# Considerations for the Design of an Aligned Funding Pilot

## RECOMMENDATIONS IN ACCORDANCE WITH SENATE BILL 19-195

Prepared by the Farley Health Policy Center for the
Colorado Department of Health Care Policy and Financing

**December 15, 2023**

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# Acknowledgements

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## About the Authors

The Farley Health Policy Center (FHPC) at the University of Colorado Anschutz Medical Campus strives to advance policy that overcomes fragmented systems and addresses the wholeness of a person — physical, behavioral, and social health in the context of family, community, and the health care system. The FHPC works with state agencies and policymakers to understand and inform achievable policy actions to improve the integration of behavioral health across health and health care systems.

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# Executive Summary

## Introduction

Colorado families struggle to meet the behavioral health (BH) needs of children, needs that span the full continuum from screening and referral to targeted prevention, integrated services, outpatient, intensive home- and community-based services, and residential care. Multiple challenges exist, including multiple funding sources, programs that don't collaborate, geographic variation in availability, and too few providers, especially for children who are multi-system involved. In response to this fragmented system and poor child and youth BH outcomes, the Colorado legislature passed SB19-195, which championed several initiatives designed to improve the child and youth serving system by ensuring state entities "collaborate with one another" and better serve children and youth at risk of out-of-home placement due to BH conditions. This report outlines the considerations, stakeholder engagement, and policy changes that have led to the following recommendations: 1) the state focus on aligning funding design changes in new initiatives planned or already underway and 2) the state not move forward at this time with a joint funding pilot.

## Why Consider an Aligned Funding Pilot?

A critical component of SB19-195, Child and Youth Behavioral Health System Enhancements, directs the Department of Health Care Policy and Financing (HCPF) to design and put forth recommendations for

a child and youth BH delivery system pilot program that integrates funding for BH intervention and treatment services across the state to serve children and youth with BH disorders. The purpose was to try and address the challenges of fragmentation and duplication of these services. Potential benefits of the pilot would include reducing the administrative burden on families, increasing access to services without fragmentation, and improving collaboration. This legislation initially had funding, but thus the state budget cuts in state fiscal year (SFY) 2020-21 due to COVID-19 included those associated with SB 19-195. Resources were restored in SFY 2021-22. While this report meets the requirements to design and recommend a pilot, the statute does not require any state agency to implement the pilot and no funding has been established for this purpose.

## Approach to the Work

HCPF selected the Farley Health Policy Center (FHPC) at the University of Colorado Anschutz Medical Center to perform the work and they sub-contracted with the Colorado Health Institute (CHI). The FHPC/CHI team worked with HCPF leaders to narrow the scope of services to facilitate discussion on the specific design decisions and mechanics of aligning funds. The selected services are high-fidelity wraparound, multi-systemic therapy, functional family therapy, respite, and day treatment services. The joint team then proceeded to gather data, develop, and narrow options for design of an aligned funding pilot. Data gathering entailed conducting an environmental scan of the literature; interviewing key informants in Colorado and across the country; presenting iterative findings to key county- and state-wide stakeholder groups; hosting two 60-minute virtual public convenings; and fielding a survey to parents/guardians and families.

## Perspectives of Stakeholders

Colorado stakeholders shared several perspectives, including:

- Families are agnostic as to who pays for services or the mechanism by which it is done. They want services to be available when they are needed and would be most helpful. They really need support and help navigating the system and finding providers.
- Services for children with intensive behavioral health needs include Day Treatment, Multi-systemic Therapy, High-Fidelity Wraparound, Respite and Functional Family Therapy.
- There are other non-traditional and emerging best practices and other non-medical services for which Health First Colorado (Colorado's Medicaid program) does not pay that can be very helpful to children and families.
- Necessary components to change current systems include trust, flexible funds, and authority to make game-time decisions.
- Aligning funds is time and resource intensive. Examples of work needed include pursuing federal approvals, passing legislation, and implementing rule changes.
- Clear outcomes, a quality assurance mechanism, and strong governance are essential to implementation.
- Work must align with other system and program changes happening at the state level.

Finally, throughout this entire engagement, Colorado stakeholders often mentioned the number of substantial BH transformation initiatives presently underway, including the launch of the Behavioral Health Administration (BHA), the creation of the Behavioral Health Administrative Service Organizations (BHASOs), and the roll out of the Accountable Care Collaborative (ACC) Phase III, as well as the risks and benefits of aligning implementation with current efforts or keeping them separate.

National experts shared many of the same perspectives regarding the need for trust, flexible funding, and authority. They also echoed that aligning funding and changing the way money flows is intense, challenging work. Another strong theme that emerged from our literature review and from key informant interviews with national leaders is to braid funds and not blend them, given numerous regulatory and reporting hurdles.

## Final Recommendations

SB19-195 is a broad piece of legislation with the over arching goal of enhancing behavioral health services and policy coordination for children and youth. The legislation specifically calls for "improved coordination among state departments and political subdivisions of the state" to reduce duplication and fragmentation of services, particularly for those "children and youth with behavioral health challenges [that] may require a multi-system level of care."[1] The FHPC/CHI team makes the following recommendations based on ability to achieve these goals, assessment of findings from state and national reports, conversations at the convenings, and feedback from Colorado stakeholders and national experts:

1. **Continue to invest in the system transformation activities currently underway**, many of which are designed to reduce fragmentation and challenges navigating multiple systems. These efforts include, but are not limited to: ACC Phase III development and implementation; payment reform initiatives; additional requirements on contracting, network standards, and minimum payments; implementation of BHA's strategic plan; and development of a statewide children's behavioral health strategy.

2. **Ensure BHA and HCPF have an aligned approach to joint funding of key initiatives,** including, but not necessarily limited to, those listed above. As these initiatives develop, state agency representatives should review opportunities and assess whether braided funding is an option that would support the goals of improved coordination and access to services while reducing fragmentation of BH services. Specifically, at regular intervals and timed with key BH transformation milestones, impacted state agencies should invite partners to determine whether aligning funds (either as a pilot or broader in scope) can be executed in emerging, yet to be solidified, systems.

3. **When appropriate, ensure any actions taken to execute aligned funding are informed by learnings presented here in this report and best practices from other states.** Some design features have strong recommendations. As one example, there is a strong recommendation to braid funds and not blend them. Blending poses significant challenges with federal dollars and also necessitates absolute trust among all partners. Another recommendation is to focus on funds that are more amenable to braiding, for example, state-controlled dollars. These initial recommendations can serve as a foundation to support moving from design to implementation.

*There was consensus from many stakeholders that there is a lot going on with several suggesting the state "just fix what we have and focus on the changes underway."*

# The Behavioral Health Challenges of Colorado's Children and Youth

## Children and Youth Are in Crisis

Across the country, states, communities, and families are struggling to meet the behavioral health (BH) needs of children and youth, a crisis amplified and exacerbated by the COVID-19 pandemic. Colorado is struggling similarly. In May 2021, Children's Hospital Colorado (CHCO) declared a "State of Emergency" for youth mental health. A year later, CHCO reported a 23% increase in emergency room visits for youth in mental health crisis between the first quarter of 2021 and the first quarter of 2022 and a 103% increase from the first quarter of 2019 as compared to the first quarter of 2022.[2,3] The State of Mental Health in America survey produced by Mental Health America suggests improvements in care for children in Colorado: Colorado ranks 13th in the country for pediatric mental health[4] in 2022, up from 42nd in 2021, yet challenges continue:

- About 15% of Colorado's children experienced a major depressive episode in the past year, and about 9% experienced a severe major depressive episode, rates akin to national rates. Colorado's kids were more likely to receive treatment — 40% not receiving treatment compared to 60% nationally, but this still means nearly 1 in 2 are not getting care.[4,5]
- About 10% of children and youth in Colorado with private insurance report their insurance does not cover mental or emotional problems (the national rate is 8%).[4]
- Nearly one in five (17%) reported seriously considering suicide in the past year, and 7% said they had attempted it.[6] Suicide is the leading cause of death for people ages 10–24 years.[7]
- The "school-to-prison pipeline" disproportionately impacts youth of color: Black students make up just under 5% of children in Colorado schools but represent more than 10% of in- and out-of-school suspensions. Frequently, these types of behavioral challenges are due to mental health struggles or past traumas. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 50-70% of youth in the juvenile justice system meet the standard for having a mental health disorder.[2]

The need for services spans the continuum from screening and referral to targeted prevention, integrated services, outpatient, intensive home- and community-based services, and residential care. Getting upstream and prioritizing prevention and early intervention particularly for high-risk populations can minimize the need for subsequent higher-intensity services.

## Many Funding Sources, Programs that Don't Collaborate, and Too Few Providers

The precise dollar amount that is dedicated to BH services for children and youth is not known because many programs fund adults. Also, much of the care is not tracked to a specific individual. In 2020, Governor Polis directed the Colorado Department of Human Services (CDHS) to implement Colorado's Behavioral Health Task Force (BHTF). One of the subcommittees, the Children's Behavioral Health Subcommittee (BHTF Children's Subcommittee), commissioned the Colorado Health Institute (CHI) to map BH expenditures for children.

The report, *Serving Colorado's Children: A Financial Map of the Behavioral Health System*,[8] estimated $404-$810 million in federal and state funds supported BH care for children and youth ages 0 to 26 in State Fiscal Year (SFY) 2018-19. These funds supported services across a full array, including promotion and prevention, school-based services, integrated BH in primary care, outpatient care, intensive community- and home-based services, residential, inpatient hospitalization, crisis services, and care coordination. Most relevant to this report and SB19-195 is funding for intensive community- and home-based services. Due to the lack of uniform data collection and inconsistency in how state agencies define BH services, less than half of state agency expenditures could be mapped to the service array. Of known spending, $32 million (8.9%) was for intensive community- and home-based services.[8]

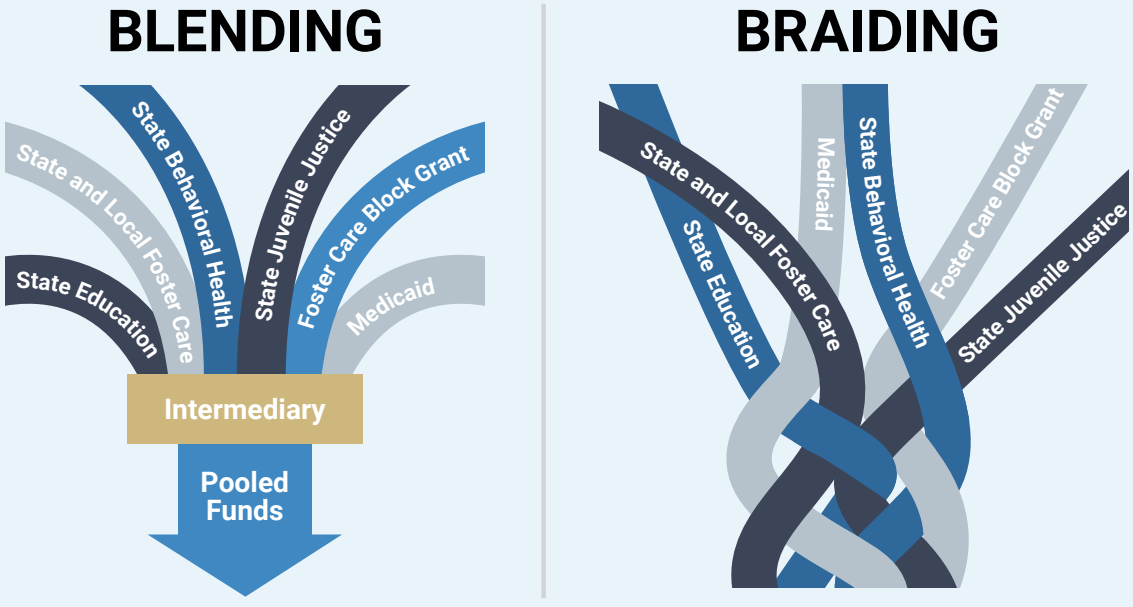
Many entities fund BH services, and programs are operated by multiple cabinet-level agencies, counties, municipalities, and community mental health centers. Funders include but are not limited to: Health First Colorado (capitated and fee-for-service), child welfare through the Child Welfare Services and Core Services Block grants, Colorado Youth Detention Continuum (CYDC), local school districts, Collaborative Management Program (CMP), Children and Youth Mental Health Treatment Act (CYMHTA), SAMHSA block grants, crisis services, and the Momentum program. All these funding streams and programs can make it difficult for families to navigate needed services and payers, and the different funders don't always work well together to ensure there is an agreed-upon payer. In addition, there is tremendous variation in access for all BH services with some parts of the state facing acute challenges.

# Exploring An Aligned Funding Pilot as One Potential Solution

Over the past several years, multiple laws have been passed in Colorado; programs have been created; funding has increased, and benefits are expanding and changing. In 2019, SB19-195 was signed into law with funding for several solutions to help improve the BH system. Specifically, the legislation directs the Department of Health Care Policy and Financing (HCPF) to implement high-fidelity wraparound services for children and youth (with federal approval) and to "design and recommend a child and youth BH delivery system pilot program that addresses the challenges of fragmentation and duplication of BH services. The pilot program shall integrate funding for BH intervention and treatment services across the state to serve children and youth with BH disorders." In this report, the pilot is referred to as the "aligned funding pilot," and the specific methods of aligning funding include blending and braiding.

- **Blending:** means combining different funding streams into one pool, under a single set of reporting and other requirements, which makes streams indistinguishable from one another as they are combined to meet needs on the ground that are unexpected or unmet by other sources.[9]
- **Braiding:** means coordinating funding and financing from several sources to support a single initiative or portfolio of interventions (usually at the community level). Braiding keeps funding/financing streams in distinguishable strands, so each funder can track resources.[9]

**Figure 1. Example depictions of blended (or pooled) and braided funding streams adapted from the National Academy of State Health Policy.[10]**



Potential benefits of a new way of paying for services would include reducing the administrative burden on families, increasing access to services without fragmentation, and improving collaboration across funding streams.

HCPF and the CDHS Office of Behavioral Health (OBH) began work on implementing SB19-195 in the beginning of SFY 2019-20. During the following legislative session, which was interrupted by the pandemic, state leaders were forced to cut the state's budget by $3 billion dollars. Lawmakers prioritized cuts to programs and activities that were authorized but not yet implemented, which included funding for SB19-195. In SFY 2021-22, funding was restored.

# Approach to the Work

In 2022, HCPF contracted with the Farley Health Policy Center (FHPC) at the University of Colorado Anschutz Medical Campus to complete the work related to the aligned funding pilot. The FHPC sub-contracted with CHI; together these entities are referred to as the FHPC/CHI Team.

## Defining the Scope

To manage the scope of research and possible design options and to ensure the work could be completed within the available time and resources, the FHPC/CHI team proposed to focus on a sub-set of services that are currently provided by multiple state agencies and community entities. Other components of SB19-195 focus on children who are at risk of out-of-home placement and need intensive services that allow them to remain in their homes and communities. Therefore, the FHPC/CHI team and HCPF staff and leadership elected to consider evidence-based services included in the intensive home- and community-based services continuum (as defined by the BHTF Children's Subcommittee).[11] The lessons learned from the research and the final recommendations made can then be applied to a broader array of services. The five services selected by HCPF staff are defined below in Table 1.

### Table 1. Definitions of services of focus.

| Service | Definition |
|---|---|
| **Multi-systemic therapy (MST)**[12] | An intensive, home-, family- and community-based treatment focusing on factors in an adolescent's environment that contribute to his/her anti-social behavior, including adolescent characteristics, family relations, peer relations, and school performance. Examples include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavioral therapies. Usual duration of MST treatment is approximately four months. MST is provided using a home-based model of service delivery. |
| **Functional family therapy (FFT)**[13] | An evidence-based intervention for youth and families designed for 11- to-18-year-old youth who are at risk or have been referred for behavioral or emotional problems. This high-quality, strengths-focused family counseling model is designed primarily for at-risk youth who have been referred by the juvenile justice, mental health, school, or child welfare systems. Services are short-term and conducted in both clinic and home settings and can also be provided in schools, child welfare facilities, probation and parole systems, and mental health facilities. |
| **High-fidelity wraparound (HFW)**[14] | An individualized approach to helping children, youth, and families with complex needs. Service providers, natural supports, and the youth and family work together to help achieve the family vision. The team honors the strengths, voices, and culture of the family to build confidence and experience success at home, in school, and in the community. |

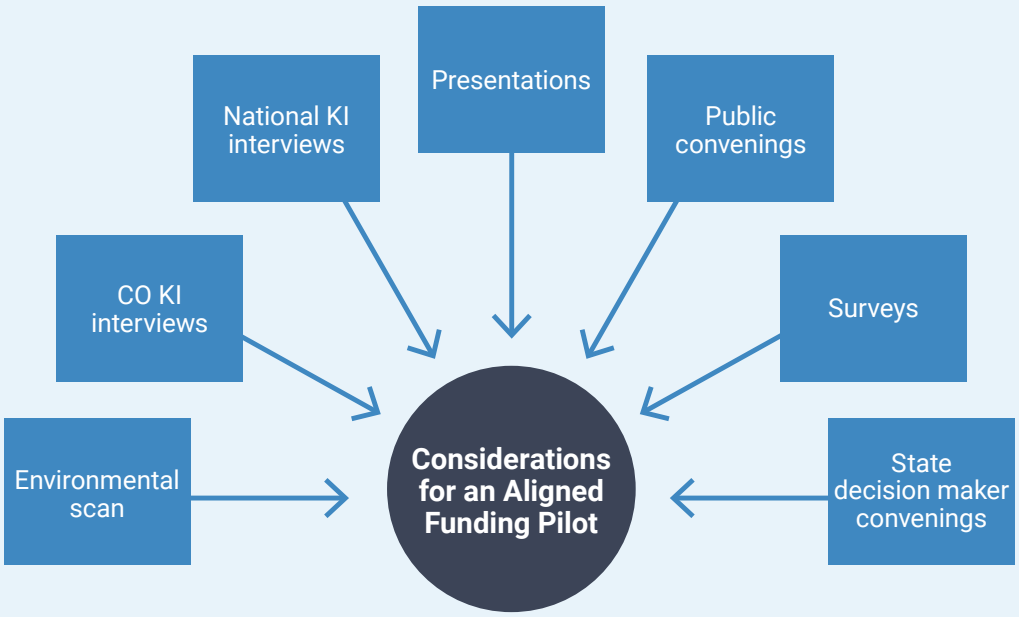
| Service | Definition |
|---|---|
| **Respite**[12] | Temporary or short-term care of a child, adolescent, or adult provided by adults other than the birth parents, foster parents, adoptive parents, family members, or caregivers with whom the member normally resides, designed to give the usual caregivers some time away from the member to allow them to emotionally recharge and become better prepared to handle normal day-to-day challenges. |
| **Day treatment**[12] | A non-residential treatment program designed for children and adolescents under the age of 21 who have emotional, behavioral, and neurobiological/substance use problems and may be at high risk for out-of-home placement. Day treatment services include psychotherapy (e.g., family, group, individual); parent-member education; skill and socialization training focused on improving functional and behavioral deficits, and intensive coordination with schools and/or other child service agencies. |

## Gathering Information

The FHPC/CHI team's work was iterative and overlapping. The literature review informed the key informants we interviewed who, in turn, identified other experts to speak with and reports to review. From spring 2022 through early 2023, the FHPC/CHI team:

1. Conducted an environmental scan of publicly available program-specific reports, presentations, summaries of funding sources, budget documents, and other recommendations and reports from state agencies, as well as the Governor's BHTF (including subcommittee reports and recommendations) and technical assistance documents on best practices in designing and implementing aligned funding initiatives. This scan included both state- and national-level documents. Appendix VI is a guide to key resources. (June 2022–January 2023; n=50 documents)
2. Interviewed key informants (KIs) across Colorado, including state agency staff and managers, Regional Accountable Entity (RAE) representatives, county Department of Human Services (DHS) leaders, and families. Appendix II describes the types of KIs that were interviewed. (June 2022–January 2023; n=119 KIs)
3. Interviewed KIs in other states including state government leaders, individuals at community organizations, foundation partners, state and national researchers, and experts on alternative funding models. Appendix II describes the types of KIs that were interviewed. (June 2022–January 2023; n=27 KIs)
4. Presented to standing meetings, including the Accountable Care Collaborative Program Improvement Advisory Committee (PIAC) Behavioral Health and Integration Strategies (BHI) Subcommittee meeting on June 1; the HRCC Collaborative Forum (The HRCC is composed of representatives from HCPF, RAEs, Child Welfare, Counties) on June 24; standing RAE meetings with county partners, and HCPF and the Behavioral Health Administration (BHA) BH reform leadership committee meetings on September 15 and November 10. Appendix II includes a list of presentations the FHPC/CHI team gave. (June 2022–November 2022; n=9 presentations)
5. Hosted two 60-minute, virtual public convenings with families, service coordinators, clinicians, and other stakeholders working with youth to help design components of an aligned funding pilot, such as how the program should be administered, which children and youth should be eligible for services, which service types should be funded, and how the program should be rolled out. (December 2022; n=15 participants)
6. Fielded an online survey to parents/guardians and family members and a second, related survey on the same topics to service coordinators, state and local agency officials, and other youth-serving stakeholders. Appendix V includes the survey questions and aggregate responses. (November–December 2022; n=68 respondents; respondents included 22 parent/guardians and family member and 46 service coordinators, providers, and youth-serving stakeholders)
7. Convened two sessions with BH decision makers from HCPF, CDHS, and BHA. During the October 2022 convening, the FHPC/CHI team solicited input to narrow options in six decision domains. During the March 2023 convening, the FHPC/CHI team shared additional information and discussed options and timing. The goal was to come to consensus on a preferred approach while ensuring that any recommendations and next steps aligned with evolving activities underway within and across multiple agencies.

**Figure 2. FHPC and CHI's data collection and stakeholder engagement methods.**




# Key Themes to Inform the Aligned Funding Pilot

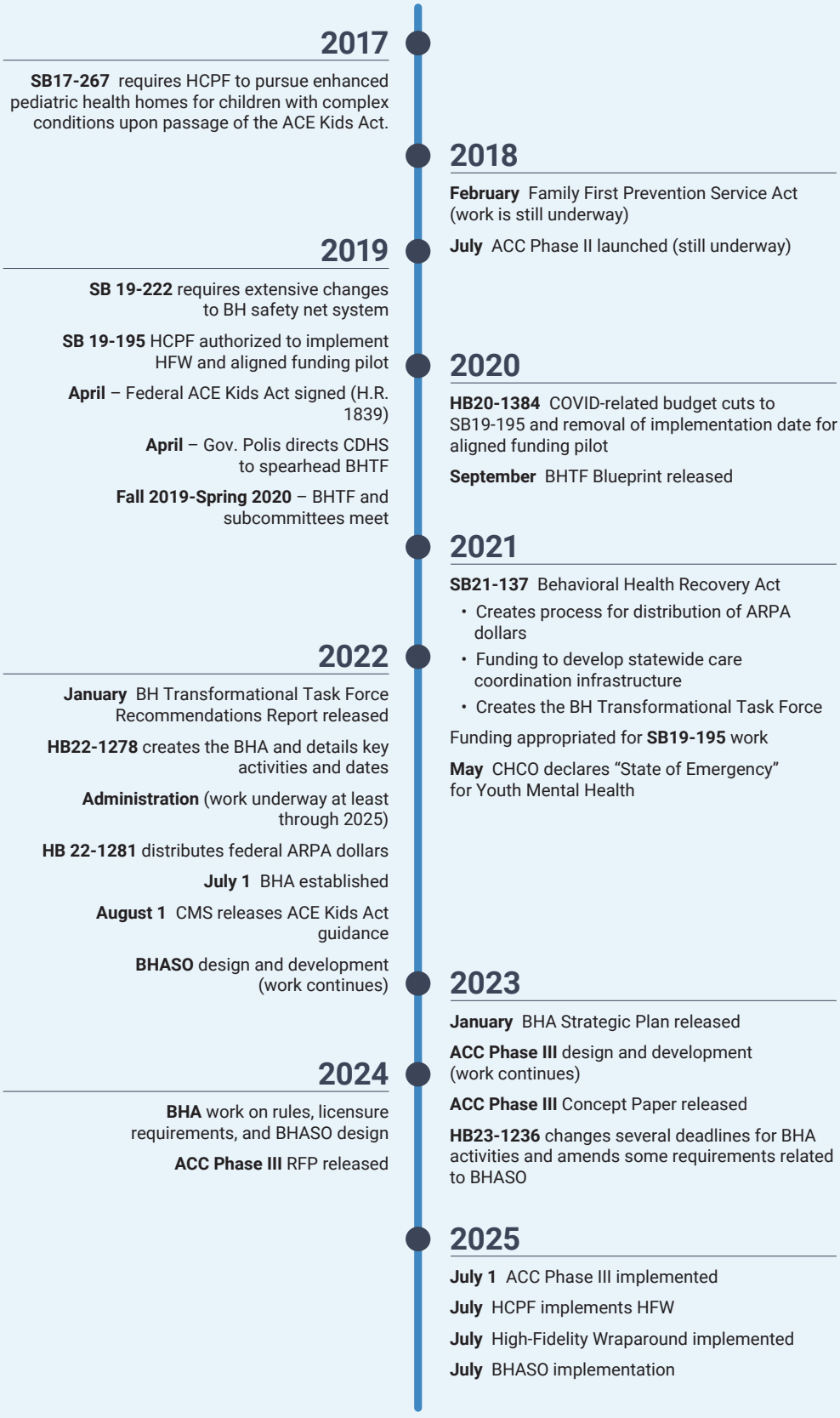
This section summarizes the perspectives and learnings from four activities that informed the final recommendations and considerations. These are:

1. Overview of the BH landscape and other transformational work underway
2. Conversations and surveys that highlight perspectives of Colorado families and other stakeholders
3. Best practices and national examples
4. Overview of convenings with state agency management

## The Landscape of BH in Colorado

Over the past eight years, there has been intense focus on improving the BH delivery system for children and youth. Figure 3 depicts some of the major efforts.

**Figure 3. Timeline of selected legislation and related activities that impact the BH landscape for children and youth in Colorado. Text describing the figure is available in Appendix I.**



**In May 2019, Governor Polis directed CDHS to spearhead the BHTF. There were three subcommittees:**

- Children's Subcommittee
- Long-Term Competency Subcommittee
- State Safety Net Subcommittee

**Much of the work and recommendations are cross-cutting and have contributed to the BH strategy for the state. The BHTF Children's Subcommittee made several recommendations that are especially pertinent to the SB19-195 work and the aligned funding pilot. These are:[11]**

- Consolidate children's BH funding streams by eligibility criteria, program size, funding flexibility, and/or services provided across state agencies/offices.
- Designate a single, publicly funded, fiscal management system used to account for funds for all publicly funded services.
- Examine all services provided by state programs that don't get a federal match and transition funding when possible to programs such as Health First Colorado, Child Health Plan Plus (CHP+), Individuals with Disabilities Education Act, Title IV-E, etc., to leverage federal funds.
- Establish an essential services package and statewide utilization management guidelines and implement a "pay-and-chase" model that identifies a single state agency to be responsible for reimbursement to a provider ("pay") for the entire cost of all services rendered up front. The identified single state agency will then be responsible for securing payment from the appropriate payer ("chase") based on an agreed upon funding hierarchy. If they are unsuccessful, this single state agency will maintain complete responsibility for the full payment for all services provided.
- Develop a systematic approach to collect information on children's BH spending across state agencies/offices to learn where dollars are going, for whom services are being provided, what services are being purchased, number and type of providers involved, where gaps remain, and how to maximize the utilization of resources across the entire array of services. This may include leveraging existing data infrastructure, e.g., Colorado Health Information Exchanges, Office of eHealth Innovation, All Payer Claims Database, and/or investing in new data infrastructure.

**Several transformational activities are underway and will have an impact on BH services for children and youth:**

- BHA, a new agency with cabinet-level leadership, was created from BHTF recommendations to reform the BH safety net system. Stakeholder and design work has begun on several components, including the new Behavioral Health Administrative Service Organizations (BHASOs);
- HCPF has multiple initiatives underway, many of them tied to Phase III of the Accountable Care Collaborative (ACC), the primary delivery system for Health First Colorado members which will be implemented by July 1, 2025. HCPF is also assessing the use of health homes, standardized benefits, alternative payment models (APMs), involvement in the new Making Care Primary Model funded by the CMS Innovation Center of BH services for children and youth; and

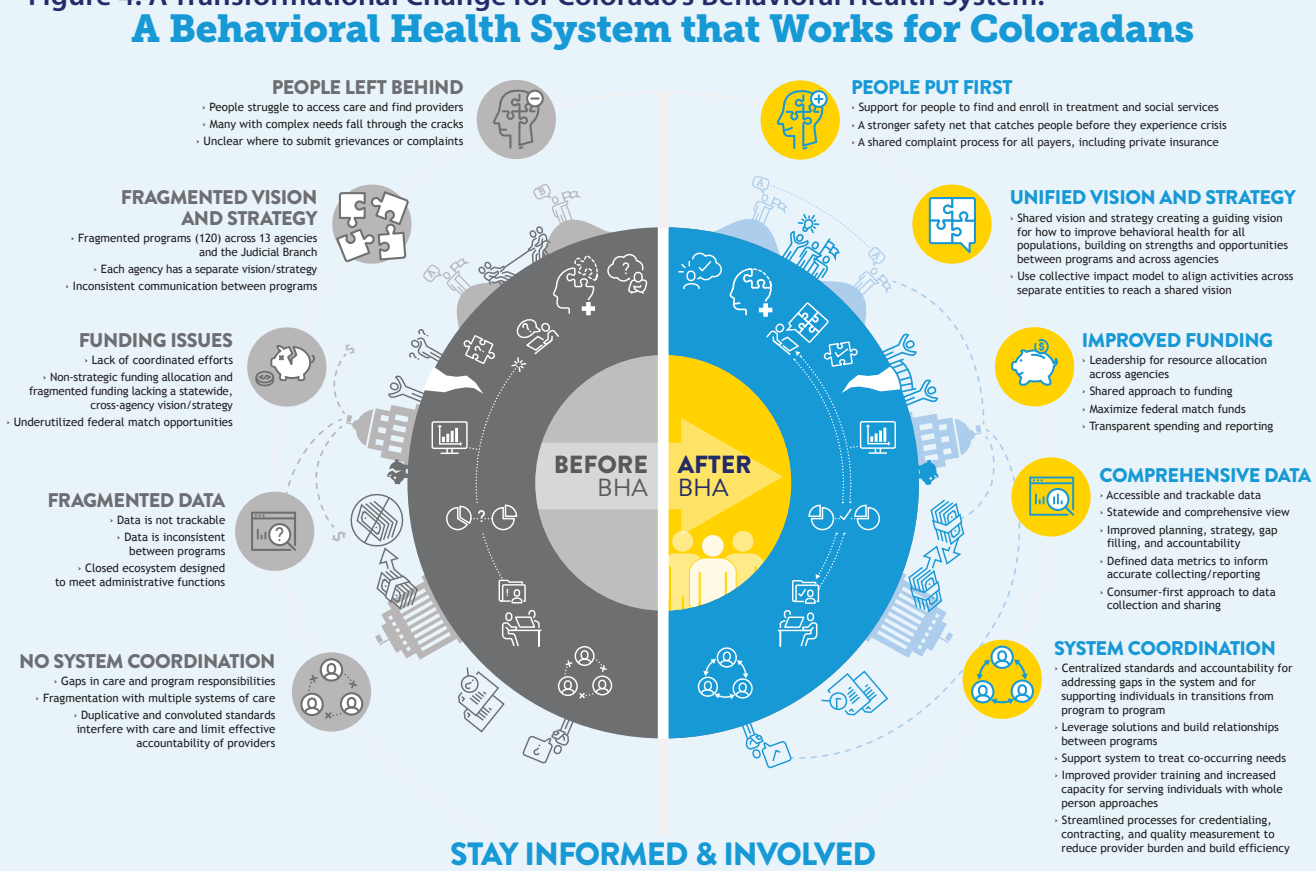
- The CDHS is implementing the FFPSA which is changing the way child welfare services are provided and paid for. Part of this work involves assessment and potential implementation of recommendations from the Delivery of Child Welfare Services Task Force Medicaid Subcommittee (in collaboration with HCPF), pursuant to SB18-254. Recommendations that may directly affect any aligned funding pilot design include, but are not limited to, work to identify fundamental services and standards of care available to all children (referenced as a recommendation from the BHTF Children's Subcommittee) and then build into ACC contracts with additional monitoring; and collaboration between CDHS, BHA, and HCPF to jointly explore funding options to continue payment for services when children and youth lose Health First Colorado eligibility.

## Behavioral Health Administration (BHA)

BHA was created by HB22-1278 (with amendments and date extensions detailed in HB23-1236) in response to the BHTF. It is "the single entity responsible for driving coordination and collaboration across state agencies to address BH needs." Implemented July 1, 2022, BHA oversees community programs such as crisis services, substance use disorder (SUD) treatment, care coordination, and other BH and SUD programs. BHA is responsible for ensuring the BH safety net in the state and is transforming the BH system in five key ways: a unified vision and strategy, system coordination, improved funding, comprehensive data, and prioritizing behavioral health, as depicted below:

Behavioral Health Administration (BHA)

**Figure 4: A Transformational Change for Colorado's Behavioral Health System.[15]**



**Many of the changes are likely to impact children and youth. These changes include, but are not limited to:**

- ***Development of a strategy focused on children and youth with BH needs***.
- ***Development and implementation of its strategic plan.*** In this plan, BHA outlined priorities and key strategies for their Affordability Pillar, demonstrating their commitment to assessing and consideration for changing their current financing systems.[16] BHA strategic plan operationalizes the priorities and recommendations established by the BHTF and links to other state working groups such as the Delivery of Child Welfare Services Task Force Medicaid Subcommittee recommendations. Relevant activities in the plan are:[16]
  - Launch a comprehensive BH budget and planning process across state agencies to "better utilize available funding streams through the braiding and blending of dollars. This approach will emphasize investments in maternal, early childhood, primary and secondary prevention, and direct services for children, youth, and families."
  - Streamline and consolidate funding streams that include maximizing federal dollars (a priority);
  - Engage other state agencies in strategic planning to maximize and align federal spending; and
  - Explore alternative payment methods to emphasize value and people-centered outcomes, in collaboration with HCPF.
- ***Development of the BHASOs*** which will be regionally informed and responsible for contracting with and expanding the network of safety net providers across the state. BHA is currently developing the full BHASO plan that will serve as the foundation of the request for proposals and any contract(s), slated to go live on July 1, 2025.
- ***Developing and defining a care coordination system such that individuals with BH needs in Colorado will have an assigned care coordinator***. This process is underway and evolving to ensure the care coordination system helps individuals receive both timely access to appropriate services and support in navigating their care needs which may be met by multiple sectors.

## HCPF

On July 1, 2025, HCPF will launch the third phase of the ACC. The ACC was created in 2011 to deliver cost-effective, quality health care services to Health First Colorado members and to improve the health of Coloradans. Goals for ACC Phase III are to:

- Improve quality care for members
- Close health disparities and promote health equity for members
- Improve access to care for members
- Improve the member and provider service experience
- Manage costs to protect member coverage, benefits, and provider reimbursements

HCPF has identified eight priority initiatives, as depicted below in Figure 5.[17]

**Figure 5. Eight priority initiatives for ACC Phase III.[17]**


The vision of ACC Phase III for children and youth is to build a system of care that is family-centered, trauma-informed, and complete across the continuum for children, youth, families, and caregivers that recognizes the distinct needs of this population from identification of need to treatment.[17]

HCPF is working to achieve that vision through design and implementation of components such as, enhanced primary care health homes; tiered, alternative-payment methodologies to pediatric providers; and improved reimbursement strategies for integrated care. Colorado is one of eight states recently selected by the CMS Innovation Center to participate in the 10.5-year multi-payer Making Care Primary (MCP) initiative. The goals of MCP are to 1) ensure patients receive primary care that is integrated, coordinated, person-centered and accountable; 2) create a pathway for primary care organizations and practices – especially small, independent, rural, and safety net organizations – to enter into value-based care arrangements; and 3) to improve the quality of care and health outcomes of patients while reducing program expenditures.[18] At the time of this report, the specific impact the initiative will have on children and youth with BH needs was not known but there may be some opportunity to leverage the program to improve the care for these children and youth.

All of these strategies have different benefits and challenges. The Department will continue discussions with providers and members to assess which components will best promote quality and improve access.

Another emerging initiative which is aligned with the goals of SB19-195 and ACC Phase III is the creation of a standardized child benefit. The figure below depicts the concept that would streamline and make more consistent the types of services children would qualify for and reduce current geographic differences:

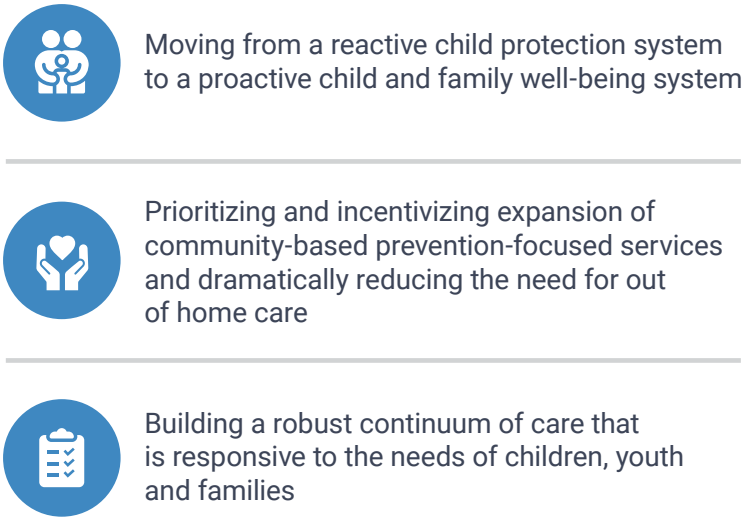
**Figure 6. Proposed services for the new standardized child benefit.[17]**


Finally, SB23-17419, "Access to Certain Behavioral Health Services," which is modeled after legislation recently passed in California, is likely to increase access to BH services for youth under age 21 by eliminating the requirement for a diagnosis for services paid for by the RAE.

## CDHS

The Families First Prevention Services Act[20] (FFPSA) is the most significant change to child welfare in decades. The FFPSA program permits federal funding to be accessed for prevention services that keep kids safe and with their families. In the short-term, CDHS had to comply with federal laws. In the medium term, the state is working toward expanding eligible placement options and expanding prevention services. The longer-term vision is to leverage FFPSA as one of many strategies to help the state achieve the goals of:

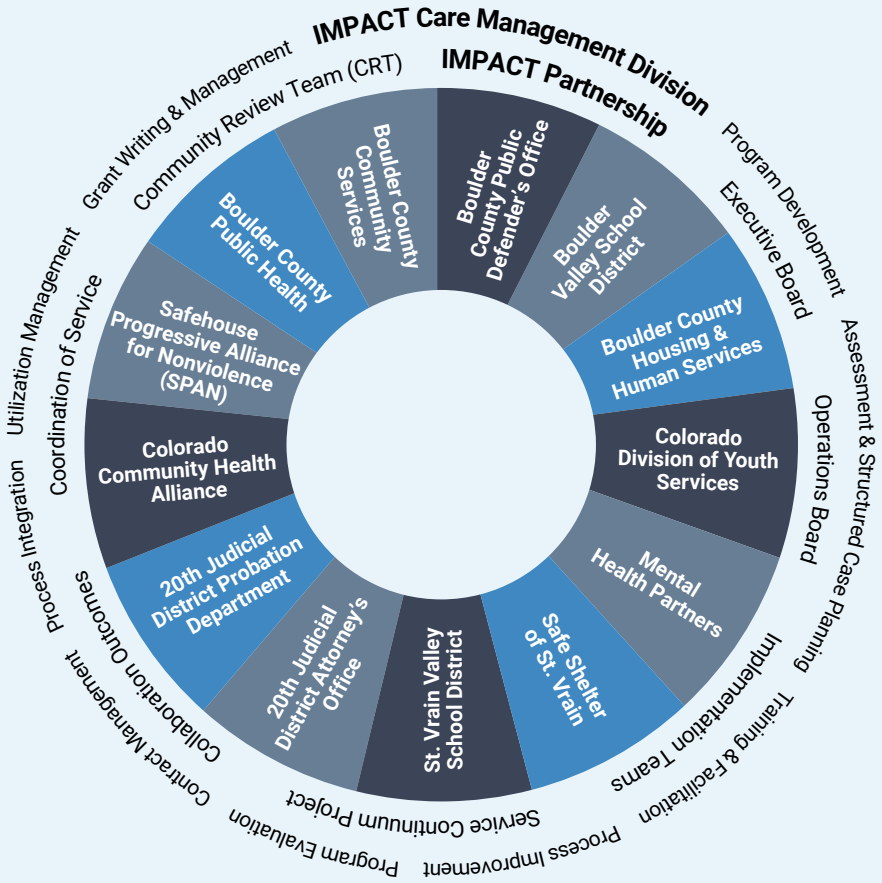
**Figure 7. Colorado's goals to improve the state's child welfare system.[20]**



## Innovative Approaches at the Local Level

Several KIs, particularly those representing county DHS agencies or other more localized programs, said they are braiding or blending funds they manage. They requested that a potential pilot not disrupt that work. One such example is the Integrated Managed Partnership for Adolescent and Child Community Treatment (IMPACT) Partnership which has been Boulder County's System of Care for children and youth since 1997. The model is a risk-sharing one that uses cooperative agreements to blend staff, resources, and funding between the partnership agencies depicted below in Figure 8.

**Figure 8. Blended staff, resources, and funding across partners in the IMPACT program.[21] Text describing the figure is available in Appendix I.**




The primary goals of IMPACT are to prevent or reduce out-of-home placements, correctional commitments, detentions, and mental health hospitalizations. They have seen success in reducing commitments and have one of the lowest rates in the state. Average length of stay in out-of-home placements has decreased by 27%, and there has been a decline in new clients for probation services.[21]

Other communities have received grants and other funding sources to develop and enhance their own BH systems; not disrupting these activities with an aligned funding pilot is important to them.

# Perspective of Colorado Families and Other Stakeholders

## Selected Services to Include in an Aligned Funding Pilot

In general, stakeholders agreed that the five services discussed are important and can have a big impact. Survey respondents specifically identified MST and HFW as the most needed from the five services and also indicated that for children with such high needs, the right match and availability of services is more important than any single service, i.e., there is no one-size-fits-all. Stakeholders identified access challenges throughout the state, with no access at all in some areas due to long travel times, lack of providers, and lack of sustainable funding. In some but not all communities, community mental health centers provide some of the services. In others, entities have received grants to build up the infrastructure and capacity to make these intensive home- and community-based services available.

Several KIs articulated that there are other non-traditional services, emerging best practices, and other non-medical services for which Health First Colorado does not currently pay. These alternative services could be prioritized or considered as a wrap-around approach to Health First Colorado services, especially using state dollars which can be more flexible. Examples include development of a "rapid response" approach that could pay for services and supports not currently being reimbursed to fill in gaps. KIs specifically called out programs such as Justice Works[22] and Connections Build Resilience Home-Based Program[23] which are being implemented with positive outcomes. Also, given the significant challenges in rural and frontier areas with sufficient staffing and high travel needs, emerging best practices may allow for more flexibility, and therefore, greater access. With the final design and implementation of an aligned funding pilot, inclusion of these types of services could be a feasible option.

## Continued Challenges

KIs and attendees at multiple meetings articulated continued challenges with Health First Colorado. Many of these challenges have been articulated elsewhere, including in the Delivery of Child Welfare Services Task Force Medicaid Subcommittee Recommendations[24] released in July 2022. They include:

- Inconsistency across the RAEs regarding interpretation of medical necessity and delays in decisions. In addition, the amount and type of services approved may be insufficient and continued reauthorizations create barriers to ongoing care.
- RAE reimbursement rates that are too low for "providers to maintain fidelity of high-intensity community-based services."
- Providers struggle to become enrolled and credentialed with the RAEs to provide services.

Given the scope of Health First Colorado and its role as a primary payer for many children and youth in need of these services, it's not surprising it was frequently mentioned. Stakeholders also said that Health First Colorado must be a part of any funding pilot or other solution and that there is opportunity to leverage better the Early, Periodic, Screening, Diagnostic and Testing (EPSDT) benefit to pay for services.

Families and other key stakeholders also shared their frustrations and challenges with having so many payers and entities. They need help navigating the system and components as much as they need access to the services. They often feel stuck in the "finger-pointing" cycle of who is responsible and then forced to navigate and fill in gaps. The term "air traffic controller" was used to identify the need for someone(s) to help track activities, opportunities, and service availability in the communities, regions, and across the state. Families and other stakeholders stressed that they need services authorized when needed, and many posited that finding a payer should not impede service provision. Some did acknowledge that this can be difficult for Health First Colorado because of restrictions about for whom and under what circumstances federal dollars can be used. This is a benefit of having other payer sources.

Finally, many people expressed concerns with current systems which can require that a child have a specific diagnosis or that children and youth are involved with a specific system, e.g., the criminal justice or child welfare systems, before they receive support. Multiple individuals advocated for an approach that would not "put children in a box."

## Preference for Statewide Contractor and Momentum

Parents and caregivers highlighted Momentum as a program that is serving their children's needs well because of the program's flexible funds, authority to organize meetings with the appropriate parties, and statewide reach. Parents and caregivers noted that often Momentum is a last resort and families would be better served if it could be a resource earlier in the process for connecting with community-based services.

The Momentum Program[25] (managed by Rocky Mountain Human Services under contract with CDHS) is a state-funded initiative that supports the transition of children and adults from inpatient mental health institutes, hospitals, home and other care settings to community living. The care team of care managers and peer specialists assesses the needs and goals of individuals and families, collaborates to create plans and build support systems to support successful transitions, and helps to identify community resources. Momentum services include support for transitions to community-based services and case management. As of the writing of this report, eligibility for the Children & Adolescents Program (age 20 and under) includes:

- Current behavioral health diagnosis
- Current inpatient psychiatric hospitalization lasting greater than two weeks
- Current inpatient psychiatric hospitalization with at least two prior inpatient psychiatric admissions at an approved hospital or acute treatment unit in the past 12 months
- Current involvement with two or more systems and the youth is in need of transitional case management, services, and/or supports not funded by another source

Since July 2018, Momentum has served nearly 992 clients.[26]

## Necessary Components

In general, families were agnostic as to who or how these services are paid for, as indicated above; they need services to be made available when necessary and when they can have the biggest impact. They and other stakeholders also identified several components that are needed to change the current system and that, where they exist, have been extremely helpful. Many of these components were also identified in the literature. These components are:

- ***Trust:*** the entity/person/group that is responsible for making decisions about services needed, duration of services, and funding must have the trust of families, providers, and other involved stakeholders. Who that person is and which organization they represent varies. Among the 20 parent and caregiver survey respondents:
  - 50% said they trusted HCPF to help children and youth in need, and 45% said they trusted the RAEs.
  - 32% said they trusted BHA, and 30% said they trusted the BHASOs (once established).
  - 40% said they trusted a statewide contractor (e.g., Momentum).
- ***Flexible funds:*** this was deemed essential for filling in gaps when there was no other payer, when Health First Colorado or private insurance could not reimburse, for non-traditional services, or to ensure services could be started or continued while a long-term funder (often Health First Colorado) was identified. There was acknowledgement that Health First Colorado funds must be included and that they are not flexible so other sources should be included. Multiple people suggested Momentum as a helpful and effective partner because they do have flexible funds and can often pay for services others cannot.
- ***Authority***: whoever has the ultimate responsibility needs to have the authority to make decisions, ensure others involved participate in solutions-driven activities, and ultimately, direct someone to pay (either from the aligned funding pilot or for other needed and supportive services).
- ***Alignment with current activities***: there are many BH changes underway in Colorado, and the landscape is evolving. This pilot and any other potential solutions should be developed and considered with these factors in mind. Several stakeholders suggested the state should focus on improving and fixing current systems and on implementing recommendations from the BHTF Children's Subcommittee and the Delivery of Child Welfare Services Task Force Medicaid Subcommittee.

# Best Practices and National Examples of Aligned Funding Models

Other cities, counties, and states have designed and implemented aligned funding for BH services. From the literature and KIs, we identified best practices and challenges that must be overcome. We also highlight recommendations and models from other states and communities HCPF could consider.

## Best practices[27]

Our review of the literature and conversations with KIs noted the following success factors with changing the way funding flows and aligns:

- ***Leadership is needed*** across different agencies and at different levels within agencies, depending on how extensive the pilot may be in terms of geography, included services, and populations of focus.
- ***While state dollars may compose much of the aligned funding, it's advantageous to incorporate funding from other sources***, including from the federal government, private philanthropy, and foundation dollars so that all funding streams and/or programs are responsible for shared outcomes.
- ***Medicaid is an essential component of aligned funding projects***, as well as leveraging state dollars to obtain a federal match to pay for needed support services that may not otherwise be funded.
- ***Public-private collaboration and interagency partnerships are key for developing aligned funding programs***, and it's critical that both are supported by formal mechanisms, e.g., memoranda of understanding, regulation, etc., and staff to manage reporting requirements.

## Challenges[28–32]

Aligning funding from multiple sources to achieve a common purpose is complex and intricate work. Our review of the literature noted the following challenges that would need to be navigated in a pilot:

- Creating a shared vision, set of priorities, accountability, and outcomes
- Aligning culture of different agencies and programs and establishing trust, especially when there hasn't been a track record of collaboration in the past or when prior collaboration has been difficult
- Building the needed infrastructure required to collect and analyze data, track funds, deliver services, and meet reporting and evaluation requirements
- Developing necessary agreements to support aligned funding, including for data-sharing and privacy
- Clarifying roles and responsibilities of each of the included partners in the aligned funding pilot

- Establishing a robust governance structure that makes clear how decisions are made and who has decision-making authority
- Reconciling different populations served and program goals of each included funding stream or program
- Recognizing which state and/or federal funding sources cannot be aligned given statutory limitations
- Managing contributed funding streams that may vary substantially in magnitude
- Assessing a realistic return on investment for what is likely to be a heavy lift
- Appreciating if bandwidth is too limited to take on a new pilot

## Recommendations

Other states' experiences offer important recommendations to consider. These include:

- Start small; be realistic about initial scope before pursuing a broader roll-out
- Create shared goals, desired outcomes, standard metrics, and accountability structures
- Identify champions for aligned funding throughout the agencies and among partners
- Build collaborative, trusted relationships through strategic funding
- Include youth and families in governance and oversight structures and ensure a diverse array of stakeholders are included
- Analyze existing funding streams for sufficiency and ability to meet desired goals
- Understand what potential funding streams for inclusion in a pilot currently cover and what restrictions each one has
- Blending is a tremendous challenge and likely not worth the effort
- Align, where possible, funding cycles and reporting requirements across different funding streams and programs
- Plan for integrated data systems, as well as broader infrastructure needed to support collaboration
- Decide on the length of an aligned funding pilot to provide adequate time to test the approach

> *Amy Clary and Trish Riley, in a brief they authored for the National Academy for State Health Policy (NASHP), summarized the challenges of aligning funding well, "State leaders would need to surmount a myriad of legal, regulatory, contracting, data-sharing, and political barriers in order to re-tool current funds to more effectively meet the needs of a state's most vulnerable populations."*[30]

That said, keeping in mind the ultimate goals of an aligned funding pilot are important, especially when considering the daily realities and frustrations children and their families face in navigating multiple aspects of the BH system: duplicative case managers, numerous registration platforms and passwords, and substantial time needed to manage appointments, providers, and services. In addition, blending and/or braiding models spread the financial burden across multiple sectors and funding streams, thus minimizing the impact of the 'wrong pockets problem.'[28]

## Key examples

### MASSACHUSETTS

**In 2022, Massachusetts passed legislation that, among other things,[33] requires an "interagency review team to collaborate on complex cases where there is a need for urgent action to address the lack of consensus or resolution between state agencies about current services needs or placement" for youth under age 22 who are disabled, have complex BH needs, and who qualify or may qualify for services from more than at least two agencies (state agency or school district).** The legislation details who must serve on the commission and includes high-ranking officials (i.e., Commissioner and Assistant Secretaries) from human services, elementary and secondary education, the Medicaid program, other state agencies, as well as representatives from school districts. The commission is required to determine the services in place, identify other needed services, and clarify the agency or agencies that have fiscal responsibility. If they cannot identify the responsible entity, the co-chairs (the Secretary of Human Services and the Commissioner of Elementary and Secondary Education) shall assume responsibility to avoid delay. The co-chairs may authorize expenditure of funds from an interagency services reserve fund in the interim. The legislation details timelines for a review and decision (30 days from referral/request from an individual if over age 16, family, or state agency and five days if an individual is waiting in a hospital emergency or medical bed). This is a new initiative, so there is little information about its effectiveness, but HCPF and other agencies could monitor their performance to assess whether the model is one to replicate in Colorado.

### NEW JERSEY[34]

**The New Jersey Children's System of Care (CSOC) in the Department of Children and Families is the state's public BH system for children and youth younger than age 21 with mental, emotional, and BH care needs, substance use disorders, and/or intellectual/developmental disabilities (IDDs). The CSOC, which is not a formal carve-out of the Medicaid managed care system, has two components under the state's 1115 waiver:**

1. **The Children's Support Services Program for youth with serious emotional disturbance, and**
2. **The Children's Support Services Program for youth with IDDs.**

The total CSOC budget for SFY23 is over $800 million, with $480 million representing the state share. In 2022, there were more than 65,000 youth with an open SCOC case and more than 50,000 receiving intensive in-community, behavioral assistance services, an increase from about 30,000 in 2015.[35]

CSOC services are available to all children and families without regard to income criteria or insurance coverage. The state has a single contracted systems administrator (PerformCare) which serves as the single point of access for a wide array of services for youth and their families, including home- and community-based, culturally competent services tailored to specific needs. While CSOC determines the clinical criteria, PerformCare makes medical necessity determinations and does prior authorizations. The state is divided into 15 catchment areas, and each catchment area has a care management organization that is a private contractor that implements wrap-around services only.

The CSOC hosts regular rounds with child protection services and care management organizations to discuss any placement and/or treatment challenges and how to solve them. For youth who are not Medicaid-eligible, a care management organization submits an application for service authorization and provider claiming. The child then receives a "Medicaid look-alike" number so that they can receive services. This part of the program is covered by state funds without a federal match. CSOC's biggest challenge are workforce shortages that impact access, especially for youth with IDDs and working with providers to ensure solid accounting practices and systems to receive funding from multiple agencies as opposed to one.

## VIRGINIA

**In 1993, Virginia passed the Children's Services Act to integrate funds from 14 separate funding streams that were serving children across the state.**[30] One of the objectives was to move children from residential care and into home- and community-based care. The state blends state and local dollars and then braids in federal dollars, including Medicaid, to support federal tracking and reporting requirements. The localities also contribute some of their own funds. These pooled funds are managed by the regional boards in each of the 133 localities. The localities are authorized to make decisions about services required and make payments to providers. While the program is operationalized and managed at the local level, the state sets the policy, develops the allocation methodology, and distributes the funds.

The eligibility is broad, including children: with persistent emotional or behavioral problems; who require resources beyond those normally provided across agencies; involved with multiple agencies; at risk of residential care; needing placement in a private school education program; or those who require foster care services. Evidence-based programs are prioritized but in some rural areas with a thinner service array, non-evidence-based programs may be authorized.

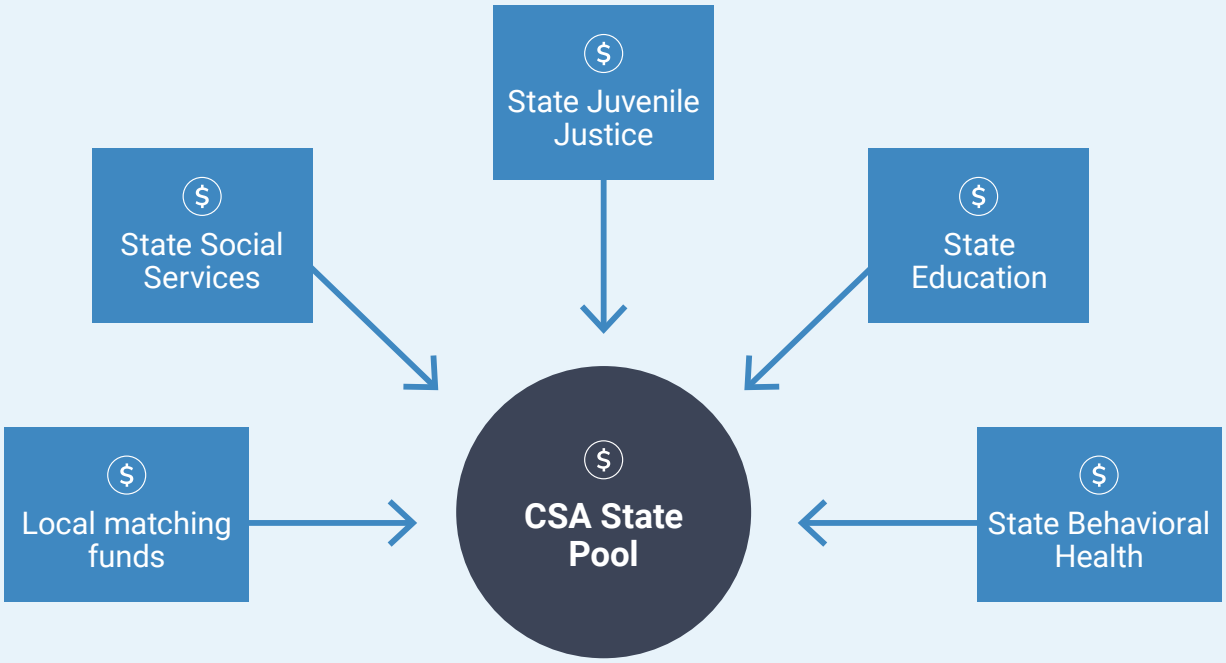



**Figure 9. Virginia's blended funds.**[30]

KIs note that the process is smoother in some areas and periodically some localities consider opting out, but ultimately remain so they don't lose access to the blended state dollars. KIs also noted that there are too many entities (133) to manage and that there are large inequities between localities. They recommended regionalization.

## Engagement with State Agency Leaders

In addition to talking with stakeholders across Colorado and in other states, the FHPC/CHI team held two convenings with senior managers from HCPF, BHA, and CDHS. The first convening was on October 21, 2022, with the goal of narrowing design options in six key domains. The options were developed based on input from stakeholders, national experts, and literature best practices and considerations. Attendees were asked to consider the domains using the following framework.

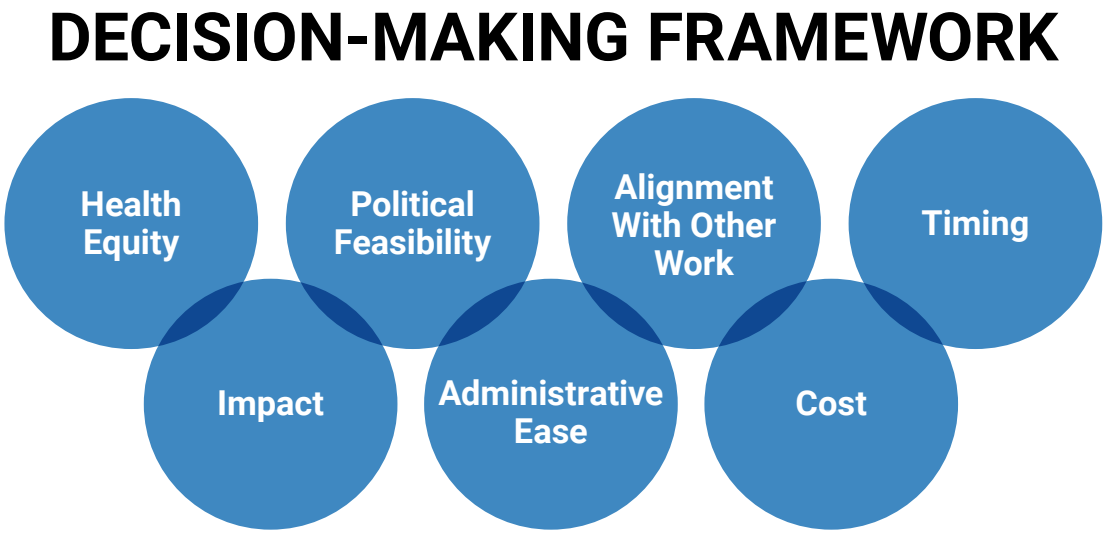


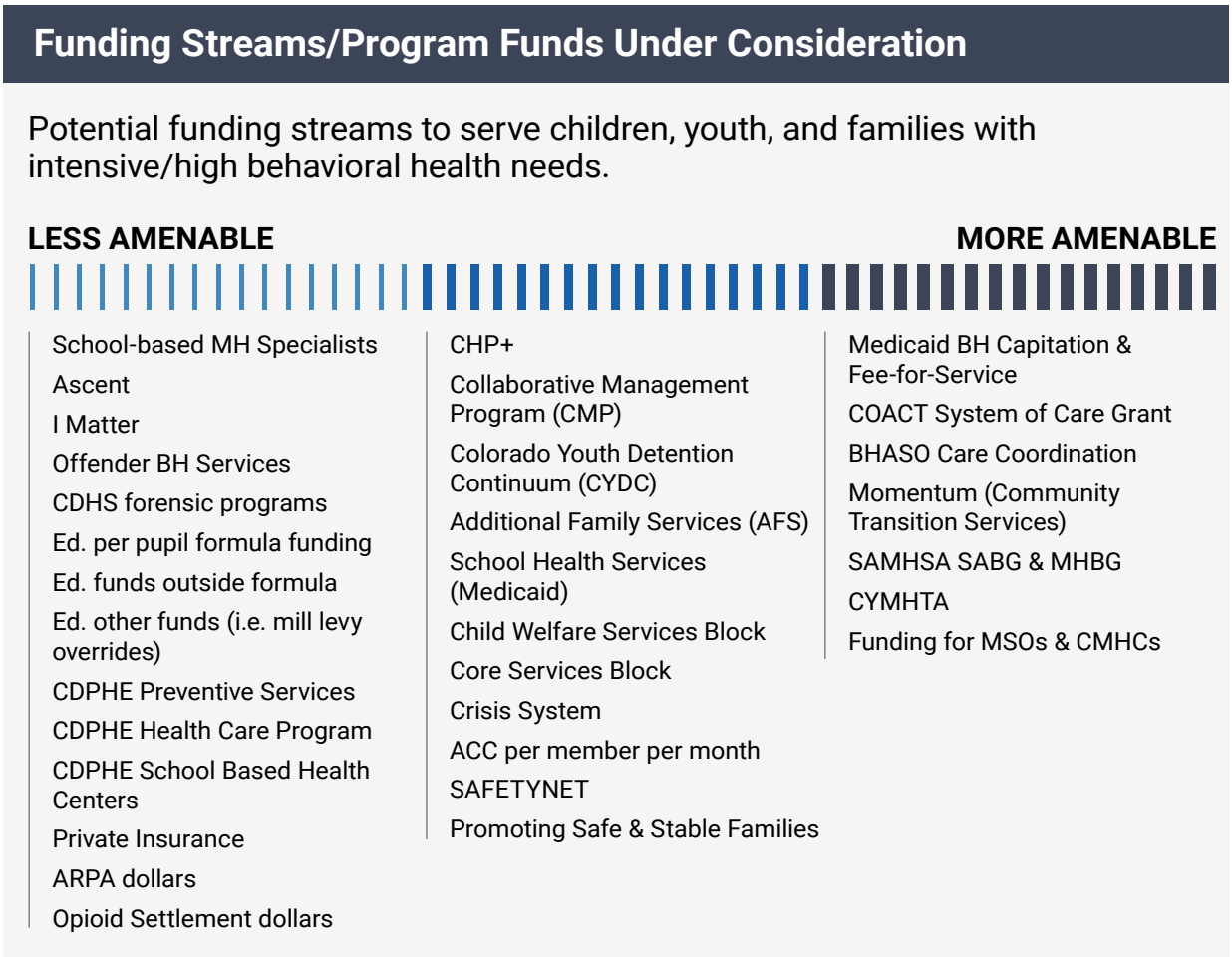

**Figure 10. Decision-making framework created by the FHPC/CHI team.**

During the convening, state agency leaders were presented with options for each of the five decision-making domains and engaged in a facilitated discussion to either reach a decision or rule out options. Appendix III includes the preparatory reading materials and the presentation, both of which provide additional detail about the information included in the table below.

**Table 2. Decision domains.**

| Domain | Options | Discussion Themes |
|---|---|---|
| **Population of Focus** | All who meet the pre-determined level of care<br>Children with a specific diagnosis<br>Children involved with child welfare<br>Children involved with multiple systems (e.g., criminal justice, child welfare) | Preference for all children who meet the pre-determined level of care/need for these services AND who are involved with multiple systems. |
| **Administrative Level and Entity** | State administrator (e.g., HCPF, BHA)<br>Regional administrators (e.g., RAEs, BHASOs)<br>Local administrators (e.g., counties, others such as Single Entry Point agencies (SEPs) or Community Centered Boards (CCBs)<br>Contracted administrator (e.g., single contractor such as Momentum or a regional option such as enhanced primary care homes) | Preference for contractor(s) and fewer of them. Preference was also given to the RAEs, BHASOs (once established), or a single contracted entity such as Momentum, as opposed to more localized entities. There are not that many children who would qualify making it hard to develop expertise in some regions. More entities could lead to large inequities. |
| **Mechanism for Aligned Funding** | Braiding: funds can be tied back to original source (like a hair braid or rope)<br>Blending: funds are pooled together and indistinguishable<br>Hybrid: some funds are braided (e.g., federal) and others are blended (e.g., state or local) | Several national experts suggested that blending is too burdensome and not worth it.<br>Attendees agreed with the decision to pursue braiding and removed blending as an option. |
| **Geographic Roll-out** | Statewide<br>Some regions | Preference was statewide. |
| **Funding Streams and Roll-out** | See Figure 12 below for funding streams discussed.<br>Roll-out discussion focused on whether to start with some dollars and then expand. | Consensus was to include the funding streams deemed somewhat or more amenable and to do so at the start of the pilot (don't start with some funds and include others later). Additional discussion focused on inclusion of private dollars and ensuring they pay for services when they are responsible. Despite this, participants recognized that using private dollars in an aligned funding pilot would be very challenging. |

**Figure 11. Funding streams/program funds considered for inclusion. Alternative text is available in Appendix I.**




A second convening was held on March 17, 2023, during which time attendees from HCPF, BHA, and CHDS discussed the timing of implementation (July 1, 2025; before; or later), potential barriers to implementation, and considerations of aligning and/or focusing on other initiatives. The second convening was used primarily to receive approval of the recommendations outlined in this report. (For more details, please refer to Appendix IV.)

# Recommendations and Design Considerations for the SB19-195 Aligned Funding Pilot

The FHPC/CHI team makes the following recommendations based on ability to achieve the goals outlined in SB19-195, assessment of findings from state and national reports, conversations at the convenings, and feedback from Colorado stakeholders and national experts:

1. Continue to invest in system transformation activities currently underway;
2. Ensure BHA and HCPF have an aligned approach to joint funding of key initiatives; and
3. When appropriate, ensure any actions taken to execute aligned funding are informed by learnings presented here in this report and best practices from other states.

The team appreciates that this aligned funding pilot was built into legislation championed by committed stakeholders and legislative sponsors in 2019. In making a recommendation to continue with the work underway while assessing the need, feasibility and timing of an aligned funding pilot, our goal was to ensure 1) there is a strong foundation capable of supporting the intensive work that will be necessary to develop and implement a successful aligned funding model, and 2) that there is still a need for it.

Additional information is provided on these recommendations below.

## Recommendation 1: Continue to invest in system transformation activities currently underway

Many stakeholders identified the multiple BH system transformation activities that are underway now or will be soon. This includes but is not limited to: ACC Phase III development and implementation; payment reform initiatives including new CMS Innovation Center work; implementation of BHA and strategies for children's behavioral health and fiscal alignment of programs; and design and implementation of the BHASOs. Successful policy and program design work, as well as actual implementation, is resource-intensive and requires time and personnel. Moreover, many of these reform efforts are designed to address some of the same issues the aligned funding pilot was designed to address. Their successful implementation may mean the aligned funding pilot is no longer necessary.

> *There was consensus from many stakeholders that there is a lot going on with several suggesting the state "just fix what we have and focus on the changes underway."*

While these large system transformations are underway, HCPF and other state agencies could consider examining and expanding existing programs such as Momentum and the Children and Youth Mental Health Treatment Act (CYMHTA) that families and caregivers report are filling essential gaps for many of the children most in need.

## Recommendation 2: Ensure BHA and HCPF have an aligned approach to joint funding of key initiatives

As part of the continued work on system transformation activities planned or underway including, but not necessarily limited to those listed above, state agency representatives should review opportunities and assess the most effective way to jointly fund shared initiatives. In particular, state agency representatives should consider whether braided funding is an option that would support the goals of improved coordination and access to services while reducing fragmentation of BH services. At regular intervals and timed with key BH transformation milestones, impacted state agencies should invite partners to determine whether aligning funds (either as a pilot or broader in scope) can be executed in emerging, yet to be solidified, systems.

## Recommendation 3: When appropriate, ensure any actions taken to execute aligned funding are informed by learnings presented here in this report and best practices from other states.

State BH decision-makers narrowed proposed design features in several areas during this phase of the work. This included eligible population, approach to funding (strong preference for braiding due to the significant challenges blending federal dollars), and identification of funding sources most amenable to a funding pilot. These initial design recommendations can serve as a foundation to support moving from design to implementation.

Guidance from national players can help Colorado's leaders and other stakeholders collaboratively make decisions. Research and national experts suggest the state will need to make decisions in the domains described below.

1 **Determine scope:**

- Other state and national experts recommend starting small and being realistic about initial scope before pursuing a broader roll-out. Small could mean limiting funding sources, geography, populations, or services.
- Decide on the length of the pilot to provide adequate time to test and evaluate the approach.

2 **Identify champions, including governmental leaders and key external stakeholders:**

- Identify champions for aligned funding at senior leadership levels in local and state government.
- Engage both programmatic and fiscal staff to design and implement an aligned funding pilot.
- Include youth and families in oversight structures, and ensure a diverse array of stakeholders are included.
- Work to build collaborative relationships across state agencies, with service providers and coordinators, and youth and families.

3 **Establish clear governance structures and accountability:**

- Create a sound governance model early in the process and invite key individuals referenced in #2 above to be involved.
- Establish parameters regarding authority about services and payment (i.e., Momentum contractor can expend up to specified amount without seeking additional approval).
- Develop accountability structures, including utilization reviews, quality assurance, and contract monitoring.

4 **Set meaningful outcomes and goals:**

- Create shared goals and desired outcomes, i.e., address fragmentation, reduce administrative burden, improve collaboration among service providers.
- Ensure outcomes, goals, and standard metrics account for what is most important to children and families, i.e., no wrong door policies, navigational ease, ability to receive services when needed, measuring what matters, etc.

5 **Consider fiscal implications:**

- Identify the proportion or amount of current dollars that are going toward these services and/or amount that should be allocated.
- Analyze these funds for sufficiency, ability to meet desired goals, and any specific restrictions on their use.
- Understand reporting requirements of funding streams.
- Align, wherever possible, funding cycles and reporting requirements across different funding streams and programs.
- Identify funds that are flexible/discretionary and include them in the aligned funding pilot.
- Maximize use of entitlement programs, especially Medicaid.
- Redirect resources from high-cost and/or programs with poor outcomes to effective practices.
- Manage funds through arrangements tied to value and incorporate risk adjustment wherever necessary; this was called out especially for complex pediatric populations.

6 **Account for administrative needs and changes:**

- Assess personnel and resource requirements for tracking and oversight.
- Understand system and technological requirements, specifically any integrated data systems and broader infrastructure needed to support cost allocation, tracking, and reporting.
- Assess state and federal legislation, rules, program guidance, and authority changes that may be needed to support an aligned funding pilot.

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