Considerations for an Aligned Funding Pilot: Appendices

Recommendations in Accordance with SB19-195

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Appendix I – Text for Complicated Figures

FIGURE 3

This timeline (from 2017-2025) shows selected legislation and related activities that impact the BH landscape for children and youth in Colorado.

In 2017, SB17-267 was passed in the legislature. This bill requires HCPF to pursue enhanced pediatric health homes for children with complex conditions upon passage of the ACE Kids Act.

In 2018, the Family First Prevention Service Act passed, work is still underway. In July ACC Phase II launched.

In 2019, SB19-222 passed, which requires extensive changes to the behavioral health safety net system. SB 19-195 also passed, authorizing HCPF to implement high-fidelity wraparound and an aligned funding pilot. In April the federal ACE Kids ACT was signed and Governor Polis directed CDHS to spearhead the Behavioral Health Task Force. In the fall, the Behavioral Health Task Force and subcommittees began meeting.

In 2020, HB20-1384, due to COVID-related fiscal challenges, SB19-195 funding was cut and the implementation date for the aligned funding pilot was removed. In September, the Behavioral Health Task Force Blueprint was released.

In 2021, SB21-137, the Behavioral Health Recovery Act was signed. The legislation created a process for distribution of ARPA dollars, provided funds to develop a statewide care coordination infrastructure, and created the behavioral health transformation task force. The legislation also funded the SB19-195 work which had lost funding in 2020. In May, Children's Hospital Colorado declared a state of emergency for youth mental health.

In 2022, the behavioral health transformation task force recommendations report was released. HB22-1278 created the behavioral health administration (BHA), detailed key activities and dates and its administration began on July 1. HB22-1281 distributed federal ARPA dollars, on August 1, CMS released ACE Kids Act guidance and work on the BHASOs design and development continued.

In 2023, the BHA strategic plan was released, ACC Phase III design and development work continued and the concept paper was released. HB22-1236 changed several deadlines for BHA activities and amended some BHASO requirements.

In 2024, the BHA will continue to work on rules, licensure requirements and BHASP design. The ACC Phase III RFP is scheduled for release.

In July of 2025, ACC Phase III, high-fidelity wraparound services, and the BHASOs are scheduled to be implemented.

FIGURE 8

In the middle of the figure, the partner entities for Boulder IMPACT are detailed (school districts, housing and human services, division of youth services, mental health partners, safe shelters, district attorney's office, probation department, regional accountable entity, public health, community services and public defender's office). Around the circle, the partnerships are identified and include the execute and operations board, implementation and community review teams, the service continuum project, collaborative outcomes and coordination of services. The IMPACT care management division includes program development, case planning, training and facilitation, process improvement, program evaluation, contract management, process integration, utilization management, and grant writing and management.

FIGURE 11

On the left, funding sources that are considered less amenable for inclusion in the funding pilot include: school-based mental health specialists; Ascent; IMatter; offender behavioral health services; CDHS forensic programs; education per pupil formula funding, funds outside of the formula and other funds such as mill levy overrides; CDPHE preventive services, health care program, and school based health centers; private insurance; ARPA dollars; and opioid settlement dollars.

In the middle, those considered somewhat amenable include: CHP+; collaborative management program; Colorado youth detention continuum (CYDC); additional family services (AFS); Medicaid school health services; child welfare services and core services block grants; crisis system, ACC per member per month; SAFETYNET; and promoting safe and stable families.

At the far right, funds considered most amenable include: Medicaid behavioral health capitation and fee-for-service: COACT system of care grant; BHASP care coordination, Momentum (community transition services); SAMHSA substance abuse and mental health block grants); children and youth mental health treatment act (CYMHTA); and funding for the MSOs and CMHCs.

Appendix II. Acronyms

Acronym	*Definition*
ACC	Accountable Care Collaborative
AFS	Additional Family Services
ARPA	American Rescue Plan Act
BH	Behavioral health
BHA	Behavioral Health Administration
BHASO	Behavioral Health Administrative Services Organization
CCB	Community Centered Boards
CDHS	Colorado Department of Human Services
CDE	Colorado Department of Education
CDPHE	Colorado Department of Public Health and Environment
CHI	Colorado Health Institute
CHP+	Child Health Plan Plus
CMHC	Community Mental Health Center
CMP	Collaborative Management Program
CMS	Centers for Medicare & Medicaid Services
COACT	Colorado's Trauma Informed System of Care
CYDC	Colorado Youth Detention Continuum
CYMHTA	Children and Youth Mental Health Treatment Act
FFPSA	Family First Prevention Services Act
FFT	Functional family therapy
FHPC	Eugene S. Farley, Jr. Health Policy Center
HCPF	Colorado Department of Health Care Policy & Financing
HFW	High-fidelity wrap around
IDD	Intellectual or developmental disability
KI	Key informant
MH	Mental health

MHBG	Mental Health Services Block Grant
MSO	Medical Services Organization
MST	Multi-systemic therapy
OBH	Office of Behavioral Health
RAE	Regional Accountable Entity
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SEP	Single Entry Point Agencies
SFY	State fiscal year
SUD	Substance use disorder

Appendix III. Stakeholder Engagement Log

Colorado Key Informant Interviews – Agency/Organization/Area of Expertise
Behavioral Health Administration
CDHS, Office of Behavioral Health
Child and Youth Mental Health Treatment Act
Child and youth services through the Managed Service Organizations
Child and youth services through the Regional Accountable Entities
Children's Hospital Colorado
COACT Colorado
Collaborative Management Programs
Colorado Behavioral Healthcare Council
Colorado Children's Campaign
Colorado Department of Human Services
Colorado Department of Public Health and Environment

Colorado Human Services Directors Association

County Administrators

Crossroads

Denver Health

Department of Education

Department of Health Care Policy and Financing

Division of Youth Services

Early and Periodic Screening, Diagnostic and Treatment

Early Intervention

Family Voices

Foster care children and youth

Health Colorado, Inc.

Health Solutions

Independent Providers

Mental Health Colorado

Momentum

Psychologists

School districts

School-based services

UnitedHealthcare – Rocky Mountain Health Plans

National Key Informant Interviews – States

California

Florida

Maryland

Minnesota

New Jersey

Oregon
Rhode Island
Texas
Virginia
Washington
Presentations at Standing Meetings
Behavioral Health Reform Leadership Committee
HCPF ACC Program Improvement Advisory Committee - Behavioral Health and Integration Strategies Subcommittee
HRCC Collaborative Forum (HCPF, RAEs, Child Welfare, Counties)
Regional RAE Meetings
Public Meetings – Interview Groups
Families
Service Coordinators/Providers
Additional Stakeholder Engagement Work
Decisionmaker Convenings
Weekly HCPF Meetings
Survey

Appendix IV. Fall Convening Materials

PRESENTATION - CONVENING OCTOBER 21, 2022, LOCATED ON THE MAIN LANDING PAGE

Per SB19-195, HCPF is tasked with designing and recommending an approach to an aligned funding pilot for children and youth with behavioral health (BH) needs. HCPF has chosen to focus this pilot on a subset of intensive home- and community-based services that are

designed to keep children in their homes and communities and out of institutions. These services are: (1) multi-systemic therapy, (2) functional family therapy, (3) high-fidelity wraparound, (4) respite, and (5) day treatment.

In the meeting on October 21, 2022, we will walk HCPF and other agency leaders through an exercise to confirm or eliminate design options in **6 decision domains** related to creating an aligned funding pilot:

- Population of focus
- Administrative level and entity
- Funding streams and/or programs
- Mechanism for funding alignment
- Geographic roll-out
- Funding stream roll-out

These design options have been selected based on CO reports and national reports on other funding initiatives and best practices. Our team also interviewed more than 50 Coloradans representing families, counties, state agency program managers, and contractors including the RAEs and MSOs, as well as more than 20 national experts. To guide you in making decisions (see below), we suggest considering these seven **criteria**: health equity, impact, political feasibility, administrative ease, alignment with other work, cost, and timing.

Overview of Decision Domains

1. **Population of focus:** How inclusive should the pilot be relative to children with intensive BH needs?
    a. Options range from being inclusive of all who meet the level of care using a standard assessment tool to more narrowly defined groups, such as children with intellectual or developmental disabilities (IDDs), autism spectrum disorders, and/or specific mental health conditions or those involved with child welfare.
    b. Are there some options that are immediately "off the table"? Why?
    c. *Note:* In general, the KIs preferred the broader approach. Not infrequently, even when KIs named priority populations, they listed several groups.

2. **Administrative level and entity**: At what level and within which entity should this pilot be managed?
    a. Should the entity be an agency at the state (or a statewide contractor affiliated with an agency), regional, or county level?
    b. Stemming from that decision, which entity is best suited to manage a pilot, e.g., HCPF or BHA at the state level; RAEs or BHASOs at the regional level, county DHS, or a different entity at the regional or local levels?
    c. Are there some options that are immediately "off the table"? Why?

d. *Note:* We did not identify strong consensus among KIs for this decision domain. Some KIs preferred state-level administration, while others valued a regional-, or even a county-level, approach. There was consensus that if a regional entity was selected, state direction and standardized parameters would help advance equity and consistency.

3. **Funding streams and/or programs:** Which funding streams and/or program dollars are most amenable and suitable?
    a. The options are depicted in Figure 6 below and categorized from less to more amenable**.** Funding streams and/or programs were categorized according to available dollars, the focus of each fund, the political and/or administrative ease of including, and input from KIs, among other factors.
    b. More detailed information about potential sources is provided in Appendix 2 and organized in the same three groups**.**
    c. Are there some funding streams that are immediately "off the table"? Why?
    d. *Note:* There was consensus among KIs that Medicaid funds must be incorporated and that many of the programs/funds that flows through the BHA should be included. Many also touted the importance of funding that has flexibility in terms of usage. The FHPC/CHI team placed funding sources and programs in the least amenable category that were called out by KIs or for which the funding sources cover less acute services.

4. **Mechanism for funding alignment:** Which funding approach is most suitable for the aligned funding pilot?
    a. The three primary mechanisms are: braiding, blending, and hybrid.
    b. Are there some funding mechanisms that are immediately "off the table"? Why?
    c. *Note:* Several national experts suggest that blending is not worth the effort, given more intricate reporting requirements– especially at the federal level. Several national KIs indicated braiding is sufficient to meet program objectives. Virginia has taken a hybrid approach in which they blend state and local dollars and braid in federal dollars.

5. **Geographic roll-out:**
    a. Should the aligned funding pilot be implemented statewide or within a smaller geographic area?
    b. If the decision is made to pursue a smaller geographic area, should that be individual counties, entire regions (RAEs or BHASOs), or something else?

c. *Note:* There is Colorado precedent for piloting initiatives within a smaller geographic footprint, e.g., the ACC with a few communities in 2011 and FFPSA which piloted in one county before expanding statewide. Alternatively, some of the programs that would likely be incorporated, such as Momentum, are statewide.

6. **Funding stream roll-out:**
    a. Should all selected funding streams be included at once, or should some be layered over time?
    b. If layering is selected, which funding streams should be included initially, and which ones should be phased in?
    c. *Note:* There is precedent for either approach; if the phased in approach is selected, any implementation plan should detail which streams, when, and how to include.

Appendix V. March Convening Materials

PRESENTATION - SEE CONVENING MARCH 17, 2023 LOCATED ON THE MAIN LANDING PAGE

Problem Statement

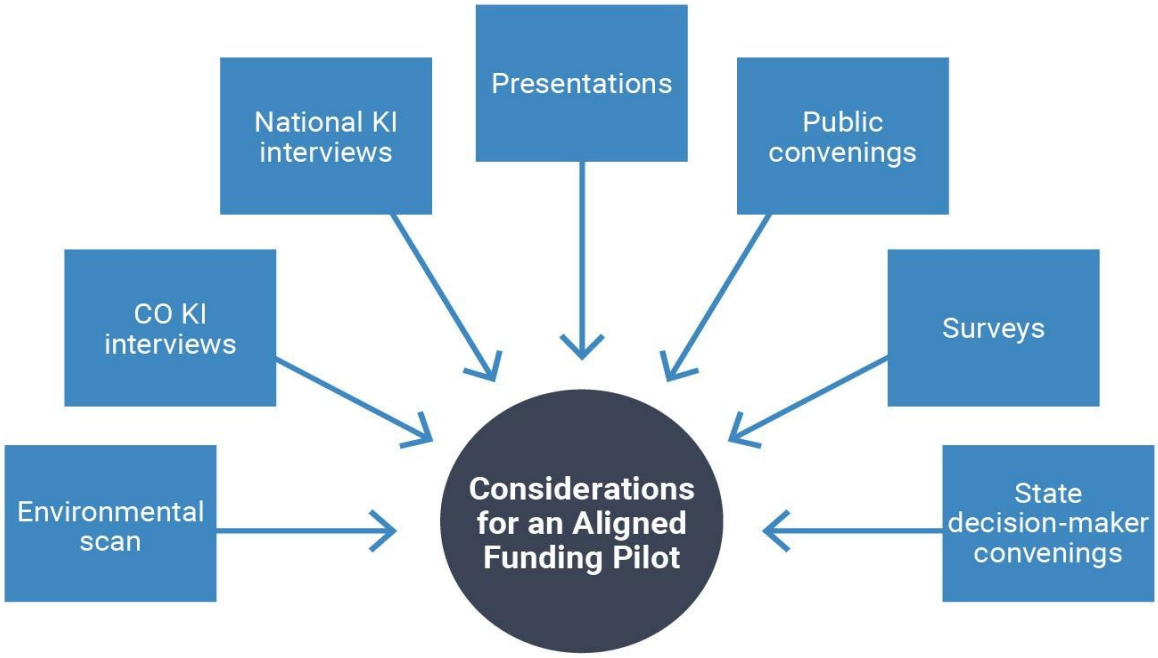
- Families struggle to meet the behavioral health (BH) needs of their children.
- Service needs span the full continuum from screening and referral to targeted prevention, integrated services, outpatient, intensive home- and community-based services, and residential care.
- Several challenges exist, including multiple funding sources, programs that don't collaborate, geographic variation, and too few providers, especially for children who are multi-system involved.

One Potential Solution – Integrated Funding Pilot

- SB19-195, Child and Youth Behavioral Health System Enhancements, directs HCPF 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."
- Potential benefits would include reducing the administrative burden on families, increasing access to services without fragmentation, and improving collaboration.
- Work was initially funded for SFY 2019-20, but the state budget was subsequently cut in SFY 2020-21. Resources were restored in SFY 2021-22. The BH landscape has changed significantly since the original legislation was passed.

Approach to Work

- **Step 1:** Define a subset of BH services for inclusion: *High-fidelity wraparound (HFW); Multi-systemic therapy (MST); Functional family therapy; respite; and day treatment*.
- **Step 2:** Gather data, develop, and narrow options for design (see below)



Key Learnings

- Aligning funds is time- and resource-intensive, e.g., can require federal approvals, legislation and rule changes, etc.
- Clear outcomes, a quality assurance mechanism, and strong governance are essential to implementation.
- Families are agnostic as to who pays or the mechanism. 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.
- Work needs to align with other system and program changes.

Decisions from Fall 2022 Convening

- Population of focus: children involved with multiple systems and who meet a pre-determined level of care/need for services
- Identified potential funding sources; preference for braiding over blending funds
- Implement statewide and not in specific counties or regions of the state; could phase-in by service or population
- Program administrator: RAEs, BHASOs, or a single contracted entity

Final Design Decisions

Two key design decisions to discuss and make are the implementation timeframe and program administrator. Stakeholders discussed the number of transformation efforts underway and the risks/benefits of aligning implementation with current efforts or keeping them separate. For purposes of our discussion, we are anchoring the first decision point to the timeframe with a proposed date concurrent with the implementation of ACC Phase III.

1. **Is July 1, 2025, the best start date?** It would be concurrent with ACC Phase III implementation and of HFW as a Medicaid benefit.
    - If it is the best time, should it be implemented as a stand-alone pilot program or as part of other changes, such as ACC Phase III, in the BHASO contracts which go-live July 1, 2024, or as part of Momentum contracts?
    - If it is the best time, who should administer the pilot and who should decide on governance and outcome metrics? Who should be responsible for regulatory or legislative changes?

2. **Is July 1, 2025, too soon?** The current system is being transformed with big changes underway, including but not limited to, implementation of the BHA strategic plan, BHASO selection and implementation, and ACC Phase III and implementation.
    - Does it make sense to delay implementation of an integrated funding pilot such that other activities may be more established? If there is a preference for delay, what makes sense as a new date to target?
    - If delayed, should it be implemented as a stand-alone pilot program or as part of other changes?
    - If delayed, who should administer the pilot and who should decide on governance and/or outcome metrics?

3. **Is July 1, 2025, too late?** There is tremendous need for families, and the legislation was originally passed four years ago.
    - Does it make sense to implement the pilot sooner? If there is a preference for sooner, what makes sense as a new date to target?
    - If sooner, should it be implemented as a stand-alone pilot program or as part of other initiatives or reform efforts?
    - If sooner, who should administer the pilot, and who should decide on governance and/or outcome metrics?

Appendix VI. Survey

The surveys, fielded in November and December 2022, collected feedback from families, service coordinators, and others. All responses were anonymous. There were 68 responses across multiple types of stakeholders.

Answer Choice	*Percent*	*N*
Parent, guardian, or family member of a child or youth with significant behavioral health needs	32.35%	22
Service coordinator	30.88%	21
A different role within a state or local agency	13.24%	9
Other youth-serving stakeholder such as a behavioral health clinician or administrator	17.65%	12
Other	5.88%	4

Respondents received the provider or family/caregiver survey depending on responses above.

Providers (N=40):

1. Were asked whether they primarily worked in rural or frontier areas (27.50%); urban areas (35.00%); or both (37.50%).
2. Could select multiple service settings in which they primarily work. Options included: schools or school districts (30.00%); county human services (40.00%); county public health (7.50%); regional accountable entity (12.50%); health care setting (clinic or system) (35.00%); Collaborative Management Program (22.50%); Momentum program (2.50%); don't work with children or youth experiencing behavioral health needs (0%); or other (7.50%).
3. Were asked about the family's familiarity with different systems:

	Very familiar	*Somewhat familiar*	*Not very familiar*	*Don't know*	*Total*
Child welfare services	82.05% (32)	15.38% (6)	2.59% (6)	0	39

School accommodations	48.70% (19)	41.93% (16)	10.26% (4)	0	39
Criminal/juvenile justice	31.59% (12)	52.63% (20)	13.10% (5)	2.63% (1)	38
Behavioral health services	60.00% (24)	35.00% (14)	5.00% (2)	0	40

4. Were asked to what extent to they feel the organizations listed are equipped to administer a program that braids together funding from different systems.

	Very well equipped	*Somewhat equipped*	*Not at all equipped*	*Don't know*	*Total*
HCPF	10.26% (4)	66.67% (26)	15.39% (6)	7.69% (3)	39
BHA	15.38% (6)	69.23% (27)	12.82% (5)	2.56% (1)	39
RAEs	17.95% (7)	61.54% (24)	15.29% (6)	5.13% (2)	39
BHASOs	10.53% (4)	63.16% (24)	18.42% (7)	7.89% (3)	38
Statewide contractor	10.53% (4)	55.26% (21)	13.16% (24)	21.05% (8)	38

5. Were asked to think about the funding sources that would be most important to include to support comprehensive treatment plans.

	Very well	*Somewhat well*	*Not at all*	*Don't know*	*Total*
Medicaid behavioral health capitation and fee-for-services	12.82% (5)	61.54% (24)	17.95% (7)	7,69% (3)	39

BHASO care coordination	15.39% (6)	53.85% (21)	12.82% (5)	17.95% (7)	39
Momentum	10.53% (4)	34.21% (13)	13.16% (5)	42.11% (16)	38
SAMHSA block grants	17.95% (7)	38.49% (15)	15.38% (6)	28.21% (11)	39
CYMHTA	17.95% (7)	46.15% (18)	12.82% (5)	23.08% (9)	39
MSOs and CMHCs	12.82% (5)	46.15% (18)	20.51% (8)	20.51% (8)	39

6. Were asked to think about which service type should be covered first in when rolling out the new, complex funding program. They could select;; day treatment; or they could specify something else.

Answer Choice	*Percent*	*N*
Multi-systemic therapy (MST)	32.50%	13
Functional family therapy (FFT)	2.50%	1
High-fidelity wraparound	37.50%	15
Respite	7.50%	3
Day treatment	5.00%	2
Something else	15.00%	6

Families and caregivers (N=20):

1. Were asked which county they live in. Respondents were from Adams, Arapahoe, Boulder, Denver, Douglas, Grand, Jefferson, Larimer, and Weld.
2. Were asked about familiarity with different systems.

	Very familiar	*Somewhat familiar*	*Not very familiar*	*Don't know*	*Total*
Child welfare services	60.00% (12)	30.00% (6)	10.00% (2)	0	20

School accommodations	85.00% (17)	10.00% (2)	5.00% (1)	0	20
Criminal/juvenile justice	20.00% (4)	35.00% (7)	45.00% (9)	0	20
Behavioral health service	65.00% (13)	30.00% (6)	5.00% (1)	0	20
Medicaid waivers	47.47% (9)	26.32% (5)	21.05% (4)	5.26% (1)	19

3. Were asked which organizations, coordinators, service providers, navigators or other members of the community they trust to help children get coordinated and comprehensive services for behavioral health needs.

	A lot	*Somewhat*	*Not very much*	*Don't know*	*Total*
HCPF	25.00% (5)	35.00% (7)	20.00% (4)	35.00% (7)	20
BHA	10.53% (2)	21.05% (4)	26.32% (5)	42.11% (8)	19
RAEs	10.00% (2)	35.00% (7)	20.00% (4)	35.00% (7)	20
BHASOs	5.00% (1)	25.00% (5)	25.00% (5)	45.00% (9)	20
Statewide contractor	30.00% (6)	10.00% (2)	15.00% (3)	45.00% (9)	20

4. Were asked which entity might administer the funding program and to what extent they would like to work with those organizations to help coordinate care.

	A lot	*Somewhat*	*Not very much*	*Don't know*	*Total*
HCPF	45.00% (9)	40.00% (8)	10.00% (2)	5.00% (1)	20

BHA	45.00% (9)	30.00% (6)	10.00% (2)	15.00% (3)	20
RAEs	40.00% (8)	35.00% (7)	15.00% (3)	10.00% (2)	20
BHASOs	45.00% (9)	25.00% (5)	10.00% (2)	20.00% (4)	20
Statewide contractor	60.00% (12)	20.00% (4)	0	20.00% (4)	20

Appendix VI. Resource Guide

Organizations/Agencies	
Agency for Healthcare Research and Quality	• **Who are they:** The Agency for Health Research and Quality (AHRQ) is the lead Federal agency that supports research to improve the safety and quality of healthcare for all Americans. • **What they offer:** AHRQ develops and provides the tools, data, and resources needed to help healthcare professionals and policymakers make decisions that will improve the healthcare system. Additional information on AHRQ's areas of focus and current research and findings, including the 2022 National Healthcare Quality and Disparities Report are available online.
New Jersey Department of Children and Families – Children's System of Care	• **Who they are:** New Jersey's Children's System of Care (CSOC) is a public behavioral health system that serves children and youth ages 21 and under that have emotional and mental health care needs. CSOC is responsible in determining developmental disability eligibility determinations for children ages 18 and under. • **What they offer:** CSOC provides substance use treatment and behavioral health and developmental disability support services to this population.

	PerformCare is the 24-hour toll-free line that serves as the landing place for youth and families to access behavioral health, substance use, and developmental/intellectual disability services.

Colorado Reports or Documents	
Colorado Department of Law 2022 Youth Mental Health Report	• **Summary of key findings:** Suicide is the leading cause of death among youth in Colorado ages 15-24 years old. The Colorado Department of Law has led and continues to lead suicide prevention efforts; however, additional investment and commitment to this work is needed to address this ongoing crisis. • **How it is a resource:** Report highlights the Department's continuous efforts to support youth mental health by leading and supporting campaigns, programs, grant programs, etc. that combat suicide. Also shares data and opportunities for others to support/engage in these efforts.
Boulder County IMPACT: Building and Sustaining Policy, Practice and Improvement Standards for a Multi-Program, Multi-System Collaborative	• **Summary of key findings:** Boulder County IMPACT identifies the core implementation elements that lead to positive care delivering system outcomes and systems change. • **How it is a resource:** Presentation outlines the core components of the Boulder County IMPACT collaborative management model including but not limited to the planning, implementation, and assessment processes that are needed to fill the current gaps
Children and Youth Mental Health Treatment Act (CYMHTA) Annual Report FY 2020-21	• **Summary of key findings:** CYMHTA has been successful in its efforts to ensure that children and youth have access to mental health treatment services and continue to make program changes to ensure they are serving as many children and youth as possible. • **How it is a resource:** CYMHTA is a program that provides resources and supports that allow children

	and youth to mental health treatment services. This report shares information on what CYMHTA is, how it is funded, what services are offered, program data, and the network of current providers.
Colorado Behavioral Health Task Force Subcommittees' Proceedings and Recommendations	• **Summary of key findings:** The report identified and offered solutions/recommendations to improve eight key areas that are hindrance to the behavioral health of Coloradans. • **How it is a resource:** Report provides the Colorado Behavioral Health Task Force's subcommittee recommendations to address the ongoing behavioral health crisis.
Colorado Family First Prevention Plan	• **Summary of key findings:** Colorado has and continues to invest in the entire prevention services continuum and are committed to implementing the Family First Prevention Plan Act. In efforts to fully implement the Act, CDHS has invested in a number of primary prevention efforts, multi-sector partnerships, and financial resources to capacity building. • **How it is a resource:** Colorado's Family First Prevention Plan is an act that ensures children, youth, and families have access to prevention services. The plan shares an in-depth overview of CDHS' current prevention efforts that include but are not limited to the Core Services Program and Collaborative Management Program.
Colorado School Finance Project Briefing Document: How are Colorado School Districts Funded?	• **Summary of key findings:** Colorado school district funding is determined by the School Finance Act's funding formula and school districts have the opportunity to receive additional revenue from local override dollars, grants, and bond dollars. • **How it is a resource:** The briefing document walks through the school district funding formula and provides information on how school districts can receive additional funds through revenue streams outside of local and state funds.

Colorado School Finance Project: School Funding	• **Summary of key findings:** Colorado schools receive revenue from state and local funds, with the amount of funds distributed to school districts being determined by the School Finance Act's total program funding formula. • **How it is a resource:** Presentation provides Colorado school finance information and data on where school district funding comes from, how funds are distributed, and the legislative process of school district funding.
HCPF's Support for Transition from Institutional Settings Report	• **Summary of key findings:** The School Health Services Program is effective in providing uninsured and underinsured students with additional access to health care services by allowing Colorado school districts to contract with HCPF and receive reimbursement for Medicaid covered services. • **How it is a resource:** Report outlines services that receive reimbursement from the federal government through participation in program. This report specifically provides information on service types, explains how these services are medically necessary, and shows the total amount of funds that were distributed to each school.
Serving Colorado's Children: A Financial Map of the Behavioral Health System	• **Summary of key findings:** The Colorado Health Institute identified five opportunities in Colorado to strengthen the behavioral health services delivery system for children and youth ages 0 to 26. • **How it is a resource:** Financial map details how Colorado's behavioral health system for children and youth is funded, what specific services these funds are paying for, and highlights the opportunities to close current gaps and maximize investments.
National Reports or Documents	
ASPE Braiding Toolkit	• **Summary of key findings:** A toolkit geared towards states and local communities to braid, blend, or layer

	multiple federal funding streams to improve a coordinated, comprehensive early childhood system. • **How it is a resource:** This document identifies 8 key aspects of the braiding process, each aspect with its own list of relevant resources. It also highlights examples of how state or local communities have carried out a particular step of the braiding process.
Budgeting to Promote Social Objectives – A Primer on Braiding and Blending	• **Summary of key findings**: This paper finds that governments at different levels have been instituting a variety of special bodies, waivers, and devices that permit a degree of braiding and blending. They authors provide recommendations to the federal government, Congress, and states. • **How it is a resource**: Provides specific recommendations for states, including examples of other states' work. Reviews common obstacles and opportunities in braiding and blending funds.
Blended and Braided Funding, Transforming Pediatrics to Support Population Health, CHDI (Child Health and Development Institute of Connecticut, Inc.)	• **Summary of key findings**: 6 recommendations to encourage blended and braided funding in support of children's health and well-being in Connecticut, written for a policy-maker audience. • **How it is a resource**: While recommendations are geared towards CT policymakers, this report provides a roadmap as well as specific examples from across that nation of braided/blending funding models.