, tools to promote parent/child interaction, etc. that are essential in ensuring model fidelity. Clear justification for the purchase of basic medical supplies must be included.

(4) Contractual: You must ensure your organization has in place and follows an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts.

You must provide:

- A clear explanation as to the purpose of each contract;
- How the costs were estimated;
- The specific contract deliverables;
- A breakdown of costs, including the level of effort for home visitor personnel, for example, full-time equivalent (you may provide a listing of each home visitor personnel); and
- Narrative justification that explains the need for each contractual agreement and how it relates to the overall project.

HRSA reserves the right to request a more detailed, line-item breakdown for each contract. Costs for contracts must be broken down in detail as described above. Reminder: you must notify potential subrecipients (e.g., LIAs) that entities receiving subawards must be registered in the System for Award Management (SAM.gov) and

provide the recipient with their Unique Entity Identifier (UEI)[50], formerly known as the Dun and Bradstreet Data Universal Numbering System (DUNS) number. "Subaward" means an award provided by a pass-through entity to a subrecipient for the subrecipient to carry out part of a federal award received by the pass-through entity. It does not include payments to a contractor or payments to an individual that is a beneficiary of a federal program. A subaward may be provided through any form of legal agreement, including an agreement that the pass-through entity considers a contract. For more information on subawards and subrecipient monitoring, see Appendix A. Consultant contractors can also be listed in this section. For each consultant, specify the scope of work for the consultant, the hourly rate, and the number of hours of expected effort.

(NOTE: Contracting and subcontracting are allowable under this program; however, subgranting is not allowable under this program. Recipients that intend to provide services through subrecipient LIAs must have a written plan in place for subrecipient monitoring and must actively monitor subrecipients. See Appendix A for a complete description of subrecipient monitoring.)

Timely Federal Funding Accountability and Transparency Act (FFATA) reporting is required by the federal grant recipient to the FFATA Subaward Reporting System (FSRS.gov). You must have policies and procedures in place to ensure compliance with FFATA. For more FFATA information, please see Section 6.d. Transparency Act Reporting Requirements of HRSA's *SF-424 Application Guide* and HRSA's FFATA page.

(5) Other: Include all costs that do not fit into any other category and provide an explanation of each cost in this category (e.g., provider licenses, audit, etc.). In some cases, rent, utilities, and insurance fall under this category if they are not included in an approved indirect cost rate. You may include the cost of access accommodations as part of your project's budget, including sign language interpreters, plain language and health literacy print materials in alternate formats (including Braille, large print, etc.); and linguistic competence modifications (e.g., translation or interpretation services). The cost of purchasing consultative assistance from public or private entities, if the state determines that such assistance is required in developing, implementing, evaluating, and administering home visiting programs, is allowable but must be clearly justified. The cost of childcare for participating families may also be allowable if within the scope of an approved project or program or as incidental costs of a project or program if incurred to enable individuals to participate as subjects in research projects or to receive health services.

c. Budget Narrative – MIECHV Pay for Outcomes Initiative

The project/budget period for a PFO initiative is up to 10 years. Provide a line-item budget narrative using the budget categories in the SF-424A, Section B, Column 2 for the period of September 30, 2022 through September 29, 2032. The narrative must explain the amounts requested for each detailed line-item in the budget (e.g., personnel, fringe, travel, equipment, supplies, contractual, other, indirect charges). Descriptions for the categories can be found above in the MIECHV Formula Award budget. NOTE: The

[50] In April 2022, the DUNS number will be replaced by the UEI, a "new, non-proprietary identifier" requested in, and assigned by, the System for Award Management (SAM.gov). For more details, visit the following pages: Planned UEI Updates in Grant Application Forms and General Service Administration's UEI Update.

proposed PFO period of performance cannot exceed the 10-year PFO statutory period of availability, however recipients do not have to budget across the entire period of availability, and should propose a period of performance length that is appropriate for the proposed activities.

Line-item information must equate to and explain the costs for the PFO initiative entered on the SF-424A budget form, Section B, Column 2. Provide a narrative explanation of the amounts requested for each line in the budget. The budget narrative should specifically describe how each item will support the achievement of proposed objectives. Line-item information must equate to and explain the costs entered in the SF-424A, Section B, Column 2 and Period of Availability Spreadsheet as **Attachment 3** (discussed later).

d. Overall Budget Narrative Items:

Following your Budget Narrative-MIECHV Formula Award and Budget Narrative – MIECHV PFO Initiative, include as a separate breakout:

1) Administrative oexpenditures: A description of activities and detailed line-item breakdown of administrative expenditures,[51] as applicable, incurred through administering the MIECHV grant. Also, include the **estimated percentage** (at no more than 10 percent) of the FY 2022 MIECHV formula grant award planned to support these activities. *(For a complete definition and examples of administrative expenditures, see Appendix A.)* Note that for applicants proposing to implement a PFO project with FY 2022 MIECHV funds, the 10 percent limit on use of funds for administrative expenditures applies to the total award (MIECHV Formula Award plus PFO Outcomes Payments and PFO Evaluation).

2) Recipient-level infrastructure expenditures: A description of activities and detailed line-item breakdown of recipient-level infrastructure expenditures, as applicable, to enable the delivery of home visiting services, including but not limited to administrative expenditures. Also, include the **estimated percentage** (at no more than 25 percent, including administrative costs estimated above) of the FY 2022 MIECHV formula grant award planned to support those activities. *(For a complete definition and examples of recipient-level infrastructure expenditures, see Appendix A.)*

Note that for applicants proposing to implement a PFO project with FY 2022 MIECHV funds, the 25 percent limit on use of funds for recipient-level infrastructure expenditures applies to the total award (MIECHV Formula Award plus PFO Outcomes Payments and PFO Evaluation).

The 25 percent limit on recipient-level infrastructure expenditures does NOT include costs incurred for:

- Evaluation of a PFO project;
- PFO outcomes payments;
- Expenditures associated with a PFO Feasibility Study; and
- Update of data management systems related to measurement and data system redesign by model developer(s).

[51] Social Security Act, Title V, § 511(i)(2)(C).

NOTE: To seek HRSA approval for spending more than 25 percent of the award amount on recipient-level infrastructure expenditures, you must provide written justification for this request (for example, providing explanation of an unusually high negotiated indirect cost rate that increases infrastructure costs). Include this justification within the Budget Narrative.

3) Evaluation activities (as applicable): If you propose any evaluation activities (as described above in the "Assurances and Proposed Program Activitivies" section of the Project Narrative), you must include a budget narrative with justification and rationale for the proposed evaluation budget and detailed line item breakdown for evaluation expenses. These include, but are not limited to costs associated with salary and benefits for staff working on the evaluation, contracts for external evaluators, data collection, travel, communication tools that share interim results with stakeholders, printing, supplies, equipment, etc.

If you are proposing to conduct both a PFO evaluation AND a CSE, the CSE budget is considered tentative because the specific evaluation designs, questions, data collection strategies, and analysis plans will be created after the award and in collaboration with fellow recipients and the national evaluation coordinating center. These activities will be reflective of the planning phase of the CSE approach. HRSA recommends a maximum funding ceiling of 10 percent of the total requested budget for evaluation activities. HRSA also recommends that a minimum of $100,000 be devoted to evaluation-related activities to ensure the appropriate level of quality and rigor (keeping in mind the additional meetings required through the CSE). You may need to rebudget based on the outcome of the coordinated planning process. Furthermore, because recipients need to spend approximately the first 6 months engaged in coordinated planning, evaluation spending may vary over the period of availability. When budgeting, keep in mind the rate of expenditure. A finalized budget will be required in the evaluation plan due to HRSA after the coordinated planning process.

e. Period of Availability Spreadsheet (applicable to all applicants)

The purpose of this spreadsheet is to support verification that MIECHV formula funds will be budgeted to last through the full 2-year period of availability. Recipients are not required to budget FY 2022 formula funds in Year 1 of the period of performance.

Submit a spreadsheet, labeled as **Attachment 3 – Period of Availability Spreadsheet**, that includes the proposed budget by object class category (personnel, fringe, travel, etc.) for each individual fiscal year of the 2-year period of performance/period of availability (9/30/2022 to 9/29/2024), as well as an additional column that indicates how funds remaining from the previous FY 2021 MIECHV formula grant are proposed to be spent in Year 1 by object class category (e.g., personnel, fringe, travel).

For example:
FY 2021 MIECHV formula award (Year 1 of the FY 2022 period of performance) (for budgetary purposes: 9/30/2022 to 9/29/2023)
Column 1: Remaining funding from FY 2021 MIECHV formula grant to be spent in Year 1 of the FY 2022 period of performance
FY 2022 MIECHV grant - Year 1 (for budgetary purposes: 9/30/2022 to 9/29/2023)
Column 2: FY 2022 MIECHV grant Year 1 proposed spending
FY 2022 MIECHV grant - Year 2 (for budgetary purposes: 9/30/2023 to 9/29/2024)

Column 3: FY 2022 MIECHV grant Year 2 proposed spending

NOTE: The sum of expenditures for service delivery, recipient-level infrastructure, and administrative costs included in this Period of Availability Spreadsheet will **not** add up to the total grant award ceiling amount because certain recipient-level expenditures do not count against the 25 percent limit on recipient-level infrastructure expenditures, and so are not included in this spreadsheet. (See Appendix A for a list of recipient-level infrastructure expenditures that do not count against the 25 percent limit.)

f. Attachment 4: Maintenance of Effort Chart

Submit the following Maintenance of Effort (MOE) chart as **Attachment 4**. Refer to Appendix A for a description of the maintenance of effort statutory requirement. Also, include an explanation for any decreases in state funding.

NON-FEDERAL EXPENDITURES		
Two Fiscal Years Prior to Application – Actual (Corresponds to State FY 2020) Actual 2 years prior state FY non-federal (State General Funds) expended for the proposed project by the **recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. **Include prior state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** This number should equal the reported expenditures entered in the "FY Prior to Application (Actual)" column submitted as Attachment 4 in response to HRSA-21-050. (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) Amount: $_____________	Fiscal Year Prior to Application - Actual (Corresponds to State FY 2021) Actual prior state FY non-federal (State General Funds) expended for the proposed project by **the recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. **Include prior state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** This number should equal the reported expenditures entered in the "Most Recently Completed Fiscal Year (Actual)" column submitted as Section V of the FY 2019 Formula Grant Final Report. (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) Amount: $_____________	Current Fiscal Year of Application – Estimated (Corresponds to State FY 2022) Estimated current state FY non-federal (State General Funds) designated for the proposed project by the **recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. **Include current state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) Amount: $_____________

APPENDIX F: Glossary of Selected Terms

Administrative Expenditures – Administrative expenditures refer to the costs of administering a MIECHV award incurred by the recipient. This 10 percent may include, but may not be limited to, the following:

- Reporting costs (Discretionary Grants Information System, Home Visiting Information System, Federal Financial Report, and other reports required by HRSA as a condition of the award);
- Project-specific accounting and financial management;
- Payment Management System drawdowns and quarterly reporting;
- Time spent working with the HRSA grants management specialists and HRSA project officers;
- Subrecipient or local site monitoring;
- Complying with Federal Funding Accountability and Transparency Act (FFATA) subrecipient reporting requirements;
- Support of HRSA site visits;
- The portion of regional or national meetings dealing with MIECHV grants administration;
- Audit expenses; and
- Support of HHS Office of Inspector General or Government Accountability Office audits.

Allocable costs – According to 45 CFR 75.405(a), a cost is allocable to a particular federal award or other cost objective if the goods or services involved are chargeable or assignable to that federal award or cost objective in accordance with relative benefits received. This standard is met if the cost:

(1) Is incurred specifically for the federal award;

(2) Benefits both the federal award and other work of the non-federal entity and can be distributed in proportions that may be approximated using reasonable methods; and

(3) Is necessary to the overall operation of the non-federal entity and is assignable in part to the federal award in accordance with the principles in this subpart.

At-risk Communities (Communities at Risk for Poor MCH Outcomes) – States are required to give service priority to eligible families residing in communities identified by the current approved statewide needs assessment. Communities at risk for poor MCH outcomes are defined as those for which indicators, in comparison to statewide indicators, demonstrated that the community was at greater risk for poor outcomes than the state as a whole. These communities are further defined as communities with concentrations of the following indicators: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of adverse prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; or child maltreatment. For the purpose of the statewide needs assessment, the term communities is operationalized as counties, county equivalents, or sub-territory geographic units.

Caseload of MIECHV Family Slots – The caseload of MIECHV family slots (associated with the maximum service capacity) is the highest number of families (or households) that could potentially be enrolled at any given time if the program were operating with a full complement of

hired and trained home visitors. All members of one MIECHV family or household represent a single MIECHV caseload slot. **The count of slots should be distinguished from the cumulative number of enrolled families during the reporting period.**

For the purposes of reporting to HRSA on performance reporting Forms 1, 2, and 4, a "MIECHV family" is defined as a family served during the reporting period by a trained home visitor implementing services with fidelity to the model and that is identified as a MIECHV family at enrollment. HRSA has identified two different methods to identify MIECHV families:

1. *Home Visitor Personnel Cost Method:* Recipients designate families as MIECHV at enrollment based on the designation of the home visitor they are assigned. Using this methodology, recipients designate all families as MIECHV that are served by home visitors for whom at least 25 percent of his/her personnel costs (salary/wages including benefits) are paid for with MIECHV funding.

2. *Enrollment Slot Method:* Recipients designate families as MIECHV families based on the slot to which they are assigned at enrollment. Using this methodology, recipients identify certain slots as MIECHV-funded and assign families to these slots at enrollment in accordance with the terms of the contractual agreement between the MIECHV state recipient and the LIA regardless of the percentage of the slot funded by MIECHV.

Once designated as a MIECHV family, the recipient tracks the family for the purposes of data collection through the tenure of family participation in the program.

Centralized Intake System – A Centralized Intake System (CIS) is a one-stop entry point (a single place or process) in which screening helps to identify a client's needs and generates referrals to programs and services that are the best fit for the family. CISs connect clients to the services they need based on individualized assessments of their family's needs. Centralized intake is a single concept that may be referenced using other names, including *coordinated intake and referral, coordinated entry, centralized/single point of access, or system "front door."* CISs often carry out common shared tasks across organizations—specifically, community outreach and recruitment, screening and assessment, determination of fit, and referral to comprehensive services. The intake system may be housed by one central entity that screens and refers all clients, or may be housed throughout various agencies with connected referral systems. Referrals may be unidirectional or bi-directional; that is, some systems may only refer the client without any follow-up to ensure the service was completed, while others may share when or if referrals were completed or other client data. The scopes of CISs also vary across states and communities in terms of geographic reach. Similarly, the scopes of CISs vary in programmatic reach: systems may include only referrals to consist of only home visiting programs, they may also include other early childhood systems partners, and or some may include broader social services as well. A strong CIS allows providers to screen clients and conduct individualized family assessments, provide and follow referrals through the system, and connect families to a wide array of family services and supports.

Deobligated Funds – As provided by MIECHV statutory authority, any funds that remain unobligated at the end of the MIECHV period of performance are returned to the Federal Government (HRSA).

Early Childhood System – An early childhood system brings together health, early care and education, child welfare, and other family support program partners, as well as community leaders, families, and other stakeholders to achieve agreed-upon goals for thriving children and

families. An early childhood system aims to: reach all children and families as early as possible with needed services and supports; reflect and respect the strengths, needs, values, languages, cultures, and communities of children and families; ensure stability and continuity of services along a continuum from pregnancy to kindergarten entry; genuinely include and effectively accommodate children with special needs; support continuity of services, eliminate duplicative services, ease transitions, and improve the overall service experience for families and children; value parents and community members as decision makers and leaders; and catalyze and maximize investment and foster innovation.

Partners within an early childhood system may include the following, as well as their local counterparts and affiliates:

- The state's Early Childhood Comprehensive Systems (ECCS) recipient, if there is one;
- The state's Maternal and Child Health Services (Title V) agency;
- The state's Public Health agency, if this agency is not also administering the state's Title V program;
- The state's agency for Title II of the Child Abuse Prevention and Treatment Act (CAPTA);
- The state's child welfare agency (Title IV-E and IV-B), if this agency is not also administering Title II of CAPTA;
- The state's Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619 lead agency(ies);
- The state's Elementary and Secondary Education Act Title I or state pre-kindergarten program;
- The state's Preschool Development Grant Birth through Five (PDG B-5) recipient, if there is one;
- Federal programs serving young children and their families, including the Healthy Start program;
- Tribal recipients funded by HHS' ACF Tribal Home Visiting program;
- Tribal entities located in identified communities;
- U.S. Department of Housing and Urban Development-funded recipients within the state, including Continuum of Care recipients, state and local housing authorities, and other organizations that serve families that are homeless or at-risk for homelessness;
- Runaway & Homeless Youth programs, particularly those funded by ACF;
- The Office of Coordinator for Education of Homeless Children and Youths in the State authorized by the McKinney-Vento Act;
- The State Advisory Council on Early Childhood Education and Care authorized by § 642B(b)(1)(A)(i) of the Head Start Act, if applicable;
- The state's Medicaid/Children's Health Insurance program (or the person responsible for Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program);
- The state's primary health care, medical home, and safety net provider organizations (American Academy of Pediatrics, American College of Obstetricians and Gynecologists, HRSA-funded health centers and look-alikes, etc.);
- The state's Child Care and Development Fund (CCDF) Administrator;
- Director of the state's Head Start State Collaboration Office;
- The state's Single State Agency for Substance Abuse Services;
- The state's domestic violence coalition;
- The state's mental health agency;

- The statewide agency(ies) or local organization(s) focused on serving court-involved families, such as the Court Improvement Program, dependency courts, or family-serving problem-solving courts including infant-toddler courts;
- The statewide agency or organization focused on crime reduction, such as the State Reentry Council, State Council on Crime and Delinquency, or Association of Problem Solving Courts;
- The state's Temporary Assistance for Needy Families agency;
- The state's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program;
- The state's Supplemental Nutrition Assistance Program (SNAP) agency;
- The state's Injury Prevention and Control (Public Health Injury Surveillance and Prevention) program; and
- The state's oral health agency.

Eligible Family – The term "eligible family," under the MIECHV authorizing statute, means: (A) a woman who is pregnant, and the father of the child if the father is available; or (B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.[52]

Equity – The consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.[53]

Evidence-Based Models – Evidence-based models are those home visiting service delivery models eligible for implementation under MIECHV that meet the HHS criteria for evidence of effectiveness. In addition to the HHS criteria for evidence of effectiveness, the statute[54] specifies that a model selected by a eligible entity "conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high-quality service delivery and continuous program quality improvement," among other requirements.

Fidelity – Fidelity is defined as a recipient's adherence to model developer requirements for high-quality implementation as well as any applicable affiliation, certification, or accreditation required by the model developer, if applicable.

Health Equity – Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and

---

[52] Social Security Act, Title V, § 511(k)(2).
[53] Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, 86 FR 7009, at § 2(a) (Jan. 20, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf.
[54] Social Security Act, Title V, § 511(k)(2).

ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[55]

HHS Criteria for Evidence of Effectiveness **–** To meet HHS' criteria for an "evidence-based early childhood home visiting service delivery model," program models must meet at least one of the following criteria:

- At least one high- or moderate-quality impact study of the model finds favorable, statistically significant impacts in two or more of the eight outcome domains; or
- At least two high- or moderate-quality impact studies of the model using non-overlapping analytic study samples with one or more favorable, statistically significant impacts in the same domain.

In both cases, the impacts must either: (1) be found in the full sample or (2) if found for subgroups but not for the full sample, be replicated in the same domain in two or more studies using non-overlapping analytic study samples. Additionally, following statute, if the program model meets the above criteria based on findings from randomized controlled trial(s) only, then one or more favorable, statistically significant impacts must be sustained for at least 1 year after program enrollment, and one or more favorable, statistically significant impacts must be reported in a peer-reviewed journal.

For results from single-case designs to be considered towards the HHS criteria, additional requirements must be met:

- At least five studies examining the intervention meet the What Works Clearinghouse's pilot single-case design standards without reservations or standards with reservations (equivalent to a "high" or "moderate" rating in HomVEE, respectively).
- The single-case designs are conducted by at least three research teams with no overlapping authorship at three institutions.
- The combined number of cases is at least 20.

Home Visiting Collaborative Improvement and Innovation Network **–** Through the Education Development Center, HRSA facilitates the Home Visiting Collaborative Improvement and Innovation Network 2.0 (HV CoIIN 2.0). The HV CoIIN 2.0 facilitates the dissemination of clinical and other interventions found to be effective in the first HV CoIIN related to alleviating maternal depression, promoting early childhood development, and linking families to service for any delays; increasing initiation and duration of breastfeeding, and enhancing and increasing family participation. Additionally, a new set of evidence-informed change strategies will continue to build the CQI capacity of MIECHV recipients and local implementing agencies (LIAs). The HV CoIIN brings together LIAs across multiple states, territories and tribal entities to seek collaborative learning, rapid testing for improvement, and sharing of best practices. The HV CoIIN uses the Model for Improvement which includes small tests of change (known as Plan-Do-Study-Act cycles) to adapt evidence-based practices recommended by faculty of the collaborative to the local context of participating agencies. The collaborative tracks individual agency and overall progress of the HV CoIIN using standardized outcomes and process measures for each target area. Each team reports on these measures monthly as they test and adapt the recommended changes.

---

[55] Healthy People 2030, https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9 Healthy People 2030, https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9

Home Visiting Evidence of Effectiveness (HomVEE) – The Department of Health and Human Services uses HomVEE to conduct a thorough and transparent review of the home visiting research literature. Using the HHS criteria for evidence of effectiveness, HomVEE provides an assessment of the evidence of effectiveness for home visiting program models that target families with pregnant women and children from birth to kindergarten entry. Additional information about HomVEE is available on the HomVEE webpage.

Infant and Early Childhood Mental Health Consultation (IECMHC) – IECMHC is a prevention-based approach that pairs a mental health consultant with adults who work with infants and young children in order to equip these caregivers to facilitate children's healthy social and emotional development. IECMHC has been shown to improve children's social skills and emotional functioning, promote healthy relationships, reduce challenging behaviors, reduce the number of suspensions and expulsions, improve classroom quality, and reduce provider stress, burnout, and turnover.

Maximum Service Capacity – The maximum service capacity (associated with the caseload of MIECHV family slots) is the highest number of households that could potentially be enrolled at the end of the quarterly reporting period if the program were operating with a full complement of hired and trained home visitors.

MIECHV Performance Measures – Performance measures are categorized into two types: performance indicators and systems outcomes. Performance indicators are relatively proximal to the home visiting intervention or shown to be sensitive to home visiting alone. Systems outcome measures are more distal to the home visiting intervention and/or are less sensitive to change due to home visiting alone due to many factors, including confounding influences or differences in available system infrastructure at the state- or community-level. A complete listing of the performance measures is available on the HRSA website.

Pay for Outcomes Initiative – The term "pay for outcomes initiative"[56] means a performance-based grant, contract, cooperative agreement, or other agreement awarded by a public entity in which a commitment is made to pay for improved outcomes achieved as a result of the intervention that result in social benefit and direct cost savings or cost avoidance to the public sector. Such an initiative shall include:

- A feasibility study that describes how the proposed intervention is based on evidence of effectiveness;
- A rigorous, third-party evaluation that uses experimental or quasi-experimental design or other research methodologies that allow for the strongest possible causal inferences to determine whether the initiative has met its proposed outcomes as a result of the intervention;
- An annual, publicly available report on the progress of the initiative; and
- A requirement that payments are made to the recipient of a grant, contract, or cooperative agreement only when agreed upon outcomes are achieved, except that a third party conducting the evaluation.

Precision Home Visiting – Precision home visiting is home visiting that differentiates what works, for whom, and in what contexts to achieve specific outcomes. It focuses on the components of home visiting services rather than on complex models of home visiting that are administered uniformly. Precision home visiting uses research to identify what elements of

[56] Social Security Act, Title V, § 511(c), as amended by the Bipartisan Budget Act of 2018, Title VI, § 50605.

home visiting work best for particular types of families in particular contexts. Additional information is available from the [Home Visiting Applied Research Collaborative (HARC) webpage](#).

Promising Approach Home Visiting Model – A home visiting service delivery model that qualifies as a promising approach is defined in statute: "the model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process."[57] The authorizing statute further requires, "An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(II)."[58]

Recipient-Level Infrastructure Expenditures – Recipient-level infrastructure expenditures refers to recipient-level expenditures necessary to enable recipients to deliver MIECHV services, but does not include the costs of delivering such home visiting services. Recipient-level infrastructure expenditures necessary to enable delivery of MIECHV services subject to the 25 percent limit may include recipient-level personnel, contracts, supplies, travel, equipment, rental, printing, and other costs to support the following (excluding costs related to state evaluation):

- Professional development and training for recipient-level staff;
- Model affiliation and accreditation fees;
- Continuous Quality Improvement (CQI) and quality assurance activities, including development of CQI and related plans;
- Technical assistance provided by the recipient to the LIAs;
- Information technology including data systems (excluding costs incurred to update data management systems related to the HRSA redesign of the MIECHV program performance measurement system which took effect on October 1, 2016);
- Coordination with comprehensive statewide early childhood systems; Administrative expenditures (further subject to a 10 percent cap); and
- Indirect costs (also known as "facilities and administrative costs") (i.e., costs incurred for common or joint objectives that cannot be identified specifically with a particular project, program, or organizational activity).

Reflective Supervision – Reflective supervision is a distinctive form of competency-based professional development that is provided to multidisciplinary early childhood home visitors who are working to support very young children's primary caregiving relationships. Reflective supervision is a practice, which acknowledges that very young children have unique developmental and relational needs and that all early learning occurs in the context of relationships. Reflective supervision is distinct from administrative supervision and clinical supervision due to the shared exploration of the parallel process, that is, attention to all of the relationships is important, including the relationships between home visitor and supervisor, between home visitor and parent, and between parent and infant/toddler. Reflective supervision supports professional and personal development of home visitors by attending to the emotional content of their work and how reactions to the content affect their work. In reflective supervision, there is often greater emphasis on the supervisor's ability to listen and wait, allowing the

[57] Social Security Act, Title V, § 511(d)(3)(A)(i)(II).
[58] Social Security Act, Title V, § 511 (d)(3)(A)(ii).

supervisee to discover solutions, concepts, and perceptions on his/her own without interruption from the supervisor.

Service Delivery Expenditures – Service delivery expenditures are those costs budgeted to deliver home visiting services to caseloads of family slots, excluding administrative and recipient-level infrastructure expenditures. Family slots are those enrollment slots served by a trained home visitor implementing services with fidelity to the model for whom at least 25 percent of his/her personnel costs (salary/wages including benefits) are paid for with MIECHV funding, or identified as MIECHV based on the designation of the slot they are assigned at enrollment and in accordance with the terms of the contractual agreement between the MIECHV state recipient and the local implementing agency (LIA).
Examples of service delivery expenditures may include but are not limited to personnel, contracts, supplies, travel, equipment, rental, printing, and other costs to support:

- Contracts to LIAs;
- Professional development and training for LIA and other contractual staff;
- Assessment instruments/licenses;
- Participant educational supplies; and
- Participant recruitment.

Social Determinants of Health – HHS defines social determinants of health as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health can be grouped into 5 domains: economic stability; education access and quality; health care access and quality; neighborhood and built environment; social and community context. You can explore evidence-based resources at the following link: Browse Evidence-Based Resources.

Unobligated Balance – The amount of funds authorized under a federal award that the recipient (non-federal entity) has not obligated. The amount is computed by subtracting the cumulative amount of the non-federal entity's unliquidated obligations and expenditures of funds under the federal award from the cumulative amount of the funds that the federal awarding agency or pass-through entity authorized the non-federal entity to obligate.[59]

Virtual Home Visit – The Consolidated Appropriations Act, 2021 specifies that the term ‘‘virtual home visit’’ means a home visit, as described in an applicable service delivery model, that is conducted solely by the use of electronic information and telecommunications technologies.[60]

[59] 45 CFR § 75.2
[60] P.L. 116-260 Division X, Section 10(b)