Braiding & Blending Funding Streams to Meet the Health-Related Social Needs of Low-Income Persons: Considerations for State Health Policymakers

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Introduction

Medicaid beneficiaries often need support outside the scope of clinical health care in order to lead healthy lives. States are uniquely poised to provide this support by addressing the social determinants of health: Medicaid benefits include an array of supportive services, and state leaders control a range of additional resources that can be used to promote wellness and efficiently provide health care and social services to residents across the state.[1] State officials have the opportunity to work across sectors and branches of government to bring all a state's resources to bear on the health and health-related social needs of residents. States also have the potential to support and scale-up local initiatives.

While states steward a variety of funding sources that address the needs of low-income populations, too often a Medicaid beneficiary must navigate a labyrinth of referrals in order to access available resources. Although many state initiatives strive to coordinate care and integrate physical and mental health, that coordination may be limited to referrals for services paid for with separate funding streams. To streamline the provision of services, state policymakers might ask: What would it take for an entity to fund a total person-centered plan of health services and supports for a Medicaid beneficiary? How might a single entity blend funding to pay for health care, home health services, physical and occupational therapy, mental and behavioral health services, safe and stable housing, nutritious food, transportation, warm clothing and shoes, as well as a single well-trained and supported case manager with the authority to arrange and pay for those services, without requiring the Medicaid beneficiary to follow up on a bewildering array of referrals to other providers and agencies?

This brief aims to bring attention to non-Medicaid funding sources that states could potentially blend or braid to address social determinants of health and other needs that are not typically covered by Medicaid. It is intended to familiarize state Medicaid, public health, and other state policymakers with the funding streams of other agencies, and sketch out a continuum of options to help states coordinate funding to better serve the needs of low-income populations. Because this brief focuses on services for adult Medicaid beneficiaries, it does not address many of the funding sources available for children's services. However, existing efforts to pool funds for children and youth—notably by the Commonwealth of Virginia—could prove instructive for states seeking to launch such an effort for adults.[2]

Determining how to fund a total plan of health services and supports is important for states because many social determinants of health—such as stable housing, safe neighborhoods, and access to healthy food—cannot be provided with Medicaid funds. This remains the case despite recent Centers for Medicare & Medicaid Services (CMS) guidance on Medicaid's flexibility to pay for housing-related activities and services for people with disabilities.[3] However, states control an array of non-Medicaid resources that can be used to address beneficiaries' needs, including funds for community development projects, housing, transportation, income support, and education.

Blending or braiding funding streams to promote positive health and social outcomes is not an easy undertaking. Despite many resources showing states how Medicaid resources can be used for social services or housing needs,[4] and exploring the challenges and benefits of braiding and blending funding,[5] many stakeholders, including providers of health care and other services, might initially resist such changes—although some providers, particularly in behavioral health, may be familiar with braiding funding from multiple streams. Also, many funds that support necessary services flow directly to local entities, such as local community organizations, local providers and provider organizations, and local governments. Aligning state and local priorities and determining state and local roles and responsibilities is an important challenge. Capitated Medicaid managed care models hold promise for incorporating supportive services, although the details of designing capitation rates that align with a braiding or blending initiative would need to be developed.[6] Data infrastructure that enables cross-agency information sharing is key to empowering an entity to fund a total plan of health services and supports. Finally, states interested in blending or braiding funding streams must contend with differences in the culture and mission of state agencies, differing views on person-centered treatment approaches, limited state capacity to undertake new initiatives, and federal requirements to account for individual program spending.

Blending vs. Braiding*

Blended Funding	Braided Funding
Stakeholders merge funding from individual sources into one funding stream, with each individual funding source losing its specific identity.	Stakeholders coordinate funding from individual sources, with each individual funding source keeping its specific identity.

*Adapted from the Association of Government Accountants, "Blended and Braided Funding: A Guide for Policy Makers and Practitioners," December 2014.

Why Blend or Braid

The problems posed by the existing fragmentation of funding streams can be illustrated by the needs of one hypothetical Medicaid beneficiary. Figures one and two explain the needs of a fictitious parent named Jean, whose needs are interrelated: uncontrolled diabetes, substance abuse, and depression compromise her ability to work full time. Working part-time at a low-wage job, Jean needs help paying rent, buying healthy food, and heating her home. A poor diet and a cold, damp apartment exacerbate her diabetes and her son's asthma, making it even more difficult for Jean to work and her son to stay healthy enough to succeed in school.

Table 1. Jean's Goals and Needs

Physical Health Care	Jean is a diagnosed diabetic whose diabetes is often uncontrolled. Her four-year-old son suffers from asthma. Jean aims to control her diabetes better and get her son the care he needs to stabilize his asthma.
Mental & Behavioral Health Care	Jean suffers from depression, which impacts her ability to work and take care of things at home. Jean wants to improve her mental health so she has more energy to work and care for her son.
Substance Abuse Care	Jean has a history of substance abuse. She wants to stay sober, and realizes she needs help to do so.
Money	Due to her mental and physical health issues Jean has trouble working consistently. Jean wants to control her diabetes and depression so she can hold down a full-time job. She works part-time at a local fast food restaurant, but still needs cash assistance.
Employment	Jean works as many shifts as she can, but would like to train for a more stable, higher-paying job.
Food	Jean aims to follow a healthy diet in order to control her diabetes, but her low income makes this difficult.
Rental Assistance	Jean's goals include cooking healthy meals at home, refrigerating her medication, and providing a stable home for her son. However, her intermittent income leaves her unable to consistently pay her rent.
Heat	Jean wants to keep her home warm so the cold, damp conditions won't exacerbate her son's asthma and her diabetes-related cold sensitivity. However, she cannot consistently afford to heat her apartment because of her sporadic income.
Transportation	Jean needs reliable transportation to and from work, well as to medical appointments. The sporadic nature of her income makes it difficult for Jean to afford necessary repairs on her car.
Childcare	As a single mother, safe and affordable childcare for her son while she is at work is a priority for Jean. Her erratic work schedule, health issues, transportation limitations, and finances make securing childcare difficult.
Excercise	Jean wants to increase her physical activity to improve her diabetes and depression, as well as increase her energy to play with her son. Her doctor suggests she walk through a park or on a trail.

Although Jean's goals are interconnected, numerous state programs with separate funding sources currently address them. Jean benefits substantially from the different programs, but spends a good deal of time bouncing from agency to agency like a Ping-Pong ball in a complex, uncoordinated system of referrals. A single entity that could supply everything she needs at one time and work with her to determine the services needed to best meet her goals would be beneficial to Jean.

Figure 1. Status Quo: How Jean's Needs are Currently Addressed

Jean is a 35-year-old single mother who works part-time at a minimum wage job. She has numerous medical conditions including diabetes and a history of depression and substance abuse. Jean's four-year-old son has asthma. She struggles to pay for food, housing, medical, and transportation costs. Jean relies on a number of state programs to help manage her diabetes and her son's asthma. She relies on different programs to assist with nutrition, housing and other needs. While it may appear her needs are adequately met through these various funding sources, Jean often feels like a ping pong ball bouncing from agency to agency in a complex, uncoordinated system of referrals.

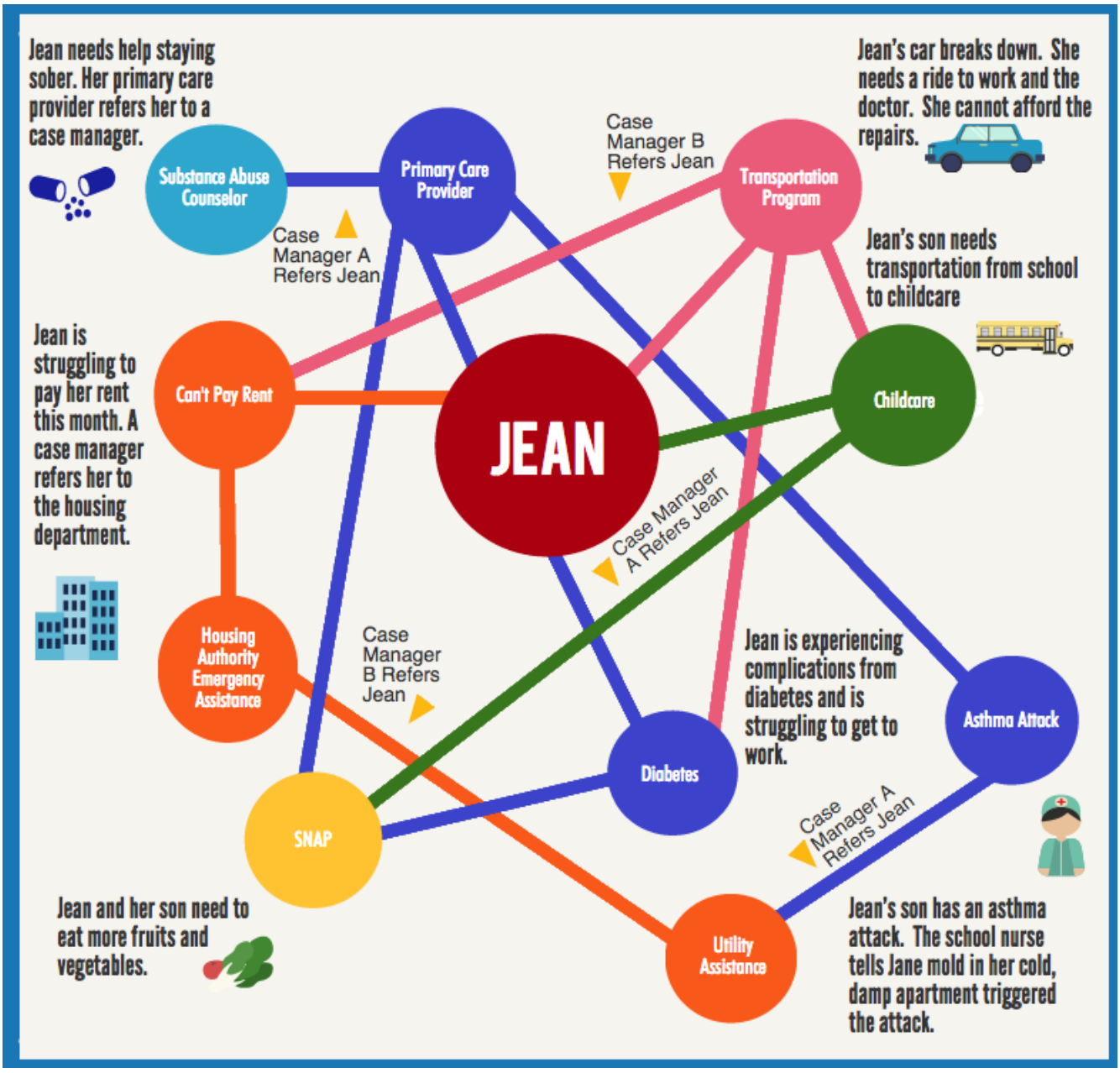


Figure 2. Braided Funding Could Provide a Coordinated Plan of Services and Supports for Jean

One way to remedy the "Ping-Pong effect" would be for a state to blend or braid funding streams under the authority of a single agency empowered to arrange and pay for all the needed services. This model would eliminate the need for Jean to bounce from program to program in order to separately obtain the elements of her total plan of health services and supports. It could also streamline the functioning of state agencies and eliminate the need for duplicative services, such as multiple case managers, and help ensure that Jean's needs were met in an efficient, coordinated manner.

Table 2. Jean's Total Plan of Health Services and Supports

Below are the components of a total plan of health services and supports, based on the benefits potentially available to Jean, a hypothetical low-income single parent. If a single entity could authorize and pay for the benefits listed below, as in a braided or blended model, the state could be confident that Jean's essential needs were efficiently met—and Jean would be spared the experience of bouncing like a Ping-Pong ball from office to office. Although progress has been made in streamlining and coordinating eligibility determinations for programs—as with the one-stop "Express Lane" eligibility processes for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Temporary Assistance for Needy Families (TANF), and other programs—Jean would benefit from similar coordination in the delivery of those services.[7] States, including Texas, are also exploring models of self-directed care in which beneficiaries control some of their own behavioral health, personal care, or other services, with the support of staff trained to assist decision-making. States exploring self-directed care could consider it in the context of a braided or blended plan of serves and supports.[8]

Need	Benefit
Physical Health Care	Medicaid coverage
Mental Health Care	Medicaid covers therapy and medication
Behavioral Health Care	Substance abuse prevention services, including community-based support services
Money	$198 per month TANF cash assistance*
Employment	CareerCenter services provided under the Workforce Investment Act**
Food	$346 monthly Food Supplement Program allotment**
Rental Assistance	Jean's rent is based on her income. She receives $350 in rental subsidy; she pays $300, for a total of $650 per month
Heat	$140 per month for 5 months***
Transportation	Jean uses a subsidized shared-ride service****
Childcare	$88 per week in subsidized child care*****
Excercise	Jean started walking on a local trail

* If Jean works 18 hours per week for four weeks, at $8.86 per hour, she would earn $638 per month. This would leave her with a small enough countable income to receive TANF of roughly $198 per month in this hypothetical example.

** "Training Information for Adult Workers," CareerCenter, accessed January 24, 2016, http://mainecareercenter.com/employment/training-adults/index.shtml.

***Assuming a monthly rent of $500 and child care expenses of $15. Note that the FY2015 average monthly SNAP benefit is $257.73.

***Based on an average benefit of $700 per winter.

**** "Regional Transportation Program," RTP, accessed January 12, 2016, http://rtprides.org.

*****This amount changes based on the annual market rate survey. The $88 figure is based on the 2013 75th percentile market rate for family-based child care. Jean may have to pay a copayment.

How Can States More Efficiently Fund Jean's Plan of Health Services and Supports?

Blending or braiding funds under the control of a single state agency may be an efficient way to fund a total plan of health services and supports for a Medicaid beneficiary, but it is a complex undertaking that presents many challenges for states. Separate federal reporting and accounting requirements, differences in state agencies' culture and mission— including the breadth of the populations served—and provider resistance have the potential to scuttle a fledgling state braiding or blending effort. Also, local organizations and providers often have direct control over funding streams that are important to a state's ability to fund a total plan of health services and supports.

A number of approaches could help states improve the efficiency of service provision for Medicaid beneficiaries short of full braiding or blending of funds. For instance, states could undertake a model demonstration in which a health and social services agency puts a person-centered case manager in charge of a small pool of funds from programs serving low-income or high-risk populations. Alternatively, states could consider an umbrella model, in which an umbrella agency or governor's office coordinates policies across agencies to facilitate person-centered care planning. Finally, states could move toward braiding and blending funding streams. All these approaches would be strengthened by cross-agency data sharing and a governance structure that includes state and local decision-makers and other key stakeholders. For example, policies related to Virginia's pooled funds for at-risk youth are developed by a State Executive Council (SEC). The SEC is made up of representatives from many state agencies, including health and human resources, social services, education, juvenile justice, and behavioral health; as well as representatives from local government, the legislature, the judiciary, and parents.[9]

Model Demonstration

Under a model demonstration, a health and human services agency commissioner with responsibility for social services, child care, mental health, and substance abuse block grants could blend a portion of that funding and allocate it to a person-centered case manager. The case manager would be a locally based person or entity tasked with developing and implementing a person-centered plan of health services and supports—one that could benefit someone like Jean.

In this model, the case manager in Jean's community would work with her to determine the full range of services she needed, including physical and mental health care, food assistance, transportation, childcare, and housing. The case manager would be responsible for ordering and arranging for services from local providers, local community organizations, managed care organizations, and the appropriate state agencies, thereby sparing Jean from contacting the providers herself. The case manager would pay for the services with the pooled money set aside from state agency grant programs, would report to the state how the money was spent, and would periodically confirm with Jean that the services met her needs as intended.

States could choose to focus the model demonstration on a subset of complex, high-cost, and/or high-risk Medicaid beneficiaries who might benefit the most from such a model. An evaluation of the demonstration would provide state policymakers with data to help determine whether such models produce a return on investment or demonstrable improvements in outcomes.

Umbrella Agency

A state umbrella agency—or a governor's office—could use its authority to ensure the consistency of policies across the agencies involved in meeting the health and social needs of low-income people. Each agency would retain authority over its own separate funding streams and manage them pursuant to the umbrella agency's comprehensive plan. The umbrella agency could coordinate timing of the

request for proposal (RFP) process across agencies, as well as the length of grant cycles, to better synchronize state efforts to meet beneficiaries' needs. Similarly, the umbrella agency could work to align data reporting requirements and the timing and content of evaluations across funding streams and agencies. The agency could also oversee the state's contracts with service providers, community organizations, managed care organizations, and other vendors to align the contracting process with overarching state goals and minimize the duplication and fragmentation of services.

An umbrella agency could contract with a local or regional integrator entity tasked with providing a beneficiary's total plan of health services and supports. The integrator would be responsible for care planning, and would pay for the plan with funds from each state agency as appropriate: for example, funds from the state's Community Mental Health Services Block Grant would pay for the mental health services arranged by the integrator, and the Social Services Block Grant would pay for social services. Although the funds would not be braided or blended, the umbrella agency's comprehensive plan would ensure that the funds align to efficiently achieve the state's goals. Washington State uses a similar model as part of their initiative to integrate physical and behavioral health.[10]

Part of the Center for Medicare & Medicaid Innovation (CMMI) Accountable Health Communities model calls for community organizations, called "bridge organizations", to play an integrator role for the entities involved in health care and community and social services.[11] The integrator role includes bringing entities together to address health-related social needs and working to overcome the barriers posed by the entities' separate funding streams, data systems, populations served, and organizational cultures. Although the CMMI initiative emphasizes referrals,[12] its integrator approach may prove useful to states seeking to move away from referrals and instead toward an entity authorized to fund a full plan of health services and supports.

This model demonstration or umbrella agency approach, if successful, could lead to the blending of funds from different state agencies. Once either approach shows promise, the state could authorize an integrator to create a full care plan for a beneficiary and disburse pooled funds from health and social services agencies to fund it. While this approach has the potential to meet health and social needs with increased efficiency and coordination, it is a complex and challenging undertaking. Some local models (see text box on page 9) offer examples of joining Medicaid funds with support from other partners to meet health and social needs, but the challenges of implementing such models on a statewide scale may be different in kind or scope. States could also consider braiding funding for services on a regional basis, perhaps aligning with state Accountable Communities for Health initiatives.[13]

Data and Resources

Two interrelated challenges associated with braiding and blending funding stem from the need for the data infrastructure necessary to combine funding streams, and the need for resources to support the staff capacity required of state agencies participating in a braiding or blending initiative. While the Association of Government Accountants suggests that the potential exists for a braiding or blending effort to ultimately reduce program costs by increasing efficiency and reducing program fragmentation and overlap, a return on investment is not guaranteed.[14]

Data infrastructure and sharing may also be a consideration for policymakers seeking to integrate funding streams. State agencies have siloed data systems that do not "talk" to each other, and privacy policies that prohibit data sharing with with other state agencies. This could pose challenges for state officials working together to provide services to the same beneficiary, especially if multiple agencies needed to contribute to and access data from a single system. Also, the data systems must be adequate to meet any record-keeping requirements associated with the source of the funding. However, a braiding or blending initiative could help identify data sharing agreements or system updates that could improve the efficiency of agencies' existing data infrastructure.

Why States?

There are a number of local and regional efforts exploring the coordination of health care and social services for Medicaid beneficiaries and other low-income people (see text box, below). From Washington State's Accountable Communities of Health[15] and Oregon's Coordinated Care Organizations,[16] to local public-private cross-sector collaborations such as those chronicled by the Build Healthy Places Network,[17] to the CMMI Accountable Health Communities Model,[18] there are vibrant regional innovations aimed at addressing social and health needs. States seeking to authorize a single entity to disburse blended or braided funds could build on such local and regional models of coordination.

States control the funding sources and policy levers necessary to address the health and social service needs of low-income residents statewide, although states vary in the degree to which they rely on local entities to meet these needs. State governments serve all residents of a state, not only those in metropolitan areas or large counties. Whereas some local efforts may depend on the resources of a large city or well-off county for support, states address the health needs of the state's population, no matter where residents live. This statewide focus allows state officials to work with local leaders and across sectors and branches of state government to scale up local initiatives, support coordination and braided funding at the local and regional level, lead statewide innovation, and bring all the state's diverse funding sources to bear on shared goals.

Local and Regional Models*

There are a number of local and regional models that join Medicaid funding with support from state and local public health entities, and additional agencies, providers, and other partners to address the social needs of Medicaid beneficiaries.

- **Minnesota's Hennepin Health** is a risk-bearing Medicaid Accountable Care Organization (ACO) that addresses the physical and mental health and social service needs of high-risk Medicaid beneficiaries living in Hennepin County, using a per member per month payment from Medicaid. Hennepin County Human Services and Public Health Departments partner with Minnesota Medicaid in this initiative through a county-owned Medicaid managed care plan.
- **Washington's King County Accountable Community of Health (ACH)** is a regional collaborative that seeks to address social determinants of health, including health equity. The local Seattle health department and King County both fund staff to support the initiative. King County's ACH is part of the Washington State Accountable Communities of Health initiative, led by the Washington State Health Care Authority. The state supports ACHs with funding from a CMMI State Innovation Model grant, as well as with some state appropriations.
- **Oregon's Coordinated Care Organizations (CCOs)** are local networks of providers who care for Medicaid beneficiaries. The CCOs are paid a fixed rate for physical, mental, and oral health care, and are accountable for their beneficiaries' outcomes. The State's Medicaid waiver allows CCOs to address social determinants by paying for some things that Medicaid would not typically reimburse.

*http://www.hennepin.us/~/media/hennepinus/your-government/projects-initiatives/documents/hennepin-county-medical-center.pdf; http://www.hennepinhealth.org/~/media/mhp/forms/Annual%20Report%202014%20web.pdf?la=en; https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/minnesota-mcp.pdf; http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx; http://www.hca.wa.gov/hw/Documents/ach_faqs.pdf; http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx

Considerations for State Policymakers

For officials considering the possibility of braiding and blending state funds to finance a total plan of health services and supports for a Medicaid beneficiary, some questions arise:

- What unmet needs are keeping Medicaid beneficiaries from living healthy lives?
- What existing funding sources could finance services to meet those needs?
    - While Medicaid is a key source of funding for health care and some limited social services for certain populations, states control a number of non-Medicaid funding streams that could also help fund a total plan of health services and supports.
- What can the different funding streams be used for? What are the restrictions on each funding source? Are federal waivers available?
- What are the accountability and reporting requirements for each funding stream? Do those requirements present barriers to blending and braiding funding? What would it take to surmount those barriers?

These questions might lead policymakers to investigate what federal and state officials could do to facilitate the blending, braiding, or coordination of available funding sources to more efficiently serve Medicaid beneficiaries. The Association of Government Accountants recommend that policymakers develop a "consolidated project plan" that brings together program and policy stakeholders, as well as legal and accounting professionals. Part of that project plan would entail consulting legal and accounting professionals to address existing barriers to braiding and blending.[19]

Funding Sources

To assist state policymakers seeking to maximize their leverage by working across state agencies to promote health, NASHP has compiled a chart of funding sources "Meeting the Health-Related Social Needs of Low-Income Persons: Funding Sources Available to States." State agencies use these sources to address social determinants of health, such as stable housing, safe and prosperous neighborhoods and communities, access to healthy food, physical and mental health care, income support, and transportation. While many documents show states how Medicaid resources can be used for social services or housing needs, this chart aims to bring attention to other funding sources that states use specifically to help adult high-cost/high-need residents live healthy and prosperous lives. Below are some federal funding sources that could help states fund a total plan of health services and supports for a Medicaid beneficiary. This is not an exhaustive list, but is intended to illustrate the range of funding sources available to support low-income adults.

Housing

National Housing Trust Fund

The National Housing Trust Fund (NHTF),[20] administered by the U. S. Department of Housing and Urban Development (HUD) makes grants to states to "increase and preserve the supply of rental housing" for extremely low- and very low-income families, including homeless families.[21] The fund focuses on developing and preserving permanent, affordable rental housing, although a small portion of the funds can be used to increase homeownership, including down payment and closing cost assistance.[22] Rental units supported by the NHTF must generally remain affordable for 30 years. Funds are primarily intended for the development of housing units, not for direct support to low-income households. The NHTF is a permanent federal program with a dedicated revenue stream that does not depend on annual appropriations. There are not yet state examples of projects developed through this new fund, which HUD expects will disburse funds to states in summer 2016.

HOME Investment Partnerships Block Grant Program

The HOME Investment Partnerships Program,[23] administered by HUD, is a block grant program intended to increase the supply of safe affordable housing for lower-income households. HOME block grant funds are allocated to states and localities, with 40 percent of funds awarded to states, and 60 percent awarded to localities with populations above a certain threshold. Most HOME awardees, or "participating jurisdictions," must match 25 percent of their grant. Participating jurisdictions have a great deal of flexibility in deciding which affordable-housing-related activities to fund with their HOME grants. States and localities can use HOME funds to construct and rehabilitate rental housing, rehabilitate owner-occupied housing, and assist homebuyers. States can also use HOME funds to provide "tenant-based rental assistance" to help people pay for rent, security deposits, and sometimes utility deposits.[24]

Emergency Solutions Grants

Emergency Solutions Grant[25] funds are administered by HUD and distributed to states and localities, which may then distribute some or all of them to nonprofits that help homeless individuals and families. Funds can be used to pay for a range of physical, mental health, and substance abuse services, as well as emergency housing and employment services for those in emergency shelter or at risk of homelessness. Grant funds can also be used for short- or medium-term rental assistance, utility and security deposits, and other services intended to quickly find housing for those in need or prevent homelessness.

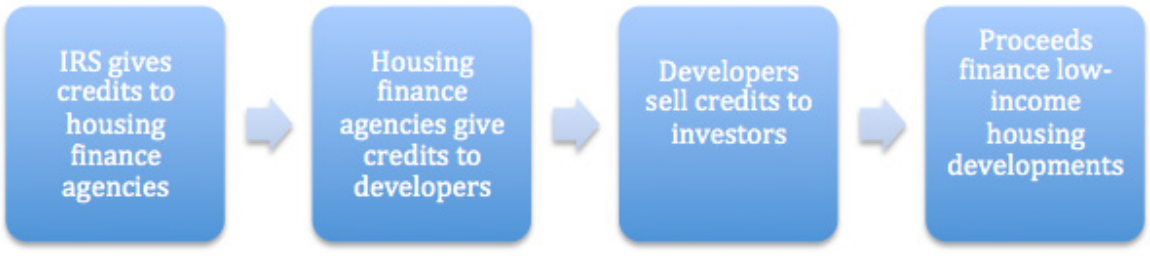
Continuum of Care Program

The Continuum of Care Program[26] is administered by HUD and distributes funds through a community process to nonprofit organizations, state and local governments, and public housing agencies. The funds can be used for a range of services for the homeless, including transitional housing, permanent supportive housing, rapid rehousing, supportive services, and Homeless Management Information Systems.[27]

Low Income Housing Tax Credit

The IRS gives federal Low Income Housing Tax Credits[28] to state housing finance agencies, to be used to construct new affordable rental housing or rehabilitate existing housing. Housing finance agencies award the credits to housing developers who have agreed to build or rehabilitate housing with a certain percentage of units designated for low-income households. Housing developers sell the credits to investors and use the proceeds to help finance the housing developments. Funds are generally used for the housing itself, not supportive housing services.

Figure 3. The Low-Income Housing Tax Credit Process



Low Income Home Energy Assistance Program (LIHEAP)

HHS awards Low Income Home Energy Assistance Program[29] block grant funds to states to help low-income renters and homeowners. States may use the funds to pay heating and cooling costs, weatherization projects, and services such as counseling on how to save energy to help grantees reduce the need for energy assistance. Most of the funding is used by states to pay for heat.

Mortgage Revenue Bonds[30]

The federal government authorizes state and local governments to issue certain bonds that are exempt from federal taxes, one of which is a mortgage revenue bond (MRB). This program promotes homeownership by supporting first-time homebuyers. State or local governments, or their housing finance agencies, sell MRBs to investors, subject to Internal Revenue Service (IRS) requirements.[31] The proceeds of the sale finance mortgages to eligible homebuyers, so that the tax exemption on the bonds in effect subsidizes the homebuyers' interest rate.

Health

Medicaid

Medicaid[32] is the primary program through which states meet the health needs of their low-income populations. For most beneficiaries, states must cover a range of medically necessary services, which generally must be offered statewide. States pay a portion of their Medicaid expenses, and may use approved waivers or state plan amendments to cover expenditures not normally allowable under federal rules.

Title V Maternal and Child Health Services Block Grant

The Title V Maternal and Child Health Services Block Grants[33] fund a wide range of primary and preventive health care services and related activities, primarily for women and children with low income. States must match some of the funds.

Community Mental Health Services Block Grant

The Community Mental Health Services Block Grant[34] supports adults with serious mental illness and children with serious emotional disturbances by funding comprehensive community mental health services, including screening and outpatient services, as well as emergency care.

Substance Abuse Prevention and Treatment Block Grant

The Substance Abuse Prevention and Treatment Block Grant[35] funds a range of activities to prevent and treat substance abuse, including primary prevention services for those at high risk for substance abuse. The grant targets pregnant women, women with dependent children, IV drug users, those in need of tuberculosis and HIV services, and those in need of primary prevention services.

Preventive Health and Health Services Block Grant

States can use funds from the CDC's Preventive Health and Health Services Block Grant[36] to address a range of public health topics, including social determinants of health. The grant has funded walking trails, bicycle helmets, and water fluoridation, among other activities.

State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease, and Stroke

State and local health departments sub-award funds from the CDC's State and Local Public Health Actions to Prevent Obesity, Diabetes, Heart Disease, and Stroke program[37] to local communities. The funds support chronic disease prevention programs, focused in four areas: epidemiology and surveillance; environmental strategies to promote healthy behaviors; health systems interventions, and community and clinical linkages.

Ryan White HIV/AIDS Program (Part B)

The AIDS Drug Assistance Program provides grants to states in accordance with Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009.[38] The grants are targeted at lower-income or uninsured people testing positive for HIV. The program funds medication to treat HIV/AIDS, medical and support services, as well as services to support HIV/AIDS treatment.

Community & Economic Development

Community Development Block Grant (CDBG)

Community Development Block Grant Entitlement Program[39] funds primarily flow to communities. The program distributes 70 percent of funds through grants to cities and urban counties; the remaining 30 percent goes to states, which then pass the funds to smaller communities whose populations are too small to qualify to receive the funds directly. At least 70 percent of funds must be used to benefit low- and moderate-income people.

States and local governments have a great deal of flexibility in the ways they choose to use CDBG funds. CDBG funds can be used to acquire and rehabilitate property for purposes including housing, public works, urban beautification, and historic preservation. CDBG funds can also support energy conservation, the development of recreational and other public facilities, and neighborhood revitalization activities. For example, funds could help make public buildings more accessible to elderly and handicapped people, develop recreational facilities to provide safe places to exercise, or rehabilitate a low-income family's home and install streetlights on their block. The CDBG program has also been used to support disaster response.

Community Services Block Grant

Community Services Block Grant[40] funds are available to states, Community Action Agencies, farm workers' agencies, and other organizations designated by states. States pass at least 90 percent of their grant funds on to eligible local entities. The program supports a range of poverty reduction and community development activities, based on community needs assessments. Funded activities can include emergency shelter and food programs, employment counseling, transportation programs, and activities for senior citizens and youth.

Child Care and Development Block Grant

The Child Care and Development Block Grant[41] supports lower-income working families by subsidizing childcare and supporting improvements in child care programs. Most families contribute childcare co-payments on a sliding scale.

Income Support and Food Security-

Child and Adult Care Food Program

Child and Adult Care Food Program[42] grants to state departments of education or health and human services support nutritious meals for children in daycare and adults in adult daycare. Meals are for lower-income participants meeting income guidelines.

Social Services Block Grant (SSBG)

States have a large amount of flexibility in determining how to use funds from the Social Services Block Grant to promote economic self-sufficiency.[43] The SSBG supports a wide range of activities in 29 service categories that promote self-sufficiency, prevent child abuse, and support care in the community for the elderly and disabled. SSBG funds can support childcare, home maintenance, home-delivered meals, transportation, substance abuse services, and other services and activities.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The WIC program, which recently celebrated its 40th anniversary, provides funds for states to support the nutritional needs of low-income children and pregnant and postpartum women.[44] The program pays for food, nutrition education, breastfeeding support, and health and social service screening and referrals for eligible women and children at nutritional risk.

Supplemental Nutrition Assistance Program (SNAP)

SNAP funds help states provide food to eligible low-income households.[45]

Temporary Assistance for Needy Families (TANF) Block Grant

The TANF Block Grant[46] provides funds to states to support low-income families with children. States generally use their TANF funds to provide cash assistance and childcare to low-income families, as well as supports related to employment. States have the flexibility to use TANF block grants in conjunction with Social Services Block Grant or the Child Care and Development Block Grant

Transportation

Surface Transportation Program (STP)

The Highway Trust Fund supplies the bulk of the funding for STP grants[47]. The federal STP grants can be used for a range of projects including highways, transit infrastructure, bicycle and pedestrian paths.

The Fixing America's Surface Transportation Act established a new National Surface Transportation and Innovative Finance Bureau within the U.S. Department of Transportation to assist state and local governments with their transportation projects. The law also continues states' ability to use funds for recreational trails, bicycle and pedestrian infrastructure, and the Safe Routes to School program.[48] These transportation funds might help states meet the needs of individuals and populations for safe spaces in which to commute and exercise.

Funding Sources Not Awarded Directly to States

Although the role of the state in the below programs varies, these programs have the potential to align with and support state health goals and initiatives to support low-income populations. Some of the programs may be of particular interest to states seeking to incorporate private capital investment in their health and social services programs, and could align well with existing cross-sector models such as Accountable Communities for Health. Tax breaks, bonds that pay for performance, and other similar mechanisms could help states attract private partners to their health and social service initiatives.

Community Development Financial Institutions (CDFIs)

CDFIs, which can include credit unions as well as non-regulated private-sector financial institutions, can provide mortgage financing, bond funding, and commercial loans in low-income communities.[49]

Federal Reserve Banks Pay for Success Programs and Social Impact Bonds

Social Impact Bonds address social services or social issues. The specific project and criteria for success are outlined in the contract between parties, but generally address a social need. The federal government contracts with an entity to provide services, and pays the entity based on their performance. The entity raises private and philanthropic capital for operations. Investors are paid back with the entity's pay for performance funds, if any.[50,51]

Massachusetts Housing and Shelter Alliance (MHSA)

The MHSA leverages a number of federal, state, and private funding sources—including a Pay for Success initiative—to provide emergency shelter, housing, meals, case management, transportation, and other services to those in need. Start-up funds from private capital investments and philanthropy helped launch the Massachusetts Pay for Success initiative, which will leverage the private funds to create permanent supportive housing for the chronically homeless. The initiative is pursuant to a contract between the Massachusetts Alliance for Supportive Housing—a subsidiary of MHSA—and the Commonwealth of Massachusetts. States seeking to access private capital to support statewide health and social services projects may benefit from examining this and other Pay for Success projects.

Table 3. MHSA Funding Sources *(2014 Financial Statements)

Federal Funding Source	Passed Through
HUD	
• Emergency Shelter Grant Program	Commonwealth of Massachusetts Division of Housing and Community Development (DHCD)
• Emergency Shelter Grant – Rapid Rehousing Program	DHCD
• Supportive Housing Program – Home and Healthy for Good Program, Post Detox/Pre-Recovery Program, and Home Front Program	Commonwealth of Massachusetts, Department of Public Health
• Supportive Housing Program	City of Boston, Department of Neighborhood Development
U.S. Substance Abuse & Mental Health Services Administration (SAMHSA)	
• Block Grants for Prevention and Treatment of Substance Abuse	Commonwealth of Massachusetts Department of Public Health

* Note: This table is for illistrative purposes only and is not meant to be exhaustive.

Hospital Community Benefits Requirements

Tax-exempt hospitals must comply with federal and state (if any) community benefit requirements in order to maintain their tax exemptions.[52] IRS requirements for tax-exempt hospitals describe the activities and services that satisfy the hospital community benefit requirements. Such activities and services generally include those supporting the health or safety of the communities served by the hospitals. Other activities can include child care services; housing rehabilitation; the provision of housing for certain patients after discharge; construction or maintenance of parks and playgrounds; economic development activities; public health emergency readiness activities; environmental improvements, such as addressing pollution and garbage. The Affordable Care Act also requires tax-exempt hospitals to conduct a community health needs assessment once every three years and plan a strategy to implement it.

New Markets Tax Credit Programs (NMTC)

Investment groups, known as Community Development Entities (CDEs), apply to the U.S. Treasury's Community Development Financial Institutions Fund for the New Markets Tax Credit (NMTC). Once the CDE gets the tax credits, it can offer them to private equity investors to attract investment in low-income communities and businesses. A number of states have established their own state NMTC that aligns with the federal program, often administered by state commerce, revenue, or finance agencies.[53,54]

Sojourner Family Peace Center, Milwaukee

NMTC granted to three different CDEs were used to finance the construction of the Sojourner Family Peace Center in Milwaukee. The Center will provide a range of on-site, multi-disciplinary supports for families affected by domestic violence, including shelter, legal resources, and physical and mental health care. It is also expected to house the Milwaukee Police Department's Sensitive Crime Unit, a Milwaukee Public Schools social worker, and other partners.

The state and local roles in funding the Center could be instructive for states looking to scale up or otherwise support statewide initiatives that similarly address health and social determinants.

Table 4. Sojourner Family Peace Center Funding Sources*(2014 Financial Statements)

Federal Funding Source	Passed Through
HUD	
• Community Development Block Grant	City of Milwaukee
• Emergency Solutions Grant	City of Milwaukee
US Department of Justice (DOJ)	
• Victims of Crimes Act	State of Wisconsin Department of Justice
• Violence Against Women Act	State of Wisconsin Department of Justice
• Safe Exchange	City of Milwaukee Health Department
• Strengthening Prosecution Grant & Encourage Arrest	Milwaukee County District Attorney
U. S. Department of Health and Human Services (HHS)	
• Domestic Violence – Basic Services	State of Wisconsin Department of Children and Families

* Note: This table is for illistrative purposes only and is not meant to be exhaustive.

Conclusion

State policymakers control a number of funding sources that could be used to fund a total plan of health services and supports—including both health and social needs—for a Medicaid beneficiary. States seeking to streamline the complex and potentially duplicative system of multiple referrals and care coordinators have several options available to them: from coordinating state agencies' efforts, to blending funding from multiple streams under the control of a single agency or entity, states could use their leverage to transform the way in which health and social needs are met.

However, such transformation poses great challenges to providers, state agencies, and other stakeholders, and requires the support of states' executive leadership. State leaders would need to surmount a myriad of legal, regulatory, contracting, data-sharing, and political barriers in order to re-tool current funds to more effectively meet the needs of a state's most vulnerable populations. States have long shown leadership in meeting the needs of the vulnerable; in the wake of national health care reform, states once again have the opportunity to lead with innovative new ways to help all residents live healthy and productive lives.

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