

Serving Colorado's Children: A Financial Map of the Behavioral Health System

Prepared for the Colorado Behavioral Health
Task Force Children's Subcommittee

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Introduction

Colorado's behavioral health system is highly complex. Services and programs span multiple agencies, objectives, and funding sources, making it difficult to identify exactly how funds are being spent for children and youth. Still, understanding the system is an important step toward evaluating its strengths and opportunities for improvement.

This evaluation is critical because many young Coloradans face mental health challenges. In 2010, 13 percent of children ages 8 to 15 lived with mental illness severe enough to cause significant impairment to their day-to-day lives.¹ The burden is even greater among older children, where 21 percent of youth ages 13-18 experienced this level of mental illness.² In Colorado, nearly half of youth with poor mental health (44.9 percent) are insured through a public payer such as Medicaid or Child Health Plan Plus (CHP+), or have no coverage and must rely on other public sources to get behavioral health care.³ And because private insurance carriers do not uniformly cover the robust array of behavioral health services, people with the most significant needs rely on publicly funded services.⁴

There is no question that Colorado's children, adolescents, and their families need these public services — and they are best served by systems that are effective and efficient.

That's why Partners for Children's Mental Health (PCMH) was created. PCMH is a new center focused on bringing together Colorado communities to improve mental health outcomes for children, youth, and families. In 2018, PCMH convened more than 600 community stakeholders from across the state to develop a strategic plan for change, including a series of recommendations. One recommendation set the foundation for this work: create a financial map to understand the children's behavioral health system in relation to prevalence, need, utilization, and cost.

PCMH contracted with the Colorado Health Institute (CHI) to create this financial map. CHI took direction from the Children's Subcommittee of the Colorado Behavioral Health Task Force, a group convened in 2019 to evaluate and set the official roadmap to improve behavioral health in Colorado, to identify the following questions that guide this report:

Takeaways

- Between \$404 million and \$810 million in federal and state funds support much-needed child and youth behavioral health services in Colorado.
- The delivery system is complex, which can make it difficult to understand who is — and isn't — being served.
- Opportunities to make this system even stronger include consolidation of funding streams, additional leveraging of federal dollars, and new investments in data collection.

- ***How are state and federal funds currently allocated in Colorado's child behavioral health delivery system?***
- ***What services are these dollars purchasing, and who are they serving?***
- ***What opportunities exist to close gaps and maximize investments?***

To conduct this research, CHI approached six state agencies requesting data on programs providing behavioral health services to children and youth. The time and effort given by these state agencies to report these data are greatly appreciated—without them, this analysis would not exist. Additional details on our research methods are included in Appendix I.

This report provides a financial map showing where state, federal, and other funds are supporting Colorado's behavioral health system for children and youth. The scope of this work does not include a

Table 1. Funding for Children’s Behavioral Health by State Agency, FY 2019

State Agency	Total Reported Funding	
Department of Human Services, Office of Children, Youth, and Families (OCYF)	\$381 million*	47.0%
Department of Health Care Policy and Financing (HCPF)	\$259 million**	32.0%
Department of Human Services, Office of Early Childhood (OEC)	\$66 million	8.2%
Department of Human Services, Office of Behavioral Health (OBH)	\$65 million	8.1%
Department of Education (CDE)	\$22 million	2.6%
Department of Public Health and Environment (CDPHE)	\$17 million	2.1%
Total:	\$810 million	

* Includes all foster care costs, not just behavioral health services **Excludes \$31 million in psychotropic medication

needs assessment identifying the types of services in greatest demand. It also does not include analysis of local or county-level funding, such as local programs available in only one region of the state. Private insurance payments, out-of-pocket spending, and philanthropic funding are also excluded from this scope of work. These are opportunities for future research.

In this report, we look at the amount and sources of money spent in Colorado, what programs are funded, who these programs serve, how the programs are funded, and opportunities moving forward.

Following the Money

In state fiscal year 2018-19 (FY 2019), up to \$810 million was spent on Colorado’s behavioral health care delivery system for children and youth ages 0 to 26. This represents funding reported to CHI by six state agencies (see Table 1). These agencies provide 34 programs across the state (see Financial Map on page 6).

This figure is inflated. It is likely that only \$404 million undeniably support behavioral health services for Colorado children and youth. The remaining \$406 million may include behavioral health services as well as related supports such as programs for families, social support services, or other non-behavioral health services. But limitations to the available data — and missing data elements — mean that it is not possible to estimate the portion of these dollars supporting only behavioral health services.

For example, the \$381 million in funding through the Office of Children, Youth and Families (OCYF), for instance, includes both child behavioral health services as well as other services such as placements in foster care. Additionally, some CDE and CDPHE funding for school-based health centers includes both physical and behavioral health services.

Despite limitations to these data, this analysis provides a first broad look at a complex behavioral health system.

State funds are the largest source, making up nearly 60 percent (\$481 million) of the total expenditure (see Figure 3). This includes both general funds and cash funds such as the Marijuana Tax Cash Fund. Though cash funds are not guaranteed for the long term, no agencies contacted for this research cited concerns about potential changes to funding sources.

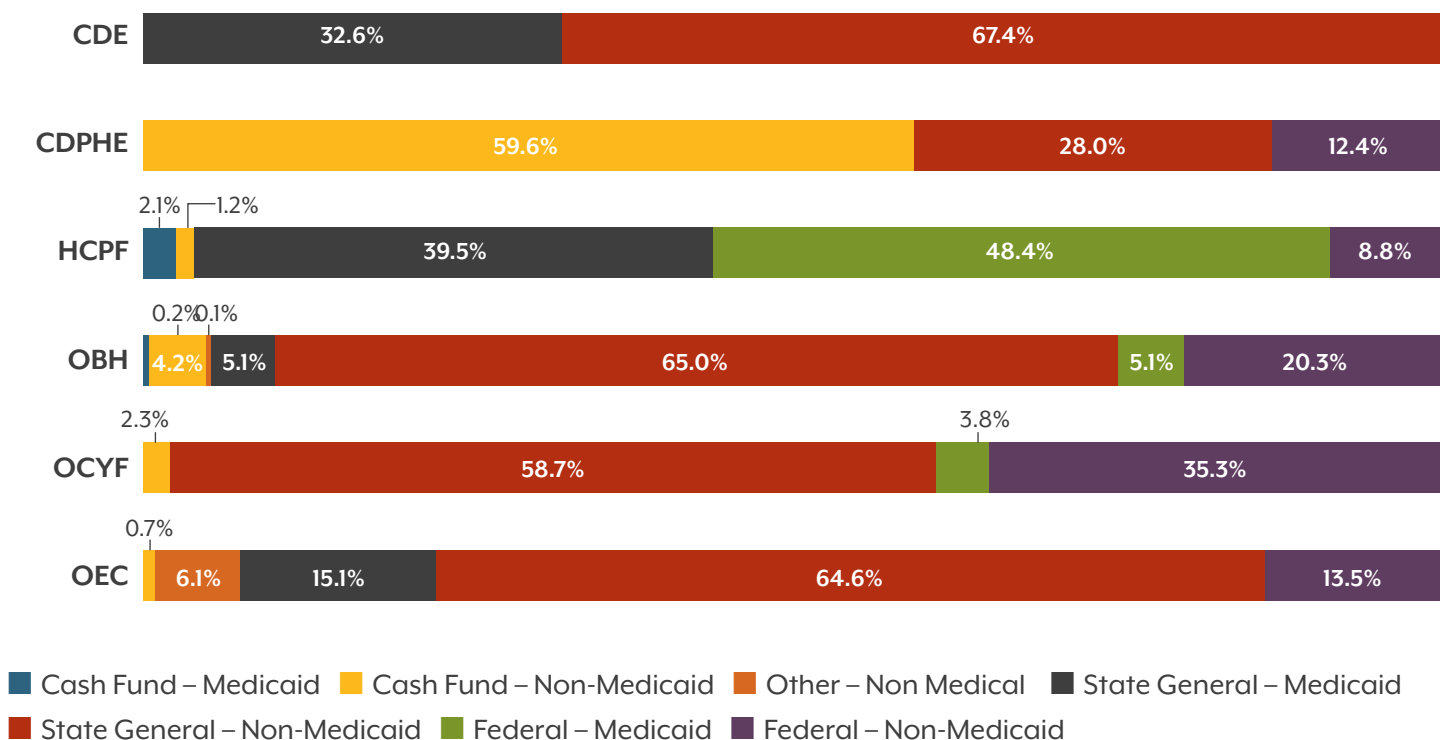
A 2007 Nevada analysis found a similar ratio: about 55 percent of behavioral spending was state funding, compared to 40 percent federal funding. (The Nevada report also included some local funding at 4 percent.) However, the distribution of state and federal funding varies significantly by agency (Figure 1).

Up to **\$810M**

was spent on Colorado’s behavioral health care delivery system for children and youth ages 0 to 26 in state fiscal year 2018-19 (FY 2019).

Figure 1. Some Agencies Rely Heavily on Federal Dollars – for Others, State Matters More

Distribution of Funding Source by State Agency



Example Programs Excluded from this Analysis

In addition to direct services and resources targeting Colorado’s behavioral health care delivery system for children and youth, \$191 million goes to data systems, evaluation efforts, and parent supports. While these programs are not detailed in the overall financial map, they nevertheless are critical components of how behavioral health is tracked and managed.

CDPHE’s Healthy Kids Colorado Survey does not directly impact youth or the providers who serve them, but the data collected by this large-scale survey is invaluable in identifying risk factors and tracking mental and other health behaviors. Its \$968,000 budget comes from a combination of federal and state funds.

The Colorado Child Fatality Prevention System reviews all child deaths in Colorado, allowing

agencies to identify child death trends and patterns and make recommendations for prevention. Its \$6.6 million budget comes entirely from the state general fund.

Multiple programs within OEC— SafeCare Colorado, Colorado Community Response, Head Start, Promoting Safe and Stable Families, Nurse Home Visiting Program, Home Instruction for Parents of Preschool Youngsters, and Parents as Teachers — help children by supporting their parents’ mental health. Overall, these have a budget of \$162.6 million from federal, state, and other sources.

Additionally, the Office of Children, Youth, and Families has a \$21 million Child Welfare Staffing Block which is allocated to counties for new county staffing.

How to Read the Financial Map

Top Level: OVERALL FUNDING SOURCES

Funding comes from three overall sources: the federal government, the state government, and other funds (usually local grants). These are represented in the top level of the financial map.

Second Level: DETAILED FUNDING SOURCES

The second level specifies six sub-sources: the federal government (non-Medicaid); federal Medicaid; state general funds (non-Medicaid); state Medicaid general funds; state cash funds; and other funding.

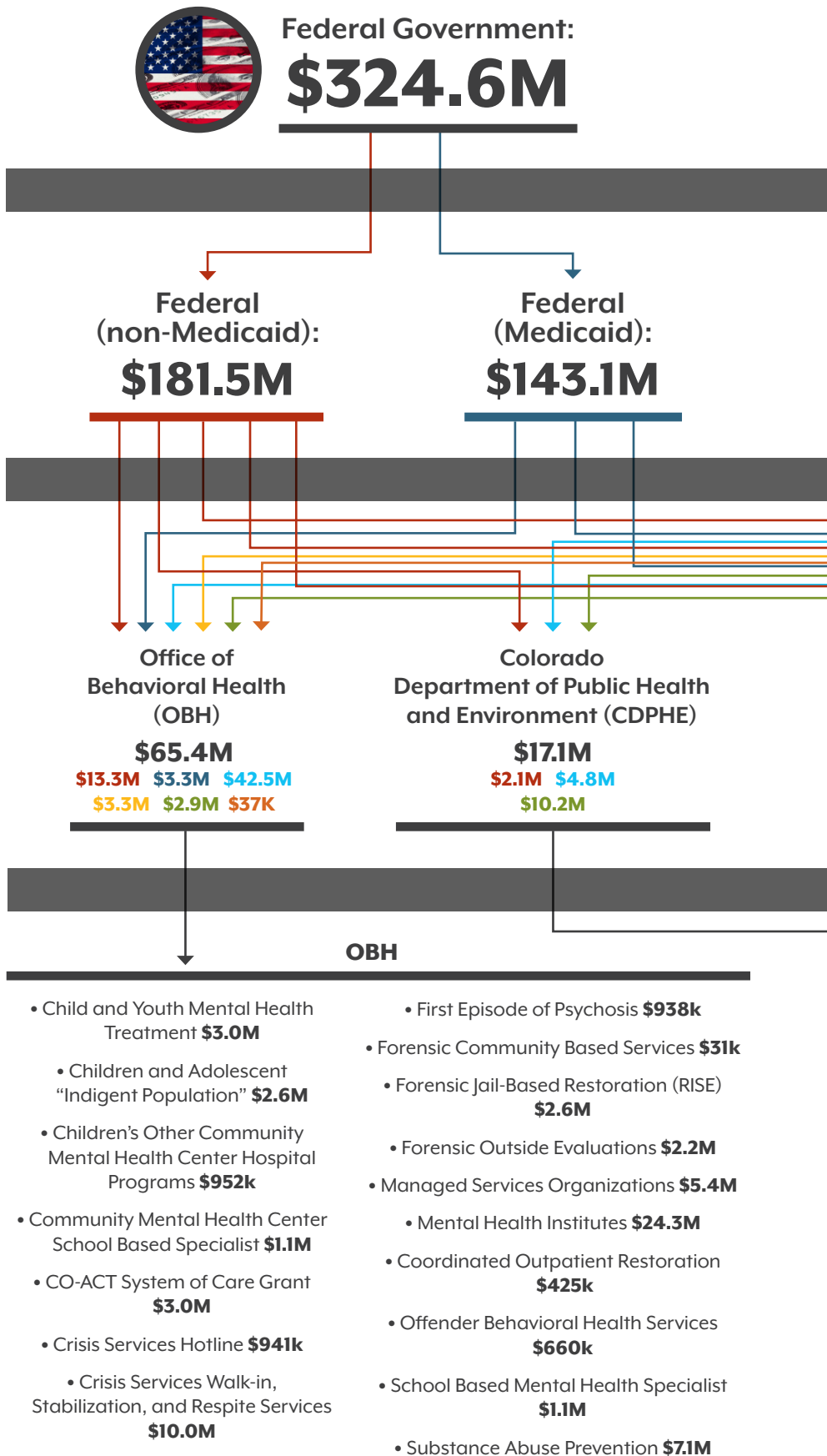
Third Level: COLORADO STATE AGENCIES

This section shows the state agencies that receive these funds. Agencies then distribute funding to programs.

Bottom Level: PROGRAM BY AGENCY

The six agencies distribute their funds for behavioral health across 34 distinct programs ranging from direct services to youth in need of behavioral health treatment to targeted training programs aimed at improving services and prevention efforts. The programs with the highest funding by department and office are bolded in the above graphic and detailed in Table 2. For a description of these programs, see Appendix 2.

Children and Youth Behavioral Health Funding



in Colorado: A Financial Map

OVERALL FUNDING SOURCES



State Government:
\$481.4M



Other:
\$4.0M

DETAILED FUNDING SOURCES

State General (non-Medicaid):
\$328.0M

State General (Medicaid):
\$122.6M

State Cash Funds:
\$25.3M

Other:
\$4.0M

COLORADO STATE AGENCIES

Colorado Department of Health Care Policy and Financing (HCPF)
\$258.9M
\$22.8M \$125.4M
\$102.2M \$8.5M

Colorado Department of Education (CDE)
\$21.6M
\$14.5M
\$7.0M

Office of Early Childhood (OEC)
\$66.0M
\$8.9M \$42.7M \$10.0M
\$481K \$4.0M

Office of Children, Youth, and Families (OCYF)
\$381.1M
\$134.4M \$14.4M
\$223.5M \$8.8M

PROGRAM BY AGENCY

- CDPHE**
- Communities that Care* **\$9.4M**
 - Garrett Lee Smith Youth Suicide Prevention **\$736k**
 - Office of Suicide Prevention School Grants **\$318k**
 - School-Based Health Center Programs* **\$6.6M**

- HCPF**
- Medicaid Capitated Behavioral Health Services **\$211.9M**
 - Medicaid Fee-For-Service Behavioral Health **\$21.1M**
 - Child Health Plan Plus (CHP+) **\$25.9M**

- CDE**
- School Health Professional Grant **\$14.5M**
 - Medicaid School Health Services* **\$7.0M**

- OEC**
- Early Intervention **\$61.3M**
 - Early Childhood Mental Health **\$2.8M**
 - Family Development Services* **\$750k**
 - The Incredible Years* **\$605k**
 - Healthy Steps* **\$578k**

- OCYF**
- Children Welfare Services Block Grant (Includes IV-E, IV-B, XX)* **\$321.3M**
 - Collaborative Management Program* **\$4.5M**
 - Core Services Block Grant* **\$55.3M**

* These programs fund more than just behavioral health services

What We're Buying: Service Array

CHI asked state agencies to report information about the types of services these funds provide. Agencies organized data based on the child and youth behavioral health service array developed by the Behavioral Health Task Force Children's Subcommittee (see box titled "The Behavioral Health Service Array").

The Behavioral Health Service Array

- **Universal Promotion and Prevention:** Awareness and education campaigns, safe community spaces, and programs that promote positive youth development
- **Targeted Prevention:** Preventive services, peer support, counseling (including trauma-informed psychoeducation), comprehensive family programs, and caregiver support and education
- **School-based Services:** Social-emotional learning and coping in classrooms, screening and assessment services, psychoeducation, suicide prevention training, and group and individual counseling
- **Integrated Care:** Integrated primary and specialty care, screening and assessment for behavioral health and substance use treatment, parenting education, and individual counseling
- **Outpatient Care:** Screening and assessment services; outpatient individual, group, and family therapy; substance use disorder treatment; telehealth; and respite care
- **Intensive Community- and Home-Based Services:** Intermediate or ancillary home-based services, multisystemic therapy, functional family therapy, high-fidelity wraparound, therapeutic preschools and schools, and respite care
- **Residential:** Therapeutic group homes and foster care, psychiatric and substance use disorder residential treatment
- **Inpatient Hospitalization:** Hospitalization, inpatient mental health, and substance use services
- **Crisis Services:** Mobile crisis services, crisis intervention or crisis stabilization, detox services
- **Care Coordination:** Execution of a patient-centered approach to facilitate an appropriate, coordinated delivery of health care services

Only 45 percent of \$810 million in behavioral health spending could be allocated to these 10 distinct service areas. A small amount (\$2.2 million) was reported as "other", but the majority (54 percent) was reported as unknown.

Of the \$364 million that could be allocated to service areas, the largest single area of spending was outpatient care, which accounted for 41 percent of service costs (see Figure 2). This was followed by school-based services at 14 percent and targeted prevention at 10 percent.

About nine cents of every dollar spent went to home and community-based services. This included services for youth and families who need multiple hours of services each week, such as frequent psychotherapy, ancillary home-based services, and evidence-based practices such as high-fidelity wraparound services and functional family therapy. However, more funding went toward these services than more intensive care such as crisis services (8 percent), inpatient hospitalization (3 percent), and residential care (3 percent).

Yet with more than half of these funds going to unknown services, there are limits to the conclusions that can be drawn. In addition, state agencies do not define behavioral health services consistently. The lack of uniform data collection methods means that reporting differs greatly between agencies. For example, some reporting systems focus on internal department metrics or funding stream reporting requirements. And none of the agencies track how they spend behavioral health dollars based on this exact service array. So mapping to this analysis' service buckets requires some interpretation and estimation. Finally, many programs contract with external organizations and vendors to provide services, and these organizations may not report this level of service detail back to state agencies. These challenges may indicate a need for better evaluation services or financial accountability to ensure that certain critical service areas are not overlooked.

A national report on Medicaid behavioral health service use and expenditures from 2005 to 2011 suggests that in some ways, Colorado's behavioral health spending is similar to national patterns. Outpatient care was the largest expenditure nationally (see Figure 3). Care coordination and intensive community- and home-based services also

Figure 2. Child Behavioral Health Funding by Service Area Category as a Percent of Known Funding

Less than half (45 percent) of agency expenditures could be mapped to the service array. Of known spending, outpatient and school-based services receive the most.

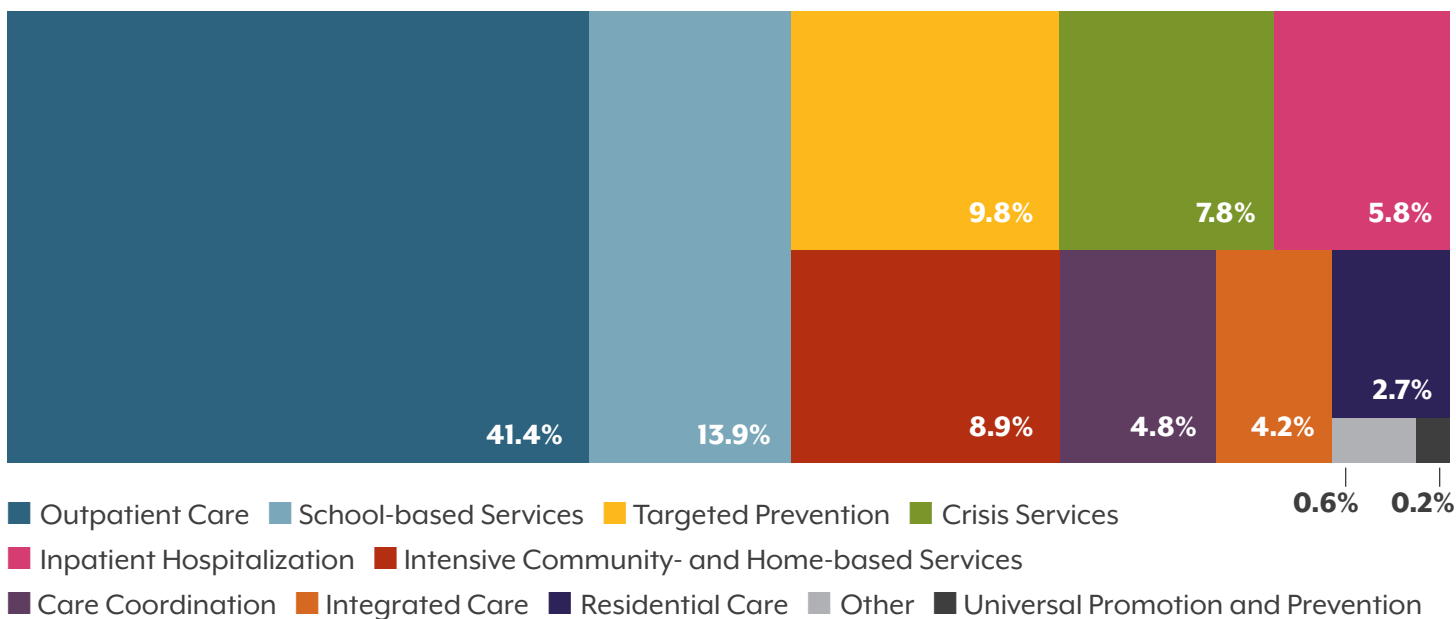


Table 2. Child Behavioral Health Funding by Service Area Category and Agency

	CDE	CDPHE	HCPF*	OBH	OCYF	OEC	Total
Unknown			\$26M	\$36M	\$321M	\$61M	\$444M
Universal Promotion and Prevention					\$563k		\$563k
Targeted Prevention		\$11M	\$6M	\$7M	\$9M	\$4M	\$36M
School-based Services	\$22M	\$7M	\$13M	\$1M	\$9M		\$51M
Integrated Care			\$7M		\$9M		\$16M
Outpatient Care			\$139M	\$4M	\$9M		\$152M
Intensive Community- and Home-Based Services			\$20M	\$3M	\$9M	\$1M	\$32M
Residential Care			\$9M	\$1M			\$10M
Inpatient Hospitalization			\$22M				\$21M
Crisis Services			\$9M	\$11M	\$9M		\$28M
Care Coordination			\$7M	\$2M	\$9M		\$17M
Other			\$2M	\$90k			\$2M
Total	\$22M	\$17M	\$259M	\$66M	\$381M	\$66M	\$810M

* Excludes \$31 million in psychotropic medication

received about the same percentage of funding in Colorado and nationally — 4 percent and 10 percent, respectively.

However, nearly a quarter of behavioral health expenditures nationally went to residential care, compared to just 3 percent in Colorado. This is likely due to Colorado’s focus on reducing the number of children in residential care by providing families with the supports they need to keep families together and interacting with at-risk families before they enter the system.

Further, there are two categories that are notably missing from the national service array — integrated care and school-based services. In Colorado, 4 percent of funding went toward integrated care services, and nearly 14 percent toward school-based services. These are indicative of recent shifts to provide behavioral health care in other clinical settings, such as schools, primary care, and other specialty care facilities.

Some of these discrepancies are likely due to the age of the Medicaid data — these figures are 8 years older than the Colorado data presented in this report. Discrepancies may also result from missing data elements and limitations in available data provided by state agencies. Additionally, it is important to note that the Colorado service array data includes services outside Medicaid.

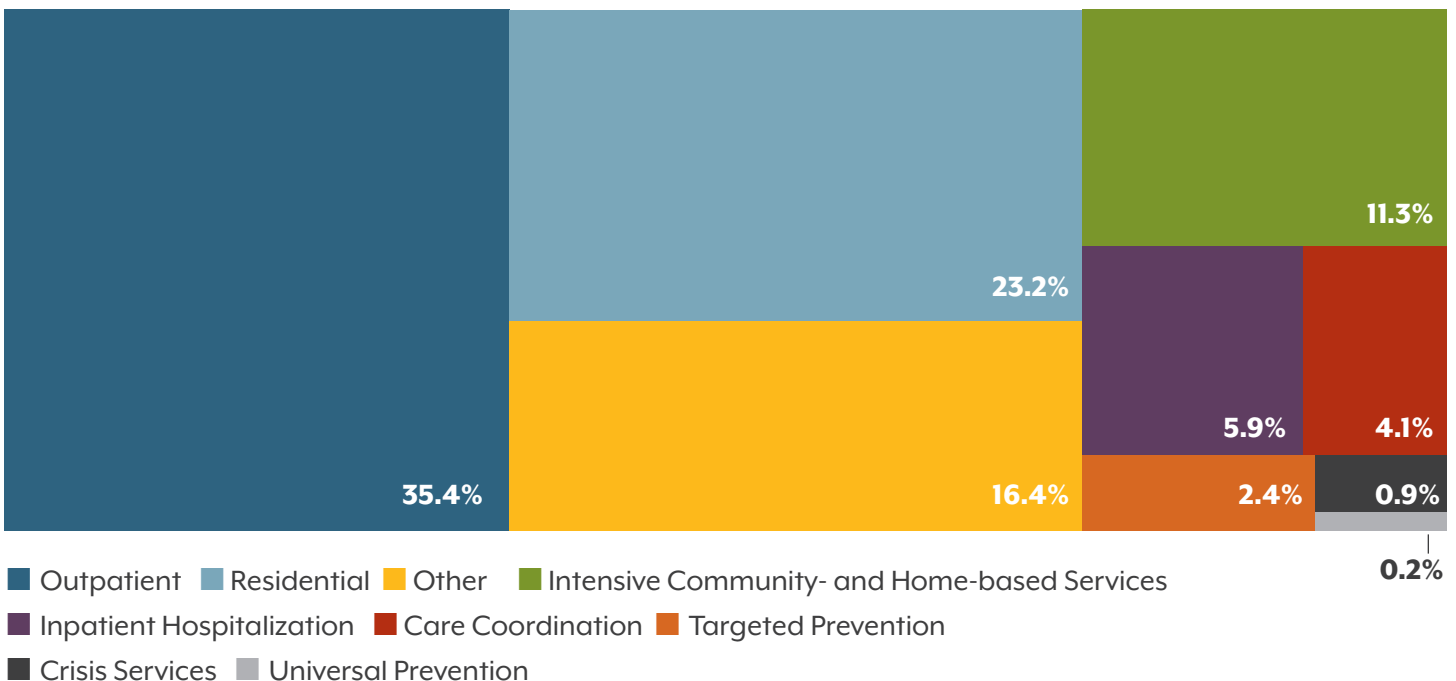
Psychotropic Medications

Psychotropic medications are an important aspect of behavioral health. In FY 2019, psychotropic drug expenditures across Medicaid and CHP+ in Colorado represented just over \$31 million — just 15 percent of the total amount HCPF spends on behavioral health services for youth. Half of that money was spent on psychotropic medication for attention deficit hyperactivity disorder, and another 30 percent was spent on antipsychotics.

Yet there are also differences in how services are defined. Just as definitions of behavioral health services are not consistently defined across the state of Colorado, there are no national standards, making it difficult to interpret this comparison. The national report provided data on 30 different service types, which CHI allocated to Colorado’s service array (for more details, see Appendix 1).

To better answer the research question, “What services are these dollars purchasing?” state agencies would need to be prepared to attribute their funding to this specific service array.

Figure 3. National Medicaid Expenditures on Behavioral Health Services, 2011



Who We're Serving: Demographics

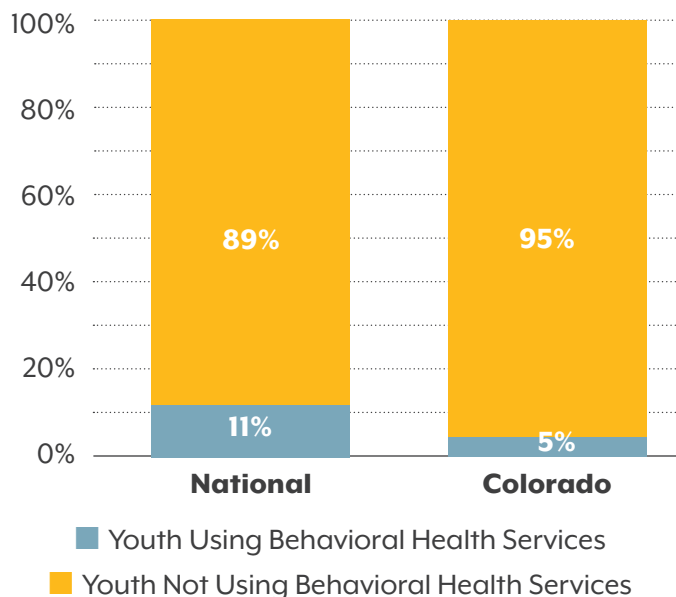
There are over 2 million children and youth between the ages of 0 and 26 in Colorado.⁵ As many as 600,000 of them may need behavioral health services.⁶

But in 2019, nearly 14 percent of these Coloradans (200,000) reported that they did not get needed mental health care in the past year.⁷ Reasons for not getting this care included concerns about cost of treatment, uncertainty of insurance coverage, and difficulty getting an appointment. This suggests that Colorado's children and youth might use behavioral health services more readily if they understood how they could receive services through different low-cost programs and had an easier time finding behavioral health care providers.

One study focused solely on care within Medicaid found that utilization of behavioral health services among young people is lower in Colorado than the rest of the nation (see Figure 4).⁸ While the reasons behind this are unclear, this indicates that there may be room for improvement within Colorado's existing systems of care.

Figure 4. Colorado Youth Use Fewer Behavioral Health Services

Behavioral Health Utilization in Medicaid: National (2011) vs Colorado (FY 2019)



Together, the six state agencies included in this analysis reported serving 1.5 million children. However, there is no way to identify instances where children used services provided by multiple programs, so it is likely that far fewer children were actually served. In order to get an unduplicated count of the number of children and youth using these programs, agencies would need to provide client-level data that could allow children to be identified across programs. This is possible for some services and programs, but not all.

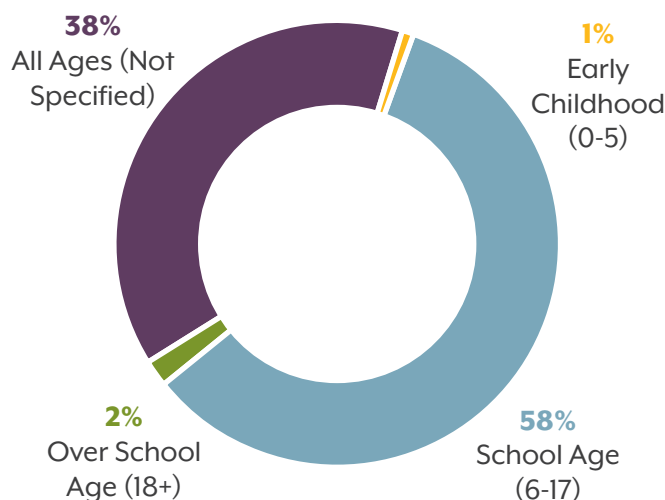
In addition to this limitation, it is hard to paint a full picture of the demographics of young people receiving services. State agencies were unable to report age data for nearly 40 percent of participants, and they could not report gender or race / ethnicity for more than 80 percent.

Given these gaps, findings should be interpreted with caution. Better data might change these results considerably. That said, current information can offer insights into the population being served by this system.

Age

Of the children and youth served whose ages are known, the vast majority (94 percent) were school-aged. About 3 percent were young adults, and 2 percent were children in early childhood (see Figure 5).

Figure 5. Among Known Ages, Most Youth Served are School-Age
Children and Youth Served by Age Group

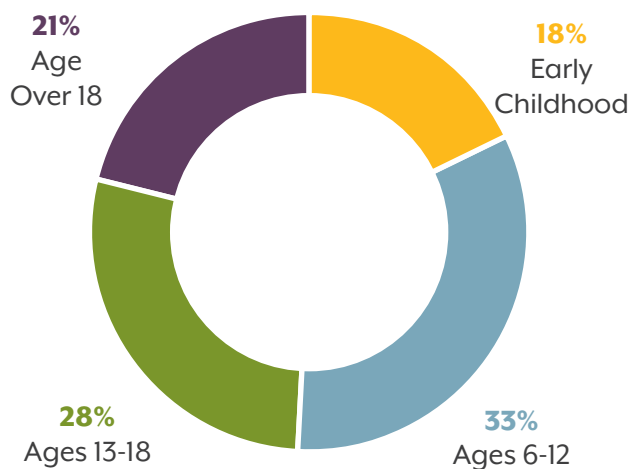


Gaps in policy may explain these findings. While the Affordable Care Act extended parental health insurance coverage to dependents under age 26, programming restrictions for state agencies often limits funding to ages 18 or younger.

For example, OEC only serves children ages 0 to 8, while CDE focuses on school-aged children. Other programs within agencies have age restrictions, such as the Children and Youth Mental Health Treatment Act and Offender Behavioral Health Services, which primarily provide services to kids ages 0 to 18.

There may be opportunities to expand funding to better represent age groups in Colorado, particularly because many of these restrictions are imposed by program, rather than funding source.

Figure 6. Insurance Claims for Youth with a Behavioral Health Diagnosis by Age, 2018



What is the Role of Insurance?

The role played by state agencies and health insurance is different. CHI analyzed data from the All Payers Claims Database (APCD) to help assess what role health insurance plays in providing behavioral health services. APCD reports on services provided by Medicaid and many other private insurers, including some self-insured employer plans.

In 2018, 7,200,000 services were provided to children

Sex / Gender

Data on sex and gender were reported for just half of children served in FY 2019, but available figures show an even split between males and females. By comparison, 41 percent of national Medicaid behavioral health utilizers between the ages of 0 and 18 are female.⁹ This may indicate that Colorado has reached a greater gender parity in service provision than the U.S. as a whole.

However, males do appear more likely than females to receive high-acuity services in Colorado. Some programs use more than 60 percent of their funding for males, including managed service organizations, forensic jail-based restoration, and coordinated outpatient restoration.

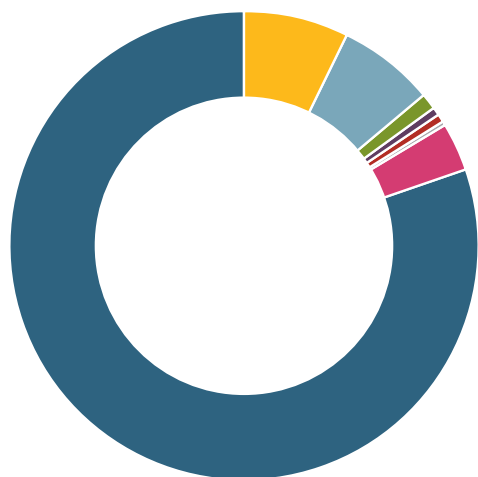
Further, the Colorado Health Access Survey (CHAS) estimates that just over 58 percent of the Colorado children and youth who did not get needed behavioral health services in 2019 were female.

Together, the limited data indicate that despite the greater unmet need for behavioral health services among females, most high-acuity spending goes to males. Setting of care – e.g., jail-based services – might be a major reason for this. While the overall split between male and female children and youth receiving behavioral health services is even, these data suggest that further analysis is needed to understand whether young men and women are, in fact, getting the care they need.

and youth with a mental diagnosis through both public and private insurance. About a third of were provided in an outpatient setting, and just 1 percent went to inpatient care.

An examination of services provided by age show that services covered by insurance are more equally distributed by age category than those reported by state agencies.

Figure 7. Race / Ethnicity is Not Known for Most Children and Youth Served by Race / Ethnicity



- Hispanic/Latinx **7.3%**
- White (non-Hispanic/Latinx) **6.5%**
- Black or African American **1.2%**
- Asian (non-Hispanic/Latinx) **0.2%**
- American Indian/Alaskan Native **0.2%**
- Native Hawaiian/Pacific Islander **0.1%**
- Multiracial/other **3.4%**
- Unknown race/ethnicity **81.1%**

Race / Ethnicity

Data on race and ethnicity were reported for less than 20 percent of children and youth receiving behavioral health services. Of those whose race or ethnicity is known, nearly 40 percent were Hispanic / Latinx, and nearly 34 percent were white (non-Hispanic / Latinx). Black or African American Coloradans accounted for 6 percent, and 18 percent were multiracial. Other races and ethnicities account for less than 1 percent each (see Figure 7).

According to the CHAS, 70 percent of children and youth who did not get needed behavioral health services were white (non-Hispanic / Latinx). However, it's important to note that low representation of certain racial and ethnic groups does not equate to lower need. For example, national data showed an overall increase in total expenditures for black or African American youth, despite a decrease in overall representation. This suggests fewer youth were using behavioral health services but at a higher rate.¹⁰ Without the ability to de-duplicate children and youth receiving care across programs, it is difficult to say whether young Coloradans of color are receiving needed services.



Table 3. Federal Funding by Mechanism

Mechanism Type	Amount	Program	State Agency
Medicaid (53 percent average federal match)	\$114M	Capitated behavioral health	HCPF
	\$14M	Child Welfare Services Block	OCYF
	\$12M	Fee-for-service behavioral health	HCPF
	\$3M	Mental Health Institutes	OBH
Child Health Plan Plus (79 percent federal match)	\$23M	CHP+	HCPF
Block Grants	\$131M	Child Welfare Services Block Grant	OCYF
	\$7M	Substance Abuse Prevention	OBH
	\$2M	Managed Services Organizations	OBH
	\$1M	School-Based Health Centers	CDPHE
	\$938k	First Episode of Psychosis	OBH
	\$3M	Core Services Block Grant	OCYF
	\$736k	Garrett Lee Smith Youth Suicide Prevention Grant	CDPHE
Other Grants	\$7M	Early Intervention	OEC
	\$2M	Early Childhood Mental Health (ECMH) Consultant	OEC
	\$3M	CO-ACT System of Care Grant	OBH

How We're Paying: Funding Mechanisms

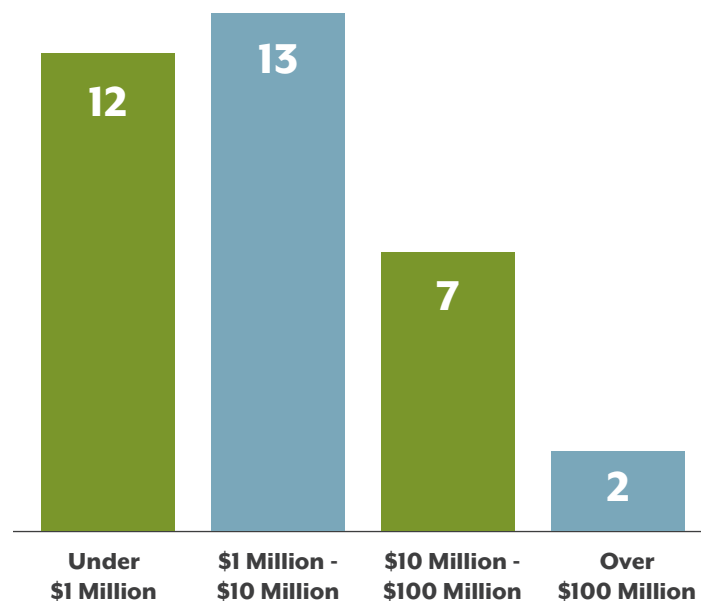
Children's behavioral health in Colorado is funded not only through a variety of sources, but by a variety of funding mechanisms. Understanding differences in how this money enters the state can help determine whether all dollars are being spent effectively.

For example, some federal funds are delivered through block grants, which come to Colorado in one lump sum, regardless of how much state funding is also provided. Other programs receive a federal funding match, meaning that for every dollar spent by Colorado, additional money can be pulled down from the federal government.

Federal match amounts vary depending on the program. In FY 2019, the average federal match rate for Medicaid programs for children and youth was 53 percent.¹¹ In other words, for every \$100 in Medicaid behavioral health expenses, the federal government covered \$53 of the cost. In FY 2019, CHP+

Figure 8. Most Programs Have Budgets Under \$10 Million

Number of Programs by 2019 Expenditures



was matched by federal dollars at a much higher rate — 79 percent—though this is expected to soon drop to 65 percent.¹² Table 2 summarizes the funding mechanisms that draw down federal dollars in Colorado.

In addition to sources of funding, there is variation in how funding is distributed across programs. Of the 34 programs identified in this financial map, most spend less than \$10 million per year (see Financial Map on pages 6 and 7 and Figure 8). Combining smaller programs is a possible opportunity to streamline services and create economies of scale.

Opportunities Moving Forward

Colorado has myriad opportunities to strengthen its system for financing behavioral health services for children and youth ages 0 to 26, and the state faces an urgent need to streamline. CHI identified five opportunities to strengthen this key behavioral health delivery system.

1. Consolidate Funding Streams and Service Delivery

Consolidating programs by their eligibility criteria, program size, funding flexibility, and services provided could reduce duplication, increase alignment and efficiencies, and improve quality and access to care for children and youth who need it most.

One approach to consolidating funding streams may be to align programs by their eligibility criteria. This analysis identified many smaller programs that provide a narrow range of services based on very specific program eligibility requirements. These programs may have similar program-eligibility requirements, populations served, and services offered. But because of small differences in administration through different state agencies, different rules associated with different funding sources, different data infrastructure, and other misalignments, services may not be sufficiently coordinated and comprehensive to reach all children in need.

One example is the interaction between the Collaborative Management Program (CMP) and the CO-ACT System of Care Grant. These programs

both offer care coordination and wraparound services, with the CO-ACT grant building on the infrastructure of the CMP. They both serve the behavioral health needs of very similar populations of youth and children. Both are spending less than \$5 million annually. But their eligibility requirements are slightly different, they are administered by different state agencies, and their service offerings may not completely align. Consolidating these two programs — either in their administration, funding, eligibility, or other alignment — could reduce confusion and better serve children and their families.

Colorado's leaders may also consider consolidating funding streams by their program size. This analysis identified 12 programs that each spend less than \$1 million dollars annually. Collectively, these programs are critical to the behavioral health of the state's youth and children. But for an individual family or provider, consolidating these programs could create economies of scale and increase access to and quality of care provided to youth and children.

Another approach to consolidating funding streams is by funding flexibility. Non-Medicaid state general funds make up 41 percent of all child behavioral health spending. More flexibility in spending of these dollars could allow programs to align with other systems. Colorado's leaders should consider a closer look at the funding restrictions currently limiting these dollars from aligning.

Colorado's leaders should also consider consolidating funding streams by their services provided. One example is the Child and Youth Mental Health Treatment Act funding and the Core Services Block Grant, which provide similar services. Both exist under CDHS. Analyzing these service offerings — as well as who is eligible to receive them — could reveal opportunities to streamline this funding to reach more children.

Recent policy examples also reveal examples of alignment by services provided. Senate Bill 19-195, for instance, requires HPCF to design an integrated funding pilot that would blend and braid federal, state, and local dollars to reduce the duplication and fragmentation of services for multi-system- involved children and youth.¹³ Consolidating funding streams across other service areas could similarly reduce duplication across the entire behavioral health system serving children and youth.

2. Maximize Federal Dollars

Colorado's leaders should use this financial map to identify opportunities to increase federal matching funds. If any services currently provided by state programs that don't get a federal match could instead be provided using funding from Medicaid or CHP+, Colorado may be able to get the federal government to pick up a greater portion of the tab.

But homing in on specific opportunities — and estimating the size of potential additional Medicaid match dollars — requires additional data that are not yet available in Colorado's data systems. Specifically, identifying Medicaid match opportunities requires an understanding of the Medicaid-eligibility of individuals served and whether the services delivered are covered by Colorado's Medicaid benefit. For example, identifying matching opportunities requires knowledge of whether the young people being served are eligible for Medicaid in terms of their income, documentation status, and other factors.

That said, this financial map provides a place to start and considerations for policymakers in the future. Colorado's leaders should look for matching opportunities by identifying potential Medicaid-aligned services under state agencies and programs that are not yet using significant Medicaid dollars.

Examples of current non-Medicaid funded programs that could warrant a Medicaid match might include the Early Childhood Mental Health programming within OEC or First Episode of Psychosis within OBH. Again, however, without knowing details on the exact nature of these services or the populations they serve, we can't say this with much certainty.

Additional considerations are described below.

Recent policy developments. Recent policy developments may reveal opportunities to pull down additional federal match dollars. For example, Colorado's Medicaid Section 1115 waiver expanding the substance use disorder treatment benefit creates matching opportunities for any programs already offering these services using existing non-Medicaid dollars.

Funding limitations. The federal government can only use Medicaid or CHP+ dollars to support specific services — and without disruption or complication to the services already available to Colorado's youth. For example, there are currently funding limitations

on some inpatient services within Medicaid. Deeply understanding which programs purchase which services is critical to maximizing the federal match.

This is especially true in the child welfare system. Though this analysis is lacking the data needed to investigate, a report by Child Trends identifies opportunities for counties to contribute to ensuring federal dollars are used whenever possible to provide services to children. This report recommends working with counties to ensure Title IV-E eligibility is documented correctly so that services provided receive a federal match.¹⁴

3. Promote Equity in Behavioral Health Funding

In addition to securing larger federal matches, changes to spending may lead to a more equitable distribution of resources. An opportunity exists to ensure funds are distributed to services for the youth populations that need them the most. More should be done to ensure all youth are actually aware of services.

Investment in young children and the 18 to 26 population is important. While data are limited, findings suggest youth ages 0 to 5 and 18 or older may be disproportionately under-funded compared with school-aged youth in Colorado and their national counterparts.

Finally, opportunities exist to reduce disparities in funding among racial and ethnic groups. Low representation among communities of color demonstrates a need for targeted outreach.

There also may be racial and ethnic groups that are more likely to be double-counted in this analysis because the data were unable to account for people who use services from multiple programs. If these data were available, further analysis could be conducted to see if certain racial and ethnic groups are more or less likely to receive multiple services, and if so what type of services they are receiving.

4. Focus on Substance Use Treatment

Colorado's leaders should consider consolidating funding streams in ways that promote access to urgently needed services. One example is access to substance use treatment services for children and youth.

This report found that substance use screening and/or treatment services are delivered across the service array — from school-based services to outpatient care and inpatient hospitalization.¹⁵ And multiple funding streams support these different services, such as Managed Services Organizations, Medicaid, Core Services Block, and the Colorado Trauma-Informed System of Care grant. This integration may provide multiple entry points for families — but it may also create fragmentation of funding, eligibility, and access to services.

Conducting additional analysis of Colorado's substance use treatment services for youth may identify inefficiencies and duplication of services.

5. Invest in Data

Colorado's behavioral health data are fragmented. The state should invest in data infrastructure to learn where dollars are going, who is receiving which services, and where gaps remain.

Increased Efficiency

Investment in data systems and associated governing structures facilitates easier and more accurate tracking of financing streams, services purchased, and populations served. The process of this analysis provides examples of this fragmentation and its implications. For instance, collecting Colorado's behavioral health financing data often required multiple phone calls with multiple staff at a single state agency — and still, interviewees were unable to provide demographic or service information on more than half of the dollars identified.

Better Understanding of Demographic and Service Gaps

As a result of this fragmentation, substantial funding is not attributed to a specific age group, gender, race, or ethnicity. Colorado's leaders should invest in common data infrastructure that allows for multiple agencies and programs to connect their data sets and understand gaps at a population level.

This information is critical not only to understanding gaps in services — but also to determining if programs are maximizing federal match dollars.

Comprehensive Service Array Information

The breadth of services being provided to children and youth with behavioral health issues is vast. Within each of the 10 service areas described on page 8, there are many different types of services. Each state agency provided data broken down by the service array. However, each agency took its own approach to estimate which parts of the service array their funds and programs were supporting.

Colorado's leaders should establish and standardize an array of services to encourage consistent reporting. This would provide a better understanding of what services each dollar is purchasing.

Individualized Service Provision

Cross-agency data sharing is critical to identify those who are receiving services from multiple agencies. Colorado's leaders should consider adopting data infrastructure best practices — such as a unique identifier for all of Colorado's children accessing services — to streamline service access.

The behavioral health task force members are considering ways to better strengthen data sharing. The proposed behavioral health service delivery structure would affect non-Medicaid public programs operating out of many of the agencies interviewed for this analysis. A new or existing singular centralized agency would administer all community-based direct services. This approach could facilitate better data sharing, more aligned service eligibility, and more streamlined contracts.

Conclusion

Every year, Colorado spends at least a half billion dollars on behavioral health services for children and youth. An examination of these finances underscores a complex, yet essential, set of systems and funding mechanisms that goes to providing these important services. Opportunities to expand the equitable, effective, and efficient use of these funds can continue to elevate the behavioral health of all Colorado youth and families.

Appendix 1: Methods

Data for the children’s behavioral health financial map were provided by state agencies at the request of the Colorado Health Institute (CHI) and the Behavioral Health Task Force children’s subcommittee.

Agencies to include were identified in consultation with taskforce subcommittee representatives and Taskforce leadership. CHI provided one or more representatives at each agency with an Excel spreadsheet to be completed. Once the completed spreadsheet was returned to CHI, it was reviewed for completeness and underwent data validation. CHI engaged with representatives at state agencies before, during, and after this data request to assess the accuracy of submissions and follow up on incomplete or confusing data.

Data represent state fiscal year 2018-2019 (FY 2019). Depending on the state agency, figures provided represent budget or expenditures.

State agencies were often unable to provide all of the information requested. In some cases, those values are not included in this report (see the table below for a summary of demographic data availability by program).

In other instances, CHI made changes to the data in order to report as much information as possible. These are described in more detail by state agency below.

Department of Health Care Policy and Financing (HCPF)

HCPF data came from multiple sources. Medical Services Premiums figures were used to report funding by source (federal, state general, or state cash funds). Data on the types of services provided came through a separate data request, as many behavioral health services are capitated and these claims are not included with the Medical Services Premiums.

Dollar amounts by funding source from the Medical Services Premiums differed from the amounts reported by service type. To reconcile these figures, total funding provided by service type was allocated

according to the proportional split of the funds by funding source reported.

Race and ethnicity data were reported separately as well. HCPF used categories that differed slightly from those in the initial data request and included Hispanic / Latinx as both a race and ethnicity category. Hispanic / Latinx enrollees were reported to be 29 percent of the population by ethnicity, and 7 percent of the population by race. In order to align these categories with those reported by other state agencies, CHI assumed that 29 percent was the correct percentage of Hispanic / Latinx enrollees, and that the 22 percent of Hispanic / Latinx enrollees not accounted for in the race breakdown most likely reported as “multiracial” in the race breakdowns provided by HCPF. This lowered the overall percentage of multiracial enrollees reported by HCPF.

Finally, the number of Child Health Plan Plus (CHP+) enrollees was also not reported. CHI used the HCPF 2020-21 budget request to determine the number of CHP+ enrollees in FY 2019.

Spending on psychotropic medications was pulled out of the HCPF funding figures. “Psychotropic” medications included HCPF drug categories of:

- Psychoactive drugs, ADHD
- Psychoactive drugs, depression, anxiety, and other
- Psychoactive drugs benzodiazepines
- Psychoactive drugs antipsychotics
- Analgesics opioid antagonist and withdrawal treatment (SUD treatment)

Data from HCPF reflect expenditures rather than budgeted figures.

Colorado Department of Education (CDE)

It is important to note that CDE was unable to separate behavioral health expenditures from other health expenditures, and so this figure is likely inflated.

CDE was unable to report data on demographics or service array. CHI assumed that 100 percent of

Table 1: Table of Available Demographic Data by Program*

	Age	Sex / Gender	Race / Ethnicity
Healthy Steps	X		
The Incredible Years	X		
Family Development Services through Family Resource Centers		X	X
Early Childhood Mental Health (ECMH) Consultants			
Early Intervention	X	X	X
School Health Professional Grant	X		
School Health Services (Medicaid)	X		
Office of Suicide Prevention School Grants (SB18-272)			
Garrett Lee Smith Youth Suicide Prevention Grant			
Communities that Care			
School Based Health Centers		X	X
Children and Youth Mental Health Treatment Act	X	X	X
Offender Behavioral Health Services (OBHS)	X	X	X
Mental Health Institutes	X	X	X
Forensic Community Based Services (FCBS)			
OBH Coordinated Outpatient Restoration	X	X	X
Non-OBH Coordinated Outpatient Restoration	X	X	X
Forensic Jail-Based Restoration (RISE)	X	X	
Forensic Outside Evaluations	X	X	X
Managed Services Organizations	X	X	X
School-Based Mental Health Specialist			
First Episode of Psychosis	X	X	X
Children and Adolescent “Indigent Population”	X		
Children’s Other CMHC Programs Hospital Alternatives	X		
Substance Abuse Prevention	X	X	X
Crisis Services Hotline	X		
Crisis Services Walk-in, Stabilization, & Respite Svcs	X		
COACT System of Care Grant	X	X	X
Core Services Block			X
Collaborative Management Program		X	X
Children Welfare Services block (Includes IV-E, IV-B, XX)			X
CHP+ Behavioral Health			
Behavioral Health Capitation		X	X
Behavioral Health Fee-for-Service		X	X

*An X notes demographic data that was provided by agency.

funding went to school-based services, and that these funds were split equally between all relevant age groups for these school-based services.

CDE did provide data on a Social Emotional Health Grant, but CHI decided not to include these funds, as the implementation cycle of this grant did not occur during FY 2019.

Data from CDE reflect budgeted figures rather than expenditures, with the exception of Medicaid funds under their control.

Colorado Department of Human Services, Office of Behavioral Health (OBH)

OBH was unable to report age data for two programs: Children and Adolescent “Indigent Population” and Children’s Other CMHC Programs Hospital Alternatives. For these programs, CHI assumed an even split of funding between the relevant age groups.

In some instances, OBH provided data that had to be parsed out for analysis.

When cells were merged and figures were reported for two groups (e.g., if “70 percent” of clients were said to be in 0 to 5 age category and the 6 to 12 age category), CHI split the figure evenly by age group (e.g., 35 percent were put in the 0 to 5 age bucket and 35 percent in the 6 to 12 age bucket).

When only a high range for a figure was provided in the demographic breakdowns (e.g., “fewer than 2 percent multiracial enrollees”), CHI assumed this percentage was the point estimate (e.g., assumed 2 percent multiracial enrollees).

Data on race and ethnicity often summed to greater than 100 percent. This is likely due to difficulties reporting which racial groups are non-Hispanic / Latinx. In these instances, CHI kept the number of

Hispanic / Latinx children served and entered the remaining children as “unknown” race.

Data from OBH reflects budgeted figures rather than expenditures.

Colorado Department of Human Services, Office of Early Childhood (OEC)

OEC data on race and ethnicity often summed to greater than 100 percent. This is likely due to difficulties reporting which racial groups are non-Hispanic / Latinx. In these instances, CHI removed the additional children from the Hispanic / Latinx group. This was handled differently than the same issue in the OBH data set because the size of this gap was relatively small.

Data from OEC reflects budgeted figures rather than expenditures.

Colorado Department of Human Services, Office of Children, Youth, and Families (OCYF)

It is important to note that OCYF was unable to parse out which expenditures went to behavioral health services and which went to other types of services within their purview. Therefore, the total expenditures is an over-estimate.

Data from OCYF reflects budgeted figures rather than expenditures.

Colorado Department of Public Health and Environment (CDPHE)

CDPHE provided data for the Colorado Pediatric Psychiatric Consultation and Access Program (CoPPCAP). CHI did not include in this analysis because FY 2019 was a planning year for the grant.

Data from CDPHE reflects budgeted figures rather than expenditures.

Appendix 2: Description of Children’s Behavioral Health Programs by State Agency

Office of Behavioral Health, Colorado Department of Human Services

Children and Youth Mental Health Treatment Act

The Children and Youth Mental Health Treatment Act is an alternative to child welfare involvement. It applies when a dependency and neglect action is not warranted and allows for families to access mental health treatment services for their children.

Offender Behavioral Health Services

Offender Behavioral Health Services provides community-based support for previously incarcerated individuals, jail-based behavioral health, and law-enforcement services such as co-responder services.

Mental Health Institutes

The Office of Behavioral Health operates two mental health institutes, or state-run psychiatric hospitals: the Colorado Mental Health Institute at Pueblo and the Colorado Mental Health Institute at Fort Logan in Denver.

Forensic Community Based Services

Forensic Community Based Services is responsible for the case management of persons found not guilty by reason of insanity, and who are transitioning from an inpatient hospital setting into a community-based outpatient setting. Acquittes on community placement and conditional release have the opportunity for continued independence, recovery, and community reintegration.

Coordinated Outpatient Restoration

The Outpatient Restoration Program serves adults and juveniles in the criminal and juvenile justice systems who are found incompetent to proceed. It provides education and case management services in or near enrollees’ communities. This program delivers competency restoration services in the least restrictive setting, increasing a person’s ability to engage with local and social support while preventing personal losses such as employment,

housing, income, and freedom. Education services are at no cost to the individual and are provided by contracted educators throughout the state. “Non-OBH” restoration refers to those not assigned to the Department of Human Services by the court.

Forensic Jail-Based Restoration (RISE)

The Jail-Based Evaluation and Restoration Program provides jail-based competency restoration services for individuals ordered by a court to receive an initial evaluation of competency to proceed, or those found incompetent to proceed and ordered to undergo competency restoration treatment.

Forensic Outside Evaluations

Competency, sanity, mental, and other examinations done outside of the Department of Human Services.

Managed Service Organizations

Regional organizations who ensure access to a full continuum of quality substance use disorder services for individuals in need.

School-Based Mental Health Specialist

School-based mental health specialists provide consultation, training, support, and mental health resources to schools.

First Episode of Psychosis

First Episode of Psychosis is a high-intensity outpatient program targeting youth with serious mental illness who have or are experiencing psychosis (typically schizophrenia-related disorders). Clients are supported by a multi-disciplinary team consisting of a team lead, therapist, supported employment/education specialist, prescriber/nurse, peer supports, and a case manager.

Children and Adolescent “Indigent Population”

The Office of Behavioral Health provides behavioral health programs and services for individuals designated as “indigent.” Qualification as “indigent” is based on uninsured status, severity of diagnosis, and household income.

Children's Other CMHC Programs Hospital Alternatives

Children's Other CMHC Programs Hospital Alternatives provides mentoring programs and other outpatient services for children

Substance Abuse Prevention

Substance abuse prevention efforts include the development of a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program targets both the general population and sub-groups that are at high risk for substance misuse.

Crisis Services Hotline

Hotline, support line, chat, and text services to receive urgent mental health assistance. The hotline can be used by any Coloradan in crisis.

Crisis Services Walk-in, Stabilization, and Respite Services

Mental health evaluations and services via walk-in, crisis stabilization units, mobile crisis response, or respite services.

COACT System of Care Grant

COACT services children and youth with serious behavioral health challenges and their families. They are provided services through High-Fidelity Wraparound with peer support to keep them at home, in school, and out of trouble.

Office of Children, Youth, and Families, Colorado Department of Human Services Core Services Block

The Core Services Block grant funds therapeutic services focused on family strengths by directing intensive services that support and strengthen the family and protect the child. It aims to prevent out-of-home placement of the child, return children in placement to their own homes, or unite children with their permanent families.

Collaborative Management Program

The Collaborative Management Program is an optional program addressing children, youth, and families involved or at risk of involvement in more than one system.

Children Welfare Services Block

Children Welfare Services Block grant funds are allocated to counties to provide child welfare services. They are generally unrestricted and flexible, being used for more than placement services.

Office of Early Childhood, Colorado Department of Human Services

Healthy Steps

Healthy Steps integrates a child development specialist into the pediatric primary care team to foster positive parenting, strengthen the child's early social and emotional development, and support early literacy. The program pairs a Healthy Steps Specialist with families with children ages birth to three.

The Incredible Years

The Incredible Years is an evidenced-based program for pre-kindergarten and kindergarten classrooms. It supports classroom management for teachers and includes a parenting program. This approach prepares children for school by teaching them how to interact with others and solve problems in a healthy, positive way.

Family Development Services through Family Resource Centers

Family Development Services serve as a single point of entry for providing comprehensive, intensive, and integrated state- and community-based services to families, individuals, children, and youth. State funding supports family development and case management services.

Early Childhood Mental Health Consultants

Early Childhood Mental Health (ECMH) consultants partner with caregivers, teachers, and child care directors to help them understand and respond effectively to children birth to 8 years old. This evidence-based solution reduces challenging behavior in the classroom and helps prevent suspensions and expulsions. ECMH increases teacher retention and helps improve classroom environments.

Early Intervention

Early Intervention provides services for children under age three with developmental delays or disabilities and their families. The program teaches positive relationships, acquisition and use of knowledge and skills, and the use of appropriate behaviors to meet their needs.

Colorado Department of Education

School Health Professional Grant Program

The School Health Professional Grant Program provides funds to eligible education providers to enhance the presence of school health professionals in both elementary and secondary schools.

School Health Services (Medicaid)

Participating school districts can bill Health First Colorado for Medicaid-covered services provided in schools. The Colorado Department of Education provides training on development of the local service plans to support students' mental and physical health needs.

Colorado Department of Public Health and Environment

Office of Suicide Prevention School Grants

Office of Suicide Prevention School Grants help school districts implement comprehensive crisis and suicide prevention strategies. The program focuses primarily on trainings for school faculty.

Garrett Lee Smith Youth Suicide Prevention Grant

Garrett Lee Smith Youth Suicide Prevention Grants focus on intensive community-level change to strengthen linkages across youth-serving systems

and improve the identification, referral, and follow-up supports for youth at risk for suicide. Communities also use grant funds to support Zero Suicide, provider trainings, and gatekeeper trainings for adults working with children.

Communities that Care

Communities That Care guides communities through a proven five-phase change process. Using prevention science as its base, the program promotes healthy youth development, improves youth outcomes and reduces problem behaviors.

School-Based Health Centers

State grant funding supports existing school-based health centers as well as the planning and start-up of new school-based health centers in Colorado.

Department of Health Care Policy and Financing

CHP+ Behavioral Health

Child Health Plan *Plus* (CHP+) is public low-cost health insurance for certain children and pregnant women. It is for people who earn too much to qualify for Medicaid, but not enough to pay for private health insurance.

Behavioral Health Capitation

Most behavioral health services provided to Medicaid enrollees are covered through capitation. HCPF pays a regional entity a monthly amount to provide or arrange for behavioral health services for all Medicaid members.

Behavioral Health Fee-for-Service

Certain behavioral health services for Medicaid enrollees, such as those provided in a primary care setting, are still paid for in a fee-for-service structure.

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Notes

Lined area for taking notes, consisting of numerous horizontal dotted lines.



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