Financing Toolkit for New York State's Child & Youth Behavioral Health System

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Prepared for The New York State Conference of Local Mental Hygiene Directors and the New York State Office of Mental Health

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CONTENTS

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PURPOSE OF THIS GUIDE

The New York State Conference of Local Mental Hygiene Directors (CLMHD) contracted with Innovations Institute at the UConn School of Social Work, on behalf of the New York State Office of Mental Health (OMH), to develop a customized financing toolkit to support New York State and its counties to access innovative financing approaches for diversified funding to continue to provide individualized, high quality, and effective services and supports to children and youth. OMH, CLMHD, the New York State Council on Children and Families (CCF) and the Cross-Systems' Deputy Commissioners' workgroup that they convene, and several local mental health directors provided valuable insight into this guide.

This toolkit is designed to serve as a guide to counties to identify where there is flexibility in funding, support the framing of requests and engagement with State partners, and identify mechanisms to implement and sustain financing. This guide is not designed as a comprehensive guide to model selection or implementation, nor does it explore the necessary system supports for effective and sustained implementation.

HOW TO USE THIS GUIDE

This toolkit is structured to assist the reader with shared decision-making with partners, including children, youth, and families. It begins by posing a series of questions to help the reader identify the specific population and services that are the focus of the desired financing. Once that is known, the reader can identify funding streams that may be appropriate to support the population and/or services. Then, the reader can explore financing strategies to access those fund sources.

Some counties and local systems of care already know the services that need to be financed or sustained for a particular population based on resource assessments, existing grants and initiatives, or years of strategic and interagency work. Other counties may find themselves starting from the beginning based on changes in demographics, leadership, or challenges because of the COVID-19 pandemic or other factors. **Readers are encouraged to move around within this toolkit based on needs assessment and resource planning activities, understanding of financing sources and strategies, and existing initiatives.**

Note: Even if you already have a service or intervention identified, consider reviewing the questions and strategies in steps 1 and 2 to make sure that you will be able to make your business case to finance the service.

Throughout the guide, we use examples to help the reader understand the strategies proposed. These examples are not endorsements of models or approaches but are meant as guides to support decision-making. Readers are encouraged to be thoughtful, specific, and solution-focused as they move through this toolkit: consider all options, even if they have been tried in the past, and be open to new approaches. We encourage readers to look for flexibility and, if you do not see it, ask about it! This guide is designed to equip you to do your research, ask questions, and be strategic and collaborative.

What is the most important premise of this guide? Financing should not drive service design and implementation. Services should be family- and youth-driven, collaborative (involving multiple child- and family-serving systems, agencies and organizations), outcomes-oriented, trauma-responsive, individualized, effective, and accessible. Financing strategies should be developed after you know who your population is, what their needs are, and what the most effective, appropriate, and culturally and linguistically responsive services are that can be provided to meet those needs, in the least restrictive environment.

STEP ONE

Who is the prioritized population? What are the needs associated with supporting that population?

Population and service array needs and priorities should drive financing approaches. To identify the population of focus and the service needs of that population, answer the following questions using data (quantitative, qualitative, and anecdotal). Review current and historical documents and resource plans, focus group reports, and community input and listening session feedback to inform your answers. Engage your community to answer these questions—including local leaders, other child and family-serving systems and agencies, and other relevant partners—and make sure to hear from individuals with lived experience! Invite them to be part of the design work from the beginning.

One strategy to help identify the prioritized population and services is to use Results-Based Accountability (RBA). This framework helps communities to identify the population, determine the desired quality of life or condition for that population (the result), figure out how to achieve that result, and how you know that you have achieved it. RBA can help to answer the questions about the population and figure out how to achieve the desired result.

QUESTIONS TO CONSIDER:

1a) Who is the population of children, youth, young adults, or families that you are focusing on and why? *Be specific about who the population is!* [1]

- What do the data tell us?
- What is the story behind the data?
- Why now?
- What is the challenge facing this population?
- Is this a population that has been identified by leadership, community partners, funders, or others?
- Has there been media attention on this population and, if so, how do the stories shared align with the data available (including information from children, youth, and families directly)?
- Which public child- and family-serving systems are involved with this population? Consider child welfare, juvenile justice, early intervention, early childhood, schools, maternal and child health, public behavioral health service providers, and other agencies or system. Children and youth served through public behavioral health systems often are involved with multiple child- and family-serving agencies. Each system or agency has a different role and responsibility for supporting the child and family and there may be different funding streams available for those activities.

1b) What are the service needs of this population?

- What are the needs that have been identified?
- What information do we have from children, youth, and families about what they want and what works well for them, from their perspectives? Are there differences in need based on geography, language, race or ethnicity, immigration status, disability, religion, sexual orientation, gender identity, or other factors?
- What do we already know based on services that already exist?
- Are there services that have been successful in supporting this population?
- What are the strengths within the identified population that could anchor services that are provided?

[1] Examples of specific populations include families with children ages 0-5 who are experiencing expulsions from preschool or youth ages 13-17 who have complex and unmanaged behavioral health needs resulting in high rates of emergency department usage.

EXAMPLE OF PRIORITIZED POPULATION & SERVICE NEEDS:

A community realizes that the **number of children entering foster care** is higher than before, including prior to the COVID-19 pandemic.

The community **reviews the administrative child welfare data** and realizes that children under 5 with caregivers who have substance use disorders and co-occurring mental health treatment needs are the population that is entering foster care at the highest rates. **They find that**, once the children go into foster care, they are remaining in foster care for two or more years. Many of the children then receive services to address developmental needs and trauma. The caregivers are involved in parenting education services while the children are in foster care.

In talking with foster care workers, families, and service providers, the community determines that many of these families could be served with the children remaining safely in their own homes if there were effective in-home and community-based services available. These services would need to address the safety and well-being of the children, substance use disorder and co-occurring mental health needs of the caregivers, and parenting and developmental interventions for the child and caregivers.

The community **determines** that there are no comprehensive programs available or accessible that can provide these services. There are some outpatient substance use treatment services and providers who offer parenting and developmental interventions, but they are not provided in an integrated fashion.

The community **reviews the data** and determines that most of the children and families are Medicaid-enrolled or eligible, even before the children enter foster care.

The **team** working on this determines that the population of focus for this community is caregivers with substance use disorders and co-occurring mental health treatment needs who have children under age 5, are likely to be Medicaid-eligible, and are at-risk for foster care.

STEP TWO

Which services are most appropriate to meet the needs of the Identified population?

Once you know *who* the priority population is and *what* their needs are, you can identify the services and interventions. Remember, it is *important to hear from families and youth with lived experience and center their recommendations and input in this process*, in addition to hearing from providers, advocates, researchers, and policymakers.

As you identify services, keep in mind considerations such as the service setting (i.e.-in-home, community settings, offices, residential settings, etc.) and who can provide the service (i.e., degrees, licensure, and type of experience of providers). These will be important later as you assess the fit of the interventions with your community and population.

Even if you already know which services or interventions you want to implement or sustain, it is helpful to go through the tools in Step 2. You will want to make a persuasive business case for financing your service or intervention. To do that, you need to be able to speak to the appropriateness of the intervention, why it is needed, how it will be impactful, and who will benefit from it. You will also need to know how significant a lift it is to implement or sustain the model. Funders are interested in programs that can be sustained and even scaled up over time.

2a) Identify possible services and interventions by:

- Speaking with children, youth, young adults, and families about their lived experiences.
- Surveying or interviewing local child- and family-serving agencies (public and private) to find out which services and supports they think might be most effective. Find out which services may be provided currently with a different population, or which interventions used to be provided but are no longer available (find out why!).
- Consider services that already exist—maybe they are underutilized, difficult to access, or are not available at the necessary scale.
- Utilize state[2] and national technical assistance centers and organizations[3] to identify evidence-based and promising practices and interventions.
    - Look for spotlights on communities and programs to learn more about innovative interventions, including those that may have been adapted for other communities.
    - Consider specialized technical assistance centers, like ones that focus on rural communities or that focus on child welfare and substance use, to help you find the most relevant suggestions.
- Review national evidence-based practice clearinghouses (including the Washington State Institute for Public Policy; California Evidence-Based Clearinghouse for Child Welfare; the Institute of Education Sciences including the What Works Clearinghouse; Blueprints for Healthy Youth Development; and the Title IV-E Prevention Services Clearinghouse).
- Consider locally developed interventions and supports that have strong anecdotal evidence and are grounded in best practices as well as promising practices. This is particularly important when serving populations that may not be well-represented in studies, where adaptations may be needed to meet cultural or linguistic needs, or when there are communities that have native or traditional practices that may not be reflected in evidence-based practice databases.

[2] Examples in New York include NYU's McSilver Institute's Technical Assistance Centers (CTAC, MCTAC, TTAC, and YTAC); the Center for Practice Innovations at Columbia Psychiatry & New York State Psychiatric Institute; and the New York State Center for School Safety.

[3] Examples of national technical assistance organizations and networks include the National Training & Technical Assistance Center for Child, Youth, & Family Mental Health; Opioid Response Network; SAMHSA's Technology Transfer Centers; the National Child Traumatic Stress Network; the Office of Head Start Training and Technical Assistance System; the SOGIE Center; the National Center on Substance Abuse & Child Welfare; Children's Bureau-funded Quality Improvement Centers; the Rural Health Information Hub; and the Child Welfare Capacity-Building Centers.

2b) Take the list of possible services and interventions that may be appropriate for your prioritized population. As a group, review the services and interventions using:

- The National Implementation Research Center's Hexagon Tool, which focuses on each of the following elements:
  - **EVIDENCE:** Measuring the strength of the evidence through number and type of studies, population characteristics (including demographics), and efficacy or effectiveness. What were the outcomes?
  - **USABILITY:** Is it a well-defined program? Can it be adapted for context, or replicated?
  - **SUPPORTS:** What are the support needs, including: expert assistance; sufficient staffing; training, coaching, & supervision; racial equity impact assessments; data systems technology support; and administrative and system support?
  - **NEED:** Does it meet the needs of the target population? Does it address service or system gaps? Utilize disaggregated data reflective of population needs as well as parent and community perceptions of need.
  - **FIT:** How does it fit with current community, regional, and state priorities? How does it fit with family and community values, culture, and history? Does it have an impact on other interventions and initiatives? Does it align with current organizational structure?
  - **CAPACITY:** What is your financial, structural, and cultural responsivity capacity to implement the program? Do your staff meet the minimum qualifications? Are you able to sustain the necessary staffing, training, data systems, performance assessment, and administration? Can you operationalize a process for a practitioner and family buy in?

- Results-Based Accountability (RBA) considerations for identifying what works:
    - **VALUES:** Does the service align with our community's values? Does it align with System of Care values, meaning it is individualized, effective, culturally and linguistically responsive, family- and youth-driven, trauma-responsive, and community-based?
    - **LEVERAGE:** Will the intervention help to achieve the desired results? Will it meet the needs of and be appropriate for the population identified? For new services, does it fill a gap in the service array?
    - **REACH & LIFT:** How hard will it be to implement the service intervention? Is it already available anywhere in county, region, or state? How expensive is it to install and implement (including training, certification, materials) and maintain (fidelity monitoring, workforce support, data collection and reporting, length of time to implement)?

RBA also encourages communities to consider specificity. This is important in defining the service and is important to be able to answer the questions around fit, capacity, leverage, reach, and lift. For example, it is not specific enough for the community to decide that they want to provide socio-emotional training and support to preschools across the community. They need to be more precise with *what* they want to provide, *where*, and to and with *which population*. A more specific decision would be that the community wants to implement the Pyramid Model for Social Emotional Competence in Infants and Young Children [what] in preschools in the community [where] that have rates of suspensions and expulsions over the past three years that are higher than the median rate across the community [who].

RETURNING TO OUR EXAMPLE...

The population of focus for this community is caregivers with substance use disorders and co-occurring mental health treatment needs who have children under age 5, are likely to be Medicaid-eligible, and are at-risk for entering foster care.

The community engages stakeholders, including families, reviews existing strategic plans and community forum input, and explores the existing service array maps that have been completed. They reach out to some of the national and state technical assistance centers and review the evidence-based clearinghouses. They keep noticing XYZ Intervention coming up in various documents and clearinghouses. It seems like a good fit because:

- It combines several evidence-based and promising practices and works with the entire family to connect them to substance use treatment, provide parenting support, and make sure the children can remain safely in the home.
- It is identified as evidence-based on two registries, including with the child welfare population, and has been shown to be effective with families with children under age 10.
- There are supports for implementation, including training and coaching, and the cost is reasonable for initial and ongoing support.
- The individuals providing the intervention do not have to be master's trained clinicians, which is helpful given a workforce shortage in the community.
- There have been three studies that showed the intervention to be effective with populations that are racially, ethnically, and linguistically similar to the population in this community.

Even though the intervention does not provide substance use treatment itself, it supports families to be connected to substance use treatment. As part of this process, the community has identified two clinics that participate with Medicaid that are willing to provide 123 Treatment, an evidence-based substance use disorder and mental health treatment intervention, to the caregivers. This is a weekly home-based model that provides interventions over a 20-week period, with clinic-based group sessions monthly. The clinicians would need to be trained in the model, but it would not require any additional supplies. The re-certification process is minimal and occurs every two years.

The community has **assessed the evidence, operability, support, need, fit, and capacity** to provide both XYZ Intervention and 123 Treatment. They have **determined** that these models align with their values, will provide the necessary leverage to achieve the desired results, and can be implemented with a moderate amount of reach and lift. These are *specific* strategies: the community is not looking to implement "a parenting support program" or a "substance use treatment program." They are looking to implement XYZ Intervention and 123 Treatment with the population of focus.

STEP THREE

What are the possible sources of funding for your program or service?

Once you know *who* you want to serve and *which service or intervention* you want to provide, you need to identify possible sources of funding. Children and youth served through public behavioral health systems are often involved with multiple child- and family-serving agencies. Each system or agency has a different role and responsibility for supporting the child and family and there may be different funding streams available for those activities. Public funding can be provided as *entitlement*, *formula*, or *discretionary* funding. (See Appendix for definitions.) Some funding may be available for specific populations, such as funding to support early childhood or transitional age youth. Most of the funding discussed below, spans ages 0-21 and is focused on addressing particular needs or providing specific services. Eligibility for some funds may be restricted by demographic, diagnostic, or other factors (e.g., the 1915(c) NY Children's Waiver described below).

PUBLIC FUNDING

MEDICAID FUNDING

Medicaid is administered by states according to federal requirements and is the single largest payer for mental health services in the country. Each state sets its own eligibility and guidelines, within federal parameters. States have flexibility in which services they provide and to whom. The federal government pays for at least 50% of Medicaid costs. In 2021, NYS Medicaid paid for behavioral health services for 488,592 children.[4] New York has several different Medicaid authorities that it uses to serve children and youth with behavioral health needs.

Medicaid should be considered as part of a comprehensive financing strategy for any behavioral health service provided to children and families involved with public child- and family-serving agencies. Medicaid is a critical resource for lower income families. Most children and youth who come into foster care are Medicaid-eligible and most children and youth with histories of foster care have access to Medicaid through age 25.

[4] New York State Office of Mental Health. (2023). *Children with behavioral health needs in NYS: An analysis of Medicaid utilization and expenditures.* Available from https://omh.ny.gov/omhweb/tableau/children.html.

New York's local systems of care need to ensure that they understand some of the primary components of New York's Medicaid Services to access Medicaid effectively:

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): EPSDT is a benefit provided to all children under 21 enrolled in Medicaid. New York, like all states, is required to provide all Medicaid coverable, appropriate, and medically necessary services that are needed to be able to ameliorate health conditions.[5] New York's EPSDT manual states, "Whether the child is in Medicaid managed care or fee-for-service, the EPSDT benefit and the entire array of New York State Medicaid services is available to him/her from birth up until age 21 years" (p.20).[6] The New York State Department of Health (DOH) oversees local departments of social services (LDSS) and provides oversight in the LDSS administration of the EPSDT program. DOH develops the standards of care to be used by the managed care organizations (MCOs). The LDSS are responsible for administering the EPSDT benefit, including conducting outreach to families, helping to locate Medicaid providers, arranging transportation, scheduling, and networking with other agencies such as WIC and Head Start. The Medicaid MCOs are responsible for providing members with information about services covered, costs, obtaining referrals, maintaining a list of participating providers, providing access to medical services, and following up to ensure that all appropriate diagnostic and treatment services, including referrals, are provided based on an EPSDT screening examination.[6] *Both the MCOs and the LDSS, as well as Children's Single Point of Access (CSPOA) are resources to local communities in identifying existing, covered services and their availability and accessibility.*

1115 Demonstration Waiver (Managed Care): New York has an 1115 Demonstration Waiver, which permits the State to provide services through managed care as well as other authorities. In 2019, NYS included the Children's Waiver and State Plan behavioral health services in the Medicaid managed care benefit. The current 1115 waiver is approved through 2027. Most children under 19 are served through the Mainstream Medicaid Managed Care Program (MMMC), which uses managed care organizations (MCOs) and primary care case management (PCCM) arrangements to provide most services. If an MCO is unable to meet the requirements to manage expanded behavioral health services, the MCO is required to contract with a managed care behavioral health organization; if the necessary medical services are not able to be provided, the MCO is required to cover those costs out of network.[7]

The NYU McSilver Managed Care Technical Assistance Center (MCTAC) maintains an MCO Plan Matrix, which enables anyone in New York to determine which MCOs offer services in their region. This website provides detailed information for each of the MCOs, including if there is a behavioral health organization (BHO) subcontracted, information for the children's services contacts (including foster care and medically fragile populations), billing and utilization management information. These links provide specific information about clinical criteria used,

[5] Centers for Medicare & Medicaid Services. (n.d.). *Early and Periodic Screening, Diagnostic, and Treatment*. Available from https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

[6] New York State Department of Health, Office of Health Insurance Programs. (2019). *New York Medicaid Child/Teen Health Program (C/THP) Provide Manual.* Available from https://www.emedny.org/providermanuals/epsdtcthp/pdfs/epsdt-cthp.pdf

[7] New York State Medicaid. (2022). *1115 Waiver Demonstration Approval.* Available from https://www.medicaid.gov/sites/default/files/2022-05/ny-medicaid-rdsgn-team-appvl-04292022.pdf.

clinical services covered, and provider availability. This tool can help communities to understand what is available and covered under the MCOs in their region and who is eligible for services. This information will assist communities if there is an interest in expanding the service array of an existing provider or cultivating a new Medicaid-enrolled provider. In addition to using tools like this, counties can review New York's 1115 waiver information to really understand what is available already; at times, underutilization occurs because of a lack of awareness about reimbursement options and what is already available but not accessible due to lack of providers or capacity within those provider organizations.

Rates for services provided by the MCOs are established by the State of New York. The rates can be found online and are an important resource in determining the cost of providing a service and calculating whether the reimbursement rate is sufficient to cover total costs for model implementation, training, and quality assurance. McSilver's MCTAC also provides a Billing Tool to help providers to submit clean claims. This tool can be utilized, along with technical assistance from the MCTAC, to support providers to be reimbursed in a timely fashion (an important part of effective implementation).

1915(c) Waivers: These waivers allow states to provide home- and community-based services to individuals who would otherwise require services in an institutional setting. In New York, there are two 1915(c) waivers that serve children.

- ***1915(c) NY Children's Waiver*:** This waiver provides services to individuals ages 0-20 who have physical or other disabilities, have brain injury, have HIV/AIDS, are medically fragile, are technology dependent, have autism, or have intellectual disabilities. It also provides services to individuals 0-18 with serious emotional disturbance and individuals 18-20 with mental illness. All these individuals must meet a hospital, nursing facility, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICC/IDD) level of care. Children and youth enrolled in this waiver have access to community habilitation, day habilitation, prevocational services, respite, supported employment, adaptive and assistive technology, caregiver/family advocacy and support services, environmental modifications, non-medical transportation, palliative care – expressive therapy, palliative care – counseling and support service, palliative care – massage therapy, palliative care – pain and symptom management, and vehicle modification services. New York operates this waiver concurrently with its 1115 authority.[8]
- ***NY OPWDD Comprehensive Waiver*:** This waiver provides services to individuals with autism, intellectual disabilities, or developmental disabilities ages 0 or older who meet an ICF/IDD level of care. It provides day habilitation, live-in caregiver, prevocational services, residential habilitation, respite, supported employment, community transition services, fiscal intermediary, individual directed goods and services, support brokerage, assistive technology/adaptive devices, community habilitation, environmental modifications (home accessibility), family education and training, intensive behavioral services, pathway to employment, and vehicle modification services and operates concurrently with a 1915(a)(1)(a) authority.[3]

[8] Centers for Medicare & Medicaid Services (CMS). (2023). *Waiver description*. Available from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/NY#4125

Health Homes Serving Children: In New York, children and youth enrolled in Medicaid who have two or more chronic conditions, have a serious emotional disturbance or complex trauma may be eligible for a health home. Children enrolled in a health home have access to six core services: comprehensive case management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community supports, and use of Health Information Technology to link to services. These services are designed to support the child to avoid an out-of-home placement and improve functioning.[9]

Administrative Claiming: State Medicaid Authorities can access federal financial participation for certain administrative costs. These are costs associated with administering the Medicaid State Plan, including training costs and some school-based services. This is a useful tool for States as they explore ways to make Medicaid more accessible to eligible children and families.

CHILD WELFARE FUNDING

As noted above, most children in foster care are eligible for Medicaid and children and youth with histories of foster care are eligible for Medicaid through age 25. However, Medicaid is not the only source of funding for services and there often are costs that are not eligible to be reimbursed by Medicaid, in full or in part, that need to be covered elsewhere. The following are some child welfare-specific funding sources that may be appropriate to support service provision, including administrative and training costs.

The New York Office of Children and Family Services (OCFS) provides policy directives and information on preventive services for children and their families, including district allocation of funds for the Flexible Fund for Family Services. It also provides information on CAPTA/CARA grants (discussed below). Funding opportunities available through OCFS are posted online.

For information about federal child welfare legislation (including the Adoption & Safe Families Act (ASFA), the Child Abuse Prevention & Treatment Act (CAPTA), Family First Prevention Services Act (FFPSA), the SUPPORT Act, the Comprehensive Addiction and Recovery Act (CARA) and more), please see the Child Welfare Information Gateway and the NY OCFS website.

[9] New York State Department of Health. (2022). *Health Home Serving Children*: Available from https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hhsc_elig_appr_prior_6core.pdf.

Title IV-B: This portion of the Social Security Act provides funding for family preservation and support services. It includes both formula and discretionary funding. One of the requirements of Title IV-B is that States provide an Annual Progress and Services Report (APSR), which includes applications for funding under the Stephanie Tubbs Jones Child Welfare Services and Mary Lee Allen Promoting Safe and Stable Families portions of the Act, as well as the John H. Chafee Foster Care Program for Successful Transition to Adulthood and Education and Training Vouchers.

New York's APSR is available on the Office of Children and Family Services (OCFS) website and is a helpful resource to understand the State's priorities, allocation of funds, and outcomes related to preventing child maltreatment and improving the well-being of children and families. This report includes an overview of how child welfare services are structured in New York, with a particular emphasis on the interagency and interdisciplinary activities and partnerships that are occurring and planned to better support children and families.

Title IV-E: Title IV-E of the Social Security Act provides funding for administrative costs, training, and care of children in foster care. However, it has significant limitations, as it is only available to support the care of children who have entered foster care who meet restrictive financial requirements. The primary requirement is that the family must meet the Aid to Families with Dependent Children (AFDC) income standard from 1996. With inflation, fewer children and families every year qualify for Title IV-E, causing the State and counties to have a greater share of the costs for caring for children who do come into foster care.

In 2018, the Bipartisan Budget Act was passed, which included the Family First Prevention Services Act (FFPSA). FFPSA enables States to access Title IV-E prevention services funding for children who are identified as at-risk of entering foster care.[10] The funding extends to in-home parenting, mental health treatment, substance abuse treatment and services provided to these children and families. States are required to identify which interventions they will provide. At least 50% of the expenditures must be from interventions identified as well-supported in the Title IV-E Prevention Services Clearinghouse. This has created limitations for States and communities who want to use the funds to better serve children without them entering foster care. However, as discussed below, obtaining federal reimbursement for some of the costs of these services can free up resources to use on other, non-eligible services. States can also claim IV-E Prevention Services reimbursement on some administrative and training costs associated with implementation of these plans.

New York's Title IV-E Prevention Services Plan was approved by the federal Children's Bureau in 2022 and includes 11 evidence-based practices that will be implemented in the first wave of FFPSA in New York. Data on New York's FFPSA implementation, including county-level data, are available here. As noted, FFPSA has significant limitations that constrain states in their use of the funds to serve children and families without having them enter foster care. However, it does provide a mechanism to reimburse some services that otherwise would have been covered with other child welfare or State funds.

[10] Note: FFPSA also has provisions relating to child care institutions, or congregate care programs; it created a new category of Qualified Residential Treatment Programs and requirements associated with receiving reimbursement for children in foster care who are in non-family-based settings.

CAPTA & CARA: The Child Abuse Prevention and Treatment Act (CAPTA) and the Comprehensive Addiction and Recovery Act (CARA) are federal laws designed to prevent child maltreatment. OCFS provides funds to LDSS to support implementation of these acts, including providing services to support families impacted by substance use disorders. In September 2022, OCFS issued a memorandum to the Local Commissioners outlining funds available through the CAPTA/CARA State Grant and the associated responsibilities and requirements.

Temporary Assistance to Needy Families (TANF) Block Grant and the Social Services Block Grant (SSBG): TANF is a federal grant program that provides states with time-limited funds to support families with children when the caregivers cannot meet the children's basic needs. Some of these funds are provided directly to families and others are allocated for work supports and related activities. Many states use a portion of their TANF funds to support child welfare services. In 2021, New York spent approximately 7% of its TANF funds on child welfare services.[11]

The SSBG is a federal grant that is allocated to states to provide social services to meet community needs. Funds are used to support child welfare services and youth at-risk of entering foster care, counseling and support, child care, health and well-being services, and more.[12]

In New York's Federal FY2022 SSBG report, OCFS states that funds from this TANF Block Grant are anticipated to be transferred to the SSBG and that local social services districts may choose to transfer a portion of their State-funded Flexible Fund for Family Services (FFFS) to the SSBG. This enables the social services districts to use funds to provide services that are eligible under Title XX of the Social Security Act, which include child welfare prevention services, child protective services, aftercare services, adoption and post-adoption services, adult protective services, domestic violence services, and other supports to families with incomes less than 200% of the official federal poverty level (p.2). This New York report provides detailed information about the services that are allowable, the State's priorities (aligned with federal requirements), and estimated levels of services and funding.

Chafee Foster Care Program for Successful Transition to Adulthood (Chafee) and Education and Training Vouchers (ETV): Chafee is a federal program designed to support older youth currently in foster care or previously in foster care to successfully transition to adulthood. In New York, Chafee funds are allocated to the LDSS and can be used to support academics, employment and training, housing, financial literacy, career preparation, and more. Currently, OCFS also provides direct cash assistance through the Chafee program to young adults. The ETV program provides vouchers to youth to support post-secondary education and training.

[11] Center on Budget and Policy Priorities. (n.d.) *New York TANF Spending*. Available from https://www.cbpp.org/sites/default/files/atoms/files/tanf_spending_ny.pdf

[12] Office of Community Services, Administration for Children and Families. (n.d.) *SSBG Fact Sheet*. Available from https://www.acf.hhs.gov/ocs/fact-sheet/ssbg-fact-sheet.

EDUCATION FUNDING

Education funding can be overwhelming because there are funds to support academics, special education, social-emotional learning, and more. Education funding comes from federal, state, and local sources. Below are highlights of some education funding specific to supporting the social and emotional health and well-being of students. Not all local educational agencies will be able to access all of these funds and like all of the funding outlined, local systems of care partner with the state child- and family-serving agencies to identify existing funds as well as new opportunities that could be pursued.

Special Education: The NYS Education Department administers special education programs and services through local school districts and allocates federal funding for special education under the Individuals with Disabilities Education Act. Section 200.5(b) of the Regulations of the Commissioner of Education establishes procedures for school districts and municipalities to access public benefits (i.e., Medicaid) to pay for certain special education and related services.

The Mental Health Service Professional Demonstration Grant Program can be accessed by state education agencies or school districts to support efforts to expand the pipeline of high-quality, trained mental health professionals in schools and to provide support for social emotional learning and mental wellness. Most of these grants are provided directly to districts, and sometimes to state education agencies.

The School-Based Mental Health Services Grant Program offers funding to State educational agencies (SEAs), local educational agencies (LEAs), and consortia of LEAs to increase the number of qualified mental health service providers in districts with demonstrated need.

School-Based Health Centers can help place needed medical, behavioral health, dental, and vision services directly in schools so that more young people can have equitable access to care. Some of the services provided are Medicaid billable.

The Safe and Healthy Students Unit provides program support and technical assistance in the Student Support and Academic Enrichment program. Some include drug and violence prevention, school-based mental health services, and schoolwide positive behavioral interventions and supports. The Safe and Healthy Students Unit administers grant programs that include the School Climate Transformation, Project Prevent, and Promoting Student Resilience.

School Based Health Center Program School-Based Service Expansion funding can expand access to primary care health services, including mental health services. Sites receiving Health Center Program funding deliver services on the grounds of schools.

Full-Service Community Schools Program: Community schools are an evidence-based strategy to transform a school into a community hub where teachers, community members, families, and youth work together to strengthen conditions for student learning and healthy development. Community schools use strategic partnerships to offer support in the school building, and can include mental health support. The federal Full-Service Community Schools Program can fund this work, and the federal government has also created a funding tool to find different ways to fund community schools initiatives with federal dollars. Currently, New York State also has a set-aside within Foundation Aid that allocates funding for community schools for high-need districts in the state.

OTHER SOURCES OF FEDERAL, STATE, AND LOCAL FUNDING

There are numerous other sources of federal funding that may be considered to fund and sustain programs and interventions. Communities are encouraged to consider the population they are interested in serving and identify the federal agencies that may have a role to play in supporting this population. If you know the local or state agency that supports this population, visiting their website and looking for reports and funding opportunities may help in identifying possible funding sources (one-time or ongoing). Below are additional examples of federal funding that may be of interest to communities in financing children's behavioral health services.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health & Human Services: SAMHSA is responsible for leading public health efforts to advance behavioral health across the country. SAMHSA issued a strategic plan for 2023-2026 to frame priorities for the coming years, which is expected to inform future funding opportunities. SAMHSA provides discretionary grants, including the System of Care Grants (Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances). Some of these grants are open to counties and providers. SAMHSA's funding forecast is available online.

SAMHSA issues the Community Mental Health Services Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG). In New York, OMH administers the MHBG and the Office of Addiction Services and Supports (OASAS) administers the SUBG.

Maternal, Infant & Early Childhood Home Visiting (MIECHV) Initiative: MIECHV is a federal initiative that provides formula funding to states to provide evidence-based home visiting programs and interventions. In New York, DOH provides funding to counties to support seven evidence-based home visiting programs. Communities can find the MIECHV-supported home visiting programs by searching the NYS Child Care, After School, and Parent Support Programs Locator.

Early Intervention Program: DOH administers New York's Early Intervention Program (EIP), which is part of the national EIP created under the Individuals with Disabilities Act (IDEA). EIP serves infants and toddlers with disabilities and their families and offers an array of services. Examples include: family education and counseling, home visits, parent support groups, as well as psychological and social work services.

Other federal agencies: Communities should consider funding opportunities made available through the Health Resources & Services Administration (HRSA) and Office of Juvenile Justice & Delinquency Prevention (OJJDP). State, regional, and local agencies of **juvenile services**, **WIC**, **Head Start**, and **public health** are critical partners in identifying possible financing to support program implementation.

Local and State General Funds & Special Revenue: New York State has a history of providing dedicated funding to support children and families. These funds may be one-time or ongoing. Many counties have experience in using local tax levies and dedicated funds to support prioritized programs. In state fiscal year 2019, 49 states and the District of Columbia imposed at least one health care-related tax. In SFY 2019, the most common health care related taxes were on institutional providers.[13] Additional sources of funding include the Opioid Settlement Agreement[14] and specific initiatives, such as Governor Hochul's funding to address pandemic learning loss and support mental health.

[13] Medicaid and CHIP Payment and Access Commission (MACPAC). (n.d). *Health Care Related Taxes in Medicaid*.https://www.macpac.gov/wp-content/uploads/2020/01/Health-Care-Related-Taxes-in-Medicaid.pdf

[14] The Opioid Settlement Fund Tracker provides information on the dates, amounts, and initiatives supported by these Funds across New York in FY2023: https://oasas.ny.gov/fy-2023-opioid-settlement-fund-initiatives

PRIVATE FUNDING

Public funds are not the only source of funding that should be considered. There are three additional main sources of non-public funds that may be appropriate to support prioritized initiatives.

HOSPITAL COMMUNITY BENEFIT FUNDS

Nonprofit hospitals are required by federal tax law to spend some of their surplus on "community benefits" to address a community's need. They must report this spending each year to stay exempt from paying federal income taxes. Allowable purposes of community benefits are to improve access to services, enhance the health of the community, advance medical knowledge, and reduce government burden. Before the Affordable Care Act, hospitals often offered free or low-cost care with these funds. As more patients have insurance now, there is an opportunity here to increase investments in population health and other community-centered programs.[15] Local hospitals may be interested in partnering with the community to address a prioritized need, particularly if the intervention may prevent children and families from requiring care through the hospital.

FOUNDATION FUNDS

Many national and local foundations offer grants and funding to support local initiatives. It is important for communities to identify foundations that have priorities and values that may be aligned and ensure that the funding cycle and administrative requirements support the needs of the community. Some foundations will only provide start-up costs and will require the community to have a plan for ongoing sustainability; this would be appropriate for an intervention that can be Medicaid-reimbursable but requires initial costs for training and materials. Many foundations provide funds for one-time use and may require the funds to be expended within a one-to-three-year period. Examples of health-care focused foundations that may be relevant to counties in New York include the Altman Foundation, Centene Foundation, Dyson Foundation, Excelleus Blue Cross Blue Shield Community Investments, New York State Health Foundation, and the Surdna Foundation. National foundations include the Robert Wood Johnson Foundation and Cigna Group Foundation.

CORPORATE SPONSORSHIP & AWARDS

Many local and regional businesses are willing to provide funding to support initiatives, particularly if there are one-time costs, such as for a training or event. They may be willing to provide initial or seed funding for a program, particularly if there is an identified sustainability plan for the services. Many nonprofit organizations have local business members serving on their boards; these businesses may be interested in supporting initiatives or making introductions to other businesses who would be able to support the program.

[15] National Center for Healthy Housing. *Hospital community benefits*. (n.d.) https://nchh.org/tools-and-data/financing-and-funding/healthcare-financing/hospital-community-benefits/

STEP FOUR

What financing strategies can be used?

Many of the sources of funding outlined above are categorical and inflexible, which requires local and state partners to be creative. As a result, **the State and counties need to develop integrated and flexible financing strategies to ensure that children and youth can access effective, individualized, and quality services in their homes and communities.**

There are **four main strategies** that states and counties use to finance child and youth behavioral health services and supports: **revenue maximization; blending & braiding funds; redirection; and generating new revenue.**[16] Consider each of these strategies and identify which ones might be most applicable and practical for your community based on the population, service, scale, and timeline for implementation.

If your community has completed a financing analysis, you can use those results here to inform your financing strategies.

Some communities may want to conduct a financing analysis or expenditures mapping to help determine how funds are being spent across public child- and family-serving agencies. Financing analyses/ expenditure mapping identifies the public expenditures for a population, by service type. This process helps to identify duplication, inefficiencies, gaps, and where funds are being used for less impactful services. This type of analysis can be time consuming and costly but helpful in exploring opportunities to restructure in support of a particular population. It can also assist with identifying structural challenges and disparities across a population. States or communities can undertake this analysis specifically related to an identified population (e.g., children under five) or across the entire child population. It can be conducted with one agency (e.g., Medicaid) or all the child- and family-serving agencies. Typically, data are analyzed for a one-year period (e.g., State Fiscal Year 2023) and the process can be replicated in future years to identify changes.

[16] Harburger, D.S., Pires, S.A., & Schober, M. (2022). Sustainable financing to support children & families: Medicaid and other fiscal, funding, and financing challenges and opportunities. In R. Denby-Brinson & C. Ingram (Eds.), *Child and family-serving systems: A compendium of policy and practice (Volume I: Evolution of protecting, strengthening, and sustaining children and families). CWLA Press.*

REVENUE MAXIMIZATION

Revenue maximization refers to ensuring that all possible federal dollars are being accessed. This includes using entitlement funds, like Medicaid and Title IV-E, to provide as many services and supports as possible. The federal government reimburses at least 50% of the eligible costs under Medicaid and Title IV-E. If a service can be included in the Medicaid State Plan, that frees up State and local funds to pay for other services. It also extends the ability of the community to pay for more individuals and/or services. State Agencies are responsible for obtaining federal reimbursement in most instances, so communities must work with their State partners to find out if there are strategies that are not being used locally or across the state. There may be opportunities for the State to draw down federal funds to support training and administrative costs that are not being maximized because they are being provided through block grants or local funds. Better utilization of existing financing strategies—including claiming Medicaid reimbursement for services that already are in the State Plan—is one of the most straightforward financing strategies.

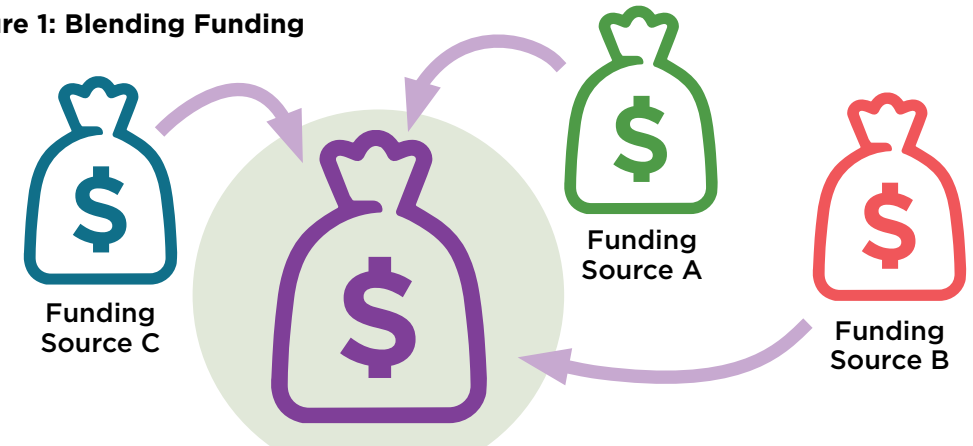
BLENDING & BRAIDING FUNDS

One of the most important strategies for communities to consider is whether they can blend or braid funds. This is important because, as noted above, **it is rare for a single funding stream to cover all costs for a service or program**. Even when federal funds are leveraged, if the State is required to provide matching funds, the source of those funds needs to be identified.

Blended and braided are financing terms used to describe how different fund sources can be combined to maximize funding. These strategies require intentional coordination and integration of more than one fund source and/or payer to finance a particular service, program, or initiative. The individuals being served should not experience the services differently whether they are braided or blended; the service provision should be the same and the burden of meeting all administrative requirements should be held at the agency or system level.

Blended funding means combining sources, often across different systems or payers, into a single pool. Blended funds lose their individual identity and associated requirements.[17]

Figure 1: Blending Funding



[17] Pires, S.A. (2020). Systems of care module 13: Financing systems of care-A strategic approach. Building Systems of Care. Innovations Institute, University of Connecticut School of Social Work. Available from https://innovations.myabsorb.com.

Braided funding means coordinating multiple funds to pay for a service or program while maintaining the original identities of the funds. In a braided funding model, the funds are distinguishable from each other and have their own identities and associated requirements. Both braiding and blending funds can help with long-term sustainability of services and can reduce fragmentation and maximize resources, particularly across multiple public systems.[17]

Figure 2: Braided Funding

In New York, OMH has braided MHBG, State, federal American Rescue Plan and Coronavirus Response and Relief Supplemental Appropriations Act funds, and SAMHSA funds to cover clinical treatment teams to serve young people ages 16-30 experiencing First Episode Psychosis through OnTrackNY.[18] The clinical treatment teams also bill Medicaid and commercial insurance for eligible services, such as psychiatric assessment and medication management, enabling the braided funds to cover costs not otherwise eligible for reimbursement.[19]

One of the most well-known examples of blended funding in children's behavioral health systems is **Wraparound Milwaukee**.

- While this model has evolved over the years, Milwaukee (a county-run system) leveraged a 1994 SAMHSA SOC grant and built on it to blend funds from multiple agencies based on the successes in decreasing costly, restrictive placements and achieving better child- and family-outcomes.
- Over 25 years, Wraparound Milwaukee created a unique managed care entity with multiple care coordination entities, a large provider network and a mobile urgent response team.

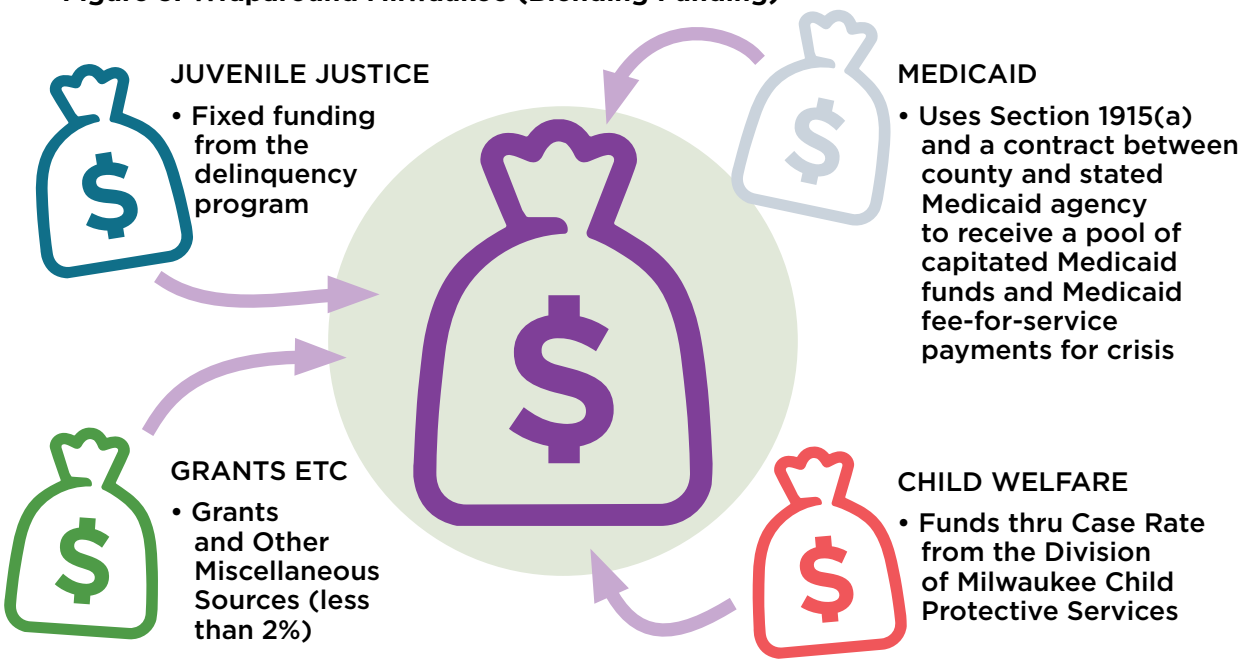
The image below provides an overview of the blended funds that are combined to create a single case rate to serve children with intensive care coordination using Wraparound, a broad array of home and community-based services, and, as needed, inpatient psychiatric care. In 2019, Wraparound Milwaukee spent an

[18] OnTrackNY is a mental health treatment program to support young people ages 16-30 across New York impacted by unexpected changes in their thinking and perceptions. See more at https://ontrackny.org/.

[19] Substance Abuse and Mental Health Services Administration (SAMHSA). (2023). *Coordinated Specialty Care for First Episode Psychosis: Costs and Financing Strategies*. (HHS Publication No. PEP23-01-00-003). Available from https://store.samhsa.gov/.

average of $2,609/month on children and youth enrolled in this model, serving children involved with child welfare, juvenile justice, Medicaid, and behavioral health services.[20, 21, 22]

Figure 3: Wraparound Milwaukee (Blending Funding)



An example of successful braided funding is **New Jersey's Children's System of Care (CSOC).**

- Like Milwaukee, New Jersey used an SOC grant to fund initial redesign efforts. The grant and a settlement agreement led to new investments, including the new Division of Children and Families.
- Over the past 20 years, New Jersey has continued to expand its CSOC, which has a contracted systems administrator, locally based care management organizations providing Wraparound, peer support, mobile response and stabilization services, and a wide array of home- and community-based services.
- New Jersey has used Medicaid funding as well as other sources of funds to serve all children across the state with behavioral health needs, including those involved with child welfare and juvenile services as well as those with intellectual and developmental disabilities and substance use disorders.

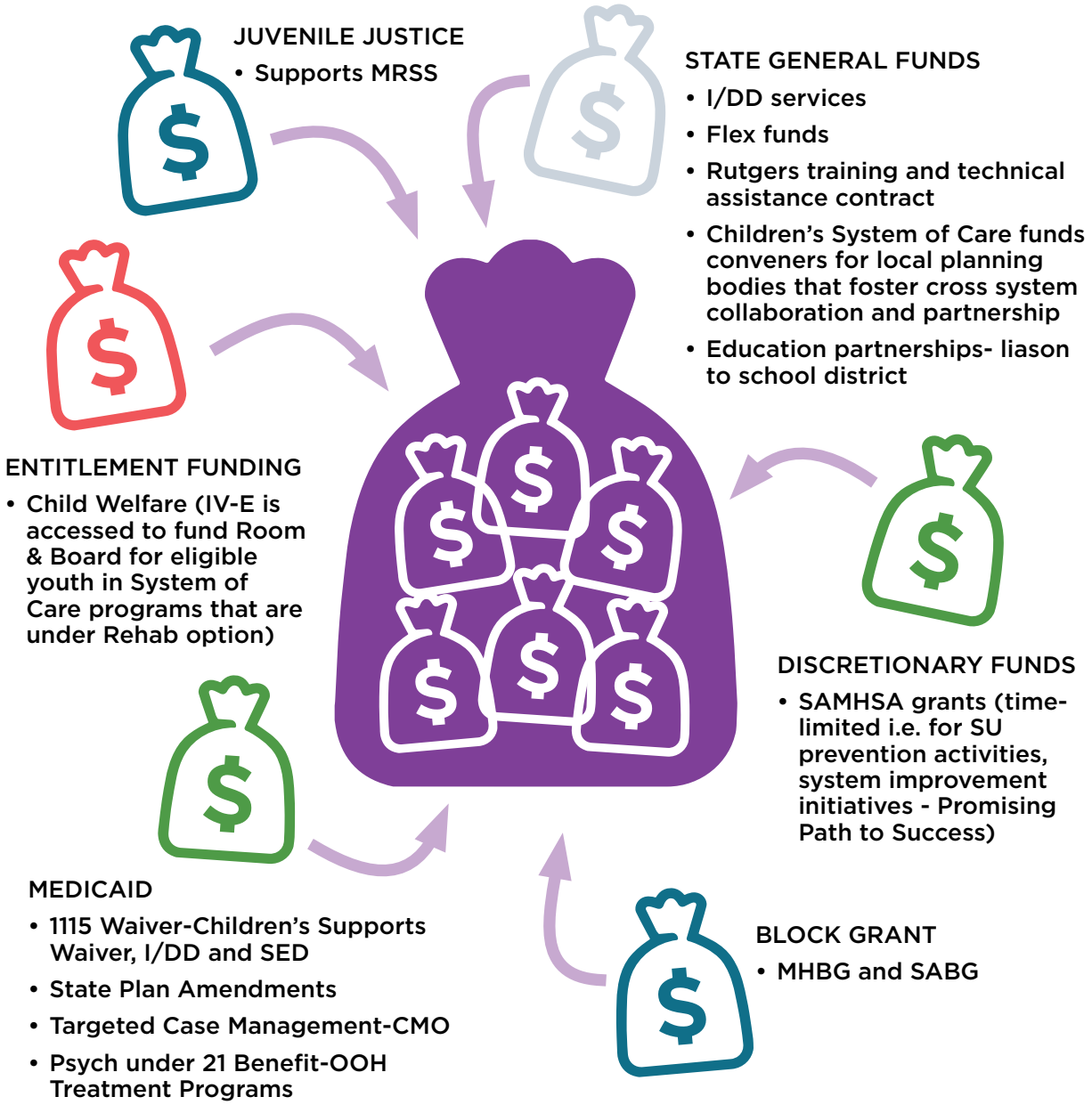
[20] Wraparound Milwaukee. (n.d.). *Wraparound Milwaukee: Background and history*. https://wraparoundmke.com/

[21] Wraparound Milwaukee System of Care. (2019). *Year end report*. https://wraparoundmke.com/wp-content/uploads/2013/09/2019-Annual-Report.pdf

[22] Pires, S.A. (2020). Systems of care module 14: Financing systems of care-Financing strategies. *Building Systems of Care*. Innovations Institute, University of Connecticut School of Social Work. Available from https://innovations.myabsorb.com.

- Children can access services regardless of their Medicaid enrollment through a Medicaid lookalike number; the State seeks reimbursement from commercial and private insurers behind the scenes. These funds stay braided, and the State can track their use, but they are used collectively to support the broad service array.[23, 24]

Figure 4: New Jersey's Children's System of Care (Braided Funding)



[23] Pires, S.A.& Stroul, B. (2013).Making Medicaid work for children in child welfare: Examples from the field. Center for Health Care Strategies. http://www.chcs.org/media/Making_Medicaid_Work.pdf

[24] Personal Communications with E. Manley (January 23, 2019) and R. Goyal-Carkeek (August 30, 2023).

REDIRECTION

Redirection is the use of existing dollars in more effective ways. A State or county can redirect funds from high cost, poor outcome services to invest in more effective and less costly services. States often look to redirect their spending from psychiatric emergency room, inpatient hospitalizations, and partial hospitalization programs to home and community-based services, like mobile response and stabilization services, intensive in-home services, intensive care coordination using Wraparound, early childhood mental health consultation, home visiting, respite care, and peer support.

In 2021, almost one-quarter of children enrolled in NYS Medicaid (488,592, or almost half a million children) used behavioral health services. 162,231 children enrolled in NYS Medicaid used intensive behavioral health services and 9,635 children were designated as having a serious emotional disorder (SED).[25]

There were notable increases in service utilization within the Children's Home- and Community-Based Services (HCBS) from 2019-2021, including planned respite and other caregiver family supports and services. There also were increases in the new Children & Family Treatment and Support Services, with growth in every category of services from 2019-2021, even with the COVID-19 pandemic. Crisis intervention services increased from 70 to 810 individuals served from 2020-2021.[26]

Despite this, the average cost of behavioral health inpatient or emergency room services for children using intensive behavioral health services was $9,000 and the average cost for children designated as SED was $20,000.[25]

These figures suggest there is an **opportunity to redirect spending from inpatient and emergency room services to outpatient and community-based services,** particularly for children using intensive behavioral health services. The overwhelming majority of these children (86%) used behavioral health outpatient specialty services, but only at an average cost of $3,400 per child. This is compared to children designated as SED, 86% of whom accessed these services at an average cost of $56,240.[25] The low average expenditure for children using intensive behavioral health services suggests that these youth received a small dosage of the service.

There also are disparities in the race and ethnicity of the children using behavioral health services through Medicaid. Children designated as SED were much more likely to be white: 70% compared with 39% and 42% for children using general behavioral health services and intensive behavioral health services, respectively. A smaller percentage of children identified as Hispanic or Latino were designated as having SED compared to the other two populations of youth.[25] Given the low average expenditure for outpatient behavioral health services for children receiving intensive behavioral health services, it is possible that children identified as Hispanic or Latino may not be receiving a sufficient dosage of the outpatient behavioral health services, which could lead to higher costs for inpatient care later.

[25] New York State Office of Mental Health. (2023). *Children with behavioral health needs in NYS: An analysis of Medicaid utilization and expenditures.* Available from https://omh.ny.gov/omhweb/tableau/children.html.

[26] New York State Office of Mental Health. (2022). *OMH Medicaid Population Characteristics and Service Utilization Trends*. Available from https://omh.ny.gov/omhweb/tableau/service-trend.html.

Although Wraparound Milwaukee and New Jersey are both provided as examples of blending and braiding funding, they are both examples of redirection. Both were able to reduce inpatient beds and high costs and were able to redirect funds to support their coordinated systems of care.

GENERATE NEW REVENUE

Finally, sometimes communities can generate new revenue. As noted above, this may be through **tax levies or charges to providers**. Charging fees for some services, including on a sliding scale fee, may help to offset some costs, and new revenue may be generated through local and state legislative actions, including the creation of trust funds. **Special fees** on housing, driver's licenses, license plates, and other purchases can generate revenue. Community members can be encouraged to **donate** through websites and local charitable campaigns. These sources of revenue may be small but could help cover one-time or special costs. The most common source of new revenue is through **grants from federal or state agencies or foundations.**

In Ohio, counties can use tax levies on property taxes to fund mental health services. In 2022, Hamilton County (which includes Cincinnati) brought in $36.5 million that was distributed by the Hamilton County Mental Health and Recovery Services Board, which are then dispersed among providers for services. The levy, in place since 2007, cost $40.93 per $100,000 of home value in 2019.[27] The County has tax levies for family services and treatment, developmental disabilities services, children's services, mental health services, and more.[28]

VALUE-BASED PAYMENT

While these four approaches are key strategies, you may also want to consider integrating a value-based payment approach to your financing strategy. Rarely is this done when a model is being implemented; more commonly, it is a strategy to achieve greater flexibility and outcomes with the same or reduced costs once a model has been implemented and has data to demonstrate its effectiveness.[29, 30]

Value-based payments link provider payments to performance. When done correctly, this strategy can reduce inappropriate and/or ineffective care, identify and reward best-performing providers, and create greater clarity around expectations for providers. Value-based payment includes performance incentives, social impact bonds, partial risk, and full risk/capitation models. In these models,

[27] Wartman, S. (2022). *Hamilton County mental health levy tax hike approved for November ballot*. Available from https://www.cincinnati.com/story/news/politics/2022/08/09/hamilton-county-tax-payers-decide-increase-mental-health-levy/10276351002/.

[28] Hamilton County, Ohio. (2023). *Learn about county levies*. Available from Hamilton County, Ohio: https://www.hamiltoncountyohio.gov/government/open_hamilton_county/projects/tax_levy_review_committee/county_levies

[29] Lewis, C., Horstman, C., Blumenthal, D., & Abrams, M.K. (2023). *Value-Based Care: What It Is, and Why It's Needed. Available from The Commonwealth Fund*: https://www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed

[30] Jaffery, J.B. & Safran, D.G. (2021). *Addressing social risk factors in value-based payment: Adjusting payment not performance to optimize outcomes and fairness*. Available from Health Affairs: https://www.healthaffairs.org/content/forefront/addressing-social-risk-factors-value-based-payment-adjusting-payment-not-performance

achieving (or failing to meet) goals can result in rewards or reduced payments. These models can range from lower risk, where funders provide incentives or bonuses when providers achieve goals, to full risk and capitation models, like New York's MCOs. A **social impact bond** is a strategy that uses private sector funds to pay for initial costs and, once certain targets are achieved, the public sector repays the project investors at the level of outcomes achieved.[31] All value-based payment models require very clear designs, policies, and contracts with comprehensive and detailed evaluation activities. All parties must agree on benchmarks and outcomes and the consequences of achieving (or missing) goals, within designated margins.

INTERAGENCY FINANCING

Communities should be prepared to address the "wrong pocket problem."[32] This happens when the entity that is paying for the service does not see the savings or benefits from it. For example, early intervention services provided to children who are identified as having an intellectual or developmental disability may generate positive outcomes in subsequent years when the children are attending school. The education system may not have expended the resources for the early intervention services but benefits from them. The early intervention programs had to pay for the services, but the children aged out of their programs before the programs could see the longer-term benefit and any reduced costs.

One way to address this is by grouping multiple "pockets" together to create interagency bodies to fund programs that benefit children across public systems. The use of a blending and braiding strategy can address this by involving multiple entities as payors to share in the cost and the outcomes. A more comprehensive and longer-term strategy is to reinvigorate the existing structure of Council on Children & Families with dedicated interagency funds and flexibility, similar to

[31] Social Finance. (2023). *Social Impact Bonds*. Available from Social Finance: https://socialfinance.org/social-impact-bonds/

[32] Butler, S., & Cabello, M. (2018). *An Antidote to the "Wrong Pockets" Problem?* Available from the Urban Institute: https://pfs.urban.org/pay-success/pfs-perspectives/antidote-wrong-pockets-problem

how children's cabinets operate in other states. For example, in Maryland, the Children's Cabinet Interagency Fund has been operating since 1978 and provides funds to support prioritized populations and initiatives.[33]

While it may be common for New York agencies to build off of each other's contracts for coordinated services or to braid funds to fund a specific project, dedicated interagency funding can be an ongoing mechanism to fund populations and services that span multiple public child- and family-serving agencies. New York State has a history of interagency funding, through the Council on Children & Families (CCF), and it is possible to establish dedicated interagency funding for priority outcomes and populations. The convened CCF member agency Commissioners and Principal Leaders, as well as the Cross-Systems Deputy Commissioners Workgroup, have demonstrated strong leadership and capacity to support interagency challenges, creating a template for this work.

[33] See https://msa.maryland.gov/msa/mdmanual/08conoff/cabinet/html/child.html

STEP FIVE

What other considerations are there? What do we need to think about in terms of making a business case for this financing?

Communities need to assess the viability of various strategies and be prepared to understand the benefits and challenges associated with what they are proposing.

Examples of these considerations are:

GEOGRAPHIC

- What are the considerations associated with the local geography?
- Are there opportunities or challenges associated with being in a rural, suburban, or urban community?
- How many individuals or families would be served each year?
- What are the costs associated with transportation?
- Is this initiative spanning multiple counties?
- What are the specific and appropriate cultural and linguistic needs of the area?

WORKFORCE

- What does the current workforce look like and what are the challenges and opportunities that exist?
- What are the credentials of the workforce?
- What are the recruitment and retention opportunities?
- What does the training pipeline look like for the workers needed to implement the intervention?

ADMINISTRATIVE BURDEN

- How complicated is it to implement the proposed financing approach?
- Will providers be able to bill, if applicable?
- Will State or local agencies have a large burden for reporting or tracking data?
- Does it take a long time to obtain necessary approvals at the federal or state levels and, if so, what can be done to expedite that?

COMPETING PRIORITIES

- What other financing strategies are being implemented at the same time?
- What is working well and what is a challenge that may be a distraction from these activities?
- What are the immediate pressures on public child- and family-serving agencies that may make it hard to implement these strategies and how are these approaches aligned to be complementary?
- Are there any possible unintended consequences to other community programs that could come from shifting funding streams, especially if you are not able to increase the total amount of funds?

Once the stakeholders have addressed these considerations, they can formulate a business case for the financing strategies. To create this business case, summarize:

1) The population that was identified (including key data) and the service needs;

2) The services identified, including if the services
    a. Were identified by families and youth or other stakeholders
    b. Are already in existence in the community or region
    c. Are identified on any evidence-based practices registry
    d. Are part of a larger initiative (e.g. New York's evidence-based home visiting models);

3) Relevant funding to support this population and service, including
    a. How likely it is the funds would be available
    b. Whether they are one-time or ongoing
    c. Who is eligible to be served by the funds;

4) Financing strategies being proposed, including
    a. The specific approaches that would be taken
    b. The timeline
    c. How funding and outcomes would be tracked;

5) Outline the considerations you have reviewed and why this is the most effective and appropriate strategy to meet the identified population needs.

Include information on the return on investment or benefit-costs associated with the intervention, the costs associated with not implementing this service/ continuing with the status quo, and the anticipated impact on other public systems.

Try not to refer to anticipated "savings" from implementing the service. Savings do not always manifest in the system or agency that is expending the funds. Additionally, when there are savings from children's behavioral health services, they often are reallocated to support general fund activities or adult behavioral health services. Instead, focus on opportunities to reduce year-over-year costs, improve outcomes, and *reinvest* in prevention and early intervention efforts.

In order to convince leaders and funders on the proposal you must start with the who (population), what (service), why (needs), where (setting/agency), and how (funding and financing strategies).

If you started this toolkit on Step 5 because you already know your population, services, and desired funding and financing strategies, you can take this opportunity to reverse engineer your business case; go back through each of these steps and make sure you speak to each of these factors. Provide citations, links, and references to back up your proposal.

STEP SIX

What will it take to implement this approach successfully and sustain it? How will you know you have made a difference?

Before you finalize your business case, you need to know how you will implement and evaluate your model.

EVALUATION AND CONTINUOUS QUALITY IMPROVEMENT ACTIVITIES:

Some funding streams may require specific data to be collected and reported at regular intervals. Regardless of whether it is required, it is always good practice to collect, analyze, and report on data.

You will want to consider the following questions:

- What is the capacity to evaluate the impact of the interventions?
- How will continuous quality improvement activities be implemented, including fidelity monitoring and satisfaction?
- How will you know that you have made a difference?
- How will you know if you have achieved your desired population result?
- Who will monitor this information and use it to support implementation?

Returning to RBA, consider using the continuous quality improvement and evaluation framework of:

1) **How much did we do?** (Process measures, such as referrals, numbers of individuals or families served, cost of services, length of stay, completion of treatment)

2) **How well did we do it?** (Satisfaction and continuous quality improvement measures, such as youth and family satisfaction, model fidelity, ongoing stakeholder engagement and implementation supports)

3) **Is anyone better off?** (Outcomes, such as individual and population-level outcomes that are both short- and long-term using administrative, qualitative, and quantitative data)

SUCCESSFUL IMPLEMENTATION:

Successful implementation requires significant and ongoing work. You are encouraged to consider the policy, management, practice, and community factors that must be addressed during pre-implementation, implementation, and sustainability phases.[34] This guide is focused on just one piece: **the system-level activities needed to finance services to support populations.**

While it touches on the decision-making that must occur prior to determining how to finance a service, it does not go into detail about the process and all the associated pre-implementation activities involved.

This guide also does not address the important aspects of agency setting, internal organizational/provider level activities that must be undertaken when implementing a practice or intervention, including ensuring a skilled workforce (including hiring, training, and coaching), developing and implementing policies and procedures, assessing the gap between policy and practice, and supporting model adherence.

Successful implementation requires careful consideration of the care pathways:

- How youth and families will access services
- How those services will be aligned and integrated with existing services and processes
- How ongoing support occurs.[34]

[34] Estep, K., Sulzbach, D. & Manley, E. (2022). System Reform Support Instrument Manual. Hartford, CT: Innovations Institute, University of Connecticut School of Social Work.

RETURNING TO OUR EXAMPLE...

The population of focus is caregivers with substance use disorders and co-occurring mental health treatment needs who have children under age 5, who are likely to be Medicaid-eligible, and are at-risk of entering foster care. The community is recommending implementation of XYZ Intervention and 123 Treatment.

FUNDING SOURCES: Both XYZ Intervention and 123 Treatment are at least partially eligible for Medicaid reimbursement. XYZ Intervention uses peer support to provide the parenting interventions and the community believes that the peer support component of the intervention could be claimed. 123 Treatment is eligible for Medicaid-reimbursement for its individual and group therapies; stakeholders are confirming that the individual therapy may be reimbursed if it is provided in the home. **The partners have identified a need to cover the other components of XYZ Intervention as well as the training costs associated with both models.** Since both models are on the Title IV-E Prevention Services Clearinghouse as well-supported interventions, the partners intend to ask if the State child welfare agency would amend the FFPSA Prevention Plan to include the service so any families identified as at-risk for foster care who meet the eligibility definition could be served through FFPSA.

FINANCING STRATEGIES: The community intends to propose maximizing revenue through both Medicaid and Title IV-E Prevention Services funds. These funds would be braided to ensure that they are tracked and reported accurately. The community is planning to propose using funds from the **Opioid Settlement Agreement** to support some of these costs and are reaching out to their **State Health Foundation and the foundation associated with the MCO** that serves their region to inquire about covering some of the start-up and training costs. They are looking for **a grant** through HRSA, SAMHSA, or the Children's Bureau to cover evaluation costs to help design and implement the continuous quality improvement process and evaluation of outcomes. They are also considering **leveraging funds** allocated through the SSBG and some county-level funds to support costs, including workforce recruitment and retention bonuses.

OTHER CONSIDERATIONS: The community is a suburban and rural mix. While there is a workforce shortage, there are enough clinics that are interested in participating and an adequate peer support infrastructure. The stakeholders have reached out to a university in the region and are looking to collaborate with them on a grant application that would enable the university to **design and implement the CQI process and evaluation**. The models are well-supported under FFPSA so they do not require a full evaluation, but the community knows that **data are necessary** to support implementation and to demonstrate outcomes. They are talking with the State's technical assistance centers to obtain support around reimbursement models and ensuring that they are accounting for the total cost of implementing the EBPs. The County has been experiencing significant hardship related to opioid use and the community is confident that this initiative will be prioritized. The community partners are creating a one-page overview and PowerPoint presentation to present the business case, with a focus on the administrative data from child welfare, the costs of the interventions, and the outcomes expected from these EBPs. The proposal will outline a multi-year timeline that includes sources of funding, pre-implementation, and implementation activities.

CONCLUSION

Now it is time to finalize your business case. You need to ensure that you **provide information in a way that is designed for the intended audience.** Consider whether you are going to share your proposal in a brief, white paper, presentation, video, infographic, or one-page document. Think about using tables if you are comparing options. Provide enough information to answer each of the questions in this guide without overwhelming the reader. Use appendices or links to other materials or summary documents to provide additional information.

Organize your proposal so that the reader can follow along with the story. **Lead with the information that will be most salient to the recipient.** A policymaker who has just been through a public hearing where they listen to numerous families and legislators about how families cannot access basic treatment services will want to know how your proposal will improve access. Likewise, if your proposal is brought before a budget office facing a deficit, focus on how this proposal will be cost efficient, enable you to serve more people for fewer dollars per person, or how it will likely keep children out of expensive residential services. Finally, make sure to proofread your proposal, use an active voice and straightforward language, and write so that you are making yourself and your proposal accessible.

Your initial proposal for financing may not be approved. **Be willing to table your complex and comprehensive proposal for a simpler, more streamlined proposal that may let you offer proof of concept.** Consider a smaller scale for implementation: one provider, one part of the community, and/or one service while you generate data that shows effectiveness. As your data grow and you have more evidence that what you are doing works, you will be better positioned to advocate for more complex and risk-based approaches to financing.

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Appendices

Definitions of Key Terms

Examples of Strategic Financing in New York State

Websites for Links in the Toolkit

Worksheet: Steps for Sustainable Financing

Worksheet: Business Case Summary

Worksheet: State Agencies and Local Contacts

Definitions of Key Terms

Blended Funds: Combining sources, often across different systems or payers, into a single pool. Blended funds lose their individual identity and associated requirements.[35]

Braided Funds: Coordinating multiple funds to pay for a service or program while maintaining the original identities of the funds. In a braided fund, the funds are distinguishable from each other and have their own identities and associated requirements.[17]

Discretionary Funds: Funds awarded through a competitive process that are made at the discretion of the funder and typically are time limited. The SAMHSA-funded SOC grant is an example of a discretionary grant.[16]

Entitlement Funds: Mandatory spending for anyone who meets the eligibility criteria. Medicaid and Title IV-E are examples of entitlement funds.[17]

Formula Funds: Funds that are awarded through a noncompetitive (and nondiscretionary) process based on a predetermined amount or formula. To receive funds, the entity must meet all the eligibility criteria for the funding. The Mental Health Block Grant is an example of a formula funded grant.[16]

Public Funding: Money that is provided by the government (federal, state, or local), regardless of whether it is provided to a public (governmental) or private institution, organization, or person.

Redirection: A strategy that uses existing dollars and spends them in other (typically more effective) ways. For example, a State may redirect funds that had been spent on inpatient psychiatric care for children and spend some of them on mobile response and stabilization services.

Revenue Maximization: A strategy that tries to ensure all possible funds (usually federal entitlement funds) are being accessed. This is done to free up other, more flexible funds to pay for services that could be paid for by the entitlement fund. The focus is usually on expanding the services, the setting, and/or the population served.

[35] Pires, S.A. (2020). Systems of care module 13: Financing systems of care-A strategic approach. Building Systems of Care. Innovations Institute, University of Connecticut School of Social Work. Available from https://innovations.myabsorb.com.

Examples of Strategic Financing in New York State

Highlighted below are some of the ways that local systems of care across New York have blended and braided funds, identified and leveraged new revenue, and used other innovative financing strategies to start and sustain services, programs, and initiatives. Special thanks to the local systems of care that have shared their stories and examples.

Broome County:

- The NYS Department of Education provides a district-specific-calculated reimbursement of funds, in the form of State Aid, for districts that participate in qualified services. These funds are cooperatively shared amongst area school districts in a participating Boards of Cooperative Educational Services (BOCES) district. Broome Tioga (BT) BOCES constructed a Community Schools CO-SER (an approved cooperative agreement between a BOCES and two or more districts) that has the potential for growth and sustainability. The language used to construct the CO-SER was intentionally broad to allow for future growth.
- NYS Education Department State Aid is reimbursed, after pre-investment of district funds, for qualified CO-SER spending.
- Presently, Community School Coordination is the only service provided under the BT COSER. BCMHD is in the VERY EARLY discussion phase with BOCES, area School Superintendents and OASAS to use a similar model to expand to OASAS Prevention Programming in the 2024-2025 School Year.
- The OMH Promise Zone supports the participation for all 13 area districts and infrastructure for BOCES to stand up the first several years of supervision of the coordination level of service.

Chemung County:

Within the Department of Human Services, the county has a division called Children's Integrated Services (CIS). This division provides the following services with blended funding in most of the areas:

- Preventive services in all schools across the county with a focus on engaging youth in services and preventing placements of any kind.
- Single Point of Access (SPOA) coordination
- Safe Harbor services for those at risk and/or victims of trafficking.
- Person in Need of Supervision (PINS) Diversion with funding from the DSS and Probation
- The local not-for-profit mental health provider provides satellite clinic services in 16 locations across three districts with a blending of third-party insurance, school funding and federal salary sharing. As a result, the no-show rate dropped from >50% to 10-15%, and there is no expense to the family and the provider is always kept whole.
- After hours respite is funded with mental health and DSS funding depending on the needs of the youth. This is arranged via contract with an OCFS voluntary group home provider.

Essex County:

The following workforce and capacity building initiatives leveraged Essex County's participation in the OMH 4-year SAMHSA System of Care (SOC) grant to engage additional funds from other SOC agencies to further the collective impact of Essex County's System of Care goals. The work is administered through Essex County's backbone organization, the Building Resilience in Essex Families (BRIEF) Coalition. There is emphasis on investments to build a sustaining local training infrastructure, and to sustain these capacities beyond the SAMHSA grant period:

- Essex County DSS is funding a train-the-trainer course, with the NYS Trauma Informed Network and Resource Center, for 16 staff across multiple Essex County agencies to become certified as trauma informed trainers. They leveraged SAMHSA SOC grant investments in cross-system trauma informed care training and consulting, with funds drawn from DSS Safe Harbor funds. This is blended into Essex County SOC's Cross-System Trauma Responsive Care Initiative.
- Essex County DSS funded a Resiliency train-the-trainer with Dr. Nan Henderson, for staff across multiple agencies to become certified trainers with the NYS Trauma Informed Network and Resource. They leveraged SAMHSA SOC grant investments in cross-system Resiliency training and consulting with funds drawn from DSS Safe Harbor funds. This is blended into SOC's Cross-System Resiliency Initiative.
- The Probation Department funded the significant startup costs for BRIEF's MindUP Social Emotional Learning (SEL) initiative (including train-the-the trainer fees and supplies). They leveraged SAMHSA SOC grant investments in MindUP and other SEL initiatives, with funds drawn from Probation's prevention funds. This is blended into SOC's Essex County Social Emotional Learning Initiative.
- BRIEF backbone organization staffing costs combine funds from SAMHSA SOC grant and OMH grant. In the coming year, as the SAMHSA grant funds wind down, BRIEF staffing funds will begin to draw from Family Peer Advocate services billing and Opioid Settlement funds. This is blended into SOC staffing infrastructure.

Onondaga County:

- Onondaga County has cross-system "No wrong door for children's concerns" teams that include education, mental health, child welfare, and juvenile justice partners. The team is called ACCESS and has more than 10 revenue sources including schools, local tax dollars, child welfare, juvenile justice and OMH funding.
- Mobile Crisis teams (5 teams across 2 agencies) use local county tax dollars, Medicaid, and local city tax dollars.
- A 911/988 pilot team is funded by county tax dollars, city tax dollars, and OMH state aid.
- A Student Assistance Program team of 11 is funded by OASAS State Aid and school district match.
- A Forensic Monitoring Team is funded by multiple OMH state aid program and funding codes and local county tax dollars.

- Mental Health Clinics in schools are funded with Managed Care, Medicaid Managed Care, county local tax dollars set aside for school based mental health for start-up costs of new satellites, OMH grants, and school districts.
- Family support for student success (55 staff in 34 schools) is funded by Child Welfare preventive funding, and a 38% match through a local community foundation
- Preventive services in all schools across Onondaga County that including funding school counselors, universal, secondary and tertiary response for youth at risk of substance use challenges, behavioral support workers in 77 schools, ACCESS team members connected to every school to address needs before they reach the level of a crisis. Funding from multiple sources.

Westchester County:

Westchester County has several examples of blended and braided funding and planning to support children's Systems of Care and cross-systems funding and activities.

Westchester County uses several interagency structures to support cross-systems funding and activities, including:

- Coordinated Children's Services Initiative (CCSI): CCSI serves as Westchester's System of Care's primary "planning structure" which brings together individuals and systems from public and private sectors in a cross-systems collaborative effort to improve the circumstances of children and families in Westchester County. This multi-tiered approach is led by a county committee that includes several subcommittees and a community-based structure focusing on specific areas of need and practice models to engage children and families in planning.
- CCSI Advisory Committee: Established in 1991, CCSI Advisory Committee is Westchester County's primary county planning body for children and family with various human services and behavioral health needs. Committee consists of leadership in child welfare, mental health, substance abuse, developmental disabilities, health, juvenile justice, domestic violence, education, community services, advocates and peer/family support.
- Early Childhood System of Care: This is Westchester County's primary system of care subcommittee addressing the needs of young children and their families. Subcommittee members include leadership in child welfare, mental health, early childhood programs, HeadStart and advocates and peer/family support.

Westchester County has also used blended and braided funding and non-traditional sources of funding to support cross-system activities across the children's Systems of Care, which are outlined in the table below.

Table 1: Westchester County, NY Examples of Cross-Systems Financing

Westchester Initiative	Funding Source(s)	Amount	Partners	Summary of Program/Services
Family Strengthening	County Tax Levy, DSS, OMH State Aid	$172,000	DCMH, DSS, Mental Health Agency	Program addresses concerns about increasing numbers of young children and preschoolers with multiple psychiatric hospitalizations, emergency room visits, school suspensions, and at high-risk for foster care placement. Families of such children also frequently have past or present DSS involvement, usually in the form of CPS investigations. Family Strengthening aims to keep children out of psychiatric hospitals and emergency rooms, and to help them succeed at school and with their families, by offering timely and intensive, evidence-informed, short-term interventions to children and families. Two clinicians provide a wide range of both clinical and case-management services with the goal of stabilizing the child's behaviors as well as the family and social context in which these behaviors occur.
Early Step Forward	DCMH County Tax Levy	$738,000	County, DCMH, DOH, Early Childhood/ HeadStart, Mental Health providers	An enhanced Mental Health Consultation model serving children ages 0-5, and their families. Program services children and families with "highest needs. The model supports all students via Second Step, Pyramid Model and other evidence-based approaches to Early Childhood Education; provide training and support for child-care staff & directors; offer a wide range of supports for parents; build organizational capacity through step-down approach; and ongoing evaluation to refine the model.
Interdepart-mental Agreement	County Tax Levy (DSS), DSS Commu-nity Optional Preventive Services (COPS), TANF	$702,197	DCMH, DSS, Probation and Multiple Services Providers	Interdepartmental Agreement to provide multiple services for children/adolescents at risk for residential placement/court involved. Funding supports creation of a Cross-Systems Unit consisting of DSS Preventive Services, Probation and Mental Health Services to offer (no wrong door, 1 collaborative unit). Funds also support children's respite options and family support.
County School District Collaborative	County Tax Levy, DSS Preventive Funds, OMH State Aid	$177,000	DCMH, DSS, School Districts	DCMH and DSS positions to support and monitor School District CSE Placements. Local government pays approximately 30% of all CSE residential placements. Westchester has 46 school districts and average 130 students in residential placements. DCMH staff provides support to districts and families at CSE level in an attempt to avert unnecessary placements and ensure systems involvement and wraparound planning. DSS staff monitors days on residential placements and lengths of stay.

Westchester Initiative	Funding Source(s)	Amount	Partners	Summary of Program/Services
School-Based Satellite Clinics	County Tax Levy, Opioid Settlement Funding, School Districts, Billing	Various amounts – total over $900,000 (not include billing funding)	DCMH, School Districts	Support school-based mental health satellite clinics throughout Westchester County. To date, 71 school based satellite clinics. Prior to 2024, providers were not able to bill commercial insurance. Creative braided funding utilized including OMH State Aid, Opioid Settlement Funding, County Tax Levy.
Out of Home Respite	DSS, DCMH, Federal Homeless Youth Funding	$650,000	DSS, DCMH, Agency	Braided funding to support 24/7 Children/Adolescent Runaway and Homeless Shelter for 12 youth for maximum stay of 30 days.
Clinical Treatment/ Fire-Setting Evaluations & Safety Planning	DSS, DCMH	$377, 548	DSS, DCMH, Treatment Provider	DCMH OMH State Aid funding, DSS COPS funding to create satellite clinic in DSS District Office as well as county-wide Fire-setting evaluations and safety planning.
Camp Morty	County Tax Levy, Foundation Funds, In-Kind Departments	$683,930	Parks Dept, DSS, DCMH	Summer Residential Camp for children/adolescents in foster care and/or Preventive Services
School District Workforce Support & Training	DCMH, Southern Westchester BOCES, Putnam/ Northern Westchester BOCES	Approx. $30,000 annually	DCMH, 2 BOCES	On-going training and technical assistance on such initiatives including Suicide Prevention Risk Assessment and Safety Planning, Mental Health First Aid, School-Wide Positive Behavioral Supports/ Multi-Tier Systems, School Safety Planning, School Avoidance.

Websites for Links in the Toolkit

Links are provided in the order they are referenced in the document

Results-Based Accountability tool: https://clearimpact.com/resources/publications/results-based-accountability-guide/

National Evidence-Based Practice Clearinghouses:

- **Washington State Institute for Public Policy:** https://www.wsipp.wa.gov/BenefitCost
- **California Evidence-Based Clearinghouse for Child Welfare:** https://www.cebc4cw.org/
- **Institute of Education Sciences:** https://ies.ed.gov/
- **What Works Clearinghouse:** https://ies.ed.gov/ncee/wwc/FWW
- **Blueprints for Healthy Youth Development:** https://www.blueprintsprograms.org/
- **Title IV-E Prevention Services Clearinghouse:** https://preventionservices.acf.hhs.gov/

New York State Technical Assistance:

- **NYU's McSilver Institute:** https://mcsilver.nyu.edu/technical-assistance/
- **Center for Practice Innovations at Columbia Psychiatry & New York State Psychiatric Institute:** https://www.practiceinnovations.org/
- **The New York State Center for School Safety:** https://www.nyscfss.org/

National technical assistance organizations and networks:

- **National Training & Technical Assistance Center for Child, Youth, & Family Mental Health:** https://nttacmentalhealth.org/
- **Opioid Response Network:** https://opioidresponsenetwork.org/
- **SAMHSA's Technology Transfer Centers:** https://www.samhsa.gov/technology-transfer-centers-ttc-program
- **National Child Traumatic Stress Network:** https://www.nctsn.org/
- **Office of Head Start:** https://eclkc.ohs.acf.hhs.gov/about-us/article/training-technical-assistance-centers
- **SOGIE Center:** https://sogiecenter.org/
- **National Center on Substance Abuse & Child Welfare:** https://ncsacw.acf.hhs.gov/
- **Children's Bureau-funded Quality Improvement Centers:** https://www.acf.hhs.gov/cb/capacity/quality-improvement-centers
- **Rural Health Information Hub:** https://www.ruralhealthinfo.org/
- **Child Welfare Capacity-Building Centers:** https://capacity.childwelfare.gov/

The National Implementation Research Center's Hexagon Tool: https://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/imce/documents/NIRN%20Hexagon%20Discussion%20Analysis%20Tool%20v2.2.pdf

Rates for services provided by the MCOs established by the State of New York: https://omh.ny.gov/omhweb/clinic_restructuring/fiscal-billing-resources/

McSilver's MCTAC Billing Tool: https://billing.ctacny.org/

OCFS information on child preventive services: https://ocfs.ny.gov/main/sppd/policy/child-preventive-services.php

Funding opportunities available through OCFS: https://ocfs.ny.gov/main/contracts/funding/

The Child Welfare Information Gateway: https://www.childwelfare.gov/pubs/other-pubs/majorfedlegis/

New York's Title IV-E Prevention Services Plan: https://ocfs.ny.gov/main/sppd/docs/FFPSA-Prevention-Plan-2022-07-29.pdf.

Data on implementation: https://ocfs.ny.gov/main/sppd/family-first-data.php

New York's Federal FY2022 SSBG report: https://ocfs.ny.gov/main/reports/cfsp/2022-SSBG-IUR.pdf

Chafee Foster Care Program for Successful Transition to Adulthood (Chafee) and Education and Training Vouchers (ETV): https://ocfs.ny.gov/programs/youth/chafee.php

Mental Health Service Professional Demonstration Grant Program: https://www.federalregister.gov/documents/2019/06/21/2019-13289/applications-for-new-awards-mental-health-service-professional-demonstration-grant-program

School-Based Mental Health Services Grant Program: https://oese.ed.gov/offices/office-of-formula-grants/safe-supportive-schools/school-based-mental-health-services-grant-program/

School-Based Health Centers: https://www.health.ny.gov/facilities/school_based_health_centers/

The Safe and Healthy Students Unit: https://www2.ed.gov/about/offices/list/oese/oshs/oshsprograms.html

Health Center Program School-Based Service Expansion: https://bphc.hrsa.gov/funding/funding-opportunities/school-based-service-expansion/frequently-asked-questions

Project AWARE: https://www.samhsa.gov/school-campus-health/project-aware

Full-Service Community Schools Program: https://oese.ed.gov/offices/office-of-discretionary-grants-support-services/school-choice-improvement-programs/full-service-community-schools-program-fscs/

SAMHSA strategic plan for 2023-2026: https://www.samhsa.gov/sites/default/files/samhsa-strategic-plan.pdf

SAMHSA discretionary grants: https://www.samhsa.gov/grants

SAMHSA's funding forecast: https://www.samhsa.gov/grants/grants-dashboard/forecasts

SAMHSA's Community Mental Health Services Block Grant (MHBG): https://www.samhsa.gov/grants/block-grants/mhbg

SAMHSA's Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG): https://www.samhsa.gov/grants/block-grants/subg

Health Resources & Services Administration (HRSA): https://www.hrsa.gov/

Office of Juvenile Justice & Delinquency Prevention (OJJDP): https://ojjdp.ojp.gov/

NY Opioid Settlement:

- **Agreement:** https://ag.ny.gov/nys-opioid-settlement
- **Fund Tracker:** https://oasas.ny.gov/fy-2023-opioid-settlement-fund-initiatives

WORKSHEET:
STEPS FOR SUSTAINABLE FINANCING

	Steps		Notes
POPULATION	**1) Who is the prioritized population?** **What are the needs associated with supporting that population?**	Who is the population of children, youth, young adults, or families that you are focusing on and why?	
		What are the service needs of this population?	
SERVICES	**2) Which Services are Most Appropriate to Meet the Needs of the Identified Population?**	Identify possible services and interventions	
		Review the possible services and interventions using the Hexagon Tool and against RBA criteria.	

	Steps		Notes
FUNDING	**3) What are the possible sources of funding for your program or service?**	Consider Public Funding (Medicaid; Child Welfare; Other Federal, State and Local Funding)	
		Consider Private Funding (Hospital Community Benefit Funds; Private Foundations; Corporate Sponsorships and Awards)	
FINANCING STRATEGIES	**4) What financing strategies can be used?**	Revenue Maximization	
		Blended and Braided Funds	
		Redirection	
		Generating New Revenue	
		Value-Based Payments	
		Interagency Financing	

	Steps		Notes
CONSIDERATIONS	**5) What other considerations are there?** **What do we need to think about in terms of making a business case for this financing?**	Geographic Considerations	
		Workforce Considerations	
		Administrative Burden	
		Competing Priorities	
		Approach for Making a Business Case	

	Steps		Notes
IMPLEMENTATION & CQI	**6) What will it take to implement this approach successfully and sustain it?** **How will you know you have made a difference?**	Evaluation & Continuous Quality Improvement Strategies	
		Successful Implementation Activities	

WORKSHEET:
BUSINESS CASE SUMMARY

POPULATION:
SERVICE NEED:
PROPOSED SERVICES & SETTING:

EVIDENCE TO SUPPORT PROPOSAL:

FINANCING STRATEGIES:

CQI AND EVALUATION PLAN:

IMPLEMENTATION APPROACH & TIMELINE:

WORKSHEET:
STATE AGENCIES & LOCAL CONTACTS

Federal Funding Stream	New York State Agency Serving as Lead for the Funding Stream	Who are your local or regional contacts? State-level contacts?
Medicaid	Department of Health	
Child Welfare	Office of Children and Families (OCFS)	
Education	State Education Department (SED)	
SAMHSA	Office of Mental Health Office of Addiction Services and Supports	
Early Intervention	Department of Health	
Maternal & Infant Home Visiting	Department of Health	
Juvenile Justice	Division of Criminal Justice Services	