# **Caring for the Whole Child:** *A New Way to Finance Initiatives to Improve Children's Health and Well-being*

Issue Brief

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## Executive Summary

A growing recognition that socioeconomic factors affect health outcomes in significant ways is fueling new community investments and change in health care delivery systems[1]. Often referred to as "social determinants of health" (SDOH), these factors refer to "the structural conditions in which people are born, grow, live, work and age" that have profound implications for an individual's overall well-being[2]. Addressing SDOH needs for children and their families is particularly important in light of the strong evidence that investments in the earliest years can have a potent impact on children's development and their ability to thrive and grow to be healthier adults. Yet children have largely been left behind with respect to SDOH investments in part because the financing for these initiatives has relied heavily on the potential for a relatively short-term return on investment (ROI) for the health sector. SDOH interventions focused on children will produce health-related financial returns but typically on a longer time horizon, and they often will result in savings outside the health care sector (for example, to the child welfare system), giving rise to what is known as the "wrong pockets" problem. Given the extraordinary impact that the COVID-19 pandemic is having on the well-being of children, and most notably children of color, the urgency to act could not be more apparent.

A Children's Health and Wellness Fund is a way to galvanize efforts focused on SDOH investments for children. On the most basic level, a Fund offers a mechanism to address the wrong pockets problem by facilitating a shared financing approach that reflects the shared interest and benefits of the many sectors that serve children—including health care, education, child welfare, and juvenile justice. A Fund can attract, collect, and administer funding derived from different sources that can help finance "whole child" care. Sources of funding can be diverse, including public and private funds that build on investments that ought to be made through Medicaid and the Children's Health Insurance Program (CHIP). But a Fund can be more than a bank account that facilitates multisector investments and spending; by bringing together diverse actors, all with a strong interest in children, a Children's Health and Wellness Fund can focus attention on children's needs and spur action on their behalf.

***There is broad agreement that investments that promote healthy childhood development should be a regular feature of pediatric care and a focus of community initiatives (i.e., both "midstream" and "upstream" interventions), but we need a different, multisector approach to design, finance and implement these efforts.***

This brief describes a pathway to ensure that children and their families benefit from SDOH investments. It reviews options for designing and implementing a Children's Health and Wellness Fund with respect to each of the issues identified below, highlighting different models that can address the core components of a Fund. Critically, all these decisions require leadership from and close collaboration with the community to be served and a consistent and focused attention on promoting equity.

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1 Research indicates that up to 80% of an individual's health outcomes can be attributed to nonmedical factors. S. Artiga and E. Hinton. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. May 10, 2018. Available: https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

2 M. Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," The Lancet 372, no. 9650 (Nov. 8, 2008):1661–1669.

1. **The overall framework for the Fund and the activities it supports.** Planning for a Children's Health and Wellness Fund must begin with foundational decisions about the vision and administration of the Fund. Planners must determine how it will be organized (e.g., as a statewide or local initiative), how funds will be disbursed, what the target population of children will be and how it can—at every step—enhance equity. In addition, Fund planners must consider how the Fund will align with existing efforts to address children's social and developmental needs.
2. **Fund responsibilities and mechanisms for oversight.** Central to launching a Children's Health and Wellness Fund is defining the scope of the Fund's responsibilities and establishing a governance structure that can competently execute those responsibilities. For example, will the entity that establishes the Fund also carry out operational responsibilities, or will those be taken on by a partner organization or organizations? The scope of the Fund's responsibilities will inform its decisions about its governance body—including who participates and what its core functions are.
3. **Potential Sources of Funding.** There are many options for financing a Children's Health and Wellness Fund. Key to success is identifying the public and private actors that have a particular interest in children's healthy development and that benefit from positive health outcomes. This is not "charity"—it is a shared investment with a shared return. Additionally, reliance on a mix of sources will help grow the Fund and promote sustainability; if one funding source later becomes unavailable, operations can continue. Sources of funds reviewed include:
    - State requirements or incentives for Medicaid managed care organizations to invest a portion of revenue/profits into the Fund.
    - Engaging hospitals and hospital systems, including those that have community benefits obligations under federal (and possibly state) law.
    - CHIP Health Services Initiatives that permit investments that benefit low-income children.
    - Direct appropriations from state or local funds, or earmarking a portion of new or existing taxes, fees, or appropriations to various child-serving agencies.
    - Leveraging flexible federal funding streams that can be directed toward addressing health-related social needs for children. This brief identifies a number of these federal programs and their allowable uses.

    These financing mechanisms are not mutually exclusive and, as noted, sustainability is promoted by relying on a mix of sources. Challenges in "blending or braiding" funds can be minimized to the extent that the target populations and allowable uses for the funds can be aligned, but that is not always possible and, at a minimum, reporting responsibilities will be distinct and will need to be managed. The operational infrastructure of a Fund will need to take this into account. Notably, Fund investments should build on and not supplant opportunities for Medicaid to finance some aspects of SDOH initiatives on behalf of children; key Medicaid financing opportunities are reviewed in depth in Appendix A.
4. **Program accountability and evaluation.** Ongoing quality improvement efforts, data tracking, reporting, and evaluation all serve to promote accountability, ensure equity goals guide the work, improve program performance, and encourage continued investment. Having clear expectations for stakeholders—for both sources of and recipients of funds—will be essential for growing the evidence base and awareness of a Children's Health and Wellness Fund as an effective mechanism for helping children stay healthy and thrive.

Never has a focus on the health and well-being of our nation's children been more important than in the wake of the COVID-19 pandemic and the health disparities it has laid bare. The short- and likely longer-term impacts of the economic and social effects of the pandemic are particularly harsh for children, and most notably for children of color. The pandemic, however, has unleashed new collaborations and opportunities for supporting children and their families; these efforts need to evolve into systemic changes in the way we prioritize and nurture the health and development of children, particularly children from marginalized communities. The development of a Children's Health and Wellness Fund offers an important opportunity at a critical moment in time to bring together stakeholders—

including states, cities, health systems, and community residents—to shape, sustainably finance, and deliver a whole child approach to supporting children and their families.

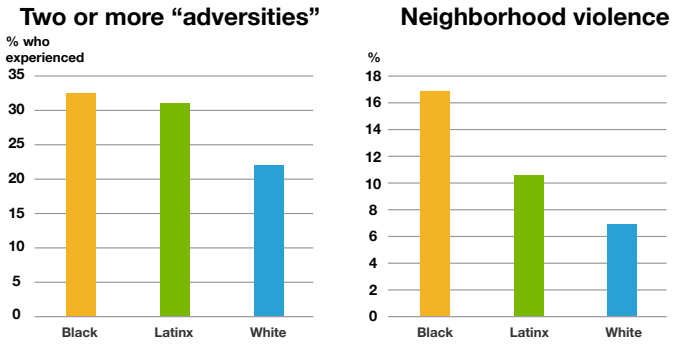
## Introduction

In recent years, a growing recognition that socioeconomic factors have a large impact on health outcomes has led to the proliferation of initiatives to address socioeconomic factors in the context of delivering health care and, to a lesser extent, through community-wide interventions[3]. Often referred to as "social determinants of health" (SDOH), these factors refer to "the structural conditions in which people are born, grow, live, work and age" that have profound implications for an individual's overall well-being, and in many cases their health care costs[4]. Sometimes considered a social determinant in and of itself, institutional racism is underlying and in many ways driving the burden of social needs and disease[5]. The public health crisis facing the nation today has only deepened awareness of these connections: In ways hard to imagine just a year ago, the pandemic and the economic dislocation it has wrought have laid bare the link between socioeconomic factors and health and the ways in which racial injustice impacts health and well-being.

Addressing SDOH needs for children is particularly important in light of the strong evidence that investments in children's health, social needs, and development can lead to long-term improvements in health, economic stability, and resiliency. Investments for children of all ages bring significant value, but research has shown that early investment is particularly impactful: "The highest rate of return in early childhood development starts from investing as early as possible, from birth to age five, in disadvantaged families. Starting at age three or four is too little too late."[6] A mounting body of evidence focusing on trauma has also shown that individuals exposed during childhood to adverse childhood events (ACEs) are more likely to suffer from cancers and ischemic heart disease and have lower reported health-related quality of life[7]. Here, too, racial

**The Root Causes of Poor Health: Midstream and Upstream Factors**

The root causes of poor health can occur at several different levels—often described as "mid-stream" and "upstream" causes. Midstream causes are thought of as intermediary determinants, or material circumstances affecting an individual's health, such as housing conditions and food security. Interventions seek to address these circumstances on behalf of particular individuals/families. Structural determinants affecting a community or population, such as structural racism, prevalence of lead in low income housing, limited access to healthy food, or violence in the community are more upstream. Interventions related to upstream causes seek to address the broader conditions in the community or societally that negatively impact health.




3 Research indicates that up to 80% of an individual's health outcomes can be attributed to nonmedical factors. S. Artiga and E. Hinton. "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity." Kaiser Family Foundation. May 10, 2018. Available at: https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

4 Michael Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," The Lancet 372, no. 9650 (Nov. 8, 2008):1661–1669.

5 Trent, M. "The Impact of Racism on Child and Adolescent Health." American Academy of Pediatrics. August 2019. Available: https://pediatrics.aappublications.org/content/pediatrics/144/2/e20191765.full.pdf

6 Heckman, J. Invest in early childhood development: Reduce deficits, strengthen the economy. 2012. Available at: https://heckmanequation.org/www/assets/2013/07/F_HeckmanDeficitPieceCUSTOM-Generic_052714-3-1.pdf.

7 Sacks, V, and Murphey, D. "The Prevalence of Adverse Childhood Experiences, Nationally, by State and by Race and Ethnicity." Child Trends. February 20, 2018. Available at: https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity.

disparities are stark. Nationally, 61 percent of Black non-Hispanic children and 51 percent of Hispanic children have experienced at least one ACE, compared with 40 percent of white non-Hispanic children.[8,9]

The coronavirus has raised the risk level for children to an extraordinary degree; while children have been less impacted than adults by infection from the virus, they are among those hit hardest by the pandemic. With families grieving, parents facing unprecedented stress due to job loss or jobs that expose their families to harm, and the lack of social interactions and supports that come from child care and school, children are facing isolation, trauma, and deprivation—with lifelong implications. And again, we see those risks particularly falling on children of color.

- In April 2020—at the beginning of the economic fallout from the pandemic—more than one in five households with children 12 and under were food insecure, and in one-fifth of those households children were going hungry[10]. Household food insecurity has insidious effects on the health and development of young children throughout their childhood and stretching later into life, including increased hospitalizations, poor health, iron deficiency, developmental risk, and behavior problems—including anxiety, depression, and attention deficit disorder.[11]
- Without school and other normal social contact and supports, and living with families facing financial stress and largely disconnected from the health care system, children face new, heightened risks of stress and trauma. Research over the course of the pandemic charts how a decline in child care availability and employment is correlated with increases in child abuse and neglect.[12]
- Years of improvements in health coverage and access to care are unraveling for children. Rates of childhood immunizations have plummeted to just a quarter of what's considered normal, while the uninsurance rate for children has increased sharply.[13] The most recent Census Bureau data show that nearly 6 percent of children are without health insurance—the highest rate in more than a decade. Hispanic children are more than twice as likely as white, non-Hispanic children to be uninsured.[14,15]

Robust and sustainable interventions targeted to children and their families are more important than ever, but they will require a new resolve, an intentional focus on racism, and new approaches, particularly with respect to financing. Despite the evidence of the unique value that SDOH interventions can have for children, to date these initiatives have largely left children behind; most of the SDOH activity has been focused on one-on-one interventions for high-cost, high-needs adults. This is largely a consequence of relying heavily on the health care system to finance SDOH interventions and on calculations relating to ROI. Typically, when a health plan or hospital system is considering investments in nonmedical interventions, it is looking to realize a return on its investment in a relatively short period of time (e.g., 12-18 months), at least to cover the cost. Investments focused on children do not typically

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8 Ibid.

9 Shonkoff, J. "Leveraging Advances in the Biology of Adversity & Resilience to Reduce Inequalities in Life Outcomes." Center on the Developing Child: Harvard University. September 30, 2020. Available: https://www.scribd.com/presentation/478172414/SHONKOFF#download&from_embed.

10 "The COVID-19 Crisis Has Already Left Too Many Children Hungry in America." Brookings. Available at: https://www.brookings.edu/blog/up-front/2020/05/06/the-covid-19-crisis-has-already-left-too-many-children-hungry-in-america/.

11 Ryu, J. et al. "Household Food Insecurity During Childhood and Subsequent Health Status: The Early Childhood Longitudinal Study—Kindergarten Cohort." American Journal of Public Health. 2012. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477974/.

12 Cao, E. et al. The Potential Impact of the COVID-19 Pandemic on Child Abuse and Neglect: The Role of Childcare and Unemployment. Vox. Available at: https://voxeu.org/article/potential-impact-covid-19-child-abuse-and-neglect.

13 Santoli, J. et al. "Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration — United States, 2020." CDC.gov. May 15, 2020. Available at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm.

14 Alker, J. Cocoran, A. "Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade." Georgetown Center for Children and Families. July 2020. Available at: https://ccf.georgetown.edu/2020/10/08/childrens-uninsured-rate-rises-by-largest-annual-jump-in-more-than-a-decade-2/.

15 "Percentage of Children Under the Age of 19 Without Health Insurance Coverage by Selected Characteristics: 2018 to 2019." U.S. Census Bureau, 2018 and 2019 American Community Surveys. https://www.census.gov/content/dam/Census/library/visualizations/2020/demo/p60-271/figure5.pdf.

realize a return that quickly. The financial benefits of those investments are more often realized years later or by actors outside the health care sector.

In light of the misaligned incentives to invest in children and the imperative to focus on children, this paper offers a new framework for moving forward, one that can be shaped in many different ways, consistent with local needs and capabilities. Though devastating to the health, financial security, and well-being of already vulnerable children and families, the public health crisis has prompted new, promising cross-sector collaborations and a once-in-a-generation opportunity to create stronger, more equitable systems that support the health and developmental needs of children, their families, and their communities. There's no time to waste.

## Addressing the Social Needs of Children and Families Is Vitally Important and Must Be Done in New Ways

### The impact of SDOH is unique for children, and different from that for adults

While adults' health can be adversely affected by social needs, stress, and trauma, unmet needs in childhood can take a more lasting toll, interfering with healthy development, impeding educational progress and leading to chronic disorders later in life. ACEs are associated with a massive burden of disease and unhealthy behaviors among adults in the United States, including 44 percent of cases of depressive disorder, 13 percent of cases of heart disease, 33 percent of regular smokers, and 24 percent of heavy drinkers.[16] Furthermore, ACEs are linked to future socioeconomic challenges such as unemployment, lower educational achievement, and not having health insurance.[17] Conversely, positive experiences over the course of childhood, such as the presence of a safe, stable nurturing environment and relationships, provide children with a foundation on which to grow and develop throughout their life span. Researchers believe that early experiences are "built" into our bodies, creating biological "memories" that shape development—for better or for worse.[18]

Children are also different from adults in that family issues have such a significant influence on their development and well-being. Because of this influence, it is well recognized that strategies to address the health-related social needs of children must include their parents or caregivers. Promising primary care programs and SDOH interventions utilize a "two-generation approach" to build child health and well-being by intentionally and simultaneously working with children and the adults in their lives together.[19,20,21] Having both a child and a parent participate in coordinated services may also lead to "multiplier effects" and improve the health and well-being of the entire family. Furthermore, a two-generation approach that coordinates services for children and parents provides a pathway to care for disenfranchised populations who may not typically utilize health care services.

### Interventions to address children and family SDOH needs often fall victim to "return on investment" calculations and the "wrong pockets" issue

Despite increased appreciation that social factors such as ACEs have a strong effect on children's development, SDOH interventions led by the health care sector have generally not focused on children. To date, the impetus for the health care sector to invest in strategies that address health-related social needs is the recognition that such interventions can improve health and lower health care costs. Health care sector financing, including by Medicaid managed care organizations or hospitals and health care systems, has largely relied on the potential for a return on investment (ROI), typically calculated over a

16 "Data Visualizations: Adverse Childhood Experiences (ACEs). Vital Signs." Centers for Disease Control and Prevention. https://www.cdc.gov/vitalsigns/aces/data-visualization.html#info2.
17 Ibid.
18 "The Foundations of Lifelong Health." The Harvard Center for the Developing Child. 2010. Available at: https://46y5eh11fh-gw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2015/05/InBrief-The-Foundations-of-Lifelong-Health-1.pdf.
19 "TwoGen Toolkit." Ascend at Aspen Institute. Available at: https://ascend.aspeninstitute.org/resources/2gen-toolbox/
20 "Two-Generation Approach." Urban Institute. Available at: https://www.urban.org/policy-centers/metropolitan-housing-and-communities-policy-center/projects/host-initiative-action/designing-housing-platform-services/two-generation-approach.
21 " Two-Generation Strategies Toolkit." NCSL. Available at: https://www.ncsl.org/research/human-services/two-generation-strategies-toolkit.aspx.

one- to two-year period. For example, if a managed care plan intervenes to stabilize the housing situation of an adult whose multiple chronic conditions cannot be effectively addressed while he or she is living on the streets, that intervention can potentially significantly reduce that plan's health care costs over an 18-month time horizon.[22,23,24] As such, plans have financial incentives to take these steps, and in many cases, state Medicaid programs have either required or encouraged such action.[25]

By contrast, SDOH interventions focused on children are more likely to produce financial returns on a 5-, 10-, 15-, or 20-plus-year time horizon, giving rise to what is known as the "wrong pockets" problem, or a situation in which the entity that bears the cost of implementing a practice or program does not receive the primary benefit. In addition to the timing issues, the wrong pockets issue also arises more for children than for adults because some of the financial benefits that are associated with healthy child development accrue outside the health care system (e.g., by resulting in reduced costs for the child welfare, special education, and even the juvenile and adult criminal justice systems).[26,27] When applied to most children, the traditional health care ROI framework generally does not work as a way to incentivize or justify investments in SDOH by individual plans and providers.

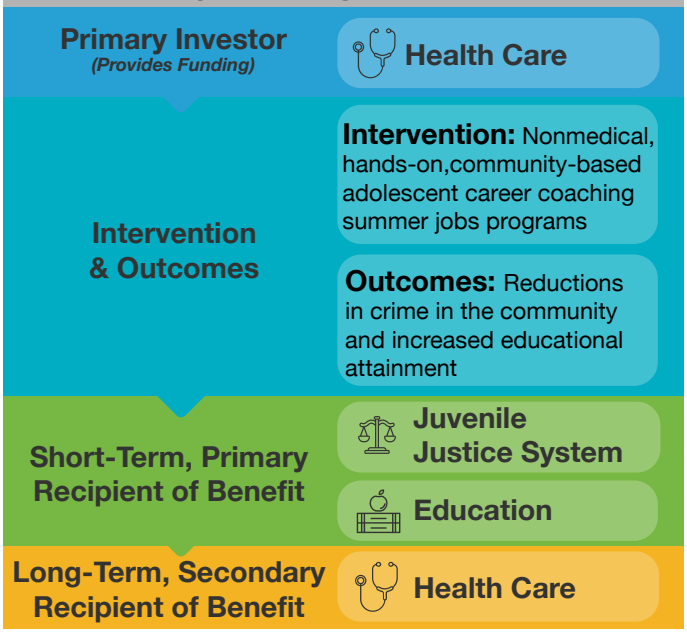
This misalignment of financial incentives in the context of investing in whole child care and population health strategies means that SDOH initiatives targeting children are a lower priority for state Medicaid programs, health plans, and health systems. While there is broad agreement that investment in SDOH interventions for children does promote better health and should be a regular feature of children's health care, without a short-term ROI to the health system, we need a different way to finance these efforts.

## Example: Wrong Pockets Problem

### The Issue

In the wake of the opioid epidemic, Community X is experiencing high rates of substance use disorder (SUD) and behavioral issues among adolescents, which is contributing to rates of neighborhood violence and absenteeism in schools. To address the high rates of SUD and behavioral issues, the local hospital funds a non-medical, hands-on, community-based career coaching and summer job placement program for adolescents to deter them from drug abuse.

### Summary of Wrong Pockets Problem




22 M. E. Larimer, D. K. Malone, M. D. Garner et al., "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems," Journal of the American Medical Association, April 1, 2009. 301(13):1349–57.

23 D. Srebnik et al. "A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services." American Journal of Public Health. 2013. Available at: https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2012.300867.

24 D. Garret. "The Business Case for Ending Homelessness: Having a Home Improves Health, Reduces Healthcare Utilization and Costs." American Journal of Health & Drug Benefits. 2012. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4046466/.

25 Even those incentives can be complicated by plan concerns that a decline in utilization of high cost health services may later drive down their revenues; value-based payment mechanisms as well as adjustments to the computation of medical loss ratios can mitigate these concerns. J. Guyer and D. Bachrach, "Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools." The Commonwealth Fund. January 31, 2018. Available at: https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review.

26 S. Butler. "How Wrong Pockets Hurt Health." JAMA Forum. August 22, 2018. Available at: https://jamanetwork.com/channels/health-forum/fullarticle/2760141.

27 J. McCullough. "Declines in Spending Despite Positive Returns on Investment: Understanding Public Health's Wrong Pocket Problem." Frontiers in Public Health. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6591259/.

## A New Paradigm for Addressing the Needs of Children and Their Families

A different complement of financing strategies and collaborations is needed for children—including youth and adolescents—one that builds on the more "traditional" Medicaid opportunities but reaches beyond those strategies, distributing costs in a way that recognizes shared interests and benefits. Medicaid requirements and incentives can be key building blocks and are described in Appendix A to this brief. For example, many state Medicaid programs are broadening the concept of pediatric primary care and care management, directing managed care plans (or their network providers) to provide and pay for linkages to the Supplemental Nutrition Assistance Program (SNAP) or housing stabilization services for children and their families. These expectations and sources of financing are foundational to any comprehensive effort focusing on children and their families. However, some of the deeper health sector investments in interventions that depend on relatively short-term ROI calculations, such as housing and transportation to services that improve health (e.g., to the farmers market or to a job interview), are not likely to be applicable to most children.

The remainder of this brief lays out a blueprint for financing whole child health and well-being initiatives, relying on a "Children's Health and Wellness Fund" A Children's Health and Wellness Fund is a way to organize support for investments for children that addresses the wrong pockets issue and provides a mechanism to attract and manage those investments. To be successful, it must be part of a broader effort aimed at creating sustained cross-sector commitments and the infrastructure and accountability needed to put those commitments to good use. The establishment and the activities of a Fund, however, can be a way to build those commitments and attract and sustain equitable financing. As discussed below, by design, a Children's Health and Wellness Fund brings to the table diverse public and private actors that have a stake in the outcome, puts a spotlight on the needs of the community being served and racial disparities, and identifies opportunities for effective interventions.

## Developing a Children's Health and Wellness Fund: An Innovative Framework for Meeting the Social Needs of Children

### Overview

In light of the wrong pockets issue and the multiplicity of agencies and programs that serve children, a multisectoral approach to the financing and delivery of care is needed. The health sector has a strong interest in whole child care and healthier communities, but so do the business community and a plethora of other publicly funded, child-serving agencies and organizations, including the child welfare, and juvenile and criminal justice systems, and state and local education authorities. A Children's Health and Wellness Fund is a mechanism to help facilitate a shared public and private financing approach that reflects shared interest and benefits.

At the most basic level, a Children's Health and Wellness Fund is a mechanism to collect and administer funding derived from different sources that can be used to support SDOH initiatives focused on children and their families, consistent with locally determined needs and priorities. More broadly, however, it is a tool to be used by a public or private entity or partnership of organizations to set and accomplish goals on behalf of children and their families. While the idea of a "Fund" is not new (and several examples of such funds are shared throughout this brief), it has yet to be widely used as a mechanism to address the needs of children and their families.[28] Sources of funding can be diverse and can include public and private funds. As noted above, such funds should complement and build on investments that can be made through Medicaid and CHIP.

Growing interest in wellness funds coincides with the current transformation of the health care system that is moving care away from traditional fee-for-service payments to value-based, global payments for the care of populations of patients. It also aligns with efforts to expand the scope of primary care for children, delivering care through

28 Len Nichols and Lauren Taylor review the wrong pockets issue as it relates to upstream investments that can impact multiple populations, not just children, suggesting a shared financing/shared benefits approach relies on a "trusted broker" to facilitate the allocation of investments; see, L. Nichols and L. Taylor. "Social Determinants as Public Goods: A New Approach to Financing Key Investments in Healthy Communities," Health Affairs. August 2018. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0039.

an integrated care team, emphasizing prevention, and often working in partnership with community-based organizations.[29] Funding for a Children's Health and Wellness Fund must be identified, but the structure can facilitate attracting and managing different funding streams. It is well suited to accommodate investments from diverse sources—both within and outside the health care system—seeking to leverage their dollars with other financing partners, reduce fragmentation and duplication of activities and services, and ensure longer-term stability than can be accomplished through smaller appropriations, grants, and investments.

**Fund Spotlight: California Accountable Communities for Health Initiative (CACHI): Local Wellness Funds**

CACHI is a public-private partnership established by the state health department and private sector funders. CACHI promotes an Accountable Community of Health (ACH) model that brings together clinical providers with public health departments, schools, social service agencies, nonprofit organizations, business groups, public safety agencies, and others in a collective effort to make a community healthier.

A key component of each ACH is the development of a "wellness fund." The wellness fund is intended to pool, manage, and/or align funds from varied sources in order to address the priorities and goals of each ACH. Wellness funds are intended to support two aspects of an ACH—resources for infrastructure and the delivery of direct services. CACHI provides support to each ACH that is attempting to blend, braid, or align funding from different sources. Imperial County, for example, focuses its fund on interventions to reduce the asthma burden in the county, build capacity of local community nonprofit organizations, and improve the management of psychiatric emergencies. A managed care organization contributes monthly "per member per month fees," which provide $1 million annually to a local health authority that oversees a wellness fund.

Those interested in launching a Children's Health and Wellness Fund will need to consider a number of issues, including:

1. **Overall framework for the Fund and the activities it supports**
2. **Fund responsibilities and mechanisms for oversight**
3. **Sources of funding**
4. **Program accountability and evaluation**

Each is discussed below.

## Overall Framework

An organizing framework for the Fund that is tied closely to the vision and goals for the overall initiative will be needed. Should the Fund be organized statewide or locally? Whom will the Fund serve? What types of services will it finance? What are the outcomes it aims to achieve? While the framework is likely to evolve over time, at the core there must be consensus around scope, key goals, priority populations, and the types of investments the Fund will make. Will it provide funding for direct services that improve child and family health as well as for associated infrastructure support? Will it (also) provide funding for upstream investments and to organizations engaged in advocating for related policy changes at the local, state, or federal level? How will equity issues be kept front and center? What will be the process for engaging the community and for rethinking decisions over time? Key considerations relating to these issues are discussed below.

1. **Will the Fund be organized statewide or regionally/locally?** A Fund can be organized in a variety of ways—as a statewide initiative, a statewide initiative with local hubs, or fully at the local level—each with its own set of opportunities and drawbacks. Statewide initiatives can get the buy-in of key stakeholders and promote sustainability by attracting a broader array of funding, but investment priorities may be disconnected from the needs of the local community. Local funds, on the other hand, may be rooted in the unique needs of their

29 Burner, C et al. "Young Child Health Care Transformation: What Practice Tells Us." InCK Marks. April 23, 2020. Available: https://www.inckmarks.org/webinars/InCKMarksPracticeTransformationComponentfinalpdf.pdf.

communities but may have less access to funds.

**Fund Spotlight: Massachusetts's Prevention and Wellness Trust Fund (PWTF)**

The PWTF was established by the Massachusetts Legislature in 2012 as an initiative designed to reduce health care costs, decrease preventable risk factors, reduce the prevalence of preventable health conditions, and improve the management of existing chronic disease through evidence-based interventions planned and delivered by community-clinical partnerships.

In January 2014, following a competitive application process, the Department of Public Health selected nine community partnerships to participate in the PWTF. The funded partnerships varied in size and configuration—some were single municipalities or parts of municipalities, others included multiple cities and towns, and one constituted an entire county. Together they comprised about 15% of the Massachusetts population. Partnerships ranged from six to 15 participating organizations, with each including, at a minimum, a municipality/regional planning agency, a community-based organization, and a clinical health provider. The grantees had to propose and then develop a partnership among clinical providers and community-based organizations that would address at least two of the four priority conditions through linking and coordinating clinical and community-based strategies. As of 2020, funding has run out and the program is no longer in effect.

A hybrid option is to establish the Fund at the state level but share decision making on use of funds with local or regional hubs. This approach may help meet the goal of sustainability while ensuring that investment decisions reflect the needs of the children and families being served by the Fund. The Massachusetts Prevention and Wellness Trust Fund is an example of a fund that was set up at the state level but left decision-making on investments and programming to the local level. Even through funding ran out and the program ended in 2020, the Massachusetts' initiative provides a helpful framework for those interested developing a state-level Fund, or one that relies on legislation to be launched. It also illustrates the need for diverse funding (discussed below) and ongoing efforts to sustain support. The CACHI trust fund (as described above) is an example of a locally established initiative.

2. **How will funds be distributed?** Another threshold decision relates to the mechanism the Fund will use to distribute its dollars. For example, a Fund could operate as a grantmaking entity to which interested organizations and providers apply to receive funding to deliver services or run programs that serve children and families in a manner that is aligned with the vision and goals of the Fund. A variation of this approach is for the Fund to release requests for proposals that entities would apply for, similar to the national Center for Medicare & Medicaid Innovation structure. Another possible approach for a Fund operating at the state level is to provide local "chapters" or "hubs" with an allocation of funds and allow them to make decisions about their use within the communities served, consistent with the principles and guidelines established statewide.
3. **How does the Fund fit into other SDOH efforts?** To the extent that other efforts to address whole child care are in effect or under consideration in the state or localities, it will be important to consider how the Fund would fit into and complement the existing landscape or perhaps prompt a realignment. Understanding what efforts exist and making sure the Fund is not duplicating or disrupting other initiatives are critical to establishing the framework for the Fund, generating the goodwill of other potential partners, and efficiently addressing the priority needs of the communities being served. In this context, it is important to keep in mind that a Fund is not a new initiative in and of itself—it is a financing mechanism. It can be used to fund new initiatives (e.g., new services and community partnerships), supplement and scale existing initiatives, or a combination of the two. For example, a newly established Fund could be designed to support only new initiatives with a commitment not to disrupt funding for the existing initiatives. A variation is that the Fund could seek to help scale existing promising initiatives, perhaps to additional communities

or to address additional community needs. There is no right answer on how best to align with existing initiatives as so much depends on local circumstances and considerations; what is essential is to consider the options carefully to promote the overall goals and vision while avoiding disruption, duplication, competition, and confusion.

**Fund Spotlight: South Carolina's Nurse-Family Partnership Pay for Success Project**

The Nurse-Family Partnership (NFP) is a home visiting program in which first-time moms partner with nurse home visitors who provide education, health services, and support throughout pregnancy and until children reach the age of two. NFP serves 1,200 families in South Carolina and is being expanded to serve 3,200.

The program in South Carolina is funded through a pay for success project, in which funders provide upfront capital to expand the NFP program and the South Carolina Department of Health and Human Services (DHHS) pays for all or part of a program only if it measurably improves the lives of participants (as determined by an external evaluator). DHHS will make up to $7.5 million in success payments to sustain NFP services only if the independent evaluators find positive results (e.g., reduction in preterm births, increase in health spacing between births, reduction in child hospitalization and emergency department usage due to injury).

4. **Who is the target population, and what types of outcomes will be pursued?** Fund organizers will need to develop a vision for whom the Fund will serve and the outcomes it is seeking to achieve. The Fund could serve a narrow population based on age or condition (e.g., 0-5-year-old children, children with developmental disorders, or foster care children), take on a broader target group (all children with health and social needs), or something in between. Having a narrow population may allow the Fund to make significant investments for a targeted group of children and their families. Target populations may also be determined by the type of funding received. Broader programming allows the Fund to reach more children, but at least initially the Fund may not have the ability to do deep investments or cover a broad geographic area, depending on the level of funding raised. A focus on all children, however, will offer greater opportunities to bring in the funding and potentially more flexibility to focus on priorities. The targeted outcomes—for example, access to affordable, safe housing; supporting kindergarten readiness; addressing child hunger; and reducing community violence—are also key to establishing the overall framework for the Fund.

5. **How will community needs be assessed and priorities determined?** Critical to the success of a Children's Health and Wellness Fund is understanding the needs and priorities of the community being served and aligning the interventions with those needs. Community priorities can also influence the extent to which the Fund focuses on root causes of poor child health and development (i.e., the upstream factors). Ensuring that community leaders are directly involved in the assessment and decision-making is key (see discussion below). A community-needs assessment can also help. Many methods exist for conducting such an assessment—some more formal and extensive than others, including stakeholder meetings, community focus groups, working sessions with community leaders, and written or verbal surveys. The assessment process could be undertaken by the Fund leadership or by partners who may have particular experience in this area, and it could be done locally even in the context of a statewide Fund. In many communities, these types of assessments may already exist; indeed, many of the federal funding sources reviewed below require some type of community assessment. Existing efforts could be leveraged for purposes of establishing Fund priorities. Optimally, a community-based assessment of needs should be built into the regular process of doing business so that the Fund continues to meet the new and changing priorities of children and families over time.

## Fund Responsibilities and Mechanisms for Oversight

Central to the design of a Children's Health and Wellness Fund is defining the scope of the Fund's responsibilities and establishing a governance structure that can competently execute those responsibilities. A threshold issue relates to the Fund's relationship to state or local government; a Fund could be publicly or privately managed. The scope of the Fund's responsibilities will also inform decisions about its governance body—including who participates and what its core functions are. Developing any new financing initiative like a Children's Health and Wellness Fund is a significant undertaking that involves coordination and alignment among numerous stakeholders across issue areas, skill sets, sectors of the economy, and other traditional silos. ReThink Health offers a helpful framework, describing the concept of regional stewards, which are "leaders (people and organizations) who take responsibility for forming working relationships with others to drive transformative change in regions. Stewards have (or are interested in developing) an equity orientation in regard to purpose, power, and wealth."[30] While there is no "one size fits all" for how a Children's Health and Wellness Fund should be governed, the following questions will need to be answered to ensure clarity of purpose and promote success.

1. **What are the core responsibilities of the Fund?** At a minimum, the Fund must ensure proper oversight of its finances and related operations (such as reporting on the use of the funds to the appropriate entity or entities). Fund leadership and staff may also make decisions about how the funds will be used and may have a role in raising funds, although it is possible that some of these functions could be taken on by a partner organization. At a minimum, the governance structure (e.g., board) will be responsible for (1) establishing policies related to the receipt and expenditure of the funds and (2) overseeing and documenting the proper expenditure of funds.
2. **How will a multisectoral group of stakeholders be engaged?** Fund organizers can make different decisions about how to oversee and carry out responsibilities—some may decide to have a broadly constituted board or an advisory group (particularly applicable to a Fund that is administered by a public agency), while others may partner with other organizations to carry out certain responsibilities. One way or another, however, given the effort to involve diverse stakeholders that have an interest in and can contribute to the Fund's activity, a multisector approach to engagement will be needed. This includes entities from a variety of sectors who have "skin in the game," including community residents, health care (care providers, payers, and public health), social services and education, and business leaders and elected officials. Community residents should have a substantial and authentic role in the priority-setting, decision-making, and oversight. And, to ensure a consistent and authentic focus on addressing disparities, engagement of leaders from communities of color is key. Meaningful participation of community residents and leaders requires support that may include trainings done by and for community residents, providing transportation to meetings, the provision of child care and, to put them on par with other participants who are likely getting paid for their engagement, stipends for the time invested.[31,32]

**Braiding and Blending Multiple Funding Streams**

Braiding and blending multiple funding streams allows states and other entities to provide comprehensive services. Braiding involves the coordination of multiple distinct funding streams; dollars can be traced to their original source and must be spent for eligible individuals and services according to the terms governing those funding streams. Blending refers to the pooling of multiple funds into a single flexible funding stream. This practice is less common given typical restrictions placed on federal sources of funding.

30 "Who Are Stewards?" ReThink Health. Available at: https://www.rethinkhealth.org/stewards-pathway/#0.
31 "Organizational-Level Consumer Engagement: What It Takes." Community Catalyst. Available at: https://www.healthinnovation.org/resources/publications/body/Organizational_Level_Consumer_Engagement.pdf.
32 "Policy Principles to Guide Health Care's Role in Social Interventions." Community Catalyst. Available at: https://www.community-catalyst.org/resources/publications/document/CC0519_PolicyPrinciplesDoc_Web.pdf.

## Financing

Many different funding streams can be sources of financing for a Children's Health and Wellness Fund, none of which are mutually exclusive. Indeed, one of the hallmarks of a Fund is that optimally it will be able to attract funding from multiple sources that may evolve over time. Some Funds have been financed in whole or in part with state appropriations or earmarked tax receipts, while others have relied primarily on foundation support. Since, to date, Funds have not been focused specifically on SDOH, that focus opens up options beyond those that other Funds have relied on, such as contributions (required or voluntary) from managed care organizations (MCOs) and hospital community benefits. Considerations include whether to seek relatively small streams of funding, as each stream is likely to require some reporting and administrative burden to manage. Certain types of funds, such as those derived from social impact bonds, can provide long-term support but can be more complicated to set up.

The goal of having a sustainable Fund is best accomplished through a mix of sources to both grow the Fund and promote sustainability. It is important to acknowledge that while the COVID-19 pandemic has made some new sources of funding available and catalyzed multisector collaboration and funding to address some of the nation's most pressing problems faced by children and families, it has also caused extraordinary budget pressures at the state and local level. While state and local budgets are very tight, even a small initial state appropriation could send a helpful signal about the state's commitment to the initiative. Federal funding from recent (or potentially new) COVID-19-related stimulus packages may provide a launchpad for setting up a Fund, but these dollars are time limited. Additional sources of sustainable, flexible funding will need to be identified to launch and sustain a Fund. A key approach for a Fund that sets it apart from other efforts is to prioritize funding from entities that have an interest in, and that would benefit from, child-focused SDOH initiatives but for whom the wrong pockets issue makes the investment less attractive. Below are some types of funding that might be considered.

### Reinvesting Medicaid Profit Back Into the Community Served

Medicaid managed care plans in Oregon—called Coordinated Care Organizations (CCOs)—are required to invest a portion of their reserves into addressing the social needs of their community. Some of the investment must go directly to community-based organizations, and the remainder may be used to finance targeted social interventions undertaken directly by the CCO or its providers. Yamhill Community Care, one of Oregon's CCOs, has established a Wellness fund that supports evidence-based community prevention programs—including those that address school readiness and child care needs—and has secured more than $1 million in blended and braided funds. Health Share, the largest CCO in Oregon, serving 25% of the state's Medicaid patients, is working on a kindergarten preparedness pilot project with elementary schools and health care and social partners. Health Share recently launched the Kindergarten Readiness Network, a multidisciplinary network focused on ameliorating the effects that race, class, and disability have on a family's access to, and use of, early childhood supports and services. While Oregon is not requiring CCOs to invest in a trust fund, this financing mechanism is easily transferable to a Children's Health and Wellness Fund approach, ensuring that health plans that will benefit from the intervention bear some of the costs.

| # | Summary of Potential Financing Mechanisms |
|---|---|
| 1 | Medicaid managed care organization payments |
| 2 | Hospital contributions, including community benefits obligations |
| 3 | CHIP Health Services Initiatives |
| 4 | Legislative action and/or appropriation |
| 5 | Federal funds (outside of Medicaid and CHIP) |
| 6 | Voter referendum |
| 7 | Pay for success |
| 8 | Philanthropic funding |

1. **Medicaid managed care organization payments.** Medicaid MCOs benefit from having members who are in more stable circumstances with access to needed health-related, nonmedical services. Because of the value to all plans of having these investments, one way of tapping that value proposition despite the wrong pockets issue is for a state to require its Medicaid MCOs to contribute to the Fund, perhaps in proportion to their Medicaid revenues. Some states have directed their Medicaid MCOs to reinvest a portion of revenue or profits into the community served, and this approach can be used to finance a Fund that will benefit all MCOs and the children they care for. Oregon and Arizona require MCOs to do this, and North Carolina encourages MCOs to make these contributions voluntarily.[33]

**Braiding and Blending Multiple Funding Streams**

Braiding and blending multiple funding streams allows states and other entities to provide comprehensive services. Braiding involves the coordination of multiple distinct funding streams; dollars can be traced to their original source and must be spent for eligible individuals and services according to the terms governing those funding streams. Blending refers to the pooling of multiple funds into a single flexible funding stream. This practice is less common given typical restrictions placed on federal sources of funding.

2. **Hospital contributions, including community benefits obligations.** Hospitals also have an interest in, and could benefit from, Fund initiatives; they may already have, or could set up, a community grant program that could support midstream and upstream interventions. Not-for-profit hospitals have a statutory obligation to provide community benefits to maintain their tax-exempt status under federal and, sometimes, state law.[34] Federal rules permit hospitals to satisfy these requirements through SDOH-related initiatives,[35] which has led some hospital systems to develop innovative programs. Hospitals can satisfy their community benefits requirement by partnering with a Children's Health and Wellness Fund as long as the use of those funds satisfies the hospitals' tax-exempt obligations.
3. **CHIP Health Services Initiatives.** Most of the CHIP funds allocated to states must be used to finance children's coverage, but a portion of a state's CHIP allotments can be used for what are referred to as Health Services Initiatives (HSIs). Federal rules allow states broad flexibility with respect to the use of these funds, including to meet public health goals relating to improving the health of low-income children (whether or not they are eligible for or receiving CHIP-funded health coverage).
4. **Legislative action and/or appropriation.** State legislatures or county/city governments may opt to fund a Children's Health and Wellness Fund through a direct appropriation or by requiring stakeholders (e.g., hospitals, health care systems, and payers) to make payments toward establishing and sustaining the Fund. Massachusetts used the second approach to set up the Massachusetts Prevention and Wellness Trust Fund (PWTF). Established by legislation in 2012, the PWTF was funded by a one-time $57 million assessment on acute hospitals and payers. The Fund was jointly administered by the Massachusetts Department of Public Health and an appointed Prevention and Wellness Advisory Board, until it ended in 2020. The fact that the assessment ended, however, underscores the importance of maintaining support and diversifying funding sources. Virginia's trust fund, by contrast, has been operating for nearly three decades with state appropriations that were originally tapped from the appropriations for separate departments, all with an interest in seeing a children's Fund succeed.

33 J. Guyer and D. Bachrach, "Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools." The Commonwealth Fund. January 31, 2018. Available at: https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review.

34 IRS Rev. Rul. 69-545, 1969-2 C.B. 117. See also IRC § 501(r).

35 IRS, "Inclusion of certain housing improvement expenditures that provide community benefit for reporting on Form 990, Schedule H" (Dec. 18, 2015). Available at: https://www.irs.gov/charities-non-profits/exempt-organizations-update-archive.

**Fund Spotlight: Virginia's Children's Services Act—Early Adopters of a Children's Health and Wellness Fund**

Virginia passed the Children's Services Act (CSA) in 1993 and has been pooling funds since to meet the needs of at-risk youth and families. In doing so, the state appropriated funds fed by seven separate funding streams from four different departments. After the pool was established, the state eliminated the separate funding streams so specific dollars were not traceable back to original sources. The state budget allocates CSA funds to localities based on a funding formula developed by the state. The state oversees the funds by setting the policy and allocating funds to localities that contribute a local match. Localities then have considerable autonomy to manage the funds through an established Community Policy and Management Team. Eligible children and families are referred to the CSA, where a Family Assessment and Planning Team assesses their eligibility and develops an individual plan of services, paid for by the Community Policy and Management Team, leveraging either CSA funds or identifying the appropriate state or federal funding stream (e.g., Medicaid).

5. **Federal funds (outside of Medicaid and CHIP).** Various federal grant programs—such as the Community Development Block Grant (CDBG) and the Social Services Block Grant (SSBG)—can be used to address health-related social needs and upstream issues. Examples of such programs are discussed below; Appendix B reviews the key features of these and other federal funding sources. Most federal grants flow to the state, which then distributes the funds to state-run programs, local governments, or community-based organizations. Some portion of these funds could be directed to a Children's Health and Wellness Fund as long as the funds are allocated and accounted for in accordance with federal program rules. As states and other stakeholders evaluate the potential of these funding options, certain constraints should be kept in mind. First, most of these federal funding streams are capped, meaning there is a finite pool of dollars available. State and local governments may have already committed their federal funds to particular programs or subgrant recipients. Although redirection of some funds to a Fund could result in efficiencies, that could result in modifying existing financing relationships. Second, each federal funding stream is governed by program rules concerning the target populations, permissible uses of funds, and oversight and reporting. These parameters may vary from program to program (and, within a program, from grant to grant), which may create administrative challenges for a centralized Fund that seeks to address a broad range of childhood social needs. Nonetheless, a Fund can promote efficiencies by braiding and, in limited cases, blending funds to provide a continuum of services.[36] One blending opportunity arises from opportunities for a state to "transfer" grant dollars; a state may, for example, transfer up to 7% of its funds under the Preventive Health and Health Services Block Grant into other block grants that address maternal and child health services, community mental health, and substance abuse prevention and treatment.[37] Moreover, a Fund structure may create administrative synergies by consolidating and coordinating activities related to community needs assessments, program planning, subgrant allocation, data collection, and reporting.

**Louisiana's Permanent Supportive Housing (PSH) program** provides permanent, subsidized rental housing with individualized housing supports for people with disabilities, many of whom qualify for Medicaid. The state uses CDBG dollars to fund housing services and supports that Medicaid cannot cover, and braids CDBG with the Low-Income Housing Tax Credit, Housing Choice Vouchers, and other funds to provide tenants with a continuum of supports and services.

36 For a review of some of the braiding and blending challenges as well as opportunities for federal policymakers and administrators to ease the process, see "Budgeting to Promote Social Objectives—A Primer on Blending and Braiding." Brookings Institute. April 2020. Available at: https://www.brookings.edu/wp-content/uploads/2020/04/BraidingAndBlending20200403.pdf.

37 42 USC 300w-3(c).

### a. Federal financing for upstream interventions that address SDOH.

A number of funding opportunities can be used to provide community-level interventions aimed at preventing or mitigating SDOH. For example, the U.S. Department of Housing and Urban Development (HUD) administers the **CDBG**, which supports state and local efforts to develop urban communities by expanding housing stock and enhancing economic opportunities for low- and middle-income people. HUD also administers the **Lead Hazard Reduction Grant Program**, which provides funds for state and local governments to conduct lead control and abatement efforts as well as targeted outreach on lead poisoning prevention. The CHIP HSI option noted above can also be directed to upstream interventions.

**Oklahoma's Community Action Project of Tulsa County (CAP Tulsa)** operates a Head Start program that, in 2016, served 2,206 children and their families. CAP Tulsa combines Head Start funding with Maternal, Infant, and Early Childhood Home Visiting dollars; an HHS Health Professionals Opportunity Grant; state funding; and philanthropic funds to support a model that includes a focus on family engagement and advancement. On the engagement side, family support and behavioral health specialists conduct home visits, perform mental health counseling, and provide parenting support. The advancement team provides job training, adult education, and other resources for families' financial and career-related needs.

### b. Federal funds that can be used to finance SDOH interventions and infrastructure.

Many federal funding streams can be used to directly fund services and, in some cases, the infrastructure needed to carry out these strategies.[38] Certain programs are narrowly targeted to specific populations and services—such as the Substance Abuse Prevention & Treatment Block Grant (**SABG**) and the Workforce Innovation & Opportunity Act (**WIOA**) Youth Program—while others allow states greater flexibility to determine how funds will be allocated.

- One of the most flexible sources of federal funding is the **SSBG**, administered by the Department of Health and Human Services' Administration for Children and Families (ACF). These funds can be directed toward activities that promote "self-sufficiency," prevent child abuse and neglect, and support community-based care such as child care, protective services, supports for children in foster care, services for youth involved in criminal activity, transportation, and employment training. ACF's Community Services Block Grant (**CSBG**) similarly provides funds for efforts aimed at alleviating poverty in low-income communities, including services related to transportation, domestic violence crisis assistance, food pantries, and emergency shelters. States pass the majority of their CSBG dollars to entities such as local governments, migrant and seasonal farm worker organizations, and Community Action Agencies.[39]
- Another potential federal funding source for a Children's Health and Wellness Fund is the Preventive Health & Health Services (**PHHS**) Block Grant, an annual grant administered by the Centers for Disease Control and Prevention (CDC) that is specifically authorized to support states' efforts to address SDOH.[40]
- The **Family First Prevention Services Act of 2018** created a new option for states to draw down federal funding for SDOH services that support children and parents. Similar to Medicaid, this funding stream is not capped, but requires states to match federal spending by putting up their own dollars.[41] Family First funding may be directed toward prevention services, behavioral health care, and skills training for

38 D. Hughes and C. Mann. "Financing the Infrastructure of Accountable Communities for Health Is Key to Long-Term Sustainability." Health Affairs. April 2020. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01581.

39 "CSBG Fact Sheet. Office of Community Services." Available at: https://www.acf.hhs.gov/ocs/resource/csbg-fact-sheet.

40 "About the PHHS Block Grant Program." CDC. Available at: https://www.cdc.gov/phhsblockgrant/about.htm.

41 The state matching requirement could be met by philanthropic contributions.

children at risk for foster care, parenting/pregnant youth, and the caregivers or parents of such children. States may administer the services themselves or through contracts with other entities, including community-based organizations. A Fund could be a conduit for these contracts, coordinating with other related on-the-ground initiatives.

c. **Programs that directly provide benefits and services that can help address SDOH.** In certain programs, states receive federal funds or administer federal benefits to support the direct provision of services to individuals and families. Examples include the nutrition support benefits and services that states provide through the Women, Infants & Children (WIC) program and SNAP. Because the Children's Health and Wellness Fund is designed as a hub for financial flows, the Fund may not have a strong role to play in these "direct services" programs, although the SDOH interventions promoted by the Fund will likely seek to incorporate efforts to connect community residents to these benefits. In limited situations, funding from a federal benefit that may be allocated by the state could be used by a Fund. For example, federal SNAP funding is available for certain outreach and education activities, which the state may perform by contracting with local governments or community-based organizations.

6. **Voter Referendum.** Many states, such as Florida, as well as counties/municipalities are authorized by their state legislatures to conduct a voter referendum to levy a new tax or an increase in a current tax or to earmark a portion of an existing tax or even general revenues for a particular purpose. The legislature in Florida, for example, authorized counties to levy a tax or set aside some of their budget, subject to voter approval, to fund "Children's Services Councils" that help fund organizations that serve children and families in the county, monitor program and provider performance, convene child advocacy partners, and provide leadership, coordination, and oversight. Subject to state law requirements for such initiatives, these approaches can be used to finance a Children's Health and Wellness Fund.

7. **Pay for Success.** Under this financing mechanism, an entity (e.g., a state or local government) enters into agreements with service providers (e.g., social service providers such as after-school programs or housing providers) and investors (e.g., foundations or private sector investors) to pay for the achievement of predefined social outcomes. These funds are distributed to service providers to cover their operating costs (e.g., covering the costs of delivering a home-visiting program). If the measurable outcomes (e.g., reductions in maternal and child mortality) agreed to upfront are achieved, the entity proceeds with payments to the bond-issuing organization or the investors.

8. **Philanthropic Funding.** Philanthropic funding can provide critical support for designing and launching a Fund and supporting the community infrastructure needed to implement interventions. While it is unlikely that funding from grants, foundations, or philanthropies will become a sustainable financing stream for ongoing interventions, this type of support could underwrite the planning efforts, help initiate the effort, fill in critical gaps in other funding, and attract other sources of financing.

The financing mechanisms referenced above are neither mutually exclusive nor exhaustive. A combination of these and other strategies would help support and sustain a robust funding stream for a Children's Health and Wellness Fund.

## Program Accountability and Evaluation

It will be important for a Children's Health and Wellness Fund to commit to ongoing quality improvement efforts, data tracking, reporting, and evaluation in order to promote accountability, improve program performance, and provide the rationale for continued investment. Having clear expectations for stakeholders—especially recipients of funds—will be essential for growing the evidence base and awareness of a Children's Health and Wellness Fund as an effective mechanism for helping children stay healthy and thrive. Key questions include how success will be defined and what metrics will be tracked to demonstrate success.

To effectively understand the success and impact of the Fund, it will be important to capture data on both process measures (e.g., does the Fund's governance

structure work effectively? Are they meeting regularly? How many disbursements has the Fund made this year?) and outcome measures (e.g., did Fund interventions reduce disparities? Did children who received Fund-supported services experience better health? Did they visit the emergency room less often? Did they improve their reading scores?). Fund leadership should consider new and broader ways to define ROI that consider how different types of interventions can, for example, support healthy child development in ways that lower longer-term health care costs, reduce foster care placements, and promote kindergarten readiness. Fund metrics may evolve over time, with earlier metrics showing progress in process-oriented activities such as infrastructure development, capacity-building, and setting up the fund itself. Midterm metrics may focus on early outcomes, including increases in health care access and use of preventive care such as well child visits and on-time immunizations. Longer-term metrics may focus on harder-to-achieve outcomes such as improvements in child development, educational attainment, and reductions in foster care placement. There are nascent efforts to develop a diverse set of SDOH-related metrics for children. For example, the Johns Hopkins Center for Health Equity and the Bloomberg American Health Initiative just released a proposed approach to measuring community health and equity, including for children, for public comment.[42]

## Call to Action

Never has the need for attending to the health and well-being of our nation's children been more important than in the wake of the COVID-19 pandemic and the disparate impact the pandemic has had on the health and well-being of people of color. The pandemic, which has been harmful in many ways to children and their families, can be—and in many communities has already been—a catalyst for change and for a stronger collective resolve to keep equity front and center. The road to recovery and improved outcomes for our nation's children and families won't be easy—doing so requires a transformational shift of the way we define, deliver, and fund health care and social services. It will require collaboration between sectors that have traditionally worked in silos, coordination instead of fragmentation, and a willingness to do things differently. Given tight budgets, hard choices will be required. A Children's Health and Wellness Fund provides a way to galvanize and finance these efforts.

Every crisis gives rise to new opportunities. While coverage advances for children have been robust (until the recent backslide), efforts to improve the way we deliver health care to children and families and strengthen the communities in which they live has often tinkered around the edges. Recent events, however, have underscored that bold system and financing changes are needed. The time is ripe for fundamentally transforming the way we care for children and families and investing in the communities in which they live.

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42 Measuring Hospital Contributions to Community Health and Equity. A Proposed Approach for Public Comment. Johns Hopkins Center for Health Equity and the Bloomberg American Health Initiative. Available at: https://americanhealth.jhu.edu/sites/default/files/in-line-files/Health%20and%20Equity%20Report-%20Mix.pdf.

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## ABOUT NEMOURS

Nemours is an internationally recognized children's health system that owns and operates the two free-standing children's hospitals: the Nemours/Alfred I. duPont Hospital for Children in Wilmington, Del., and Nemours Children's Hospital in Orlando, Fla., along with outpatient facilities in five states, delivering pediatric primary, specialty and urgent care. Nemours also powers the world's most-visited website for information on the health of children and teens, KidsHealth.org, and offers on-demand, online video patient visits through Nemours CareConnect. Nemours ReadingBrightstart.org is a program dedicated to preventing reading failure in young children, grounded in Nemours' understanding that child health and learning are inextricably linked, and that reading level is a strong predictor of adult health.

Established as The Nemours Foundation through the legacy and philanthropy of Alfred I. duPont, Nemours provides pediatric clinical care, research, education, advocacy and prevention programs to families in the communities it serves.

## Appendix A: Medicaid and CHIP Financing

Even with a Children's Health and Wellness Fund, Medicaid financing remains an important building block for comprehensive system change in how children's care is delivered. Through regular "state plan" authority (i.e., no waiver required), managed care flexibilities and waivers, Medicaid can pay for some core components of a child and family-centered approach to health care. The key ways in which Medicaid can help finance SDOH for children are identified below along with some examples of how such authorities can be or have been used; see also, Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate Setting Tools.

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Practice design strategies:** Enhancing Primary Pediatric Care | | | | |
| **Pedriatic Medical Home** | • A pediatric medical home provides a comprehensive, coordinated system of care relying on an integrated team of providers who can be well positioned to support the medical and nonmedical needs of children and their families.<br>• States can offer an add-on payment for pediatric providers who meet state-established standards for such medical homes; depending on design this can be done without a waiver. | • Comprehensive developmental and behavioral screening that includes social and emotional development.<br>• Parenting and family support activities<br>• Use of team-based care including community health workers and peer navigators.<br>• Integration of physical and behavioral health.<br>• Linkages to social and economic supports within a community.<br>• Provider training on social and emotional development and supporting parent-child relationships. | Often requires practice redesign and investments to support and sustain necessary resource enhancements over time. | **Colorado** pays pediatric and family medicine providers an "add on" payment for screening new mothers for depression at well-child visits under either the mother's or child's Medicaid. The state also covers up to six visits of short-term behavioral health services—which includes diagnostic evaluation and family psychotherapy—delivered by behavioral health clinicians such as family therapists, social workers, and psychologists in a primary care setting[43]. |

43 Colorado Department of Health Care Policy & Financing (2018, June). Short-term Behavioral Health Services in the Primary Care Setting. Available at: http://3b0c642hkugknal3z1xrpau1-wpengine.netdna-ssl.com/wp-content/uploads/2019/11/01-06-144-1119C_COA-Short-Term-Behavioral-Health-Services-in-Primary-Care_fillable.pdf

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Managed Care Strategies:** Leveraging managed care contracts to cover screening, assessment, and treatment services for children and their parents | | | | |
| **Medicaid MCO Reinvestment Requirement** | • States may require in their contracts with managed care organizations (MCOs) that a portion of savings or revenue generated by the MCO be reinvested into the community served.<br>• States may define parameters on how the funds must be spent (e.g., 75% of allocated % of profit must be spent on initiatives to improve two-generational health and wellness and/or spent in accordance with community preferences) | • Providing funding for kindergarten preparedness programs<br>• Investing in after school programs<br>• Launching home vising programs for new moms and babies | • N/A | Pursuant to **Oregon's** Coordinated Care Organization (CCO) contract requirement to spend "a portion of their annual net income or reserves on services designed to address SDOH needs, including by paying partners for the delivery of services or programs" and in collaboration with local schools and social services partners, Health Share, the largest CCO in Oregon, recently launched the Kindergarten Readiness Network, a multidisciplinary network focused on ameliorating the effects of race, class, and disability by enhancing families' access to, and use of, early childhood supports and services. |

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **Care Management Requirements** | • All Medicaid managed care organizations (MCOs) are required to provide care management for children and adults, including parents. In states with managed care, the state can set standards for "care management" that include a focus on the social and emotional development of children and a dyadic approach to screening and care.<br>• States can also require plans to deliver important services for parents in the context of providing pediatric care, such as maternal depression screenings. | • Provide screening for social and emotional needs as part of comprehensive developmental and behavioral health screenings<br>• Require plans to consider the social and emotional health of young children when establishing criteria for identifying who will receive intensive care management<br>• Require MCOs employ or contract with housing specialists; require linkages to social services (e.g., food banks, medical-legal partnerships) | • Limits on what Medicaid can pay for in the absence of a waiver (e.g., the care management benefit cannot be used to pay for ongoing housing, but it can provide housing support services and referrals to housing services).[44] | **Minnesota** has a robust initiative to screen children routinely in accordance with American Academy of Pediatrics Bright Futures guidelines, including screenings for social and emotional development and social determinants of health.[45] |

44 Medicaid's Role in Housing. MACPAC Issue Brief. October 2018. Available at: https://www.macpac.gov/wp-content/uploads/2018/10/Medicaid%E2%80%99s-Role-in-Housing.pdf.
45 Child and Teen Checkups. Minnesota Department of Human Services. July 2019. Available at: https://www.health.state.mn.us/people/childrenyouth/ctc/index.html.

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **MCO Flexibility to Pay for Services other than Those Covered in the Medicaid Program** | • Medicaid managed care organizations must meet their contractual obligation to provide covered benefits and care management services that are covered under the state's Medicaid program or required for children under "Early Periodic Screening Diagnostic and Treatment" However, MCOs have considerable flexibility to pay for other health-related, nonmedical services either as "In Lieu of Services" or "Value-Add" services.<br>• **In Lieu of Services: ILOS** are services or settings a plan substitutes for a similar Medicaid service covered under the contract. In-lieu-of service expenditures can count for rate-setting unless a statute or regulation explicitly requires otherwise (i.e., spending is captured in an MCO's capitation rate).<br>• **Value-Added Services:** MCOs can use its capitation payments from the state Medicaid program to pay for benefits and services not covered by Medicaid that could improve health outcomes and reduce costs. Expenditures do not count for purposes of rate setting. | **ILOS (Examples)**<br>• Instead of a typical prenatal clinic visit, an MCO could offer home visits for pregnant mothers to provide preventive health, prenatal support, training in parenting skills, and assistance connecting other key community services<br>• A plan could offer medically tailored home delivered meals in lieu of home care services.<br>**Value-Added Services (Examples)**<br>• Programs for exercise and wellness<br>• Support for high-risk pregnant women (e.g., birthing classes, nutrition counseling)<br>• Home remediation for children with asthma (e.g., rug cleaning, air conditioning)<br>• "Reach out and Read" programs | MCOs cannot deny access to covered Medicaid services even if they also offer in-lieu-of or value-added services.<br>**ILOS**<br>• MCOs must demonstrate the cost effectiveness of ILOS and request approval from the state's Medicaid agency. The state Medicaid agency can also identify an approved list of in-lieu-of services<br>**Value-Added Services**<br>• While value-added services do not count in the calculation of the rate they can be counted as services for the purposes of the medical loss ratio | **Texas** encourages its plans to offer value-added services that promote healthy plan and exercise. The "STAR Kids" health plan for children with disabilities offers $150 towards an approved summer camp of the members' choice and gives $50 per school year for Boys & Girls Club memberships.[46]<br><br>**California** is planning to allow a range of ILOS for children and adults with significant health and social needs, particularly related to obtaining and maintaining housing and addressing food insecurity.[47] |

46 Compare "Value-Added" or Extra Services Offered by STAR Kids Health Plans by Service Area. Texas Department of Health and Human Services. Available at: https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/star-kids/comparison-charts/hidalgo.pdf.

47 "CalAIM Proposal." California Department of Health Care Services. October 28, 2019. Available: https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM_Proposal_102819.pdf.

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Managed Care Financial Incentives: Alternative Payment Models** | • To incentivize and reward improved health outcomes and cost-efficiency in their Medicaid programs, states have been designing and implementing value-based payment (VBP) initiatives. With VBP, states are seeking to move away from reimbursing providers based on the volume of care they provide and move toward reimbursing them for improving outcomes and reducing costs.<br>• Payment incentives (or withholds) can be designed to promote initiatives focused on the social and emotional development of children. | • Provide enhanced payments to providers for pursuing high-performing pediatric medical homes that integrate promotion of social and emotional development<br>• Leverage quality incentives and/or "withholds" to reward plans with strong performance on promoting social and emotional development | • VBP initiatives focused on cost saving will typically be limited to children with high-cost or chronic conditions. | **Oregon:** Since 2011, Oregon has implemented an incentive program that allows its managed care plans (referred to as "Coordinated Care Organizations") to earn as much as 4.25% above their capitation payments. Each year the state assesses how well the CCOs performed on specific measures and awards incentive funds based on performance. In recent years, child development screening has been one of the measures, and CCOs have made impressive improvements, tripling screening rates statewide from 2011 to 2017.[48]<br><br>**Virginia:** Virginia requires its Medicaid managed care plans to maintain and implement a VBP strategy that focuses on pediatric services. Part of the state's plan for VBP is that managed care organizations must implement special medical home initiatives— called Medallion System Innovation Partnerships (MSIP)—that feature value-based payment arrangements with providers, performance-based incentives, and/or other incentive reforms tied to state-approved quality metrics and financial performance. The state's contract requires that the MSIP focus on pediatric services and target pediatric populations, and that services provided through the MSIP be designed to individually coordinate Medicaid primary and acute care and mental health services.[49] |

48 7 Oregon Health Authority. (n.d.). Oregon Health Plan Health Plan Services Contract: Coordinate Care Organization, 2020. Available at: https://www.oregon.gov/oha/OHPB/CCODocuments/03-CCO-RFA4690-0-Appendix-B-Sample-Contract-Final.pdf.

49 Medallion 4.0 Medicaid Managed Care Contract. Virginia Department of Medical Assistance Services. Available at: http://www.dmas.virginia.gov/files/links/1566/Medallion%204.0%20 Contract%20(07.26.2018).pdf.

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Risk Adjusting Capitation Payments for Social Factors** | • States have traditionally considered age, gender, eligibility category, and region/ locality when setting capitation rates. States can also risk-adjust by incorporating information on socioeconomic status and social factors into their risk adjustment models. | • N/A | • Obtaining the relevant data can be a challenge; Massachusetts' model relies on readily available data/information.[50]<br>• Risk adjustment does not increase overall payments, but rather aligns payments to MCOs in accordance with measured risk.<br>• Does not directly finance SDOH-related interventions | **Massachusetts:** In 2016, Massachusetts implemented a Medicaid risk-adjustment model that incorporates factors relating to SDOH, including indicators of unstable housing and neighborhood stress. For example, individuals who have had three or more addresses in a single calendar year or individuals who have been identified as homeless increase an MCO's risk score, resulting in higher payments to the plan. Neighborhood stress scores include a composite measure of financial stress from census data. Enrollees who live in neighborhoods with higher than average stress scores may also trigger higher payments to MCOs. |

50 Ash, A. et al. Social Determinants of Health in Managed Care Payment Formulas. JAMA. October 2017. Available: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2647322.

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Waivers:** Waivers: Using comprehensive or more targeted waivers to secure funding for health-related benefits and services | | | | |
| **Medicaid 1115 Waiver** | • Under Section 1115 of the Social Security Act, the Secretary of HHS can permit states to use federal Medicaid funds in ways that are not otherwise allowed under the federal rules, as long as the Secretary determines that the initiative is an "experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives of the program."<br>• Section 1115 waivers can be used to make broad changes in Medicaid eligibility, benefits, and cost-sharing, and/or provider payments across their programs, or they can be designed to implement more narrow changes. | • Home visiting pilot programs<br>• Non-medical services to ameliorate toxic stress in childhood<br>• Select housing services (home remediations, move-in costs, 1st month's rent)<br>• Support for food insecurity (medically tailored meals)<br>• Transportation to nonmedical services | • Waivers are typically approved for five years and while they can be renewed, system transformation waivers are generally seen as time-limited demonstrations that eventually should be transitioned to "regular" Medicaid financing.<br>• States can design an 1115 waiver to be statewide or regional and to cover some or all of the state's Medicaid enrollees. | **Maryland Home Visiting Services Pilot Program:** Maryland received 1115 waiver authority to launch a home visiting program for high-risk pregnant women, and children up to age two, through the use of the Nurse-Family Partnership and Healthy Families America models.<br><br>**North Carolina—"Healthy Opportunities" Pilots (to be launched):** North Carolina received 1115 waiver authority to launch regionally based pilots to pay for evidence-based, nonmedical interventions related to housing, food, transportation, interpersonal safety, and toxic stress to high-needs Medicaid enrollees, including children ages 0-21.[51] |

51 "North Carolina's Healthy Opportunities Pilots: A Review of Design for Interested Stakeholders." North Carolina Department of Health and Human Services. February 15, 2019. Available at: https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf.

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **Medicaid 1915 (c) waivers**[52] | • Medicaid 1915(c) waivers—which allow payment for home- and community-based long-term services and supports (LTSS)—can cover nonmedical support services.<br>• Overall, the average per-participant expenditures for the waiver and nonwaiver Medicaid services must be no more than the average cost of providing institutional (and other Medicaid state plan) services to people who have the same level of care. | • Home modifications for children with disabilities or chronic illnesses<br>• Respite services to offer relief to, and reduce stress for, caretakers<br>• Transportation to community services, activities, and resources | • 1915(c) waivers can be statewide or geographically limited, and they can target narrow or broader groups of individuals; participants must need LTSS<br>• The number of people served and the total cost of services provided can be capped under the waiver.<br>• Does not cover payment for rent. | **Kansas:** The state has an active 1915(c) waiver targeted to young children (ages 0-5) with autism. The waiver provides Home and Community Based Services, support, and training to parents of children and children with an autism spectrum disorder, including through the provision of intensive individual supports, clinical & therapeutic services, family adjustment counseling, interpersonal communication therapy, and parent support & training (peer-to-peer).[53] |

52 "Application for a 1915(c) Home and Community-Based Waiver. Instructions, Technical Guide and Review Criteria. CMS. January 2019. Available at: https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf.

53 Autism (AU) Waiver Program. Kansas Department for Aging and Disability Services. Available at: https://www.kdads.ks.gov/commissions/home-community-based-services-(hcbs)/programs/autism.

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **Other Authorities:** Other Authorities: Other federal authorities to support addressing the social needs of children and families | | | | |
| **CHIP Health Services Initiatives (HSIs)** | • A CHIP Health Services Initiative (HSI) is option under CHIP that allows states to fund initiatives that improve the health of low-income children.<br>• States can use HSIs to cover the costs of direct services or to support public health priorities. | • School-based services and supports, such as mobile vision services or family counseling<br>• Lead abatement<br>• Violence prevention | • HSI expenditures along with CHIP administrative spending cannot exceed 10% of the amount of CHIP funds states spend on health coverage<br>• Children served do not have to be eligible for, or receiving, CHIP or Medicaid. | **Ohio's HSI** helps fund lead abatement efforts in low-income neighborhoods.[54]<br>**Oklahoma's CHIP** HSI provides funds to train pediatric primary care providers to promote early literacy during well-child visits in accordance with the AAP practice recommendations. The HSI is also intended to help increase the percentage of young children attending well-child visits and improve the percentage of children receiving standardized developmental screening.[55] |

54 Ohio State Plan Amendment 0038. Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. Available at: https://www.medicaid.gov/sites/default/files/CHIP/Downloads/OH/OH-17-0038.pdf.

55 Oklahoma CHIP annual report FY 2017. Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. December 29, 2017. Available at: https://www.medicaid.gov/chip/downloads/annual-reports/ok-chipannualreport.pdf.

| Strategy | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Medicaid Information Technology (IT) Authorities** | • Under section 1903(a)(3) of the Social Security Act, states may receive enhanced federal funding (90% Federal Financial Participation (FFP) for the administration of the Medicaid electronic health record (EHR) incentive program and promotion of health information exchanges (HIE)<br>• In addition, section 1903(a)(3) permits states to receive enhanced federal funding for activities related to their Mechanized Claims Processing and Information Retrieval Systems—that is, the IT that supports eligibility and enrollment (E&E) and their Medicaid Management Information Systems (MMIS). States may receive 90% FFP for the design, development, installation, or enhancement of these systems and 75% FFP for their maintenance and operation. | • EHR/HIE promotion activities, such as the design, development, or implementation of tools to connect to HIEs and build provider directories, master patient indexes, and a public health reporting and surveillance infrastructure<br>• Activities to enhance and rapidly scale state telehealth technologies and infrastructure<br>• Activities to expand information exchange capabilities<br>• Other activities outlined in guidance[56] | States must go through the Advance Planning Document approval process in order to receive federal funds.<br><br>With respect to HIE/EHR funding, this opportunity is available through 2021. In addition, states must encourage the adoption and "meaningful use" of certified EHR technology and electronic exchange of health information and comply with certain other restrictions. | Massachusetts secured enhanced Medicaid IT funding to develop an app and online tool to help state residents experiencing potential COVID-19 symptoms participate in a triage process, receive guidance for seeking care, and be assessed for Medicaid eligibility.[57] |

56 See Manatt's summary of these funding opportunities at https://www.shvs.org/wp-content/uploads/2020/05/MES-Funding-for-Covid-Response.pdf.

57 Manatt Health. "Strategies for Supporting and Strengthening Medicaid Information Technology During the COVID-19 Crisis." SHVS.org Available at: https://www.shvs.org/wp-content/uploads/2020/05/MES-Funding-for-Covid-Response.pdf.

## Appendix B: Select Non-Medicaid Federal Programs and Funding Mechanisms to Address the SDOH of Children and Families

This appendix provides a high-level view of federal funding streams that could potentially be channeled through a Children's Health and Wellness Fund to support SDOH-related programs focused on children and their families. This is not an exclusive list; other funding opportunities may exist, including new grants or programs that may be announced following the publication of this brief. For those interested in learning more about program rules—such as the permissible uses of program funds, or oversight and reporting requirements— the relevant authorizing statutes, implementing regulations, and program guidance are cited in the footnotes to this appendix.

To assess the applicability of these programs and funding streams to a Children's Health and Wellness Fund, we have determined the following:

1. **All programs identified appear to allow pass-through funding,** meaning that a state may pass its federal dollars on to local governments, community-based organizations, or other entities. These "subrecipients" or "subgrantees" then spend those dollars on program activities, whether by providing services directly or by awarding subgrants to additional subrecipients. The state, as the official "recipient" of the federal funds, remains responsible for oversight to assess performance and ensure that funds are spent in accordance with program rules.[58] The state typically will require the entity receiving the funds to report on the use of the funds.
2. **No prohibition on the use of a Wellness Fund.** Although each federal program places restrictions on the types of entities that are eligible to receive funds, none expressly prohibits federal funds from being held in a trust account pending disbursement to the ultimate recipient. A Children's Health and Wellness Fund may not qualify as an eligible recipient of funds under certain programs because the Fund would not itself not be directly providing any program services. A state or locality could, however, allow a Fund to hold federal dollars until they are ultimately disbursed to an eligible recipient who will provide grant-eligible services. This type of "Fund pass-through" will generally be simplest if the Fund is structured as an arm of state government.[59] The state could also disburse the funding to a Fund organized by an independent private (or public-private) entity, although the state may need to draw up "subrecipient" contracts in accordance with federal requirements.
3. **Braiding and blending funds** For some federal funding streams, federal law allows states to transfer, apply for, or use federal funding in ways that facilitate blending and braiding. This can occur in three main ways:
    1. *States may transfer a portion of funds from Grant X to Grant Y.* For example, up to 7% of a state's funds under the Preventive Health and Health Services Block Grant may be transferred to the Maternal and Child Health Services Block Grant, the Community Mental Health Services Block Grant, and/or the Substance Abuse Prevention and Treatment Block Grant. If a transfer is made, the rules and reporting under Grant Y, not Grant X, apply to the transferred funds.
    2. *The list of permissible activities under Grant X includes all the activities under Grant Y.* For example, Community Services Block Grant funds may be spent on any activity that would qualify for funding under Lead Hazard Reduction Grant Program. Reporting would still need to be separate for each grant program.
    3. *A state may submit a "combined" application for Grant X and Grant Y,* requesting funds from both programs to support coordinated planning and program implementation efforts. For example, a state may submit a proposal for employment and training activities that would combine funds under the Workforce Innovation and Opportunity Act and the Community Services Block Grant.

58 As an example, see the definitions of "recipient" and "subrecipient" in the Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, 42 CFR 200.0 et seq.

59 States that receive federal funds generally have the freedom to deposit those dollars in any state-held account, as long as the funds can be tracked in accordance with program oversight requirements, 31 USC 6503(h); see also 31 CFR 205.2 (defining the "state," for purposes of intergovernmental transfers, as including all "agencies" and "instrumentalities" of the state).

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Potential Grant or in-Kind Funding from Hospitals** | | | | |
| **Hospital Community Benefit Requirement** (26 USC 501(r); 26 CFR 1.501(r)-3) | Hospitals must comply with federal and, sometimes, state community benefit requirements in order to maintain tax-exempt status.[60] Spending on SDOH activities that meet a documented community need can satisfy this requirement, according to the Internal Revenue Service.[61] | • Eligible services may include, but not limited to, child care and mentoring programs for vulnerable populations, neighborhood support groups, violence prevention programs, and public health emergency activities.[62] | • Hospitals must conduct a community health needs assessment<br>• When developing an implementation strategy to address community health needs, a hospital may collaborate with entities such as other health care providers, governmental departments, and nonprofit organizations.<br>• The hospital must identify the actions it plans to take and the resources it plans to commit to addressing community health needs. A hospital can provide a grant to satisfy some or all of their community benefit requirement. | **Maryland:** Johns Hopkins Bayview Medical Center operates Community Care-A-Van, a mobile health clinic, to provide free health screenings and mobile care to Baltimore residents as a community benefit initiative. Through this program, over 2,000 adults and children are provided access to primary care, immunizations, and other screenings each year.[63] |

60 IRS Rev. Rul. 69-545, 1969-2 C.B. 117. See also IRC § 501(r).
61 "Inclusion of certain housing improvement expenditures that provide community benefit for reporting on Form 990, Schedule H" IRS. December 2015. Available: https://www.irs.gov/charities-non-profits/exempt-organizations-update-archive.
62 Instructions for Schedule H (Form 990) (2019), Hospitals, Part II. Community Building Activities. IRS. Available: https://www.irs.gov/instructions/i990sh#d0e521.
63 "Johns Hopkins Health System Community Benefit Report" Johns Hopkins. Available: https://www.hopkinsmedicine.org/about/downloads/community-benefit-report-fy2017.pdf.

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **U.S. Department of Health and Human Services** | | | | |
| **Community Mental Health Services Block Grant (MHBG)** (42 USC 300x et seq.)[64] | The Substance Abuse and Mental Health Services Administration (SAMHSA) provides MHBG funds to all states and territories—and in some circumstances, to tribes—to carry out plans to provide comprehensive community mental health services for adults with serious mental illnesses and children with serious emotional disturbances. In addition to paying for community health services, the funds can be used for SDOH-type interventions. | • Case management services<br>• Coordination with local entities for services related to health, rehabilitation, employment, housing, educational, substance use disorder, legal, law enforcement, social, child welfare, medical and dental care, and other domains<br>• Training for providers of emergency health services on mental health | • States must conduct a needs assessment to identify unmet service needs and gaps.<br>• States may spend up to 5% of funds for administrative costs.<br>• Funds may not pay for: most inpatient services; cash payments to recipients of health services; land, construction, or major medical equipment; as a source of nonfederal matching funds; or financial assistance to any entity other than a public or nonprofit private entity. | **Arizona:** As part of the development of a "High Fidelity Wraparound" program to support children with severe mental illness, North Carolina has leveraged its MHBG dollars to develop a cadre of peer support specialists, including through training and capacity-building. Families can opt for peer and family support specialists a part of their care team. The state also uses its MHBG funds to contract with community-based organizations such as "NC Families United" which support the implementation of the program.[65] |

64 Community Mental Health Services Block Grant." SAMHSA. Available. https://www.samhsa.gov/grants/block-grants/mhbg. The MHBG program is subject to HHS' general rules on block grants, as described at 45 CFR 96.1 et seq.

65 "State Behavioral Health Assessment and Plan: Community Mental Services Block Grant." North Carolina Department of Health and Human Services. Available: https://files.nc.gov/ncdhhs/MHBG%20Plan%20SFY18-19_0.pdf.

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Community Services Block Grant (CSBG)** (42 USC 9901 et seq.)[66] | The CSBG provides flexible funding for efforts aimed at alleviating poverty for low-income communities. CSBG funds are issued to states, territories, and tribes, which pass the majority of these dollars to local eligible entities that include local governments, migrant and seasonal farm worker organizations, and Community Action Agencies.[67]<br><br>States may designate "intermediate organizations" to select grantees on the states' behalf.[68] | • Funds may support a wide range of activities aimed at alleviating the causes and conditions of poverty, including child care and other "youth development programs."<br>• Services often include employment training and placement, income management, education, emergency services, health care, nutrition, transportation, housing assistance, and providing linkages among anti-poverty programs. | • Federal eligibility requirements do not attach to these dollars.<br>• With limited exceptions, funds may not pay for construction or purchase of land or political activities.<br>• States must spend at least 90% of CSBG funds on program grants; remaining funds may be spent on administrative costs (subject to a cap), as well as on technical assistance (TA), coordination, and assessment activities.<br>• In addition to the CSBG itself, supplemental federal funds are available to public and private entities for CSBG TA and program evaluation, as well as economic development projects.[69] | **Colorado:** Douglas County Department of Community Development, a public Community Action Agency in a suburb of the Denver Metro area, has taken a community partnership approach to providing a bundle of services to individuals. This group of partners, known as Douglas County CARES, includes schools, food banks, mental health providers, government service agencies, faith-based organizations, domestic violence service providers, and more.[70] |

66 Community Mental Health Services Block Grant." SAMHSA. Available. https://www.samhsa.gov/grants/block-grants/mhbg. The MHBG program is subject to HHS' general rules on block grants, as described at 45 CFR 96.1 et seq.
67 Ibid.
68 42 USC 9920(e)
69 42 USC 9903(b)(2) & (3)
70 "Bundling Services to Improve Outcomes: Three Cases." Community Action Partnership. Available: https://communityactionpartnership.com/wp-content/uploads/2018/07/Anti-Poverty-Practice_BundledServices_11.2017.pdf.

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Family First Prevention Services Act of 2018** (SSA Title IV E, as amended by Title VII, Part I of the Bipartisan Budget Act of 2018 (Pub. L. 115-123) (Feb. 9, 2018))[71] | Family First authorized a new state option for states to fund certain prevention services for children who are candidates for foster care,[72] pregnant or parenting youth in foster care, and the parents or kin caregivers of those children and youth. Six states have received approval to take up the option.[73]<br>In addition, Title IV E's John H. Chafee Foster Care Independence Program (CFCIP) supports state and tribal efforts to help current and former foster care youths achieve self-sufficiency.[74]<br>At the federal level, Family First is administered by ACF.[75] At the state level, the prevention services must be administered by, or administered by an entity supervised by, the state agency responsible for Title IV E foster care and adoption services.[76] | • Mental health/SUD prevention and treatment services provided by qualified clinicians<br>• In-home parent skill-based programs, including parenting skills training, parent education, and individual and family counseling<br>• Support for evidence-based kinship navigator programs<br>• CFCIP may fund programs related to education, employment, financial management, housing, and emotional support for older youth in foster care | • Administrative costs and staff training are reimbursable at a rate of 50% federal financial participation (FFP).<br>• The costs of prevention services are reimbursable at 50% FFP for FYs 2020-2026; beginning in FY 2027, prevention services will be reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) for the Medicaid program. | **District of Columbia:** DC received HHS' first approval for a Family First plan to provide prevention services. DC offers a range of evidence-based services related to in-home parenting support (e.g., the Healthy Families America, Parents as Teachers, and Transition to Independence programs), SUD and mental health therapies (e.g., recovery coaches, trauma-focused cognitive behavioral therapy, family therapy, and parent-child interaction therapy), and other cross-cutting services. DC is also pursuing a larger, locally funded companion initiative that will serve broader groups of people by serving target communities in the District (rather than specific eligible individuals), and that will provide primary prevention services (rather than the secondary and tertiary prevention services under Family First).[77] |

71 Requirements of the legislation are summarized in ACF, HHS, State Requirements for Electing Title IV-E Prevention and Family Services and Programs (Nov. 30, 2018), https://www.acf.hhs.gov/sites/default/files/cb/pi1809.pdf. See also the Family First Transition Act, Section 602 of the Further Consolidated Appropriations Act of 2020 (Pub. L. 116-94) (Dec. 20, 2019)

72 Defined as a child who is identified in a Title IV-E prevention plan as being at imminent risk of entering foster care, but who can remain safely in the child's home or in a kinship placement as long as the Title IV-E prevention services that are necessary to prevent the entry of the child into foster care are provided. See S.S.A. § 475(13).

73 "Status of Submitted Title IV-E Prevention Program Five-Year Plans. Children's Bureau." Available: https://www.acf.hhs.gov/cb/resource/title-iv-e-five-year-plan

74 42 USC 677; https://www.acf.hhs.gov/cb/resource/chafee-foster-care-program.

75 ACF has issued several resources to guide implementation, and conducted a webinar providing updates in March 2020. https://www.acf.hhs.gov/sites/default/files/cb/iv_e_ppp_webinar_march9.pdf

76 42 USC 671(a)(2).

77 Letter to Brenda Donald, Director, District of Columbia Child & Family Services Agency from ACF (Oct. 29, 2019), https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/DC_CFSA_Family_First_Prevention_Plan_2019_Final.pdf

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **CDC Healthy Schools** (42 USC 247b(k)(2))[78] | CDC provides time-limited competitive and noncompetitive grants to states, local health and education departments, and other entities for various school-based public health activities through its National Center for Chronic Disease Prevention and Health Promotion. | • Example: Grant to state education agencies for implementation and evaluation of activities to prevent obesity, reduce the risk of children developing chronic disease, and manage chronic health conditions prevalent in student populations [Improving Student Health and Academic Achievement Through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools (2018)[79]] | • Example: Funds cannot be used for research, clinical care except as allowed by law, furniture or equipment, lobbying materials, or construction [Improving Student Health and Academic Achievement Through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools (2018)] | **Florida:** With the support of a CDC Healthy Schools grant,[80] the Florida Department of Health identified high-need school districts using a process that incorporated findings from the state's MIECHV needs assessment. After districts were selected, the Healthy Districts/Schools Project was launched with the goal to "strengthen schools as the heart of health." Participating districts were encouraged to participate in the HealthierUS School Challenge and to establish a Comprehensive School Physical Activity Program.[81] |

78 "Healthy Schools: How CDC Helps Students Get a Healthy Start." CDC National Center for Chronic Disease Prevention and Health Promotion. Available: https://www.cdc.gov/chronicdisease/resources/publications/factsheets/healthy-schools.htm

79 "Improving Student Health and Academic Achievement through Nutrition, Physical Activity and the Management of Chronic Conditions in Schools (CDC-RFA-DP18-1801)." CDC National Center for Chronic Disease Prevention and Health Promotion. Available: https://foa.grantsolutions.gov/files/pa/cdc/1043839/1152891.htm

80 This work was done through a CDC Healthy Schools cooperative agreement that predated CDC-RFA-DP18-1801 called "State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health" (cooperative agreement # DP13-1305).

81 "Using Partnerships to Increase Healthy Eating and Physical Activity Among Students." CDC National Center for Chronic Disease Prevention and Health Promotion. Available: https://www.cdc.gov/healthyschools/success-stories/florida.htm

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Maternal and Child Health Services (MCH) Block Grant** (SSA Title V, 42 USC 701 et seq.)[82] | The MCH Block Grant aims to improve the health of low-income children, mothers, and pregnant women. HRSA provides states and territories with formula and competitive grant funding to support services and activities under this program; states can then disburse the dollars to qualified entities. | • • Funds may generally be used for four types of core services: (1) health care (e.g., basic health care, or services for children with special health care needs); (2) enabling services (e.g., case management, transportation, coordination with other programs), (3) population-based services (e.g., newborn screening and lead screening), and (4) infrastructure building activities (e.g., needs assessments).<br>• States must coordinate activities with Medicaid, WIC, and other health, developmental disability, and family planning programs.<br>• States must provide eligible women and infants with application assistance for Medicaid. | • To receive funding, states must complete a needs assessment every five years and submit a plan for addressing the needs identified.<br>• States must match every $4 of federal Title V money that they receive by at least $3 of state or local money.<br>• States may spend up to 10% of funds for administrative costs.<br>• Funds may not pay for: inpatient care (with exceptions); cash payments; land, construction, or major medical equipment; research or training to any entity other than a public or nonprofit private entity; as a source of nonfederal matching funds; or services furnished by providers excluded from Medicare or Medicaid. | **Washington:** the state passes the majority of its MCH Block Grant to 34 local health jurisdictions (LHJs) and one local hospital district to strengthen public health systems and provide maternal and child health services throughout the state. LHJs must have plans to provide preventive, primary care, and family support services for children with special health care needs. Medium and large LHJs must also pursue projects that support universal developmental screening and/or address the effects of, and prevent, adverse childhood experiences.[83] |

82 CRS, Maternal and Child Health Services Block Grant: Background and Funding (Aug. 28, 2017), https://fas.org/sgp/crs/misc/R44929.pdf. In addition to the MCH, Title V of the Social Security Act authorizes additional grants, including for the Maternal, Infant, and Early Childhood Home Visiting Program (described separately in this chart), for research and treatment regarding postpartum depression (no funds were ever appropriated for this program), and for the Personal Responsibility Education Program (which provides grants for youth education on sexual health and other subjects).

83 "Maternal and Child Health Services Title V Block Grant Washington FY 2021 Application/FY 2019 Annual Report." Washington State Department of Health. September 2020. Available: https://www.doh.wa.gov/Portals/1/Documents/8330/140-139-MCH-ServicesTitleVBlockGrantWashington.pdf

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program** (42 USC 711) | Under this program, funding is allocated to states, territories, and tribes—or a nonprofit entity, in states that had not implemented an approved program as of 2012—based on formula and competitive grants for home visiting services provided to eligible families in at-risk communities, as determined by a needs assessment.[84] This program is administered by HRSA in partnership with ACF. | • Home visiting services conducted by nurses, mental health clinicians, social workers, or paraprofessionals with specialized training to eligible families | • Grantees must carry out needs assessments to identify at-risk communities.<br>• Families participate on a voluntary basis.<br>• States may spend up to 10% of funds for administrative costs . | **Indiana:** In 2011, Goodwill of Central & Southern Indiana (GCSI) and Nurse-Family Partnership (NFP) Indiana came together under one roof to form a MIECHV Local Implementing Agency (LIA). These two organizations provided complementary expertise, with NFP bringing experience in home visiting, health services, and early childhood development and Goodwill bringing experience in adult education and workforce development. The program combines MIECHV funding with state general revenue, Title V block grant dollars, private funding, and funding from hospital and community foundations to colocate the provision of home visiting, education, and employment support.[85] |

84 "Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Background and Funding." CRS. Available: https://fas.org/sgp/crs/misc/R43930.pdf.

85 "Home Visiting's Two-Generation Approach: Supporting Primary Caregiver Education, Family Self-Sufficiency, and Children's' Wellbeing." HRSA. Available: https://mchb.hrsa.gov/sites/default/files/mchb/Maternal-ChildHealthInitiatives/HomeVisiting/HVTwoGenerationResource.pdf.

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
|---|---|---|---|---|
| **Preventive Health and Health Services (PHHS) Block Grant** (42 U.S.C. 300w et seq.)[86] | Under this program, CDC provides annual allotments to states, territories, and tribes to address their public health needs and to achieve the objectives outlined in *Healthy People 2020*.[87] | • Wide range of services, including clinical services, preventive services, outbreak control, workforce training, program evaluation, public education, data surveillance, chronic disease, injury and violence prevention, infectious disease, environmental health, community fluoridation, tobacco prevention, and emergency medical response | • States may spend up to 5% of funds for administrative costs.<br>• Up to 7% of PHHS funds may be transferred to the MCH, MHBG, or SABG.[88]<br>• Funds may not pay for: inpatient services; cash payments to recipients of health services; land, construction, or major medical equipment (with exceptions); nonfederal matching funds; or financial assistance to any entity other than a public or nonprofit private entity. | States have used (and subgranted) dollars for diverse initiatives, including efforts to provide children dental health care at schools (**North Carolina**), increase physical activity and healthy eating among students (**Pennsylvania** and **South Carolina**), help health care organizations become more culturally competent through training and TA (**Mississippi**), expand state public health emergency alert systems (**California**), and provide education about neonatal abstinence syndrome (**Tennessee**).[89] |

86 "About the PHHS Block Grant Program." CDC. Available: https://www.cdc.gov/phhsblockgrant/about.htm.
87 Funds may be used for "activities consistent with making progress toward achieving the objectives established by the Secretary for the health status of the population of the United States for the year 2000." 42 USC 300w-3(a)(1)(A).
88 42 USC 300w-3(c).
89 "Preventive Health and Health Services (PHHS) Block Grant: Recipient Stories." CDC. Available: https://www.cdc.gov/phhsblockgrant/granteehighlights.htm; https://msdh.ms.gov/msdhsite/_static/44,529,407.html.

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **Social Services Block Grant (SSBG)** (42 USC 1397 et seq.)[90] | ACF administers formula-based allotments to states to be used for activities that promote self-sufficiency, prevent child abuse and neglect, and support community-based care such as child care, protective services, services for children in foster care, transportation, employment, and others. | • Adoption and foster care, case management, day care services for children or adults, education and training, employment services, family planning, health-related and home health services, home-based services, home-delivered meals, housing services, independent and transitional living, assessment of client needs and referral to public and private services, legal services, pregnancy and parenting services for young parents, prevention and intervention services, protective services for adults, recreational services, residential treatment, services for persons with developmental or physical disabilities, services for youth involved in or at risk of involvement with criminal activity, SUD services, transportation, and other services[91] | • Federal law does not specify minimum eligibility criteria for recipients of SSBG-funded services.<br>• States may transfer up to 10% of TANF grants to SSBG; SSBG has no eligibility criteria so transfer authority can expand possible uses of TANF funds<br>• Similarly, states may transfer up to 10% of SSBG funds into certain other HHS-administered grants, including MCH, MHBG, PHHS, SABG.[92]<br>• Funds may not pay for land, construction, or capital improvements; cash payments for costs of subsistence or room and board (with exceptions); wages as a social service (with exceptions); medical care (with exceptions); social services provided by a hospital, skilled nursing facility, intermediate care facility, or prison; public education; child care that does not meet applicable state and local standards; and other specified services. | **Maine:** Maine uses its SSBG funds to finance several programs for children, including building capacity for children in foster care. The state uses its SSBG funds to provide day care services to young children in the foster care system and transportation for those children to appointments, school, after-school programs, etc.[93] |

90 "Social Services Block Grant." Congressional Research Service. November 2018. Available: https://fas.org/sgp/crs/misc/IF10115.pdf; see also 45 CFR 96.72 et seq.
91 "SSBG Legislation Uniform Definition of Services." Office of Community Services. January 2009. Available: https://www.acf.hhs.gov/ocs/resource/uniform-definition-of-services.
92 45 CFR 96.72.
93 "Maine Social Services Block Grant (SSBG) Pre-Expenditure Report (Intended Use Plan)." Maine Department of Health and Human Services. 2018. Available: https://www.maine.gov/dhhs/ocfs/documents/F2018%20SSBG%20Intended%20Use%20Plan2.pdf.

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **Substance Abuse Prevention and Treatment Block Grant (SABG)** (42 USC 300x 21 et seq.)[94] | SABG funds are provided by SAMHSA to all states and territories and to one tribal entity for the purpose of planning, implementing, and evaluating activities to prevent and treat SUD for pregnant women, women with dependent children, intravenous drug users, and those in need of tuberculosis and HIV services. States may provide SABG services "through grants, contracts, or cooperative agreements … with nongovernmental organizations."[95] | • Coordination with other health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services | • States must conduct a needs assessment to identify unmet service needs and gaps.<br>• States may spend up to 5% of funds for administrative costs.<br>• With limited exceptions, funds may not pay for: inpatient services; cash payments to recipients of health services; land, construction, or major medical equipment; nonfederal matching funds; or financial assistance to any entity other than a public or nonprofit private entity. | **North Carolina:** SABG funding supports the North Carolina Pregnancy and Opioid Exposure Project, an umbrella under which information, resources, and TA are disseminated regarding the subject of pregnancy and opioid exposure. The project is hosted by the University of North Carolina School of Social Work.[96] |

94 "Substance Abuse Prevention and Treatment Block Grant." SAMHSA. Available: https://www.samhsa.gov/grants/block-grants/sabg; see also 45 CFR 96.120 et seq.
95 42 USC 300x-65(b)(1); SAMHSA guidance (Aug. 5, 2009), https://www.samhsa.gov/sites/default/files/grants/guidance-on-sapt-and-community-mh-svcs-bg-reqmts.pdf .
96 "About NC Pregnancy and Opioid Exposure Project." North Carolina Pregnancy and Opioid Exposure Project. Available: https://ncpoep.org/about-nc-poep/

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **U.S. Department of Housing and Urban Development** | | | | |
| **Community Development Block Grant (CDBG)** (42 U.S.C. § 5301 et seq.)[97] | HUD provides annual grants on a formula basis to states, local governments, territories, and tribes to develop urban communities by providing housing and suitable living environments, and by expanding economic opportunities, principally for low- and moderate-income persons.<br>In addition, HUD funds competitive "special purpose" grants for both public and private entities.<br>Grantees may act as pass-through entities, allowing CDBG activities to be conducted "through loans or grants under agreements with subrecipients." Eligible subrecipients include public or private nonprofit entities, and, in limited circumstances, for-profit entities.[98] | • Rehabilitation of residential and nonresidential structures<br>• Under certain circumstances, a portion of funds may be used for "public services," including employment, child care, health, SUD, education, welfare, and other services.<br>• Economic development activities<br>• Housing services<br>• Homeownership assistance<br>• CDBG funds may generally be used to pay for any nonfederal share that may be required to access other CDBG funds.<br>• Competitive special purpose grants may be used for, among other things, TA services. | • Grantees may generally spend up to 20% of funds on planning and administrative costs (measured against the sum of the grant plus any program income during the applicable year); additional limits apply to administrative and TA costs for states that administer CDBG funds.[99]<br>• Funds may not pay for government expenses; purchasing equipment; repairs or operations of public buildings; political activities; certain income payments; or construction of new housing (with exceptions); additional restrictions apply to certain types of CDBG funding. | **Wisconsin:** The city of Westboro transformed an unused church into a library and community center focused on child development. The community center includes various programs for elementary school children, including a weekly arts education program.[100] |

97 "State CDBG Program Eligibility Requirements." HUD Exchange. Available: https://www.hudexchange.info/programs/cdbg-state/state-cdbg-program-eligibility-requirements; 24 C.F.R. Part 570.
98 24 CFR 570.200(f) & 570.500(c). Further, 24 CFR 570.503 requires that recipients enter into written subrecipient agreements that meet regulatory standards. In general, 24 CFR 570.489, 570.502 & 570.610 mandate compliance with the Office of Management & Budget's (OMB's) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, including the standards on identifying, managing, and monitoring subrecipients, as codified at 2 CFR 200.330–32.
99 24 CFR 570.489.
100 16 Inspiring Examples of Communities Capitalizing on CDBG Funding. SEH. Available: http://www.sehinc.com/news/16-inspiring-examples-communities-capitalizing-cdbg-funding.

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **Emergency Solutions Grants (ESG) Program** (42 USC 11371 et seq.)[101] | ESG grants are available to states, territories, urban counties, and metropolitan cities for activities related to preventing and mitigating homelessness. State recipients must subgrant all funds to local government or nonprofits (except for administrative costs); other direct grant recipients may subgrant as they see fit.[102] | • Rehabilitation/conversion of buildings for use as emergency shelters for the homeless, operating expenses and essential services for emergency shelters, street outreach for the homeless, homelessness prevention, and rapid rehousing assistance | • Grantees must generally contribute a minimum match of 50%.<br>• Grantees may spend up to 7.5% of funds for administrative costs. | **New York:** ESG funds were directed toward New York's existing Homelessness Prevention and Rapid Re-Housing Program, which supported households at imminent risk of homelessness by paying for rental and utility arrears, providing short- and medium-term rental and utility assistance, and furnishing case management.[103] |

101 24 CFR 576.1 et seq.; https://www.hudexchange.info/programs/esg/.
102 42 USC 11373.
103 "Columbia County Plan to End Homelessness." CARES Inc. Available: https://caresny.org/wp-content/uploads/2014/04/Columbia-County-Plan-to-End-Homelessness_final.pdf.

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **Lead Hazard Reduction Grant Program** (42 U.S.C. § 4851 et seq.) | HUD issues grants to states, local governments, and tribes to evaluate and reduce lead-based paint hazards in nonpublic housing. Grantees may deploy grant funds through "a variety of programs, including grants, loans, equity investments, revolving loan funds, loan funds, loan guarantees, interest write-downs, and other forms of assistance," subject to HUD approval.[104] | • Facility assessments, lead abatement, health screenings, temporary relocation, and education<br>• Example: Maximize the number of children under six years old who are protected from lead poisoning by targeting lead hazard control efforts in housing units where children less than six years of age are at greatest risk, building local capacity to safely and effectively address lead hazard, and conducting targeted outreach on lead poisoning prevention [Lead Hazard Reduction Grant Program (2019)][105] | • State and local government grantees must contribute a minimum match of 10%.<br>• State and local government grantees may spend up to 10% of funds for administrative costs.<br>• HUD may impose additional restrictions on individual grants; the 2019 Lead Hazard Reduction Grant Program, for example, could not be used to purchase medical services for children with elevated blood lead levels; purchase real property, gut renovation services, or equipment above a certain price threshold; or perform lead hazard control activities in buildings built after 1977. | **Michigan:** Michigan's Lead Safe Home Program (LSHP) uses its Lead Hazard Reduction Grant, Flint Supplemental Funding, CHIP HSI funding, and state funds to provide lead abatement statewide. In collaboration with Michigan's Childhood Lead Poisoning Prevention Program, LSHP enrolls families with a child identified as having elevated blood lead levels, but also focuses enrolling units in high-burden areas as primary prevention. LSHP partners with local health departments to provide residents with educational resources, nursing case management, lead inspection and risk assessments, and lead abatement for qualified applicants.[106] Medicaid expenditure authority is available for targeted case management services under this program through a Section 1115 waiver, which expires in February 2021.[107] This benefit assists eligible children and pregnant women gain access to needed medical, social, educational, and other services. |

104 42 USC 4852(f).

105 "Lead Hazard Reduction Grant Program." U.S. Department of Housing and Urban Development. August 2019. Available: https://www.hud.gov/sites/dfiles/SPM/documents/FY19_LeadHazardReductionGrantProgram.pdf. HUD's authority for this grant opportunity arose under both the provisions discussed above regarding lead hazard reduction, as well as the Healthy Homes provisions (12 USC 1701z-2. The grant was funded by the Consolidated Appropriations Act of 2018 (Pub. L. 115 141) and the Consolidated Appropriations Act of 2019 (Pub. L. 116 6).

106 "Expenditures for Healthy Homes Program." Michigan Department of Health and Human Services. January 2019. Available: https://www.michigan.gov/documents/mdhhs/Section_1182-2_648424_7.pdf; https://www.medicaid.gov/sites/default/files/CHIP/Downloads/MI/MI-16-0017.pdf

107 "Michigan Application Certification Statement-Section 1115(a) Extension." Michigan Department of Health and Human Services. Available: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mi-health-impacts-potential-lead-exposure-pa.pdf

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **U.S. Department of Agriculture** | | | | |
| **Supplemental Nutrition Assistance Program (SNAP)** (7 USC 2011 et seq.)[108] | SNAP provides monthly food assistance benefits to eligible families based on federal eligibility criteria. The program is administered at the state level. The SNAP program will share the cost of outreach with states (up to 50% match), which in turn could be provided to qualified community-based organizations.<br>SNAP-Ed grants are available for educational programming around healthy living, which can be provided "through agreements with other State or local agencies or community organizations."[109] | • Outreach efforts to help individuals/families learn about applying for SNAP benefits<br>• SNAP-Ed educational programming on topics such as nutrition, cooking, budget-conscious meal planning, and physical activity | • SNAP dollars can fund outreach, but cannot fund recruitment or advertisements designed to promote SNAP enrollment.<br>• A state's Plan of Operations must describe its outreach activities, including any intended collaboration with outside organizations; the Plan must be updated to reflect any significant changes. | **Maryland:** Maryland has a community-based outreach infrastructure to support enrollment in SNAP. For example, the Maryland Food Bank's SNAP Outreach Team travels to selected community centers, faith-based organizations, and residential housing facilities to help eligible Marylanders sign up for SNAP benefits.[110] |

108 CRS. "Supplemental Nutrition Assistance Program (SNAP): A Primer on Eligibility and Benefits." December 2014. Available: https://fas.org/sgp/crs/misc/R42505.pdf; see also 7 CFR 271.1 et seq.
109 7 CFR 272.2(d)(2). Sample SNAP-Ed Materials Available: https://snaped.fns.usda.gov/library
110 "Supplemental Nutrition Assistance Program (SNAP) Outreach Program. Maryland Department of Human Services. Available: https://dhs.maryland.gov/food-supplement-program/snap-outreach-program/; https://mdfoodbank.org/hunger-in-maryland/approach/programs/snap-outreach

| Federal Program or Opportunity | Description | Examples of Permissible Activities & Services | Limits and Other Considerations | Select State Examples |
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| **U.S. Department of Labor** | | | | |
| **Workforce Innovation and Opportunity Act (WIOA) Youth Program** (29 USC 3161 et seq.)[111] | Title I of WIOA authorizes formula grants to states for job training, education, and related services for youth as well as adults and dislocated workers.<br>The majority of funds must be passed through to "local workforce investment areas," where local workforce development boards help carry out and oversee WIOA activities.<br>A local area may designate an entity to serve as a local grant subrecipient or fiscal agent. Alternatively, a local area may designate the Governor as the grant recipient, in which case the Governor may select a subrecipient or fiscal agent.[112] And generally, any recipient of WIOA funds may "enter into subgrants in order to carry out the grant," subject to any conditions that HUD may impose.[113] | • • Tutoring<br>• • Alternative secondary school services<br>• • Education offered concurrently with workforce preparation and training<br>• • Postsecondary education and training preparation activities<br>• • Leadership development<br>• • Mentoring, guidance, counseling<br>• • Paid and unpaid work experiences<br>• • Occupational skills training<br>• • Financial literacy education<br>• • Entrepreneurial skills training<br>• • Services that provide labor market and employment information | • • Up to 15% of funds may be reserved for statewide activities; the remainder must be passed to local workforce investment areas.<br>• • Local boards may spend up to 10% of their funds for administrative costs<br>• • Funds may not be used for wages of incumbent employees participating in economic development activities or public service employment<br>• • Under certain conditions, funds must not be used for the encouragement of a business to relocate, or for customized training for a business that has relocated<br>• • States may submit proposals for programming that would draw on federal funds under WIOA and one or more other grant programs, including CSBG.[114] | **California:** Los Angeles's Performance Partnership Pilot integrates the delivery of education, workforce, and social services using local education funds, WIOA dollars, and a Workforce Innovation Fund grant. Under this program, local Youth Source Centers (YSCs) conduct outreach to and serve disconnected youth. The LA Unified School District colocates a school counselor at each YSC to provide youth with school reenrollment assistance and to make referrals to school system resources, such as mental health services and other supports.[115] |

111 "Youth Program Fact Sheet" Workforce GPS. July 2019. Available: https://youth.workforcegps.org/resources/2017/08/29/08/48/FactSheet
112 29 USC 3122(d)(12)(B)(i)
113 29 USC 3241. In addition, 29 USC 3244(a)(3) requires that states, local areas, and grantee providers adhere to OMB's Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, including the standards on identifying, managing, and monitoring subrecipients, as codified at 2 CFR 200.330–32.
114 29 USC 3113(a)
115 Performance Partnership Pilots for Disconnected Youth. First Annual Report to Congress. June 2017. Available: https://youth.gov/sites/default/files/P3-Report-to-Congress-508.pdf; https://www.urban.org/sites/default/files/publication/100013/innovative_strategies_for_investing_in_youth_justice_0.pdf