Planning Title IV-E Prevention Services: A Toolkit for States

Understanding Roles of Funding and Decision Points

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UNDERSTANDING ROLES OF FUNDING AND DECISION POINTS

After you identify priorities for prevention services planning, you will want to consider how to offer services to families, including the appropriate funding mechanisms.[1] Braiding funds (as defined in the introduction to this toolkit) can help states ensure that available services are comprehensive, coordinated, and non-duplicative. Funding strategies must account for a variety of factors, such as the status of Title IV-E prevention services as payer of last resort (see Section C.1 of this document and Appendix A of this toolkit for more details), and which issues or populations' needs you plan to address. The following are examples:

- If your state is looking to cover services for populations that *are not* eligible for insurance (and eligibility is not expected to change), you will need to consider various non-Medicaid funding sources (including Title IV-E prevention services reimbursement). Key parameters of these funding sources vary, such as which services can be funded and for whom.
- If you want to address issues related to those who *are* covered by Medicaid, you can talk with your state Medicaid agency about whether Medicaid coverage might change (also see Section A.2 of this document about existing flexibilities under Medicaid managed care) and consider non-Medicaid funding sources.
- To address the timeliness of services that already have a funding source, you can consider the causes of delays and whether Title IV-E prevention services reimbursement might be an appropriate mechanism to address them (for further information, see Section C.1 of this document).

The information in this document can help stakeholders understand the current state of funding and coverage in their state (for example, implications of Medicaid's use of a particular coverage mechanism) as well as considerations when considering changing the usage of funding sources. This part of the toolkit includes information on the following:

(1) Coverage and funding mechanisms for mental health (MH) and substance use disorder (SUD) services (Section A)

(2) Coverage and funding mechanisms for in-home parent skill-based programs (Section B)

(3) Additional considerations related to coverage and funding mechanisms (such as the interplay of various funding mechanisms as well as funding for infrastructure, administration, and ancillary services) (Section C). For stakeholders interested in background on Medicaid, see Appendix C of this toolkit.

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[1] As in Section C of the "Determining priorities, goals, and actions" companion document in this toolkit, a range of strategies can help you address goals, including those that do not involve additional funding. For example, child welfare agencies can strengthen partnerships with existing organizations that deliver services.

A. Coverage and funding mechanisms for MH and SUD services

Together, Medicaid and private health insurance account for the majority of spending on both MH and SUD services (SAMHSA 2019). Other federal, state, and local funding (including funding spent by child welfare agencies) also comprise significant portions of total spending on MH and SUD services (SAMHSA 2019). To support understanding of available coverage and funding mechanisms, this section features the following:

- Table 1 provides a high-level overview of some key features of state-administered MH and SUD services coverage and funding mechanisms that involve a federal component—such as for whom they can cover services, which services they can cover, federal versus state funding, limitations on the mechanism, and sources for additional information.
- The subsections after Table 1 provide additional background related to each of these mechanisms, focusing on Medicaid as a key source of coverage for families with children at risk of entering foster care. These sections also include information about the following:
  - The impact of Medicaid managed care authorities on coverage and availability of MH and SUD services (Section A.2)
  - Additional coverage and funding mechanisms that are not mentioned in Table 1, such as those that apply to some sub-populations of families with children at risk of entering foster care, and funding for community health centers (Section A.6)

Table 1. Key relevant coverage and funding mechanisms that states can use for MH and SUD services

Coverage or funding mechanism	Coverable services: Which services?	Coverable services: For whom?	Coverable services: Which settings or providers?	Basics of mechanism: How can a state obtain this mechanism?	Basics of mechanism: Federal or state funding	Basics of mechanism: Key limits (duration, and so on)	Additional notes and key considerations	Source or for more information
Medicaid coverage mechanisms								
Medicaid State Plan	Wide and variable range of services. Some are mandatory for state to cover, and others are optional (per section 1905(a) of the SSA). Includes benefits such as EPSDT, under which states must cover all "medically necessary" 1905(a) services for children under 21, regardless of the state's service package for adults.	Applies to most Medicaid-covered people in the state. Unless combined with other authority, services generally are statewide and comparable within types of eligibility groups.	State defines providers in state plan. Medicaid FFS services can be provided by any qualified, willing provider. Services to people in IMDs are generally excluded.	All states have state plan that outlines parameters of Medicaid program. Changes (such as changes in reimbursement methodology) require a SPA.	State generally receives regular FMAP, currently ranging from 50 percent to 76 percent. (See Mitchell 2018.)	SPA does not expire.	Various managed care authorities also impact service coverage and availability. See Section A.2 of this document for information and examples.	CMS website about: Benefits, Financial Management, and Managed Care. MACPAC website about State Plan
Section 1945 Health Home State Plan Option	Must include comprehensive care management, care coordination, health promotion, transitional care or follow-up, beneficiary and family or caregiver support, and referral to community or social support services.	Medicaid-covered people who have chronic conditions, which can include SMI, SED, or SUD. State defines specifics of target population and can target by geography.	State defines requirements for health home providers, which can include a provider, a team of health professionals, or a health team.	State proposes program details to CMS via SPA (including details on payment methodology, target population, and other features). Changes (such as changes in reimbursement methodology) require a SPA.	State receives 90 percent FFP for health home services for the first 8 quarters after approval (or 10 quarters for newly approved SUD programs) and regular FMAP afterward.	SPA does not expire.	State must meet quality measurement and reporting requirements. State can also request grant funds from CMS for planning the health home program. As of August 2019, 20 states have health homes that address SUD, SMI, or SED.	CMS Health Home Information Resource Center

Table 1 *(continued)*

Coverage or funding mechanism	Coverable services			Basics of mechanism			Additional notes and key considerations	Source or for more information
	Which services?	For whom?	Which settings or providers?	How can a state obtain this mechanism?	Federal or state funding	Key limits (duration, and so on)		
Section 1915(i) State Plan HCBS	HCBS (such as case management, partial hospitalization, psychosocial rehab, or other services).	Medicaid-covered people who meet needs-based criteria defined by the state. Can target by condition but not geography. May expand income-related eligibility.	Services provided by any qualified, willing provider (unless state combines with another authority that allows limits on providers). HCBS settings rule (42 CFR 441.710(a)(1)(2)) applies to settings where services are delivered.	State submits SPA to CMS. Changes to the approved 1915(i) benefit require a SPA.	State receives applicable FMAP.	If state targets specific population(s), 1915(i) benefit is limited to five years, with the option for the state to request renewal. Otherwise, does not have time limit.	State must meet reporting requirements. State cannot limit participation to a specific number of people or limit enrollment to specific geographic areas of the state. In FY 2017, six states had 1915(i) HCBS for people with MH disabilities (Musumeci et al. 2019).	CMS website about 1915(i) HCBS; CMS HCBS Technical Assistance Website
Section 1915(c) HCBS Waiver	HCBS (such as case management, partial hospitalization, psychosocial rehab, or other services to avoid institutionalization).	Medicaid-covered people whose needs require an institutional level of care. Can target by condition and geography. May expand income-related eligibility.	Services provided by any qualified, willing provider (unless state combines with another authority that allows limits). HCBS settings rule (42 CFR 441.301(c)(4)(5)) applies to settings where services are delivered.	State submits waiver application to CMS. Must meet cost neutrality requirements.	State receives applicable FMAP.	Generally approved for three years and can be renewed for five years.	State must meet reporting requirements. State can limit participation to a specific number of people. Some states have 1915(c) waiver concurrent with 1915(b) managed care authority. In FY 2017, 12 states had 1915(c) waivers for individuals with MH disabilities (Musumeci et al. 2019).	CMS website about 1915(c) waivers; CMS HCBS Technical Assistance Website

Table 1 *(continued)*

Coverage or funding mechanism	Coverable services			Basics of mechanism			Additional notes and key considerations	Source or for more information
	Which services?	For whom?	Which settings or providers?	How can a state obtain this mechanism?	Federal or state funding	Key limits (duration, and so on)		
Section 1115 Demonstration	SUD and SMI/SED demos allow state to receive FFP for short-term stays in IMDs. Some states cover additional services via section 1115 demonstrations.	State defines Medicaid-covered population included in its demonstration application.	Allows FFP for short-term IMD stays; state can further define providers of these and other services within its demonstration application. HCBS settings rule (42 CFR 441.301(c)(4)(5) and 42 CFR 441.710(a)(1)(2)) applies to settings where services are delivered.	State submits application to CMS. Must meet various requirements, including those related to budget neutrality.	State receives applicable FMAP.	Generally approved for five years and can be renewed.	State must work to meet other goals and milestones (for SUD and SMI/SED demos). Must also meet monitoring and evaluation requirements. As of November 2019, CMS has approved one SMI/SED and 27 SUD demonstrations.	CMS website about section 1115 demonstrations; CMCS 2017, CMCS 2018a
SAMHSA funding mechanisms								
MHBG	Wide range of MH services (such as outpatient services, supported employment, rehabilitation services, crisis stabilization, case management, wraparound services).	Adults with SMI or children with SED. For either group, must have a diagnosable behavioral health issue that disrupts daily life or community participation.	"Appropriate, qualified community programs" and community mental health centers that meet certain criteria (see 42 USC 300x-2(b)).	State can apply on an annual basis and submit a biannual plan. MHBG is formula-based and noncompetitive.	Federal grant	State must spend at least 10 percent of grant on EBPs for early SMI. State must meet MOE requirements.	State must form a planning council that provides input on MH plans and must meet management and monitoring requirements.	SAMHSA website about MHBG

Table 1 *(continued)*

	Coverable services			Basics of mechanism				
Coverage or funding mechanism	**Which services?**	**For whom?**	**Which settings or providers?**	**How can a state obtain this mechanism?**	**Federal or state funding**	**Key limits (duration, and so on)**	**Additional notes and key considerations**	**Source or for more information**
SABG	Wide range of services that prevent and treat SUD.	Services can be used for a general population, but targeted populations include pregnant women and women with dependent children. (See Section A.3 for information regarding services for these populations.)	SABG is not prescriptive but focuses on providers and organizations that provide substance abuse prevention and treatment services.	State can apply on an annual basis and submit a biannual plan. SABG is formula-based and noncompetitive.	Federal grant	State must spend at least 20 percent of grant on prevention services (additional caps on administrative spending). State must meet MOE requirements.	State must develop a SUD primary prevention program, provide specialized services to pregnant women and women with dependent children, and meet management and monitoring requirements.	SAMHSA website on SABG
Child welfare funding mechanisms								
Title IV-E prevention services	Time-limited MH, SUD services, and in-home parent skill-based programs to prevent foster care placement. Services must be evidence-based (approved by the Clearinghouse or approved for transitional payments). (See Section B for information on in-home parent skill-based programs.)	Children at imminent risk of foster care placement and their parents or kin caregivers. Can also be used for pregnant or parenting youth in foster care.	Title IV-E is not prescriptive about specific setting or providers. Programs and services must be specified in the state's prevention program plan.	State submits and receives approval for a five-year Title IV-E prevention program plan. State must create a prevention plan for each child, which documents prevention plan strategy and services to be provided.	FFP of 50 percent of spending on eligible services (or state's FMAP starting October 2026). State can also receive 50 percent FFP for administrative costs and staff training in accordance with statutory and regulatory requirements.	State must meet MOE requirements. Title IV-E is payer of last resort, though it can be used to help prevent delay of timely provision of services (pending reimbursement from the source that has ultimate responsibility).	Services and programs must be provided under a trauma-informed approach to service delivery. State must monitor and evaluate services provided.	Regarding state requirements: ACYF-CB-PI-18-09; Regarding tribal agency requirements: ACYF-CB-PI-18-10; Regarding transitional payments: ACYF-CB-PI-19-06; Title IV-E Prevention Services Clearinghouse

Table 1 *(continued)*

Coverage or funding mechanism	Coverable services			Basics of mechanism			Additional notes and key considerations	Source or for more information
	Which services?	For whom?	Which settings or providers?	How can a state obtain this mechanism?	Federal or state funding	Key limits (duration, and so on)		
Title IV-B	Broad range of services designed to support children and families. Might include parenting training as well as MH and SUD services.	Children and families either in foster care or at risk of child abuse or neglect.	State generally allowed to use funds on any service that is intended to meet the program's broad purpose of preventing maltreatment.	Grant funding to states and territories. Some components are formula-based and some are competitive.	State receives 75 percent FFP up to maximum allotment.	State cannot use funds to meet regular education costs or medical care needs. Also includes limitations on use of funds for purposes such as child care.	Regional Partnership Grants target services to children and parents affected by parental SUD. They are discretionary and not available to all states.	ACYF-CB-PI-19-02; Stoltzfus 2012; Rosinsky and Williams 2018
Additional family support funding								
CBCAP	Funds can be used for a broad range of community-based services to prevent child abuse and neglect, including supporting respite care programs, parenting education, MH or SUD services.	General public or families at risk of maltreatment.	Emphasis on community-based services and cross-system collaboration. CBCAP agency encouraged to work with social services, physical health, MH, and SUD services.	State applies to receive funding. If state has a CBCAP office, it is eligible to receive the federal funds.	$200,000 base fund to all states. 70 percent of funds are allotted based on the number of children in each state. 30 percent allotted based on other funds leveraged.		States are strongly encouraged to braid and blend private-public funds.	ACYF-CB-PI-19-05; FRIENDS National Center for CBCAP 2018

Table 1 *(continued)*

Coverage or funding mechanism	Coverable services: Which services?	Coverable services: For whom?	Coverable services: Which settings or providers?	Basics of mechanism: How can a state obtain this mechanism?	Basics of mechanism: Federal or state funding	Basics of mechanism: Key limits (duration, and so on)	Additional notes and key considerations	Source or for more information
TANF Block Grant	Program goals of providing assistance to needy families; promoting job preparation, work, and marriage; preventing and reducing the incidence of out-of-wedlock pregnancies, and encouraging formation and maintenance of two-parent families.	Individuals must be either pregnant or responsible for children under 19, low or very low-income, and be under- or un-employed. Each state and territory establishes the specific eligibility criteria.	Each state and territory selects the benefits provided through TANF. Funds can be used flexibly and include basic assistance, work-related activities, work supports, childcare, program management, tax credits, child welfare services, pre-kindergarten or Head Start, and other areas.	States receive a fixed annual amount of federal TANF funding.	$16.5 billion total in federal funds to states. There is no state match requirement for TANF.	Although TANF includes work requirements and time limits for cash assistance, they do not apply when the benefits are applied toward families in which the child is the recipient. State must meet MOE requirements.	States can transfer up to 10 percent of TANF grant funds to SSBG, which allows for greater flexibility in state use of TANF funds.	Falk 2017
SSBG	Broad goals include providing support to eliminate dependency, achieve or maintain self-sufficiency, prevent maltreatment of children and adults, reunite families, prevent inappropriate institutional care, and secure admission to institutional care when necessary.	Households with low income. There are no federal eligibility criteria for SSBG participants, and states set their own eligibility criteria.	States decide how to use the funds, but the largest expenditures for services under SSBG were for child care, foster care, and special services for the disabled.	States and territories submit a plan specifying how grant funds will be used. An annual post-expenditure report is also required.	In FY 2019, $1.7 billion total funds. States can provide services directly or sub-allocate funds to local qualified providers. States can transfer up to 10 percent of their TANF funds to SSBG.		SSBG appropriations have been subject to sequestration.	Lynch 2016

Notes: This table provides a high-level summary of some key features of these coverage and funding mechanisms and does not fully summarize or replace guidance from any federal agency. Although this toolkit focuses on states, many of the coverage and funding mechanisms also apply to territories, and some apply to tribal communities. Some of the rules for these mechanisms, however, vary for territories or tribal communities.

CBCAP = Community Based Child Abuse Prevention; CMS = Centers for Medicare & Medicaid Services; EBP = evidence-based practice; EPSDT = Early and Periodic Screening, Diagnostic, and Treatment; FFP = federal financial participation; FFS = fee for service; FMAP = federal medical assistance percentage;

Table 1 *(continued)*

FY = fiscal year; HCBS = home and community-based services; IMD = institution for mental diseases; MH = mental health; MHBG = Community Mental Health Services Block Grant; MOE = maintenance of effort; SABG = Substance Abuse Prevention and Treatment Block Grant; SAMHSA = Substance Abuse and Mental Health Services Administration; SED = serious emotional disturbance; SMI = serious mental illness; SPA = state plan amendment; SSA = Social Security Act; SSBG = Social Services Block Grant; SUD = substance use disorder; TANF = Temporary Assistance for Needy Families

1. Which MH and SUD services can Medicaid cover, and by what mechanisms can it do so?

Medicaid can cover a broad variety of MH and SUD services (see resources in Section C of the "Assessing population, service needs, and service coverage" companion document in this toolkit regarding services covered by state). States use various mechanisms (known as authorities) to cover services. Broadly, the authorities involve using the **state plan** or requesting from the Secretary of Health and Human Services a **waiver** of certain Medicaid program requirements. The following Medicaid authorities are most relevant to understanding MH and SUD service coverage:

- **State plan.** Each Medicaid state plan details the parameters of a state's Medicaid program, including the services covered under a benefit.[2] Section 1905(a) of the Social Security Act (SSA) outlines the benefits that must be covered and those that are optional. Some of the categories of benefits under section 1905(a) of the SSA are broad (such as physician services and rehabilitative services) and leave room for states to define specifics and identify limits on the amount, duration, or scope of services. Services provided to people who reside in institutions for mental diseases (IMDs), which could include residential treatment settings of more than 16 beds, have historically not been eligible for reimbursement under the Medicaid state plan.[3] There are some exceptions, however, for people younger than age 21 (section 1905(a)(16) of the SSA) and older than 65 (section 1905(a)(14) of the SSA). The SUPPORT for Patients and Communities Act (passed in October 2018) allows states to apply for a time-limited state plan option to receive federal financial participation (FFP) for some SUD-related stays in an IMD under particular conditions (section 5052 of the SUPPORT for Patients and Communities Act). It also allows a partial exception for coverage of services to pregnant and postpartum women outside of an IMD, when the woman is receiving SUD treatment services in an

[2] Although state plan services are generally applicable across Medicaid eligibility groups and throughout a state, there are some exceptions (and there can be variations in service coverage between some types of eligibility groups). For example, the adult Medicaid expansion population must be (and some other populations can be) covered under alternative benefit plans, which must also cover MH and SUD services and do so at parity with physical health services. Yet MACPAC (2018) noted that states that expanded Medicaid generally offered the same SUD benefit across eligibility groups. For people covered under the state plan, services must generally be comparable within types of eligibility groups (details and exceptions are described in Subpart B of 42 CFR 440).

[3] IMDs are hospitals, nursing facilities, or other institutions with more than 16 beds that are "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases."(1905 (i) of the SSA, 42 CFR 435.1010) Clause B following section 1905(a) of the SSA (or see 42 CFR 435.1009(a)) excludes from Medicaid federal financial participation eligibility any services provided to people age 64 or younger who reside in IMDs. As in 42 CFR 435.1009(a), however, there is an exception to the IMD exclusion for people who are in IMDs and are receiving "inpatient psychiatric services for individuals under age 21" in accordance with 42 CFR 440.160 (known as the "psych under 21" benefit).

IMD (section 1012 of the SUPPORT for Patients and Communities Act) (Musumeci and Tolbert 2018).[4]

A few mechanisms for covering MH and SUD under a Medicaid state plan could be of particular interest to stakeholders who are planning prevention services:

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).** States are required to make available to Medicaid-covered children and adolescents younger than age 21 any 1905(a) Medicaid-coverable, medically necessary treatment or service required to "correct or ameliorate" physical or mental health conditions, even if the service is not in the state plan (see section 1905(r) of the SSA).[5] Notably, this requirement can apply to some services that are medically necessary for a child and are for the child's direct benefit but from which parents (even those who are not eligible for Medicaid) may receive some benefit. Examples include counseling or training a parent to address a child's neonatal abstinence syndrome (CMCS 2018b), some types of family therapy (MACPAC 2015), and maternal depression treatment services (CMCS 2016).[6] Such services also must be coverable under one or more section 1905(a) benefit categories.

- **Rehabilitative services optional service.** The "rehab services option" is a vehicle that states commonly use to cover clinical and non-clinical, community-based behavioral health services, such as peer support and psychiatric rehabilitation services (SAMHSA 2013; Zur et al. 2017). All states as of 2013 used the rehabilitative services option to cover at least some behavioral health services and it provides multiple flexibilities (SAMHSA 2013). For example, it allows services to be provided in a variety of settings and be provided by people who are not licensed under professional scope of practice laws (such as trained peers). It allows coverage of services for the purposes of reducing disability and restoring function.

- **Section 1945 health home state plan option.** As an optional benefit, states can create health homes to coordinate care for Medicaid beneficiaries who have chronic conditions (including MH and SUD conditions). States define the eligible populations and health home providers (for example, teams of health professionals in a community mental health center). There are certain services that health homes must provide: comprehensive care management, care coordination, health promotion, comprehensive transitional care or follow-up, beneficiary and family or caregiver

[4] For relevant state guidance, see CMCS's 2019 Informational Bulletin.

[5] Cohen Ross et al. 2019 and Johnson and Bruner 2018 have additional information about EPSDT and describe opportunities in Medicaid to improve care for children.

[6] The Center for Medicaid and CHIP Services's 2019 Informational Bulletin about residential pediatric recovery centers as an optional provider type (based on section 1007 of the SUPPORT for Patients and Communities Act) also discusses this concept in relation to providing services to infants with neonatal abstinence syndrome and their mothers or other appropriate family members and caretakers.

support, and referrals to community and social support services. States receive a 90 percent enhanced federal medical assistance percentage for these services for up to the first 8 quarters after the program is approved (or 10 quarters for health homes approved in October 2018 or later that focus on people with SUD [Musumeci and Tolbert 2018]).[7]

- **Section 1915(i) state plan home and community-based services (HCBS).** Through this option, states can cover HCBS (such as psychosocial rehabilitation for people with chronic mental illness or respite services) for Medicaid-covered people who meet needs-based eligibility criteria set by the state that are less stringent than criteria for an institutional level of care. States can target these services to a specific population based on age, disability, diagnosis or Medicaid eligibility group, but they cannot target only a particular geographic area of the state; nor can they limit the number of participants who meet the defined needs-based criteria that can receive HCBS. Under 1915(i) state plan HCBS, states can also provide Medicaid to some people who meet certain income-related criteria and would not otherwise have qualified for Medicaid (see 42 CFR 435.219). In fiscal year 2017, six states had enrollees in 1915(i) state plan HCBS that focused on people with mental health disabilities (most people served by other 1915(i) state plan HCBS have intellectual or developmental disabilities) (Musumeci et al. 2019).

- **Section 1915(c) HCBS waiver.** This optional waiver authority allows states to offer HCBS to Medicaid-covered people who require an institutional level of care. States can limit enrollment in ways that they cannot under 1915(i) state plan HCBS (by limiting enrollment to specific areas within the state or capping enrollment to a certain number of people). 1915(c) waivers must be cost neutral to be approved, which can be difficult for states to demonstrate for non-elderly adults, especially because of the IMD exclusion (Dorn et al. 2016).[8] 1915(c) waivers cover services necessary to avoid institutionalization. States can also use 1915(c) waivers to provide Medicaid to some people who meet certain income-related criteria and would not otherwise have qualified for Medicaid unless living in an institution. In fiscal year 2017, almost 27,000 people across 12 states were enrolled in 1915(c) waivers that focused on people with mental health disabilities (most waivers targeted individuals with physical, intellectual, or developmental disabilities) (Musumeci et al. 2019).
- **Section 1115 demonstrations.**[9] In broad terms, section 1115 demonstrations involve waiving specific federal rules of the Medicaid program to implement a demonstration that

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[7] Some states have more than one health home state plan amendment, for example, to expand to a new geographic area or new chronic conditions. Note that states can claim the enhanced match for a maximum of eight quarters per beneficiary.

[8] Demonstrating cost neutrality for children might not be as difficult, depending on the state's existing spending for services for children (such as payments for psychiatric residential treatment facilities, the therapeutic component of residential treatment centers that are less than 16 beds, or psychiatric inpatient hospitalization).

[9] All references in this toolkit to Medicaid section 1115 demonstrations refer to demonstrations authorized by section 1115(a) of the SSA.

promotes the objectives of Medicaid. In recent years, the Centers for Medicare & Medicaid Services (CMS) has announced opportunities for states to apply for section 1115 demonstrations to enhance care for SUD, serious mental illness, and serious emotional disturbance (CMCS 2017; CMCS 2018a). These opportunities allow states to receive FFP for short-term IMD stays, and they require states to work toward additional goals and milestones in reforming their delivery systems for SUD, serious mental illness, and serious emotional disturbance more broadly. Through section 1115 demonstrations, some states also made additional changes related to behavioral health by, for example, covering additional community-based behavioral health services or by implementing delivery system reforms to integrate physical and behavioral health (Hinton et al. 2019; Seibert et al. 2019). Subject to approval by CMS, states have the flexibility to define features such as delivery systems, populations covered, and geographic area. Demonstrations must meet federal requirements such as those related to budget neutrality, monitoring, and evaluation.

2. How do Medicaid managed care authorities impact the coverage and availability of MH and SUD services?

As described in Appendix C of this toolkit (Background on Medicaid), most Medicaid enrollees receive at least some services through managed care delivery systems. Although the services covered within Medicaid managed care are generally based on a state's Medicaid state plan, enrollment in Medicaid managed care (as opposed to fee-for-service Medicaid) is relevant to the coverage and availability of MH and SUD services for many reasons, such as the following:

- **Risk-based Medicaid managed care entities[10] can cover some additional services beyond the state plan either as value-added or in lieu of services.**
  - **Value-added services.** Risk-based managed care entities can voluntarily agree to provide additional services, though the cost of those services cannot be included when determining a state's payments to these entities (42 CFR 438.3(e)(1)(i)).
  - **In lieu of services.** Risk-based managed care entities can cover services or settings that are in lieu of services or settings covered under the state plan as long as they meet specific conditions outlined in 42 CFR 438.3(e)(2). For example, a state must determine that the service or setting is a medically appropriate and cost-effective substitute, and these services must be identified in the state's contract with the managed care entity. Notably, states can use this in lieu of authority to receive FFP for managed care capitation payments for adults who receive psychiatric or SUD treatment in an IMD for up to 15 days in a given month (Zur et al. 2017), though some states view this 15-day limit as too restrictive (MACPAC 2018).

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[10] These entities include managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans (see 42 CFR 438.2 for definitions).

- **Enrollees in Medicaid managed care organizations must have access to behavioral health services at parity with physical health services.** See Subpart K of 42 CFR 438 for details.[11]
- **Utilization management under Medicaid managed care entities can affect access to services.** Managed care entities have various policies and procedures regarding utilization management (such as prior authorization requirements), which can affect their enrollees' access to services.
- **Enrollees in Medicaid managed care can be limited to receiving services from providers in their managed care entity's network,** whereas enrollees in fee-for-service Medicaid can receive services from any qualified, willing provider. Managed care entities must maintain network adequacy, including for behavioral health services (consistent with 42 CFR 438).
- **Some specific Medicaid managed care authorities allow for coverage of some services that are in addition to state plan services.** Using a 1915(b)(3) waiver, states can use projected cost savings to cover additional Medicaid coverable services. Some states also implement managed care (or other programs) by using section 1115 demonstration authority, and some of these demonstrations cover additional services (or they waive other Medicaid requirements to allow states to have a demonstration that furthers the goals of the Medicaid program).

As noted in Section C of the "Assessing population, service needs, and service coverage", companion document in this toolkit, it is also important to understand the varying structures of state Medicaid behavioral health service delivery systems (whether fee for service, managed care, or other carved-out entities) in order to understand the roles of managed care entities and how to coordinate with them.

3. Which MH and SUD services can the Substance Abuse and Mental Health Services Administration (SAMHSA) funding mechanisms cover?

The key relevant funding mechanisms via SAMHSA are the **Community Mental Health Services Block Grant** and the **Substance Abuse Prevention and Treatment Block Grant.** These block grants are highly flexible and can be used for behavioral health prevention, treatment, and recovery support services. The grants aim to supplement services covered by Medicare, Medicaid, and private insurance. This is especially useful for addressing the health care needs of uninsured and low-income populations as well as those with high-priority needs. For example, with the Substance Abuse Prevention and Treatment Block Grant, states are required to prioritize pregnant women, injection drug users, and women with

[11] Alternative benefit plans also must meet parity requirements.

dependent children for services.[12] Every state has a women's treatment coordinator designated for the block grant.[13] The grants are non-competitive and formula based. Although the grants are flexible, most states use them to pay for outpatient services and, less frequently, for residential services or inpatient detoxification (Woodward 2015). All states and multiple territories receive both the Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant (SAMHSA n.d.).[14] When compared with other sources of funding, however, the block grants tend to make up a small percentage of total state-controlled funding for MH and SUD services (SAMHSA 2019).

Many other sources of discretionary grant funding for services are available through SAMHSA, such as the **State Targeted Response to the Opioid Crisis Grants,** the **State Opioid Response Grant,** and the **System of Care Expansion and Sustainability Grants.** (For information about current funding announcements, see https://www.samhsa.gov/grants.) States receiving funds through these additional sources must consider how they contribute to the continuum of care, even though they tend to be time limited.

4. In addition to Title IV-E, what federal child welfare funding mechanisms can fund MH and SUD services?[15]

States can also use **Title IV-B** to fund MH and SUD services and related supports for families at risk of foster care placement. Title IV-B of the SSA consists of two subparts. The relevant prevention services in each subpart include the following:

- Subpart 1 (Child Welfare Services) funds can be used for services intended to meet the program's broad purposes of protecting and promoting the welfare of all children, preventing child abuse and neglect, and permitting children to remain in their own homes. Funds can be used for services for parents and children.
- Subpart 2 (Promoting Safe and Stable Families) includes funds for community-based family support services and family preservation services for children and parents. Services to prevent child maltreatment or to preserve families might include a range of family supports, including parenting classes, MH services, and SUD services. In addition, this subpart also includes competitive, discretionary Regional Partnership Grants (which

[12] Under the Substance Abuse Prevention and Treatment Block Grant, states are required to provide specialized services for pregnant women and women with dependent children, including treating the family as a unit, providing primary care for women and children, offering gender-specific SUD treatment, giving priority admission to pregnant women, and providing transportation services and case management to women and children.

[13] See the Women's Services Network Contact List.

[14] Stakeholders can find information about their state's Community Mental Health Services Block Grant spending through SAMHSA's Uniform Reporting System reports.

[15] For information about parameters of Title IV-E prevention services, see the Administration for Children and Families guidance (such as ACYF-CB-PI-18-09, ACYF-CB-PI-18-10, ACYF-CB-PI-19-06, and the Child Welfare Policy Manual) and Appendix A of this toolkit.

are available to some states) to provide services to families affected by parental substance use.

States vary widely in how they use Title IV-B funds, which make up a small proportion (four percent in State Fiscal Year 2016) of federal funds spent by child welfare agencies (Rosinsky and Williams 2018). For both subparts, 75 percent of program costs (up to the state's maximum allotment) are covered by the federal government.

5. What additional family support funding mechanisms can fund MH and SUD services?

Additional federal funds given to states can be used to fund prevention services, including **Community Based Child Abuse Prevention (CBCAP) grants, Temporary Assistance for Needy Families (TANF),** and the **Social Services Block Grant (SSBG).**[16]

CBCAP, which is part of the Child Abuse Prevention and Treatment Act (CAPTA), provides formula-based grants to states to support community-based efforts to prevent child abuse and neglect. Funding can support a broad array of services to support families, including developing, maintaining, or redesigning community-based child abuse and neglect prevention program services (such as respite care services, MH services, and SUD services) (ACYF-CB-PI-19-02). States are encouraged to braid and blend funds to maximize federal contributions. In total, 70 percent of program costs are reimbursed by the federal government (FRIENDS National Center for CBCAP 2018). In fiscal year 2018, CBCAP appropriations totaled about $40 million (Stoltzfus 2018).

TANF was created in 1996 (replacing Aid to Families with Dependent Children) with goals of providing assistance to needy families; promoting job preparation, work, and marriage; preventing and reducing the incidence of out-of-wedlock pregnancies; and encouraging formation and maintenance of two-parent families. Each state and territory establishes the specific eligibility criteria, but applicants must be either pregnant or responsible for children under 19, low or very low income, and be under or unemployed. In SFY 2016, child welfare agencies reported spending $2.7 billion in TANF funds on child welfare services (Rosinsky and Williams 2018).

Each state and territory selects the benefits provided through TANF. Funds can be used flexibly and include basic assistance, work-related activities, work supports, child care, program management, tax credits, child welfare services, pre-kindergarten or Head Start, and other areas.

SSBG is a flexible funding source that enables states and territories to tailor social service programming to their population's needs. There are 28 service categories defined in the legislation, and many relate to child welfare. The broad goals for SSBG include providing

[16] States focusing on preventing adoption disruption may also want to consider funding mechanisms for post-adoption support, such as Adoption Opportunities Grant Funds and Promoting Safe and Stable Families (Title IV-B, Subpart 2) adoption promotion and support funding.

support to eliminate dependency, achieve or maintain self-sufficiency, prevent maltreatment of children and adults, reunite families, prevent inappropriate institutional care, and secure admission to institutional care when necessary. There are no federal eligibility criteria for SSBG participants, and states set their own eligibility criteria for households with low incomes. Similarly, states decide how to use the funds, but the largest expenditures for services under SSBG were for child care, foster care, and special services for people who are disabled. In SFY 2016, child welfare agencies reported spending $1.5 billion in SSBG funds on child welfare services (Rosinsky and Williams 2018).

6. What other coverage and funding mechanisms must states consider while braiding funding for MH and SUD services to prevent foster care placement?

The funding mechanisms mentioned previously are the key sources that involve at least some federal money and that states can consider when building a comprehensive array of services for families with children at risk of entering foster care.[17] But child welfare administrators must be aware of some additional coverage and funding mechanisms when evaluating individuals' needs and Title IV-E funding as a payer of last resort. Some people will be enrolled in **private health insurance, Medicare** (such as people who have disabilities), or the **Children's Health Insurance Program (CHIP).**[18] Other sources of funding or service administration include the **U.S. Department of Defense,** the **Veterans Health Administration,** the **Indian Health Service,** and **corrections or justice departments and agencies (federal, state, or local)**—including the federal **Office of Juvenile Justice and Delinquency Prevention.**[19] In addition, some funding through the Health Resources and Services Administration (HRSA) can support MH and SUD services, such as the **Title V Maternal and Child Health Services Block Grant** and **funding for community health centers and rural organizations** (see HRSA 2019a for an example of such funding).[20] These funding sources will be relevant for some people.

[17] State and local general funds comprise a significant portion of expenditures on MH and SUD services (SAMHSA 2019).

[18] With CMS's approval, states can use some CHIP administrative funding for Health Services Initiatives to improve the health of children, such as public health initiatives. Some states use these initiatives to fund behavioral health services and parenting educations services and supports (MACPAC 2019a).

[19] Funding by the Office of Juvenile Justice and Delinquency Prevention includes a variety of grants to states, some of which can be used for MH, SUD, or child abuse prevention. See https://ojjdp.ojp.gov/programs/formula-grant-areas. Coordinating with the juvenile justice system can be especially useful because of the number of youth who are involved or at risk for involvement in both the child welfare and juvenile justice systems.

[20] Information about additional HRSA-funded programs regarding integrating behavioral health with primary medical care is available on HRSA's behavioral health website.

B. Coverage and funding mechanisms for in-home parent skill-based programs

In-home parent skill-based programs include various types of parenting skills training and parent education and do not have to take place in a home setting (as described in ACYF-CB-PI-18-09).[21] In-home parent skill-based programs can vary widely (for example, some of them focus on MH needs and are provided by MH agencies), and, therefore, potential funding sources will depend on the scope of the program. This section focuses mainly on home visiting, because in comparison with funding for other in-home parent skill-based programs, the funding sources for home visiting are more formalized and have been more systematically documented in federal guidance and other documents. Key funding sources include the following:

- **Funding for home visiting programs.** The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, administered by HRSA in partnership with the Administration for Children and Families, is the largest federal funding source dedicated to evidence-based home visiting.[22] In some states, MIECHV is the most significant or the only funding source for home visiting, but other states cover or fund home visiting with other sources such as Medicaid; TANF; Title V Maternal and Child Health Services Block Grants; and private, state, or local funds (Herzfeldt-Kamprath et al. 2017).
- **Funding for other in-home parent skill-based programs.** Because programs vary in scope and focus, potential funding sources will vary. Some programs might be coverable by Medicaid, and others might be funded by sources such as Title V Maternal and Child Health Services Block Grants; CAPTA; and private, state, and local funding.

Table 2 provides an overview of some key features of Medicaid and HRSA home visiting coverage and funding mechanisms, many of which can also apply to some other types of in-home parent skill-based programs. The subsections following the table provide additional background and narrative about these mechanisms, the impact of Medicaid managed care, and other funding mechanisms.

[21] See Box 2 of the "Assessing population, service needs, and service coverage" companion document in this toolkit regarding the definitions of and relationship between "home visiting" and "in-home parent skill-based programs." In addition, the Prevention Services Clearinghouse Handbook of Standards and Procedures (Wilson et al. 2019) includes further information about characteristics of in-home parent skill-based programs that might be eligible for the Clearinghouse.

[22] For an HRSA resource for MIECHV awardees regarding supporting families affected by opioid use and neonatal abstinence syndrome, see HRSA 2018.

Table 2. Key Medicaid and HRSA coverage and funding mechanisms that states can use for home visiting programs (and some other in-home parent skill-based programs)

Coverage or funding mechanism	Which services?	For whom?	How can a state obtain this mechanism?	Federal or state funding	Key limits	Sources
Medicaid coverage mechanisms						
Traditional Medical Assistance Services	Section 1905(a) of the SSA and 2 CFR 440 define various mandatory and optional services, and states describe details in their state plans. (For example, it can be care by other licensed practitioners [42 CFR 440.60] or home health services [42 CFR 440.70].)	Applies to most Medicaid-covered people in the state. Unless combined with another authority, services generally are statewide and comparable within types of eligibility groups.	No SPA needed if practitioner types and services are already in state plan. Changes (such as changes in reimbursement methodology) require a SPA.	State generally receives regular FMAP, currently ranging from 50 percent to 76 percent. (See Mitchell 2018.)	Services must meet definitions described in 1905(a) of SSA, which might not include all activities provided in home visiting programs.	CMCS/ HRSA 2016; Johnson 2019; Normile et al. 2017
Targeted Case Management	Services to help people in "gaining access to needed medical, social, educational, and other services." Includes assessment, care plan development, referrals to services, and monitoring or follow-up (42 CFR 440.169).	States can target services to specific populations of Medicaid-covered people and to specific geographic areas.	No SPA needed if practitioner types and services are already in state plan. Changes (such as changes in reimbursement methodology) require a SPA.	State receives applicable FMAP.	Does not cover direct medical services.	CMCS/ HRSA 2016; Normile et al. 2017
Administrative Case Management	Case management to facilitate access to and coordinate Medicaid services (such as securing authorizations for services and assisting with service coordination).	All Medicaid-covered people statewide.	Does not require a SPA. State must submit Cost Allocation Plan for administrative claims to CMS for approval.	State receives 50 percent FFP (administrative match).	Cannot be used to reimburse for direct medical services.	Johnson 2019; Normile et al. 2017
EPSDT Benefit	Any Medicaid-coverable, medically necessary 1905(a) benefit that is needed to "correct or ameliorate" physical or mental health conditions (section 1905(r) of the SSA).	Medicaid-covered children and adolescents younger than age 21. Some EPSDT services (which are medically necessary for a child and are for the child's direct benefit) might also benefit parents.	States must cover EPSDT services; therefore, state plan coverage pages are not required. State must have reimbursement methodology in state plan, so it might need to submit a SPA.	State receives applicable FMAP.	Services must be medically necessary and for the direct benefit of the child. The state cannot have hard limits on the services.	CMCS 2016; Johnson 2019

Table 2 *(continued)*

Coverage or funding mechanism	Which services?	For whom?	How can a state obtain this mechanism?	Federal or state funding	Key limits	Sources
Extended Services for Pregnant Women	Services related to pregnancy or conditions that might complicate pregnancy (42 CFR 440.250(p)).	Pregnant women and mothers up to 60 days postpartum.	State submits a SPA to CMS.	State receives applicable FMAP.	Coverage only during pregnancy and 60 days postpartum.	CMCS/ HRSA 2016; Johnson 2019
HRSA funding mechanisms						
MIECHV	Delivery of comprehensive high-quality voluntary early childhood home visiting services to families and coordination with statewide and local early childhood systems to support the needs of those families.	Pregnant women and parents with children up to kindergarten entry living in at-risk communities identified in a statewide needs assessment.	States apply annually for MIECHV formula funding. States must update their statewide needs assessment by October 2020.	Federal grant. As of 2018, HRSA allocates up to $400 million per year across states, territories, and tribal entities.	States must invest 75 percent of funding in evidence-based home visiting models; up to 25 percent can be invested in promising approaches.	HRSA home visiting website; HRSA, MIECHV Brief
Title V Maternal and Child Health Services Block Grants	Preventive and primary care services, care coordination, and case management. Some states use Title V to fund components of home visiting.	Low-income women and children.	States apply annually for Title V funding. States complete needs assessment every 5 years.	State must match every $4 of the Title V federal dollars with at least $3 in state or local funding.	State must spend 30 percent of federal funds on preventive and primary care services for children, and at least 30 percent for services for children with special health care needs. States can request waiver of this requirement.	HRSA 2019b

Notes: This table provides a high-level summary of some key features of these coverage and funding mechanisms and does not fully summarize or replace guidance from any federal agency. Although this toolkit focuses on states, many of the coverage and funding mechanisms also apply to territories, and some apply to tribal communities. Some of the rules for these mechanisms, however, vary for territories or tribal communities.

CMCS = Center for Medicaid and CHIP Services; CMS = Centers for Medicare & Medicaid Services; EPSDT = Early and Periodic Screening, Diagnostic and Treatment; FFP = federal financial participation; FMAP = federal medical assistance percentage; HRSA = Health Resources and Services Administration; MIECHV = Maternal, Infant, and Early Childhood Home Visiting; SPA = state plan amendment; SSA = Social Security Act.

1. Which home visiting programs does MIECHV fund?

Authorized by Title V, the MIECHV Program funds evidence-based home visiting programs that serve at-risk pregnant women and parents with young children up to kindergarten entry. In 2018, HRSA awarded $361 million in funding to all 50 states, the District of Columbia, and five territories.[23] States are required to prioritize services to families living in at-risk communities identified through a statewide needs assessment; states must update their needs assessments by October 1, 2020. By law, state and territory grantees must spend the majority of their MIECHV program grants to implement evidence-based home visiting models, with up to 25 percent of funding available to implement promising approaches that will undergo rigorous evaluation. The Home Visiting Evidence of Effectiveness web page includes information on which models are eligible for MIECHV funding.

State-specific information about MIECHV funds is available through HRSA, including state-by-state fact sheets of home visiting programs and populations served.

2. Which components of home visiting programs can Medicaid cover, and by what mechanisms can it do so?

As discussed in relation to MH and SUD services (see Section A.1 of this document), states can use various authorities within Medicaid to cover services. Under the Medicaid state plan (in which states detail parameters of their Medicaid program), states can use multiple benefits to cover components of home visiting programs, including the following:

- **Traditional medical assistance services.** States might consider covering some components of home visits as mandatory or optional benefits (as defined under section 1905(a) of the SSA). A joint informational bulletin by CMS and HRSA includes examples of medical assistance services that states might consider covering when they are provided as part of a home visit, such as other licensed practitioner services, preventive services, rehabilitative services, and home health services (CMCS/HRSA 2016). But some educational and care coordination activities that are part of home visits might not be covered in this way (Normile et al. 2017).
- **Case management.** Case management services (defined in 42 CFR 440.169 and 42 CFR 441.18) include comprehensive assessment of an eligible individual, development of a specific care plan, referral to services, and monitoring activities. The case management benefit does not include services such as counseling or medical services that might be provided as part of a home visit, but these services can be provided via other Medicaid benefit categories (CMCS/HRSA 2016). Types of case management that are coverable under Medicaid include the following:
  - **Targeted case management.** Most states that cover components of home visiting programs as part of Medicaid do so via the targeted case management benefit

[23] See HRSA's home visiting website for links to state-by-state information, such as formula funding award amounts.

(Johnson 2019; Herzfeldt-Kamprath et al. 2017). For targeted case management, states can define the specific populations (for example, first-time parents), specific geographic areas within a state, providers (such as lay providers), and models that can be reimbursed (Normile et al. 2017). A state plan amendment is not required if practitioner types and services are already in the state plan, but changes will require a state plan amendment.

- **Administrative case management.** Administrative case management is an optional Medicaid benefit that facilitates access to and coordinates Medicaid services (such as securing authorizations for services and helping coordinate services) (Normile et al. 2017). States can claim an administrative federal match of 50 percent for core components of administrative case management (Johnson 2019). Providing administrative case management does not require a state plan amendment, but it does require a CMS-approved Cost Allocation Plan.

Box 1. Oklahoma example: Using Medicaid targeted case management to support home visiting

Oklahoma uses the Medicaid targeted case management benefit to support home visits to low-income first-time mothers through the Nurse-Family Partnership model. The home visiting program is administered by the Oklahoma Department of Health and operates statewide. Trained public health nurses visit homes and can bill Medicaid under targeted case management or nurse assessment codes, which cover a subset of services provided during a home visit. The annual program budget is $8.5 million, of which $1 million represents Medicaid spending, more than $7 million comes from state general revenue funds, and about $400,000 comes from Maternal, Infant, and Early Childhood Home Visiting program funds (Normile et al. 2017).

States might also consider authorities for services that are focused on children or pregnant women, including the following:[24]

- **EPSDT.** As described in the context of MH and SUD services in Section A.1, EPSDT is a benefit that entitles all children and adolescents who are younger than age 21 and enrolled in Medicaid to any 1905(a) Medicaid-coverable service that is medically necessary for correcting or ameliorating conditions identified by screening services regardless of whether these are covered under the state plan (see section 1905(r) of the SSA). EPSDT can cover core components of home visiting programs that serve children, including screenings for developmental delays or for identifying health needs such as hearing and vision problems, as well as case management (CMCS/HRSA 2016).

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[24] States might also wish to consider CMCS's 2019 Informational Bulletin about residential pediatric recovery centers as an optional provider type, based on section 1007 of the SUPPORT for Patients and Communities Act. Residential pediatric recovery centers are centers or facilities that provide services to infants with neonatal abstinence syndrome and their mothers (and other appropriate family members and caretakers).

- **EPSDT benefit and parents.** As described in Section A.1, some EPSDT services (which are medically necessary for a child and are for the child's direct benefit) might indirectly also benefit parents—even those who are not Medicaid eligible. EPSDT services can therefore include some components of home visiting programs, such as family therapy (MACPAC 2015) or maternal depression screening and treatment services (CMCS 2016).
- **Extended services for pregnant women.** Through this optional benefit, states can provide services to pregnant women and mothers up to 60 days after birth as long as services are related to pregnancy or conditions that might complicate the pregnancy (Normile et al. 2017). States submit a state plan amendment to cover these services. Pregnancy-related services are those that are "necessary for the health of the pregnant woman and fetus" and include "prenatal care, delivery, postpartum care, and family planning services" (see 42 CFR 440.250(p) and CFR 440.210(a)(2)) (CMCS/HRSA 2016).

Some of these Medicaid coverage mechanisms can also apply to other in-home parent skill-based programs, though their applicability will depend on the scope of the program. A survey of states noted that 12 state Medicaid programs (of 49 responding states) paid for parenting programs designed to help parents of young children promote children's social-emotional development and address child mental health needs (Smith et al. 2017).[25] Potential settings for these programs included mental health clinics, medical settings, homes, and other community settings.

3. How do Medicaid managed care authorities impact the coverage and availability of home visiting programs?

Medicaid managed care service delivery can impact coverage and availability of services in multiple ways (see Section A.2 of this document). Some states implement home visiting under section 1915(b) or 1115 waivers, which can allow states some flexibility in how they target and design the home visiting program (Normile et al. 2017; Seibert et al. 2019). Notably, most states that cover home visiting in Medicaid (even those with managed care for other health services) pay for it on a fee-for-service basis, separate from payments to managed care entities—though some states include home visiting within Medicaid managed care (Herzfeldt-Kamprath et al. 2017; Johnson 2019). For example, Minnesota includes its home visiting program in managed care, and its Medicaid managed care entities contract with local health departments to provide home visiting (Herzfeldt-Kamprath et al. 2017).[26]

[25] Smith et al. 2017 also describes how two of these states (Michigan and Oregon) require providers to use evidence-based parenting programs.

[26] For more information about the funding and structure of Minnesota's home visiting program, see Minnesota Department of Health's website at https://www.health.state.mn.us/communities/fhv/index.html#Example1.

4. What other funding mechanisms fund in-home parent skill-based programs such as home visiting programs?

As discussed in Section A.6, some people will be enrolled in coverage such as **private health insurance** or **CHIP,** which could cover in-home parent skill-based programs.[27] In addition, **Early Head Start** offers in-home and center-based programming to support healthy child development and school readiness for families with pregnant women and children younger than age 3.[28] Families that are living in poverty, are homeless, or are receiving public assistance (such as TANF or Supplemental Security Income) can be eligible (Child Trends Databank 2018).

States can also use a variety of other relatively flexible funding mechanisms—such as **Title V Maternal and Child Health Services Block Grants, TANF,** and some **child welfare funding mechanisms (such as Title IV-B and CAPTA)**—to fund home visiting (Johnson 2019) and other in-home parent skill-based programs. For example, HRSA administers the Title V Maternal and Child Health Services Block Grant program to support access to quality health care for mothers and children—particularly those with low income or with limited availability of health services—in the 59 states and jurisdictions. Goals of the program include increasing access to prenatal and postpartum care, rates of health assessment and services for children, and access to preventive services for children. Grants are formula-based, and states must match every $4 of Title V federal dollars with at least $3 in state or local funding (HRSA 2019b). States are also required to conduct statewide needs assessments once every five years (HRSA 2019b). State Action Plans and State Snapshots, available through HRSA, offer state-specific Title V program details about funding, services (such as home visiting and parenting education), population served, and performance.

C. Additional considerations related to coverage and funding mechanisms

While planning Title IV-E prevention services and working more broadly to meet the needs of families with children at risk of entering foster care, states reported multiple challenges in relation to funding streams. These include concerns related to Title IV-E as a payer of last resort, working to braid funds, and considering funding sources for infrastructure, administration, and ancillary services.[29] Each of these concerns appears here.

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[27] As mentioned in Section A.6, with CMS approval, states can use some CHIP administrative funding for Health Services Initiatives to improve the health of children, such as public health initiatives. Some states use these initiatives to fund parenting educations services and supports (MACPAC 2019a).

[28] For more information about Early Head Start, including links to state-specific information, see https://eclkc.ohs.acf.hhs.gov/programs/article/early-head-start-programs.

[29] These examples are based on Mathematica's stakeholder discussions, which are described in the introduction to this toolkit.

1. Payer of last resort

As discussed in ACYF-CB-PI-18-09 and noted previously in this toolkit, the Family First Prevention Services Act (FFPSA) stipulates that Title IV-E is the payer of last resort. Specifically, if the cost of providing a Title IV-E prevention service to an individual would have been paid from another public or private source if not for the enactment of FFPSA, a Title IV-E agency is not considered to be a legally liable third party for the cost of providing such services to that individual with one exception: a Title IV-E agency can use Title IV-E prevention program funding under section 474(a)(6) of the act to pay a provider for these services to prevent delaying the timely provision of appropriate early intervention services (pending reimbursement from the public or private source that has ultimate responsibility for the payment) (section 471(e)(10)(C) of the act).

Therefore, if public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the Title IV-E prevention program, those providers have the responsibility to pay for these services before the Title IV-E agency would be required to pay. For example, if a parent with Medicaid coverage is receiving MH services that would be covered by Medicaid and that are also allowable under the Title IV-E prevention program, Medicaid must pay for the covered service before the Title IV-E portion (if any) is paid. This provision in effect makes Title IV-E the payer of last resort for Title IV-E prevention services in this instance.

Title IV-E agencies must consider the best ways to track, reimburse, and bill for services. For example, Title IV-E agencies have flexibility in how they set reimbursement structures and rates for Title IV-E prevention services. The agency might also consider how to identify other potential funding sources relevant to a given individual. States should consult with the Administration for Children and Families Children's Bureau Regional Offices regarding questions about Title IV-E prevention services reimbursement as the payer of last resort.

2. States' efforts to braid Title IV-E funds

As discussed in Sections A and B, many funding streams are available for funding comprehensive MH, SUD, and in-home parent skill-based programs for families with children at risk of entering foster care. In our conversations with states, many were in the early stages of planning for FFPSA and reported exploring the specifics of available funding mechanisms and planning for technical details of braiding funds (including relevant administrative functions). Most mentioned using more than one funding stream to meet the diverse needs of their population. For example, a member of the FFPSA planning leadership in the District of Columbia noted having mapped out current funding sources for services for these families; examples of funding sources used included local funding, Medicaid, CAPTA, and Title IV-B (both Stephanie Tubbs Jones Child Welfare Services grants and Promoting Safe and Stable Families).

In addition, one state planning lead summarized how some states are exploring usage of funds and leveraging partnerships to do so:

"We don't currently have any TANF funds in child welfare, and I know some states do have access to TANF. If they have it available, they can actively explore how they can meet the purposes of TANF, and free up other funds. The other area may be how to use SSBG (Title XX funds). And then I think just partnering with other entities that do some of those services. We've talked about Medicaid, but also there are home visiting funds... We're looking at how we might partner with agencies that may already be doing something like this. Is there a way we can both find greater capacity by doing it together?"

Many states discussed braiding funds to pay for home visiting programs, including potentially scaling up existing programs by using Title IV-E prevention services reimbursement for in-home parent skill-based programs. For example, Virginia funds Healthy Families America and other programs through TANF, CAPTA, and Title IV-E. In addition, Virginia's health department and private entities use MIECHV funds to offer Nurse-Family Partnership. The state has a home visiting consortium that is represented on their FFPSA planning committee.

3. Funding infrastructure and administrative activities related to evidence-based practices (EBPs)

Funding infrastructure and administrative activities related to EBPs can be challenging for states. Examples of these activities include staff training and fidelity monitoring required for many EBPs, developing and managing data infrastructure, interagency collaboration, case consultation, and reporting to the court on treatment progress. The following are a few funding sources that states can consider to support these activities:

- **Title IV-E reimbursement for administrative costs** will be available at 50 percent FFP for the proper and efficient administration of the Title IV-E prevention program. As described in ACYF-CB-PI-18-09, these include activities to develop necessary processes and procedures to establish and implement the provision of prevention services for eligible people, policy development, program management, data collection, and reporting. They also include child-specific costs, such as the development and maintenance of the child's prevention plan, and case management activities, such as verification and documentation of program eligibility, referral to services, and preparation for and participation in judicial proceedings Training for some types of staff is considered a reimbursable administrative cost (see ACYF-CB-PI-18-09 for details). Examples of staff training topics that are eligible for reimbursement include how to determine eligibility, identify and provide appropriate services, and oversee and evaluate appropriateness of services.
- **Medicaid** allows some types of investments in data systems or information technology to receive an administrative match or, in some cases, enhanced FFP (90 percent for the design, development, and implementation of systems and 75 percent for maintenance and operation). One example is technology to share data between providers and agencies (CMCS 2018a). When such systems also apply to people not covered by Medicaid, a state would need to properly allocate costs to Medicaid to be eligible for reimbursement under the Medicaid program.

- **SAMHSA block grants** can be used to support some infrastructure and administrative activities, such as staff training (including training staff to assess the fidelity of EBPs), information systems, infrastructure support (for example, crisis-response capacity), and partnerships across state and local agencies.[30]
- **Other child welfare funding.** Some Title IV-B funds can be used for program-related administrative costs, research, evaluation, training, or technical assistance (for example, see sections 422(c)(1) and 426 of the SSA) (Stoltzfus 2012). With CBCAP, states can fund activities such as training, technical assistance, and information management and reporting (ACYF-CB-PI-19-05).
- **Other funding.** TANF block grants can, for example, support a variety of services and supports for families, including for purposes related to family preservation (Rosinsky and Williams 2018; Schott et al. 2019). Because TANF block grants are quite flexible, they might be applicable to some types of infrastructure and administrative activities.

Box 2. Washington example

Washington State used its Title IV-E waiver to help plan for new services. In spring 2019, the state reported exploring mechanisms to pay for social workers' time working with families to connect them with appropriate referrals, including potentially as an administrative cost under Title IV-E prevention services reimbursement or through a coverage mechanism under Medicaid.

4. Funding for ancillary services (such as transportation and childcare costs)[31]

With respect to ancillary services for Title IV-E prevention services, the states' most commonly mentioned concerns related to the transportation costs of implementing EBPs and ensuring access to services, especially in rural areas.[32] Rural areas might have a limited pool of providers who are trained to deliver evidence-based services. In addition, if there are no local providers, some families live hundreds of miles from the nearest provider, making it very difficult to provide services for these families. It is not yet clear how families who live far from providers will receive the services described in the prevention plan or how these costs will be covered. Nevertheless, states are considering how to provide services in remote areas. In Medicaid, some states are expanding the use of telehealth to provide behavioral health services (Schober et al. n.d.). Some child welfare agencies are considering helping

[30] This information is based on the block grant application (available at https://www.samhsa.gov/grants/block-grants).

[31] The National Academy of State Health Policy compiled a matrix of funding sources available to states to address the health-related social needs (such as transportation, housing, and child care) of people with low income (see Meeting the Health-Related Social Needs of Low-Income Persons: Funding Sources Available to States).

[32] Note that although Medicaid covers non-emergency medical transportation, the scope of the benefit varies by state (MACPAC 2019b).

people access transportation by leveraging ridesharing services in areas with limited transportation options.

Some states also reported considering available funds to address the housing needs of people in families with children at risk of entering foster care. For example, the Community Development Block Grant can serve to fund housing supports. Notably, the SUPPORT for Patients and Communities Act includes a provision to facilitate creation of a pilot program that provides grants to states to support temporary housing for people in recovery from SUD (grants are to be treated as though they were Community Development Block Grant funds; section 8071 of the SUPPORT for Patients and Communities Act).

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