



Blending, Braiding, and Block-Granting Funds for Public Health and Prevention: Implications for States

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Introduction

State health officials nationwide know that many factors, such as nutritious food and safe housing, that are outside of the clinical care system are important to achieving and maintaining health. Yet, state public health agencies have historically relied on narrowly focused federal funding streams that target only one disease or condition. The tension between tightly targeted funding and broader, cross-sector approaches to health comes at a time when the federal government has proposed to reconfigure and curtail public health funding.

State innovation, such as transforming Medicaid to address a broader range of prevention and social factors that impact health, is taking place against a backdrop of federal funding uncertainty. The prospect of changes in federal policy and funding will continue to present planning challenges to state public health and Medicaid officials. There is an urgent need for state health policymakers to plan for the changes to state health programs that would ensue should significant changes come to pass, such as

What could state health leaders do with greater flexibility?

- Some states want to initiate large-scale, cross-sector, evidence-based pilot projects to better address non-medical needs such as housing and nutrition.
- Many state leaders are interested in a data-driven, systems approach to health that aligns the goals of Medicaid, public health, and social services. A cross-sector set of metrics to assess length and quality of life could be a useful tool.
- Greater support for replicating other states' successful, evidence-based programs would create great efficiencies in program implementation.

State officials remain concerned that increased flexibility may not be enough to compensate for funding cuts.

block-granting Medicaid, combining public health programs, or giving states more latitude to change mandatory essential health benefits.

This report shares insights and recommendations from state public health and Medicaid policymakers to help both federal and state leaders think strategically about possible responses to potential policy and funding changes. The suggestions presented in this document were formed by an ad-hoc group of state officials during an invitation-only meeting convened in September 2017 by the de Beaumont Foundation, in partnership with the Association of State and Territorial Health Officials and the National Academy for State Health Policy (NASHP). The suggestions below are not those of NASHP or any other organization or entity. They represent important

analysis of recent federal proposals to blend, braid, or block-grant funds for public health and prevention,¹ and may help chart a way forward for states interested in maximizing their ability to coordinate work and resources across programs.

- Develop a pathway to enable states to **pilot large-scale cross-agency federal demonstration waiver projects** that braid, blend, and align public health and Medicaid funding beyond what is permitted under current law. This could include funding from agencies such as the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), the US Department of Housing and Urban Development (HUD), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the US Department of Agriculture (USDA), in order to efficiently address health-related needs for food, shelter, and other items. States could also use such cross-sector waiver authority to **combat addiction** and **leverage synergy** between programs.
- **Align funding cycles, application processes, and reporting requirements** across federal grants, to make it easier for states to apply for and implement federal grants in line with their goals.
- **Pilot a voluntary, well-funded, public health block grant** of at least five years' duration that tests the collective impact of state public health and Medicaid agencies working together to address social factors that impact health.
- Support states in **sharing Medicaid, public health, and substance abuse data** in order to strategically plan a state program across agencies.
- Implement a **streamlined approval process** for states applying to replicate other states' successful waivers, and give states substantial **freedom to implement evidence-based public health interventions** and programs.
- **Establish a health care waiver oversight committee** made up of state and federal members to evaluate and approve state applications for waivers, including Medicaid Section 1115 demonstration waivers and Affordable Care Act (ACA) Section 1332 waivers.² This could also include fast-track waiver approval for states that use similar waivers that have already been approved in other states.
- **Use standard metrics** to determine outcomes important to both Medicaid and public health, such as the length and quality of life.³
- **Define what states can do now**, without waiting for federal changes. States could work within the existing Medicaid waiver process to establish **multi-payer payment reform** as the basis for broader, cross-sector changes. Some states are further along in this process than others in efforts to pay for value over volume, **incentivize upstream prevention**, and use Medicaid savings to address the health-related social needs of enrollees.
- State and federal leaders can also **take a systems approach** to state health planning to help form a comprehensive, intergenerational, view of the health needs of individuals and families.

Background

The proposed White House 2018 budget for the US Department of Health and Human Services (HHS) would reduce funding for public health infrastructure and services primarily by cutting \$1.2 billion from CDC's 2017 funding level.⁴ Additionally, the budget proposes significant changes to CDC's chronic disease grants to states. It is important to consider what the administration's priorities could mean for public health, even though Congressional appropriations bills differ from the proposed White House budget.⁵ Legislative proposals to eliminate the Prevention and Public Health Fund would likewise seriously impact public health budgets.⁶

States for years have been working to safeguard the health of populations with flat funding for ongoing public health capacity and infrastructure, with temporary funding for selected emergencies such as Ebola and Zika.⁷ State public health departments have been called upon to respond to threats from emerging infectious diseases, the opioid crisis, natural disasters such as hurricanes, and catastrophes such as the lead poisoning in Flint's water—all without significant federal support. Medicaid has also taken an active role in responding to these public health crises. For example, Michigan received fast-track approval for a Section 1115 Medicaid demonstration waiver to cover residents affected by the Flint water crisis.⁸ Despite the gravity of these new and perennial challenges, state public health funding has remained roughly level on average nationwide for nearly a decade, when adjusted for inflation.⁹ Medicaid spending on public health priorities, in response to the emergencies noted above, may offset some of this flat public health funding. However, Medicaid must also carry out its core responsibilities in the face of its own budget constraints. State Medicaid and public health agencies also traditionally focus on different populations, with Medicaid responsible for the health of its enrollees, and public health responsible for the health of the entire state's population.

In addition to combating infectious disease, state health leaders are also moving upstream to prevent chronic disease. Upstream interventions include designing communities with safe and tobacco-free spaces for play and exercise, and other non-clinical efforts to keep people healthy.¹⁰ As part of this trend, many state Medicaid programs are collaborating with public health departments on these initiatives. Some state Medicaid programs are also addressing upstream prevention and the social determinants of health, in an effort to improve health and control costs.¹¹ Medicaid Section 1115 demonstration projects in Massachusetts and Oregon permit accountable care entities to use Medicaid funds for flexible, health-related services to address social needs such as nutrition and healthy housing.¹² However, while Medicaid is an important partner in advancing state public health goals, it should not be considered a funding source to fill gaps created by state or federal public health budget cuts.

An increasing number of state policymakers are thinking beyond the clinical care paradigm to recognize that people's environments and communities are key contributors to their health—and health problems.¹³ Examining state funding models that incorporate that shift to clinical and community thinking could help state policymakers identify the types of federal flexibility needed to efficiently replicate those models.

State public health and prevention funding may be threatened if legislative proposals to eliminate the Prevention and Public Health Fund (PPHF) gain traction.¹⁴ The ACA created the PPHF and mandated annual appropriations to support a broad (and unspecified) range of programs. In recent years, Congress itself has chosen the specific programs to fund through the PPHF, most of which existed long before the ACA, such as vaccine programs and the Preventive Health and Health Services block grant.¹⁵ Proposals to eliminate the PPHF call into question the future of that funding, including funding for long-standing programs that predate the PPHF, which may or may not be funded if the PPHF is abolished. States received over \$625 million from the PPHF in fiscal year 2016.¹⁶

The FY 2018 President's budget also proposed a consolidation of CDC chronic disease programs. Variations on this theme have been debated in previous appropriations cycles, and the previous Administration made proposals for greater integration of chronic disease funding. Therefore, even if the White House proposal is not adopted, it is possible that some form of consolidation will be considered.

Roughly three-quarters of the CDC's budget supports state and local programs, including those funded by PPHF.¹⁷ In addition to these public health cuts, the proposed White House FY 2018 budget would reduce Medicaid spending by \$610 billion over 10 years.¹⁸ The proposed budget would also cut HUD housing assistance¹⁹ and shift some of the cost of the Supplemental Nutrition Assistance Program (SNAP) to states by phasing in a new requirement for states to match part of the program costs.²⁰ While it is unclear at this time whether Congress will revisit health care legislation, recent proposals to repeal and/or replace ACA have also included significant cuts and changes to Medicaid and public health funding.²¹ Significant cuts to public health, Medicaid, and the social safety net would force states to make difficult choices about how to spend the reduced funding.

Approach

This paper examines historic and existing sources of block-granted and categorical, disease- or condition-specific, federal funding to states in support of public health goals, and how states currently use those funds. It also looks at states' use of Medicaid waiver authorities to support public health goals, and at ways in which public health and Medicaid have worked together. It proposes state responses to possible federal funding scenarios, focusing on potential changes to federal CDC funding. These response scenarios—which are not mutually exclusive and do not represent the full range of possible responses to cuts—highlight the benefits and challenges of each response.

Categorical Imperatives: History of Block Grants and Categorical Funding for Public Health

Historical changes to public health and health-related funding streams shed light on current budget proposals. One pivotal moment in funding for health and social services programs was the passage of the Reagan administration's 1981 block grant legislation, which affected more than 50 categorical funding streams. The Omnibus Budget Reconciliation Act of 1981 (OBRA) combined those grant programs, as well as three existing block grants, into nine block grants, to be administered by states.²²

While the block grants were intended to provide states with more funding flexibility, they also reduced the funding available to states (see Figure 1).²³ Then as now, it made it difficult to assess the block grants on their own merits. According to a 1984 Government Accountability Office (GAO) report, "It was often difficult for individuals to separate the block grants—the funding mechanism—from block grants—the budget-cutting mechanism."²⁴

Some of the block grants created by the sweeping 1981 legislation and accompanying budget cuts still exist today, and they could be affected by additional cuts proposed by the current Administration.

Figure 1. Selected Block Grants Created in 1981

Block Grant	Agency	Programs Replaced	Reduction in Funding: Year One (1982), Compared to Programs Replaced	Reduction in Funding: 1982-2017†	Flexibility	Can States Transfer \$ to Other Block Grants?
Preventive Health and Health Services	CDC - OSTLTS	<ul style="list-style-type: none"> - Health incentive grant - Health education and risk reduction - Hypertension - Fluoridation - Emergency medical services - Urban rat control - Home health services²⁵ 	-14.5%*	-21%	Initially required large set-asides requirements, but no longer	Yes
Maternal and Child Health	HRSA - MCHB	<ul style="list-style-type: none"> - Disabled children's program - Maternal and child health - Lead-based paint poisoning prevention - Sudden infant death syndrome - Adolescent pregnancy prevention - Genetic disease testing and counseling - Hemophilia diagnostic and treatment centers - Disabled children receiving supplemental security income benefits²⁶ 	-18%**	-29%	Contains metrics and set-asides for children with special health care needs, and preventive and primary care for children	No ²⁷
Social Services Block Grant	HHS – ACF	Title XX programs ²⁸	-20%***	-73%	Very flexible	Yes

*<http://www.gao.gov/assets/150/141487.pdf>

**<http://www.gao.gov/assets/150/141495.pdf>

***<http://www.gao.gov/assets/230/220911.pdf>

† Adjusted for inflation. Adjusting for population as well as inflation yields greater percentage change. Source: CBPP, <https://www.cbpp.org/research/federal-budget/block-granting-low-income-programs-leads-to-large-funding-declines-over-time>

The Preventive Health and Health Services Block Grant

In 1981, OBRA merged seven public health grants—a health incentive grant, health education and risk reduction, hypertension, fluoridation, emergency medical services, urban rat control, and home health services—to create the Preventive Health and Health Services block grant (PHHS).²⁹ The creation and evolution of PHHS sheds light on flexibility and funding issues widely applicable to other block grants.

PHHS did not only combine existing funding streams—it cut them. Initial funding for the grant represented a roughly 14.5 percent reduction in funding for the programs it replaced. Its funding dropped 21 percent between 1982 and 2015, adjusted for inflation.³⁰ Today, PHHS is a flexible source of funding

to support states' work toward the goals of Healthy People 2020.³¹ PHHS, like some of the other 1981 block grants, allows states to transfer funds from it to other block grants, giving states even greater latitude to fund a range of priorities. Since 2014, funding for the block grant has been provided through the Prevention and Public Health Fund, which was created by the ACA.³²

PHHS did not entirely abolish requirements to fund specific programs and priorities.³³ For example, it initially set-aside 75 percent of its funding for hypertension programs.³⁴ However, that set-aside was abolished in 1985, and allocation decisions have since largely been left up to the states, as long as states and localities do not use PHHS to replace state and local funds.³⁵ Despite this flexibility, federal officials are still able to leverage the funds to advance federal priorities. For example, the 2009 Omnibus Appropriations Act required states receiving PHHS funds to develop a plan for reducing health care-acquired infections, but did not require that funds be used to implement the plan.³⁶

The GAO reports that the creation of PHHS relieved some administrative burden for states. In fact, it reports that before this block grant, Texas state officials were required to submit a total of 90 copies of applications for the five categorical programs that had been replaced by the PHHS block grant. Some states also reported that the block grant's relief from administrative requirements, such as reporting requirements and preparing grant applications, allowed their staff to spend more time on program activities.³⁷

With additional flexibility came additional responsibility for states to manage programs funded by PHHS, establish funding priorities, and oversee program administration and results.³⁸ With the advent of PHHS, states were required to hold public legislative hearings and draft public reports on their proposed use of grant funds. Many states gathered input from the public and interested stakeholders through advisory groups and committees, as well as through public hearings. Governors and state legislators were called upon to play a more active role in making funding decisions under the new block grant structure, with its diminished funding, than they played under the categorical grants.³⁹ States also were—and remain—responsible for overseeing the service providers and other partners who carry out PHHS-funded activities, and did not necessarily release service providers from administrative burdens in response to their own relief from some federal requirements. In short, PHHS required states to invest resources in actively managing it.

While states were generally satisfied with the flexibility of the block grant approach, the reduced funding levels concerned state officials and other stakeholders. State officials reported that benefit derived from additional flexibility was somewhat counterbalanced by funding cuts, while interest groups generally opposed the block grants because the diminished funding resulted in cuts to services for particular populations or conditions.⁴⁰

The flexibility that allows states to use PHHS for a wide range of programs and activities also makes it difficult to conduct meaningful state-to-state and year-to-year comparisons of the program's effectiveness.⁴¹ Proposals by multiple administrations to eliminate PHHS⁴² have been motivated in part by the difficulty demonstrating its impact and accountability. States, too, may struggle to make the investments necessary to measure the impact of their activities in the absence of rigorous federal reporting requirements, which could undercut their advocacy for sustained PHHS funding.

Title V Maternal and Child Health Services Block Grant Program

Like PHHS, OBRA of 1981 created Title V Maternal and Child Health Services block grant program (MCH) by combining eight categorical programs: disabled children's, maternal and child health, lead-based paint poisoning prevention, sudden infant death syndrome, adolescent pregnancy prevention, genetic disease testing and counseling, hemophilia diagnostic and treatment centers, and disabled children receiving supplemental security income benefits.⁴³ In the first year of MCH, funding decreased by 18 percent compared to the funding for the categorical programs.⁴⁴ MCH's funding dropped 29 percent between 1982 and 2015 when adjusted for inflation.⁴⁵

Today, MCH funding is divided into three categories: grants to state health agencies based on the number of children in poverty make up approximately 85 percent of funding, and competitive discretionary grants that address Special Projects of Regional and National Significance and Community Integrated Service Systems make up the rest.⁴⁶ States are required to spend 30 percent of their MCH funds on children with special health care needs (CSHCN), and 30 percent on preventive and primary care for children.⁴⁷ Some advocates suggest the success of MCH may be due to this mix of set-asides and the accompanying spending formula.

Social Services Block Grant

The Social Services Block Grant (SSBG) grew out of the Title XX block grant, which predated the 1981 OBRA.⁴⁸ Its funding was reduced by roughly 20 percent in the first year—the largest cut experienced by any of the new 1981 block grants. SSBG provides funding to states to support a range of services and activities aimed at promoting self-sufficiency and preventing abuse of vulnerable populations, including children, the elderly, and people with disabilities. Examples include home-delivered meals, employment services, and support for child care and transportation.⁴⁹

States are empowered to use SSBG funds for a broad range of activities, and may also transfer up to 10 percent of SSBG funds to other programs, such as Temporary Assistance for Needy Families (TANF). This flexibility may have eroded some support for the block grant, as evidenced by efforts to repeal it on the basis that it lacked accountability and duplicated other funding streams.⁵⁰ It can be challenging to shore up support for programs if loosened state reporting requirements mean that federal officials are not fully aware of how states are spending their funds. The 2018 White House budget currently proposes to eliminate SSBG.⁵¹

CDC Chronic Disease Categorical Funding

In addition to block grants, states also rely on CDC chronic and infectious disease categorical funding to address particular conditions and risk factors, such as tobacco use and different types of cancer. The CDC awards these funds to state programs that address infectious diseases such as influenza, HIV/AIDS, viral hepatitis, sexually transmitted infections, emerging and animal-borne diseases, and chronic diseases such as heart disease and stroke, diabetes, and different types of cancer.⁵²

States also use categorical funding to meet the goals and requirements associated with each funding stream. Many states rely on the categorical funding streams to support staff and programs with the focused expertise necessary to produce the deliverables required by each grant. “We created silos for functional reasons,” said one state official. In turn, federal officials acknowledge that many states operate separate programs for conditions such as diabetes and hypertension because of the categorical nature of CDC funding requirements.

In an effort to enhance flexibility available under current funding streams, federal policymakers combined some funding streams to states⁵³ through CDC programs such as:

- The Coordinated Chronic Disease Prevention program, which advances health promotion and chronic disease prevention.⁵⁴
- The State Public Health Actions to Prevent and Control Diabetes, Obesity, and Associated Risk Factors, and Promote School Health (DP13-1305) program.⁵⁵
- The WISEWOMAN program, which addresses multiple conditions within one program. It helps participants receive additional preventive services and screenings in conjunction with the National Breast and Cervical Cancer Early Detection program.⁵⁶
- The Cooperative Agreement for Public Health Emergency Preparedness give states latitude to build their public health infrastructure and workforce to strengthen emergency responses. The grant has placed disease detection field staff in 33 states, and supported laboratory infrastructure and other cross-cutting investments. However, states have reported challenges in using the annual discretionary funds to build a stable public health emergency management workforce.⁵⁷

Some recent CDC programs have also encouraged state and local coordination at the community level:

- Funded through PPHF, Community Transformation Grants helped states, community organizations, and local governments implement programs that address chronic diseases at the community level.⁵⁸ From 2011 to 2014, the grant supported cross-condition health and wellness strategies such as increasing physical activity and healthy eating.⁵⁹
- The Healthy Communities Program similarly addressed physical activity, nutrition, and tobacco use before it ended in 2012.⁶⁰
- Through the ongoing Racial and Ethnic Approaches to Community Health program, CDC funds state and local health departments and community organizations to reduce health disparities across a range of conditions.⁶¹

Some state leaders are fashioning their own flexible solutions while working within the defined parameters of CDC's categorical funding streams. For example, Scenario Two describes Oregon's silo-cracking public health transformation.

Temporary Aid to Needy Families (TANF)

When states have broad discretion to use block grant funds as they choose, they do not always use them for the purposes Congress intended. One example of that is the TANF program. After the federal government eliminated the Aid to Families with Dependent Children cash assistance program in 1996 and replaced it with the TANF block grant, the percentage of TANF funds states spent on cash assistance to needy families fell from 77 percent in 1997 to 36 percent in 2011. Nearly 4 million families per month received cash assistance in 1997; only 1.4 million families received it in 2014.⁶² Federal flexibility allows states to spend TANF funds on things other than cash assistance, or save them.⁶³

State officials recognize the need to ensure that a new public health block grant would not follow TANF's example and be used for other purposes. "I understand the need to make funding categorical, and not use diabetes funding to pave roads," said one state official.

Medicaid

Roughly one in five people in the United States—69 million individuals—are covered by Medicaid, a program designed to cover low-income people including children, senior citizens, pregnant women, some adults, and people with disabilities.⁶⁴ States have latitude in determining the eligibility standards for their Medicaid programs within broad federal guidelines. For example, some states cover pregnant women whose incomes are above 300 percent of the federal poverty level (FPL), while other states only cover pregnant women with incomes at or below 133 percent FPL.⁶⁵

The ACA as written required states to expand Medicaid eligibility to single, non-elderly adults up to 133 percent of the federal poverty level, and provided increased federal funding to support this expansion.⁶⁶ The Supreme Court decision in the *National Federation of Independent Business v. Sebelius* effectively rendered the Medicaid expansion optional for states.⁶⁷ People who qualify for Medicaid under their state's eligibility requirements are entitled to guaranteed coverage, whether or not they live in a state that expanded Medicaid.⁶⁸ The fact that Medicaid is guaranteed to those eligible sets it apart from non-entitlement programs, such as affordable housing programs that serve less than one-third of eligible recipients.⁶⁹

Medicaid is a partnership between states and the federal government, with both parties bearing a portion of the program's cost. Currently, the federal government pays from 50 to 75 percent of states' Medicaid expenses, with wealthier states generally receiving lower levels of federal support, known as the Federal Medical Assistance Percentage (FMAP).⁷⁰ State FMAPs are adjusted based on economic changes, particularly per-capita incomes over a three-year period.⁷¹ In return for the federal funds, state Medicaid programs must follow federal requirements to cover certain populations and provide them with certain services.

Existing Flexibilities

Within these federal requirements, states currently have the flexibility to tailor their Medicaid programs. States can use Medicaid State Plan Amendments to make a range of permanent changes to their programs and waive some federal requirements. States can also use several different waiver authorities to, for example, provide long-term care services in home and community-based settings rather than in institutions. Section 1115 demonstration projects permit states to evaluate the effectiveness of a wide range of modifications to Medicaid eligibility requirements, benefit packages, and or service delivery methods.⁷² States can also structure their benefits according to an alternative benefit plan (ABP), which allows them to provide different benefits to different subgroups, within federal parameters.⁷³ The waivers and demonstration authorities are generally time-limited, and place some boundaries on how much flexibility they allow.⁷⁴

At least seven states that chose to accept federal funding to expand Medicaid eligibility did so through the Section 1115 demonstration waiver process.⁷⁵ Some states are also seeking to impose work requirements, require premium contributions, or place other conditions on their Medicaid recipients through the waiver process. CMS, which reviews states' Section 1115 demonstration project requests, has signaled its support for these conditions, whereas the previous Administration refused state requests to predicate Medicaid enrollment on work requirements.⁷⁶

Medicaid and Federal Health Reform

Recently proposed federal legislation would change Medicaid from an entitlement program, which guarantees coverage to anyone who qualifies, to a program with limited financing. Both the American Health Care Act⁷⁷ passed by the House of Representatives and the Senate's proposed Better Care Reconciliation Act⁷⁸ would have instituted a per-capita limit on spending for Medicaid beneficiaries. Both bills would also have allowed states to finance their Medicaid programs through a block grant, with increased state flexibility accompanying the diminished funding. Although neither bill nor financing model passed, revamping Medicaid financing using these approaches remains a priority for some lawmakers.⁷⁹

Per-capita caps: The proposed legislation would have established a maximum federal funding limit for state Medicaid programs. The spending limit would generally be based on the number of people enrolled in each state's Medicaid program during a base year, and would be indexed in subsequent years. If a state exceeded this maximum limit—its per-capita cap—its Medicaid allocation would be reduced in the subsequent year. Certain groups and expenditures would be excluded from the per-capita cap funding formula.⁸⁰

Block grants: Providing Medicaid funding to states through block grants would also change Medicaid from a program that must provide certain services to everyone who is eligible, to one supported by a fixed pool of funds. Under a block grant, states would have considerable flexibility to decide which services and populations to cover, and what sorts of cost-sharing, work requirements, or other conditions to impose within loose federal guidelines. Because these new funding mechanisms would reduce the amount of federal Medicaid funds provided to most states, the Congressional Budget Office expects states will respond by restricting Medicaid eligibility, eliminating some covered services, or both.⁸¹

Four Types of State Responses to Federal Funding Cuts

Current federal proposals could reduce the current constellation of block grants and categorical funding sources to fewer, and potentially smaller, block grants in exchange for greater administrative flexibility. States may respond by keeping their operations status quo, albeit on a smaller scale. Alternatively, the federal changes may spur greater inter- and intra-agency alignment, as state leaders could use flexible funding to break down categorical silos and maximize efficiencies in administration. The four scenarios below represent a range of responses and are designed to help state policymakers craft their own strategic responses.

While the scenarios appear to represent a continuum of approaches, from more siloed to less, the situation on the ground may not be so clear or linear. One policymaker noted that states' responses to federal changes are not necessarily either/or reactions. For instance, some states currently work across sectors on some programs and initiatives but not others. Similarly, cities and counties may combine public health funding streams in innovative ways, while the state maintains disease-specific programs. The degree of difficulty and change inherent in each of the four scenarios may also not follow a straight-line trajectory.

The below four scenarios highlight the pros and cons of hypothetical state responses, designed to help state officials consider responses to changing federal funding for public and population health. The first three scenarios respond to this fictional funding situation:

A new block grant, such as the Administration’s FY 2018 America’s Health Block Grant proposal, has replaced existing public health block grants and many CDC categorical formula grants. States now have greater flexibility to apply federal public health dollars to their state-specific needs. However, net public health funding to states is cut significantly. This would be the latest in a lengthy series of state public health funding cuts.⁸²

Figure 2. Four Scenarios: Benefits and Challenges

Scenario		Benefits	Challenges
1	Status Quo: A state maintains its health department’s structure, but scales back in response to budget cuts	It’s easier in the short run because no state agency reorganization or realignment is required	<ul style="list-style-type: none"> - Sustaining operations that meet department goals is challenging - State officials do not leverage their increased flexibility to compensate for reduced funding
2	Department-Wide Change: A state breaks down disease- or program-specific silos within a department	<ul style="list-style-type: none"> - There is an opportunity to maximize synergy between programs, reassign staff more efficiently - Decision-makers share health department priorities - Reduced reporting burden and administrative support for categorical programs 	<ul style="list-style-type: none"> - Time and resources are needed to reorganize, transition staff, and maintain an integrated infrastructure - Risk losing focused expertise - Increased flexibility may not compensate for reduced funding
3	Cross-Sector Integration: A state breaks down silos across departments and sectors	<ul style="list-style-type: none"> - There is an opportunity to leverage a range of state resources and expertise to improve health and upstream prevention - Greater flexibility allows for innovation and a reduced reporting burden 	<ul style="list-style-type: none"> - Complex models require dynamic governance and cross-sector leadership - Potential for unintended consequences - Intensive advocacy and lobbying may accompany the allocation and prioritization of funds - Potential for “turf battles” among agencies - Increased flexibility may not compensate for reduced funding
4	No Federal Change: A state uses existing waivers and policy levers to braid, blend, and realign funding streams	- A state uses existing policy levers without relying on new federal action	<ul style="list-style-type: none"> - Siloed federal funding makes cross-agency work challenging - Using existing Medicaid waiver authority can be burdensome for states, and waiver approval can take years

Scenario 1: A State Maintains the Status Quo

A state's health department continues its work and programs as usual. However, it lays off some staff in response to budget cuts, and leaves some vacant positions unfilled. These losses are spread fairly evenly across programs, and the surviving staff try valiantly to maintain the same level of service and productivity that existed before the budget cuts. As federal funds dwindle, staff and resources are spread so thin that it becomes difficult to achieve desired outcomes in any program area. Legislators and stakeholders point to the ineffectiveness of the resource-starved department as justification for further cuts. Public and population health suffers.

As described above, some states try to keep their public health programs as close to status quo as possible in the face of budget cuts by absorbing cuts evenly. Under this scenario, states continue to operate separate chronic disease programs, environmental health activities, infectious disease investigation and surveillance departments, and other functions as best as they can with reduced funding. Alternatively, states could prioritize some programs and cut others. This approach requires states to make difficult choices about whether to invest in conditions and outcomes that affect the greatest number of people, those that demonstrate the greatest disparities between populations, or those expected to respond most robustly to increased investment.

Past experience shows that significant reductions in federal funding, as suggested in this scenario, eventually result in states discontinuing or scaling back public health programs due to lack of funds.⁸³ State and local health departments would likely shed staff through attrition, layoffs, or unpaid furloughs, as happened in the aftermath of the 2008 recession. Nearly 20 percent of state and local health department jobs nationwide were lost between 2008 and 2014, and more than 40 percent of state health departments cut programs addressing chronic diseases, HIV/AIDS, sexually transmitted infections, and family health and nutrition during that time period.⁸⁴

When their diminished resources are overwhelmed, states may lean more heavily on federal assistance to respond to emergencies, such as natural disasters or emerging infectious disease outbreaks. Some states already rely on Congressional appropriations to bolster Zika preparedness and response.⁸⁵ States' ability to rely on this emergency funding would depend on the amount of federal funds available through the proposed Emergency Response Fund⁸⁶ or other funding vehicles. As noted above, Medicaid has also come to states' assistance during public health crises. Its ability to do so in the future may be compromised by the White House budget proposal to cut Medicaid by \$610 billion over 10 years.⁸⁷ If Medicaid funding is reduced and allocated through block grants, states might be able to use some enhanced administrative flexibility to align Medicaid funding more closely with the needs of the diminished public health programs.

Benefits, Challenges, and Considerations

States that attempt to maintain the status quo across departments and programs in the face of profound changes to federal Medicaid and public health funding face a host of challenges.

- Maintaining the status quo sidesteps the need for organizational restructuring and the upheaval that often ensues. However, diminished funding will nevertheless force leaders to make difficult decisions about which programs to prioritize and sustain. In the meantime, staff and infrastructure are likely to be overwhelmed and stretched past capacity.
 - “Trying to stay status quo with reduced funding leads to disaster,” noted one state official.
- Continuity avoids fracturing coalitions of public health advocates, who may have invested considerable resources into building relationships and expertise.

- Maintaining even reduced categorical programs leaves a framework in place that can be rebuilt if the fiscal environment changes.
- States may have to choose whether to use their own funding to maintain programs and services previously supported by categorical funding.
 - After the creation of the 1981 block grants, some states were initially able to use carried-over funds from the recently defunct categorical funding streams to smooth the transition to the block grant. Once those carried-over funds dried up, some states used their own funds to make up for the shortfall.⁸⁸
- What can policymakers learn from states' experiences with funding cuts in the aftermath of the 1981 block grants and the Great Recession?
- Could state leaders take a hybrid approach by maintaining the status quo in some programs or divisions, but also making some agency-wide structural changes in others? If so, how would they make decisions while navigating the competing priorities of providers, constituency groups, advocates, and other stakeholders?

Scenario 2: Department-Wide Change

With support from executive leadership, a state health department decides to invest time and resources to reorganize. After spending a year speaking with stakeholders, reviewing funding sources and accountability requirements, and identifying department-wide goals and priorities, the department rolls out its plan. Some programs and functions are cut or transferred to community partners. Remaining programs are integrated, with a focus on aligning initiatives, metrics, and data collection. Some staff leave, and those who stay take time to adapt to their new roles. Eventually, after the planning and adjustment period, the department ramps up its new integrated programs and is on track for measurable success. The new block grants reduce staff time spent on reporting and administration, but it is not clear whether that time saved compensates for the overall loss of funding.

As suggested above, some states braid, blend, and/or align funding streams to maximize available resources in support of public health priorities. In this scenario, states identify areas where their health department's work was previously siloed by separate federal funding streams—such as condition-specific chronic disease programs, or, if flexibility extended beyond existing proposals for chronic disease programs, separate state programs for HIV and viral hepatitis⁸⁹—and make strategic decisions to combine and/or more closely align their work in those areas. States also look for other efficiencies by coordinating and possibly braiding funds across programs within a state's public health department. Oregon's example is a model for states considering this approach.

Oregon. Between 2008 and 2012, the Oregon Health Authority's Public Health Division reorganized its siloed Health Promotion and Chronic Disease Prevention Section into a more integrated model. The goal was to integrate programs funded by **more than 20 categorical grants** to better address the factors underlying a range of chronic diseases. It also sought to ensure that staff and partners worked collaboratively toward that common mission.⁹⁰

Oregon did not require a waiver from federal officials in order to braid together its categorical funding. Instead, officials aligned their grant objectives before submitting applications. As a result, they were able to bring together more than 20 different categorical funding streams to support their integrated model.⁹¹ While this approach did not require a federal waiver, it also did not reduce Oregon's reporting burden. State officials had to show federal funders that they were meeting the expectations of the categorical programs while simultaneously proving to federal leaders that their new strategy was moving toward systemic change in the state.

To accomplish this department-wide breaking down of silos, the division **reorganized its staff according to function** (such as disease surveillance, communications, or policy) instead of segregating them by disease condition or topic area as had been done previously. As a result, their tobacco staff person could be simultaneously working on cancer objectives, or vice versa. Instead of having staff funded by categorical tobacco and cancer grants each analyzing data from the Behavioral Risk Factor Surveillance System (BRFSS) separately for use in their respective programs, dedicated staff perform one BRFSS analysis and share it across the department.

Benefits, Challenges, and Considerations

States working to break down silos within a public health agency in order to more efficiently and effectively meet their goals face a number of challenges and opportunities. States integrating public health silos in response to federal funding cuts will face even greater challenges, coupled, perhaps, with a greater sense of urgency.

- One benefit to breaking down silos within a public health agency, as opposed to across agencies, is that the agency's staff share a mission and focus. This means that decisions about the use of newly braided or blended funding still reside within the public health agency and will be made by leaders who generally share the agency's goals, instead of by others who may have competing priorities.
 - Even within the department, leadership must establish priorities in order to decide how the reduced funds are allocated.
- Enhanced flexibility within state Medicaid programs, such as through the Section 1115 demonstration waiver process, could enhance synergies between Medicaid and public health agencies. For example, Oregon's renewed Medicaid Section 1115 demonstration project waiver holds the state's Medicaid coordinated care organizations (CCOs) accountable for a range of improvements in focus areas, one of which involves coordinating public health services and other resources to address chronic diseases within a specific geographic area.⁹²
- Integrating categorical programs requires staff time to establish effective infrastructure for collaboration.
 - Establishing and transitioning to a new model also occupies time and resources that could otherwise have been spent on programs.
 - Staff may have difficulty transitioning to the model, especially if they have not had meaningful involvement in planning and implementation.
 - Departments risk losing valuable, condition-specific staff expertise cultivated by categorical grant-funded programs.

Scenario 3: Cross-Sector Integration

After working for years with private philanthropy groups and state Medicaid, housing, and education agencies, the state's public health agency asks federal officials for permission to pool its newly block-granted—and reduced—federal public health funds with federal funds that support the state's housing authority or education department. Those pooled funds would be used to address upstream prevention such as tobacco-free housing for homeless children with asthma or diabetes and their families, with access to safe recreational spaces and healthy food choices.

To administer the pooled funds at the state level, executive staff would create a governance structure composed of leadership from all the state agencies involved and task them with establishing shared goals and priorities for the funds. State staff from those agencies would be required to work together on shared terminology, eligibility requirements, and data and reporting systems. For the pool to be successful, all constituencies and their advocates need to support the shared goals and believe that their interests were served. This may be challenging to accomplish with the reduced levels of federal funding.

Attention to upstream prevention and social determinants does not stop at the doors of state public health and Medicaid agencies. In addition to aligning priorities and funding within health departments and across state agencies, states might consider whether they would benefit from a new waiver idea that would bestow flexibility—similar to Medicaid waiver authority—upon public health, housing, or other state agencies to address public and population health and upstream prevention. This approach would build on strategies currently employed in some states to marshal the resources of a host of agencies—such as public health, Medicaid, housing, education, social services, transportation, and criminal justice agencies—and devise innovative funding structures to support the cross-agency work.⁹³

Virginia's Children's Services Act blends state juvenile justice, behavioral health, education, and social services funds to provide flexible funding to address the health and social needs and goals of at-risk youth and families. The program's child-centered approach and **pooled funding** system gives it the flexibility to provide unorthodox services to support children and families, such as **building an addition** on a grandmother's house to keep her grandchildren out of foster care. Child-serving state agencies collaborate on the administration of this state-supervised, locally administered program. Medicaid funds are braided with pooled state funds to support an overall plan of services and supports.⁹⁴

Vermont's Blueprint for Health similarly **braids funding** from private partners to support initiatives such as the Support and Services at Home (SASH) program.⁹⁵ SASH braids funds from a number of state agencies and programs, including Vermont's Department of Health, Department of Disabilities, Aging, and Independent Living, and the Vermont Housing and Conservation Board, as well as a Medicaid Section 1115 demonstration waiver,⁹⁶ a Multi-Payer Advanced Primary Care Practice initiative from CMS,⁹⁷ the Million Hearts initiative from CMS and CDC,⁹⁸ and private sources.⁹⁹ The program seeks to lower costs and improve health outcomes for elderly residents of affordable housing by providing individualized nurse coaching, care coordination, and health and wellness education, and linking participants to community resources. An independent evaluation of the program found that Medicare expenditures grew more slowly for SASH participants than a comparison group.¹⁰⁰ In 2018, SASH will be funded by Medicare through the Vermont All-Payer model via the Medicare Next Generation Accountable Care Organization (ACO) Risk Program.¹⁰¹ One state official described that **all-payer model** as similar to a block grant that encompasses public health, Medicaid, and Medicare. CMS provided start-up funding for the all-payer ACO, which will partially fund SASH and other programs that support collaboration between community providers and clinical practices. Statewide accountability measures are designed to incentivize collaboration between state public health and the care delivery system.¹⁰²

South Carolina couples the flexibility available through Medicaid waivers with private philanthropic donations and pay-for-success investments in support of population health goals. The South Carolina Department of Health and Human Services (DHHS) leads a **Nurse-Family Partnership Pay-for-Success Program** that braids Medicaid funding through a 1915(b) waiver with pooled philanthropic funds.¹⁰³ DHHS entered into a contract to conduct an **evidence-based program** in which public health nurses visit low-income new mothers in their homes to reduce preterm births and improve health outcomes.¹⁰⁴ If the program is successful, as determined by an outside evaluator, the state will make success payments to its funders.

The program **blends funds into several braids**. It blends funds from several private investors and philanthropic organizations together, and then braids them with Medicaid funds pursuant to a Medicaid Section 1115 demonstration waiver.¹⁰⁵ The braided funds are all collected and held in escrow by an outside trustee, who disburses the success payments and protects the funds from shifts in political leadership.¹⁰⁶ The state was able to successfully leverage its public health and Medicaid infrastructure to attract outside investors.

These examples show that some states are already coordinating across sectors to meet public and population health goals. The flexibility currently available through the Medicaid waiver process has helped some states break down silos. Waiver authority from the federal government for public health agencies to test innovations, similar to Section 1115 waivers, could amplify and accelerate cross-sector innovations in public health. If states received similar waiver authority in housing or nutrition support programs, they might be able to pool federal funds from these sectors to meet public and population health goals. This sort of cross-sector blending and braiding could be directed by a state health official working with other agency leaders to align efforts in the service of a common vision.

Benefits, Challenges, and Considerations

States may plan to capitalize on the flexibility rendered by a federal block grant similar to those recently proposed,¹⁰⁷ or a hypothetical new waiver authority that allowed states to braid or pool federal funds across state agencies, possibly enacted as part of Congressional restructuring of federal grant programs. This approach would allow states to use federal funds in ways that align with their statewide and local public health priorities, and would incentivize cross-sector partnerships. Any new flexibilities available in Medicaid block grants or existing waiver authority could also be used to support cross-sector partnerships to address the social determinants of health and health-related social needs.

- Successful cross-sector braiding and blending initiatives are complex and require active governance and implementation, as well as the support of stakeholders and advocates.
- This flexibility might allow states to use federal dollars to leverage more private investment.
- States need to be responsive to any unintended consequences that arise, such as vulnerable populations inadvertently left behind once federal mandates are relaxed.
 - Federal requirements currently give states cover for continuing important public health programs that may be locally unpopular.
- As with the other scenarios, the reduced funding that accompanies such flexibility makes it difficult to predict how much public health and Medicaid initiatives would suffer due to reduced funding even under new, innovative models.

Scenario 4: No Federal Change

State health policymakers have heard federal officials promise more flexibility to design and administer public health programs, and to modify Medicaid design and eligibility standards. They have also heard that federal funding for their health programs might be reduced. Faced with this federal uncertainty, state officials take matters into their own hands.

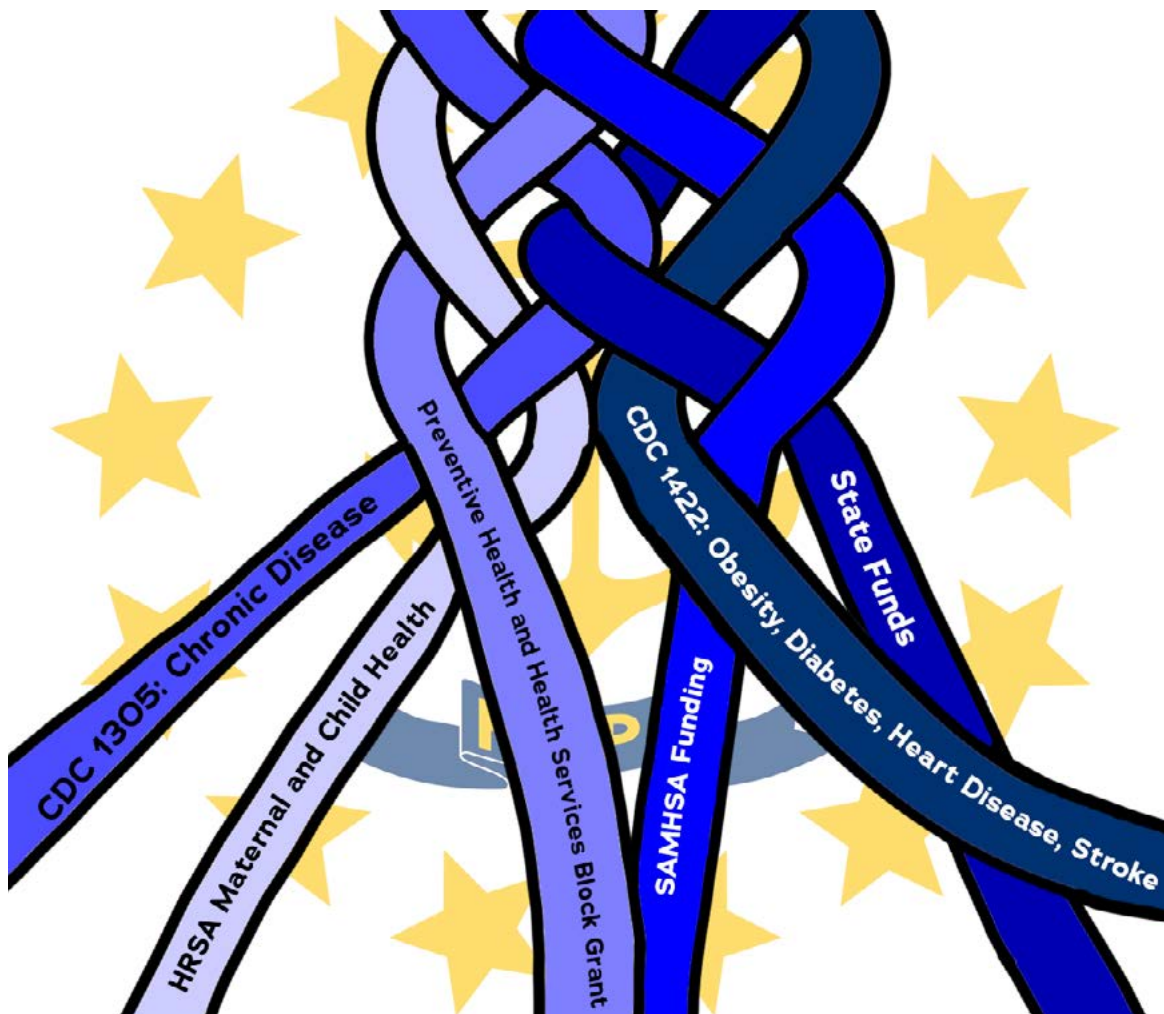
First, they take an inventory of what program flexibility is currently available to them. They note all the existing types of Medicaid waivers and state plan amendments that could enable innovation.¹⁰⁸ Next, officials examine the ways in which public health agencies in other states have aligned categorical programs to achieve a common goal without requiring federal approval. After completing their research, they develop an internal work plan that helps them maximize existing resources and flexibilities—including actions that don't require approval from Washington, DC.

Within state public health agencies, some leaders are managing work plans, staff, and resources to align their disparate categorical funding streams. These changes allow some states to break down silos created by categorical funding and maximize the efficient use of staff and resources to achieve data-driven goals. The Rhode Island Department of Health (DOH) used this approach.

Rhode Island. Rhode Island DOH determined that the categorical approach to chronic disease and health promotion was not maximizing its effectiveness at meeting the needs of local communities. DOH officials first tested collaboration through integrated projects, such as bringing together staff from diabetes, obesity, and maternal and child health programs and community partners to work on a shared initiative. They then took stock of their funding sources and looked for opportunities to **divest** from categorical funding and **invest** in place-based funding. They ultimately designed a method to braid funds within DOH and issued a request for proposals aligned with their emphasis on health equity and local health priorities.¹⁰⁹ The work initially focused on cross-cutting interventions, such as needs assessments and infrastructure-building.

The DOH did not need federal authorization for its braiding model because each funding source maintained its own identity. That placed the burden on the DOH to create a system that aligned the work done in the communities with the work plans and deliverables attached to each funding stream. Developing a database that **linked grant-specific requirements with the work plans** and timelines of staff in the field helped the DOH track categorical grant requirements in a way that was invisible to staff in the field. State leaders organized staff into policy teams that met weekly to discuss progress toward collaborative goals.

Figure 3. Funds Braided by the Rhode Island Department of Health



Washington State's Department of Health also **integrated** its work on chronic and infectious disease priorities, while still adhering to the strictures of categorical federal funding. As in Rhode Island, Washington's disease investigators and data analysts work across disease categories, rather than working within one siloed area. The department also sees itself as instrumental in implementing the public health elements of the state's Medicaid transformation plan.¹¹⁰

While the public health approaches taken by Rhode Island and Washington can be implemented independent of federal review, state innovations in Medicaid are bolstered by federally approved waivers or state plan amendments. Many state policymakers use the flexibility available through these Medicaid authorities to support public health goals, while recognizing that Medicaid must fund core functions that may differ from public health priorities. States have used Medicaid flexibility to address the social determinants of health¹¹¹ and health equity for their beneficiaries, often as part of efforts to transform Medicaid programs to reward value over volume.¹¹² Lessons from states that maximize Medicaid's existing flexibility may be helpful to public health officials exploring ways to capitalize on any new flexibility in federal funding streams.

Louisiana. As part of its **permanent supportive housing** program, Louisiana Medicaid covers some supportive housing services, such as assisting beneficiaries to find and apply for housing, and help them communicate with landlords and neighbors. Research shows the program reduced unnecessary emergency department visits and lowered Medicaid costs. The close working relationship between Medicaid and the Louisiana housing agency has contributed to the success of the program. In Louisiana, the public health and Medicaid agencies both sit within the Louisiana Department of Health, which may facilitate the cross-agency focus on common goals.¹¹³

The **tenancy supports** provided by the program are included in the state's Medicaid Section 1915 (c) Home and Community-Based Services waivers for people with disabilities, as well as in its mental health rehabilitation state plan amendment.¹¹⁴ Louisiana enhances these Medicaid flexibilities by braiding Medicaid funds with the Community Development Block Grant and a range of affordable housing programs to house people with disabilities who need support to live in the community.

Through its Section 1115 demonstration waiver, **Maryland** Medicaid gives **matching funds to local health departments** for two pilot programs addressing housing and maternal and child health. Local health departments may be able to use public health dollars for their share of the match, demonstrating the innovative ways in which existing Medicaid waiver authority allows a state to bring together Medicaid and public health funding streams to address shared priorities.¹¹⁵ The two pilots are:

- Assistance in Community Integration Services, designed to keep high-risk Medicaid enrollees housed in the community by providing tenancy support and housing case management; and
- Evidence-Based Home Visiting Services, which seeks to improve outcomes for high-risk pregnant women and their children. The pilot aligns with other evidence-based home visiting models such as the Nurse Family Partnership.

Oregon. In 2012, Oregon brought more than 40 separate Medicaid managed care organizations under the umbrella of 13 (now 16) accountable health structures, known as CCOs, which have the flexibility to pay for things like a **vacuum cleaner** for a beneficiary with asthma, or an **air conditioner** for someone with a heart condition.¹¹⁶

As part of a Section 1115 waiver project,¹¹⁷ the OHA makes per-member per-month global payments to CCOs. Within this **global budget**, which grows at a fixed rate, CCOs are responsible for their members' physical, behavioral, and oral health needs. CCOs are rewarded for their success on a set of **incentive measures**, which include measures of childhood obesity, tobacco use, immunization rates, and contraceptive use. The state is taking steps toward perhaps including kindergarten readiness in a future set of incentive measures.¹¹⁸

Washington State. Accountable Communities of Health (ACH) are an important component of Washington's Medicaid Section 1115 waiver program. ACHs are permitted to pay for services not ordinarily reimbursed by Medicaid, such as those associated with **supportive housing** and **supportive employment**.

- ACHs are required to include at least one local public health jurisdiction on their decision-making body, which can help ACHs take a regional approach to developing health improvement projects.¹¹⁹
- The state public health agency is also alert to the opportunity to align the priorities of Medicaid, public health, and community partners through the work of ACHs.

Benefits, Challenges, and Considerations

State public health departments have the autonomy to innovate across silos independent of federal action, as demonstrated by Rhode Island, Washington, and other states.

- This sort of departmental restructuring presents opportunities for innovation and improvement, but it requires a considerable investment of time and resources, as discussed in Scenario 3.
- State officials face challenges communicating changes to advocacy groups or other stakeholders when the changes are not instigated by federal policy. Building support among executive leadership, advocates, and other stakeholders requires sharing information and educating them about the changes.

Much has been written about the opportunities and challenges of using Medicaid waiver authorities to address health-related needs that extend beyond traditional clinical care.¹²⁰ As existing state innovations demonstrate, waivers can give states considerable freedom to test new approaches. However, that freedom comes with rules and guidelines. Waiver projects are also expected to demonstrate budget neutrality by costing the same as or less than the state's Medicaid program would have cost without the waiver.¹²¹

- Opportunities exist for states to amplify the impact of Medicaid waivers by aligning waiver priorities with those of public health, housing, social services, and other agencies.
 - However, without cross-agency waiver authority, the scope of that alignment may be limited.
 - Cross-agency waiver authority could also be designed to allow states to apply savings to public health or other state programs toward their budget neutrality requirement.
- Applying for a Medicaid Section 1115 demonstration waiver is a time- and resource-intensive process.
 - States would benefit if they had the freedom to replicate other states' successful, evidence-based waivers without the need for a lengthy federal application and approval process.

Figure 4. Selected State Uses of Medicaid Flexibility to Address Non-Clinical Health Needs

State	Project	What It Does	Medicaid Authority	How Success Is Measured
Louisiana	Permanent Supportive Housing	Braids funding for housing and supportive services to house vulnerable people with disabilities in the community	- Section 1915 (c) Home and Community Based Waivers - State plan amendment – mental health rehabilitation	- How many enrollees remain housed - Rates of ED use - Medicaid savings
Maryland	Community Health Pilots	Provides matching funds to localities that participate in: 1) a community integration pilot for people who need support to live in the community, or 2) a home-visiting pilot for at-risk mothers and children	Section 1115 demonstration project	- Performance and process measures for the home visiting pilot are in the RFP . - Outcome measures for the community integration pilot will be determined by the state; the local government entity can propose additional measures.
Oregon	Coordinated Care Organizations	Uses global budgeting to integrate physical, behavioral, and oral health care, and address non-clinical health needs such as housing and exercise	- Section 1115 demonstration project	- Set of incentive measures includes public health.
Washington	Healthier Washington; Accountable Communities of Health	- Each Accountable Community of Health implements regional projects that address the opioid crisis and the integration of physical and behavioral health, among other topics. Food security, housing linkages, and educational opportunity are themes of many projects. - Supportive housing and employment is also part of the Healthier Washington demonstration project	- Section 1115 demonstration project	- Statewide common measures include public health and prevention measures - Project -specific measures will also be used

Questions for Policymakers

Some key questions for state public health and Medicaid officials to consider in light of proposed federal funding changes include:

1. How will states set and meet their goals in an era of greater flexibility and reduced funding? States have historically aligned their goals with those mandated by categorical funding streams. How will states reach consensus on policy goals and priorities in a more flexible environment, given competing pressures from advocates and other stakeholders?
2. What evidence or models exist to bolster the assumption that more integrated approaches deliver greater health impact?
3. How can states capitalize on increased funding flexibility to offset diminished public health funding? Will blending or braiding funds achieve efficiencies? How will other state programs be affected?
4. How will states handle the competition between programs and constituents that could arise from a block grant? If states were given free rein to choose which programs or divisions to fund, how would they decide? Will these decisions change with changes in political leadership? How will states navigate the competing interests of providers, constituency groups, advocates, and other stakeholders?
5. Will states require state legislation, federal waivers, or other policy levers to make the most of flexibility accompanying deep funding cuts?
 - a. Core public health functions include assessing and monitoring diseases, responding to disasters and crises, developing evidence-based public health policies, communicating with the public, and developing community partnerships, according to the CDC, Trust for America's Health, the Institutes of Medicine, and others. Which functions could be potentially improved through a waiver, or could be shared with or delegated to other agencies or partners?
6. How can states ensure that Congressional intent is followed for any newly flexible public health funding streams, and that states, in turn, will provide sufficient accountability to justify ongoing federal investment?
 - a. What will states need to balance flexibility with accountability for health outcomes?
7. What will states need to adapt to proposed requirements for state public health programs to compete, bear risk, and/or demonstrate performance outcomes to maximize federal funds from public health block grants or cooperative agreements?¹²²
8. How important is it to states whether programs are funded by block grants or categorical formulas? How important is the prospect of entitlements (such as Medicaid) changing to capped spending programs?

Recommendations

The following suggestions were made by an ad hoc group of state officials during a closed meeting; they are not those of NASHP, nor of any organization or entity. They reflect key issues of concern to state leaders, and may help inform important conversations among federal and state health policymakers about a path forward for state health programs.

Pilot New, Cross-Agency, Demonstration Waivers

Develop a pathway to enable states to pilot large-scale cross-agency federal demonstration waiver projects that braid, blend, and align public health and Medicaid funding beyond what is permitted under current law. Such waiver projects could include funding from agencies such as CMS, CDC, HUD, HRSA, SAMHSA, and the USDA, in order to efficiently address health-related needs for food, shelter, and other supports.¹²³ They could also spur greater alignment between federal agencies. To maximize the waivers' effectiveness, policymakers could:

- Set a **five-year time frame** for cross-agency waivers, and establish goals that can be achieved within that time period.
- Require waiver applications to contain a **core set of measures** agreed upon by the state Medicaid and public health agencies.
- Permit states that have **accountable care entities**¹²⁴ to fold public health and other agencies into those entities, and/or expand them to include investment from Medicare.
- States might use such waiver authority to address the needs of special populations or **combat addiction**. Currently, federal funds to prevent and treat drug addiction flow to states from CDC, SAMHSA, HRSA, and other federal agencies. Medicaid also makes substantial investments in addiction treatment services. The flexibility to align funding across agencies and reduce reporting burden could help states meet the challenge of addiction in their communities.
- **Align eligibility requirements** across programs. Medicaid and safety net programs have different eligibility thresholds.¹²⁵ Some states are already working to align these programs to maximize their impact, such as Louisiana’s enrollment of residents into expanded Medicaid using SNAP eligibility data.¹²⁶
- Help states strategically invest their time in applying for grants by **aligning funding cycles and application requirements**.

Pilot an Optional, Well-Funded, Public Health Collective Impact Block Grant

An **optional, well-funded, public health block grant** of at least five years’ duration could test the collective impact of state public health and Medicaid agencies working together to address factors outside of the health care system that influence health. Such a public health block grant could help states define and clarify the changing roles of public health and Medicaid in an era of transforming payment and delivery systems. The test could start with a small number of **self-selected states** that choose to participate.

- To receive the block grant, state Medicaid and public health leaders would be required to **delineate** their duties and goals to complement each other and avoid duplication.
- The block grant would support states in sharing Medicaid, public health, and substance abuse **data** in order to strategically plan a state program across agencies. Data to be shared could include Medicaid claims, Medicaid MCO contracting information, public health infectious and chronic disease data, and substance abuse data.
 - Federal **clarification** is needed on permitted state uses of covered services by 42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Records.¹²⁷
- The block grant would require a **core set of measures** to establish comparability between states. The measures would include metrics that gauge the length and quality of life.
- Consider both Medicaid (state and federal portions) and public health spending as the baseline against which to measure **budget neutrality** and savings.
 - Some Section 1115 Medicaid demonstration waivers allow states to access federal matching dollars for services that are not typically eligible for a federal match. For example, Maryland is using savings from its Medicaid managed care program to draw down a federal match for two community health pilot programs,¹²⁸ which are offered in partnership with local governments through state grants.¹²⁹
 - Another potential model is California’s budget neutrality calculations for Medi-Cal 2020, which allow the state to keep a portion of the federal funding saved by the demonstration in the form of a “shared savings” performance payment.¹³⁰

Consider What States Can Do Without New Federal Action

As Scenario 4 illustrates, states currently have a number of policy levers at their disposal, even without additional federal flexibility. Using existing federal waiver authorities or state-level actions, states can make policy decisions to address health-related social needs and prioritize prevention.

- States can work within the Medicaid Section 1115 demonstration waiver process to establish **multi-payer payment reform** as the basis on which more comprehensive reforms are built. For example, **Vermont’s** Section 1115 demonstration project includes an All-Payer Accountable Care Organization model that will include Medicaid, Medicare, and private payers and align them in the service of value-based, coordinated care.¹³¹
- States can also work within existing waiver authorities to **reinvest Medicaid savings** from addressing non-clinical health needs and prevention. For example, **Oregon’s** Section 1115 waiver clarifies the ways in which “non-traditional services that improve health” are accounted for in global budgets. CCOs are encouraged to invest in those services.¹³²
- State Medicaid and public health agencies can jointly establish a core set of **metrics** that assesses progress on public health goals, and attach payment incentives to them.
- Develop a cross-agency **systems approach** to state health strategy. A systems approach would view health as affected by things outside of the clinical context—such as the environment in which people live and work, the food they eat, and their transportation and educational experiences. State agencies steward a range of resources that affect these things, and are well-positioned to align those resources for maximum impact.

Other Recommendations

- Implement a **streamlined approval process** for states seeking to replicate waivers that are successful in other states,¹³³ and give states substantial **freedom to implement evidence-based public health interventions** and programs.
 - Just as the health care delivery system is required to pay for certain services recommended by the US Preventive Services Task Force, state policymakers should be supported in implementing evidence-based public health interventions.
 - Draw on the expertise of public health agencies in identifying appropriate evidence-based interventions.
- Establish a health care **waiver oversight committee** or advisory committee with state and federal members. The committee would oversee the evaluation and approval of state requests for waivers affecting health in states, including Medicaid Section 1115 demonstration waivers and ACA Section 1332 waivers, or provide guidance on issues related to implementation.¹³⁴

Conclusion

Federal proposals to create block grants and cut public health funding to states require focused attention from state public health officials. It is only by assiduously tracking, preparing for, and responding to such proposals that states will be able to successfully tackle the challenges. Preparing for federal changes may also help state Medicaid and public health agencies clarify their shared goals and roles and identify actionable steps they can take even without any additional federal flexibility. This document paints different pictures of a state response to federal changes, and poses some key questions for officials to ponder in the months ahead.

When asked about the federal proposals, many state officials were wary of the cuts that would accompany flexibility:

- “My fear is that a block grant would just be less money and less accountability, which would make it hard to demonstrate our programs’ effectiveness, which would lead to even greater funding reductions.”
- “Block grants would make my life much easier, by eliminating some complicated and unnecessary reporting and accountability systems. Flexibility would be much easier, but I would be concerned with the level of funding cuts. I would keep the reporting burden to keep the funding. Our level of funding already isn’t what it needs to be. It’s a dangerous zone.”

Proposed federal changes represent an opportunity for state leaders to articulate their visions for the future, and to determine the funding levels and mechanisms that will help them achieve their goals. At a time when much attention is focused on changes flowing from Washington, DC, strategic state leaders can navigate this uncharted territory to safeguard and promote the health of communities nationwide.

Endnotes

1. According to the Association of Government Accountants, braided funding is that in which individual funding sources are coordinated, but each keeps its own identity. In a blended funding model, the separate funding sources are blended into a single stream, and each loses its individual identity. See <https://www.agacgm.org/getattachment/Intergovernmental/Free-Online-Products-for-Financial-Managers/BlendedandBraidedFundingIntergov.pdf.aspx> and <http://www.nashp.org/wp-content/uploads/2016/02/Jean1.pdf>.
2. State and federal officials could jointly determine the most appropriate scope, authority, and governance structure for this committee. If it were constituted under the Federal Advisory Committee Act (FACA) to advise the Executive Branch, it would not have decision-making authority. See: <https://www.gsa.gov/policy-regulations/policy/federal-advisory-committee-management/increasing-the-transparency-of-federal-advisory-committee-act-faca-information>.
3. The HealthyPeople 2020 Foundation Health Measures, or other models which include measures of healthy life expectancy, could serve as guides: <https://www.healthypeople.gov/2020/About-Healthy-People/Foundation-Health-Measures>.
4. Amy Clary, “Three Ways the Proposed White House Budget Could Affect Public Health in States,” National Academy for State Health Policy, June 20, 2017, <http://nashp.org/three-ways-the-proposed-white-house-budget-could-affect-public-health-in-states/>.
5. The House Appropriations Committee’s draft FY 2018 Labor, Health and Human Services, and Education Funding bill, which would cut \$198 million from the CDC: <https://appropriations.house.gov/news/documentsingle.aspx?DocumentID=394995>. See also ASTHO, <http://www.astho.org/Final-ASTHO-FY18-House-LHHS-Bill/>. The FY 2018 Senate Labor, HHS, and Education Appropriations bill maintains CDC chronic disease prevention funding: <https://www.appropriations.senate.gov/news/majority/committee-approves-fy2018-labor-hhs-and-education-appropriations-bill/>; <https://www.appropriations.senate.gov/imo/media/doc/FY2018%20Labor%20HHS%20Education%20Appropriations%20Bill%20-S1771.pdf>.
6. Amy Clary, Jill Rosenthal, and Trish Riley, “The Prevention and Public Health Fund—Lessons from States; Questions for Policymakers,” National Academy for State Health Policy, March 14, 2017, <http://nashp.org/the-prevention-and-public-health-fund-lessons-from-states-questions-for-policymakers/>.
7. Laura M. Segal and Alejandra Martin, *A Funding Crisis for Public Health and Safety: 2017 State-by-State Public Health Funding and Key Health Facts, Trust for America’s Health*, April 2017, <http://healthyamericans.org/assets/files/TFAH-2017-FundingCrisisRpt-FINAL.pdf>.
8. Alexandra King, “What can States do during Public Health Crises? Lessons Learned from Environmental Threats in Michigan, Rhode Island, and West Virginia,” National Academy for State Health Policy, January 24, 2017, <http://www.nashp.org/what-can-states-do-during-public-health-crisis-lessons-learned-from-environmental-threats-in-michigan-rhode-island-and-west-virginia/>.
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125. For a description of the different eligibility thresholds for Medicaid and Housing Choice Vouchers, see <http://nashp.org/federal-and-state-collaboration-to-improve-health-through-housing/>.
126. “Louisiana Receives Approval for Unique Strategy to Enroll SNAP Beneficiaries in Expanded Medicaid Coverage,” Louisiana Department of Health, June 1, 2016, <http://dhh.louisiana.gov/index.cfm/newsroom/detail/3838>; see additional resources on coordinating Medicaid and SNAP from the Center for Budget and Policy Priorities: <https://www.cbpp.org/blog/coordinating-medicaid-and-snap-renewals-can-help-participants-and-states>.
127. “42 CFR Part 2 – Confidentiality of Substance Use Disorder Patient Record,” Cornell Law School, accessed November 9, 2017, <https://www.law.cornell.edu/cfr/text/42/part-2>.
128. Maryland Department of Health and Mental Hygiene, Community Health Pilots, <https://mmcp.health.maryland.gov/pages/healthchoice-community-health-pilots.aspx>.
129. Maryland Department of Health and Mental Hygiene, Maryland HealthChoice Program §1115 Waiver Renewal Application, Medicaid.gov, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/md-healthchoice-pa.pdf>.
130. *California Medi-Cal 2020 Demonstration*, Centers for Medicare & Medicaid Services, last modified November 22, 2016, <http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs11-22-16.pdf>;
131. Ena Backus, Al Gobeille, Cornelius Hogan et al., “The All-Payer Accountable Care Organization Model: An Opportunity for Vermont and an Exemplar for the Nation,” *Health Affairs Blog* (blog), Health Affairs, November 22, 2016, <http://healthaffairs.org/blog/2016/11/22/the-all-payer-accountable-care-organization-model-an-opportunity-for-vermont-and-an-exemplar-for-the-nation/>; “Global Commitment to Health 1115 Waiver: 2017 Documents,” Department of Vermont Health Access, last modified June 27, 2017, accessed November 9, 2017, <http://dvha.vermont.gov/global-commitment-to-health/global-commitment-to-health-1115-waiver-2017-documents>.
132. *Oregon Health Plan*, CMS; *Oregon’s Waiver Renewal: Overview*, Oregon Health Authority, <http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Documents/1115%20Overview%202017.pdf>.
133. This idea has surfaced in other contexts, notably as one opportunity to strengthen Medicaid’s role in creating a culture of health. See Rosenbaum, Sara, Trish Riley, Alexandra L. Bradley, Benjamin W. Veghte, and Jill Rosenthal (2017). “Strengthening Medicaid as a Critical Lever in Building a Culture of Health.” Washington, DC: National Academy of Social Insurance. https://www.nasi.org/sites/default/files/research/Strengthening_Medicaid_as_a_Critical_Lever_Low_Res.pdf
134. See note 2.

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