Delivery of Child Welfare Services Task Force
Medicaid Subcommittee
Recommendations
July 2022

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A message of gratitude

The Medicaid subcommittee of the Delivery of Child Welfare Services Task Force, made up of a broad range of participants, held many meetings throughout 2020-2022 to review and discuss the current child welfare system and the barriers and challenges related to Medicaid utilization for Colorado children and families. A special thank you to the following individuals and agencies for your commitment to supporting Colorado children, youth and families, for your persistence and follow through as it relates to this important work. It has been a privilege to work alongside you. Thank you.

Subcommittee chairs and DCWSTF members:

- John Laukkanen, HCPF
- Kendra Kleinschmidt, Eagle County DHS

Core subcommittee members: **This list is not exhaustive as many individuals joined meetings for a specific purpose/limited timeframe over the years.*

- Mimi Scheuermann, Denver County DHS and DCWSTF member
- Norma Aguilar-Dave, Savio and DCWSTF member
- Robert “Bob” Dorshimer, Mile High Behavioral Healthcare and DCWSTF member
- Lexi Kuznick, CHSDA
- Jamie Ulrick, Weld County DHS
- Doug Hainley, Weld County DHS
- Tim Hermann, CDHS
- Meghan Langfield, CDHS
- Bradly Borgess, CDHS
- Matt Holtman, CDHS
- Marisa Gullicksrud, Invest in Kids, Child First

Introduction

The Medicaid Subcommittee of the Delivery of Child Welfare Services Task Force (Task Force) was formed to develop recommendations relating to the following provision in SB-254: 26-5-105.8 (1)(g).

- Evaluate Medicaid rates and the eligibility determination process and timeline specifically related to individuals involved in the child welfare system
- Develop a process through which counties can maximize Medicaid utilization

The Medicaid subcommittee, made up of a broad range of participants, held many meetings from 2020-2022 to review and discuss the current child welfare system and the barriers and challenges related to Medicaid utilization for Colorado children and families. The subcommittee recognizes itself as one of many groups actively committed to reform efforts related to child welfare and/or the broader behavioral health system in Colorado. "Medicaid services" can be provided, referred, or coordinated through County Human Services (referred to also as child welfare), a Regional Accountable Entity (RAE), or even via a State level staffing. The Department of Health Care Policy & Financing (HCPF) is the Medicaid State Authority for Colorado, and Health First Colorado is the Medicaid Program for Colorado. The Medicaid subcommittee focused on identifying and understanding gaps and barriers to accessing Medicaid services, with a specialized focus on the experiences of families involved with child welfare, the juvenile justice system, and families with children with intellectual and developmental disabilities (IDD). HCPF provided content specific presentations for subcommittee members to further understand the complexities of the Medicaid program. Through these meetings and in depth conversation to understand gaps and barriers, the subcommittee developed key findings and initial recommendations to address each finding.

Stakeholder engagement

The Medicaid Subcommittee presented draft recommendations to the Task Force in June 2021 and revised recommendations based on Task Force input and feedback. Then in February and March 2022, the Medicaid subcommittee completed presentations to different stakeholder groups in order to gather feedback with the goal of improving recommendations. During the stakeholder engagement process, inputs were received from:

- Executive leadership at HCPF
- Executive leadership at CDHS
- Executive leadership from County Departments of Human Services via Colorado Human Services Directors Association (CHSDA) Executive Team
- HCPF, RAEs, CDHS and County Departments of Human Services - known as HRCC
- County Departments of Human Services - Children, Family CHSDA Committee
- Case Management Agencies
- Family voices at Raise the Future

Following the stakeholder engagement process, the subcommittee members reviewed all feedback provided by stakeholders and revised the recommendations yet again. Finally, in July 2022, the subcommittee presented the following recommendations to the Task Force.

Background

Due to the passage of the Family First Prevention Services Act of 2018 (Family First), the child welfare system has a greater focus on preventing child maltreatment, keeping children and youth safely at home and, when necessary, providing out of home placements that are short-term and treatment focused. Accessing local behavioral health services, and physical health services, paid for by the Medicaid entitlement are essential components to keep families safely living together and to safely reunify families in their communities. Numerous funding streams are leveraged to pay for such services across Colorado including federal, state and county funds. Medicaid is an important funding stream in this equation and when maximized appropriately, Medicaid approved services can meet many of the needs of children and families across the state. Unfortunately as the subcommittee learned, there are complex issues and rules that have prevented this from happening and as a result the subcommittee offers the following recommendations as part of a process through which counties can maximize Medicaid utilization.

Information & technology improvements

Findings 1: In July 2021 a time sensitive matter came to the attention of the Delivery of Child Welfare Services Task Force, as the Medicaid Subcommittee has engaged county staff, state employees, and key stakeholders with lived experience, that some children who have the Medicaid entitlement have experienced a disruption in their health insurance benefit due to technological glitches that continue to confound parties across the systems. Since the Medicaid program spans numerous agencies and databases there is no single authority over the technical resolution of these issues and no one agency takes accountability for fixing the issues in a timely manner. This has resulted in an “us versus them” mentality. These disruptions are taking months (or even up to a year) to resolve. During this disruption in benefits, children and families are unable to access necessary physical health and behavioral health care services. For families caring for children through adoption subsidies or waiver services, when these benefits are disrupted sometimes the only recourse is to turn to the child welfare system in order to get their needs met. It appears help desk tickets are not being appropriately resourced, prioritized and resolved, leaving some help desk tickets open for far too long. Lack of training for county human services employees who operate Medicaid in Trails and CBMS further complicates the issue. The Medicaid Subcommittee understands that there are several efforts across these systems to improve interoperability, data alignment, and system mapping, etc. However, the Medicaid Subcommittee is concerned about the immediate impact on children and families as they wait for the larger system to be streamlined. The below recommendations were put forward individually due to the time sensitivity and much progress has been made to rectify these issues between July 2021 and the stakeholder engagement process in February and March 2022.

Recommendation 1: On July 28th 2021 the Delivery of Child Welfare Services Task Force recommended the Colorado Department of Health Care Policy & Financing (HCPF), the Colorado Department of Human Services (CDHS) and the Governor's Office of Information Technology (OIT) immediately prioritize the resolution of Medicaid help desk tickets in all state databases.

- **It is recommended that one entity is identified as responsible and held accountable for ensuring Medicaid Help Desk tickets are resolved, even as partnership and collaboration across the system is needed to address these issues.**
- **It is recommended that a dedicated team with OIT is tasked to resolve Medicaid help desk tickets in Trails, CBMS and InterChange/Bridge in a timely manner as designated per Service Level Agreements and as designated by priority ticket time frames.**
- **It is recommended that CDHS designate a full-time employee to address Medicaid data entry issues that require CDHS action in order to be successfully resolved.**
- **It is recommended that HCPF and CDHS jointly establish policies and procedures that ensure the effective management of Medicaid across the different databases used in Colorado. These policies and procedures need to outline who is responsible for completing each component of work in Trails and CBMS, related deadlines for service delivery and how to resolve technological problems.**
- **It is recommended that HCPF and CDHS jointly distribute information and ensure Medicaid policies and procedures reach the correct county staff.**
- **It is recommended that CDHS create new or leverage existing Medicaid training to ensure county human services staff working in Trails and CBMS, as well as key staff at CDHS, HCPF, OIT, and the RAEs have the knowledge required to operate and understand the Medicaid program.**

Finding 2: For different reasons county departments of human and social services sometimes utilize Core dollars, child welfare block funds or other local and state funding to pay for Medicaid eligible services for Medicaid eligible children in the child welfare system (i.e. Medicaid should pay for such services in order to maximize funding). As a result, Medicaid funding is not fully utilized to pay for the essential services that can keep children safely with their families. Currently, there is no system to identify when local or state funds have been used instead of Medicaid and there are no business processes to recoup Core dollars or claim for Medicaid reimbursement after state dollars have been expended. In addition, there is not a mechanism for the state or counties to view this data and understand the frequency and the context where this is happening. Therefore, stakeholders are missing an opportunity to truly analyze "why" this is happening and how to make real improvements. Workgroups through CDHS have been established to help resolve some of these issues, but workgroups have not been appropriately resourced to effectively mitigate and manage this large systems issue.

Recommendation 2:

- **It is recommended that CDHS, HCPF, and Counties identify, through qualitative and quantitative data, when and to what extent Core dollars are utilized for Medicaid eligible children and families and the systemic reasons "why" this is happening in order to offer solutions to maximize Medicaid in these circumstances. It is further recommended that CDHS and HCPF make recommendations for systems improvements based on the data gathered through this effort.**

Finding 3: There is not a consistent policy or practice for county child welfare workers to enter information into Trails to generate Medicaid eligibility for a child who is placed in the custody of human services. Currently, counties are not clear on the expectation or how this documentation in Trails affects the ability of children to receive a timely Medicaid entitlement. Some stakeholders report having 90 days, while others report having 45 days to add this information into Trails. Medicaid eligibility often begins once a Title IV-E eligibility determination has been made, and Title IV-E eligibility takes time because counties must gather family financial information.

Recommendation 3: To generate Medicaid eligibility in a timely manner for the children who are in the custody of county Departments of Human/Social Services due to abuse and neglect,

- **It is recommended that CDHS review, revise and create best practice guidelines and training resources for county child welfare staff who enter Medicaid eligibility information into Trails.**
- **It is recommended that CDHS be mindful of the workload requirements already on county child welfare staff and therefore create best practice guidelines that are realistic and achievable.**

Access to high-intensity, community based services

Finding 4: All Medicaid members in Colorado do not have access to the same behavioral health evidence-based practices (EBPs). There are no clearly defined standards of care or requirements for RAEs to ensure Medicaid members have access to high-intensity, community based services and substance use disorder (SUD) services across the state. The subcommittee asked, how can HCPF require RAEs to offer, or perhaps incentivize, payers to provide appropriate coverage for these services and how can the subcommittee facilitate a shared "buy-in" so all stakeholders understand the importance and cost effectiveness of offering access to them? Furthermore, based on county and provider experience, there are concerns that RAEs may not approve the adequate number of sessions/units, and or reimbursement rate, in order for providers to maintain fidelity of high-intensity, community based services (i.e. multisystemic therapy, family functional therapy, etc.) and inpatient and outpatient SUD services for children/youth. The lack of transparency as it relates to sharing information about the RAE rates due to antitrust laws is a major ongoing barrier. Finally, the subcommittee knows that many of

these high-intensity, community based services and SUD services are offered by independent network providers; however, providers face many barriers in being admitted to the RAE networks and working with the RAEs directly. These barriers, combined with low rates, discourage providers from offering these essential services to Medicaid clients.

Recommendation 4:

- **It is recommended that HCPF engage in a robust stakeholder engagement process, utilize data specific to child welfare and juvenile justice, and give specific consideration to programs listed on the federal title IV-E prevention services clearinghouse in order to identify fundamental services and standards of care available to all children as outlined within recommendations from the Behavioral Health Task Force, Children's Subcommittee.**
- **It is then recommended that HCPF incorporate these fundamental services and standards of care into the RAE contracts, where legally allowable, and include consideration for geographical access within each region.**
- **It is recommended that HCPF collect data to monitor RAE compliance with the availability of these fundamental services and standards of care, which will be reflected in RAE contractual responsibilities, deliverables and the dashboard identified in recommendation 7.**
- **It is recommended that HCPF will ensure funding is built into RAE contracts that will cover high-intensity, community-based behavioral health services to fidelity, which may likely require HCPF to create unique billing codes for such services.**
- **It is recommended that HCPF review and assess decisions made by RAEs related to the number of approved sessions/units of treatment to ensure adequate sessions/units are approved and in line with the fidelity of EBP's.**

Finding 5: The current Medicaid billing guidelines prevent some behavioral health providers from billing and receiving reimbursement for certain treatment modalities. This is common for "cross over youth" or youth who are involved in both the child welfare system and the Division of Youth Services (DYS). For example, a child may be the client referred and approved for services, however, if the child is detained through DYS, the services for the family will not be reimbursed because Medicaid is suspended on the date a child or youth is detained and/or when a child or youth is admitted to a state hospitals. When a child's Medicaid is suspended, providers are unable to continue working with the child's family which can lead to negative outcomes for children and families. Sometimes, Medicaid suspensions result in inaccurate information in the Provider Portal which creates confusion for counties and providers regarding coverage and reimbursement.

Recommendation 5: High-intensity community based behavioral health modalities often require parents to receive support and services separate from their child in order to successfully reunify families and achieve permanency. In order to maintain continuity of clinical interventions and family support:

- **It is recommended that CDHS OCYF, the Behavioral Health Administration (BHA) and HCPF jointly explore reimbursement/funding options to continue payment for**

services provided to families when a child becomes ineligible for Medicaid due to hospitalization or detention.

- **It is recommended that CDHS create billing guidelines for a blended or braided funding approach that incorporates a 2Gen lens for the delivery of services in order to promote the best outcomes for children and families.**

Finding 6: Medicaid members and counties are not aware of the behavioral health services and/or treatment modalities available locally or within the RAE networks, at community mental health centers and with independent providers. In our experience, the RAE's have directories on their websites that are inadequate and difficult to navigate.

Recommendation 6: We recognize that some of this work may be underway through the BHA and we request that this recommendation be included in those considerations.

- **It is recommended that each RAE enhance and improve their behavioral health service directory and map to contain detailed information about enrolled providers, treatment/certification/population specialties, that it be searchable by location and is satisfactory to stakeholders. This directory should be consistent between RAEs, updated monthly, proactively shared with human services partners, and accessed on the home page of HCPF and CDHS websites.**
- **It is recommended that HCPF monitor and ensure each RAE has a directory as outlined above which are easily accessible on the website.**

Using data to understand unaddressed needs

Finding 7: There is no business process to assess the efficacy of the system to ensure children and families are able to receive the services and support they need via their Medicaid entitlement. For example, at community mental health centers, the subcommittee knows children and families have trouble accessing timely and consistent behavioral health services. However, data such as performance indicators for each RAE, medical necessity denials, grievance trends, etc. are not readily available (and perhaps not collected at all). Therefore, trend analysis is not able to be generated to help improve the system over time.

Recommendation 7:

- **It is recommended that HCPF enhance their data collection, reporting and dashboard capabilities for system monitoring and improvement to include those criteria required by Centers for Medicare and Medicaid Services (CMS), under new managed care reporting toolkits. This data should be available to the public for transparency and accountability. For example, performance data for each RAE, data collected related to standards of care (as outlined in recommendation 4), data around medical necessity denials (see recommendation 8), and grievance trends. This list is not meant to be all inclusive and other data points identified as helpful from other stakeholders should be considered.**
- **Specifically, it is recommended that HCPF collect data on the timeliness of access and frequency of services.**

Findings 8: Families with the Medicaid entitlement are unable to access behavioral health services they require, sometimes due to the RAE denying services due to medical necessity, denying services because services are not a covered benefit or denying services for a different reason (including not contracting with any providers who offer that service).

Recommendation 8:

- **It is recommended that HCPF collect data on medical necessity denials and make this data available to the public in a way that is simple and understandable.**
- **It is recommended that HCPF track the services and outcomes for individual children and youth who are denied services due to medical necessity to determine if and when they should be approved for higher cost services.**
- **It is recommended that HCPF utilize the data on medical necessity denials to assess the performance of the RAEs and hold them accountable for meeting the needs of their customers.**
- **It is recommended that HCPF collect data on medical necessity denials specific to residential treatment services to analyze the service utilization trends for this population, how members progress through the system, and to identify trends by region.**

Finding 9: A group of children with significant behavioral health needs are coming to county child welfare systems as a way to get behavioral health treatment, not because of child maltreatment. Hospitals and the RAEs may be the common entry points for these children being directed to child welfare. As a result, families become involved with the child welfare system in order to access services even though there are no child maltreatment issues.

Recommendation 9:

- **It is recommended that counties collect specific examples of children who enter the child welfare system in order to access services without concerns of child maltreatment.**
- **It is recommended that counties, BHA, CDHS and HCPF work together to analyze the reasons why children who are not victims of maltreatment nor youth in conflicts enter the child welfare system. This research would result in a better understanding of the true barriers to accessing treatment and then inform future recommendations needed to resolve this issue.**

Finding 10: Medicaid waivers are not utilized to the fullest extent, which includes but is not limited to the Developmental Disability (DD) waiver and Children's Habilitation Residential Program (CHRP). The Community Center Boards (CCBs) are the gatekeepers for many of these Medicaid waivers. These waivers provide critical services that can keep children with their families and out of the child welfare system. However, there is a lack of knowledge (and likely a lack of training) within county human services, and the broader helping professions, about the different types of Medicaid waivers and how to access these waivers for children. It seems like there is a lack of transparency, accountability and ultimately a lack of awareness which prevents

eligible children from receiving these critical services. Moreover, there may be gaps in what these waivers cover or a lack of access to services once waivers are secured. Counties may be supplementing costs that could be covered by the waiver. How do other programs, like Momentum and EPSDT, interface with waivers and possibly provide funding to support meeting the needs of children?

Recommendation 10:

- **It is recommended that HCPF lead and convene a group of stakeholders, including members of the DCWSTF Medicaid Subcommittee and other system partners (i.e. RAEs, CMAs, SEPs, CCBs, providers, etc.), to further research the current access and utilization of Medicaid waivers, the related barriers and explore recommendations for improvements across the system. This may include exploring the role of system navigators, measuring the effectiveness of the CCB's community outreach plan, and potentially developing key performance indicators related to these efforts.**

Customer service & grievance resolution improvements

Finding 11: Current grievance processes are complicated, not streamlined and not easy to access for stakeholders, especially Medicaid members who have low literacy levels or who are English language learners. When counties have raised challenges and grievances with HCPF, they are regularly directed to a variety of HCPF staff--there does not appear to be a consistent response or process. HCPF responds to concerns about system barriers with requests for specific examples. The challenge is that those specific concerns then get problem-solved as one-off issues and not addressed as a system shortcoming. In addition each RAE has its own grievance process. Because of the various different forums for grievances - it is difficult to understand trends and ensure the needed improvements are made. According to Managed Care Regulations, HCPF is required to analyze this data to improve the performance of the managed care system. There is a specific Managed Care Ombudsman who can hear complaints and the BHA will have a role in working through complaints. Despite these other avenues the subcommittee recommends the following:

Recommendation 11:

- **It is recommended HCPF, or the BHA in coordination with HCPF, create and manage one, streamlined and easy to access grievance process, with one phone number/email, for all stakeholders, including Counties, to grieve about anything related to the Medicaid entitlement.**
- **It is recommended that HCPF, or the BHA in coordination with HCPF, review and analyze grievance data in order to identify trends and ensure improvements take place. These improvement efforts should be made public on at least an annual basis (in line with the Managed Care Ombudsman report or as part of a dashboard).**

- **It is recommended that this grievance review process include stakeholders, like a Medicaid consumer and an independent provider, to help analyze grievances, identify trends/concerns and offer solutions.**

Finding 12: Many Medicaid members are involved in numerous systems, need numerous services and Medicaid is the payor of first resort for those services. Medicaid members often report receiving poor customer service, including limited access to language services. The system is terribly complicated. Miscommunication and misunderstandings take place between the members, RAE's, counties, HCPF, and other stakeholders, including CCBs, and there seems to be confusion related to who is responsible for what among the RAE's, counties, HCPF, and others. The Subcommittee hears from families that they are routinely directed to the county department of human services for all services related to children on Medicaid with behavioral health needs, regardless of their risk for maltreatment. Care coordination may be part of the solution and many discussions related to care coordination are taking place at this time.

Recommendation 12:

- **It is recommended that the service navigation infrastructure out of the BHA include HCPF/Medicaid services to ensure the appropriate level of engagement and interactions are provided to meet the individual needs of children and families, with special consideration to accessing services via telephone.**
- **It is recommended that the RAE's be responsible for a level of customer service that identifies and helps children and families secure the appropriate services in a timely manner, to include understanding and interpreting denial letters and related next steps, a warm handoff to a provider (not just a list) and follow up calls to ensure needs are sufficiently met.**
- **It is recommended HCPF explore establishing incentives to incorporate customer service expectations into contracts with RAE's.**

Support for broader system reform

Findings 13: In light of all the barriers, concerns, and challenges identified in the preceding findings and recommendations, a single entity that specializes in the services delivery for children could resolve many concerns.

Recommendation 13:

- **We recommend HCPF research, explore and complete a stakeholder engagement process (that includes counties) to modify the RAE structures, specifically to determine if something like the creation of one RAE to serve all Colorado children would be the right fit for Colorado children and families.**

Recommendation 14:

- **It is recommended that Counties, CDHS and HCPF support the following recommendations addressed by the Behavioral Health Task Force Children's Subcommittee as included below.**
    - THE SUBCOMMITTEE RECOMMENDS that the State of Colorado determines clear, reasonable, and limited metrics to measure the quality of the Children's Behavioral Health system. This effort should first evaluate existing data points already collected across the system to limit adding more administrative burden on providers/facilities, as well as identify uniform data points, consistently defined, across the system over time. This effort should include metrics to understand statewide awareness of the system, access, unmet need, impact on member functioning and caregiver well being, shared decision making, cost, utilization, and be designed to direct system improvement. This effort should ensure family representation on all quality review teams/initiatives of the behavioral health system.
    - In order to measure and support Colorado's child/youth behavioral health network THE SUBCOMMITTEE RECOMMENDS that the State of Colorado research, develop, and publish specific standards of care for children and youth, ages 0-26, that include network adequacy and access measures, wait time/waitlist limits, and general care considerations (time between appointments/services, length of treatment, episode of care, how many touches do members need to get services, efficient use of appointments, integrating multiple appointments in one system – medications, therapy, physical health, etc.). These standards should be aligned with evidence-based best practices, be developmentally appropriate, and specific for respective places of service
    - In order to promote and ensure transparency and accountability THE SUBCOMMITTEE RECOMMENDS that a statewide, unblinded dashboard for payers and behavioral health provider entities be published at least annually using a clear scale/grade and informed by the standards produced by the State of Colorado. This effort should be implemented with robust stakeholder input.
    - In order to make the behavioral health system more member-focused and reduce the barriers and complexity of navigating the system, THE SUBCOMMITTEE RECOMMENDS that the State of Colorado adopt a single, statewide utilization management guideline for all payers, aligned with an array of essential services. This will promote transparency in the system and reduce some level of grievance and appeals related to disparity in access to services across the state and among payers. This can also address parity issues related to access to physical and behavioral health services.
    - In order to address a patchwork of different programs that serve children and families and to determine the ideal distribution of programs along the service continuum, THE SUBCOMMITTEE RECOMMENDS that the State of Colorado partner with local stakeholders to create a menu of evidence-informed or promising practices and determine how to invest resources and workforce training for implementation. This should include specific guidelines for early

childhood (children 0-8), school-aged children, adolescents, and youth 18+. This standard/model can help inform local communities, counties, and school districts regarding staffing ratios, program offerings, and partnerships, as well as analyze their resources/programs and address gaps as identified.

- In order to streamline billing and claiming processes; to support meaningful and consistent data collection; and to remove the burden from providers and family members, THE SUBCOMMITTEE RECOMMENDS the State of Colorado designate a single, publicly funded, fiscal management system be used to account for funds for all publicly funded services, including HPCF, OBH, and OEC, and to allocate funds as necessary.
- In order to maximize the use of state dollars by identifying opportunities to increase federal matching funds, THE SUBCOMMITTEE RECOMMENDS examining all services provided by state programs that don't get a federal match and changing those that could be provided using funding from Medicaid or Child Health Plan Plus, Individuals with Disabilities Education Act, Title IV-E, etc. while not compromising essential services within the service array. Colorado may be able to get the federal government to pay a greater portion of the cost or be able to deliver more services.
- In order to maximize the dollars that are being deployed and to make informed decisions, THE SUBCOMMITTEE RECOMMENDS developing a systematic approach to collect information on children's behavioral health spending across the 6 state agencies/offices (i.e., OBH, CDPHE, HCPF, CDE, OEC, OCYF) to learn where dollars are going, for whom services are being provided, what services are being purchased, number and type of providers involved, where gaps remain, and how to maximize the utilization of resources across the entire array of services. This may include leveraging existing data infrastructure (i.e., Colorado Health Information Exchanges, Office of E-health, All-payers Claims Database) and/or investing in new data infrastructure.
- To understand where there are gaps in essential services as defined by the Continuum, THE SUBCOMMITTEE RECOMMENDS the State of Colorado complete a comprehensive service gap analysis to identify local, regional and systemic service gaps. This analysis would define and assess:
    - Timeliness. Adequacy of timely access to essential services (timely access to be defined within context of service gap analysis), including entry points that allow services to be offered at the right level of need without requiring an outcome failure to move to the next step of services.
    - Workforce. Adequacy of trained and competent workforce to support essential services.
    - Financing. Level and distribution of financing to support essential services
    - Statute and Rules. Review of legislative and regulatory policies that support or create barriers to access to essential services by all Colorado children and their families.