Caring for the Whole Child:

Issue Brief

December 2020

Executive Summary

A growing recognition that socioeconomic factors a fect health outcomes in signi fcant ways is fueling

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 " א ᴺ ʻ ʻ % ū ŧ

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sectors that serve children—including health care, education, child welfare, and juvenile justice. A Fund can attract, collect, and administer funding derived from di ferent sources that can help n ʻ

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 n " healtg " ȯ ʊ ɮ ˬ ɮ ᵀ ȳ א ᵀ ʊ ȳ ᵀ conde t n delivewing ˬ ʊ l ɔ ɋ ˬ þ ɾ ᵐ ɨ e senu, chro ﺽ ʊɳ ˬ ŭ ʻ

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 fve households with children 12 and under were food insecure, and in one-ffth of those households children were going hungry[10]. Household food insecurity has insidious efects on the health and development of young children throughout their childhood and stretching later into life, including increased hospitalizations, poor health, iron defciency, developmental risk, and behavior problems—including anxiety, depression, and attention defcit disorder.[11]
- Without school and other normal social contact and supports, and living with families facing fnancial 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 nw cur
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11 Ryu, J. et al. "Household Food Insecurity During Childhood and Subsequent Health Status: The Early Childhood Longitudi1nal Study—Kindergarten Cohort." American Journal of Public Health. 2012. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477974/.

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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

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 c Þ Ų˜ l ˈ " Ç t є Ď א v ȝ в ˈ ogr, hl ȣ ᴏ nitn ˈ wi

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

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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 identifed, but the structure can facilitate attracting and managing diferent 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 fnancing partners, reduce fragmentation and duplication of activities and services, and ensure longer-term stability than can be accomplished through smaller appropriations, grants, and investments.

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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.

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.

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.

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 ()l ɜ ḍ l l tg fud ex t e er

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.

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33 J. Guyer and D. Bachrach, "Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Vexi1Wixxrk Xssw2÷ Xli Gsqqsr{iexl Jyrh2 Neryev} 750 645<2 Ezewefi ex> lxxtw>33{{{2gsqqsr{iexljyrh2svk3tyfgexsrw3jyrh1vi1tsvxw3645<3er3irefrk1wywxerefi1rziwxqirx1wsgei1rxivzirxsrw1vizi{.

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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 fow 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

36 For a review of some of the braiding and blending challenges as well as opportunities for federal policymakers and administrators xs iewi xli tvsgiww0 wii öFyhkixmrk xs Tvsqsxi Wsgmep Sfnigxmziwõ E Tvmqivsr Fpirhmrk erh hmwgywwih fipsb erh hmrWr'

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.

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 p ” ή ǀƀ φ ɋ ʊ ᴰ sꞥ w̅ ǀ ж v ꞥ ǀ f m m
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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.

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

42 Measuring Hospital Contributions to Community Health and Equity. A Proposed Approach for Puble0_Prog3003B004F004CAt. 5.0379 54.1

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. • 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 • Investing in after school programs • 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

Strategy	Description	Examples of Permissible Activities & Services		

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-e f ciency 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. • 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 • 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 specifc 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] **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 fnancial 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]

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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			

Strategy	Description	Examples of Permissible Activities & Services	Limits and Other Considerations	Select State Examples
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. • 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 • Lead abatement • Violence prevention	• HSI expenditures along with CHIP administrative spending cannot exceed 10% of the amount of CHIP funds states spend on health coverage • 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] **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/ ‘ ɾ dicaid.gov/sites/ ‘ ɾ ‘ & tא

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) • 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%			

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:

   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.

   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.

   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
Family First Prevention Services Act of 2018 (SSA Title IV E, as				

Federal Program or Opportunity	Description	Examples of Permissible Activities & Services	Limits and Other Considerations	Select State Examples
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, 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.	•		

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 .[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. • Up to 7% of PHHS funds may be transferred to the MCH, MHBG, or SABG.[88] • 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**), or h

Federal Program or Opportunity	Description	Examples of Permissible Activities & Services	Limits and Other Considerations	Select State Examples
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. • 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 • Similarly, states may transfer up to 10% of SSBG funds into certain other HHS-administered grants, including MCH, MHBG, PHHS, SABG.[92] • 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
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. • States may spend up to 5% of funds for administrative costs. • 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				

Federal Program or Opportunity	Description	Examples of Permissible Activities & Services	Limits and Other Considerations	Select State Examples
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%. • 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
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 • 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%. • State and local government grantees may spend up to 10% of funds for administrative costs. • 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/dfles/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/fles/CHIP/Downloads/MI/MI-16-0017.pdf

107 "Michigan Application Certifcation 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
U.S. Department of Agriculture				
Supplemental Nutrition Assistance Program (SNAP) (7 USC 2011 et seq.)[108]	SNAP provides monthly food assistance benefts 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 qualifed community-based organizations. 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 benefts • 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. • A state's Plan of Operations must describe its outreach activities, including any intended collaboration with outside organizations; the Plan must be updated to refect any signifcant 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 benefts.[110]

108 CRS. "Supplemental Nutrition Assistance Program (SNAP): A Primer on Eligibility and Benefts." 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