Colorado Medicaid Coverage for Justice-Involved Population Re-entry, Severe Mental Illness, and Continuous Eligibility

Substance Use Demonstration Amendment Request

Demonstration Project No. 11-W-00336/8
Effective January 1, 2021, through December 31, 2025

April 1, 2024

COLORADO
Department of Health Care Policy & Financing

Section I. Introduction

Program Description and Objectives

The Department of Health Care Policy and Financing (HCPF) is requesting an 1115 waiver Amendment (Amendment) for their Substance Use Disorder (SUD) Demonstration "Expanding the Substance Use Disorder Continuum of Care," Waiver #: 11-W-00336/8 from the Centers for Medicare and Medicaid Services (CMS). The initial SUD waiver period is from January 1, 2021, through December 31, 2025.

The Amendment request seeks to authorize three program initiatives:

1. Prerelease services for adults and youth transitioning from correctional facilities to begin July 1, 2025. Colorado (State) is requesting this authority to design and implement a "Re-entry Initiative," similar to the authority granted to California on January 26, 2023, to provide:

    A. **Medicaid Coverage** for eligible individuals in the State's prisons and juvenile correctional facilities. Eligible individuals include any individual exiting those facilities who is eligible for Medicaid.

    B. **A Targeted Benefit Package** for these individuals to include case management services, medication-assisted treatment (MAT) for SUD, a 30-day supply of medications upon release, and certain other supportive services.

    C. **A Coverage Period of up to 90 Days** immediately prior to the release of the incarcerated individual from the correctional system.

2. Severe Mental Illness Initiative to begin July 1, 2025— Reimbursement for acute inpatient and residential stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED).

3. Continuous Eligibility Initiative to begin January 1, 2026 —

    A. Extending continuous Medicaid and CHP+ coverage for children to age three.

    B. Extending 12 months of continuous Medicaid coverage for adults leaving incarceration from a Department of Corrections facility.

This suite of coverage provisions and services will be implemented across the State, creating and strengthening connections between carceral settings, government agencies, health and social service entities, and many others — all collaborating to better support individuals' health, through an improved re-entry into the community while maintaining their health and well-being, a complete continuum of care for individuals with SMI, and continuous eligibility for children to age three and adults leaving incarceration.

Goals of Each Requested Initiative

Re-entry Initiative

Consistent with the CMS goals as outlined in the April 17, 2023, State Medicaid Director (SMD) letter, the State's specific goals for the Re-entry Initiative are to:

1. **Increase coverage, continuity of coverage, and appropriate service uptake** through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
2. **Improve access to services** prior to release and improve transitions and continuity of care into the community upon release and during re-entry;
3. **Improve coordination and communication** between correctional systems, Medicaid systems, administrative services organizations, and community-based providers;
4. **Increase additional investments in health care and related services**, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;
5. **Improve connections between carceral settings and community services** upon release to address physical health, behavioral health (BH), and health-related social needs (HRSN);
6. **Reduce all-cause deaths** in the near-term post-release; and
7. **Reduce the number of emergency department (ED) visits and inpatient hospitalizations** among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and BH care.

The State intends to implement the Demonstration statewide on or after July 1, 2025. The State requests to operate the Demonstration through the end of the current SUD Demonstration approval period, which is December 31, 2025. This amendment request provides a detailed overview of coverage and service provisions, as well as Re-entry initiative objectives, financing, implementation, and monitoring/evaluation.

Severe Mental Illness Initiative

Overview

In November 2020, HCPF received approval of its "Expanding the Substance Use Disorder (SUD) Continuum of Care" §1115 Demonstration in furtherance of the State's objective to complete the State SUD continuum of care. Through this amendment, HCPF seeks to expand this authority to reimburse for acute inpatient and residential stays in IMD for individuals diagnosed with a SMI or SED. This request is part of the State's ongoing efforts to reform its system to develop a comprehensive BH safety net.

Currently, the State utilizes "in lieu of" authority through its managed care contracts with managed care entities (MCE) to provide IMD reimbursement for stays of up to 15 days in a calendar month. This authority provides sufficient coverage for most acute psychiatric

inpatient stays. However, there remain IMD stays that exceed the 15-day limit due to issues such as patient acuity and additional time needed to ensure a safe and appropriate transition to community-based services. In these cases, the State is not able to cover any portion of the stay.

This amendment incorporates feedback from stakeholders that requests HCPF seeks authority to reimburse for stays up to 60 days while maintaining an average length of stay (ALOS) of 30 days, pending legislative and budget actions. This will permit the State to modify its current practice through which a prorated capitation payment is made to the MCE for the days within the month that the enrollee was not in an IMD and the MCE's subsequent payment recoupment from the IMD for the entire stay.

By addressing current financial losses experienced by IMDs for these stays, HCPF anticipates several benefits. For example, the following potential opportunities were identified through focus groups with current IMDs operating in the State:

- Increased provider investments in step-down services such as intensive outpatient or partial hospitalization.
- Prevent closure of adult inpatient IMD beds.
- Potential ability to increase wages to attract the needed workforce.

HCPF requests an effective date of July 1, 2025, for the IMD component of this amendment.

The State's goals are aligned with those of CMS for this waiver opportunity, including:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
- Reduced preventable readmissions to acute care hospitals and residential settings.
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the State.
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and BH care.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Continuous Eligibility Initiative

State House Bill 23-1300 directed the HCPF, by April 1, 2024, to seek Federal authority to provide continuous Medicaid coverage for children up to age three and for twelve months for adults who have been released from a State Department of Corrections facility, regardless of any change in income during that time.[1] Through this legislation, the State aims to improve the health and well-being of Coloradans through consistent access to comprehensive physical and BH benefits, during critical periods in life. Continuous coverage assists children in healthy

[1]Continuous Eligibility Medical Coverage Act, HB23-1300. 2023 Colorado State Legislative Session. Retrieved from https://leg.colorado.gov/bills/hb23-1300

early development and strengthens overall mental health through regular connections with the health system. Additionally, ensuring continuous coverage for previously incarcerated adults not only improves health outcomes but supports BH and may also improve public safety by reducing rates of recidivism. For example, adults with SUD convictions have a greater risk of criminal re-involvement and recidivism.[2]

Background

State Medicaid Program

The Medicaid program in the State, known as Health First Colorado, covered approximately 1.6 million Coloradans during 2022. This means roughly 26.9% of the State's population was enrolled in Health First Colorado[3]. Of those enrolled, over 37% were children and adolescents (covered by Health First Colorado and Child Health Plan *Plus*, or CHP+)[4]. These programs covered 43% of all births in the State in calendar year (CY) 2021.

Health First Colorado, Colorado's Medicaid program, provides access to physical and BH care, hospitalization, nursing facility care, prescription drugs, dental care and other benefits for qualifying adults and children. HCPF pays for physical health services through a fee-for-service (FFS) structure while BH and care coordination services are capitated and provided by Regional Accountable Entities (RAEs) through contracts with HCPF. The RAEs have data sharing agreements with the Department of Corrections to better support members as they transition to the community.

Since 2011, the Accountable Care Collaborative (ACC) has served as the core vehicle for delivering and managing member care for Health First Colorado. All full-benefit Health First Colorado members are enrolled in the ACC except for members enrolled in the Program for All Inclusive Care for the Elderly. The ACC integrates managed FFS physical health care and managed care for BH. The ACC's regional model is divided into seven regions, plus two physical health managed care programs within those regions, which allows it to be responsive to unique community needs. Key components of the ACC include care coordination and member support.

Children and pregnant people in the CHP+ are enrolled in one of four fully capitated managed care organizations.

Re-entry Initiative

In October 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "SUPPORT Act") in response to the imperative to implement concrete changes to address the opioid epidemic. Per the SUPPORT Act, Congress required the Department of Health and Human Services (DHHS) to convene a stakeholder group to develop best practices for ensuring continuity of coverage and relevant social services for individuals who are incarcerated and transitioning to the

[2] NIDA. (2020) *Criminal Justice DrugFacts*. National Institute on Drug Abuse. Retrieved from: https://nida.nih.gov/publications/drugfacts/criminal-justice
[3] Health Care Policy & Financing (HCPF) (2023) *State of Colorado Fact Sheet*. Colorado Department of Health Care Policy & Financing. Retrieved from: https://hcpf.colorado.gov/sites/hcpf/files/Statewide%20Fact%20Sheet.pdf
[4] Health Care Policy & Financing (HCPF) (2023) *Health Care Policy & Financing Report to the Community Fiscal Year 2021-2022*. Colorado Department of Health Care Policy & Financing. Retrieved from: https://hcpf.colorado.gov/2022-report-to-community

community. The legislation also directed DHHS to work with states to develop innovative strategies to help such individuals enroll in Medicaid and to, within a year of enactment, issue an SMD letter regarding opportunities to design section 1115 Demonstration projects to improve care transitions to the community for incarcerated individuals who are eligible for Medicaid. On April 17, 2023, CMS published an SMD letter outlining the opportunities to test transition-related strategies to support community re-entry and improve care transitions for individuals who are incarcerated. This letter, plus the approval of California's Demonstration amendment for incarcerated individuals, provides guidance for the development and submission of this 1115 Demonstration amendment for incarcerated individuals who are transitioning to release. The State is seeking to collaborate with DHHS to develop an innovative Demonstration that will help to ensure continuity of care when the State's justice-involved (JI) populations transition from incarceration to the community under this new guidance.

National data has shown that the JI population contains a disproportionate number of persons with BH conditions (i.e., SUDs and mental health disorders), as well as HIV and other chronic diseases. Nationally, an estimated 80% of individuals released from prison in the United States each year have an SUD or chronic medical or psychiatric condition.[5] In 2011–2012, half of people in state and federal prison and local jails reported ever having a chronic condition.[6] 21% of people in prisons and 14% of people in jail reported ever having an infectious disease, including tuberculosis, hepatitis B and C, and other sexually transmitted diseases, compared with 4.8% of the general population.[7] **In the first two weeks following release from incarceration, individuals are 129 times more likely to die from an overdose** than their peers in the community, and they often have higher rates of cardiac conditions, diabetes, Hepatitis C, mood, and anxiety disorders as well as severe and persistent mental illness.[8]

In addition, according to the Bureau of Justice Statistics, 53% of all state prisoners and 45% of all federal prisoners meet the Diagnostic and Statistical Manual of Mental Disorders, Fourth Revision, criteria for drug dependence.[9] Estimates for the jail population indicate that 47% have issues with alcohol use and 53% suffer from drug dependency or abuse.[10]

The JI population also suffers from mental and BH issues. According to the Bureau of Justice Statistics, in 2005, 56% of people in state prison, 45% of people in federal prison, and 64% of people in jail reported symptoms of a mental health disorder.[11]

As of 2023, there were over 17,000 individuals incarcerated in 21 State prisons. The average stay in state prisons is 33 months, and over 94% of prisoners are male. There are approximately 5,883 releases per year, with 4,070–5,295 of those released likely eligible for Medicaid.

[5] Shira Shavit et al., "Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison," Health Affairs 36, no. 6 (June 2017): 1006–15
[6] L. Maruschak, M. Bersofsky, and J. Unangst. Medical Problems of State and Federal Prisoners and Jail Inmates. Bureau of Justice Statistics Special Report (NCJ 248491), U.S. Department of Justice, February 2015
[7] *Ibid*
[8] Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release from prison--a high risk of death for former inmates. N Engl J Med. 2007 Jan 11;356(2):157-65. doi: 10.1056/NEJMsa064115. Erratum in: N Engl J Med. 2007 Feb 1;356(5):536. PMID: 17215533; PMCID: PMC2836121.
[9] Mumola, C. and Karberg, J. Drug Use and Dependence, State and Federal Prisoners, 2004. Bureau of Justice Statistics Special Report (NCJ213530), U.S. Department of Justice, October 2006
[10] Karberg, K. C., James, D. J. Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002. Bureau of Justice Statistics Special Report (NCJ 209588), U.S. Department of Justice, July 2005.
[11] James, D. and Glaze, L. Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics Special Report (NCJ 213600), U.S. Department of Justice, September 2006. Available at: http://www.bjs.gov/index.cfm?ty_pbdetail&iid_789

There are 15 State Department of Youth Corrections facilities that provide onsite health care and contract with outside providers. There are approximately 242 individuals released from these facilities annually, with 126–163 individuals eligible for Medicaid.

The State believes uninterrupted health coverage is imperative to ensure this high-risk, high-need population receives much-needed care as individuals transition back to their communities. If approved, this specific Demonstration will allow the State to leverage existing eligibility processes, improve suspension of benefits procedures, and more seamlessly transition incarcerated individuals to the appropriate Medicaid program during the 90 days prior to release from incarceration. Providing MAT is an essential service for individuals who experience forced abstinence, such as those in jails and prisons. Individuals with SUDs or substance-related criminal charges who are reentering the community are at greater risk of criminal re-involvement and recidivism, underscoring that addressing public health needs may help advance public safety outcomes and reduce future incarceration.

The State has undertaken significant reform efforts designed to improve outcomes, services, and care for the JI population. In 2022, the Legislature committed to exploring federal authorities to improve outcomes for this population through Senate Bill 22-196. Recommendations for developing a State Section 1115 Re-entry Demonstration align with CMS' overall objectives to increase equitable access to quality health care for individuals in the re-entry period, improve care transitions from carceral settings, and reduce unnecessary emergency room usage and preventable deaths upon release. Research from Senate Bill 22-196 had the following findings:

- As of 2023, there were over 17,000 individuals incarcerated in the State's 21 prisons.[12]
- The average length of stay in state prisons is 33 months, and over 94% of prisoners are male.[13]
- The State prison health care delivery system provides physical health, mental health, dental, vision, and pharmaceutical services. A third-party contractor typically manages acute or emergency services delivered outside the prison.
- There are 61 county and municipal jails in the State which house over 10,000 inmates. The average length of stay is 45 days for felonies and 17 days for misdemeanors.[14]
- Health care delivered in the State jails varies by county, and sometimes jails within counties, but this is primarily focused on physical health and BH. Several jails participate in the State's Jail Based Behavioral Health Services program, funded through the Behavioral Health Administration (BHA).
- There are 15 Department of Youth Corrections facilities, managed by the Colorado Department of Human Services (CDHS) Office of Child and Youth Services (OCYF) that provide onsite health care and contract with outside providers.[15]

[12] "Statistics," Department of Corrections, accessed January 5, 2024, https://cdoc.colorado.gov/about/data-and-reports/statistics.
[13] "Statistics," Department of Corrections, accessed January 5, 2024, https://cdoc.colorado.gov/about/data-and-reports/statistics.
[14] Colorado Division of Criminal Justice Jail Data Dashboard https://tableau.state.co.us/t/CDPS_Ext/views/JailDataDashboard_7/HB19-1297-Jail_Capacity?%20%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no#2.
[15] "DYS Residential Youth Centers," Colorado Department of Human Services, Division of Youth Services, accessed January 5, 2024, https://cdhs.colorado.gov/our-services/youth-services/dys-residential-youth-centers.

Six stakeholder groups were interviewed and all recommended that HCPF pursue a Section 1115 Medicaid Re-entry Demonstration. The following recommendations emerged from stakeholder interviews:

Services should include durable medical equipment (DME), transportation, Health Related Social Needs (HRSN) (particularly housing), transition services, and Medication Assisted Treatment (MAT). MAT treatment will be included in the benefit package offered as part of the CMS requirements. DME and HRSN services will be evaluated and potentially incorporated in a later phase as part of the individual's post-release benefit.

Eligibility should include juvenile population, jails,[16] and prisons. Juvenile and prison populations will be incorporated in the initial phase of the implementation plan. Jail populations will be phased in at the renewal period.

Data there should be investments to enhance health information exchange across agencies and facilities, with clear data standards and outcomes that are continuously monitored. While the development and standardization of the Health Information Exchanges (HIEs) is outside the scope of this waiver benefit directly, Colorado is already implementing these systems and instituting standards.

Technical Assistance carceral facilities will need assistance with encounter-based care, billing, MAT, and change management. Best practices and procedures will be determined, and education provided to all carceral settings.

Interagency Coordination planning and coordination should occur across agencies as the demonstration is developed. HCPF will work with state authorities such as DOC and DYS throughout the development of the implementation plan, assuring all agencies are involved.

Severe Mental Illness Initiative

State Behavioral Health System of Care

The State public BH care system includes substance use and mental health services and is administered and funded primarily by three separate executive branch departments: HCPF, CDHS which houses the BHA, and the Office of Civil and Forensic Mental Health (OCFMH), and the Colorado Department of Public Health and Environment (CDPHE). HCPF serves as the state Medicaid authority, the BHA is the single state authority (SSA) for substance abuse services and the state mental health authority (SMHA), and CDPHE serves as the state public health authority and leads prevention efforts for the state.

[16] Please note that due to the complex nature of the jail structure in the State, additional research is being conducted and jails will be phased into the demonstration at a later date.

Figure 1: Overview of the State's Public BH System Administration

HCPF
• Medicaid single state agency • Provides primary oversight of Medicaid-funded services • Contracts with MCEs to administer Medicaid benefits, including BH
BHA
• Designed to be the single entity responsible for driving coordination and collaboration across state agencies to address BH needs • Administers, licenses, and regulates community-based public BH services • Purchases BH services for under/uninsured individuals • Formulates and implements policy governing public BH services
CDPHE
• State public health authority • Has primary regulatory oversight and licensing of health facilities, including psychiatric hospitals • Leads prevention efforts

Managed Care Entities & Behavioral Health Administrative Services Organizations

The State began utilizing managed care over 25 years ago through the establishment of Behavioral Health Organizations responsible for promoting optimized mental health and wellness for all members and ensuring delivery of medically necessary mental health and SUD services. The first iteration of the ACC was established in 2011. Regional Care Coordination Organizations were designed to work alongside the Behavioral Health Organizations by supporting the physical health of members through the development of formal contracted networks of primary care medical homes and informal networks of specialists and ancillary providers.

Beginning in July 2018, Phase II of the ACC established RAEs, which combined the responsibilities of the Regional Care Coordination Organizations and Behavioral Health Organizations under one entity to promote an integrated, whole-person approach to members' physical health and BH. The State also has a MCO that provides both physical health and BH services. Together, seven RAEs and two MCOs are referred to as MCEs. As the core of Health First Colorado (Colorado Medicaid), MCEs:

- **Provide a regionally responsive approach and oversight to care** particularly for members with chronic and complex health care conditions with needs that span multiple agencies and jurisdictions. As regional organizations, MCEs are expected to understand the nuances among populations in the geographic area they cover to create cohesive provider and community support networks that deliver coordinated, whole-person care that improves health outcomes.
- **Administer the Capitated Behavioral Health Benefit** by maintaining a network of providers and providing or arranging for the delivery of medically necessary mental health and SUD services utilizing a community-based continuum of care that adapts to a member's changing needs and provides appropriate access to care.

- **Contract with and support a network of Primary Care Medical Providers (PCMPs)** to serve as medical homes for members, providing whole person, coordinated, and culturally competent care. MCEs also provide training and practice transformation support to providers to ensure the delivery of comprehensive, cost-effective, quality care that improves the member and provider experience.
- **Manage overall administration, data and information, and member access to care and support** by leveraging technology and establishing the infrastructure, tools, and resources that enable the timely and cost-effective delivery of health care services and supports that improve member outcomes.

HCPF is currently contracted with five organizations to provide MCE responsibilities in seven designated regions. Contracts with the MCEs will end on June 30, 2025. HCPF is in the process of designing the next iteration of the ACC, referred to as Phase III, which will begin on July 1, 2025. ACC Phase III is a critical part of HCPF's efforts to improve care quality, service, equity, and affordability. Phase III will incorporate, complement, and expand on policies and programs being implemented by HCPF and other state agencies to advance health care throughout Colorado.

Several ACC Phase III planned initiatives encompass BH services and programming, such as:

- **Improving access to care.** Ensuring members have access to affordable, high-quality care is a key priority. HCPF has supported several initiatives to increase the number of providers that see Health First Colorado members, such as increasing payment rates, providing grant funding to improve rural health care access, leveraging American Rescue Plan Act (ARPA) dollars to increase BH access, and streamlining processes and advancing provider tools to reduce administrative burden.
- **Health equity.** HCPF is dedicated to meeting its mission to improve equity and reduce health disparities. While HCPF is working hard to apply a health equity lens across all programs and initiatives, four initial health disparity areas of focus have been identified, one of which is BH.
- **Home and community-based care.** The ARPA provided HCPF with more than $550 million of stimulus funds to implement lasting transformation for people with disabilities and long-term care needs. HCPF's 63 ARPA initiatives enhance, expand, and strengthen home and community- based services in the State through the end of 2024. This includes $138 million in programs that address BH. At the same time, HCPF has been implementing several Case Management Redesign initiatives, including a new care and case management web-based tool.
- **Behavioral Health.** HCPF is partnering with the BHA and all state agencies to transform the State's BH system and in so doing, improve the system for Health First Colorado members. This includes adding new crisis benefits, creating new payment models for cost based or informed rates for safety net providers, increasing residential and step-down beds, expanding the provider network, improving transparency and reporting, reducing administrative burden, and catalyzing care coordination.

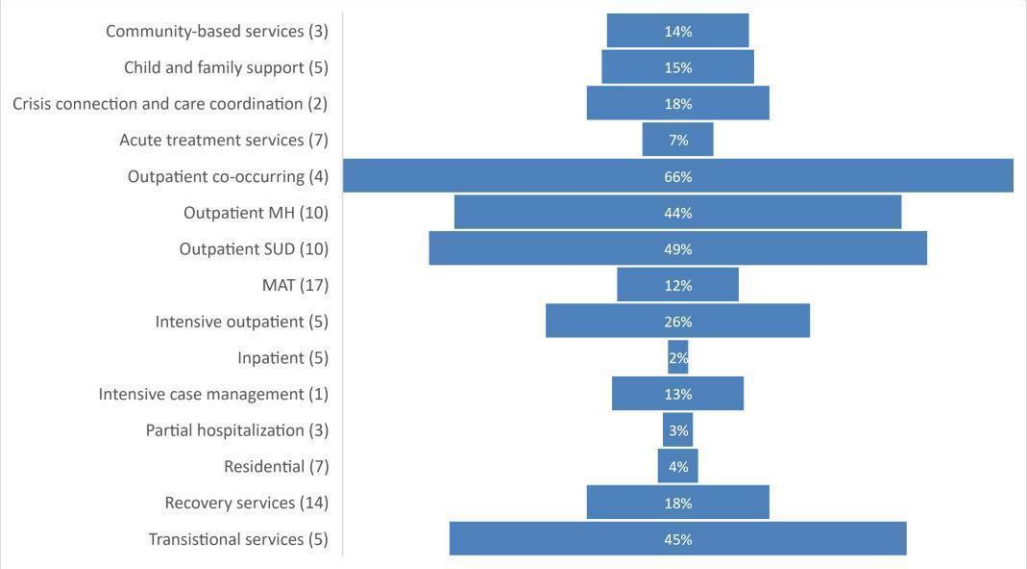
In addition to these Health First Colorado initiatives, the State is in the process of consolidating BH networks for its safety net system into one behavioral health administrative services organization (BHASO) per region. BHASOs are intended to help individuals and families initiate BH care and ensure timely access to services. The BHASOs will be

implemented regionally by July 2025 and will consolidate MCO (SUD treatment services), Administrative Service Organizations (crisis services), and services offered by Community Mental Health Centers (CMHCs). The BHASOs will provide a continuum of BH safety net services and care coordination. They will also be expected to interface and align with the MCEs.

Service Continuum

In 2020, the State conducted a Behavioral Health Needs Assessment to assess service gaps and areas for improvement. This included an analysis of the continuum by using Substance Abuse and Mental Health Services Administration (SAMHSA) Locator that has detailed service level data, the BHA Licensing and Designation Database and Electronic Records System data, and a provider survey. Based on the SAMHSA locator data, as illustrated in Figure 2, outpatient mental health and SUD treatment and transitional services are the most comprehensive offerings among BH providers in the State, while the least comprehensive services are available for acute needs like inpatient, partial hospitalization, and residential care. Stakeholders emphasized the need for more specialized and intensive services, particularly mental health transitional services. When examining specific components of transitional services, discharge planning was identified as the highest need. HCPF seeks to address these identified needs through this Demonstration.

Figure 2: BH Provider Services Profile (Average Percent of Service Types Offered per Provider Along Continuum)[17]



Behavioral Health Provider Designation and Licensing

The BHA is responsible for licensing BH treatment programs and designating mental health treatment programs. In alignment with House Bill 19-1237, House Bill 22-1278, and House Bill 23-1326, BHA updated its licensing structure and process, with new BHA provider rules

[17] The number of services per continuum category included in the analysis are provided in parentheses (#). Source: SAHMSA Locator, March 2020.

approved by the State Board of Human Services on November 3, 2023. As of January 1, 2024, BHA has the authority to issue Behavioral Health Entity (BHE) licenses to agencies that qualify as a BHE.

BHE is responsible for the approval of Essential and Comprehensive Providers that elect to participate in the safety net system to ensure all those in the State who need services have access to them.

The authority to issue BHEs transitioned to the BHA from the CDPHE on January 1, 2024, and replaced the existing structure of SUD treatment licenses, and CMHC designations in the State.

The BHE license model provides a "cafeteria-style" license in which an agency holds a single BHE license with different endorsements, allowing the agency to offer various services at multiple locations. This allows flexibility and ultimately will support easier addition of services and locations for the agency to meet the needs of their populations served. This licensing and designation structure transition is expected to continue through the early months of 2025. Endorsements under a BHE license may include:

- Level of Care Endorsements
  - Recovery Supports
  - Outpatient and High Intensity Outpatient Services
  - Residential and Overnight Services
- Crisis Endorsements
  - Crisis Services
    - Walk-in Clinic
    - Mobile Crisis
    - Community-Based Respite
    - Acute Treatment Units (ATUs)
    - Crisis Stabilization Units (CSUs)
    - Residential Respite
- Population-Specific Endorsements
  - Emergency and Involuntary Commitment
  - Children and Families
  - Women's and Maternal BH Treatment
  - Criminal JI Services

Behavioral Health Safety Net Providers

BH safety net providers serve priority populations and comply with the safety net no refusal requirements, ensuring that priority populations receive access to the care and care coordination that they need to achieve whole person health. BH providers can continue to enroll with Health First Colorado and serve Medicaid members without being approved as a BH safety net provider. Seeking approval is voluntary for providers. However, only approved safety net providers are eligible for enhanced reimbursement rates.

Comprehensive Community BH Providers: A Comprehensive Provider is a licensed BH entity or provider approved by the BHA to provide care coordination and the following BH safety net services, either directly or through formal agreements with BH providers in the community or region:

- Emergency and crisis BH services
- Mental health and substance use outpatient services
- BH high-intensity outpatient services
- Care management
- Outreach, education, and engagement services
- Mental health and substance use recovery supports
- Outpatient competency restoration
- Screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicators

Comprehensive Providers are required to serve all priority population individuals unless the individual requires a level of care the provider does not provide, or the provider does not have the capacity to serve the individual within an appropriate time frame. Prior to changes in the State's BH provider licensing and designations, the public mental health system consisted of 17 contracted CMHCs. Each CMHC received state general funds, mental health block grant funds, and payments from public and private insurers to provide mental health services including Medicaid. All CMHCs have or are expected to transition to comprehensive providers by early 2025.

Essential Behavioral Health Safety Net Provider: An Essential Provider is a licensed BH entity or provider approved by the BHA to provide care coordination and at least one of the following BH safety net services:

- Emergency or crisis BH services
- BH outpatient services
- BH high-intensity outpatient services
- BH residential services
- Withdrawal management services
- BH inpatient services

- Integrated care services
- Hospital alternatives
- Additional services that the BHA determines are necessary in a region or throughout the state

Essential Providers can be approved to serve a subset of priority populations (i.e., a specific age range). Essential Providers must still comply with the no refusal requirements for the subset of priority populations they are approved to serve. Essential Provider approval is not predicated upon a BHE license, unless the provider is otherwise required to hold a BHE license. BH providers that do not require a BHE license can be approved as an Essential Provider by demonstrating that they hold any required licenses, and that those licenses remain in good standing (i.e., individual professional license, CDPHE hospital license).

Independent Provider Network

The State's Independent Provider Network (IPN) includes licensed BH providers, ranging from independent solo practices or individual practice groups. Each IPN may contract for a scope of services they wish to provide to Health First Colorado members up to the level they are licensed to provide. During State Fiscal Year (SFY) 2021, the volume of services provided by the IPN increased by 24 percent.

Crisis Services

After the 2014 Aurora theater shooting, the State implemented a statewide crisis response system, guaranteeing that all Coloradans have access to BH care regardless of ability to pay. The coordinated BH crisis response system improves access to the most appropriate resources and crisis interventions via a statewide hotline, mobile response, and walk-in crisis services across the state and includes the following key service components:

- **Statewide 24-hour crisis help line:** A 24-hour telephone crisis service that is staffed by skilled professionals and peers who can assess crisis situations and make the appropriate referrals to resources and treatment. In July 2022, Colorado launched the new 988 Suicide and Crisis Lifeline alongside the existing state crisis line. As 988 capacity grows, the state crisis line will be integrated with 988.
- **Statewide awareness campaign and communication:** Multi-media campaign, branding, and communication to increase awareness of BH illness and resources. The communication plan includes a website (www.coloradocrisisservices.org), social marketing, billboards, brochures, television, and radio ads.
- **Walk-in crisis services:** Walk-in crisis services with the capacity for immediate clinical intervention, triage, and stabilization. The walk-in crisis services employ an integrated health model based on evidence-based practices that consider an individual's physical and emotional health, are part of a continuum of care, and are linked to mobile crisis services and crisis respite services.
- **Crisis stabilization units:** Facilities, using a restrictive egress alert device, which serve individuals requiring 24-hour intensive BH crisis intervention for up to five days. CSUs employ an integrated health model based on evidence-based practices that consider an individual's physical and emotional health, are a part of a continuum of care, and are linked to mobile crisis services and crisis respite services.

- **Mobile crisis services:** Twenty-four-hour mobile crisis units can respond within one-hour in urban and two-hours in rural areas to a BH crisis in the community for immediate clinical intervention, triage, stabilization, and connection to services. Effective July 1, 2023, the mobile crisis response (MCR) benefit was expanded to adopt standards in alignment with requirements under Section 9813 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). These standards support trauma-informed and evidence-based practices with the goal of reducing reliance on criminal justice and EDs for BH needs.
- **Crisis Respite:** Crisis respite services are overnight services provided in a 24-hour facility. Services are designed to improve/maintain the condition and functional level of the member and prevent relapse/hospitalization. Services include assessment, supervision, structure and support, and care coordination. Respite crisis services are linked to the walk-in crisis services. Crisis respite services that include a range of short-term crisis residential services, such as an ATU.
- **Acute Treatment Units:** An ATU is a facility or a distinct part of a facility for short-term psychiatric care, which may include treatment for SUD, that provides a 24-hour therapeutically planned and professionally staffed environment for persons who do not require inpatient hospitalization but need more intense and individual services than are available on an outpatient basis, such as crisis management and stabilization services.

Further, in January 2023, the BHA launched the Crisis Resolution Team Pilot Program (CRT) in 17 counties. The CRT program supports families with youth and young adults who are experiencing BH challenges and would benefit from intensive, short-term (six to eight weeks), in-home services and connection to ongoing support. CRT services are available to state youth and young adults ages zero to 21. Additionally, in response to state legislation (House Bill 22-1283), the BHA is expanding a community-based crisis response system for pregnant and parenting people, children, youth, and families.

Through this Demonstration amendment, HCPF seeks to reimburse for stays in CSUs and ATUs that meet the definition of an IMD.

Inpatient Services

The OCFMH administers and operates two mental health institutes (state hospitals) to provide inpatient hospitalization for individuals with SMI. These hospitals serve:

- Forensic clients with pending criminal charges who require inpatient evaluations of competency to stand trial and inpatient services to restore competency.
- Individuals who have been found not guilty by reason of insanity and require hospitalization.
- Adults and adolescents who are referred for admission by CMHCs, the Department's Division of Youth Services, and other health providers.

Additionally, there are currently seven privately operated adult inpatient psychiatric facilities that meet the definition of an IMD in Colorado. Through this Demonstration, HCPF intends to only reimburse for stays in private IMDs.

Mental Health Transitional Living Homes

Mental Health Transitional Living (MHTL) Homes are part of a new program that will provide an added layer of services within the State BH continuum of care. These homes will be used as a transition to a less restrictive setting for individuals with severe mental health conditions. Clients may stay as long as necessary for stabilization with a goal of successfully reintegrating in the community.

MHTLs provide continued support with social and life skills development, as well as assistance with other daily life activities based on the client's individual needs. By May 2024, it is anticipated 125 MHTL beds will be available.

Services for Children, Youth, and Families

HCPF and BHA ensure a culturally competent and trauma-informed approach in collaboration with state and local child- and youth-serving agencies to provide a comprehensive array of core mental health services for children, youth, and families. In addition, CDHS's Division of Child Welfare provides oversight and monitoring of the quality of child-serving programs and services. Health First Colorado provides a full continuum of mental health services for children and youth, including case management, individual and group therapy, prevention/early intervention services, residential mental health services (psychiatric residential treatment facility (PRTF) and Qualified Residential Treatment Programs (QRTPs)), school-based, and day treatment services, among others. In addition, through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, members aged 20 and under have access to comprehensive and preventive mental health services through Health First Colorado.

Continuous Eligibility Initiative

Consistent access to health care is critical to prevention, intervention, and ongoing treatment of individuals with physical and BH needs. This waiver amendment proposal by HCPF seeks to improve health outcomes, promote long-term recovery, and reduce overdose deaths by extending member coverage for priority populations.

For children ages zero to three, continuous coverage means they have immediate access to services from birth across multiple developmental stages with a consistent and trusted health care provider, uninterrupted by changes in insurance[18]. Through regular screenings, providers can detect problems faster in individuals, as well as their caregivers and home environments leading to earlier prevention and intervention efforts. Early adversity, such as home life instability, abuse, or illness can interrupt foundational brain development in the first years of life putting children at greater risk of developing lifelong health problems, including SUDs[19]. Continuous coverage ensures children ages zero to three and their caregivers have access to mental health services like the State's Child First home-visiting program, proven to reduce poor BH among the child and caregiver, decrease exposure to traumatic events, and increase access to services[20]. Families can receive screenings, therapeutic interventions, care coordination, and develop trusted relationships with a consistent provider which act as

[18]Cohen, S. (2021) *Three Principles to Improve Outcomes for Children and Families, 2021 Update*. Center on the Developing Child at Harvard University. Retrieved From: https://harvardcenter.wpenginepowered.com/wp-content/uploads/2017/10/3Principles_Update2021v2.pdf
[19]Ali N., Borgman, R., Costello, E., Cruz K., Govindu, M., Roberts M., Rooks-Peck, C., Wisdom, A., Herwehe, J., McMullen, T. (2022) *Overdose Data to Action Case Studies: Adverse Childhood Experiences*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Retrieved from: https://www.cdc.gov/drugoverdose/od2a/pdf/OD2A-ACEs-case-study-508.pdf
[20]Crusto, C.A. Lowell, D.I., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S. R., & Kaufman, J. S. (2008) *Evaluation of a Wraparound Process for Children Exposed to Family Violence*. Best Practices in Mental Health: An International Journal, 4(1), 1-18

protective factors in preventing adverse childhood events, substance misuse and other negative outcomes for children as they grow[21].

Continuous and immediate access to reliable health care is critical to individuals upon release from a correctional facility when they are at highest risk of recidivism, illness, overdose, and death. Individuals leaving adult and youth correctional facilities may only receive timely services if they are quickly connected to health care services, which is why the State seeks to improve pre-release services to ensure that eligible individuals are already connected to the community-based support they need prior to release. Continuous coverage for eligible individuals guarantees health care access for 12 months after release which may lead to outcomes including reducing the likelihood of initiating or returning to substance use. For individuals with SMI or SED who may need additional support in an IMD acute or residential stay, expanding reimbursement opportunities can improve quality and access to these services. This amendment to the State's current 1115 "Expanding the Substance Use Disorder Continuum of Care" Waiver for children, youth, and adults promotes access to health care as a core component of substance misuse prevention, reducing hospitalization and incarceration, and prioritizing physical and BH promotion in the State.

Objectives and Milestones

Re-entry Initiative

Under Section 1115 of the Social Security Act, states may implement "experimental, pilot or Demonstration projects which, in the judgment of the Secretary [of Health and Human Services] are likely to assist in promoting the objectives of [Medicaid]." The State believes this Demonstration is likely to promote the objectives of Medicaid by providing transitional services to ensure high-risk Justice-Involved (JI) populations have critical coverage and supports in place when released from incarceration. Colorado plans to request approval to waive the federal inmate exclusion policy for state operated facilities (DOC and DYS), and will develop a comprehensive plan for including jails next year. Any adjustments will be amended in the waiver as part of the renewal process.

Colorado's proposal is consistent with the CMS goals as outlined in the April 17, 2023, SMD letter. Under this Demonstration, the State will be able to bridge relationships between community-based Medicaid providers, carceral staff and incarcerated individuals prior to release, thereby improving the chances individuals with a history of SUD, serious mental illness (SMI), and/or chronic diseases receive stable and continuous care. To successfully design and implement the Re-entry Initiative, Colorado agrees to the required deliverables and milestones CMS has put forward via recent guidance.

The State will submit a Re-entry Demonstration Initiative implementation plan using the most recent CMS guidance to describe its approach to implementing the Re-entry Demonstration Initiative, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The State will submit the draft

[21]Child First (2023) *Home-Based Intervention. Child First*. Retrieved from: https://www.childfirst.org/our-work/home-based-intervention

implementation plan to CMS for review no later than 120 calendar days after approval of the Re-entry Demonstration Initiative.

In the implementation plan, the State will provide additional details regarding the implementation of the Re-entry Demonstration Initiative that are not already captured in the Special Terms and Conditions (STCs). Contingent upon CMS's approval of the State's implementation plan, the State may begin claiming Federal Financial Participation (FFP) for services provided through the Re-entry Demonstration Initiative at the time of inclusion of the STCs, expected to begin no earlier than July 1, 2024.

The implementation plan will describe the implementation settings, the time period that pre-release services are available, and the phase-in approach to implementation, as applicable. Other than providing such contextual information, the core requirement of the implementation plan is for the State to describe the specific processes, including timelines and programmatic content where applicable, for meeting the milestones below, such as to remain on track to achieve the key goals and objectives of the program. For each milestone — and specifically for any associated actions that are integral aspects for attaining the milestone — the implementation plan will document the current state of affairs, the intended end state to meet the milestone, the date by which the milestone is expected to be achieved, and the activities that will be executed by that date for the milestone to be achieved. Furthermore, for each milestone, the implementation plan will identify the main anticipated implementation challenges and the State's specific plans to address these challenges. The implementation plan will document the State's strategies to drive positive changes in healthcare quality for all beneficiaries, thereby reducing disparities and improving health equity. The following describes the overall State commitment to meeting each milestone with a summary of the current state and future strategies for addressing the required milestones:

Milestone 1: Increasing coverage and ensuring continuity of coverage for individuals who are incarcerated.

The State will establish processes to allow and assist all individuals who are incarcerated at a participating facility to access and complete a Medicaid application including providing information about where to complete the Medicaid application for another state and will ensure make available a Medicaid identification number or card to an individual upon release. Colorado will ensure that any Medicaid-eligible person, who is incarcerated at a participating facility but not yet enrolled, is afforded the opportunity to apply for Medicaid and is offered assistance with the Medicaid application process. Colorado will also ensure that all individuals at a participating facility who were enrolled in Medicaid prior to their incarceration are offered assistance with the Medicaid renewal or redetermination process requirements. The current status and future strategies related to this milestone include:

- Colorado has no formal policy outside of best practice and operational memos directing both Department of Correction (DOC) and county eligibility staff to suspend full Medicaid benefits for the incarcerated population who are actively enrolled in Medicaid. This is a manual process between DOC staff and the county eligibility staff. The local Department of Human Services or Medicaid Assistance site will manually move incarcerated Medicaid-enrolled individuals onto a limited benefits plan (Incarceration Benefit, or INCAR), which only allows access to inpatient hospitalization for 24 hours or more. Current practice allows full Medicaid benefit reinstatement at the time of release from the carceral setting. For the incarcerated status to be updated, the member or authorized representative must inform the county Department of Human Services of a setting change.

— HCPF will work with State partners to establish standard policies and procedures to ensure all active Medicaid members' benefits transition to incarcerated benefits during incarceration and upon release will transition back to full Medicaid benefits.

— Policies and procedures will also be strengthened to ensure a standardized approach to Medicaid suspension upon incarceration.

- In prisons, State policy states that incarcerated individuals or their representatives may submit applications for Health First Colorado (Colorado's Medicaid program) at any time during incarceration. Individuals entering prison sign a paper consent form to release information, and facility staff enter it into an electronic internal storage system. Forty days before release, if the individual has consented, the facility staff reviews Medicaid status online and works with a contracted vendor to determine Medicaid eligibility. In juvenile facilities, case managers assist individuals with submitting paperwork if the individual asks the facility case manager. Case managers do not review benefit status unless requested by an individual or family.

  — HCPF will work with State authorities over carceral facilities (such as DOC and Division of Youth Services (DYS)) to develop a consistent and efficient process for managing consent and authorization for Medicaid eligibility determinations, including evaluating staffing, training, and technology needs. HCPF will expand its functionality of existing enrollment technology to allow DOC and DYS staff to support enrolling Medicaid-eligible members in a consistent and timely fashion.

- In prisons, the prison staff reviews eligibility status approximately 40 days prior to release. The prison case manager only assists with the application process, not the redetermination process. In juvenile facilities, DYS does not review Medicaid status for individuals entering the facility. Individuals must address Medicaid renewals upon release through their county of residence.

  — HCPF will work with State authorities over carceral facilities (such as DOC and DYS) to develop a consistent and efficient process for managing consent and authorization for eligibility determination and enrollment prior to release. This will include an evaluation of staffing, training, and technology needs.

- There is no State requirement for DOC or DYS facilities to provide access to enrollment documentation and information on using Medicaid coverage. DOC facility staff provide a copy of Medicaid cards to individuals exiting prison facilities; however, this is not a current requirement.

  — The State will create statewide requirements, including required components of the release package. HCPF will work with State partners at DOC and DYS to establish guidance on adherence to the requirements.

- Facility staff assist individuals with the application process for Medicaid benefits. This is a standardized process to apply to State Medicaid programs only; there is no standard process for supporting access to Medicaid applications in another state at the time of release.

  — HCPF will work with State authorities over carceral facilities to create processes and best practices for each entity, including screening, assisting with recertifying benefits, connecting to out-of-state Medicaid resources, and applying standardized tracking metrics.

Milestone 2: Covering and ensuring access to the expected minimum set of pre-release services for individuals who are incarcerated, to improve care transitions upon return to the community.

Colorado will provide access for individuals to the minimum short-term, pre-release benefit package, including:

- Case management to assess and address identified physical and behavioral health needs and health-related social needs (HRSN);
- MAT services for all types of SUD as clinically appropriate with accompanying counseling; and
- A 30-day supply of medication (as clinically appropriate based on the medication dispensed and the indication) provided to the beneficiary immediately upon release.

Under the demonstration, the State's Managed Care Entities (MCE's) will be required to provide post-release case management transition services. Today, the Colorado prison health care delivery system provides physical health, mental health, dental, vision, and pharmaceutical services. A third-party contractor typically manages acute or emergency services delivered outside the prison. The 15 youth corrections facilities provide on-site health care and contract with outside providers to provide the care.

In the implementation plan, Colorado will describe how it will implement processes to assure that all pre-release service providers, as appropriate for the provider type, have the necessary experience and training, and case managers have knowledge of (or means to obtain information about) community-based providers in the communities where individuals will be returning upon release. Further, as applicable, the State will establish state requirements for carceral health providers who are not participating in Medicaid or Children's Health Insurance Program (CHIP) that are similar to Medicaid provider standards, as well as program integrity standards to ensure appropriate billing. The current status and future strategies related to this milestone include:

- Per federal requirements to be waived via this Amendment request, pre-release services for prisons are coordinated outside of the Medicaid program. DOC facility case managers identify Medicaid enrolled individuals to receive support through Managed Care Entities (MCEs) upon re-entry beginning forty days prior to exit and securely email the receiving MCE. DOC shares a roster with HCPF to share with MCEs with members who have been released or anticipate being released and assigned to their MCE. The roster contains summary physical health and behavioral health information, which is distributed daily, and is used by MCEs to manage outreach. Juvenile facilities currently have no comparable processes.
    - All individuals released from prisons and juvenile facilities will be eligible for pre-release services under the Demonstration. Current processes for prisons will be coordinated via the Demonstration and consistent with the STCs and CMS guidelines. Processes for juvenile facilities will be developed and implemented in a comparable manner, also consistent with upcoming State plan and EPSDT requirements.
- Clinical providers in the prison staff provide MAT medication, including long-acting injectables, close to release from prison. DOC staff do not provide additional MAT medication for after release. Individuals receive the MAT provider's information at the

time of release, and prison MAT case managers make any appointments needed for continued MAT services post-release. Juvenile facility staff screen youth and plan pre-release services at the time of entry. At exit, youth are referred to community resources to address physical health, behavioral health, and health-related social needs. DYS facilities offer no other pre-release services on a standard basis.

  - Develop and implement a state-wide system, including updating eligibility, for managing an individual's behavioral health, physical health, care coordination, and referrals among professionals during pre and post-release periods. Allow MCEs or their contracted providers to perform in-reach activities for pre-release individuals to assure continuity during the re-entry period. Develop and implement a pre-release benefit package that meets the demonstration criteria. The available Medicaid benefits package for incarcerated individuals will be updated to reflect the newly reimbursable re-entry services.

- In prisons, MCE care coordinators work directly with providers in their regions and coordinate with other MCEs when inter-region referrals are needed. HCPF monitors MCEs on their effectiveness in this coordination. MCEs connect high-acuity individuals released from DOC to community-based providers. In juvenile facilities, facility staff assign the youth a case manager upon entry into detention, and the case manager becomes the parole officer at the time of exit. At exit, staff offer youth community resources and support related to HSRN.

  - The MCE's will contract with pre-release case management to ensure warm linkages to community providers and coordinated transition back into the community, according to STC requirements and federal guidance.

Milestone 3: Promoting continuity of care.

In the implementation plan, the State will detail the operational steps and timeline to provide or facilitate timely access to post-release medical supplies, equipment, medication, additional exams, or other post-release services to address the physical and behavioral health care needs identified during the case management assessment and the development of the person-centered care plan. Colorado will outline its processes for promoting and ensuring collaboration between case managers, providers of pre-release services and providers of post-release services, to ensure that appropriate care coordination is taking place. The current status and future strategies related to this milestone include:

- In the current prison system, there are no State requirements for incarcerated adults to receive a care plan before exiting prison. Adult inmates receive education and instructions for physical or mental health needs provided by prison medical staff. Facility staff review medications prescribed for individual conditions at exit and provide thirty days of prescription medication for physical and medical conditions. All infectious disease medication, regardless of amount, is provided at the time of exit. The prison MAT case manager completes MAT medication and care coordination referrals but does not provide MAT medication at the time of exit from the prison setting. Youth detention centers offer limited case management. Youth are assigned a case manager upon entry into the facility. The case manager remains with the individual post-release, serving as the parole officer upon release. The case manager coordinates medical appointments with family or another designee upon release for physical health needs only. Mental health, SUD, or MAT services are not provided via the facility contractor as part of case management for youth

transitioning from the detention facility. Case managers connect youth with local mental health services where care is offered outside of the Medicaid program on a sliding scale.

  - HCPF will establish MCE contract expectations to ensure each individual exits their facility of incarceration with an appropriate care plan. The care plan will identify needs and facilitate connections for members with appropriate community-based resources through targeted case management. HCPF will work in conjunction with OCL to establish connections for evaluation for HCBS and long-term services and supports (LTSS) needs. HCPF will provide guidance on the information exchange needed to establish LTSS. Additionally, coordination and connections will be made within the network of Medicaid-enrolled community providers to ensure continuity of care upon release.

- For individuals released from prisons, MCEs provide post-release connections and timely access to services to care for high-acuity individuals identified by DOC as part of the contract requirements. The State has contracted with the MCE's and has outlined expectations for performance measures for individuals exiting carceral settings. For youth, the detention center case manager coordinates medical appointments with family or designee upon release for physical health needs only. Case management offers mental health, SUD, or MAT services for youth as part of the transition plan from detention facilities utilizing contracted facility providers. Youth leave carceral settings with whatever is left of their current prescription and prescription to refill.

  - HCPF will set the standards for MCE case managers as well as define the scope of services included under billable targeted case management. As part of the contract requirements the MCE will be responsible for the timeliness of post-release care coordinators connecting with individuals and executing the care plan.

- For individuals exiting prisons, MCEs are contracted to address coordination with DOC, and a data-sharing agreement is in place to facilitate information sharing for members released from DOC. Individuals typically enter a parole or probation setting upon release, but services for adults transferring to another state remain for the individual to pursue. Standards do not currently exist for what specific relevant health information should be exchanged for continuity of care and care coordination purposes. Youth services are provided based upon assessed need post release not by the MCE but by a parole officer. The parole office provides care coordination information to a contractor provided by the detention services.

  - HCPF will support MCEs with any identified gaps with established data-sharing agreements needed to facilitate the sharing of relevant information. HCPF will update RAE contracts to include language on expectations for appropriate continuity of care and community connections.

- For prisons, the State provides guidance and best practices to outline expectations for the RAE's to connect with community-based providers or warm handoffs for post-release case management. In Juvenile facilities, youth services are not provided immediately upon release through the MCE but rather by a provider contracted by the detention facility. The pre-release case manager and post-release parole officer are the same individual.

  - HCPF will determine policy and procedures for adherence to both new and established processes. HCPF will develop and enforce a process for monitoring and evaluating case management hand-off.

Milestone 4: Connecting to services available post-release to meet the needs of the reentering population.

Colorado has an extensive network of behavioral health and substance use providers and will implement a system to monitor the delivery of post-release services and ensure that such services are delivered within the appropriate time frame. The implementation plan will describe how ongoing post-release case management is monitored and adjusted and describe its process to help ensure the scheduling and receipt of needed services, as well as other services needed to address HRSN and LTSS. Additionally, the implementation plan will describe how the State will ensure that case managers are able to effectively serve Medicaid-eligible individuals under the Demonstration who are transitioning into the community. The current status and future strategies related to this milestone include:

- In the current prison system, information is entered into the state system for individuals exiting prisons that the MCE will review and monitor post-release care. Upon exit, it is up to the individual to meet any post-release requirements for the appointment. The MCE's have procedures in place to initiate contact with the individual, clarify medical information and coordinate services across various systems of care and social needs. Case managers do not reach out to individuals post-release. The state juvenile facility health IT system (known as "Trails") will offer some information regarding placement status and services provided. Trails and the state eligibility systems are linked, allowing for members to be tracked using this system integration. The parole officer is the same individual who provides pre-release case management and follows up within 24 hours post-release.
    - HCPF will determine the process for monitoring and evaluating case management hand-off and ensure the contracted provider is meeting contracted requirements.
    - HCPF will designate an approved state system for storing and sharing individual information, care plan(s), and other relevant information. HCPF will be responsible for determining access for different user types.
- For adult releasees from prison, MCE Care Coordinators have a responsibility to connect members to identified services or appointments. However, there is no process to monitor a care plan. Youth receive follow-up services by the assigned parole officer. The parole officer will provide assessments on a regularly occurring schedule and report to the team on progress toward goals as a condition of parole from the detention center. A limited set of contracted providers offer services, and individuals may decline to work with them. Individuals who decline a provider still need to comply with parole requirements with a different provider chosen by the individual or designee.
    - HCPF will establish expectations for the frequency and timeliness of updates from case managers, including re-evaluations of the care plan.
- For individuals exiting prison, the MCE provider offers connection to HRSN and LTSS. Juvenile facility staff connect contracted providers to the individual as part of the exit plan and parole. Individuals are offered resources for potential HRSN resources for family and youth in order for the youth to be as successful as possible. If needs fall outside the prescribed resources list, the individual must seek out the additional HRSN resources. The contractor will not duplicate care coordination provided through LTSS and HCBS waivers and other programs designed for special populations; rather, the contractor will work to link and organize the different care coordination activities to promote a holistic approach to a member's care. LTSS is not a part of the review of resources that is made available.

— HCPF will establish case manager expectations for sharing member information for LTSS and HRSN. Policies and procedures will be developed to ensure warm hand-offs where appropriate, as to not leave it up to the individual to connect to services.

- State facilities have set standards for caseload and capacity as a best practice for case managers in youth and adult carceral facilities. These standards can vary depending on the members' acuity or level of need. Carceral facilities do monitor this workload.

  — HCPF will collaborate with State partners to review and establish staff capacity expectations to provide effective case management to address timeframes for responses to the specific needs of the individual, expectations, and goals for the transition period, and criteria of levels of need. HCPF will determine monitoring and evaluation mechanisms. The unique needs and challenges related to serving individuals releasing from carceral facilities will be considered when determining provider reimbursement.

Milestone 5: Ensuring cross-system collaboration.

In the implementation plan, Colorado will outline how the state operated facilities will address incarcerated beneficiaries' access to community health care providers, including case managers, either in person or via telehealth. The implementation plan will also outline its plans for establishing communication and engagement between correctional systems, community supervision entities, health care organizations, the State Medicaid agency, and supported employment and housing organizations. Colorado has already developed plans to connect its carceral electronic health records to the Colorado Health Information Exchange. The State will utilize these systems to monitor individuals' health care needs, HRSN, and their access to and receipt of health care services pre- and post-release and identify anticipated challenges and potential solutions. Furthermore, the State will develop and share its strategies to improve awareness about Medicaid coverage and access among stakeholders, including those who are incarcerated. The current status and future strategies related to this milestone include:

- Carceral facilities vary in the provision of pre-release services staff do not provide pre-release services to incarcerated individuals. Carceral facility services are provided based on the availability of contracted providers within the facility.

  — HCPF will work with State partners that oversee carceral facilities to determine and develop metrics for readiness and program goals within correctional facilities. HCPF will determine the technology system needs, including billing, coding, and claims for provided services.

- Organizational engagement and system coordination are currently limited to meetings and conferences. The State does not have an organized plan outlining the communication or coordination structure for addressing services for individuals exiting carceral settings.

  — HCPF will work with state partners to determine representatives from the respective organizations. HCPF will work with stakeholders to determine the timeline for completion of the plan for engagement, coordination of care, and communication across the continuum. HCPF will aid the work group in developing goals and outcomes for each category. HCPF will work with participants to determine the mode of communication for the final plan.

- Education efforts regarding Medicaid coverage, access to services, and awareness of individual needs are limited. The strategies vary across the state. HCPF is carrying out ARPA 8.10 — Criminal Justice Partnerships. This project has engaged key stakeholders from the criminal justice system and Medicaid, including individuals with lived experience, correctional facilities, and providers.
    - HCPF will determine strategies and initiatives to improve awareness and education for individuals exiting the carceral setting as well as providers linked to assist with care coordination. HCPF will determine stakeholders that will participate in developing the awareness and education plan. HCPF will work with participants to determine timelines and implementation of key activities.
- The State has not established or implemented processes to monitor health needs or HRSN for individuals exiting carceral settings.
    - HCPF will explore expanding the use of Z Codes for members in carceral settings and establish coding and billing guidelines for case managers to include these details on a member's care plan as well as claims for services.

Re-Entry Reinvestment Plan

HCPF leadership is exploring the current funding landscape with State partners and will develop reinvestment opportunities within the timeline for implementation of the Demonstration. The reinvestment plan will prioritize programs and services that seek to improve health outcomes for the incarcerated population the State is seeking to support via this Demonstration request.

Administrative funds will be claimed to support the implementation of the demonstration focused on education, technical assistance, implementation, and access to the State's Health Information Exchange.

Severe Mental Illness Initiative

State Strategies for Addressing Waiver Milestones

The State has developed a comprehensive strategy to address the milestones associated with this Demonstration, as articulated in State Medicaid Director Letter #18-011. A summary of the State's current status and planned activities associated with each milestone is provided below.

Milestone 1: Ensuring Quality of Care

The State has in place standards and processes to oversee the quality of care rendered by psychiatric hospitals, CSU, and ATUs that will operate under this Demonstration. This includes standards for licensure, monitoring and oversight, and program integrity.

All psychiatric hospitals must be licensed by CDPHE, who is responsible for ensuring psychiatric hospitals maintain ongoing compliance with licensure requirements and is granted authority to conduct both announced and unannounced visits. Additionally, the State has a performance incentive for psychiatric hospitals that demonstrate high performance during re-licensure such as inspection completion with full and timely cooperation and inspection findings with no documented harm or potential harm to clients.

All BHEs are licensed by the BHA, including those with endorsements to operate CSUs and ATUs. As such, the BHA is responsible for ongoing CSU and ATU oversight, including through announced and unannounced site visits. Currently, accreditation is not required for CSUs and ATUs. HCPF will require national accreditations for all BHEs with an ATU or CSU endorsement as a condition of enrollment as a HCPF provider under this Demonstration.

IMDs participating under the Demonstration must be enrolled to participate in Health First Colorado to receive reimbursement. MCEs reimburse IMDs as an "in lieu of" service and are only permitted to contract with Health First Colorado screened and enrolled providers. HCPF provider screening and enrollment processes fully comply with 42 CFR Part 455 Subparts B&E.

Processes are also in place to ensure beneficiaries have access to the appropriate levels and types of BH care and to provide oversight on lengths of stay in inpatient and residential settings. Specifically, MCEs conduct utilization reviews for all stays. MCEs are required to use the State's medical necessity criteria and utilization management protocols must be based on nationally recognized tools such as InterQual, MCG, or ASAM.

Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care

The State is committed to improving care coordination and transitions to community-based care through this Demonstration. The State has several strategies and initiatives in place to support serving beneficiaries in community-based settings and intends to expand these efforts during the Demonstration. For example, both psychiatric hospitals and MCEs are responsible for pre-discharge planning. Through licensure rules, hospitals are mandated to initiate timely discharge planning, conduct housing need assessments, and connect members with relevant housing resources. MCEs are contractually required to work with the appropriate treatment providers in their region to transition members from hospitals to safe and alternative step-down environments. HCPF also has an incentive plan for MCEs tied to follow-up appointments within seven days of an inpatient discharge for a mental health condition. Several initiatives are also in place to prevent or decrease ED utilization among beneficiaries with SMI or SED prior to admission, such as the aforementioned statewide crisis response system. Additionally, BH safety net providers are also required to meet state-established standards for care coordination, care management, outreach, education, and engagement.

Several BHA programs also provide care coordination. For example, the Momentum/Transition Services Program provides care coordination to assist children and adults discharging from psychiatric hospitals into the community. Care coordination is typically short-term and assists with connection to longer-term supports to reduce cycling back to inpatient care. Supports available through this program include assistance in securing appropriate housing following inpatient discharge. Additionally, while HCPF and the BHA do not fund housing, they coordinate and partner with the Department of Local Affairs, which manages the housing voucher and all other housing programs in support of programming to assist individuals with BH needs.

As part of ACC Phase III, HCPF aims to improve care coordination and case management within the system by enhancing and standardizing the requirements for MCEs. Key components for care coordination in Phase III will be centered around the following objectives:

- Improve the quality, consistency, and measurability of interventions for care coordination and case management.

- Improve the quality, consistency, and measurability of interventions for health improvement program engagement and the availability of system data insights (claim utilization, member demographics, gaps in care, etc.) that connect member needs with appropriate programs and supports.
- Increase member, provider and key partner awareness and understanding of care coordination and case management services, roles, and responsibilities in relation to other parts of the system.
- Increase equitable access to care coordination and case management.

Relative to BH, stakeholders have recommended alignment of care coordination standards with the BHA. This has led to joint development of a tiered approach to care coordination to be implemented in ACC Phase III. This approach will include levels of coordination that range from short- term supports, condition specific management interventions, and more intensive supports for individuals with more complex or high-risk physical and/or BH conditions.

Additionally, there will be clearer, more explicit requirements within the MCE contracts for transitions of care from acute clinical settings, regardless of tier, with National Council of Quality Assurance Healthcare Effectiveness Data and Information Set measures used for accountability. Creating consistent definitions and expectations will increase accountability for appropriate management of behavioral and physical health by allowing HCPF to use the same metrics to measure the progress of each MCE.

Additionally, as part of ACC Phase III, HCPF intends to implement payment initiatives to further support the availability of care coordination. For example, MCEs will be expected to distribute a portion of their administrative per member per month (PMPM) payments to their PCMP network for collaborating with the MCEs to achieve ACC program goals and for providing delegated care coordination or health improvement program services to members. MCEs will tier their payments to PCMPs based on their capacity to deliver advanced team-based care, such as proactive population health management, health improvement programs, and effective coordination of BH and physical health care. MCEs will also be encouraged to distribute additional payments to community-based organizations and other providers within the health neighborhood to meet members where they are and to address the full range of members' medical and HRSNs.

HCPF has also established an ACC Phase III strategic objective to improve follow-up and engagement in treatment for mental health and SUD by 20 percent and is considering the following incentive payment measures tied to this objective:

- Follow-up after hospitalization for mental illness (seven days)
- Follow-up after ED visit for alcohol and other drug abuse or dependency (seven days)
- Initiation and engagement of SUD treatment

Finally, HCPF will require MCEs to include in their contracts with all IMDs participating in the Demonstration a requirement to follow-up with beneficiaries and community-based providers within 72 hours post discharge.

Milestone 3: Increasing Access to a Continuum of Care

As described above, and reflected in the attached Mental Health Availability Assessment, the State has participated in ongoing, strategic initiatives to increase access to the continuum of BH services. HCPF is committed to continually evolving the capitated BH benefit by either adding new services or improving the MCE contracts and operations to fill gaps in the continuum of care. Gaps can occur for a variety of reasons, including lack of state and/or federal authority to cover a service, provider capacity and availability of certain services, differences in reimbursement models, and MCE processes and procedures. HCPF is working closely with the BHA to identify where critical gaps are occurring within the state network of safety net BH services while identifying the most appropriate potential solutions. As described further below, over the course of the Demonstration, HCPF anticipates implementing payment reforms and administrative activities to reduce barriers to provider participation and increase access across the BH continuum.

As part of ACC Phase III, BH Alternative Payment Models (APM) are being designed in collaboration with the BHA to support the implementation and sustainability of BH safety net providers throughout the state. For Comprehensive Safety Net Providers that will be accountable for delivering the greatest range of services for members, HCPF has designed a cost-based, prospective payment model. This funding arrangement is designed to ensure that Comprehensive Safety Net Providers can provide the full continuum of community-based services to members, even those services that may not be used frequently but are considered essential treatment models, especially for those diagnosed with SMI. Additionally, the State is working to develop APMs for Essential Safety Net Providers that are licensed to provide a more limited scope of services critical to the statewide BH network compared to Comprehensive Safety Net Providers, but still meet BHA standards and serve priority populations.

HCPF will also leverage the MCEs and the flexibility of the capitated BH benefit to expand the provider network. This will include creating new Health First Colorado provider definitions and types that align with the BHA's new licensing strategies, with an emphasis on those providers that can enhance BH service availability and continuity of care. Most of these new provider definitions and types will be linked to the new payment framework to support the long-term sustainability of the BH safety net.

One particular focus for improvements to the provider network is increasing availability of high intensity outpatient services. These high frequency, community-based, member and family-centered services are designed to engage adults and youth with severe mental health and/or substance use conditions in extended and consistent treatment to prevent unnecessary hospitalizations, developmental challenges, involvement in criminal and juvenile justice systems, and/or institutionalization. HCPF and the MCEs have begun work to improve the availability of high intensity outpatient services utilizing ARPA funding. This includes incentives to expand access to intensive outpatient services, assertive community treatment, multisystemic therapy, community psychiatric supportive treatment, and step-down services for people leaving institutions and corrections. For ACC Phase III, HCPF will partner with the MCEs to develop solutions that fill gaps in the continuum of high intensity outpatient services, to improve transitions between levels of care, and to add care levels that better reflect member needs. Using a combination of strategies that includes new payment models, lessons learned from the ARPA project will be leveraged to implement strategies that support the long-term sustainability of these services. Strategies will be designed to encourage existing providers, particularly those working in traditionally underserved areas, to become Health

First Colorado providers, add new services, and expand service availability and quality. The State is also exploring the certified community behavioral health clinic (CCBHC) model and anticipates applying for SAMHSA's CCBHC Planning Grant in 2024.

HCPF is implementing processes to reduce administrative burden faced by providers to allow for more equal participation among different sized practices, especially for independent BH care providers. For example, HCPF is considering strategies to centralize the credentialing process for all BH providers. Currently, providers are credentialed separately by each MCE. In ACC Phase III, providers would be credentialed through a single entity and those credentials would be accepted by each MCE. The goal is to reduce the administrative burden that comes from credentialing with multiple entities to encourage more providers to participate in the ACC.

The Universal Contracting Provisions are another joint project led by the BHA to reduce provider administrative burden and ensure consistency and accountability for BH service delivery. These provisions will define expectations for BH providers and state agencies when contracting for BH services utilizing standardized contract content of expectations for both providers and MCEs around items such as data collection and reporting, access to care, compliance with BH safety net standards, claims submission, and billing procedures. The Universal Contracting Provisions, overseen by the BHA, will be utilized for any provider that is contracted by the State to provide BH services.

Milestone 4: Earlier Identification & Engagement in Treatment

HCPF is committed to earlier identification of serious mental health conditions and focused efforts to engage individuals in treatment sooner. The State has been engaged in several initiatives to advance the integration of physical and BH care. This includes joining the administrative responsibilities for BH and primary care under the MCEs, participation in the State Innovation Models initiative, and implementation of the Six Short-Term Behavioral Health Benefit.

Under this benefit enrollees can receive short-term BH services provided by licensed BH clinicians working as part of a member's PCMP. This model supports the delivery of early interventions in a convenient location to prevent exacerbation of both medical and behavioral conditions.

Additionally, the State Legislature passed House Bill 22-1302 in May 2022 with the goal of supporting, improving, and expanding integrated BH services in the state. Through distribution of funds allocated by ARPA, HCPF received funding for the expansion of integrated BH services in primary care settings. The legislation earmarked $31 million toward the task with the majority of funds going directly to providers to expand access to integrated BH services.

As part of ACC Phase III, HCPF is exploring development of a distinct Integrated Care Benefit. This benefit is intended to align and advance the various efforts to encourage integrated care over the years and would fold in the current Six Short-Term Behavioral Health Benefit. HCPF is currently investigating potential ways to allow reimbursement for standard Current Procedural Terminology code sets often used to support integrated care models, such as the Health and Behavioral codes and/or the Collaborative Care Model service codes. Lessons learned and best practices from implementation of House Bill 12-1302 grant funded pilots will be leveraged in development of this new benefit.

Continuous Eligibility Initiative

The State expects to impact thousands of adults and children with the proposed continuous coverage policies. Colorado expects that together, these two proposed waiver amendment requests will eliminate or substantially reduce gaps in coverage (churn) among young children and adults leaving incarceration due to:

- Small or short-term fluctuations in income
- Incomplete renewal applications and other procedural terminations

Preventing this churn will reduce administrative cost and burden for both the State and Medicaid member, and more importantly, preserve access and promote continuity of care, including BH care. A 2015 cost analysis of national data (2005-2010) estimated that the administrative cost of disenrolling and re-enrolling one person in coverage within a year is between $400 and $600, an amount which would likely be higher today.[22] A detailed description of the background and benefits of the continuous coverage request is found in the overview paper included in the Appendix as Attachment 11.

The State is seeking to implement both continuous coverage requests by January 1, 2026. These continuous coverage requests are contingent on the receipt of FFP to the maximum extent allowed under Federal law.

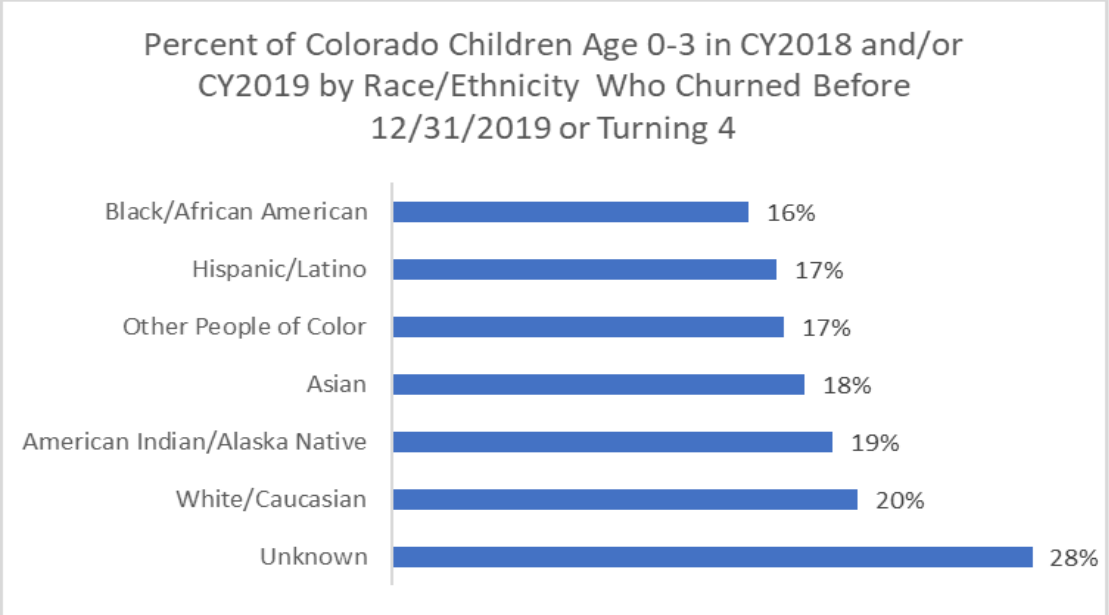
Continuous coverage for children to age three: The State is seeking new federal authority to provide continuous coverage in Medicaid or CHP+ for young children who have incomes below 142 percent Federal Poverty Level (FPL) for Medicaid and 260 percent FPL for CHP+ at the time of application through the end of the month their third birthday falls. A Medicaid or CHIP eligible child shall remain continuously eligible for without regard to changes in family income. The State will act on annual reported family income changes to re-assign children between CHP+ and Medicaid appropriately. Eligibility will continue to be monitored by the State. Children who have moved out of state will not retain coverage. When the family has requested voluntary disenrollment coverage will not be retained.

The State previously adopted the 12-month continuous coverage state plan option for children. While that policy is effective in maintaining coverage during the 12 months between redetermination of Medicaid eligibility, even with a streamlined renewal process, coverage losses at redetermination continue to be an issue for children and families due to change of address, paperwork issues, and other administrative reasons.

An analysis of the State's enrollment data in CY2018 and CY2019 shows that 20 percent of children ages zero to three with eligibility at any time in the two years experienced Medicaid or CHP+ coverage gaps. See Figure 3 below for coverage gaps broken out by race and ethnicity.

[22] Swartz K., Farley Short P., Roempke Graefe D., Uberoi N. (2015) *Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective*. Health Affairs. Retrieved from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

Figure 3: Percent of Colorado Children Age 0-3 in CY2018 and/or CY2019 by Race/Ethnicity Who Churned Before 12/31/2019 or Turning 4



In September of 2022, Oregon received Federal authority from CMS to provide continuous coverage for Medicaid and CHIP enrolled children from zero to age six, regardless of income. In June 2023, Washington received similar authority for continuous coverage for Medicaid enrolled children from zero to age five. The State seeks the same Federal authority to provide continuous coverage with FFP for Medicaid and CHIP enrolled children from birth to age three.

Adults leaving State correctional facilities: Colorado is seeking new federal authority to provide continuous coverage in Medicaid for adults who have been released from a State DOC facility. A Medicaid-eligible adult shall remain continuously eligible for Medicaid without regard to income for a period of 12 months beginning on the date of release. Eligibility will continue to be monitored by the State. Eligible adults who have moved out of state will not retain coverage. When an adult has requested voluntary disenrollment, the State determines eligibility was erroneously granted, or if the individual is deceased coverage will not be retained.

The State has seen recent improvement in engagement in BH services for adults at re-entry. RAEs, that manage BH services and care coordination for Medicaid members, implemented data sharing agreements in 2019 with DOC and Judicial to better support members as they transition from incarceration to the community. These data connections have resulted in higher engagement in BH services (from 9% to 20%) within 14 days of release. Providing continuous coverage will enhance these important gains.

In September 2022, Massachusetts received Federal authority from CMS to provide 12 months of continuous coverage for Medicaid enrolled adults leaving incarceration. The State seeks the same Federal authority to provide continuous coverage with FFP for Medicaid enrolled adults leaving State correctional facilities.

Section II. Demonstration Eligibility

Re-entry Initiative

Suspension of Coverage. As noted above, in the prison system, there is a manual process for moving eligibility from a full Medicaid benefit package to a limited inpatient benefit package. However, in the youth detention facilities, there is no formal process. Colorado is interested in automating the "suspend" functionality for Medicaid members in DOC. In addition, DOC staff will need to increase their timeframe for review of documents to ensure all eligible members are actively enrolled in Medicaid to access 90 day pre-release benefits. DYS staff will need to implement practices to identify Medicaid-eligible youth to ensure access to 90 day pre-release services status with the additional component of notifying the individual of status.

As is required for JI 1115 Demonstrations, HCPF will work to maintain and enhance eligibility processes to ensure individuals who were enrolled in Medicaid at the time they entered the correctional system can have their coverage quickly and easily reinstated as part of pre-release planning, and ensure that for those who were not enrolled in Medicaid when entering the correctional system, the State will improve its eligibility process for Medicaid coverage applicable to all individuals leaving a prison or jail setting, ensuring that individuals receive assistance with completing and submitting an application for Medicaid, unless the individual declines such assistance or wants to decline enrollment.

If an individual who is incarcerated would be eligible for CHIP if not for their incarceration status, and qualify to receive pre-release services, then pre-release services will be covered under this amendment.

Re-entry Demonstration Initiative populations are defined as persons who are enrolled in Medicaid or who would be eligible for CHIP except for their incarceration status, or who are incarcerated in a State prison or juvenile facility who meet the eligibility criteria below. Like Washington, no specific health condition is required for demonstration eligibility. To receive services under the Re-entry Demonstration, a beneficiary will meet the following qualifying criteria:

- Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a State prison or juvenile facility; and
- Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and
- Identified as expected to be released in the next 90 days and identified for participation in the Demonstration.

Individuals deemed a "qualified inmate" will have eligibility determined for the appropriate Medicaid program for which they meet eligibility requirements. For example, if a "qualified inmate" meets the eligibility criteria for the Adult Expansion Medicaid program, then they would be enrolled in that specific Medicaid program.

A "qualified inmate" must meet general Medicaid program requirements. These include:

1. Must be a Colorado resident

2. Must be a U.S. Citizen or qualified alien[23]

3. Must meet the income and asset standards for the applicable Medicaid program

Possible Medicaid programs include, but are not limited to:

1. Temporary Assistance for Needy Families (TANF) or related groups

2. CHIP

3. Aged, Blind or Disabled Medicaid or related groups

4. Adult Expansion Medicaid

The tables below show estimates of the incarcerated population in the State that may be impacted by this Demonstration.

Table 1. Incarcerated Population

Aggregate Releases	Average Daily Population	Annual Releases	Average Length of Stay	Number of Releases estimated to be eligible for Medicaid
Adult Population in 21 State prisons	17,000[24]	5,883	33 months	4,070–5,295
Youth Population in 15 Youth Corrections Facilities	173[25]	242	19.81 days	126–163

Severe Mental Illness Initiative

All enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage would be eligible for stays in an IMD under the Demonstration. Only the eligibility groups outlined in Table 2 below will not be eligible for stays in an IMD as they receive limited Medicaid benefits only.

Table 2: Eligibility Groups Excluded from the Demonstration

Eligibility Group	Social Security Act and CFR Citations
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries	1902(a)(10)(E)(iii)

[23] Medicaid financings for Non-qualified non-citizens reimburses the Emergency Only program pursuant to 2 CFR § 435.139

[24] Colorado Department of Health Care Policy and Financing, Federal Authority to Support Health-Related Re-entry Services for Incarcerated Populations, October 19, 2023, p. 4.

[25] Colorado has a statutory cap on juvenile detention beds. In 2023, the cap was 215. Accessed on 12/18/2023: 2022-2023 Colorado Senate Bill 21-071 Inaugural Analysis Report to Inform Performance Standards and Outcome Measures for Pre-Adjudicated and Adjudicated Youth p. 10.

Eligibility Group	Social Security Act and CFR Citations
Qualified Individual Program	1902(a)(10)(E)(iv)
Qualified Disabled Working Individual Program	1902(a)(10)(E)(ii) 1905(s)
Presumptively Eligible Pregnant Women	1920 42 CFR §435.1103

Continuous Eligibility Initiative

Existing eligibility criteria will continue for each existing program in the SUD waiver.

The populations affected by this amendment request are:

Medicaid and CHP+ enrolled children aged zero to three. The State is seeking to ensure continuous Health First Colorado coverage for children during the first three years of their lives. The State covers Health First Colorado children up to 142 percent FPL with Medicaid funds and up to 260 percent FPL with CHIP funds through the Child Health Plan Plus. The proposed continuous enrollment policy will apply to Medicaid-enrolled children with incomes up to 142 percent FPL, CHP+ children with incomes up to 260 percent FPL, and children who would be eligible for medical assistance coverage but lack a qualifying immigration status. The State estimates that in 2019 there were 43,984 children who lost eligibility or had a gap in eligibility before December 31, 2019, or before they turned 4. The continuous enrollment initiative would have prevented these children from churning off coverage. On average 31,000 young children will receive continuous coverage through this initiative.

Medicaid enrolled adults leaving State DOC. The State is seeking to ensure 12 months continuous Health First Colorado coverage for adults aged 19 to 65 beginning the day they leave a corrections facility. The State covers Health First Colorado adults up to 138% FPL who do not qualify for Medicare. It is estimated that approximately 31,000 Colorado residents are incarcerated in local jails, federal and state prisons, and other criminal justice facilities. As of 2023, there were over 17,000 individuals incarcerated in 21 state prisons. The average stay in state prisons is 33 months, and over 94% of prisoners are male. There are approximately 5,883 releases per year, with 4,070–5,295 of those released are likely eligible for Medicaid.

Table 3: Continuous Eligibility Criteria

Existing Eligibility Criteria	Federal Regulation Citation	Income level
Medicaid and CHP+ enrolled children aged zero to three	42 CFR 457.310 42 CFR 435.916	260 FPL
Medicaid enrolled adults aged 19 to 65 leaving State DOC	42 CFR 435.916	138 FPL

Section III. Demonstration Benefits and Cost-Sharing Requirements

Re-entry Initiative

The pre-release services authorized under the Re-entry Demonstration Initiative include the provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. All facilities must implement the three required minimum services listed below. The State may begin claiming FFP for services covered through the initiative, expected to begin on or after July 1, 2024, once the implementation plan is approved by CMS. Cost-sharing requirements will not differ from those provided under the State Plan.

The minimum benefit package for pre-release coverage includes:

- Re-entry transitional case management services to assess and address physical and BH needs and HRSN;
- MAT, for all Food and Drug Administration (FDA)-approved medications, including coverage for counseling; and
- Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) provided to the individual immediately upon release from the correctional facility

The Re-entry Demonstration Initiative implementation plan will describe the implementation settings and the time period that pre-release services are available.

Table 4. Service Definitions for the Re-entry Demonstration Initiative

Covered Service	Definition
Service Level One	
Re-entry Transitional Case Management (RTCM)	RTCM will be provided in the period up to 90 days immediately prior to the expected date of release and is intended to facilitate re-entry planning into the community to: • Support the coordination of services delivered during the pre-release period and upon re-entry; • Ensure smooth linkages to social services and support; and • Ensure the arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community. Services will include: — Conducting a health risk assessment, as appropriate; — Assessing the needs of the individual to inform development, with the client, of a discharge/re-entry person-centered care plan, with input from the clinician providing consultation services and the correctional system's re-entry planning team:

Covered Service	Definition
	• While the re-entry transitional person-centered care plan is created in the pre-release period and is part of the case management pre-release service to assess and address physical and BH needs and HRSN identified, the scope of the plan extends beyond release; — Obtaining informed consent, when needed, to furnish services and/or to share information with other entities to improve coordination of care; — Providing warm linkages with designated care managers (including potentially a care management provider, for which all individuals eligible for pre-release services will be eligible) upon re-entry. • Ensuring that necessary appointments with physical and BH care providers, including, as relevant to care needs, with BH coordinators and providers, are arranged; • Making warm linkages to community-based services and supports, including, but not limited to educational, social, prevocational, vocational, housing, nutritional, transportation, childcare, child development, and mutual aid support groups; • Providing a warm hand-off, as appropriate, to post-release case managers who will provide services under the Medicaid State Plan or other waiver or Demonstration authority; • Ensuring that, as allowed under federal and state laws and through consent with the beneficiary, data are shared and, as relevant, to physical and BH providers to enable timely and seamless hand-offs; • Conducting follow-up with community-based providers to ensure engagement was made with individual and community-based providers as soon as possible and no later than 30 days from release; and • Conducting follow-up with the individual to ensure engagement with community-based providers, BH services, and other aspects of discharge/re-entry planning, as necessary, no later than 30 days from release.
MAT	• MAT for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Act (42 U.S.C. 262) to treat OUDs as authorized by the Social Security Act Section 1905(a)(29). • MAT for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders includes all FDA-approved drugs and services to treat AUD and other SUDs. • Psychosocial services delivered in conjunction with MAT for OUD as covered in the State Plan 1905(a)(29) MAT benefit, and MAT for AUD and Non-Opioid Substance Use Disorders as covered in the State Plan 1905(a)(13) rehabilitation benefit, including assessment; individual/group counseling; patient education; prescribing,

Covered Service	Definition
	administering, dispensing, ordering, monitoring, and/or managing MAT. Services in the correctional system may be provided by professionals/programs that are not Medicaid-certified providers as otherwise required under the State Plan for the provision of the MAT benefit.
Services Provided Upon Release	Services provided upon release include: • Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with approved Medicaid State Plan).

Section IV. Delivery System

Re-entry Initiative

Colorado will deliver non-behavioral health medical services, pharmacy and MAT benefits through the fee-for-service (FFS) delivery system. All other behavioral health services will be delivered through the capitated behavioral health program.

The pre-release services will be provided in the State prisons and juvenile correctional facilities, or outside of the correctional system with appropriate transportation and security oversight provided by the carceral facility, subject to State approval of a facility's readiness, according to the implementation schedule.

Participating practitioners, including licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under the State scope of practice statutes, will provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws. Participating practitioners eligible to deliver services under the Re-entry Demonstration Initiative may be either community-based or correctional-facility-based providers. All participating providers, practitioners, and staff, including carceral practitioners, will have the necessary experience and receive appropriate training, as applicable to a given carceral facility, prior to furnishing Demonstration-covered pre-release services under the Re-entry Demonstration Initiative. Participating providers of re-entry case management services may be community-based or carceral providers who have expertise working with JI individuals who are enrolled in Medicaid.

Severe Mental Illness Initiative

All cost-sharing for services provided through this Demonstration will be consistent with the Medicaid State Plan applicable to a member's specific eligibility category. No modifications are proposed through this amendment.

As previously described, the State operates a capitated managed care structure for the delivery of BH benefits. IMD stays under the Demonstration will be reimbursed by the MCEs and will be considered in the capitation rate setting process.

Through the Demonstration, HCPF will reimburse for clinically appropriate short-term inpatient and residential stays for acute psychiatric care. All services will be subject to medical necessity.

This amendment incorporates feedback from stakeholders that requests HCPF seeks authority to reimburse for stays up to 60 days while maintaining an average length of stay (ALOS) of 30 days, pending legislative budget action.

Continuous Eligibility Initiative

Benefits provided under this amendment request will not differ from those provided under the Medicaid State Plan. Also, the cost-sharing requirements will not differ from those provided under the Medicaid State Plan.

The State is not seeking any changes to the existing Health First Colorado delivery systems. Health First Colorado and CHP+ enrollees will continue to access care through delivery systems defined in the State Plan and other waivers in place. These delivery systems include ACC that has served as the core vehicle for delivering and managing member care in Medicaid, and fully capitated managed care organizations in CHP+. All full-benefit Health First Colorado members are enrolled in the ACC except for members enrolled in the Program for All Inclusive Care for the Elderly. The ACC integrates managed FFS physical health care and managed care for BH through RAEs.

Section V. Implementation and Enrollment in Demonstration

Re-entry Initiative

The State intends to implement the Demonstration with the Department of Correction (DOC) (state prison and jail system) and with the Judicial Branch Court Support Services Division which operates juvenile and community residential centers, as a process is already in place for expedited Medicaid eligibility for individuals discharging from state prison within 90-days of their release date.

Delivery of pre-release services under this Demonstration will be implemented using a phased-in approach, as described below. All participating State prisons and juvenile correctional facilities, must demonstrate readiness, as specified below, prior to participating in this initiative. (FFP will not be available on expenditures for services furnished to qualifying beneficiaries who are incarcerated in a facility before the facility meets the readiness criteria for participation outlined below). Colorado's juvenile correctional facilities will have the services identified above reimbursed under the Demonstration and an accompanying State Plan Amendment to cover State Plan services for certain JI youth pursuant to the Consolidated Appropriations Act, 2023 by January 1, 2025. HCPF will determine when each applicable facility is ready to participate in the Re-entry Demonstration

Initiative based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

1. Pre-release Medicaid and CHIP application and enrollment processes for individuals who are not enrolled in Medicaid or CHIP prior to incarceration and who do not otherwise become enrolled during incarceration;
2. The screening process to determine a beneficiary's qualification for pre-release services;
3. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. If a facility is not equipped to provide or facilitate the full set of pre-release services, the facility must provide a timeline of when it will be equipped to do so, including concrete steps and its anticipated completion dates that will be necessary to ensure that qualifying beneficiaries are able to receive timely any needed pre-release services;
4. Coordination among partners with a role in furnishing health care, housing, and HRSN services to beneficiaries, including, but not limited to, State agencies and State-contracted providers, as well as administrative services organizations, other BH agencies, and community-based providers, including Federally Qualified Health Centers;
5. Appropriate re-entry planning, pre-release care management, and assistance with care transitions to the community, including connecting beneficiaries to physical and BH providers and the administrative services organizations, and making referrals to care management and community support providers that take place throughout the 90-day pre-release period, and providing beneficiaries with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan);
6. Operational approaches related to implementing certain Medicaid and CHIP requirements, including, but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Re-entry Demonstration Initiative;
7. A data exchange process to support the care coordination and transition activities;
8. Reporting of requested data from HCPF to support program monitoring, evaluation, and oversight; and
9. A staffing and project management approach for supporting all aspects of the facility's participation in the Re-entry Demonstration Initiative, including information on the qualifications of the providers that the correctional system will partner with for the provision of pre-release services.

Continuous Eligibility Initiative

The State is seeking to implement continuous coverage requests by January 1, 2026, with the assumption that there may be a phased-in approach and a ramp up of continuous enrollment of individuals over the course of the demonstration.

These continuous eligibility requests are contingent on the receipt of FFP to the maximum extent allowed under Federal law.

Section VII. Proposed Waiver and Expenditure Authorities

Re-entry Initiative

The State seeks the following waiver authority as necessary under the Demonstration to receive a federal match on costs not otherwise matchable for services rendered to individuals who are incarcerated 90 days prior to their release. The State also requests the following proposed waivers authority to operate the Demonstration.

Table 5: Proposed Waivers Authority

Waiver Authority	Reason and use of Waiver Authority will enable the State to:
Statewide Section 1902(a)(1) 42 CFR 431.50	To enable the State to provide pre-release services, as authorized under this Demonstration, to qualifying beneficiaries on a geographically limited basis according to the statewide implementation phase-in plan, in accordance with the Re-entry Demonstration Initiative implementation plan.
Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) and 1902(a)(17)	To enable the State to provide only a limited set of pre-release services, as specified in these STCs, to qualifying beneficiaries that are different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the State Plan or the Demonstration.
Freedom of Choice Section 1902(a)(23)(A) 42 CFR 431.51	To enable the State to require qualifying beneficiaries to receive pre-release services, as authorized under this Demonstration, through only certain providers.
Requirements for Providers under the Medicaid State Plan Section 1902(a)(27) and 1902(a)(78)	To enable the State to not require carceral providers to enroll in State Medicaid, in order to provide, order, refer, or prescribe pre-release services as authorized under this Demonstration.
Title XXI Requirements Not Applicable to the Title XXI Expenditure Authority Above Requirements for Providers Under the State Plan Section 2107(e)(1)(D)	To enable the State to not require carceral providers to enroll in State CHIP, in order to provide, order, refer, or prescribe pre-release services as authorized under this Demonstration.

Expenditure Authority

The State requests expenditure authority to provide Medicaid benefits to Demonstration eligible individuals.

Table 6: Expenditure Authority Pre-Release Services

Title XIX Expenditure Authority	Expenditures
Expenditures Related to Pre-Release Services	Expenditures for pre-release services, as described in these STCs, are provided to qualifying Medicaid beneficiaries and beneficiaries who would be eligible for Medicaid if not for their incarceration status for up to 90 days immediately prior to the expected date of release from a participating State prison or juvenile facility.
Expenditures for Allowable Administrative Costs to Support the Implementation of Pre-Release Services	Expenditures for allowable administrative costs to support the implementation of pre-release services as outlined in the April 17, 2023, SMD letter #23-003 relating to administrative information technology (IT) and transitional, non-service expenditures, including administrative costs under an approved cost allocation plan.

Title XXI Expenditure Authority	Expenditures
Expenditures Related to Pre-Release Services	Expenditures for pre-release services, as described in the STCs, are provided to qualifying Demonstration beneficiaries who would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating State prison or juvenile facility.

Severe Mental Illness Initiative

The State requests expenditure authority to provide Medicaid benefits to Demonstration eligible individuals.

Table 7: Expenditure Authority Severe Mental Illness

Title XIX Expenditure Authority	Expenditures
Expenditures Related to IMD services	Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals, who are primarily receiving treatment for an SMI/SED who are short-term residents in facilities that meet the definition of an IMD.

Continuous Eligibility Initiative

The State requests expenditure authority to provide Medicaid benefits to Demonstration eligible individuals.

Table 8: Expenditure Authority Continuous Coverage

Waiver Authority	Reason and use of Waiver Authority will enable the State to:
Section 1902(a) to the extent it incorporates 42 CFR 435.916 42 CFR 457.343 Waive redetermination of eligibility regardless of changes in circumstances for children aged zero until age three.	To enable the State to waive the annual redetermination requirements, including required procedures for reporting and acting on changes that would completely disenroll a children aged zero until age three from Medicaid and CHP+ (other than a change in residence to out of state, voluntary disenrollment, erroneously granted enrollment). The State will act on annual reported family income changes to re-assign children between Medicaid and CHP+ appropriately. Continuous enrollment for children at the time of application through the end of the month their third birthday falls.
Section 1902(a) to the extent it incorporates 42 CFR 435.916 Waive redetermination of eligibility regardless of changes in circumstances for 12 months prior the release from correctional facilities for adults aged 19 and over.	To enable the State to waive the annual redetermination requirements, including required procedures for reporting and acting on changes to would completely disenroll an adult. 12 Month Continuous Eligibility for adults leaving incarceration age 19 and over.

Title XIX Expenditure Authority	Expenditures
Continuous enrollment for children at the time of application through the end of the month their third birthday falls.	Expenditures for continuous enrollment for Medicaid and CHIP children: authority to receive FFP for the continuous enrollment of Medicaid and CHIP children, even if a child's family income exceeds eligibility limits. The State will act on annual reported family income changes to re-assign children between CHP+ and Medicaid appropriately.
12 Month continuous enrollment for adults leaving incarceration age 19 and over.	Expenditures for 12 months of continuous enrollment for adults leaving incarceration aged 19 and over.

Section VI. Demonstration Financing and Budget Neutrality

Budget Neutrality — Caseload and Expenditure Estimates

Refer to Budget Neutrality — Attachment 1 for the State's historical and projected expenditures for the requested period of the Demonstration.

The State proposes to finance the non-federal share of expenditures under this request using State general funds and existing hospital provider fees approved by CMS that have been in place since 2014 to support the funding of expansion populations. Expenditures under this amendment will be treated as hypothetical or "pass-through" for the purposes of budget neutrality.

The following presents the State, HCPF projected caseload and expenditures. Table 9 presents the current demonstration periods; Table 10 presents the proposed Amendment demonstration periods.

Table 9: Current Demonstration Periods

Demonstration Year	DY1	DY2	DY3	DY4	DY5
Begin Date	1/1/2021	1/1/2022	1/1/2023	1/1/2024	1/1/2025
End Date	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025

Table 10: Amendment Demonstration Periods

Demonstration Year	DY5	DY6	DY7	DY8	DY9
Begin Date	1/1/2025	1/1/2026	1/1/2027	1/1/2028	1/1/2029
End Date	12/31/2025	12/31/2026	12/31/2027	12/31/2028	12/31/2029

Table 11 illustrates the demonstration amendment proposals and effective dates. This proposed demonstration amendment will not reduce or negatively impact current Medicaid enrollment. The proposed demonstration amendment will not negatively impact the State's CHIP Allotment.

Table 11: Demonstration Proposal Effective Dates

Demonstration Proposals	Effective Date
FFP for up to 60 days of care in an IMD for non-substance use disorder for adults between 18 to 64 years old.	July 1, 2025

Demonstration Proposals	Effective Date
	(six-months of DY5)
Re-entry Transitional Case Management, Medication Assisted Treatment, and 30-days medication in hand upon release from a juvenile institution facility or DOC facility.	July 1, 2025 (six-months of DY5)
Allow for an eligible child (under the age of 18) who is less than three years of age to remain continuously eligible for Medicaid or CHP+ without regard to a change in household income until the child reaches three years of age.	January 1, 2026 (DY6)
Continuous coverage for eligible individuals released from a DOC facility for a period of one year beginning on the date of the individual's release.	January 1, 2026 (DY6)

Tables 12 through 15 presents information by proposed Medicaid Eligibility Group (MEG) for the estimated caseload(member months), as well as projected per capita and total expenditures (total computable) for each proposed amendment. The proposed demonstration will increase the annual enrollment for each of the populations included in the demonstration proposals.

HCPF makes the following assumptions regarding budget neutrality:

- HCPF proposes a per capita budget neutrality model for the populations covered under the demonstration amendment;
- State administrative costs are not subject to the budget neutrality calculations;
- Since the proposed demonstration amendment expenditures are "hypothetical" there are no projected savings, and the without-waiver and with-waiver per capita amounts are equal;
- Nothing in this demonstration application precludes HCFP from applying for enhanced Medicaid funding as CMS issues new opportunities or policies; and
- The budget neutrality agreement is in terms of total computable so that HCPF is not adversely affected by future changes to federal medical assistance percentages.

Table 12: Caseload and Total Computable Expenditure Projections (Hypothetical Expenditures)- Severe Mental Illness

Demonstration Proposal: Federal Financial Participation (FFP) for up to 60 days for non-SUD IMD stays– Effective July 1, 2025 (six-months of DY5)

The state does not currently receive FFP for non-SUD IMD stays that exceed 15 days. This demonstration proposal will enable the state to receive FFP for up to 60 days while maintaining an average length of stay of 30 days. The following table includes the estimated

number of member months (months of eligibility) for each MEG impacted by the demonstration proposal over the five-year demonstration period.

	DY5	DY6	DY7	DY8	DY9
MEG 3 - Non-Expansion Adults					
Demonstration Member Months	4	8	9	9	9
Per Capita (PMPM)	$39.79	$41.87	$44.01	$46.25	$48.61
Projected Demonstration Expenditures	$166	$353	$375	$398	$423
MEG 4 - Expansion Adults					
Demonstration Member Months	53	107	108	109	111
Per Capita (PMPM)	$56.78	$59.98	$63.04	$66.26	$69.63
Projected Demonstration Expenditures	$3,016	$6,437	$6,832	$7,253	$7,699
Demonstration Proposal Enrollment, Per Capita and Expenditure Projection Notes: *1) DY5 represents a 12-month period between 1/1/2025 – 12/31/2025; however, IMD services begin 7/1/2025. The DY5 PMPM represents a six-month period.* *2) The non-SUD IMD services for up to 60 days will be covered by the behavioral health capitated program. All other services covered via fee-for-service (FFS). The per capita reflects the weighted average of the BH rate impact plus the FFS expenditures in the month the individual is inpatient in a non-SUD IMD.*					

Demonstration Proposal: Pre-release Services for Individuals Prior to Release from Juvenile facility or Colorado Department of Corrections – Effective July 1, 2025 (six-months of DY5)

The state does not reimburse for medical services for individuals (juveniles and adults) incarcerated in correctional centers. This demonstration proposal will enable the state to provide a targeted package of services 90-days prior to the individual's release from a juvenile or DOC facility. The following table includes the estimated increase in the number of member months (months of eligibility) for each MEG impacted by the demonstration proposal over the five-year demonstration period. Additionally, this demonstration proposal includes a request for administrative expenditures to support information and technology.

Table 13: Caseload and Total Computable Expenditure Projections (Hypothetical Expenditures)- Pre-Release Services

	DY5	DY6	DY7	DY8	DY9
MEG 5 –Justice-Involved Youth					
Demonstration Member Months	79	80	81	82	83
Per Capita (PMPM)	$896.59	$942.32	$990.38	$1,040.89	$1,093.97
Projected Demonstration Expenditures	$70,831	$75,386	$80,221	$85,353	$90,800

MEG 6 - Non-Expansion Adults					
Demonstration Member Months	276	279	282	285	288
Per Capita (PMPM)	$886.52	$931.73	$979.25	$1,029.19	$1,081.68
Projected Demonstration Expenditures	$244,678	$259,952	$276,147	$293,318	$311,523
MEG 7 - Expansion Adults					
Demonstration Member Months	7,812	7,890	7,969	8,049	8,129
Per Capita (PMPM)	$934.30	$981.95	$1,032.02	$1,084.66	$1,139.98
Projected Demonstration Expenditures	$7,298,723	$7,747,550	$8,224,205	$8,730,412	$9,266,861
Administrative Information Technology – Total Computable Aggregate Annual Limits					
Admin/FTE Costs (50% FFP)	$320,000	$475,000	$551,500	$578,000	$636,000
Systems Costs (90/10 or 75/25 FFP)	$550,000	$110,000	$27,500	$27,500	$27,500
Total Administration Costs	**$870,000**	**$585,000**	**$579,000**	**$605,500**	**$663,500**
Demonstration Proposal Enrollment, Per Capita and Expenditure Projection Notes: *1) DY5 represents a 12-month period between 1/1/2025 – 12/31/2025; however, pre-release services begin 7/1/2025. The DY5 PMPM represents a six-month period.* *2) As developed, pre-release services will be provided through fee-for-service.*					

Demonstration Proposal: Continuous Eligibility for Children (Under age 18) who are less than 3 years old – Effective January 1, 2026 (DY6)

This demonstration proposal will expand Medicaid eligibility to provide uninterrupted coverage for all children who are less than 3 years old. A non-material number of youth are expected to be in CHIP. The following table includes the estimated number of member months (months of eligibility) for each MEG impacted by the demonstration proposal over the five-year demonstration period.

Table 14: Caseload and Total Computable Expenditure Projections (Hypothetical Expenditures)- Continuous Eligibility for Children who are less than 3 years old

	DY5	DY6	DY7	DY8	DY9
MEG 8 – Medicaid Children					
Demonstration Member Months	n/a	535,475	540,830	546,238	551,700
Per Capita (PMPM)	n/a	$317.26	$333.44	$350.44	$368.32
Projected Demonstration Expenditures	n/a	$169,883,723	$180,333,270	$191,425,570	$203,200,157

Demonstration Proposal Enrollment, Per Capita and Expenditure Projection Notes:
1) Continuous coverage begins January 1, 2026 (DY6).

Demonstration Proposal: Continuous Coverage for Eligible Individuals Released from a Department of Corrections (DOC) facility for a period of 1 year beginning on the date of the individual's release – Effective January 1, 2026 (DY6)

This demonstration proposal will expand Medicaid eligibility to provide uninterrupted coverage for a period of one year for Medicaid eligible individuals following release from a juvenile or DOC facility. The populations included in this demonstration proposal include Medicaid children, non-expansion adults, and expansion adults. A non-material number of Medicaid children are expected to be in CHIP. The following table includes the estimated number of member months (months of eligibility) for each MEG impacted by the demonstration proposal over the five-year demonstration period. Additionally, this demonstration proposal includes a request for administrative expenditures to support information and technology.

Table 15: Caseload and Total Computable Expenditure Projections (Hypothetical Expenditures)- Continuous Eligibility for Individuals Released from DOC

	DY5	DY6	DY7	DY8	DY9
MEG 9 –Justice-Involved Youth					
Demonstration Member Months	n/a	302	439	443	448
Per Capita (PMPM)	n/a	$698.49	$734.12	$771.56	$810.91
Projected Demonstration Expenditures	n/a	$210,945	$322,292	$342,117	$363,160
MEG 10 - Non-Expansion Adults					
Demonstration Member Months	n/a	762	1,055	1,065	1,076
Per Capita (PMPM)	n/a	$1,752.55	$1,841.93	$1,935.87	$2,034.60
Projected Demonstration Expenditures	n/a	$1,335,445	$1,942,539	$2,062,025	$2,188,860
MEG 11 - Expansion Adults					
Demonstration Member Months	n/a	23,368	31,791	32,109	32,430
Per Capita (PMPM)	n/a	$182.90	$192.23	$202.03	$212.34
Projected Demonstration Expenditures	n/a	$4,274,080	$6,111,160	$6,487,057	$6,886,076
Administrative Information Technology – Total Computable Aggregate Annual Limits					

Admin/FTE Costs (50% FFP)	$1,200,000	$1,386,000	$1,524,500	$1,677,000	$1,845,000
Systems Costs (90/10 or 75/25 FFP)	$1,100,000	$220,000	$55,000	$55,000	$55,000
Total Administration Costs	**$2,300,000**	**$1,606,000**	**$1,579,500**	**$1,732,000**	**$1,900,000**

Impact on Enrollment

The proposed demonstration will impact the annual enrollment for each of the populations included in the demonstration proposals. Enrollment projections are shown through tables 12 through 15 through estimated number of member months (months of eligibility) for each MEG impacted by the demonstration proposal over the five-year demonstration period. Table 16 below shows enrollment projections by individual member.

Table 16: Estimated Annual Enrollment:

Demonstration	Medicaid Expansion Group	DY5	DY6	DY7	DY8	DY9
Severe Mental Illness	MEG 3 - Non-Expansion Adults	4	7	7	7	7
	MEG 4 - Expansion Adults	44	89	90	91	92
Pre-Release Services	MEG 5 - Justice-Involved Youth	26	27	27	27	28
	MEG 6 - Non-Expansion Adults	92	93	94	95	96
	MEG 7 - Expansion Adults	2,604	2,630	2,656	2,683	2,710
Continuous Eligibility for Children who are less than 3 years old	MEG 8 - Medicaid Children	-	64,339	64,982	65,632	66,288
Continuous Eligibility for Individuals Released from DOC	MEG 9 - Justice-Involved Youth	-	32	46	47	47
	MEG 10 - Non-Expansion Adults	-	101	140	141	142
	MEG 11 - Expansion Adults	-	2,812	3,825	3,863	3,902

Capped Hypothetical Administration for Re-Entry

Administrative costs that the State may need to facilitate and support data interoperability between the Medicaid Agency and carceral facilities to support the Medicaid billing and reporting requirements associated with this initiative are separately included in the estimated total computable cost. There are additional funding opportunities under this demonstration initiative to help the State establish IT with participating carceral facilities. This administrative funding will be included in the budget neutrality as a capped hypothetical expenditure and is subject to state share in accordance with federal financial requirements. According to the SMD guidance, CMS is permitting broad flexibility in State identification of IT/infrastructure needs, at enhanced FFP rates (i.e., 90/10 or 75/25) for certain administrative activities. The State is including administrative changes needed to support the

provision of demonstration re-entry services. Estimates of potential State administrative needs and associated costs are similar to the CMS approved $1.85 billion in California and $300 million in Washington for administrative IT/infrastructure (separate from the costs authorized for the actual re-entry benefit).

Table 17: Capped Hypothetical Administration for Re-Entry

MEG	Expenditure Type	Total Spending	Test	DY5	DY6	DY7
MEG 12 JI Non-Services	Total Expenditure	$300,000,000	Agg. Capped Hypothetical	$120 million	$105 million	$75 million

Overall Budget Neutrality Summary

Member Months under the Amendment*	DY5	DY6	DY7	DY8	DY9
MEG 3 – SMI Non-Expansion Adults	4	8	9	9	9
MEG 4 – SMI Expansion Adults	53	107	108	109	111
MEG 5 – JI Youth	79	80	81	82	83
MEG 6 – JI Non-Expansion Adults	276	279	282	285	288
MEG 7 – JI Expansion Adults	7,812	7,890	7,969	8,049	8,129
MEG 8 – CC Medicaid Children	n/a	535,475	540,830	546,238	551,700
MEG 9 – JI CC Youth	n/a	302	439	443	448
MEG 10 – JI CC Non-Expansion Adults	n/a	762	1,055	1,065	1,076
MEG 11 – JI CC Expansion Adults	n/a	23,368	31,791	32,109	32,430
Total projected member months under the Amendment	8,208	568,240	582,531	588,356	594,240
Projected Services Costs under the Amendment**	**DY5**	**DY6**	**DY7**	**DY8**	**DY9**
MEG 3 – SMI Non-Expansion Adults	$166	$353	$375	$398	$423
MEG 4 – SMI Expansion Adults	$3,016	$6,437	$6,832	$7,253	$7,699
MEG 5 – JI Youth	$88,430	$94,117	$100,153	$106,560	$113,361
MEG 6 – JI Non-Expansion Adults	$308,472	$327,728	$348,146	$369,794	$392,744
MEG 7 – JI Expansion Adults	$9,182,426	$9,747,089	$10,346,762	$10,983,615	$11,658,514
MEG 8 – CC Medicaid Children	n/a	$169,883,723	$180,333,270	$191,425,570	$203,200,157
MEG 9 – JI CC Youth	n/a	$210,945	$322,292	$342,117	$363,160
MEG 10 – JI CC Non-Expansion Adults	n/a	$1,335,445	$1,942,539	$2,062,025	$2,188,860
MEG 11 – JI CC Expansion Adults	n/a	$4,274,080	$6,111,160	$6,487,057	$6,886,076
MEG 12 – JI Non-Services	$120,000,000	$105,000,000	$75,000,000		
Total Projected Cost	$129,581,634	$290,878,023	$274,509,519	$211,782,255	$224,808,729

*Using a 1% caseload growth rate; SMI/SED and Re-Entry Initiative effective July 1, 2025 (six-months of (DY5)); Continuous eligibility effective January 1, 2026 (DY6)
**Using a 5.1% trend rate; SMI/SED and Re-Entry Initiative effective July 1, 2025 (six-months of (DY5)); Continuous eligibility effective January 1, 2026 (DY6)

SMI CHIP Allotment

This requirement is not applicable to this amendment request, as the amendment does not make any changes to the CHIP program.

SMI Maintenance of Effort

In accordance with the November 13, 2018, CMS State Medicaid Director Letter, HCPF understands the IMD Demonstration is subject to a maintenance of effort (MOE) requirement to ensure the authority for more flexible inpatient treatment does not reduce the availability of community-based BH services. Table 17 details the SFY2022–SFY2023 outpatient BH expenditures by delivery system and funding source. Of note, these expenditures do not include adjustments for the SUD risk corridor or medical loss ratio reconciliations. As the exact reconciliation amounts are not yet known, an estimate is also provided in Table 18 based on SFY2021–SFY2022 reconciliations.

Table 18: SFY2022-SFY2023 Outpatient BH Expenditures Without Reconciliations

Item	Total Dollars	Federal Dollars	State Dollars
Medicaid BH Capitations	$916,440,539	$659,547,872	$256,892,667
Medicaid BH FFS	$21,816,098	$15,093,440	$6,722,658
CHP+ Capitations	$4,201,059	$2,840,564	$1,360,495
Total	$942,457,696	$677,481,876	$264,975,820

Table 19: SFY2022-SFY2023 Outpatient BH Expenditures with Estimated Reconciliations

Item	Total Dollars	Federal Dollars	State Dollars
Medicaid BH Capitations	$830,079,676	$597,395,314	$232,684,362
Medicaid BH FFS	$21,816,098	$15,093,440	$6,722,658
CHP+ Capitations	$4,201,059	$2,840,564	$1,360,495
Total	$856,096,833	$615,329,318	$240,767,515

The State is committed to maintaining or improving access to community-based BH services and intends for IMD services to compliment but not replace outpatient services. However, the following caveats are considerations for measuring MOE based strictly on total expenditures:

- Unpredictable State budgets may impact the amount of funding available for services.
- The State may pursue programmatic changes over the course of the Demonstration that may impact expenditures.

- As the State transitions to more value-based reimbursement, costs may decline slightly without any loss of access or quality.

Re-entry Demonstration Initiative Reinvestment

To the extent that the Re-entry Demonstration Initiative covers services that are the responsibility of and were previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries, the State will reinvest all new federal dollars, equivalent to the amount of FFP projected to be received for such services, as further defined in the Re-entry Demonstration Initiative Reinvestment Plan submitted consistent with the terms and conditions of the Demonstration. The Reinvestment Plan will define the amount of reinvestment required over the term of the Demonstration, based on an assessment of the number of projected expenditures for which reinvestment is required. FFP projected to be expended for new services covered under the Re-entry Demonstration Initiative, defined as services not previously provided or paid by the carceral facility or carceral authority with custody of qualifying beneficiaries before the individual facility implemented the Re-entry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Re-entry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in the Re-entry Demonstration Initiative Reinvestment Plan), is not required to be reinvested.

Within 120 days of approval, the State will submit a Re-entry Demonstration Initiative Reinvestment Plan, as part of the required implementation plan for CMS approval, which memorializes the State's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the Demonstration period. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, will be made throughout the Demonstration period. Allowable reinvestments include, but are not limited to:

- The State share of funding associated with new services covered under the Re-entry Demonstration Initiative;
- Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the HRSN of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated BH conditions;
- Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Re-entry Demonstration Initiative opportunity;
- Improved health IT and data sharing;
- Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, JI individuals or individuals at risk of justice involvement;
- Expanded or enhanced community-based services and supports, including services and supports to meet the HRSN of the JI population; and
- Any other investments that aim to support re-entry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health

of the JI population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

Section VIII. Demonstration Hypotheses and Evaluation

Re-entry Initiative

With the help of the independent evaluator, the State will amend the approved SUD evaluation plan for evaluating the hypotheses indicated below. Colorado will calculate and report all performance measures under the Demonstration. The State will submit the updated SUD evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this Demonstration related to the five Re-Entry milestones as required in CMS guidance and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

By providing Medicaid coverage prior to an individual's release from incarceration, the State will be able to bridge relationships between community-based Medicaid providers and JI populations prior to release, thereby improving the likelihood that individuals with a history of behavioral health conditions and/or chronic diseases will receive stable and continuous care. The following hypotheses and goals will be tested during the approval period:

Hypotheses: The full 90-day timeline will enable the State to support pre-release identification, stabilization, and management of certain serious physical and behavioral health conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) which could reduce post-release acute care utilization.

By allowing early interventions to occur in the full 90-day period immediately prior to expected release, such as for certain BH conditions and including stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, the State expects that it will be able to reduce decompensation, suicide-related deaths, overdoses, and overdose-related deaths in the near-term post-release.

Questions: The State will test, and comprehensively evaluate through robust hypothesis testing, the effectiveness of the extended full 90-day coverage period before the beneficiary's expected date of release on achieving the articulated goals of the initiative:

- Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;
- Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during re-entry;

- Improve coordination and communication between correctional systems, Medicaid systems, administrative services organizations, and community-based providers;
- Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;
- Improve connections between carceral settings and community services upon release to address physical health, BH, and HRSN;
- Reduce all-cause deaths in the near-term post-release; and
- Reduce the number of ED visits and inpatient hospitalizations among recently released Medicaid beneficiaries through increased receipt of preventive and routine physical and BH care.

Data Source: Claims/encounter data.

Evaluation Design: Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons and interrupted time series analysis.

Severe Mental Illness Initiative

The State's Independent Evaluator will work with CMS to amend the Demonstration evaluation design. Below are proposed hypotheses for this initiative. The specific evaluation methodology will be submitted with the updated Evaluation Design upon approval of the amendment.

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Goal 1: Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.		
The demonstration will result in reductions in utilization and length of stays in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment.	• Does the demonstration result in reductions in utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings? • How does the demonstration effect utilization reduction and lengths of stay in EDs among Medicaid beneficiaries with SMI/SED by geographic area or beneficiary characteristics? • How do demonstration activities contribute to reductions in utilization and lengths of stays in EDs among	Data Sources: • Claims data • Medical or administrative records • Interviews or focus groups Analytic Approach: • Difference-in- differences model • Subgroup analyses • Qualitative analysis

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
	Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?	
Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings.		
The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	• Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings (including short-term inpatient and residential admissions to both IMDs and non-IMD acute care hospitals, critical access hospitals, and residential settings)? • How does the demonstration effect preventable readmissions to acute care hospitals and residential settings by geographic area or beneficiary characteristics? • How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings? • Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during	Data Sources: • Claims data • Interviews or focus groups • Medical records • Beneficiary survey Analytic Approach: • Difference-in- differences models • Qualitative analysis • Descriptive quantitative analysis

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
	acute care psychiatric hospital and residential setting stays and increased treatment for such conditions after discharge?	
Goal 3: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the State.		
The demonstration will result in improved availability of crisis stabilization services throughout the State.	• To what extent does the demonstration result in improved availability of crisis outreach and response services (including crisis call centers, mobile crisis units, crisis observation/ assessment centers, and coordinated community crisis response teams) throughout the State? • To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization? • To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?	Data Sources: • Annual assessments of availability of mental health services • Area Health Resources File (AHRF) data • National Mental Health Services (NMHSS) survey • Administrative data • Provider survey Analytic Approach: • Descriptive quantitative analysis
Goal 4: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and BH care.		
Access of beneficiaries with	• Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to	Data Sources: • Claims data

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and BH care.	address their chronic mental health needs? • To what extent does the demonstration result in improved availability of specific types of community-based services needed to comprehensively address the chronic needs of beneficiaries with SMI/SED? • To what extent does the demonstration result in improved access of SMI/SED beneficiaries to specific types of community-based services that they need? • How does the demonstration effect access to community-based services by geographic area or beneficiary characteristics? • Does the integration of primary and BH care to address the chronic mental health care needs of beneficiaries with SMI/SED increase under the demonstration?	• Annual assessments of availability of mental health services • AHRF • NMHSS survey • Administrative data • Uniform Reporting System • Child and Adult Core Set • Medical records Analytic Approach: • Descriptive quantitative analysis • Chi-squared analysis • Difference-in- differences model
Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.		
The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	• Does the demonstration result in improved care coordination for beneficiaries with SMI/SED? • Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? • Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries who are	Data Sources: • Claims data • Child and Adult Core Set • Inpatient Psychiatric Facility Quality Reporting program • Medical records • Interviews or focus groups • Facility records Analytic Approach: • Difference-in- differences model • Descriptive quantitative analysis

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
	transitioning out of acute psychiatric care in hospitals and residential treatment facilities? • How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?	• Qualitative analysis

In addition to the independent evaluation, HCPF will provide quarterly and annual reporting specific to this amendment and in accordance with a CMS-approved Monitoring Protocol to be submitted following approval.

Continuous Eligibility Initiative

The State's Independent Evaluator will work with CMS to amend the Demonstration evaluation design. Below are proposed hypotheses for this initiative. The specific evaluation methodology will be submitted with the updated Evaluation Design upon approval of the amendment.

Population: Children zero to age three continuously enrolled in Medicaid and CHP+

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Goal 1: Ensure continuous Medicaid and CHP+ coverage for young children		
Continuous coverage will reduce churn and gaps in coverage for young children enrolled in Medicaid	Does continuous enrollment reduce gaps in coverage?	Examine Medicaid and CHP+ enrollment data by age to determine changes in insured rates and gaps in coverage over time.
Goal 2: Promote longer-term access to and continuity of physical health, BH, and dental care, and preventive services.		
Continuous coverage will increase preventive care utilization, primary care utilization and dental care visits.	Does continuous coverage improve utilization of preventive care and well child visits?	Analyze administrative claims data to determine changes in preventive care, well child visits, primary care visits.
Goal 3: Combat racial inequities.		

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Continuous coverage will reduce churn and gaps in coverage for young children enrolled in Medicaid, including for racial and ethnic groups that experience disproportionately high rates of churn.	Does continuous enrollment reduce gaps in coverage for all racial and ethnic groups?	Examine Medicaid and CHP+ enrollment data by race and ethnicity to determine gaps in coverage over time.
Goal 4: Improve health outcomes and well-being for low-income young children.		
Coverage with fewer gaps in coverage for young children will result in improved health outcomes and well-being.	Does continuous coverage improve health outcomes and well-being?	Measures will be selected from the list of measures that HCPF is calculating as part of the development of our quality metrics program.

Population: Medicaid enrolled adults leaving a correctional facility

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Goal 1: Ensure 12 months of continuous Medicaid coverage for adults leaving a DOC facility.		
Continuous coverage will reduce gaps in coverage for adults leaving a correctional facility.	Does 12 months of continuous enrollment reduce gaps in coverage?	Examine Medicaid enrollment data by age to determine changes in insured rates and gaps in coverage over time.
Goal 2: Promote longer-term access to and continuity of physical and BH care and care coordination.		
Continuous coverage will increase preventive, primary care, and BH engagement.	Does continuous coverage increase primary care and preventive service utilization and BH service utilization?	Measures will be selected from the list of measures the HCPF is calculating as part of the development of a Providers of Distinction quality metrics program.
Goal 3: Combat racial inequities.		

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Continuous coverage will reduce churn and gaps in coverage for adults leaving correctional facilities and enrolled in Medicaid, including for racial and ethnic groups.	Does continuous coverage reduce gaps in coverage for all racial and ethnic groups?	Examine Medicaid enrollment data by race and ethnicity to determine gaps in coverage over time.
Goal 4: Improve short and long-term physical and BH outcomes and reduce recidivism for adults leaving a State DOC facility.		
Continuous coverage will reduce ED visits, hospitalizations, and crisis services.	Does continuous coverage reduce ED visits, hospitalizations, and crisis services?	Analyze administrative claims data to determine changes in preventive care, ED utilization, hospitalizations, crisis service utilization.

Section IX. Compliance with Public Notice and Tribal Consultation

Summary of Public Comments

A summary of feedback from commenters received during the public comment period will be provided in Attachment 7 after the public comment period has been completed.

Public Notice Process

Information on the Amendment and a copy of the public notice is available on the HCPF website at this link: https://hcpf.colorado.gov/1115sudwaiver. Additional information regarding the public notice process, including public hearings, will be updated after the public comment period has been completed.

Tribal Consultation

There are two federally recognized Tribes within the State of Colorado, the Southern Ute Indian Tribe and the Ute Mountain Ute Tribe. The State will solicit feedback and carry out recommendations from both Tribes by sending emails to the Tribal representatives and pertinent program staff with a summary of the Demonstration, plus a copy of the public notice, and waiver application (as well as a link to the HCPF website with the relevant documents). While this process follows the State's approved tribal consultation State Plan Amendment, the Department will continue to engage the Tribes in meaningful, in-person Tribal consultation upon request. The State attended the Colorado Commission of Indian

Affairs 3rd Quarterly Meeting on March 14, 2024 to discuss the proposed amendment. Feedback received during the meeting will be provided in Attachment 9.

Section X. Demonstration Amendment Contact

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Section XI. Appendix

Attachment 1

- **Compliance with Budget Neutrality Requirements**

Attachment 2

- **Mental Health Availability Assessment**

Attachment 3

- **Public Notice Requirements**

Attachment 4

- **Full Public Notice**

Attachment 5

- **Abbreviated Public Notice**

Attachment 6

- **Public Hearing Slides**

Attachment 7

- **Public Notice Comments**

Attachment 8

- **Tribal Consultation**

Attachment 9

- **Tribal Consultation Comments**

Attachment 10

- **Stakeholder Feedback**

Attachment 11

- **Overview Paper**

Attachment 1: Compliance with Budget Neutrality Requirements

Member Months under the Amendment*	DY5	DY6	DY7	DY8	DY9
MEG 3 — SMI Non-Expansion Adults	4	8	9	9	9
MEG 4 — SMI Expansion Adults	53	107	108	109	111
MEG 5 — JI Youth	79	80	81	82	83
MEG 6 — JI Non-Expansion Adults	276	279	282	285	288
MEG 7 — JI Expansion Adults	7,812	7,890	7,969	8,049	8,129
MEG 8 — CC Medicaid Children	n/a	535,475	540,830	546,238	551,700
MEG 9 — JI CC Youth	n/a	302	439	443	448
MEG 10 — JI CC Non-Expansion Adults	n/a	762	1,055	1,065	1,076
MEG 11 — JI CC Expansion Adults	n/a	23,368	31,791	32,109	32,430
Total projected member months under the Amendment	8,208	568,240	582,531	588,356	594,240
Projected Services Costs under the Amendment**	**DY5**	**DY6**	**DY7**	**DY8**	**DY9**
MEG 3 — SMI Non-Expansion Adults	$166	$353	$375	$398	$423
MEG 4 — SMI Expansion Adults	$3,016	$6,437	$6,832	$7,253	$7,699
MEG 5 — JI Youth	$88,430	$94,117	$100,153	$106,560	$113,361
MEG 6 — JI Non-Expansion Adults	$308,472	$327,728	$348,146	$369,794	$392,744
MEG 7 — JI Expansion Adults	$9,182,426	$9,747,089	$10,346,762	$10,983,615	$11,658,514
MEG 8 — CC Medicaid Children	n/a	$169,883,723	$180,333,270	$191,425,570	$203,200,157
MEG 9 — JI CC Youth	n/a	$210,945	$322,292	$342,117	$363,160
MEG 10 — JI CC Non-Expansion Adults	n/a	$1,335,445	$1,942,539	$2,062,025	$2,188,860
MEG 11 — JI CC Expansion Adults	n/a	$4,274,080	$6,111,160	$6,487,057	$6,886,076
MEG 12 — JI Non-Services	$120,000,000	$105,000,000	$75,000,000		
Total Projected Cost	$129,581,634	$290,878,023	$274,509,519	$211,782,255	$224,808,729

*Using a 1% caseload growth rate; SMI/SED and Re-Entry Initiative effective July 1, 2025 (six-months of (DY5)); Continuous eligibility effective January 1, 2026 (DY6) **Using a 5.1% trend rate; SMI/SED and Re-Entry Initiative effective July 1, 2025 (six-months of (DY5)); Continuous eligibility effective January 1, 2026 (DY6)

Attachment 2: Mental Health Availability Assessment

State Name	Colorado
Date of Assessment	June 30, 2023
Time Period Reflected in Assessment	Colorado Fiscal Year 2022-2023

Geographic Designation			**Beneficiaries**											
			Adult					**Children**			**Total**			
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of adult Medicaid beneficiaries (18 - 20)	Number of adult Medicaid beneficiaries with SMI (18 - 20)	Number of adult Medicaid beneficiaries (21+)	Number of adult Medicaid beneficiaries with SMI (21+)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (0 - 17)	Number of Medicaid beneficiaries with SED (0 - 17)	Percent with SED (0-17)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)	Beneficiary Category Notes
ADAMS	Urban		12348	346	109059	5540	5%	76883	756	1%	198290	6642	3%	25 individuals could not be accounted for by County
ALAMOSA	Rural		457	19	5490	325	6%	2663	7	0%	8610	351	4%	
ARAPAHOE	Urban		10745	423	118258	7224	6%	71519	763	1%	200522	8410	4%	
ARCHULETA	Rural		193	8	2967	131	4%	1497	16	1%	4657	155	3%	
BACA	Other-please explain	Frontier	69	2	1011	76	7%	570	5	1%	1650	83	5%	
BENT	Other-please explain	Frontier	115	7	1539	133	8%	641	5	1%	2295	145	6%	
BOULDER	Urban		3504	174	45830	3394	7%	18793	268	1%	68127	3836	6%	
BROOMFIELD	Urban		646	19	7131	472	6%	3636	76	2%	11413	567	5%	
CHAFFEE	Rural		209	8	3776	170	4%	1386	5	0%	5371	183	3%	
CHEYENNE	Other-please explain	Frontier	24	0	360	22	6%	253	3	1%	637	25	4%	
CLEAR CREEK	Urban		82	5	1483	98	7%	429	4	1%	1994	107	5%	
CONEJOS	Rural		192	6	2455	100	4%	1332	4	0%	3979	110	3%	
COSTILLA	Other-please explain	Frontier	100	4	1716	71	4%	639	2	0%	2455	77	3%	
CROWLEY	Rural		71	6	1162	95	8%	478	8	2%	1711	109	6%	
CUSTER	Other-please explain	Frontier	55	1	949	44	4%	439	6	1%	1443	51	4%	
DELTA	Rural		646	28	7922	430	5%	4045	53	1%	12613	511	4%	
DENVER	Urban		12726	365	165298	10491	6%	77783	548	1%	255807	11404	4%	
DOLORES	Other-please explain	Frontier	64	7	583	34	6%	235	3	1%	882	44	5%	
DOUGLAS	Urban		2394	138	26276	1522	6%	14514	280	2%	43184	1940	4%	
EAGLE	Rural		571	11	5588	171	3%	3817	25	1%	9976	207	2%	
EL PASO	Urban		11628	628	141479	10265	7%	78838	1099	1%	231945	11992	5%	
ELBERT	Urban		261	12	2624	138	5%	1589	19	1%	4474	169	4%	
FREMONT	Rural		852	40	11538	735	6%	4940	53	1%	17330	828	5%	
GARFIELD	Rural		1103	26	10053	526	5%	7254	55	1%	18410	607	3%	
GILPIN	Urban		44	1	1002	45	4%	361	3	1%	1407	49	3%	
GRAND	Rural		129	6	1844	52	3%	842	7	1%	2815	65	2%	
GUNNISON	Other-please explain	Frontier	198	6	2925	141	5%	1083	8	1%	4206	155	4%	
HINDSALE	Other-please explain	Frontier	5	0	123	7	5%	50	0	0%	178	7	4%	
HUERFANO	Other-please explain	Frontier	153	5	2423	136	5%	871	5	1%	3447	146	4%	
JACKSON	Other-please explain	Frontier	19	1	216	1	1%	101	0	0%	336	2	1%	
JEFFERSON	Urban		6128	215	81173	5436	6%	36154	523	1%	123455	6174	5%	
KIOWA	Other-please explain	Frontier	37	0	341	20	5%	204	1	0%	582	21	4%	
KIT CARSON	Other-please explain	Frontier	168	3	1488	86	5%	1009	11	1%	2665	100	4%	
LA PLATA	Rural		776	23	10983	552	5%	4632	123	3%	16391	698	4%	
LAKE	Rural		121	3	1362	53	4%	748	4	1%	2231	60	3%	
LARIMER	Rural		4540	241	57774	4340	7%	25922	358	1%	88236	4939	6%	
LAS ANIMAS	Other-please explain	Frontier	317	8	4891	330	6%	1862	10	1%	7070	348	5%	
LINCOLN	Other-please explain	Frontier	90	3	1162	64	5%	675	8	1%	1927	75	4%	
LOGAN	Rural		336	17	4228	396	9%	2117	32	2%	6681	445	7%	
MESA	Rural		2979	185	35618	3364	9%	18154	430	2%	56751	3979	7%	
MINERAL	Other-please explain	Frontier	11	0	174	6	3%	60	0	0%	245	6	2%	
MOFFAT	Other-please explain	Frontier	255	9	2862	215	7%	1721	27	2%	4838	251	5%	
MONTEZUMA	Rural		595	21	7739	377	5%	3767	42	1%	12101	440	4%	
MONTROSE	Rural		873	46	9956	672	7%	5591	58	1%	16420	776	5%	
MORGAN	Rural		648	27	6454	326	5%	4803	27	1%	11905	380	3%	
OTERO	Rural		553	20	5966	447	7%	3176	41	1%	9695	508	5%	
OURAY	Rural		36	1	641	29	4%	221	0	0%	898	30	3%	
PARK	Rural		180	7	2935	110	4%	1041	17	2%	4156	134	3%	
PHILLIPS	Rural		76	1	795	40	5%	526	2	0%	1397	43	3%	
PITKIN	Rural		78	3	1570	51	3%	487	8	2%	2135	62	3%	
PROWERS	Rural		362	13	3621	236	6%	2154	19	1%	6137	268	4%	
PUEBLO	Urban		4225	217	52893	4339	8%	25854	272	1%	82972	4828	6%	
RIO BLANCO	Other-please explain	Frontier	76	3	1132	94	8%	702	9	1%	1910	106	6%	
RIO GRANDE	Rural		276	7	3475	160	4%	1599	12	1%	5350	179	3%	
ROUTT	Rural		188	10	2926	154	5%	1146	20	2%	4260	184	4%	
SAGUACHE	Other-please explain	Frontier	130	2	2080	61	3%	935	6	1%	3145	69	2%	
SAN JUAN	Other-please explain	Frontier	8	0	172	6	3%	63	1	2%	243	7	3%	
SAN MIGUEL	Other-please explain	Frontier	67	0	1090	32	3%	419	7	2%	1576	39	2%	
SEDGWICK	Other-please explain	Frontier	44	1	612	39	6%	256	4	2%	912	44	5%	
SUMMIT	Rural		236	7	3595	107	3%	1663	14	1%	5494	128	2%	
TELLER	Urban		312	24	4732	248	5%	2002	33	2%	7046	305	4%	
WASHINGTON	Frontier		68	0	991	51	5%	597	6	1%	1656	57	3%	
WELD	Urban		6168	181	58429	3115	5%	42023	332	1%	106620	3628	3%	
YUMA	Other-please explain	Frontier	230	4	1935	72	4%	1502	9	1%	3667	85	2%	
Total			**90790**	**3604**	**1058875**	**68217**	**6%**	**571266**	**6552**	**1%**	**1720931**	**78373**	**5%**	

Geographic Designation	Providers														
	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe							Other Practitioners Certified and Licensed to Independently Treat Mental Illness							
Geographic designation	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Total Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Category Notes	Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental	Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness Accepting New	Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to	Practitioners Certified or Licensed to Independently Treat Mental Illness to Medicaid-	Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness to Medicaid-	Other Practitioner Category Notes
ADAMS	2181	607	549	10.94233937	3.593080725	1.10564663	Due to the method in which the Department of Regulatory Agencies (DORA, which manages and regulates licensed providers in the state of Colorado) collects location information from individuals applying for appropriate licensure or certification, discrepancies exist between data supplied by DORA and data collected on Health First Colorado enrolled providers. DORA collects location information for the county in which a provider resides, while HCPF collects information on where a provider practices.	1239	1297	1110	5.121048574	0.955281419	1.168468468	Due to the method in which the Department of Regulatory Agencies (DORA, which manages and regulates licensed providers in the state of Colorado) collects location information from individuals applying for appropriate licensure or certification, discrepancies exist between data supplied by DORA and data collected on Health First Colorado enrolled providers. DORA collects location information for the county in which a provider resides, while HCPF collects information on where a provider practices.
ALAMOSA	56	22	22	15.95454545	2.545454545	1		79	77	74	4.558441558	1.025974026	1.040540541	
ARAPAHOE	2835	488	443	17.23360656	5.80942623	1.101580135		2406	1126	1027	7.468916519	2.136767318	1.096397274	
ARCHULETA	49	15	15	10.33333333	3.266666667	1		25	19	18	8.157894737	1.315789474	1.055555556	
BACA	6	8	8	10.375	0.75	1		0	3	3	27.66666667	0	1	
BENT	3	3	3	48.33333333	1	1		1	3	3	48.33333333	0.333333333	1	
BOULDER	1928	197	181	19.47208122	9.78680203	1.08839779		2554	595	550	6.447058824	4.292436975	1.081818182	
BROOMFIELD	338	36	36	15.75	9.388888889	1		288	110	107	5.154545455	2.618181818	1.028037383	
CHAFFEE	94	6	6	30.5	15.66666667	1		50	29	28	6.310344828	1.724137931	1.035714286	
CHEYENNE	2	7	7	3.571428571	0.285714286	1		0	1	1	25	0	1	
CLEAR CREEK	16	2	2	53.5	8	1		12	17	16	6.294117647	0.705882353	1.0625	
CONEJOS	10	11	11	10	0.909090909	1		12	4	4	27.5	3	1	
COSTILLA	2	11	11	7	0.181818182	1		5	2	2	38.5	2.5	1	
CROWLEY	4	2	2	54.5	2	1		0	2	2	54.5	0	1	
CUSTER	12	3	3	17	4	1		3	1	1	51	3	1	
DELTA	69	25	25	20.44	2.76	1		43	54	54	9.462962963	0.796296296	1	
DENVER	6092	676	634	16.86982249	9.01183432	1.066246057		5556	1980	1797	5.75959596	2.806060606	1.101836394	
DOLORES	1	12	12	3.666666667	0.083333333	1		0	8	8	5.5	0	1	
DOUGLAS	2969	273	266	7.106227106	10.87545788	1.026315789		875	348	331	5.574712644	2.514367816	1.051359517	
EAGLE	265	23	23	9	11.52173913	1		110	62	56	3.338709677	1.774193548	1.107142857	
EL PASO	3391	391	365	30.67007673	8.672634271	1.071232877		2602	1188	1116	10.09427609	2.19023569	1.064516129	
ELBERT	50	13	13	13	3.846153846	1		49	16	14	10.5625	3.0625	1.142857143	
FREMONT	105	20	20	41.4	5.25	1		120	101	101	8.198019802	1.188118812	1	
GARFIELD	250	20	18	30.35	12.5	1.111111111		143	45	41	13.48888889	3.177777778	1.097560976	
GILPIN	8	4	4	12.25	2	1		17	10	10	4.9	1.7	1	
GRAND	33	1	1	65	33	1		17	6	6	10.83333333	2.833333333	1	
GUNNISON	70	20	20	7.75	3.5	1		35	23	23	6.739130435	1.52173913	1	
HINDSALE	2	0	0	-	-	-		0	0	0	-	-	-	
HUERFANO	16	21	19	6.952380952	0.761904762	1.105263158		11	14	7	10.42857143	0.785714286	2	
JACKSON	2	0	0	-	-	-		5	0	0	-	-	-	
JEFFERSON	2518	279	262	22.12903226	9.025089606	1.064885496		2280	1063	937	5.80809031	2.144873001	1.134471718	
KIOWA	3	5	5	4.2	0.6	1		0	0	0	-	-	-	
KIT CARSON	13	2	2	50	6.5	1		7	4	4	25	1.75	1	
LA PLATA	416	25	25	27.92	16.64	1		253	110	104	6.345454545	2.3	1.057692308	
LAKE	17	17	17	3.529411765	1	1		14	6	6	10	2.333333333	1	
LARIMER	1750	302	301	16.35430464	5.794701987	1.003322259		1503	940	918	5.254255319	1.59893617	1.023965142	
LAS ANIMAS	31	6	6	58	5.166666667	1		13	29	27	12	0.448275862	1.074074074	
LINCOLN	13	14	14	5.357142857	0.928571429	1		6	14	14	5.357142857	0.428571429	1	
LOGAN	41	13	12	34.23076923	3.153846154	1.083333333		30	27	27	16.48148148	1.111111111	1	
MESA	896	103	100	38.63106796	8.699029126	1.03		370	215	205	18.50697674	1.720930233	1.048780488	
MINERAL	3	0	0	-	-	-		2	0	0	-	-	-	
MOFFAT	25	7	7	35.85714286	3.571428571	1		17	28	26	8.964285714	0.607142857	1.076923077	
MONTEZUMA	80	14	14	31.42857143	5.714285714	1		35	13	10	33.84615385	2.692307692	1.3	
MONTROSE	144	24	23	32.33333333	6	1.043478261		66	82	80	9.463414634	0.804878049	1.025	
MORGAN	53	10	9	38	5.3	1.111111111		21	32	32	11.875	0.65625	1	
OTERO	40	25	25	20.32	1.6	1		26	26	25	19.53846154	1	1.04	
OURAY	23	19	19	1.578947368	1.210526316	1		14	9	9	3.333333333	1.555555556	1	
PARK	17	42	42	3.19047619	0.404761905	1		22	18	18	7.444444444	1.222222222	1	
PHILLIPS	6	15	15	2.866666667	0.4	1		3	3	3	14.33333333	1	1	
PITKIN	96	5	4	12.4	19.2	1.25		58	13	13	4.769230769	4.461538462	1	
PROWERS	12	7	7	38.28571429	1.714285714	1		12	11	11	24.36363636	1.090909091	1	
PUEBLO	738	85	78	56.8	8.682352941	1.08974359		456	249	224	19.38955823	1.831325301	1.111607143	
RIO BLANCO	16	0	0	-	-	-		9	3	3	35.33333333	3	1	
RIO GRANDE	29	13	13	13.76923077	2.230769231	1		16	6	4	29.83333333	2.666666667	1.5	
ROUTT	149	31	29	5.935483871	4.806451613	1.068965517		70	35	33	5.257142857	2	1.060606061	
SAGUACHE	4	10	10	6.9	0.4	1		11	5	5	13.8	2.2	1	
SAN JUAN	1	0	0	-	-	-		1	0	0	-	-	-	
SAN MIGUEL	4	18	18	2.166666667	0.222222222	1		13	18	18	2.166666667	0.722222222	1	
SEDGWICK	6	10	10	4.4	0.6	1		5	5	5	8.8	1	1	
SUMMIT	126	38	38	3.368421053	3.315789474	1		69	73	70	1.753424658	0.94520548	1.042857143	
TELLER	76	45	45	6.777777778	1.688888889	1		44	50	50	6.1	0.88	1	
WASHINGTON	3	7	7	8.142857143	0.428571429	1		8	1	1	57	8	1	
WELD	907	121	120	29.98347107	7.495867769	1.008333333		689	339	324	10.7020649	2.032448378	1.046296296	
YUMA	12	5	5	17	2.4	1		6	22	19	3.863636364	0.272727273	1.157894737	
Total	**29127**	**4234**	**4001**	**18.51039206**	**6.879310345**	**1.058235441**		**22406**	**10590**	**9735**	**7.400661001**	**2.115769594**	**1.087827427**	

Geographic Designation	Community Mental Health Centers							Intensive Outpatient or Partial Hospitalization Providers						
Geographic designation	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs	Ratio of Total CMHCs to Medicaid-Enrolled CMHCs	Medicaid-Enrolled CMHCs to Medicaid-Enrolled CMHCs Accepting	CMHC Category Notes	Number of Intensive Outpatient/ Partial Hospitalization Providers	Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients	Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Intensive Outpatient/	Partial Hospitalization/ Day Treatment Providers to Medicaid-Enrolled Intensive	Enrolled Partial Hospitalization/ Day Treatment Providers to Medicaid-Enrolled Intensive Outpatient/ Partial	Intensive Outpatient/ Partial Hospitalization Category Notes
ADAMS	1	1	1	6642	1	1	Total number of CMHC counts reflect that each CMHC has a designated catchment area to ensure coverage across the state.	35	0	0	-	-	-	As of June 2023, no Colorado IOPs or PHPs were enrolled with Health First Colorado. Colorado reimburses for Members to recieved IOP/PHP services but does not have distinct enrollment requirement for these individual programs
ALAMOSA	1	1	1	351	1	1		2	0	0	-	-	-	
ARAPAHOE	2	2	2	4205	1	1		41	0	0	-	-	-	
ARCHULETA	1	1	1	155	1	1		0	0	0	-	-	-	
BACA	1	1	1	83	1	1		1	0	0	-	-	-	
BENT	1	1	1	145	1	1		2	0	0	-	-	-	
BOULDER	1	1	1	3836	1	1		21	0	0	-	-	-	
BROOMFIELD	1	1	1	567	1	1		3	0	0	-	-	-	
CHAFFEE	1	1	1	183	1	1		2	0	0	-	-	-	
CHEYENNE	1	1	1	25	1	1		0	0	0	-	-	-	
CLEAR CREEK	1	1	1	107	1	1		0	0	0	-	-	-	
CONEJOS	1	1	1	110	1	1		0	0	0	-	-	-	
COSTILLA	1	1	1	77	1	1		0	0	0	-	-	-	
CROWLEY	1	1	1	109	1	1		3	0	0	-	-	-	
CUSTER	1	1	1	51	1	1		1	0	0	-	-	-	
DELTA	1	1	1	511	1	1		2	0	0	-	-	-	
DENVER	1	1	1	11404	1	1		40	0	0	-	-	-	
DOLORES	1	1	1	44	1	1		0	0	0	-	-	-	
DOUGLAS	1	1	1	1940	1	1		9	0	0	-	-	-	
EAGLE	1	1	1	207	1	1		2	0	0	-	-	-	
EL PASO	1	1	1	11992	1	1		31	0	0	-	-	-	
ELBERT	1	1	1	169	1	1		2	0	0	-	-	-	
FREMONT	1	1	1	828	1	1		10	0	0	-	-	-	
GARFIELD	1	1	1	607	1	1		9	0	0	-	-	-	
GILPIN	1	1	1	49	1	1		0	0	0	-	-	-	
GRAND	1	1	1	65	1	1		0	0	0	-	-	-	
GUNNISON	1	1	1	155	1	1		2	0	0	-	-	-	
HINDSALE	1	1	1	7	1	1		0	0	0	-	-	-	
HUERFANO	1	1	1	146	1	1		1	0	0	-	-	-	
JACKSON	1	1	1	2	1	1		0	0	0	-	-	-	
JEFFERSON	1	1	1	6174	1	1		28	0	0	-	-	-	
KIOWA	1	1	1	21	1	1		1	0	0	-	-	-	
KIT CARSON	1	1	1	100	1	1		0	0	0	-	-	-	
LA PLATA	1	1	1	698	1	1		3	0	0	-	-	-	
LAKE	1	1	1	60	1	1		1	0	0	-	-	-	
LARIMER	1	1	1	4939	1	1		22	0	0	-	-	-	
LAS ANIMAS	1	1	1	348	1	1		1	0	0	-	-	-	
LINCOLN	1	1	1	75	1	1		0	0	0	-	-	-	
LOGAN	1	1	1	445	1	1		1	0	0	-	-	-	
MESA	1	1	1	3979	1	1		8	0	0	-	-	-	
MINERAL	1	1	1	6	1	1		0	0	0	-	-	-	
MOFFAT	1	1	1	251	1	1		1	0	0	-	-	-	
MONTEZUMA	1	1	1	440	1	1		3	0	0	-	-	-	
MONTROSE	1	1	1	776	1	1		2	0	0	-	-	-	
MORGAN	1	1	1	380	1	1		0	0	0	-	-	-	
OTERO	1	1	1	508	1	1		2	0	0	-	-	-	
OURAY	1	1	1	30	1	1		1	0	0	-	-	-	
PARK	1	1	1	134	1	1		0	0	0	-	-	-	
PHILLIPS	1	1	1	43	1	1		0	0	0	-	-	-	
PITKIN	1	1	1	62	1	1		2	0	0	-	-	-	
PROWERS	1	1	1	268	1	1		2	0	0	-	-	-	
PUEBLO	1	1	1	4828	1	1		10	0	0	-	-	-	
RIO BLANCO	1	1	1	106	1	1		0	0	0	-	-	-	
RIO GRANDE	1	1	1	179	1	1		1	0	0	-	-	-	
ROUTT	1	1	1	184	1	1		1	0	0	-	-	-	
SAGUACHE	1	1	1	69	1	1		0	0	0	-	-	-	
SAN JUAN	1	1	1	7	1	1		0	0	0	-	-	-	
SAN MIGUEL	1	1	1	39	1	1		2	0	0	-	-	-	
SEDGWICK	1	1	1	44	1	1		0	0	0	-	-	-	
SUMMIT	1	1	1	128	1	1		1	0	0	-	-	-	
TELLER	1	1	1	305	1	1		1	0	0	-	-	-	
WASHINGTON	1	1	1	57	1	1		1	0	0	-	-	-	
WELD	1	1	1	55.8153846	0.015385	65		9	0	0	-	-	-	
YUMA	1	1	1	-	-	0		1	0	0	-	-	-	
Total	**65**	**65**	**65**	**1205.73846**	**1**	**1**		**324**	**0**	**0**	**-**	**-**	**-**	

Geographic Designation	Residential Mental Health Treatment Facilities												
	Residential Mental Health Treatment Facilities (Adult)												
Geographic designation	Number of Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Medicaid-Enrolled Residential Mental Health Treatment Facilities Accepting New	Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health	Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled	Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) to	Total Number of Residential Mental Health Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)	of Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Adult	Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health	Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health	Medicaid-Enrolled Residential Mental Health Treatment Beds to Medicaid-Enrolled	Residential Mental Health Treatment Facility Category Notes (Adult)
ADAMS	0	0	0	-	-	-	0	0	0	-	-	-	As of June, 2023, no Adult Residential Mental Health Treatment Facilities were enrolled as Health First Colorado providers. BHA confirms that no ATUs, CSUs, or Psychiatric Hospitals were included in this count. Due to current licensing practices, BHA is unable to confirm facility bed counts at this time. The state will collaborate across departments to ensure this metric is captured in future assessments.
ALAMOSA	0	0	0	-	-	-	0	0	0	-	-	-	
ARAPAHOE	3	0	0	-	-	-	-	0	0	-	-	-	
ARCHULETA	0	0	0	-	-	-	0	0	0	-	-	-	
BACA	0	0	0	-	-	-	0	0	0	-	-	-	
BENT	0	0	0	-	-	-	0	0	0	-	-	-	
BOULDER	0	0	0	-	-	-	0	0	0	-	-	-	
BROOMFIELD	0	0	0	-	-	-	0	0	0	-	-	-	
CHAFFEE	1	0	0	-	-	-	-	0	0	-	-	-	
CHEYENNE	0	0	0	-	-	-	0	0	0	-	-	-	
CLEAR CREEK	0	0	0	-	-	-	0	0	0	-	-	-	
CONEJOS	0	0	0	-	-	-	0	0	0	-	-	-	
COSTILLA	0	0	0	-	-	-	0	0	0	-	-	-	
CROWLEY	0	0	0	-	-	-	0	0	0	-	-	-	
CUSTER	0	0	0	-	-	-	0	0	0	-	-	-	
DELTA	0	0	0	-	-	-	0	0	0	-	-	-	
DENVER	0	0	0	-	-	-	0	0	0	-	-	-	
DOLORES	0	0	0	-	-	-	0	0	0	-	-	-	
DOUGLAS	0	0	0	-	-	-	0	0	0	-	-	-	
EAGLE	0	0	0	-	-	-	0	0	0	-	-	-	
EL PASO	1	0	0	-	-	-	-	0	0	-	-	-	
ELBERT	0	0	0	-	-	-	0	0	0	-	-	-	
FREMONT	0	0	0	-	-	-	0	0	0	-	-	-	
GARFIELD	0	0	0	-	-	-	0	0	0	-	-	-	
GILPIN	0	0	0	-	-	-	0	0	0	-	-	-	
GRAND	0	0	0	-	-	-	0	0	0	-	-	-	
GUNNISON	0	0	0	-	-	-	0	0	0	-	-	-	
HINDSALE	0	0	0	-	-	-	0	0	0	-	-	-	
HUERFANO	0	0	0	-	-	-	0	0	0	-	-	-	
JACKSON	0	0	0	-	-	-	0	0	0	-	-	-	
JEFFERSON	0	0	0	-	-	-	0	0	0	-	-	-	
KIOWA	0	0	0	-	-	-	0	0	0	-	-	-	
KIT CARSON	0	0	0	-	-	-	0	0	0	-	-	-	
LA PLATA	1	0	0	-	-	-	-	0	0	-	-	-	
LAKE	0	0	0	-	-	-	0	0	0	-	-	-	
LARIMER	3	0	0	-	-	-	-	0	0	-	-	-	
LAS ANIMAS	0	0	0	-	-	-	0	0	0	-	-	-	
LINCOLN	0	0	0	-	-	-	0	0	0	-	-	-	
LOGAN	0	0	0	-	-	-	0	0	0	-	-	-	
MESA	0	0	0	-	-	-	0	0	0	-	-	-	
MINERAL	0	0	0	-	-	-	0	0	0	-	-	-	
MOFFAT	0	0	0	-	-	-	0	0	0	-	-	-	
MONTEZUMA	0	0	0	-	-	-	0	0	0	-	-	-	
MONTROSE	1	0	0	-	-	-	-	0	0	-	-	-	
MORGAN	0	0	0	-	-	-	0	0	0	-	-	-	
OTERO	1	0	0	-	-	-	-	0	0	-	-	-	
OURAY	0	0	0	-	-	-	0	0	0	-	-	-	
PARK	0	0	0	-	-	-	0	0	0	-	-	-	
PHILLIPS	0	0	0	-	-	-	0	0	0	-	-	-	
PITKIN	0	0	0	-	-	-	0	0	0	-	-	-	
PROWERS	0	0	0	-	-	-	0	0	0	-	-	-	
PUEBLO	1	0	0	-	-	-	-	0	0	-	-	-	
RIO BLANCO	0	0	0	-	-	-	0	0	0	-	-	-	
RIO GRANDE	0	0	0	-	-	-	0	0	0	-	-	-	
ROUTT	0	0	0	-	-	-	0	0	0	-	-	-	
SAGUACHE	0	0	0	-	-	-	0	0	0	-	-	-	
SAN JUAN	0	0	0	-	-	-	0	0	0	-	-	-	
SAN MIGUEL	0	0	0	-	-	-	0	0	0	-	-	-	
SEDGWICK	0	0	0	-	-	-	0	0	0	-	-	-	
SUMMIT	0	0	0	-	-	-	0	0	0	-	-	-	
TELLER	0	0	0	-	-	-	0	0	0	-	-	-	
WASHINGTON	0	0	0	-	-	-	0	0	0	-	-	-	
WELD	1	0	0	-	-	-	-	0	0	-	-	-	
YUMA	0	0	0	-	-	-	0	0	0	-	-	-	
Total	**13**	**0**	**0**	**-**	**-**	**-**	**0**	**0**	**0**	**-**	**-**	**-**	

Geographic Designation	Residential Mental Health Treatment Facilities												
	Psychiatric Residential Treatment Facilities												
Geographic designation	Number of Psychiatric Residential Treatment Facilities (PRTF)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PTRFs	Ratio of Total PTRFs to Medicaid-Enrolled PRTFs	Medicaid-Enrolled PRTFs to Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds	Number of Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Medicaid Beneficiaries with SED to Medicaid-Enrolled PRTF Beds Available to Medicaid	Ratio of Total Number of PRTF Beds to Medicaid-Enrolled PRTF Beds	Medicaid-Enrolled PRTF Beds to Medicaid-Enrolled PRTFs Available to Medicaid	Psychiatric Residential Treatment Facility (Under 21) Category Notes
ADAMS	0	0	0	-	-	-				-	-	-	PRTFs must be enrolled in Medicaid in the State of Colorado. The facility located in Jefferson County is no longer serving as a PRTF and therefore does not have licensure per the regulatory agency. Its bed count has been captured as zero. Like Psychiatric facilities considered IMDs, Health First Colorado members are referred from all parts of the state as appropriate to the 4 current PRTFs. All PRTF bed counts were self-reported by the individual facilities
ALAMOSA	0	0	0	-	-	-				-	-	-	
ARAPAHOE	1	1	1	763	1	-	34	34	34	22.44117647	1	1	
ARCHULETA	0	0	0	-	-	-				-	-	-	
BACA	0	0	0	-	-	-				-	-	-	
BENT	0	0	0	-	-	-				-	-	-	
BOULDER	0	0	0	-	-	-				-	-	-	
BROOMFIELD	0	0	0	-	-	-				-	-	-	
CHAFFEE	0	0	0	-	-	-				-	-	-	
CHEYENNE	0	0	0	-	-	-				-	-	-	
CLEAR CREEK	0	0	0	-	-	-				-	-	-	
CONEJOS	0	0	0	-	-	-				-	-	-	
COSTILLA	0	0	0	-	-	-				-	-	-	
CROWLEY	0	0	0	-	-	-				-	-	-	
CUSTER	0	0	0	-	-	-				-	-	-	
DELTA	0	0	0	-	-	-				-	-	-	
DENVER	1	1	1	548	1	0.5	32	32	32	17.125	1	1	
DOLORES	0	0	0	-	-	-				-	-	-	
DOUGLAS	0	0	0	-	-	-				-	-	-	
EAGLE	0	0	0	-	-	-				-	-	-	
EL PASO	1	1	1	1099	1	1	24	24	24	45.79166667	1	1	
ELBERT	0	0	0	-	-	-				-	-	-	
FREMONT	1	1	1	53	1	1	136	136	136	0.389705882	1	1	
GARFIELD	0	0	0	-	-	-				-	-	-	
GILPIN	0	0	0	-	-	-				-	-	-	
GRAND	0	0	0	-	-	-				-	-	-	
GUNNISON	0	0	0	-	-	-				-	-	-	
HINDSALE	0	0	0	-	-	-				-	-	-	
HUERFANO	0	0	0	-	-	-				-	-	-	
JACKSON	0	0	0	-	-	-				-	-	-	
JEFFERSON	0	1	0	523	0	1	0	0	0	-	-	-	
KIOWA	0	0	0	-	-	-				-	-	-	
KIT CARSON	0	0	0	-	-	-				-	-	-	
LA PLATA	0	0	0	-	-	-				-	-	-	
LAKE	0	0	0	-	-	-				-	-	-	
LARIMER	0	0	0	-	-	-				-	-	-	
LAS ANIMAS	0	0	0	-	-	-				-	-	-	
LINCOLN	0	0	0	-	-	-				-	-	-	
LOGAN	0	0	0	-	-	-				-	-	-	
MESA	0	0	0	-	-	-				-	-	-	
MINERAL	0	0	0	-	-	-				-	-	-	
MOFFAT	0	0	0	-	-	-				-	-	-	
MONTEZUMA	0	0	0	-	-	-				-	-	-	
MONTROSE	0	0	0	-	-	-				-	-	-	
MORGAN	0	0	0	-	-	-				-	-	-	
OTERO	0	0	0	-	-	-				-	-	-	
OURAY	0	0	0	-	-	-				-	-	-	
PARK	0	0	0	-	-	-				-	-	-	
PHILLIPS	0	0	0	-	-	-				-	-	-	
PITKIN	0	0	0	-	-	-				-	-	-	
PROWERS	0	0	0	-	-	-				-	-	-	
PUEBLO	0	0	0	-	-	-				-	-	-	
RIO BLANCO	0	0	0	-	-	-				-	-	-	
RIO GRANDE	0	0	0	-	-	-				-	-	-	
ROUTT	0	0	0	-	-	-				-	-	-	
SAGUACHE	0	0	0	-	-	-				-	-	-	
SAN JUAN	0	0	0	-	-	-				-	-	-	
SAN MIGUEL	0	0	0	-	-	-				-	-	-	
SEDGWICK	0	0	0	-	-	-				-	-	-	
SUMMIT	0	0	0	-	-	-				-	-	-	
TELLER	0	0	0	-	-	-				-	-	-	
WASHINGTON	0	0	0	-	-	-				-	-	-	
WELD	0	0	0	-	-	-				-	-	-	
YUMA	0	0	0	-	-	-				-	-	-	
Total	**4**	**5**	**4**	**1310.4**	**0.8**	**1.25**	**226**	**226**	**226**	**28.99115044**	**1**	**1**	

Geographic Designation	Inpatient																			
	Psychiatric Hospitals					Psychiatric Units														
Geographic designation	Number of Psychiatric Hospitals	Psychiatric Hospitals Available to Medicaid Patients	Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals Available to Medicaid	Psychiatric Hospitals to Psychiatric Hospitals Available to Medicaid Patients	Psychiatric Hospital Category Notes	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs	Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid	Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute	Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute	Ratio of Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs	Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled	Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric	Psychiatric Unit Category Notes
ADAMS	1	2	3321	0	Due to licensing and regulatory methodologies differing from Medicaid enrollment in the State of Colorado as of June 2023, a discrepancy exists between the regulatory agency count of Psychiatric Hospitals and HCPF count of enrolled psychiatric hospital facilities. The regulatory agency (CDPHE) captures Psychiatric Hospital licenses for each organization. Each organization may have multiple campuses, each of which is enrolled separately as a distinct Health First Colorado provider. Four Hospitals licensed by CDPHE as psychiatric hospitals are Eating Disorder Facilities.	0	0	0	0	0	0	-	-	-	-	-	-	Per CDPHE, no psychiatric units or dedicated beds are currently licensed in Critical Access Hosptials in Colorado. However, due to the nature of available medical support for behavioral health needs, it is likely that these facilities do provide crisis stabilization and emergency behavioral health care to members of their communites. 4 Hospitals licensed by CDPHE as psychiatric hospitals are not currently enrolled as Colorado Medicaid providers.
ALAMOSA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
ARAPAHOE	1	7	1201.428571	0.142857143		40	0	40	0	40	0	210.25	-	1	-	1	-		
ARCHULETA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
BACA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
BENT	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
BOULDER	1	6	639.3333333	0.166666667		26	0	26	0	26	0	147.5384615	-	1	-	1	-		
BROOMFIELD	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
CHAFFEE	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
CHEYENNE	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
CLEAR CREEK	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
CONEJOS	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
COSTILLA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
CROWLEY	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
CUSTER	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
DELTA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
DENVER	4	6	1900.666667	0.166666667		106	0	106	0	106	0	107.5849057	-	1	-	1	-		
DOLORES	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
DOUGLAS	1	2	970	0.5		0	0	0	0	0	0	-	-	-	-	-	-		
EAGLE	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
EL PASO	2	3	3997.333333	0.666666667		28	0	28	0	28	0	428.2857143	-	1	-	1	-		
ELBERT	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
FREMONT	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
GARFIELD	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
GILPIN	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
GRAND	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
GUNNISON	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
HINDSALE	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
HUERFANO	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
JACKSON	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
JEFFERSON	0	4	1543.5	0		67	0	67	0	67	0	92.14925373	-	1	-	1	-		
KIOWA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
KIT CARSON	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
LA PLATA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
LAKE	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
LARIMER	1	5	987.8	0.2		43	0	43	0	43	0	114.8604651	-	1	-	1	-		
LAS ANIMAS	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
LINCOLN	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
LOGAN	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
MESA	1	1	3979	1		0	0	0	0	0	0	-	-	-	-	-	-		
MINERAL	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
MOFFAT	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
MONTEZUMA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
MONTROSE	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
MORGAN	0	0	-	-		10	0	10	0	10	0	38	-	1	-	1	-		
OTERO	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
OURAY	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
PARK	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
PHILLIPS	0	1	43	0		0	0	0	0	0	0	-	-	-	-	-	-		
PITKIN	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
PROWERS	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
PUEBLO	1	2	2414	0.5		25	0	25	0	25	0	193.12	-	1	-	1	-		
RIO BLANCO	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
RIO GRANDE	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
ROUTT	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
SAGUACHE	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
SAN JUAN	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
SAN MIGUEL	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
SEDGWICK	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
SUMMIT	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
TELLER	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
WASHINGTON	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
WELD	0	3	1209.333333	0		22	0	22	0	22	0	164.9090909	-	1	-	1	-		
YUMA	0	0	-	-		0	0	0	0	0	0	-	-	-	-	-	-		
Total	**13**	**42**	**1866.02381**	**0.30952381**		**367**	**0**	**367**	**0**	**367**	**0**	**213.5504087**	**-**	**1**	**-**	**1**	**-**		

Geographic Designation	Inpatient					Institutions for Mental Diseases								
	Psychiatric Beds					Residential Treatment Facilities That Qualify As IMDs						Psychiatric Hospitals That Qualify As IMDs		
Geographic designation	Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to	Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds Available to	Psychiatric Beds Category Notes	Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as	Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as	Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health	Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-	Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health	Number of Psychiatric Hospitals that Qualify as IMDs	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	Facilities That Qualify As IMDs Category Notes
ADAMS	0	0	-	-	It is important to distinguish bed and patient availability versus bed and patient capacity. Due to healthcare pressures includes staffing limitations facility and unit bed capacity may be significantly less than bed availability as reflected in this worksheet.	0	0	0	-	-	-	0	-	7 current IMD designated facilities serve populations from all Colorado Counties by referral
ALAMOSA	0	0	-	-		0	0	0	-	-	-	0	-	
ARAPAHOE	365	365	23.04109589	1		0	0	0	-	-	-	1	8410	
ARCHULETA	0	0	-	-		0	0	0	-	-	-	0	-	
BACA	0	0	-	-		0	0	0	-	-	-	0	-	
BENT	0	0	-	-		0	0	0	-	-	-	0	-	
BOULDER	457	457	8.393873085	1		0	0	0	-	-	-	1	3836	
BROOMFIELD	0	0	-	-		0	0	0	-	-	-	0	-	
CHAFFEE	0	0	-	-		0	0	0	-	-	-	0	-	
CHEYENNE	0	0	-	-		0	0	0	-	-	-	0	-	
CLEAR CREEK	0	0	-	-		0	0	0	-	-	-	0	-	
CONEJOS	0	0	-	-		0	0	0	-	-	-	0	-	
COSTILLA	0	0	-	-		0	0	0	-	-	-	0	-	
CROWLEY	0	0	-	-		0	0	0	-	-	-	0	-	
CUSTER	0	0	-	-		0	0	0	-	-	-	0	-	
DELTA	0	0	-	-		0	0	0	-	-	-	0	-	
DENVER	1719	1719	6.634089587	1		0	0	0	-	-	-	0	-	
DOLORES	0	0	-	-		0	0	0	-	-	-	0	-	
DOUGLAS	86	86	22.55813953	1		0	0	0	-	-	-	1	1940	
EAGLE	0	0	-	-		0	0	0	-	-	-	0	-	
EL PASO	488	488	24.57377049	1		0	0	0	-	-	-	2	5996	
ELBERT	0	0	-	-		0	0	0	-	-	-	0	-	
FREMONT	0	0	-	-		0	0	0	-	-	-	0	-	
GARFIELD	0	0	-	-		0	0	0	-	-	-	0	-	
GILPIN	0	0	-	-		0	0	0	-	-	-	0	-	
GRAND	0	0	-	-		0	0	0	-	-	-	0	-	
GUNNISON	0	0	-	-		0	0	0	-	-	-	0	-	
HINDSALE	0	0	-	-		0	0	0	-	-	-	0	-	
HUERFANO	0	0	-	-		0	0	0	-	-	-	0	-	
JACKSON	0	0	-	-		0	0	0	-	-	-	0	-	
JEFFERSON	575	575	10.7373913	1		0	0	0	-	-	-	0	-	
KIOWA	0	0	-	-		0	0	0	-	-	-	0	-	
KIT CARSON	0	0	-	-		0	0	0	-	-	-	0	-	
LA PLATA	0	0	-	-		0	0	0	-	-	-	0	-	
LAKE	0	0	-	-		0	0	0	-	-	-	0	-	
LARIMER	465	465	10.62150538	1		0	0	0	-	-	-	1	4939	
LAS ANIMAS	0	0	-	-		0	0	0	-	-	-	0	-	
LINCOLN	0	0	-	-		0	0	0	-	-	-	0	-	
LOGAN	0	0	-	-		0	0	0	-	-	-	0	-	
MESA	64	64	62.171875	1		0	0	0	-	-	-	1	3979	
MINERAL	0	0	-	-		0	0	0	-	-	-	0	-	
MOFFAT	0	0	-	-		0	0	0	-	-	-	0	-	
MONTEZUMA	0	0	-	-		0	0	0	-	-	-	0	-	
MONTROSE	0	0	-	-		0	0	0	-	-	-	0	-	
MORGAN	50	50	7.6	1		0	0	0	-	-	-	0	-	
OTERO	0	0	-	-		0	0	0	-	-	-	0	-	
OURAY	0	0	-	-		0	0	0	-	-	-	0	-	
PARK	0	0	-	-		0	0	0	-	-	-	0	-	
PHILLIPS	0	0	-	-		0	0	0	-	-	-	0	-	
PITKIN	0	0	-	-		0	0	0	-	-	-	0	-	
PROWERS	0	0	-	-		0	0	0	-	-	-	0	-	
PUEBLO	866	866	5.575057737	1		0	0	0	-	-	-	0	-	
RIO BLANCO	0	0	-	-		0	0	0	-	-	-	0	-	
RIO GRANDE	0	0	-	-		0	0	0	-	-	-	0	-	
ROUTT	0	0	-	-		0	0	0	-	-	-	0	-	
SAGUACHE	0	0	-	-		0	0	0	-	-	-	0	-	
SAN JUAN	0	0	-	-		0	0	0	-	-	-	0	-	
SAN MIGUEL	0	0	-	-		0	0	0	-	-	-	0	-	
SEDGWICK	0	0	-	-		0	0	0	-	-	-	0	-	
SUMMIT	0	0	-	-		0	0	0	-	-	-	0	-	
TELLER	0	0	-	-		0	0	0	-	-	-	0	-	
WASHINGTON	0	0	-	-		0	0	0	-	-	-	0	-	
WELD	378	378	9.597883598	1		0	0	0	-	-	-	0	-	
YUMA	0	0	-	-		0	0	0	-	-	-	0	-	
Total	**5513**	**5513**	**14.21603483**	**1**		**0**	**0**	**0**	**-**	**-**	**-**	**7**	**11196.14286**	

Geographic Designation	Crisis Stabilization Services											Federally Qualified Health Centers		
Geographic designation	Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Crisis Stabilization Units	Number of Coordinated Community Crisis Response Teams	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response	Crisis Stabilization Services Category Notes	Number FQHCs that Offer Behavioral Health Services	Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	FQHC Category Notes
ADAMS	2	1	1		1	3321	6642	6642	-	6642	Colorado has a Single State-Wide Crisis Call center available in all counties and to all Colorado residents. Additionally, Colorado participates in 988 which connects to a national support call center for all Colorado residents.	9	738	2 facilities within BHA's records could not be attributed to a specific county
ALAMOSA	2	1				175.5	351	-	-	-		5	70.2	
ARAPAHOE	2	1	1	2	3	4205	8410	8410	4205	2803.333333		10	841	
ARCHULETA	2	1				77.5	155	-	-	-		1	155	
BACA	2	1			1	41.5	83	-	-	83		0	-	
BENT	2	1				72.5	145	-	-	-		2	72.5	
BOULDER	2	1	1		3	1918	3836	3836	-	1278.666667		6	639.3333333	
BROOMFIELD	2	1			1	283.5	567	-	-	567		0	-	
CHAFFEE	2	1		1	1	91.5	183	-	183	183		1	183	
CHEYENNE	2	1				12.5	25	-	-	-		0	-	
CLEAR CREEK	2	1				53.5	107	-	-	-		0	-	
CONEJOS	2	1				55	110	-	-	-		1	110	
COSTILLA	2	1				38.5	77	-	-	-		1	77	
CROWLEY	2	1			1	54.5	109	-	-	109		1	109	
CUSTER	2	1				25.5	51	-	-	-		0	-	
DELTA	2	1			1	255.5	511	-	-	511		2	255.5	
DENVER	2	1	1		3	5702	11404	11404	-	3801.333333		46	247.9130435	
DOLORES	2	1				22	44	-	-	-		1	44	
DOUGLAS	2	1			1	970	1940	-	-	1940		1	1940	
EAGLE	2	1			2	103.5	207	-	-	103.5		5	41.4	
EL PASO	2	1	1		2	5996	11992	11992	-	5996		21	571.047619	
ELBERT	2	1				84.5	169	-	-	-		0	-	
FREMONT	2	1			1	414	828	-	-	828		1	828	
GARFIELD	2	1				303.5	607	-	-	-		4	151.75	
GILPIN	2	1				24.5	49	-	-	-		1	49	
GRAND	2	1				32.5	65	-	-	-		0	-	
GUNNISON	2	1				77.5	155	-	-	-		0	-	
HINDSALE	2	1				3.5	7	-	-	-		0	-	
HUERFANO	2	1				73	146	-	-	-		0	-	
JACKSON	2	1				1	2	-	-	-		0	-	
JEFFERSON	2	1	1		2	3087	6174	6174	-	3087		4	1543.5	
KIOWA	2	1				10.5	21	-	-	-		0	-	
KIT CARSON	2	1				50	100	-	-	-		0	-	
LA PLATA	2	1			1	349	698	-	-	698		2	349	
LAKE	2	1			2	30	60	-	-	30		2	30	
LARIMER	2	1		1	1	2469.5	4939	-	4939	4939		3	1646.333333	
LAS ANIMAS	2	1				174	348	-	-	-		1	348	
LINCOLN	2	1				37.5	75	-	-	-		1	75	
LOGAN	2	1				222.5	445	-	-	-		0	-	
MESA	2	1			1	1989.5	3979	-	-	3979		5	795.8	
MINERAL	2	1				3	6	-	-	-		0	-	
MOFFAT	2	1				125.5	251	-	-	-		1	251	
MONTEZUMA	2	1				220	440	-	-	-		1	440	
MONTROSE	2	1	1	1	1	388	776	776	776	776		1	776	
MORGAN	2	1				190	380	-	-	-		1	380	
OTERO	2	1			1	254	508	-	-	508		2	254	
OURAY	2	1				15	30	-	-	-		0	-	
PARK	2	1				67	134	-	-	-		1	134	
PHILLIPS	2	1				21.5	43	-	-	-		0	-	
PITKIN	2	1			1	31	62	-	-	62		1	62	
PROWERS	2	1			1	134	268	-	-	268		5	53.6	
PUEBLO	2	1	1		1	2414	4828	4828	-	4828		8	603.5	
RIO BLANCO	2	1				53	106	-	-	-		0	-	
RIO GRANDE	2	1				89.5	179	-	-	-		2	89.5	
ROUTT	2	1				92	184	-	-	-		2	92	
SAGUACHE	2	1				34.5	69	-	-	-		0	-	
SAN JUAN	2	1				3.5	7	-	-	-		0	-	
SAN MIGUEL	2	1				19.5	39	-	-	-		1	39	
SEDGWICK	2	1				22	44	-	-	-		0	-	
SUMMIT	2	1			1	64	128	-	-	128		5	25.6	
TELLER	2	1				152.5	305	-	-	-		1	305	
WASHINGTON	2	1				28.5	57	-	-	-		0	-	
WELD	2	1	1	1	1	1814	3628	3628	3628	3628		6	604.6666667	
YUMA	2	1				42.5	85	-	-	-		0	-	
Total	**128**	**64**	**9**	**6**	**35**	**612.2890625**	**1224.578125**	**8708.111111**	**13062.16667**	**2239.228571**		**175**	**447.8457143**	

Attachment 3: Public Notice Requirements

Overview

Colorado certifies that it provided public notice regarding the proposed Section 1115 waiver demonstration as required by federal regulations at 42 C.F.R.431.408, as follows. The full and abbreviated public notices can be found below.

Screenshot of Colorado Registry January 25, 2024

Non-Rulemaking Public Notices and Other Miscellaneous Rulemaking Notices

Department / Agency	Filed date	Notice
Department of Health Care Policy and Financing	01/24/2024	Notice of Public Comment Process Medicaid Section 1115 Demonstration Amendment
Department of Health Care Policy and Financing	01/24/2024	Substance Use Demonstration Amendment Request
Department of Health Care Policy and Financing	01/24/2024	Notice of Public Comment Process Medicaid Section 1115 Demonstration Amendment - Abbreviated

Attachment 4: Full Public Notice

COLORADO
Department of Health Care Policy & Financing

Notice of Public Comment Process
Medicaid Section 1115 Demonstration Amendment

Public Comment Period Begins: January 25, 2024, at 8:00 a.m. MST

Public Comment Period Ends: February 24, 2024, at 5:00 p.m. MST

Public notice is hereby given that the State of Colorado's Department of Health Care Policy & Financing (HCPF) is seeking public comments on an amendment to the Expanding the Substance Use Disorder (SUD) Continuum of Care Section 1115 Demonstration (Demonstration).

Proposed Amendment Summary

Colorado is requesting an amendment to the Demonstration to authorize:

1. Pre-release services for individuals transitioning from state-run correctional facilities;
2. Reimbursement for acute inpatient and residential stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED); and
3. Continuous eligibility for children ages 0-3 and adults leaving a Colorado Department of Corrections (DOC) facility.

HCPF is requesting to have an effective date of January 1, 2025 for the proposed amendment to provide the necessary time to implement and operationalize the services and eligibility components within the amendment.

Pre-Release Services

The State intends to implement the Demonstration statewide on or after July 1, 2025. The State requests to operate the Demonstration through the end of the current SUD Demonstration approval period, which is December 31, 2025. This amendment request provides a detailed overview of coverage and service provisions, as well as Reentry initiative objectives, financing, implementation, and monitoring/evaluation.

In alignment with Senate Bill 22-196, this amendment request would authorize Medicaid-funded reentry services to incarcerated individuals across several settings, including state prisons and youth in correctional facilities. The 90-day reentry services would include:

- Case management (care coordination) services that include physical and behavioral health clinical screenings and consultation services;
- A 30-day supply of prescription medications and medication administration upon release; and

- Medication assisted treatment (MAT) for all FDA-approved medications (including counseling and long acting injectables).

IMD

The State intends to implement the Demonstration statewide on or after July 1, 2025. The State requests to operate the Demonstration through the end of the current SUD Demonstration approval period, which is December 31, 2025.This amendment request provides a detailed overview of coverage and service provisions, as well as SMI/SED initiative objectives, financing, implementation, and monitoring/evaluation.

Currently, Colorado utilizes "in lieu of" authority under its managed care 1915(b) Waiver to pay for care in an IMD. This allows managed care entities (MCE) to provide IMD reimbursement for stays of up to 15 days in a calendar month. This authority provides sufficient coverage for most acute psychiatric inpatient stays. However, there remain IMD stays that exceed the 15-day limit due to issues such as patient acuity and additional time needed to ensure a safe and appropriate transition to community-based services.

Through this amendment, HCPF seeks authority to reimburse the first 15-days of stays that exceed the current limit under the "in lieu of service" authority. This will permit Colorado to modify its current practice through which a prorated capitation payment is made to the MCE for the days within the month that the enrollee was not in an IMD and the MCE's subsequent payment recoupment from the IMD for the entire stay. Under the amendment, HCPF proposes to eliminate the capitation recoupment process, account for IMD stays of up to 15 days in the capitation rate setting process and require MCEs to reimburse IMDs for the first 15 days of a stay.

Continuous Eligibility

HCPF is seeking to implement the continuous eligibility component of this amendment by January 1, 2026. Colorado House Bill 23-1300 (HB23-1300) authorizes HCPF to seek federal authority to provide continuous Medicaid and Child Health Plan Plus (CHP+) coverage for children up to age three and for twelve months for adults who have been released from a Colorado DOC facility, regardless of any change in income during that time. Through this Demonstration amendment, Colorado aims to improve the health and well-being of enrollees through consistent access to health care coverage during critical periods in life. Providing continuous coverage can decrease gaps in insurance coverage, and enhance the continuity of care and delivery of physical and behavioral health services during early childhood and when adults experience the difficult transition of leaving the criminal justice system.

Amendment Objectives and Goals

Pre-Release Services

This Demonstration amendment will allow for the continuity of medical assistance services for individuals leaving the DOC and DYS facilities. Consistent with the CMS goals as outlined in the April 17, 2023, State Medicaid Director (SMD) letter, the State's specific goals for the Re-entry Initiative are to:

Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;

Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during re-entry;

Improve coordination and communication between correctional systems, Medicaid systems, administrative services organizations, and community-based providers;

Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;

Improve connections between carceral settings and community services upon release to address physical health, behavioral health (BH), and health related social needs (HRSN);

Reduce all-cause deaths in the near-term post release; and

Reduce the number of emergency department (ED) visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and BH care.

IMD

The State's goals for reimbursement of short term stays in IMDs are aligned with those of CMS for this Demonstration opportunity, including:

- Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Continuous Eligibility

This Demonstration amendment will end churn among Medicaid and CHP+ enrolled children through age three, enabling families and providers to better address their primary and preventive health care needs. This request seeks to:

- Ensure continuous Medicaid and CHP+ coverage for young children;

- Promote longer-term access to and continuity of physical health care, behavioral health care, dental care, and preventive services;
- Combat racial inequities; and
- Improve health outcomes and well-being for low-income young children.

This request will also ensure that coverage disruptions do not prevent adults leaving incarceration in Colorado DOC facilities from receiving ongoing treatment for physical or behavioral health needs during a critical time. This is anticipated to improve SUD and mental health treatment, reduce recidivism rates, and reduce costly hospitalizations and unnecessary emergency department (ED) visits. This request seeks to:

- Ensure 12 months of continuous Medicaid coverage for adults leaving a DOC facility;
- Promote longer-term access to and continuity of physical and behavioral health care and care coordination;
- Combat racial inequities; and
- Improve short and long-term physical and behavioral health outcomes and reduce recidivism for adults leaving a Colorado DOC facility.

Health Care Delivery

Health First Colorado is a Medicaid insurance program that provides access to physical and behavioral health care, hospitalization, nursing facility care, prescription drugs, dental care and other benefits for qualifying adults and children. Physical health services are paid for through the traditional fee-for-service structure through HCPF. While behavioral health and care coordination services are capitated and provided by MCEs through contracts with HCPF. The MCEs have data sharing agreements with the Department of Corrections to better support members as they transition to community.

Since 2011, the Accountable Care Collaborative (ACC) has served as the core vehicle for delivering and managing member care for Health First Colorado. All full-benefit Health First Colorado members are enrolled in the ACC except for members enrolled in the Program for All Inclusive Care for the Elderly. The ACC integrates managed fee-for-service physical health care and managed care for behavioral health. The ACC's regional model allows it to be responsive to unique community needs. Key components of the ACC include care coordination and member support.

The health care delivery system is not anticipated to change under this amendment.

Eligibility

Re-Entry Initiative:

Suspension of Coverage. As noted above, in the prison system, there is a manual process for moving eligibility from a full Medicaid benefit package to a limited inpatient benefit package. However, in the youth detention facilities, there is no formal process. The State is interested in automating the "suspend" functionality for Medicaid members in DOC. In addition, DOC staff will need to increase their timeframe for review of documents to ensure all eligible

members are actively enrolled in Medicaid to access 90-day pre-release benefits. DYS staff will need to implement practices to identify Medicaid-eligible youth to ensure access to 90-day pre-release services status with the additional component of notifying the individual of status.

As is required for JI 1115 Demonstrations, HCPF will work to maintain and enhance eligibility processes to ensure individuals who were enrolled in Medicaid at the time they entered the correctional system can have their coverage quickly and easily reinstated as part of pre-release planning, and ensure that for those who were not enrolled in Medicaid when entering the correctional system, the State will improve its eligibility process for Medicaid coverage applicable to all individuals leaving a prison or jail setting, ensuring that individuals receive assistance with completing and submitting an application for Medicaid, unless the individual declines such assistance or wants to decline enrollment.

If an individual who is incarcerated would be eligible for CHIP if not for their incarceration status, and qualify to receive pre-release services, then pre-release services will be covered under this amendment.

Re-entry Demonstration Initiative populations are defined as persons who are enrolled in Medicaid or who would be eligible for CHIP except for their incarceration status, or who are incarcerated in a State prison or juvenile facility who meet the eligibility criteria below. Like Washington, no specific health condition is required for demonstration eligibility. To receive services under the Re-entry Demonstration, a beneficiary will meet the following qualifying criteria:

Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a State prison or juvenile facility;

Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and

Identified as expected to be released in the next 90 days and identified for participation in the Demonstration.

SMI/SED Initiative:

All enrollees eligible for a mandatory or optional eligibility group approved for full Medicaid coverage would be eligible for stays in an IMD under the Demonstration. Only the eligibility groups outlined in Table 1 below will not be eligible for stays in an IMD as they receive limited Medicaid benefits only.

Table 1: Eligibility Groups Excluded from the Demonstration

Eligibility Group	Social Security Act and CFR Citations
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries	1902(a)(10)(E)(i) 1905(p)
Specified Low Income Medicare Beneficiaries	1902(a)(10)(E)(iii)
Qualified Individual Program	1902(a)(10)(E)(iv)

Eligibility Group	Social Security Act and CFR Citations
Qualified Disabled Working Individual Program	1902(a)(10)(E)(ii) 1905(s)
Presumptively Eligible Pregnant Women	1920 42 CFR §435.1103

Continuous Eligibility: The proposed continuous eligibility policy will apply to Medicaid-enrolled children with incomes up to 215 percent of the federal poverty level (FPL), CHP+ children with incomes up to 260 percent FPL, and children who would be eligible for medical assistance coverage but are not because of their immigration status. Once enrolled in Medicaid or CHP+, these children will remain continuously enrolled during their first three years of life without regard to family income. Additionally, Medicaid-eligible adults leaving a Colorado DOC facility will remain continuously eligible for Medicaid without regard to income for a period of 12 months beginning on the date of release.

HCPF will continue disenrollment of individuals who move out of state, request voluntary disenrollment, had initial eligibility erroneously determined, or die. The Demonstration will have no enrollment limits and no other eligibility modifications are proposed under this amendment.

Benefits

Through this amendment, HCPF proposes to provide the following services to incarcerated individuals during the 90 days prior to their release date:

- Case management (care coordination) services that include physical and behavioral health clinical screenings and consultation services;
- A 30-day supply of prescription medications and medication administration post release; and
- MAT for all FDA-approved medications (including counseling and long acting injectables).

Additionally, HCPF proposes to reimburse the first 15-days of acute psychiatric care stays in an IMD that exceed the current 15-day limit under "in lieu of service" authority.

The continuous eligibility provisions will not affect benefits under the demonstration.

Cost Sharing

There are no proposed changes to cost sharing under this amendment.

Delivery System

No changes to Colorado's delivery system are proposed under this amendment. Benefits will continue to be managed by the state's MCEs.

Demonstration Hypotheses and Measures

Re-entry Initiative

With the help of the independent evaluator, the State will amend the approved SUD evaluation plan for evaluating the hypotheses indicated below. The State will calculate and report all performance measures under the Demonstration. The State will submit the updated SUD evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this Demonstration related to the five Re-entry milestones as required in CMS guidance and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

By providing Medicaid coverage prior to an individual's release from incarceration, the State will be able to bridge relationships between community-based Medicaid providers and JI populations prior to release, thereby improving the likelihood that individuals with a history of BH conditions and/or chronic diseases will receive stable and continuous care. The following hypotheses and goals will be tested during the approval period:

Hypotheses: The full 90-day timeline will enable the State to support pre-release identification, stabilization, and management of certain serious physical and BH conditions that may respond to ambulatory care and treatment (e.g., diabetes, heart failure, hypertension, schizophrenia, SUDs) which could reduce post-release acute care utilization.

By allowing early interventions to occur in the full 90-day period immediately prior to expected release, such as for certain BH conditions and including stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs, the State expects that it will be able to reduce decompensation, suicide-related deaths, overdoses, and overdose related deaths in the near-term post-release.

Questions: The State will test, and comprehensively evaluate through robust hypothesis testing, the effectiveness of the extended full 90-day coverage period before the beneficiary's expected date of release on achieving the articulated goals of the initiative:

Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;

Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during re-entry;

Improve coordination and communication between correctional systems, Medicaid systems, administrative services organizations, and community-based providers;

Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;

Improve connections between carceral settings and community services upon release to address physical health, BH, and HRSN;

Reduce all-cause deaths in the near-term post-release; and

Reduce the number of ED visits and inpatient hospitalizations among recently released Medicaid beneficiaries through increased receipt of preventive and routine physical and BH care.

Data Source: Claims/encounter data.

Evaluation Design: Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons and interrupted time series analysis.

Severe Mental Illness Initiative

The State's Independent Evaluator will work with CMS to amend the Demonstration evaluation design. Below are proposed hypotheses for this initiative. The specific evaluation methodology will be submitted with the updated Evaluation Design upon approval of the amendment.

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Goal 1: Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.		
The demonstration will result in reductions in utilization and length of stays in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment.	Does the demonstration result in reductions in utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings? How does the demonstration effect utilization reduction and lengths of stay in EDs among Medicaid beneficiaries with SMI/SED by geographic area or beneficiary characteristics? How do demonstration activities contribute to reductions in utilization and lengths of stays in EDs among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings?	Data Sources: Claims data Medical or administrative records Interviews or focus groups Analytic Approach: Difference-in- differences model Subgroup analyses Qualitative analysis
Goal 2: Reduced preventable readmissions to acute care hospitals and residential settings.		
The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	Does the demonstration result in reductions in preventable readmissions to acute care hospitals and residential settings (including short-term inpatient and residential admissions to both IMDs and non-IMD acute care hospitals, critical access hospitals, and residential settings)?	Data Sources: Claims data Interviews or focus groups Medical records Beneficiary survey Analytic Approach: Difference-in- differences models Qualitative analysis Descriptive quantitative analysis

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
	How does the demonstration effect preventable readmissions to acute care hospitals and residential settings by geographic area or beneficiary characteristics? How do demonstration activities contribute to reductions in preventable readmissions to acute care hospitals and residential settings? Does the demonstration result in increased screening and intervention for comorbid SUD and physical health conditions during acute care psychiatric hospital and residential setting stays and increased treatment for such conditions after discharge?	
Goal 3: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units; intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the State.		
The demonstration will result in improved availability of crisis stabilization services throughout the State.	• To what extent does the demonstration result in improved availability of crisis outreach and response services (including crisis call centers, mobile crisis units, crisis observation/ assessment centers, and coordinated community crisis response teams) throughout the State? • To what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization? • To what extent does the demonstration improve the availability of crisis stabilization services provided during acute short-term stays in each of the following: public and private psychiatric hospitals, residential treatment facilities, general hospital psychiatric units, and community-based settings?	Data Sources: Annual assessments of availability of mental health services Area Health Resources File (AHRF) data National Mental Health Services (NMHSS) survey Administrative data Provider survey Analytic Approach: Descriptive quantitative analysis

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Goal 4: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and BH care.		
Access of beneficiaries with SMI/SED to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and BH care.	• Does the demonstration result in improved access of beneficiaries with SMI/SED to community-based services to address their chronic mental health needs? • To what extent does the demonstration result in improved availability of specific types of community-based services needed to comprehensively address the chronic needs of beneficiaries with SMI/SED? • To what extent does the demonstration result in improved access of SMI/SED beneficiaries to specific types of community-based services that they need? • How does the demonstration effect access to community-based services by geographic area or beneficiary characteristics? • Does the integration of primary and BH care to address the chronic mental health care needs of beneficiaries with SMI/SED increase under the demonstration?	Data Sources: Claims data Annual assessments of availability of mental health services AHRF NMHSS survey Administrative data Uniform Reporting System Child and Adult Core Set Medical records Analytic Approach: Descriptive quantitative analysis Chi-squared analysis Difference-in- differences model
Goal 5: Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.		
The demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	Does the demonstration result in improved care coordination for beneficiaries with SMI/SED? Does the demonstration result in improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities? Does the demonstration result in improved discharge planning and outcomes regarding housing for beneficiaries who are transitioning out of acute	Data Sources: Claims data Child and Adult Core Set Inpatient Psychiatric Facility Quality Reporting program Medical records Interviews or focus groups Facility records Analytic Approach: Difference-in- differences model Descriptive quantitative analysis Qualitative analysis

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
	psychiatric care in hospitals and residential treatment facilities? How do demonstration activities contribute to improved continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities?	

In addition to the independent evaluation, HCPF will provide quarterly and annual reporting specific to this amendment and in accordance with a CMS-approved Monitoring Protocol to be submitted following approval.

Continuous Eligibility Initiative

The State's Independent Evaluator will work with CMS to amend the Demonstration evaluation design. Below are proposed hypotheses for this initiative. The specific evaluation methodology will be submitted with the updated Evaluation Design upon approval of the amendment.

Population: Children zero to age three continuously enrolled in Medicaid and CHP+

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Goal 1: Ensure continuous Medicaid and CHP+ coverage for young children		
Continuous coverage will reduce churn and gaps in coverage for young children enrolled in Medicaid	Does continuous enrollment reduce gaps in coverage?	Examine Medicaid and CHP+ enrollment data by age to determine changes in insured rates and gaps in coverage over time.
Goal 2: Promote longer-term access to and continuity of physical health, BH, and dental care, and preventive services.		
Continuous coverage will increase preventive care utilization, primary care utilization and dental care visits.	Does continuous coverage improve utilization of preventive care and well child visits?	Analyze administrative claims data to determine changes in preventive care, well child visits, primary care visits.
Goal 3: Combat racial inequities.		
Continuous coverage will reduce churn and gaps in coverage for young children enrolled in Medicaid, including for racial and ethnic groups that experience disproportionately high rates of churn.	Does continuous enrollment reduce gaps in coverage for all racial and ethnic groups?	Examine Medicaid and CHP+ enrollment data by race and ethnicity to determine gaps in coverage over time.

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Goal 4: Improve health outcomes and well-being for low-income young children.		
Coverage with fewer gaps in coverage for young children will result in improved health outcomes and well-being.	Does continuous coverage improve health outcomes and well-being?	Measures will be selected from the list of measures that HCPF is calculating as part of the development of our quality metrics program.

Population: Medicaid enrolled adults leaving a correctional facility

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
Goal 1: Ensure 12 months of continuous Medicaid coverage for adults leaving a DOC facility.		
Continuous coverage will reduce gaps in coverage for adults leaving a correctional facility.	Does 12 months of continuous enrollment reduce gaps in coverage?	Examine Medicaid enrollment data by age to determine changes in insured rates and gaps in coverage over time.
Goal 2: Promote longer-term access to and continuity of physical and BH care and care coordination.		
Continuous coverage will increase preventive, primary care, and BH engagement.	Does continuous coverage increase primary care and preventive service utilization and BH service utilization?	Measures will be selected from the list of measures the HCPF is calculating as part of the development of a Providers of Distinction quality metrics program.
Goal 3: Combat racial inequities.		
Continuous coverage will reduce churn and gaps in coverage for adults leaving correctional facilities and enrolled in Medicaid, including for racial and ethnic groups.	Does continuous coverage reduce gaps in coverage for all racial and ethnic groups?	Examine Medicaid enrollment data by race and ethnicity to determine gaps in coverage over time.
Goal 4: Improve short and long-term physical and BH outcomes and reduce recidivism for adults leaving a State DOC facility.		
Continuous coverage will reduce ED visits, hospitalizations, and crisis services.	Does continuous coverage reduce ED visits, hospitalizations, and crisis services?	Analyze administrative claims data to determine changes in preventive care, ED utilization, hospitalizations, crisis service utilization.

Proposed Federal Demonstration Authorities

Re-entry Initiative

The State seeks the following waiver authority as necessary under the Demonstration to receive a federal match on costs not otherwise matchable for services rendered to individuals who are incarcerated 90 days prior to their release. The State also requests the following proposed waivers authority to operate the Demonstration.

Waiver Authority	Reason and use of Waiver Authority will enable the State to:
Statewide Section 1902(a)(1) 42 CFR 431.50	To enable the State to provide pre-release services, as authorized under this Demonstration, to qualifying beneficiaries on a geographically limited basis according to the statewide implementation phase-in plan, in accordance with the Re-entry Demonstration Initiative implementation plan.
Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) and 1902(a)(17)	To enable the State to provide only a limited set of pre-release services, as specified in these STCs, to qualifying beneficiaries that are different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the State Plan or the Demonstration.
Freedom of Choice Section 1902(a)(23)(A) 42 CFR 431.51	To enable the State to require qualifying beneficiaries to receive pre-release services, as authorized under this Demonstration, through only certain providers.
Requirements for Providers under the Medicaid State Plan Section 1902(a)(27) and 1902(a)(78)	To enable the State to not require carceral providers to enroll in State Medicaid, in order to provide, order, refer, or prescribe pre-release services as authorized under this Demonstration.
Title XXI Requirements Not Applicable to the Title XXI Expenditure Authority Above Requirements for Providers Under the State Plan Section 2107(e)(1)(D)	To enable the State to not require carceral providers to enroll in State CHIP, in order to provide, order, refer, or prescribe pre-release services as authorized under this Demonstration.

Expenditure Authority

The State requests expenditure authority to provide Medicaid benefits to Demonstration eligible individuals.

Title XIX Expenditure Authority	Expenditures
Expenditures Related to Pre-Release Services	Expenditures for pre-release services, as described in these STCs, are provided to qualifying Medicaid beneficiaries and beneficiaries who would be eligible for Medicaid if not for their incarceration status for up to 90 days immediately prior to the expected date of release from a participating State prison or juvenile facility.
Expenditures for Allowable Administrative Costs to Support the Implementation of Pre-Release Services	Expenditures for allowable administrative costs to support the implementation of pre-release services as outlined in the April 17, 2023, SMD letter #23-003 relating to administrative information technology (IT) and

Title XIX Expenditure Authority	Expenditures
	transitional, non-service expenditures, including administrative costs under an approved cost allocation plan.

Title XXI Expenditure Authority	Expenditures
Expenditures Related to Pre-Release Services	Expenditures for pre-release services, as described in the STCs, are provided to qualifying Demonstration beneficiaries who would be eligible for CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating State prison or juvenile facility.

Severe Mental Illness Initiative

The State requests expenditure authority to provide Medicaid benefits to Demonstration eligible individuals.

Title XIX Expenditure Authority	Expenditures
Expenditures Related to IMD services	Expenditures for otherwise covered Medicaid services furnished to otherwise eligible individuals, who are primarily receiving treatment for an SMI/SED who are short-term residents in facilities that meet the definition of an IMD.

Continuous Eligibility Initiative

Waiver Authority	Reason and use of Waiver Authority will enable the State to:
Section 1902(a) to the extent it incorporates 42 CFR 435.916 42 CFR 457.343 Waive redetermination of eligibility regardless of changes in circumstances for children aged zero until age three.	To enable the State to waive the annual redetermination requirements, including required procedures for reporting and acting on changes that would completely disenroll a children aged zero until age three from Medicaid and CHP+ (other than a change in residence to out of state, voluntary disenrollment, erroneously granted enrollment). The State will act on annual reported family income changes to re-assign children between Medicaid and CHP+ appropriately. Continuous enrollment for children at the time of application through the end of the month their third birthday falls.
Section 1902(a) to the extent it incorporates 42 CFR 435.916 Waive redetermination of eligibility regardless of changes in circumstances for 12 months prior the release from correctional facilities for adults aged 19 and over.	To enable the State to waive the annual redetermination requirements, including required procedures for reporting and acting on changes to would completely disenroll an adult. 12 Month Continuous Eligibility for adults leaving incarceration age 19 and over.

Title XIX Expenditure Authority	Expenditures
Continuous enrollment for children at the time of application through the end of the month their third birthday falls.	Expenditures for continuous enrollment for Medicaid and CHIP children: authority to receive FFP for the continuous enrollment of Medicaid and CHIP children, even if a child's family income exceeds eligibility limits. The State will act on annual reported family income changes to re-assign children between CHP+ and Medicaid appropriately.
12 Month continuous enrollment for adults leaving incarceration age 19 and over.	Expenditures for 12 months of continuous enrollment for adults leaving incarceration aged 19 and over.

Estimated Impact of the Demonstration

The proposed demonstration will impact the annual enrollment for each of the populations included in the demonstration proposals. Enrollment projections are shown through the tables below through estimated number of member months (months of eligibility) for each MEG impacted by the demonstration proposal over the five-year demonstration period.

Estimated Projections of Annual Enrollment

Member Months under the Amendment*	DY5	DY6	DY7	DY8	DY9	5 year total
Total projected member months without the Amendment	0	0	0	0	0	
Total projected member months under the Amendment	8,208	568,240	582,531	588,356	594,240	2,341,575

*Using a 1% caseload growth rate; SMI/SED and Re-Entry Initiative effective July 1, 2025 (six-months of (DY5)); Continuous eligibility effective January 1, 2026 (DY6)

The table below estimates the projected annual expenditures (without and with the waiver) for each DY.

Estimated Projections of Annual Expenditures

Projected Services Costs under the Amendment*	DY5	DY6	DY7	DY8	DY9	5 year total
Total projected costs without the Amendment	0	0	0	0	0	0
Total projected costs under the Amendment	$129,581,634	$290,878,023	$274,509,519	$211,782,255	$224,808,729	$ 1,131,560,160

*Using a 5.1% trend rate; SMI/SED and Re-Entry Initiative effective July 1, 2025 (six-months of (DY5)); Continuous eligibility effective January 1, 2026 (DY6)

Demonstration Proposal: Federal Financial Participation (FFP) for up to 15 days for non-SUD IMD stays that exceed 15 days – Effective July 1, 2025 (six-months of DY5)

	DY5	DY6	DY7	DY8	DY9	5-Year Total
MEG 1 - Non-Expansion Adults						
Demonstration Member Months	3	6	6	6	6	**27**
Per Capita (PMPM)	$39.79	$41.81	$43.95	$46.19	$48.54	**$47.30**
Projected Demonstration Expenditures	$124	$263	$279	$296	$315	**$1,277**
MEG 2 - Expansion Adults						
Demonstration Member Months	38	78	78	79	80	**353**
Per Capita (PMPM)	$56.82	$59.72	$62.76	$65.97	$69.33	**$63.73**
Projected Demonstration Expenditures	$2,182	$4,633	$4,918	$5,221	$5,542	**$22,496**

Demonstration Proposal Enrollment, Per Capita and Expenditure Projection Notes:

3) *DY5 represents a 12-month period between 1/1/2025 – 12/31/2025; however, IMD services begin 7/1/2025. The DY5 PMPM represents a six-month period.*

4) *The non-SUD IMD services for up to 15 days will be covered by the behavioral health capitated program. All other services covered via fee-for-service (FFS). The per capita reflects the weighted average of the BH rate impact plus the FFS expenditures in the month the individual is inpatient in a non-SUD IMD.*

Demonstration Proposal: Pre-Release for Individuals Prior to Release from Juvenile facility or Colorado Department of Corrections – Effective July 1, 2025 (six-months of DY5)

	DY5	DY6	DY7	DY8	DY9	5-Year Total
MEG 3 –Justice-Involved Youth						
Demonstration Member Months	79	80	81	82	83	**405**
Per Capita (PMPM)	$896.59	$942.32	$990.38	$1,040.89	$1,093.97	**$994.05**
Projected Demonstration Expenditures	$70,831	$75,386	$80,221	$85,353	$90,800	**$402,591**
MEG 4 - Non-Expansion Adults						
Demonstration Member Months	276	279	282	285	288	**1,410**
Per Capita (PMPM)	$886.52	$931.73	$979.25	$1,029.19	$1,081.68	**$982.71**
Projected Demonstration	$244,678	$259,952	$276,147	$293,318	$311,523	**$1,385,618**

Expenditures						
MEG 5 - Expansion Adults						
Demonstration Member Months	7,812	7,890	7,969	8,049	8,129	**39,849**
Per Capita (PMPM)	$934.30	$981.95	$1,032.02	$1,084.66	$1,139.98	**$1,035.60**
Projected Demonstration Expenditures	$7,298,723	$7,747,550	$8,224,205	$8,730,412	$9,266,861	**$41,267,751**
Administrative Information Technology – Total Computable Aggregate Annual Limits						
Admin/FTE Costs (50% FFP)	$320,000	$475,000	$551,500	$578,000	$636,000	**$2,560,500**
Systems Costs (90/10 or 75/25 FFP)	$550,000	$110,000	$27,500	$27,500	$27,500	**$742,500**
Total Administration Costs	**$870,000**	**$585,000**	**$579,000**	**$605,500**	**$663,500**	**$3,303,000**
Demonstration Proposal Enrollment, Per Capita and Expenditure Projection Notes: *3) DY5 represents a 12-month period between 1/1/2025 – 12/31/2025; however, pre-release services begin 7/1/2025. The DY5 PMPM represents a six-month period.* *4) As developed, pre-release services will be provided through fee-for-service.*						

Demonstration Proposal: Continuous Eligibility for Children (Under age 18) who are less than 3 years old – Effective January 1, 2026 (DY6)

	DY5	DY6	DY7	DY8	DY9	5-Year Total
MEG 6 – Medicaid Children						
Demonstration Member Months	n/a	535,475	540,830	546,238	551,700	**2,174,243**
Per Capita (PMPM)	n/a	$317.26	$333.44	$350.44	$368.32	**$342.58**
Projected Demonstration Expenditures	n/a	$169,883,723	$180,333,270	$191,425,570	$203,200,157	**$744,842,720**
Demonstration Proposal Enrollment, Per Capita and Expenditure Projection Notes: *1) Continuous coverage begins January 1, 2026 (DY6).*						

Demonstration Proposal: Continuous Coverage for Eligible Individuals Released from a Department of Corrections (DOC) facility for a period of 1 year beginning on the date of the individual's release – Effective January 1, 2026 (DY6)

	DY5	DY6	DY7	DY8	DY9	5-Year Total
MEG 7 –Justice-Involved Youth						
Demonstration Member Months	n/a	302	439	443	448	**1,632**
Per Capita (PMPM)	n/a	$698.49	$734.12	$771.56	$810.91	**$758.89**
Projected Demonstration Expenditures	n/a	$210,945	$322,292	$342,117	$363,160	**$1,238,514**

MEG 8 - Non-Expansion Adults						
Demonstration Member Months	n/a	762	1,055	1,065	1,076	**3,958**
Per Capita (PMPM)	n/a	$1,752.55	$1,841.93	$1,935.87	$2,034.60	**$1,902.19**
Projected Demonstration Expenditures	n/a	$1,335,445	$1,942,539	$2,062,025	$2,188,860	**$7,528,869**
MEG 9 - Expansion Adults						
Demonstration Member Months	n/a	23,368	31,791	32,109	32,430	**119,698**
Per Capita (PMPM)	n/a	$182.90	$192.23	$202.03	$212.34	**$198.49**
Projected Demonstration Expenditures	n/a	$4,274,080	$6,111,160	$6,487,057	$6,886,076	**$23,758,373**
Administrative Information Technology – Total Computable Aggregate Annual Limits						
Admin/FTE Costs (50% FFP)	$1,200,000	$1,386,000	$1,524,500	$1,677,000	$1,845,000	**$7,632,500**
Systems Costs (90/10 or 75/25 FFP)	$1,100,000	$220,000	$55,000	$55,000	$55,000	**$1,485,000**
Total Administration Costs	**$2,300,000**	**$1,606,000**	**$1,579,500**	**$1,732,000**	**$1,900,000**	**$9,117,500**

Opportunity for Public Comment

The proposed Section 1115 Demonstration amendment is available for public review and comment at:

1115 SUD Demonstration Amendment Request

To request a copy of the amendment, please contact HCPF by:

- Sending an email request to hcpf_1115waiver@state.co.us;
- Sending a request by fax to 303-866-4411, Attn: 1115 SUD Demonstration Amendment; or
- Obtaining in person at the Colorado Department of Health Care Policy and Financing, 303 E 17th Avenue, Denver, CO 80203.

During the public comment period, comments may be sent to hcpf_1115waiver@state.co.us. Public comments may also be submitted by post to:

Director, Health Programs Office

Colorado Department of Health Care Policy and Financing

303 E 17th Avenue

Denver, Colorado 80203

ATTN: Public Comment – 1115 SUD Demonstration Amendment

Additional information will be posted on HCPF's *Ensuring a Full Continuum of SUD Benefits* webpage, at https://hcpf.colorado.gov/1115sudwaiver .

Public Hearings

HCPF invites the public to attend public hearings in person or join by teleconference/webinar to learn more about Colorado's Demonstration amendment and provide comments.

	Public Hearing #1	**Public Hearing #2**
Date	February 7, 2024	February 8, 2024
Time	3pm-5pm MST	9am-11am MST
Venue	Pueblo City-County Library District - Patrick A. Lucero Branch, 1315 E 7th St, Pueblo, CO 81001 Lucero Large Community Room	Colorado Department of Health Care Policy and Financing 303 E 17th Ave, Denver, CO 80203 Room 11B
Teleconference	833-548-0276	833-548-0276
Webinar	https://us06web.zoom.us/webinar/register/WN_patMQrKgRGCqeqXh2tE_Pg	https://us06web.zoom.us/webinar/register/WN_L3BIfl8KSGyxxQm5gY3bdQ

Reasonable accommodations will be provided upon request. Auxiliary aids and services for individuals with disabilities and language services for individuals whose first language is not English may be provided upon request. Please notify 303-866-3438 or the 504/ADA Coordinator at hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.

CMS/Medicaid Demonstration Website

Relevant webpages and additional information regarding the Medicaid Demonstration can be viewed on the CMS/Medicaid website, at: https://www.medicaid.gov/medicaid/section-1115-demo/index.html

This notice is submitted pursuant to Title 42 Code of Federal Regulations, Part 431.408, Subpart G, which outlines public notice processes and transparency requirements for Section 1115 Demonstrations.

Attachment 5: Abbreviated Public Notice

COLORADO
Department of Health Care Policy & Financing

Notice of Public Comment Process
Medicaid Section 1115 Demonstration Amendment

Public Comment Period Begins: January 25, 2024 at 8:00 a.m. MST

Public Comment Period Ends: February 24, 2024 at 5:00 p.m. MST

Public notice is hereby given that the State of Colorado's Department of Health Care Policy & Financing (HCPF) is seeking public comments on an amendment to the Expanding the Substance Use Disorder (SUD) Continuum of Care Section 1115 Demonstration (Demonstration). Colorado is requesting an amendment to the Demonstration to authorize:

1. Pre-release services for individuals transitioning from correctional facilities (targeted to begin July 1, 2025);
2. Reimbursement for acute inpatient and residential stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED) (targeted to begin July 1, 2025); and
3. Continuous eligibility for children ages 0-3 and adults leaving a Colorado Department of Corrections (DOC) facility (targeted to begin January 1, 2026).

HCPF is requesting to have an effective date of January 1, 2025 for the proposed amendment to provide the necessary time to implement and operationalize the services and eligibility components within the amendment.

Opportunity for Public Comment

The proposed Section 1115 Demonstration amendment, and a copy of the full public notice, is available for public review and comment at:

Full Public Notice

1115 SUD Demonstration Amendment Request

To request a copy of the amendment, please contact HCPF by:

- Sending an email request to hcpf_1115waiver@state.co.us;
- Sending a request by fax to 303-866-4411, Attn: 1115 SUD Demonstration Amendment; or
- Obtaining in person at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203.

During the public comment period, comments may be sent to hcpf_1115waiver@state.co.us. Public comments may also be submitted by post to:

Director, Health Programs Office

Colorado Department of Health Care Policy and Financing

1570 Grant Street

Denver, Colorado 80203

ATTN: Public Comment – 1115 SUD Demonstration Amendment

Additional information will be posted on HCPF's *Ensuring a Full Continuum of SUD Benefits* webpage, at https://hcpf.colorado.gov/1115sudwaiver.

Public Hearings

HCPF invites the public to attend public hearings in person or join by teleconference/webinar to learn more about Colorado's Demonstration amendment and provide comments.

	Public Hearing #1	**Public Hearing #2**
Date	February 7, 2024	February 8, 2024
Time	3pm-5pm MST	9am-11am MST
Venue	Pueblo City-County Library District - Patrick A. Lucero Branch, 1315 E 7th St, Pueblo, CO 81001 Lucero Large Community Room	Colorado Department of Health Care Policy and Financing 303 E 17th Ave, Denver, CO 80203 Room 11B
Teleconference	833-548-0276	833-548-0276
Webinar	https://us06web.zoom.us/webinar/register/WN_patMQrKgRGCqeqXh2tE_Pg	https://us06web.zoom.us/webinar/register/WN_L3BIfl8KSGyxxQm5gY3bdQ

Reasonable accommodations will be provided upon request. Auxiliary aids and services for individuals with disabilities and language services for individuals whose first language is not English may be provided upon request. Please notify 303-866-3438 or the 504/ADA Coordinator at hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.

CMS/Medicaid Demonstration Website

Relevant webpages and additional information regarding the Medicaid demonstration can be viewed on the CMS/Medicaid website, at: https://www.medicaid.gov/medicaid/section-1115-demo/index.html

Summary Description of Proposed Amendment

This abbreviated public notice provides information regarding the proposed amendment request to the Centers for Medicare & Medicaid Services (CMS) for three initiatives: 1) Pre-release services for individuals transitioning from correctional facilities; 2) Reimbursement for acute inpatient and residential stays in institutions for mental disease (IMD) for individuals diagnosed

with a serious mental illness (SMI) or serious emotional disturbance (SED); and 3) Continuous eligibility for children ages 0-3 and adults leaving a Colorado Department of Corrections (DOC) facility.

Re-entry Initiative: The Re-entry Initiative will enable Medicaid coverage and federal financial participation (FFP) using Medicaid and Children's Health Insurance Program (CHIP) matching funds for adults incarcerated by DOC and youth detained throughout the State receiving a targeted benefit package that would ordinarily not be covered under federal law. This Re-entry Initiative will ensure a continuum of care strategy that enables robust coordination, service provision, and community connections after release.

Colorado is requesting this authority to design and implement a "Re-entry Initiative" that provides:

1. **Medicaid Coverage** for eligible inmates in the State's correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), juvenile and community residential centers throughout the State. Eligible inmates include those with behavioral health needs including mental health disorders and substance use disorder (SUD), certain other health conditions and incarcerated youth.

2. **A Targeted Benefit Package** for these individuals to include case management services, medication-assisted treatment for SUD, a 30-day supply of medications upon release, and certain other supportive services.

3. **A Coverage Period of up to 90 Days** immediately prior to the release of the incarcerated individual from the correctional system.

Colorado's specific goals for the Re-entry Initiative are to:

1. Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings just prior to release;

2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during re-entry;

3. Improve coordination and communication between correctional systems, Medicaid systems, managed care organizations, and community-based providers;

4. Increase additional investments in health care and related services, aimed at improving the quality of care for beneficiaries in carceral settings and in the community to maximize successful re-entry post-release;

5. Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and HRSN;

6. Reduce all-cause deaths in the near-term post-release; and

7. Reduce the number of emergency department ED visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries through increased receipt of preventive and routine physical and behavioral health care.

To receive services under the Re-entry Initiative, a beneficiary will need to meet all of the following qualifying criteria:

- Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a State correctional system, including all correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile and community residential centers; and
- Be enrolled in Medicaid or otherwise eligible for CHIP if not for their incarceration status; and
- Identified as expected to be released in the next 90 days and identified for participation in the Demonstration.

This Re-entry Initiative will not change the underlying Medicaid or CHIP program; in particular, it will not change the current Colorado managed care delivery system, eligibility requirements, covered services, or cost- sharing. This Re-entry Initiative will allow for the provision of certain approved services within carceral settings in the 90 days prior to release, and designate new entities able to coordinate and provide those services. Cost-sharing requirements will not differ from those provided under the State Plan for either Medicaid or CHIP. HCPF will determine when each applicable facility is ready to participate in the Re-entry Initiative based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement.

The pre-release services authorized under the Re-entry Initiative include the provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth. All facilities must implement service level one with the minimum CMS benefits. Service level one is structured as the CMS-required minimum benefit package for pre-release coverage:

- Re-entry transitional case management services to assess and address physical and behavioral health needs and HRSN;
- MAT, for all Food and Drug Administration approved medications, including coverage for counseling; and
- Covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate, consistent with the approved Medicaid State Plan) provided to the individual immediately upon release from the correctional facility.

Administrative FFP will be available for the following activities related to JI infrastructure development for technology, development of business or operational practices, workforce development, outreach, education and stakeholder convening.

Serious mental illness (SMI) and serious emotional disturbance (SED):
Through this amendment, HCPF seeks to expand this authority to reimburse for acute inpatient and residential stays in an IMD for individuals diagnosed with a SMI or SED. This request seeks to:

- Reform HCPF's current IMD reimbursement policy to cover up to 15 days each calendar month without length of stay restriction, so long as providers maintain an average length of stay of 30 days or less;
- Reduce utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;

- Reduce preventable readmissions to acute care hospitals and residential settings;
- Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

CMS provides two options for states to receive FFP for short-term IMD stays. First, states may use "in lieu of authority" through its managed care contracts to reimburse IMD stays of up to 15 days in a calendar month. Second, under 1115 waiver authority, states may reimburse for IMD stays of up to 60 days if an average statewide length of stay of 30 days or less is maintained. Currently, Colorado utilizes "in lieu of" authority through its managed care contracts with RAEs to provide IMD reimbursement for stays of up to 15 days in a calendar month. This authority provides sufficient coverage for most acute psychiatric inpatient stays. However, there remain IMD stays that exceed the 15-day limit due to issues such as patient acuity and additional time needed to ensure a safe and appropriate transition to community-based services. Stays that exceed the 15-day LOS rule are not eligible for any reimbursement for services rendered.

Through this amendment, HCPF seeks authority to reimburse up to 15-days each calendar month even if a stay exceeds the current limit under "in lieu of authority." This will permit Colorado to modify its current practice through which a prorated capitation payment is made to the RAE for the days within the month that the enrollee was not in an IMD and the RAE's subsequent payment recoupment from the IMD for the entire stay. It will also address the clinical decision making challenges in which providers are choosing between discharging a patient and receiving 15 days of reimbursement, and recognizing that some clients may have extended LOS due to discharge barriers such as housing, transportation, access to step down or psychiatric care, or physical safety in the home.

Continuous Eligibility:

Colorado House Bill 23-1300 authorizes HCPF, by April 1, 2024, to seek federal authority to provide continuous Medicaid coverage for children up to age three and for twelve months for adults who have been released from a Colorado Department of Corrections facility, regardless of any change in income during that time by January 1, 2026.[26] Through this legislation, Colorado aims to improve the health and well-being of people in Colorado through consistent access to health care coverage during critical periods in life. During the COVID-19 public health emergency, longer periods of continuous coverage in the state's medical assistance programs allowed more Colorado families to access and maintain health insurance. This continuous coverage reduces family stress, increases the use of preventive services, and reduces costly, avoidable emergency department (ED) visits and hospitalization stays.

[26] Continuous Eligibility Medical Coverage Act, HB23-1300. 2023 Colorado State Legislative Session. Retrieved from https://leg.colorado.gov/bills/hb23-1300

Continuous coverage assists children in healthy early development and strengthens overall mental health through regular connections with the health system.

Providing continuous Medicaid coverage can decrease gaps in insurance coverage (churn: losing and then re-enrolling in coverage often for administrative reasons or small fluctuations in income) and enhance the continuity of care and delivery of physical and behavioral health services during early childhood and when adults experience the difficult transition of leaving the criminal justice system.

This demonstration request will end churn among Medicaid and CHP+[27] enrolled children through age three, enabling their families and providers to better address their primary and preventive health care needs.[28] Children need consistent access to health care, especially in their early years, when frequent screenings, vaccinations, and wellness checkups are critical to their development and school readiness. This request will ensure that coverage disruptions do not prevent children from receiving ongoing treatment and services they require during the critical early years of development and growth. This request seeks to:

- Ensure continuous Medicaid and CHP+ coverage for young children;
- Promote longer-term access to and continuity of physical health care, behavioral health care, dental care and preventive services;
- Combat racial inequities; and
- Improve health outcomes and well-being for low-income young children.

This demonstration request will also end churn among Medicaid-enrolled adults for the year after they leave a Colorado DOC facility and re-enter the community, enabling these individuals and their providers to better address their physical and behavioral health care needs. Ensuring continuous coverage for previously incarcerated adults not only improves health outcomes but supports stability and may also improve public safety by reducing rates of recidivism. For example, adults with substance use disorder (SUD) convictions have a greater risk of criminal re-involvement and recidivism.[29]

This request will ensure that coverage disruptions do not prevent adults leaving incarceration in Colorado DOC facilities from receiving ongoing treatment for physical or behavioral health needs during a critical time that can improve SUD and mental health treatment, reduce recidivism rates and reduce costly hospitalizations and unnecessary ED visits.[30] This request seeks to:

- Ensure 12 months of continuous Medicaid coverage for adults leaving a DOC facility;
- Promote longer-term access to and continuity of physical and behavioral health care and care coordination;

[27] In Colorado, the Children's Health Insurance Program is called the Child Health Plan Plus (CHP+)

[28] Alker, J., Kenney G., Rosenbaum S. (2022) T*he Biden Administration Should Approve Oregon's Request To Cover Children Until Their Sixth Birthday*. Health Affairs. Retrieved from: https://www.healthaffairs.org/content/forefront/biden-administration-should-approve-oregon-s-request-cover-children-until-their-sixth

[29] NIDA. (2020) *Criminal Justice DrugFacts*. National Institute on Drug Abuse. Retrieved from: https://nida.nih.gov/publications/drugfacts/criminal-justice

[30] Frank, J. W., Linder, J. A., Becker, W. C., Fiellin, D. A., & Wang, E. A. (2014) *Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: results of a national survey*. Journal of general internal medicine, 29(9), 1226–1233. Retrieved from: https://doi.org/10.1007/s11606-014-2877-y

- Combat racial inequities; and
- Improve short and long-term physical and behavioral health outcomes and reduce recidivism for adults leaving a Colorado DOC facility.

This notice is submitted pursuant to Title 42 Code of Federal Regulations, Part 431.408, Subpart G, which outlines public notice processes and transparency requirements for Section 1115 Demonstrations.

Attachment 6: Public Hearing Slides

The state held two public hearings where individuals could join in person or join by teleconference/webinar to learn more about Colorado's Demonstration amendment and provide comments. Below are the slides for the hearings. The State had over 50 individuals attend either in person or virtually.

Public Hearing

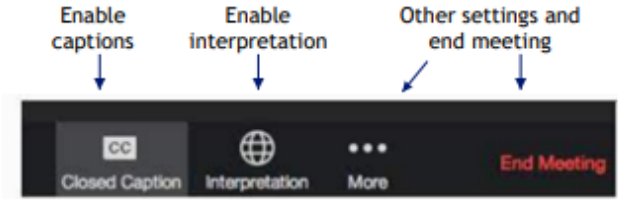
Opportunities for Expanded Medicaid Coverage in Colorado
1115 SUD Waiver Amendment

Health Care Policy & Financing

COLORADO
Department of Health Care Policy & Financing

Webinar Logistics

- ✓ We are recording - avoid sharing protected health information
- ✓ Accessibility: Closed captioning services are available through the toolbar at the bottom of your screen.



- ✓ If you are listening by phone press *6 to unmute your line or *9 to raise hand
- ✓ Have a question? Use Q&A, Chat, or “Raise Hand” on the Zoom toolbar.

COLORADO
Department of Health Care Policy & Financing

What We Do

The Department of Health Care Policy & Financing administers Health First Colorado (Colorado's Medicaid program), Child Health Plan *Plus* (CHP+) and other health care programs for Coloradans who qualify.

COLORADO
Department of Health Care Policy & Financing

Our Mission

Improving health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

COLORADO
Department of Health Care Policy & Financing

What is a 1115 waiver?

- ✓ Federal rules set minimum standards related to Medicaid and CHP+ eligibility and required benefits
- ✓ States can request to WAIVE some federal rules to have more flexibility and offer coverage to more people and cover more services
- ✓ Five year agreement
  - Option for renewal
  - States can amend existing 1115 waivers to ask for additional services
- ✓ Waivers require additional reporting to CMS and an evaluation component to demonstrate the waivers effectiveness

COLORADO
Department of Health Care Policy & Financing

1115 Expanding the Substance Use Disorder Continuum of Care Waiver

- ✓ HCPF received Federal approval to cover Substance Use Disorder (SUD) services in Institutions for Mental Disease (IMDs) and other settings through an 1115 SUD Demonstration Waiver
- ✓ CMS Approval: January 1, 2021- December 31, 2025
- ✓ Goals of the 1115 Demonstration
  - Increase treatment options and usage
  - Reduce excess service utilization
  - Reduce overdose and death

COLORADO
Department of Health Care Policy & Financing

Colorado's 1115 SUD Waiver Amendment (April 2024)

Continuous Eligibility Coverage for Children 0-3 Years

Will extend continuous eligibility coverage for children >3 years of age. Includes eligible children who face barriers due to immigration status.

Implementation Date Jan 2026

Continuous Eligibility Coverage for Adults Released from Colorado Department of Corrections Facilities

Will extend eligibility coverage for 12 months to adults released from a Colorado Department of Corrections facility.

Implementation Date Jan 2026

Criminal Justice Reentry Services

Coverage will include case management services, medication-assisted treatment (MAT) for SUD, a 30-day supply of medications upon release from Department of Corrections and Division of Youth Services facilities.

Implementation Date July 2025

Serious Mental Illness and Serious Emotional Disturbance (SMI & SED) Inpatient Care

Will allow HCPF to pay for up to 15 days per month for each member staying in an Institute of Mental Disease (IMD) regardless of the number of days in each episode of care.

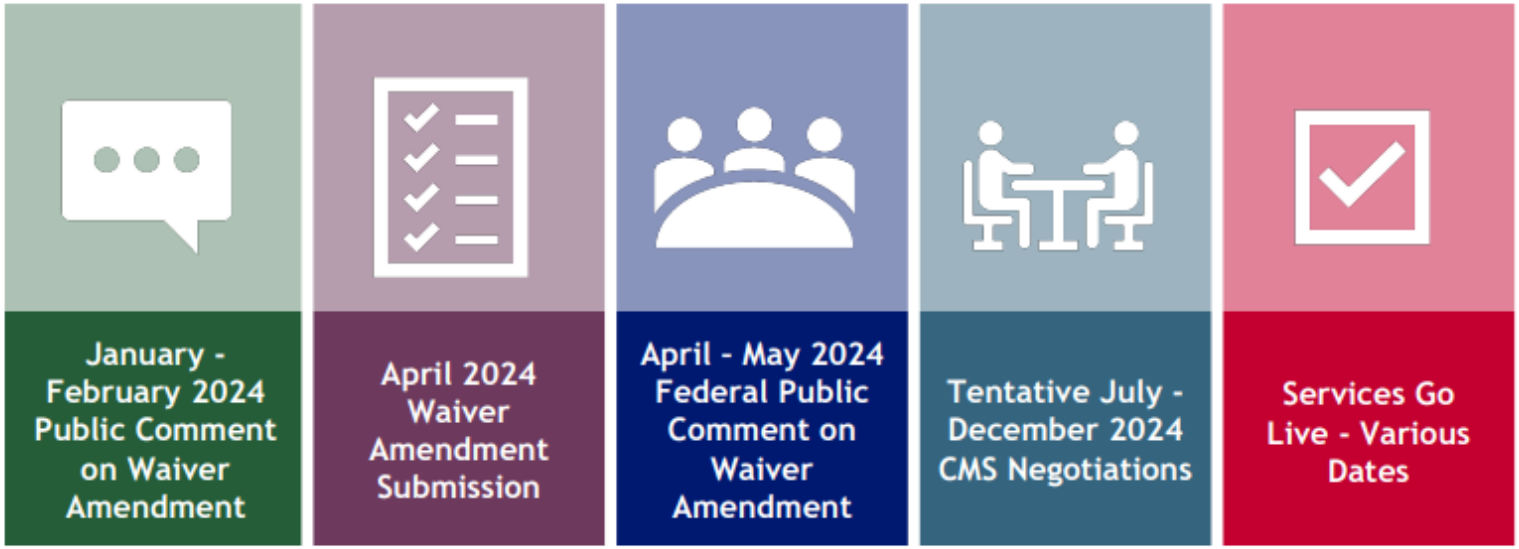
Implementation Date July 2025

HCPF is requesting to have an effective date of January 1, 2025

COLORADO
Department of Health Care Policy & Financing

7

1115 Waiver Amendment Timeline



COLORADO
Department of Health Care Policy & Financing

Comments

The amendment is currently posted on the Department's website

Open for public comment until February 24th, 2024 at 5:00 pm MST

During the public comment period, comments may be submitted via the following:

- During one of the Public Hearing meetings
- Email to hcpf_1115waiver@state.co.us
- Fax to 303-866-4411, Attn:1115 SUD Demonstration Amendment
- Mail your comments to:
  Colorado Department of Health Care Policy and Financing
  Attn: Public Comment - 1115 SUD Demonstration Amendment
  303 E. 17th Avenue
  Denver, CO 80203

COLORADO
Department of Health Care Policy & Financing

Colorado's 1115 SUD Waiver Amendment (April 2024)

- ✓ Extending continuous Medicaid & CHP+ coverage for children to age three
- ✓ Extending 12 months of continuous Medicaid for adults leaving incarceration from a Department of Corrections facility
- ✓ Prerelease services for adults and youth transitioning from correctional facilities
- ✓ Reimbursement for acute inpatient and residential stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED)

COLORADO
Department of Health Care Policy & Financing

COLORADO
Department of Health Care Policy & Financing

Comments & Questions

Contact Info

hcpf_1115waiver@state.co.us

Attachment 7: Public Notice Comments

Summary of Comments and State Responses
Colorado received 38 comments and 11 letters of support during the public comment period that took place from January 25, 2024 – February 24, 2024. The following is a summary of the comments and questions received and the state's responses.

Comments/Questions	State Response
General 1115 SUD Amendment Questions/Comments	
Will we get copies of this presentation after this meeting?	Here is a link to a more robust slide deck with information on our 1115 SUD Waiver Amendment efforts which include the waiver amendment timeline: https://hcpf.colorado.gov/1115sudwaiver#:~:text=Report%20Part%20B-,Stakeholder%20Forums,-HCPF%20held%20two
What is the overall timeline for submission of the 1115 Amendment?	The public comment period is 30 days through February 24, with official submission of the amendment in April 2024.
Can you please explain how HCPF will ensure access to services, especially in rural areas? I think expanding eligibility is important, but folks currently enrolled in Medicaid already have difficulty accessing services because of lack of providers. Have you considered differential pay scales for rural areas?	HCPF focuses a lot of our payment and budget approach toward rural providers. We have increased payments for rural hospitals and clinics, through grant programs, the hospital provider fee, and incentives payments through our Health IT plan. HCPF tries to focus on rural areas and ensure consideration. But there is nothing specific in this amendment to take on additional access in rural areas. One of the benefits to continuous coverage is that we have greater certainty in payments to providers, so you do not have your patients falling on/off coverage. This will also decrease administrative burden for the Medicaid population. This does not mean there is not going to be a significant expansion of the number of kids covered, it is just ensuring they are covered without lapses. Within respect to 12 months continuous coverage leaving DOC, these individuals will usually be eligible for Medicaid when leaving. We are currently serving these individuals and will ensure there are no gaps in coverage.
Please explain the statement: HCPF is requesting to have an effective date of 1/1/25 as shown on slide 7. Is the effective date different from the implementation date?	Colorado is requesting different effective and implementation dates. The effective date is earlier than the implementation date. Colorado wants to have time for system changes and administrative changes that will take place prior to the implementation date. Colorado is asking for an effective date prior to implementation go-live, so we can be administratively prepared.

I want to express appreciation to the department working toward this and express our support.	The state appreciates the comment and support in this important work.
The Colorado Consumer Health Initiative is appreciative and supportive of the department's work	The state appreciates the comment and support in this important work.
When does budget neutrality need to be achieved?	Budget Neutrality has to be achieved across the 5 years of the demonstration. CMS has provided states budget neutrality formulas to follow, for continuous coverage and housing supports. The CMS formulas may not look budget neutral but meet the CMS budget neutrality requirements related to expenditures.
Re-entry Initiative Comments/Questions	
Is it possible to include Tribal detention centers to the list of eligible facilities? I noticed it states that we may take a phased approach to adding facilities, but I'm wondering if we can try to prioritize Tribal detention centers if at all possible.	The state appreciates the comment and will need to work with the tribes and CMS to see if this is a possibility in the future.
Is there any element of this amendment that applies to people incarcerated in county jails, or just DOC?	The state's overarching intent is to include all carceral facilities; city or county jails, state run prisons and youth detention centers. Federal prisons will not be included. This amendment seeks federal authority to begin with state run prisons and youth detention centers. Jails will be included in a second phase. The state plans to seek federal authority to expand to jail settings in the waiver renewal.
I was under the impression it was a phased approach for the re-entry approach. This was DOC, DYS and then jails the final.	HCPF does plan to have a phased approach. Jails are not included in this amendment. The state plans to seek federal authority to expand to jails in the waiver renewal and there is not yet a go-live date for jails. The goal of this phased approach is to ensure successful implementation of reentry services, beginning with state facilities before expanding to jails. This approach will allow sufficient time to engage with jails across the state and plan for implementation.
Are you making folks in the prison aware that this will be happening?	HCPF is working with colleagues at the DOC to communicate with current incarcerated individuals.
Will the criminal justice reentry services apply to all patients in DOC or potentially jails or only to	All Medicaid eligible individuals leaving an eligible facility, such as DOC, will have access to reentry services.

individuals with a SUD diagnosis?	
Is there any element of this amendment that applies to people incarcerated in county jails, or just DOC?	The states intent is to include all carceral facilities; city or county jails, state run prisons and youth detention centers. Federal prisons will not be included. This amendment seeks federal authority to begin with state run prisons and youth detention centers. Jails will be included in a second phase. The state plans to seek federal authority to expand to jail settings in the waiver renewal.
Can you define a little more about what is involved in case management. Is that a broader term that will include peer services?	There are typically four common elements of Medicaid transitional case management: assessment, development of a care plan, referral for services and monitoring. However, states with already approved re-entry initiative demonstrations have also included other coordination including obtaining consent for release of information. There is a definition of case management in the demonstration for individuals to accept. This will be a partnership with DOC. DOC case manager (counseling and life long parole) and then we will have our RAEs be the medical side of the case management to help individuals transition from parole into the community assessments. We currently have that coordination set up with the RAEs right now, but we will be incorporating more into contracts with the approval of this amendment.
Right now clients are being paroled and are leaving with incarcerated benefits. This is being addressed through the implementation. And this should happen prior to release?	Release dates can be provided to an individual's county social services office at any time prior to or upon release to have the individual moved from incarcerated status to full benefits on that day. It is a manual process, and individuals may remain in incarcerated status if their change of incarceration status is not properly reported. Please reach out to HCPF if you are having difficulty with individuals leaving with incarcerated benefits after a release date is reported.
Including peer support in the reentry might go really nicely with case management. Incorporating peer services would be of interest in this.	The state appreciates the comment and can take this back to DOC and discuss the option.
I'd like to second that comment regarding including peer support in the reentry might go really nicely with case management. Incorporating peer services would be of interest in this.	The state appreciates the comment and can take this back to DOC and discuss the option.

Could you talk a little bit more about the logistics of the medications? So the medications at hand will be billed to Medicaid or to a RAE. Then the DOC providers will have to be enrolled as Medicaid providers?	You are exactly correct. We plan on enrolling DOC as a Medicaid provider. HCPF is actively working through this process with partners at DOC.
Does DOC use a centralized pharmacy?	Yes, DOC does have a centralized pharmacy.
In terms of the 90 day prerelease services for folks incarcerated. How is the 30 day supply of medication going to work? Will it be something that they were taking while incarcerated? or will this be a new prescription? As your waiver documents, there is very high rates of Hep C, but also other infectious disease that have very expensive medications. Jails cannot prescribe these medications because they are cost prohibitive, but Jails can diagnosis individuals while they are in jail. Would it have to be a medication that they are already on.	That policy has not yet been determined. HCPF will need to discuss with DOC on how they want to coordinate this.
Then medications for opioid use disorder would not be covered. Thats a core strategy for this waiver. In reference to not covering E&M services. Indeed both DOC and jails are doing E&M visits for OUD- a bill last year mandated that. I think that everyone was under the impression that those would be covered by the waiver. - I thought medications, was going to be covered under this waiver - If a DOC physician covers the consultation	We do need to cover MAT services and MAT services are covered under E&M codes, but the question is does the consultation code fit within the case management component of this piece. This is currently not covered as part of the minimum benefit package. HCPF will evaluate expansion of this service at the renewal. Any services that are currently happening will not be disrupted. The waiver is focusing on where Medicaid can cover the cost.

now, will that be covered?	
It was my understanding as well that the 1115 Waivers could allow for a state Medicaid Program to cover evaluation and management (E&M) services for an array of medical services not only SUD related services	HCPF needs to take that back and have additional conversations around.
If the RAEs will be responsible for case management in concert with DOC, will this be a "new" deliverable for the RAE, and is it included in the new draft contract just released by HCPF for ACC 3.0?	We are still in negotiations and conversations for ACC phase 3. You will see in the current draft, that it is pretty high level. When the RFP for ACC 3.0 goes out we will have more clarification.
Is there an allotment to go toward EHRs and administrative aspects for DOC, DYS and eventually jails?	Yes. With our negotiations with CMS we will discuss what we will do with the savings from the waiver. What Colorado wants to do is reinvest the savings from the waiver, back into the community for justice involved.
I am basing this off a national webinar that I attended. It does say that states are required to provide a minimum benefit package for the re-entry services. These slides are saying that in addition to the minimum, states have the ability to include other benefits such as hep c, family planning services, and medical provisions or supplies. This is what can and cannot be included in the 1115 waiver.	CMS has given states a template, and this is what they have approved in other states. To ease the approval process, Colorado is applying for the minimum benefits required by CMS. There will be further opportunities to incorporate additional services with the waiver renewal in 2025.
I think there is benefit to the phased approach, due to the massive engagement needed, and not just telling, over funded and over burdened, facilities. Allowing time for buy-in and appropriate level of engagement for facility	The state appreciates the comment.

partners is important.	
This isn't a mandate that DOC has to do this.	True. The mandate will come through the general assembly.
Severe Mental Illness Initiative Comments/Questions	
Will the amendment affect current RAE contract rates?	Clarification that contracts and MCE rates will not be affected in ACC Phase II contracts, but may be in ACC Phase III
Will the waiver cover 15 or 30 day stays in a given month?	The waiver amendment request is to expand reimbursement for acute inpatient and residential stays in IMDs for individuals diagnosed with a SMI or SED to cover up to 15 days regardless of total days. There is a possibility of expanding this coverage based off stakeholder feedback, negotiations with CMS and budget authority.
Continuous Eligibility Initiative Comments/Questions	
The Children's campaign is in support of HB23-1300 and excited to see this moving and to comment. We know that even brief gaps have impacts on children. We know that continuous eligibility has impacts. Colorado was one of five states that saw the largest increase in lose of health coverage during the COVID-19 pandemic. Just highlighting the impact of continuous coverage. When parents are covered, the children are more likely to be covered.	The state appreciates the comment and support in this important work.
We did see in the amendment request there is a phased in approach in the demonstration. Could you speak to this phased in approach? It was on Pg 41 of the amendment document	The phased approach relates only to criminal justice re-entry. The continuous coverage would not have a phased in approach. Criminal justice re-entry is having a phased in approach to begin with DOC initially. The jail portion of the amendment will be phased into the criminal justice re-entry in 6-12 months.
Renewal packets will be sent to the families, which is great, to check the whole household. The noticing is going to have to be super clear to parents that their children are going to still be enrolled. I think it would be	Thank you for that comment. HCPF is currently working with other states that have implemented similar waivers to create continuous coverage for children to learn from their experiences communicating with families. We recognize that this will be challenging to communicate when the children are continuing their coverage without renewal, but the rest of the family may require renewals. We will also work with members to review communications for clarity.

beneficial to work directly with families to ensure the renewals are clear.	
To clarify on continuous eligibility that is independent from income	Correct. It does not matter if a families income changes. Children from age 0-3 can be disenrolled in only four ways: move out of state, deceased, erroneously enrolled initially, or voluntarily disenrolled.
Continuous coverage also reduces stress on the members. I have worked with a lot of clients that have denied jobs due to the possibility of losing their Medicaid.	The state appreciates the comment and for sharing your experiences.
Moving kids between Medicaid and CHIP within the first three years. Does this have any positives? Has this been discussed?	Yes, this has been discussed. Colorado is including Medicaid and CHIP for the amendment. If a child is on Medicaid and they become CHIP eligible, they will stay on Medicaid. It is a requirement to give the kids the higher Medicaid benefit. Colorado does need to do some system changes, to ensure we are in compliance. For the waiver, at the annual renewal time, we will move a child between eligibility categories. With continuous coverage, a child aged 0-3 cannot move from CHIP to no coverage at all.
For the continuous eligibility coverage for adults released from DOC, will they be put on a managed plan? Open Medicaid? If on a managed plan can they opt out within that 12 months?	Colorado will use our standard attribution policy. They can opt out if they choose. It is based on claims history, family connection or other criteria. For those in Denver they will be assigned to Denver health and do have the option to opt out.
Does the opt out plan follow the standard process?	Yes, they will follow the standard process, there will be nothing special for continuous coverage and incarceration. We are not changing the process too much, we are moving back their start date 90 days prior to release. HCPF needs to work through these details and will be working with RAEs.
If you put forward a waiver amendment to start with DOC and DYS re-entry services. It is not implementing the exact same waiver, would it be a different approach?	Yes, we can have a different section for Jail. If they were exactly the same, we could change it to mimic other areas. You will see broad descriptions. As long as it is within those same bounds. You can add codes and services within the waiver, without amending it. It does not have to be exactly the same for the 5 years.

Summary of the 11 Letters of Support

Comment: American Cancer Society Cancer Action Network (ACS CAN) – The goals of the Medicaid and CHP+ programs are to provide health coverage and access to care for people who need it. This proposal meets this goal, and we support the Department's waiver request because it will improve access to and continuity of care for multiple populations in Colorado with cancer.

ACS CAN supports the continuous eligibility portions of the amendment proposal for children in Medicaid CHP+ through age 3 and for adults ages 19-65 leaving incarceration and urges the Agency to advance the request to the Centers for Medicare and Medicaid Services. Providing continuous eligibility as proposed will minimize disruptions and remove administrative hassle for the state. It will also improve continuity of care for low-income cancer patients, survivors, and those who will be diagnosed with cancer. When individuals and families who do not have continuous eligibility lose coverage due to small – often temporary – fluctuations in income, it results in loss of access to health care coverage, making it difficult or impossible for those with cancer to continue treatment. For cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Research also shows the detrimental impact of coverage gaps on Medicaid enrollees who have a history of cancer. Individuals who had coverage disruptions in the previous year were less likely to report that they used preventive services, and more likely to report problems with care affordability and any cost-related medication nonadherence. A 2020 systematic review of evidence found that among patients with cancer, those with Medicaid disruptions were statistically significantly more likely to have advanced stage and worse survival than patients without disruptions.

ACS CAN supports the re-release proposals, which will support continuity of care and access to care for individuals who are transitioning back into society from incarceration. Research shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive. A recent study showed that individuals with incarceration history were more likely to be uninsured and to experience longer periods of uninsurance, and that targeted programs to improve health insurance coverage in this population may reduce disparities associated with incarceration. Cancer is the leading cause of mortality in incarcerated individuals older than 45 years and the fourth leading cause of mortality in the overall incarcerated population. Individuals who have been incarcerated are more than twice as likely to have a history of cancer than general populations.

Response: Thank you for your comment.

Comment: Colorado Coalition for the Homeless (the Coalition) - We support the submission of this 1115 Waiver to seek federal approval to provide continuous medical coverage for children aged 0-3 and 12 months of coverage for adults leaving Department of Corrections facilities. The Coalition advocated for the inclusion of continuous coverage for people experiencing homelessness in the submission of an 1115 waiver amendment through HB23-1300. Living without stable housing presents unique health risks and leads to higher incidence of chronic conditions, health problems and ultimately, shorter lifespans for people experiencing homelessness. To treat these conditions, consistent, reliable, and accessible care is crucial. Unfortunately, people experiencing homelessness will not be included in the current 1115

Waiver that will be submitted, but will be included in a feasibility study to consider future populations that may be incorporated. We hope that future changes to Colorado's Medicaid program provide continuous eligibility medical coverage for people experiencing homelessness… We also know that populations included in the feasibility study, including adults with low incomes and those experiencing homelessness, would greatly benefit from continuous coverage… By expanding populations included in access to continuous medical coverage, we can provide more reliable and regular care to meet the unique health needs of people experiencing homelessness. We support the submission of the current waiver and urge the Department of Health Care Policy and Financing to consider broadening the population of people with access to continuous eligibility in the future.

Response: Thank you for your comment.

Comment: Colorado Hospital Association - CHA strongly supports reimbursement for acute inpatient and residential stays in institutions for mental disease (IMDs) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED) and request that the Department of Health Care Policy and Financing work with Colorado's Joint Budget Committee to expand this request to cover up to 30 days. Currently, the IMD loses access to all reimbursement if an individual diagnosed with a SMI or SED stays in an IMD more than 15 days within a given calendar month. CHA requests action to expand the amendment request to 30 days to further those goals:

Stabilization: Fifteen days is not enough time for certain treatment plans to work. 2 CCR 502-1 outlines strict procedures for involuntary medications that often take longer than 10 days to administer. Additionally, these antipsychotic medications can take up to four or six weeks to work.

1. Readmission rates: the average length of stays for SMI and SED patients ranges from 10 to 30 days, and fully completing inpatient treatment is shown to reduce costly readmissions. For example, Vermont covers up to 30 days and cites a low readmission rate of 8% following discharge.

2. Emergency room usage: Discharge from an IMD before a patient is ready leads to higher rates of emergency department usage. Vermont found a 23% to 44% decline in emergency room use 30-days post discharge following implementation of its waiver.

Only patients with significant treatment needs are likely to exceed 15 days at an IMD. In Colorado, this would account for a projected 343 visits annually. CHA appreciates the waiver to cover up to 15 days and requests your consideration of the request to extend that timeline to 30 days and improve access to care for patients diagnosed with SMI or SED.

Response: In response to this comment, the Department is modifying its proposal to request reimbursement from CMS for up to 60 days of a member's stay (while maintaining an average of 30 days) at an Institute for Mental Disease (IMD) for patients diagnosed with SMI or SED, pending legislative approval.

Comment: Colorado Behavioral Healthcare Council (CBHC) - CBHC and its member organizations support for the changes being made in the Department of Health Care Policy and Financing's federal 1115 SUD Demonstration Waiver Amendment. We have reviewed the proposed changes and are confident that they will increase access to needed care as well as

improve outcomes for Colorado's most vulnerable citizens. We are committed to supporting the implementation of all the changes and are particularly excited to partner with the Department on implementing prerelease services for individuals transitioning from correctional facilities.

Response: Thank you for your comment.

Comment: Colorado Children's Campaign and the undersigned organizations (Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR); Colorado Consumer Health Initiative; Colorado Immigrant Rights Coalition (CIRC); Colorado Coalition for the Homeless; Colorado Safety Net Collaborative; Health District of Northern Larimer County; Spring Institute for Intercultural Learning; American Academy of Pediatrics, Colorado Chapter; Illuminate Colorado; Covering Kids and Families; Jefferson County Public Health; Adams County Health Department; Healthier Colorado; Colorado Center on Law and Policy; Colorado Access; Rachal Velasquez) - We enthusiastically support the submission of this waiver amendment to receive federal approval from the Centers for Medicare & Medicaid Services (CMS) to implement continuous coverage for children birth to age 3, and 12 months of continuous coverage for adults leaving Colorado Department of Corrections (DOC) facilities. Even brief gaps in health insurance are associated with negative health outcomes for children. A lack of consistent health insurance also affects the health of adults. We also support the inclusion of both the Reentry Initiative and the Severe Mental Illness Initiative detailed in the waiver amendment request. We are especially supportive of the proposal to cover reentry services up to 90 days pre-release for justice-involved individuals and believe this is an important step to address the health impacts of incarceration for Colorado's justice involved population.

According to HCPF's analysis of enrollment data in 2018 and 2019, 20% of children ages zero to three with eligibility at any time in those two years experienced Medicaid or CHP+ gaps. A disproportionate percentage of these children who churned were children of color, and these trends have continued throughout the unwinding of the pandemic-era continuous eligibility provision. It is estimated that one churn event, where someone loses coverage and then is re-enrolled not long after, costs approximately $600. Most of the time, these initial losses in coverage are due to procedural reasons such as paperwork issues, and not related to their income eligibility for Medicaid or CHP+. Extending continuous coverage reduces coverage loss due to procedural reasons, which is disproportionately common among underserved groups – including children, Black and Latino families, and people experiencing homelessness. It also avoids costs associated with churn events, and drives more efficient health care spending.

Response: Thank you for your comment.

Comment: Colorado Children's Campaign and the undersigned organizations - On pg. 41 of the amendment request under the "Continuous Eligibility Initiative" section, it states, "The State is seeking to implement continuous coverage requests by January 1, 2026, **with the assumption that there may be a phased-in approach and a ramp up of continuous enrollment of individuals over the course of the demonstration."** We understand that there will most likely be an increase in children aged zero to three and adults leaving DOC facilities receiving continuous coverage over the course of the demonstration. However, the HB23-1300 legislation states in subsection 7(e), "Upon approval of the federal authorization sought pursuant to this subsection (7), **the state department shall implement the continuous eligibility coverage requirements pursuant to this subsection (7) by January 1, 2026**. A phased-in approach to implementing continuous coverage for the populations specified in the legislation is acceptable, as long as it begins **before** January 1, 2026 and **all** eligible

populations who enroll or are already enrolled in Medicaid and CHP+ on or after January 1, 2026 receive their expanded continuous coverage. We ask that the Department work to the best of its ability to adhere to this timeline.

Response: The Department will work to the best of its ability to adhere to the timeline in the legislation, understanding that timing of CMS approval of the demonstration is beyond its control.

Comment: Colorado Access - We are pleased to support the Department's waiver amendment for continuous eligibility for recently incarcerated individuals and children birth to age three, as well as pre-release services for incarcerated individuals, and the serious mental illness initiative. We enthusiastically support approval of these provisions in the waiver amendment as they will allow for greater continuity of care for these populations and improved health and quality of life outcomes.

Having the ability to connect with members pre-release will allow care coordinators and case managers to ensure they have accurate contact information and will facilitate more streamlined follow-up upon their release. Additionally, the current system places the onus on the member for arranging post-release appointments. In the complex and often overwhelming transition from incarceration to release and re-integration, this can be overly burdensome for individuals and cause interruptions in their care. Allowing pre-release in-reach care and case management from MCEs or their contracted providers will help smooth this transition by supplying members with specific dates and times for follow-up appointments, thereby facilitating warm handoffs to community providers.

Colorado Access established a community partnership with Tribe Recovery, which is a sober living home that offers substance use and mental health treatments for people releasing from prison. Through this program, peer support specialists connect with members prior to their release to help educate them on the services and supports available to them in their communities. Providing in-reach education through peer support programs such as Tribe Recovery allows incarcerated members to get connected with providers outside of the carceral system to build trust and facilitate open communication to increase the likelihood of continued engagement in their treatment. As proof of this strategy's success, Colorado Access observed an increase in engagement rates for the behavioral health screening within the first 14 days of release from an average of 16% to more than 45% in the first four months of our community partnerships for in-reach services.

COA strongly supports continuous 12-month eligibility for adults leaving carceral settings. Providing continuous eligibility for adults recently released from incarceration is another critical step in smoothing an individual's transition and re-integration into their community. Ensuring individuals have continuous and immediate access to reliable health care is critical to individuals upon release.

Colorado Access welcomes the opportunity to provide continuous eligibility for children from birth to age three in CHP+ and Medicaid. For children ages zero to three, continuous coverage means they have immediate coverage for services from birth across multiple developmental stages with a consistent and trusted health care provider, uninterrupted by changes in insurance.

Response: Thank you for your comment.

Comment: Colorado Access - We urge the Department to further the serious mental illness initiative and reimburse for up to 60 days of a member's stay (while maintaining an average of 30 days) at an Institute for Mental Disease (IMD). Based on length-of-stay data shared by the Department and our own length-of-stay data, reimbursement for up to 60 days, with an average of 30 days, supports how our members access needed care. Colorado Access further supports the inclusion of the severe mental illness initiative, which would allow for reimbursement of a member's first 15 days of treatment for a serious mental illness (SMI) or serious emotional disturbance (SED) at an IMD regardless of whether the member stays longer. We also urge the Department to pursue reimbursement of up to 60 days regardless of how long the member stays, while maintaining an average of 30-day lengths of stay as required by federal rules. Currently, the state only reimburses for these types of acute inpatient stays for up to 15 days. However, if a member requires treatment for longer than the 15-day limit, the state is not able to cover any portion of the stay. This status quo puts clinicians in a difficult bind when a member needs treatment beyond 15 days because the providers then do not receive reimbursement for that stay.

Approval of this change would help improve the continuum of care for these members by ensuring they have adequate time to receive the appropriate level of inpatient care before they transition to community-based services. Ensuring that the state can reimburse IMD providers for these stays will also help improve provider investments in step-down services such as intensive outpatient or partial hospitalization services, prevent closure of adult inpatient IMD beds, and potentially give providers the ability to increase wages to attract the needed workforce.9 We believe these changes will result in positive outcomes for both our members with serious mental illness and the providers who serve them.

Response: In response to this comment, the Department is modifying its proposal to request reimbursement from CMS for up to 60 days of a member's stay (while maintaining an average of 30 days) at an Institute for Mental Disease (IMD) for patients diagnosed with SMI or SED, pending legislative approval.

Comment: Children's Hospital Colorado - Strongly supports the Department's effort to expand young children's continuous eligibility in both the Medicaid and Child Health Plan Plus (CHP+) programs, effective January 1, 2026. Providing continuous coverage decreases avoidable gaps in insurance coverage and enhances the continuity of care and consistent delivery of both physical and behavioral health services during the critical early childhood period. The expansion in continuous eligibility is an important component of the State's effort to improve health and health equity, while reducing stress and financial uncertainty among families. We support the Department's proposal for monitoring and evaluation and will look forward to working with the independent evaluator to ensure that the selected quantitative and qualitative measures capture patient family experience and positive impacts throughout the system as a result of this demonstration. We have been concerned about the rapid losses in coverage that children in Colorado have experienced since the end of the federal public health emergency, with over 128,000 children having been disenrolled from Medicaid through December 2023. We know from national studies that churn is costly from a state administrative perspective, costing $400 - $600 per instance – in 2015 dollars. We hope that this waiver, once approved, will demonstrate that churn can be reduced and the associated expense and difficulties for families can be avoided.

Response: Thank you for your comment.

Comment: Children's Hospital Colorado - We echo the comments of many partners in the advocacy community and respectfully request that the Department work to ensure that

expanded continuous eligibility is fully operational by January 1, 2026. While we understand the desire to "test and expand" through a phased-in approach to implementation, we hope the Department will be able to commit to the timeline from House Bill 23-1300 and begin phasing in this approach early to achieve the January 1, 2026 full go-live date.

Response: HCPF will take this timeline into consideration and work with CMS for approval and implementation at the earliest possible date.

Comment: Creative Treatment Options – Please vote YES on waiver application 1115 Medicaid Expansion to help our community members get the care they need so they can recover and thrive following their incarceration. Medicaid coverage is key to helping people access their badly needed treatment services and expanding it to cover incarcerated individuals for 90 days prior to their release would significantly reduce gaps in coverage that prevent those who have recently been released from accessing crucial care. This would benefit not only those individuals, but also treatment providers in making sure that we are meeting the needs of the clients we see as well as the community at large.

Response: Thank you for your comment.

Comment: Valley-Wide Health Systems – We serve and receive referrals from many of those area jails and I am writing on behalf of the agency in support of the 1115 waiver application. This waiver would allow people who are suffering from addiction disorders the ability to receive treatment, including Medication Assisted Treatment, while incarcerated. These services could also continue uninterrupted upon release as the person would maintain those benefits. Many individuals who have been incarcerated, then released do not know how to navigate the benefits system and therefor fail to follow through with treatment. By having benefits upon release, it increases the likelihood of follow up with a provider and increases the change of improved outcomes.

Response: Thank you for your comment.

Comment: Healthcare Company (ViiV): ViiV Healthcare Company (ViiV) appreciates the opportunity to submit comments to the Colorado regarding its proposed amendment to its §1115 Demonstration Amendment to offer reentry health care services to incarcerated individuals with substance use disorders (SUD) and/or HIV who are Medicaid-eligible. ViiV urges Colorado to align the efforts of this proposed amendment request with national EHE and state ETS efforts to improve health outcomes for soon-to-be-released individuals with SUD, people who could benefit from PrEP, and people with HIV.

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people with HIV and those vulnerable to HIV. From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

ViiV is proud to be part of the nation's success in reducing the number of new HIV cases and increasing viral suppression rates. We recognize our important role as a research-based

pharmaceutical company is limited without the ongoing collaboration among public health officials such as those in Colorado.

In the United States, an estimated 1.1 million people are living with HIV, at least 13 percent of whom are unaware that they have the virus. Despite groundbreaking treatments that have slowed the progression and burden of the disease, surveillance and retention remain a challenge. In 2020, at least one in five new HIV cases in the United States were diagnosed in late stages of the disease. Only half of all people with HIV are retained in treatment.

In 2019, the U.S. Department of Health and Human Services (HHS) launched *Ending the HIV Epidemic in the U.S.* (EHE). which has set a goal to reduce new cases of HIV by 90 percent by 2030. The plan proposes to use scientific advances in antiretroviral therapy to treat people with HIV and expand proven models of effective HIV care and prevention. The EHE includes four pillars—*Diagnose*, *Treat*, *Prevent*, and *Respond*—and coordinates efforts across government agencies to stop the HIV epidemic with a focus on state and local areas.

ViiV supports Colorado's effort to provide targeted Medicaid services for people experiencing incarceration with SUD and people with HIV (PWH) and encourages Colorado to further align the amendment with the national EHE and Colorado's ETS initiatives by:

- **Including HIV testing in the pre-release health assessments**
- **Providing HIV treatment and linkage to care upon release to people with HIV.**
- **Providing access to PrEP prior to release for people with SUD.**
- **Case management services should include those with HIV.**

People with HIV are disproportionately involved in the criminal justice system with sero-positive rates more than three times that of the general population; often they face complex medical, mental health, and substance abuse needs. In 2006, an estimated 14 percent, or more than 150,000 PWH, passed through a correctional facility, while the proportion was closer to 20 percent for Black and Hispanic PWH. Fortunately, the population of state and federal prisoners living with HIV has been falling steadily since 1998.

People experiencing incarceration are more likely to engage in behaviors that increase their risk for HIV transmission, including having multiple sexual partners, condomless sex, and injection drug use.

Substance use can increase risky behaviors for HIV transmission, and injection drug use in a population can fuel transmission of blood-borne infectious diseases such as HIV. People who inject drugs intravenously in their lifetime are more than 30 times as likely to be diagnosed with HIV. In 2021, people who inject drugs accounted for 7 percent of new HIV infections.

Comment: Healthcare Company (ViiV): Include HIV testing in the pre-release comprehensive assessments. ViiV recommends that the proposed case management assessments include HIV testing for individuals diagnosed with SUD consistent with guidelines from the Centers for Disease Control and Prevention (CDC), the American Society of Addiction Medicine (ASAM), and the US Preventive Services Task Force (USPSTF).

The CDC recommends opt-out HIV screening for all individuals entering a correctional facility and additional screening for people who inject drugs. The CDC, ASAM, and USPSTF all recommend routine HIV testing for people who inject drugs or are being assessed for opioid use disorder. The amendment proposal suggested HIV screening could be included in additional service level categories, but screening for HIV in SUD programs for people

experiencing incarceration is critical for identifying HIV status and linking people with HIV to care.

In an analysis across six major American cities, targeted on-site HIV testing for patients receiving medication for opioid use disorder was projected to be cost saving or highly cost-effective.

Response: There pre-release case management assessments will include a review of existing diagnoses of each releasee.

Comment: Healthcare Company (ViiV): Provide HIV treatment and linkage to care upon release to people with HIV

ViiV supports the state's proposal to provide a 30-day supply of clinically necessary prescribed medications upon release, including antiretrovirals (ARV) to treat HIV. For people with HIV, ViiV urges the state to consider taking this even farther, and to provide long term antiretroviral (ARV) treatment in the form of either a 90-day supply of HIV treatment or a long-acting (LA) complete HIV treatment regimen along with other medications and linkage to medical care to ensure adherence.

People experiencing incarceration with HIV often have access to HIV treatment and care during incarceration, but this care is often disrupted following their release.

Response: It is anticipated that the 30-day supply of medications, will be provided as clinically appropriate based on the medication dispensed and the indication. We will continue discussions on the implementation of that guidance. Regarding care transitions, re-entry transitional case management services will assist with linkages to care upon release.

Comment: Healthcare Company (ViiV): Provide access to PrEP for SUD populations prior to and upon release. For individuals who may benefit from PrEP, ViiV recommends that the state of Colorado provides counseling on HIV pre-exposure prophylaxis (PrEP) and PrEP prescriptions in accordance with CDC guidelines.35,36 For people who can benefit from PrEP, ViiV urges the state to provide oral PrEP or administration of LA PrEP as part of the proposed pre-release services up to 90 days prior to release as well as a 90-day supply of PrEP or administration of LA PrEP upon release.

As you may know, PrEP is available in either a daily oral option or a LA injectable option with dosing every 2 months, or as few as 6 times per year.37,38 LA PrEP offers an important prevention option for vulnerable populations like those individuals recently released from incarceration who are experiencing transitions in housing, employment, community, and health care. LA PrEP also may benefit those who fear disclosure of taking PrEP to avoid stigma associated with daily oral pills.

In 2023, the USPSTF assigned a "Grade A" rating to PrEP as a highly effective preventive intervention.39 PrEP has been shown to reduce the risk of acquiring HIV from sex by 99 percent and from injection drug use by 74 percent.40 The CDC recommends that for soon-to-be-released incarcerated individuals who engage in behaviors that increase their risk for HIV infection, such as injection drug use, "starting HIV PrEP (or providing linkage to a community clinic for HIV PrEP) for HIV prevention should be considered.

Response: As mentioned above, case management assessment content will be outlined within the implementation plan.

Comment: Healthcare Company (ViiV): ViiV supports the state's proposal to provide case management services for people with SUD, especially for those individuals who may be identified as HIV positive. Targeted interventions for HIV and SUD can complement each other and benefit from coordination between correctional and community health systems. Studies demonstrate that medical case management can improve care engagement and treatment adherence. Case management services can also smooth reentry for people with HIV by helping them navigate the complex US healthcare system.

Response: Re-entry Transitional Case Management activities will include any diagnoses that the individual has identified during the case management assessment, which may include HIV.

Comment: Front Range Clinic – I provide my strongest endorsement for this program and can testify to the very positive impact it will have on individuals and the system. I provide mental health and substance use disorder MAT services in both Routt and Grand County jails. I have seen firsthand the perils of clients not having insurance and access to these essential services. I bear witness of the positive impact in Clients' lives and outcomes, and system improvement in recidivism through treatment and ongoing support of this population… Disabled and Black, Native American, Hispanic and individuals with uncontrolled mental health issues are vastly overrepresented in prisons and jails. Therefore, ensuring that people who are in carceral settings are enrolled in Medicaid and connected with services upon release is essential to reducing recidivism, health disparities and advancing health equity.

Response: Thank you for your comment

Attachment 8: Tribal Consultation

Colorado certifies that it conducted tribal consultation in accordance with the state's approved tribal consultation State Plan Amendment. The State solicited feedback from both tribes by sending emails to the tribal representatives with a summary of the Demonstration, plus a copy of the public notice, and waiver amendment application (as well as a link to the HCPF website with the relevant documents). This process follows the State's approved tribal consultation State Plan Amendment. During the 60-day tribal consultation period, the State received 3 comments and/or questions. The State attended the Colorado Commission of Indian Affairs 3rd Quarterly Meeting on March 14, 2024 to discuss the proposed amendment.

Tribal Consultation: Programmatic Action Log #542

Log Date: 1/25/2024

	TRIBAL CONSULTATION - PROGRAMMATIC ACTION LOG						Estimated Effective Date:			
	COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						END OF PHE	New additions or updates to the Log		
							Estimated Submission Date	Item was on previous Log; Project is ongoing; there may be future updates		
							1-Feb-23	Item was on previous Log; Item is basically completed		
Log #	Log Date	Major Program (Medicaid, CHP+, etc)	Action Type (SPA, waiver, other)	Category (Eligibility, benefits, rates, etc)	Programmatic Action Title	Brief Description	Important Dates and Timelines	Clearly Foreseeable Tribal Implications	Actionable or Non-Actionable Item - Why	
542	1/25/2024	Colorado Medicaid and Child Health Plan Plus (CHP+)	1115 SUD Demonstration Amendment	Covered Benefits, Client Eligibility, and Reimbursement Policy	Section 1115 Demonstration Amendment	Colorado is requesting an amendment to the Demonstration to authorize: 1. Continuous eligibility for children ages 0-3 and adults leaving a Colorado Department of Corrections (DOC) facility; 2. Pre-release services for individuals transitioning from correctional facilities; and 3. Reimbursement for acute inpatient and residential stays in institutions for mental disease (IMD) for individuals diagnosed with a serious mental illness (SMI) or serious emotional disturbance (SED). Currently, IMDs are not reimbursed for any days for stays that exceed 15 days. Under the proposed amendment, the first 15-days of a stay exceeding 15 days would be reimbursed.	Estimated Submission Date: April 1, 2024 Proposed Effective Date: 1. Continuous Eligibility: January 1, 2026 2. Pre-release services: HCPF is seeking to implement pre-release services for individuals transitioning from state-run facilities operated by the Colorado DOC and Division of	1. Continuous Eligibility: The proposed continuous eligibility policy will apply to Medicaid-enrolled children with incomes up to 215 percent of the federal poverty level (FPL), CHP+ children with incomes up to 260 percent FPL, and children who would be eligible for medical assistance coverage but are not because of their immigration status. Once enrolled in Medicaid or CHP+, these children will remain	Non-Actionable: The authority for continuous eligibility is being requested as a result of House Bill 23-133. The authority for pre-release services is being requested due to Senate Bill 22-196. Actionable: The IMD component of the amendment is not legislatively mandated. Rather, it is being requested as the result of stakeholder input from participating IMDs regarding the impacts of current reimbursement limitations.	

COLORADO

Lt. Gov. Dianne Primavera

AGENDA

Colorado Commission of Indian Affairs 3rd Quarterly Meeting

March 14, 2024

9:00 AM - 2:00 PM

Zoom

8:50 am: Zoom room opens

9:00 am - 9:05 am: Call to Order - Lieutenant Governor Primavera, Chair

- Invocation - Southern Ute Indian Tribe
- Establishment of quorum and introductions - Lieutenant Governor Primavera, Chair

9:05 am - 9:10 am: Meeting Materials Review - Lieutenant Governor Primavera, Chair

- Approval of Agenda and Minutes
- Executive Director Report - Kathryn Redhorse

9:10 am - 9:20 am: SB 21-116 Discussion - Lieutenant Governor Primavera, Chair

- Vote to update the list of schools

9:20 am - 9:40 am: FHL Bank Topeka- Native American Housing Grant- Kylie Mergen, FVP, Community Investment Officer, Director of HCD

9:40 am - 10:10 am: Colorado State University- Patrese Atine, Assistant Vice President for Indigenous and Native American Affairs

10:10 am - 10:20 am: BREAK

10:20 am - 10:40 am: Federal Updates from the Offices of Senators Bennett and Hickenlooper

10:40 am - 11:00 am: Substance Use Disorder Waiver - HCPF

11:00 am - 12:00 pm: Commissioner Updates - Lieutenant Governor Primavera, Chair

12:00 pm - 12:30 pm: Lunch

12:30 pm - 1:40 pm: Ex-Officio Member and other Agency Updates -
Lieutenant Governor Primavera, Chair

1:40 pm - 1:42 pm: Public Comment

1:42 pm - 1:45 pm: Wrap-up & Adjournment

Attachment 9: Tribal Consultation Comments

Comments/Questions	State Response
Was notice provided to the Southern Ute Indian Tribe and the Ute Mountain Ute Tribe Behavioral Health facilities?	Yes, notice was provided through the Tribal Programmatic Action log on January 25, 2024.
Is there a program in place now that covers FTE for someone to go to a home and check diabetic people; feet, vitals. A reimbursable program? If not is that something we can create?	Thank you for the question. HCPF can always use the extra support to weigh in with our policy makers. HCPF is aware of the needs and are actively looking into them now.
The current IHS funding may not be sufficient to take care of our tribal members. That is why we look to Medicaid, to help provide additional support for members.	Thank you for your comment.

Attachment 10: Stakeholder Feedback

HCPF held multiple stakeholder forums virtually in November 2023, December 2023 and January 2024 to review the proposed amendment to the 1115 SUD Waiver and provided an opportunity for participants to ask questions. Below is a summary of comments and questions received.

Opportunities for Expanded Medicaid Coverage in Colorado — 1115 SUD Waiver Amendment Stakeholder Forums

November and December 2023

About the Forums

The 1115 SUD Waiver Amendment Stakeholder Forums were held virtually in November and December 2023. During each forum, the Department reviewed the Opportunities for Expanded Medicaid Coverage in Colorado through the 1115 amendment, the amendment components, and provided an opportunity for participants to ask questions. The three amendment components include: Continuous Coverage, Criminal Justice Reentry Services, and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Services in an Institution for Mental Disease (IMD). There were four opportunities for the public to attend. Forums were held on the following dates and times:

- Monday, November 27, 2023, 10 am–12 pm
- Wednesday, November 29, 2023, 5–7 pm
- Thursday, November 30, 2023, 2–3 pm (Forum was specific to SMI/SED)
- Wednesday, December 6, 2023, 6–7:20 pm

Summary

Cumulative number of attendees: 101

Q&A

Question #1: Could we take this opportunity to allow an exception to personal attendants who work under the CDASS LTSS delivery option so that they get medical insurance through their employment?
Thank you for the comment. At this time, we are only able to address the three proposed components but may consider additional amendment topics in the future. We will bring this comment to our Long-Term Care team.

Question 2: Why are we limiting the April 2024 implementation to only DOC? Jails are in a similar situation, with an opportunity to provide ongoing services and prevent an individual from entering into DOC and reducing recidivism.

> **Follow up Comment: To the comment jails would be more difficult to implement due to the 51 different entities to work with - County government can implement programs more quickly and with more latitude than statewide government processes.**

Our current waiver amendment request does not include jails at this time due to limitations in the State agency regulatory process and variability in county level regulations. We will share this question with our Criminal Justice teams. This has to be a statewide approach, and it does take longer to get approval from all counties. It is really important that even if one individual jail can do this, Medicaid is a statewide program, and we need to implement the amendment statewide. When we include jails, we would need to budget for every jail to participate, noting that some jails may not want to participate. We want to build clear partnerships and a sustainable program that individuals want to participate in.

Question 3: If the waiver will cover individuals in state or federal carceral facilities, why not county jails?

We will be focusing on DOC as a first phase. Our current waiver amendment request does not include jails at this time due to limitations in State agency regulatory process and variability in county-level regulations.

Question 4: How will the "no incarceration" status be communicated to Medicaid? As of right now we have many patients that are still showing "incarceration" status and we cannot obtain payment due to inability to get the status updated.

Thank you for this comment. If individuals are having issues with this, the individual needs to reach out to their county caseworker to update their "living status", this way they will no longer show as "incarcerated" since the person will be released and eligible for benefits. Please reach out to our team as needed with these concerns.

Operational memo provided in chat:
https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20OM%2023-058%20CBMS%20Limited%20Medicaid%20Benefits%20for%20Incarcerated%20Individuals.pdf

Question 5: What kind of technical assistance will be provided to community corrections programs to become Medicaid providers?

Technical assistance opportunities will be shared once they are available, upon waiver amendment approval. For updates on the criminal justice work, please sign up for email notifications, email sign up. For more information on criminal justice please use our resources available on our website Health First Criminal Justice website. Please subscribe to the criminal justice newsletter to be informed.

Question 6: Does case management also include peer support services? For Peer Support Professionals who are working in the jails, reentry, and/or court who develop reentry

plans for community members on the inside, will these services also be covered under this waiver/fall under case management?
Yes, peer support services are covered.

Question 7: What happened to trying to get 60 days for stays in IMD?
It is a tough budget year and 15 days is what HCPF has identified this year for funding. A lot of individuals are getting the services they need in a psychiatric hospital within 3–7 days. To cover these individuals with SMI/SED, we are removing the strict limitation and allowing more time for stabilization.

Question 8: This is all so helpful, thank you! So even though the current waiver is up for renewal in 2025, the continuous coverage provisions will still be set for 2026–2031? Just want to make sure I am understanding correctly.
Correct, HCPF is working on an amendment to the current waiver which ends in December 2025, year 5 of the waiver. If the amendment components being requested are approved in April 2024, HCPF will have authority to implement continuous coverage starting January 2026.

Question 9: Can you clarify how the counties will be notified that the incarcerated status has changed so that counties can update the case?
DOC puts the release date into the system, and it should switch from "incarcerated" status to "in community" status. There is a medical assistance team that coordinates this for a smooth transition. If the individual's date of release is not input (which primarily happens via the jail) then that individual would need to contact their county case worker to update their "living situation". This is up to the individual.

Question 10: Will RAEs & MCOs be responsible for the services during the 90-day pre-release period?
Yes, it is the intention that these services will go under the managed care behavioral health benefit. Since the RAEs are responsible for this work, we do anticipate that they will be in charge of care coordination and case management. The only part in question is the pharmacy portion. Since our pharmacy benefit is a fee-for-service arrangement through Magellen, HCPF is unsure if the prisons will bill directly, or how this will look. This is the only area that will not be under RAEs.

Question 11: That's correct Peer Support Professionals (PSPs) do not provide Case Management (CM) services, but peer support services are needed in addition to CM services. PSPs work alongside CMs and SWs. Who should I speak with about ensuring peer support services will also be included under the waiver?
Please email hcpf_peerservices@state.co.us and we can discuss peer services more.

Question 12: I know that the legislation requires at least three stakeholder sessions re: the feasibility study, is the Department planning for how this process will look?
Yes, these opportunities will be publicized once available in the new year.

Question 13: Will there be a stakeholder process in 2024 or 2025 to inform the feasibility study to understand the additional county workload needs?
Yes, these opportunities will be publicized once available in the new year.

Question 14: This seems like a great opportunity, before the continuous eligibility for 0–3-year-olds gets implemented, to discuss the messaging and process for families. Thinking ahead to ensure it's not confusing for families about why they still have to do redetermination for the rest of the household even if they have a 0–3-year-old who has continuous eligibility. We don't want families falling off/coming back on Medicaid because the timeframes are confusing!
Thank you for this feedback. We agree this will need to have special messaging.

Question 15: What is the SUD legislation/bill that is working through committee? Any link to its current form?
https://leg.colorado.gov/content/iopioidsubstance2023alegislation See Bill B, Section 17

Question 16: When you say there's additional reporting, where does the administrative burden fall? (provider level, CDPHE?)
The reporting requirement falls on the Department.

Question 17: Your slide says coverage up to 90 days, following the 90 days, they don't need to re-apply for 12 months?
Correct.

Question 18: If you get the waiver, are we prepared do we have adequate networks for case management and MAT services.
Under Senate Bill (SB) 22-196, we were required to do research into the waiver and whether or not to pursue it. Currently these services are already being provided through DYS and DOC. This new opportunity allows us to pull down federal match for things we are already funding through the general fund. Roughly 50% will be paid with federal funds.

Question 19: If you have the continuous coverage, do we have the coverage to provide these services?
We do and are working to provide technical trainings for providers to provide care to these populations.

Question 20: You have this cohort of professions with their own lobbying power, how can our affiliated associations support this, if it makes sense?
We will have some public hearings in our public comment period once the draft amendment is released, which will be a good opportunity for additional engagement.

Question 21: Do you have a one-pager that we can share this out?
We are working to create a one-pager that is succinct and can be translated into additional languages.

Question 22: Is one of the goals that there would be enough compelling information to eventually fund continuous coverage for more than the listed groups?
While there are compelling reasons to do that, the fiscal realities may not allow for this expansion. HCPF will continue to monitor these opportunities.

Questions from the November 30, 2023 Forum Specifically on SMI/SED:

Question 1: Is there an electronic health record component to this work, especially related to Health IT plans and psychiatric hospital paper charting? How does this work and what are the expectations?
Yes, CMS has established milestones for a Health IT plan. The Health IT plan covers the following areas: Closed loop referrals and e-Referrals, Electronic Care Plans & Medical Records, E-Consent, Interoperability in Assessment Data, and expansion of Telehealth.

Question 2: Do facilities under the IMD waiver amendment component need to be accredited? If so, what are the licensing standards?
Yes, facilities that include crisis stabilization units will need national accreditation. More information on this is forthcoming.

Opportunities for Expanded Medicaid Coverage in Colorado — 1115 SUD Waiver Amendment Stakeholder Forums

December 2023 and January 2024

About the Forums

The 1115 Substance Use Disorder (SUD) Waiver Amendment Stakeholder Forums were held virtually in December 2023 and January 2024. In the forums, the Department of Health Care Policy & Financing (HCPF) reviewed the Opportunities for Expanded Medicaid Coverage in Colorado through the 1115 amendment, presented the amendment components, and provided an opportunity for participants to ask questions. The three amendment components include: Continuous Coverage, Criminal Justice Re-Entry services, and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Services in an Institution for Mental Disease (IMD). Particular forums were tailored to specific aspects of the 1115 Waiver Amendment, noted below. There were five opportunities for the public to attend. Forums were held on the following dates and times:

- Wednesday, December 20, 2023, 11:00am
- Wednesday, January 3, 2024, 10:00 am (focused on Criminal Justice Re-Entry Services and Continuous Coverage for adults leaving incarceration)
- Tuesday, January 9, 2024, 11:00 am (focused on Criminal Justice Re-Entry Services and Continuous Coverage for adults leaving incarceration)
- Wednesday, January 10, 2024, 1:00 pm
- Tuesday, January 16, 2024, 10:00 am (focused on Criminal Justice Re-Entry Services and Continuous Coverage for adults leaving incarceration)

Summary

Cumulative number of attendees: 178

Q&A

Question #1: What are the financial implications and costs of care? What does "immediately prior to release" mean for Colorado?
Pre-release services are available 90-days prior to release for Medicaid enrolled individuals. Program financing will be leveraged to provide improvements in existing programs and improve Medicaid access and services to individuals exiting incarceration.

Question #2: Regarding Continuous Coverage, why is the State pursuing a waiver instead of a State Plan Amendment?
A waiver allows the state to gain approval for an innovative or pilot policy that expands our current state plan before permanently modifying it, that way the state can evaluate it after the pilot period to determine if it is feasible as a permanent state plan addition. Currently there is no spa provision for continuous eligibility for this population, therefore an 1115 is needed.

Question #3: Does the Department of Corrections (DOC) include county jails? There is a small window during release to get coverage.
House Bill 23-1300 allows authority for continuous coverage for all adults leaving DOC, not including jails. Re-entry services target all Medicaid members leaving carceral facilities. HCPF will be adding in county jails as part of a phased-in approach detailed in the implementation plan.

Question #4: Information about these opportunities isn't accessible while incarcerated. How is this information getting to them?
Information and resources will be accessible as part of transition planning and based on individual needs.

Question #5: What does IMD mean? Isn't the term "mental illness and mental diseases" locked in by the government? It is not person first language.
IMD is the acronym for Institutions for Mental Diseases. The term is a formal legal term that HCPF must use and acknowledges it is not a person-centered term that the Department prefers to use.

Question #6: Regarding the 90-day reconsideration period, is the member retroactively covered? Does the member have to ask for retroactive coverage? The Public Health Emergency unwinding FAQ says they must be retroactively enrolled.
Members are not retroactively enrolled. Members need to appeal immediately if ruled ineligible to be covered.

Question #7: No claw back for members, but how are providers affected?
Appealing disenrollment also protects providers by preventing them from being listed as inactive.

Question #8: Regarding Criminal Justice Re-Entry Services, what is the implementation timeline for the Consolidated Appropriations Act (CAA) and the waiver?
HCPF is tentatively planning to submit the 1115 waiver amendment application by April 2024 with implementation phase in beginning July 2025. Medicaid and CHP+ coverage for transition services for post-adjudicated youth will expand in January 2025 in compliance with the Consolidated Appropriations Act of 2023, Section 5121.

Question #9: Regarding Criminal Justice Re-Entry Services in the 1115 waiver, is it for adults only or juveniles too? Who currently pays for the juvenile transition services?

The waiver is for all carceral settings starting with prisons and juvenile detention facilities. HCPF will be adding in county jails as part of a phased-in approach detailed in the implementation plan. Currently, juvenile transition services are covered through the Department of Youth Services. Medicaid and CHP+ coverage for transition services for post-adjudicated youth will expand in January 2025 in compliance with the Consolidated Appropriations Act of 2023, Section 5121.

Question #10: Regarding the re-entry services component, who is eligible for these services, how do they enroll in re-entry services and Medicaid, and how do they access care or coordination post release? Who is eligible? How does enrollment work? Is there access to care post release?
All Medicaid enrolled incarcerated individuals would be eligible for this pre-release benefit. Individuals will be assisted with care coordination post release via the Regional Accountable Entities (RAEs).

Question #11: Regarding Criminal Justice Re-Entry Services, will Managed Care Organizations and RAEs be involved prior to release?
In-reach services will be coordinated prior to release in order to provide a smooth transition to the community.

Question #12: Was the slide (regarding continuous coverage for adults) including information on technical violations information related to California, or Colorado? We have a law against this.
The continuous coverage for adults leaving the DOC slide was referring to a study in California to illustrate the importance of continuous coverage as a way to prevent disenrollment due to technicalities.

Question #13: Regarding Criminal Justice Re-Entry Services and Continuous Coverage, there was legislation passed the year before to do studies targeting certain populations. Is the work discussed in this meeting looking at all of DOC, or specific priority populations in DOC?
Continuous coverage for adults leaving DOC is focused on all adults leaving DOC. Re-entry services target all Medicaid members leaving carceral facilities.

Question #14: Why does the presentation refer to ages 21-64? Children become adults at 18 in CO.
There are currently federally recognized exceptions to the IMD exclusion rule which allows inpatient psychiatric care with no length of stay limitations for Health First Colorado members aged 21 (and in some circumstances aged 22) and under via the "Psych under 21" benefit as per federal guidance. The State Medicaid Manual (Section 43-90) also offers clarification on this topic: “Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22.”

Question #16: So Criminal Justice Re-entry Services and continuous coverage will not cover kids over the age of 3 and is not for people doing inpatient treatment or being

released from a treatment program, correct? It is only support for people after addiction has taken hold in a person's life?
These amendment components, including the re-entry and continuous coverage, apply to individuals regardless of the presence of a SUD. The amendment components are for people exiting jail, prison, or youth detention settings.

Question #17: I'd like to interject workforce and service provider development. We can improve access but there is a shortage of providers and workforce that supports these folks across the continuum of needs/ages. We need to invest in workforce development (providers, paras, therapists, nurses, you name it).
Thank you for the feedback. HCPF will keep this in consideration and continue to work with the RAEs on network adequacy.

Question #18: Can states specify that case management must include addressing whole-family supports for individuals with children? This may include multi-system coordination. Follow up comment: Especially since these kiddos/families would potentially qualify for Early Intervention Services.
Yes, states can specify certain requirements around case management in their waiver request.

Question #19: What is the location of the public comment meeting in Pueblo?
February 7, 2024, 3:00 pm–5:00 pm MST
Pueblo City — County Library District — Patrick A. Lucero Branch,
1315 E 7th St., Pueblo, CO 81001
Lucero Large Community Room
Register in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_patMQrKgRGCqeqXh2tE_Pg

Question #20: Regarding Criminal Justice Re-Entry Services and Continuous Coverage, if individuals are released from incarceration just generally, why do we need a waiver for them to be Medicaid eligible? Or does it mean something more for what HCPF does?
The 12 months of continuous coverage is regardless of income. This will allow individuals to integrate into the community without having to worry about health insurance coverage. A lot of individuals leaving might go slightly above the income level and get taken off, and this will allow them to not have disrupted care and become destabilized.

Question #21: Do we have enough Medicaid providers to provide services in the community for re-entry services? Have we looked at network adequacy for this?
There are enough services in the community to cover individuals for their care. HCPF will need to take this question back and ensure we consider the increase of individuals looking for service and ensure our network can support them.

Question #22: Are there any lessons learned from other states of individuals taking advantage of this service?
HCPF will need to look into this and provide information to this group.

Question #23: Is there a timeline for non-DOC individuals for continuous coverage component?
We do not have authority from HB1300 for anyone other than DOC populations. The feasibility study will provide more insight into how this would impact members and potentially extend beyond DOC.

Question #24: Regarding Criminal Justice Re-Entry Services and Continuous Coverage, is it planned to work with DOC on enrolling individuals in Medicaid pre-release? How will we assist non-DOC facilities in enrolling individuals?
DOC already has a program in place and has a benefit acquisition team to support individuals be enrolled in Medicaid. DOC works with RAEs prior to an individual's release to ensure individuals are able to begin case management upon release. HCPF did a study in the Spring 2023 which showed inconsistency between counties as to their processes for enrolling individuals in Medicaid. It is in state statute that jails should be providing resources to enroll in Medicaid, but there is some variability in enforcing this statue.

Comments:

Comment #1: To add to the end of public health emergency conversation, we work with a lot of high need families and worrying about continuous coverage. There is a discrepancy between data and the actual experience of members. If you ever show ineligibility, you won't get your needs met those days unless you have a provider willing to take the risk to provide services in hopes it will be covered soon. Families have to spend hours to navigate this, and it can't continue like this. Back-dating is not effective.

Comment #2: Providers who provide services when the status is inactive are at risk of not being reimbursed if the coverage is not backdated when it gets fixed (if ever). Appealing prevents them from ever being listed as inactive.

Comment #3: Large negative impact that continuous coverage unwind is having on Colorado Federally Qualified Community Health Centers (FQHC). Some FQHCs have already contracted, and Salud Family Health will likely contract next year as well which will unfortunately mean lost services for many patients.

Comment #4: Including the intersection of Title V and Title X in feasibility study would also be wise.

Comment #5: Including parent/child supports in the feasibility study would be great, thanks! I can connect you with some Children's providers that work in that space. Thank you! Response: HCPF will consider a variety of policies in the HRSN feasibility study and invite stakeholders to share this feedback once opportunities are made available.

Comment #6: Regarding Criminal Justice Re-Entry Services, the experience we have is that Medicaid providers are usually not interested in being a part of our system. If we want to get treatment reports, we have to find providers willing to have releases signed.

We also have ran into that we have pay out of pocket or other funding sources rather than billing Medicaid.

Attachment 11: Overview Paper

Colorado's 1115 SUD Waiver Amendment Overview

November 2023

Waiver Amendment Overview to expand services through an 1115 SUD Medicaid Demonstration Waiver: continuous coverage (0-3 & adults leaving incarceration), serious mental illness (SMI) and serious emotional disturbance (SED), criminal justice re-entry.

Introduction

Consistent access to health care is critical to prevention, intervention, and ongoing treatment of individuals with physical and behavioral health needs. This waiver amendment proposal by the Colorado Department of Health Care Policy and Financing (HCPF) seeks to improve health outcomes, promote long-term recovery, and reduce overdose deaths by extending member coverage for priority populations. For children ages zero to three, continuous coverage means they have immediate access to services from birth across multiple developmental stages with a consistent and trusted health care provider, uninterrupted by changes in insurance[31]. Through regular screenings, providers can detect problems faster in individuals, as well as their caregivers and home environments leading to earlier prevention and intervention efforts. Early adversity, such as home life instability, abuse or illness, can interrupt foundational brain development in the first years of life putting children at greater risk of developing lifelong health problems, including substance use disorders[32]. Continuous coverage ensures children ages zero to three and their caregivers have access to mental health services like Colorado's Child First home-visiting program, proven to reduce poor behavioral health among the child and caregiver, decrease exposure to traumatic events, and increase access to services[33]. Families can receive screenings, therapeutic interventions, care coordination, and develop trusted relationships with a consistent provider which act as protective factors in preventing adverse childhood events, substance misuse and other negative outcomes for children as they grow[34].

Continuous and immediate access to reliable healthcare is critical to individuals upon release from a correctional facility when they are at highest risk of recidivism, illness, overdose and death. Individuals leaving adult and youth correctional facilities may only receive timely services if they are quickly connected to health care services, which is why Colorado seeks to improve pre-release services to ensure that eligible individuals are already connected to the community-based support they need prior to

[31] Cohen, S. (2021) *Three Principles to Improve Outcomes for Children and Families, 2021 Update*. Center on the Developing Child at Harvard University. Retrieved From: https://harvardcenter.wpenginepowered.com/wp-content/uploads/2017/10/3Principles_Update2021v2.pdf

[32] Ali N., Borgman, R., Costello, E., Cruz K., Govindu, M., Roberts M., Rooks-Peck, C., Wisdom, A., Herwehe, J., McMullen, T. (2022) *Overdose Data to Action Case Studies: Adverse Childhood Experiences*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Retrieved from: https://www.cdc.gov/drugoverdose/od2a/pdf/OD2A-ACEs-case-study-508.pdf

[33] Crusto, C.A. Lowell, D.I., Paulicin, B., Reynolds, J., Feinn, R., Friedman, S. R., & Kaufman, J. S. (2008) *Evaluation of a Wraparound Process for Children Exposed to Family Violence*. Best Practices in Mental Health: An International Journal, 4(1), 1-18

[34] Child First (2023) *Home-Based Intervention. Child First*. Retrieved from: https://www.childfirst.org/our-work/home-based-intervention

release. Continuous coverage for eligible individuals guarantees health care access for 12 months after release which may lead to outcomes including reducing the likelihood of initiating or returning to substance use. For individuals with SMI or SED who may need additional support in an institutes for mental disease (IMD) acute or residential stay, expanding reimbursement opportunities can improve quality and access to these services. This amendment to Colorado's current 1115 "Expanding the Substance Use Disorder Continuum of Care" Waiver for children, youth and adults promotes access to health care as a core component of substance misuse prevention, reducing hospitalization and incarceration, and prioritizing physical and behavioral health promotion in Colorado.

Colorado goals for this request

HCPF oversees Colorado State's Section 1115 Medicaid demonstration waiver called "Expanding the Substance Use Disorder Continuum of Care" (1115 SUD Waiver). The 1115 SUD waiver demonstration approval period is January 1, 2021 through December 31, 2025.

HCPF is requesting an amendment to the current 1115 SUD waiver, which would authorize:

- Continuous eligibility for ages 0-3 and adults leaving a Colorado Department of Corrections (DOC) facility;
- Prerelease services for individuals transitioning from correctional facilities; and
- Reimbursement for acute inpatient and residential stays in IMD for individuals diagnosed with a SMI or SED.

Continuous coverage for children to age three and adults leaving a Colorado Department of Corrections (DOC) facility

Colorado House Bill 23-1300 authorizes HCPF, by April 1, 2024, to seek federal authority to provide continuous Medicaid coverage for children up to age three and for twelve months for adults who have been released from a Colorado Department of Corrections facility, regardless of any change in income during that time by January 1, 2026. [35] Through this legislation, Colorado aims to improve the health and well-being of people in Colorado through consistent access to health care coverage during critical periods in life. During the COVID-19 public health emergency, longer periods of continuous coverage in the state's medical assistance programs allowed more Colorado families to access and maintain health insurance. This continuous coverage reduces family stress, increases the use of preventive services, and reduces costly, avoidable emergency department (ED) visits and hospitalization stays. Continuous coverage assists children in healthy early development and strength's overall mental health through regular connections with the health system. Providing continuous Medicaid coverage can decrease gaps in insurance coverage (churn: losing and then re-enrolling in coverage often for administrative reasons or small fluctuations in income) and enhance the continuity of care and delivery of

[35] Continuous Eligibility Medical Coverage Act, HB23-1300. 2023 Colorado State Legislative Session. Retrieved from https://leg.colorado.gov/bills/hb23-1300

physical and behavioral health services during early childhood and when adults experience the difficult transition of leaving the criminal justice system.

This demonstration request will end churn among Medicaid and CHP+[36] enrolled children through age three, enabling their families and providers to better address their primary and preventive health care needs.[37] Children need consistent access to health care, especially in their early years, when frequent screenings, vaccinations, and wellness checkups are critical to their development and school readiness. This request will ensure that coverage disruptions do not prevent children from receiving ongoing treatment and services they require during the critical early years of development and growth. This request seeks to:

- Ensure continuous Medicaid and CHP+ coverage for young children;
- Promote longer-term access to and continuity of physical health care, behavioral health care, dental care and preventive services;
- Combat racial inequities; and
- Improve health outcomes and well-being for low-income young children.

This demonstration request will also end churn among Medicaid-enrolled adults for the year after they leave a Colorado DOC facility and re-enter the community, enabling these individuals and their providers to better address their physical and behavioral health care needs. Ensuring continuous coverage for previously incarcerated adults not only improves health outcomes but supports stability and may also improve public safety by reducing rates of recidivism. For example, adults with substance use disorder (SUD) convictions have a greater risk of criminal re-involvement and recidivism.[38]

This request will ensure that coverage disruptions do not prevent adults leaving incarceration in Colorado DOC facilities from receiving ongoing treatment for physical or behavioral health needs during a critical time that can improve SUD and mental health treatment, reduce recidivism rates and reduce costly hospitalizations and unnecessary ED visits.[39] This request seeks to:

- Ensure 12 months of continuous Medicaid coverage for adults leaving a DOC facility;
- Promote longer-term access to and continuity of physical and behavioral health care and care coordination;
- Combat racial inequities; and
- Improve short and long-term physical and behavioral health outcomes and

[36] In Colorado, the Children's Health Insurance Program is called the Child Health Plan Plus (CHP+)

[37] Alker, J., Kenney G., Rosenbaum S. (2022) T*he Biden Administration Should Approve Oregon's Request To Cover Children Until Their Sixth Birthday*. Health Affairs. Retrieved from: https://www.healthaffairs.org/content/forefront/biden-administration-should-approve-oregon-s-request-cover-children-until-their-sixth

[38] NIDA. (2020) *Criminal Justice DrugFacts.* National Institute on Drug Abuse. Retrieved from: https://nida.nih.gov/publications/drugfacts/criminal-justice

[39] Frank, J. W., Linder, J. A., Becker, W. C., Fiellin, D. A., & Wang, E. A. (2014) *Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: results of a national survey*. Journal of general internal medicine, 29(9), 1226–1233. Retrieved from: https://doi.org/10.1007/s11606-014-2877-y

reduce recidivism for adults leaving a Colorado DOC facility.

Pre-release services for individuals transitioning from correctional facilities

In 2022, the Colorado Legislature committed to exploring whether the state should seek federal authority to improve health outcomes for the justice population through Senate Bill 22-196. This 1115 demonstration request will allow for the continuity of medical assistance services for people in Colorado leaving the DOC and Division of Youth Services (DYS) facilities. To best scale these services, the demonstration would begin with state-run prisons and detention centers first. This request seeks to:

- Improve health outcomes for individuals with complex or unmet health needs;
- Create greater health equity within the healthcare continuum; and
- Reduce the disparities for criminal justice-involved individuals by improving access to quality health care, allowing for successful transitions back to the community.

Serious mental illness (SMI) and serious emotional disturbance (SED)

Through this amendment, HCPF seeks to expand this authority to reimburse for acute inpatient and residential stays in an IMD for individuals diagnosed with a SMI or SED. This request seeks to:

- Reform HCPF's current IMD reimbursement policy to cover up to 15 days each calendar month without length of stay restriction, so long as providers maintain an average length of stay of 30 days or less;
- Reduce utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
- Reduce preventable readmissions to acute care hospitals and residential settings;
- Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
- Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Background

Continuous coverage for children to age three

People need insurance coverage to access health care and maintain good health for

themselves and their families.[40] Among families without insurance coverage, children are less likely to access pediatric preventive care than their Medicaid-covered peers.[41] Continuity of coverage for young children provides an essential base for providers and health plans to focus their efforts on necessary primary and preventive care and early diagnosis and treatment of problems that will improve long-term physical and behavioral health.

Over the past two years, COVID-19 disrupted early childhood services and programs, severely impacting the development, and emotional and behavioral health of children and youth. In particular, children ages zero to five from lower income households, single-parent families, and Black households, as well as young children with disabilities, experienced significant increases in emotional or behavioral problems, including depression.[42] Now, more than ever before, we need to ensure uninterrupted coverage and access to health care for children. Continuous enrollment will keep young children connected to coverage and care without the risk of coverage losses and the discontinuity in care. Through this proposal, Colorado seeks to ensure that young children get the care they need when they need it.

Studies demonstrate inconsistent coverage (churn) leads to a higher likelihood of unmet medical, prescription and dental needs, a delay in accessing urgent care and a lower likelihood of having a usual source of care and well child care. [43] [44] [45] Therefore, continuous coverage for young children is an important tool to promote consistent access to health care and the preventive services needed to identify and address physical, behavioral, and developmental concerns before they impede a child's performance in school.[46] These gaps in access are particularly consequential for the preschool aged children that Colorado has prioritized, as experts recommend 12 well-child checks before age 3.[47]

Colorado previously adopted the 12-month continuous coverage state plan option for children. While that policy is effective in maintaining coverage during the 12 months between redetermination of Medicaid eligibility, even with a streamlined renewal process, coverage losses at redetermination continue to be an issue for children and

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[40] Hailun L., May A.B., and Shaker M. E. (2019) *Health Needs, Utilization of Services and Access to Care Among Medicaid and Uninsured Patients with Chronic Disease in Health Centres. Journal of* Health Services Research & Policy 24, no. 3 (Jul 2019): 172-181.

[41] Venkataramani, M., Pollack C. E., Roberts E. T. (2017) *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*. Pediatrics. 140 (6): e20170953. Retrieved from: https://doi.org/10.1542/peds.2017-0953.

[42] Jones, K. (2021) *The Initial Impacts of Covid-19 on Children and Youth (Birth to 24 Years): Literature Review in Brief*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Retrieved from: https://aspe.hhs.gov/sites/default/files/documents/188979bb1b0d0bf669db0188cc4c94b0/impact-of-covid-19-on-children-and-youth.pdf

[43] Sugar, S., Peters C., DeLew. N., Sommers, BD. (2021*) Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic (Issue Brief No. HP-2021-10)*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Retrieved from: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[44] DeVoe, J. E., Graham, A., Krois, L., Smith, J., & Fairbrother, G. L. (2008) *"Mind the Gap" in children's health insurance coverage: does the length of a child's coverage gap matter*. Ambulatory pediatrics : the official journal of the Ambulatory Pediatric Association, 8(2), 129–134. Retrieved from: https://doi.org/10.1016/j.ambp.2007.10.003

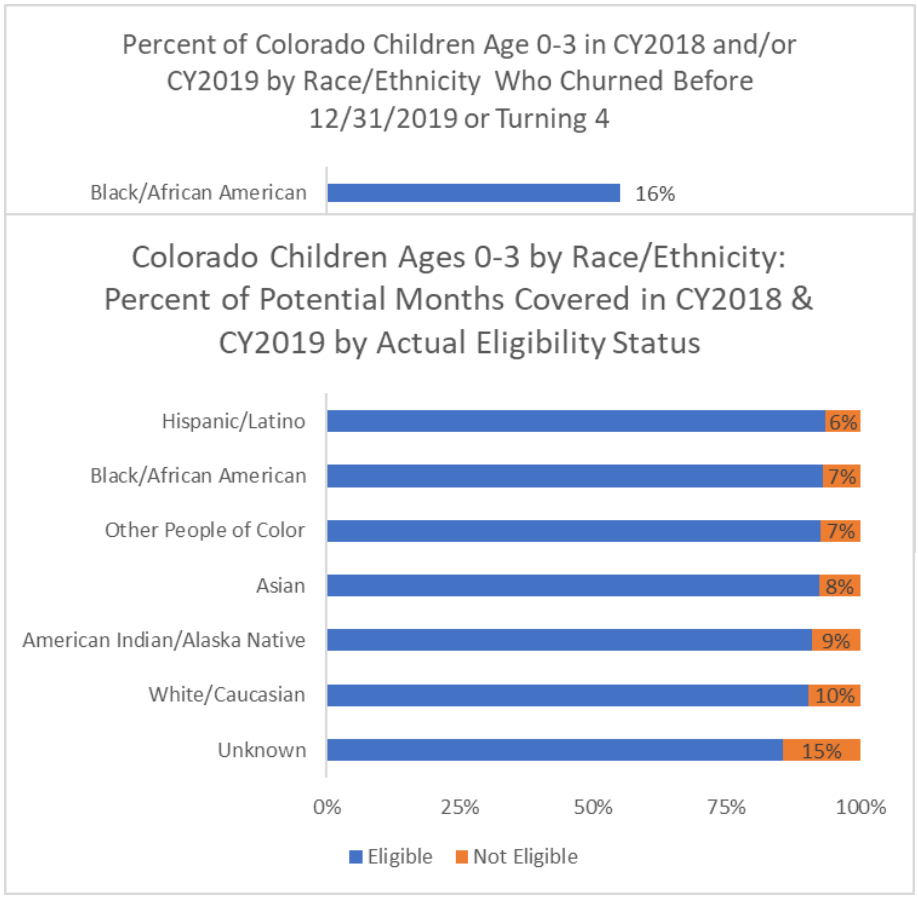
[45] Cassedy A., Fairbrother G., Newacheck P. W. (2008) *The impact of insurance instability on children's access, utilization, and satisfaction with health care.* Ambulatory Pediatrics. 2008 Sep-Oct;8(5):321-8. doi: 10.1016/j.ambp.2008.04.007. Epub 2008 Jun 16. PMID: 18922506.

[46] Brooks T., Gardner A. (2021) *Continuous Coverage in Medicaid and CHIP.* Georgetown University Health Policy Institute, Center for Children and Families. Retrieved from: https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf

[47] Burak E. W. (2018) *Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP).* Georgetown University Health Policy Institute, Center for Children and Families. Retrieved from: https://ccf6.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf

families due to change of address, paper work issues and other administrative reasons.

An analysis of Colorado's enrollment data in calendar years 2018 and 2019 shows that 20 percent of children ages 0-3 with eligibility at any time in the two years experienced Medicaid or CHP+ coverage gaps. See the charts for coverage gaps broken out by race and ethnicity.



In September of 2022, Oregon received Federal authority from the Centers for Medicaid and Medicare Services (CMS) to provide continuous coverage for Medicaid and Children's Health Insurance Program (CHIP) enrolled children from 0 to age 6, regardless of income. In June 2023, Washington received similar authority for continuous coverage for Medicaid enrolled children from 0 to age 5. Colorado seeks the same Federal authority to provide continuous coverage with Federal Financial Participation (FFP) for Medicaid and CHIP enrolled children from birth to age 3.

Adults leaving a Colorado Department of Corrections (DOC) facility

Evidence shows that continuous enrollment improves continuity of care, access to preventive services and quality. One 2015 study examined the impact of churn and found that people who experienced a coverage gap as part of their churn were more likely to have to switch doctors and more likely to skip doses or stop taking medications, compared to those who changed coverage without a coverage gap. They were also more likely to report delaying care due to cost, having trouble paying bills, or receiving low-quality care. Half of those who experienced a coverage gap reported it had a negative impact on their overall health and quality of care, compared to 20%

for those without a gap.[48]

Risks associated with churn and lack of health insurance are exacerbated for the justice-involved population at reentry.[49] Ensuring Medicaid coverage for this population, particularly for individuals who experience racial inequities, is a high priority for Colorado. Continuity of care is an important approach to alleviate health inequities, reduce recidivism, prevent overdoses, and reduce costly hospitalizations[50] [51]

Formerly incarcerated individuals have higher rates of chronic health conditions, including hepatitis C, diabetes, and high blood pressure, as well as higher rates of addiction and mental health needs[52]. 80% of those returning to the community have chronic physical or behavioral health concerns at release. Ensuring access to preventive health services during reentry may be especially critical for incarcerated people with mental illness or substance use disorder. One study of people on parole in California found that 53% of those with mental illness were reincarcerated within one year, compared with 30% of those without mental illness. Importantly, reincarceration for those with mental illness was often due to technical violations such as failing to attend mental health appointments.[53] Additionally, the risk of opioid overdose within two weeks after release is 40 times higher than the general population.[54] Providing coverage and access to care is critical to address the SUD and mental health needs of adults at reentry.

Colorado has seen recent improvement in engagement in behavioral health services for adults at reentry. Regional Accountable Entities (RAEs), that manage behavioral health services and care coordination for Medicaid members, implemented data sharing agreements in 2019 with DOC and Judicial to better support members as they transition from incarceration to the community. These data connections have resulted in higher engagement in behavioral health services (from 9% to 20%) within 14 days of release. Providing continuous coverage will enhance these important gains.

In September of 2022, Massachusetts received Federal authority from CMS to provide 12 months of continuous coverage for Medicaid enrolled adults leaving incarceration. Colorado seeks the same Federal authority to provide continuous coverage with FFP for Medicaid enrolled adults leaving a Colorado DOC facility.

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[48] Sommers B. D., Gourevitch R., Maylone B., Blendon R. J., and Epstein A. M. (2016) *Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many.* Health Affairs 2016 35:10, 1816-1824 Retrieved from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0455

[49] Sawyer J., Wachino V., Walsh A., Lomax S. (2022) *Providing Health Care at Reentry Is a Critical Step in Criminal Justice Reform.* To the Point (blog), Commonwealth Fund, Sept. 9, 2022. Retrieved from: https://doi.org/10.26099/g765-7947

[50] Albertson, E. M., Scannell, C., Ashtari, N., & Barnert, E. (2020) *Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration.* American journal of public health, 110(3), 317–321. Retrieved from: https://doi.org/10.2105/AJPH.2019.305400

[51] Frank et al (2014)

[52] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007) *Release from prison--a high risk of death for former inmates.* The New England journal of medicine, 356(2), 157–165. Retrieved from: https://doi.org/10.1056/NEJMsa064115

[53] Louden J. E., Skeem J. L. (2011) *Parolees with mental disorder: toward evidence-based practice.* The Bulletin UC Irvine. Retrieved from: https://ucicorrections.seweb.uci.edu/files/2013/06/Parolees-with-Mental-Disorder.pdf.

[54] Ranapurwala, S. I., Shanahan, M. E., Alexandridis, A. A., Proescholdbell, S. K., Naumann, R. B., & Edwards, D. (2018) *Opioid overdose mortality among former North Carolina inmates: 2000-2015. American Journal of Public Health, 108*(9), 1207–1213. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6085027/

Pre-release services for individuals transitioning from correctional settings

The Inmate Payment exclusion has been in place since the Medicaid program began in 1965. The inmate payment exclusion as provided in the last paragraph of section 1905 (a) of the Social Security Act[55] outlines that federal Medicaid funds may not be used to pay for services for individuals while they are incarcerated, except when they are inpatients in a medical institution. Individuals released from carceral settings like jails and prisons often have complex co-occurring health concerns, including SUD, mental health needs, and ongoing chronic and infectious illness – all requiring linkages to community-based care upon reentry. In the first two weeks following release from incarceration, individuals are 129 times more likely to die from an overdose than their peers in the community, and they often have higher rates of cardiac conditions, diabetes, Hepatitis C, mood, and anxiety disorders as well as severe and persistent mental illness.[56] Providing medication-assisted treatment (MAT) is an essential service for individuals who experience forced abstinence, such as those in jails and prisons. Individuals with substance use disorders or substance-related criminal charges who are reentering the community are at greater risk of criminal re-involvement and recidivism, underscoring that addressing public health needs may help advance public safety outcomes and reduce future incarceration. Colorado has undertaken significant reform efforts to improve health outcomes, services, and care for the justice-involved population.

As of April 30, 2023, Colorado correctional institutions reported an inmate population of approximately 31,000 individuals[57]. About 70-80% of these individuals have a substance use disorder, mental health diagnosis, or chronic health condition, which has required the corrections system to become the de facto primary provider of behavioral health and SUD services for justice-involved individuals[58]. Individuals with recent criminal justice involvement makeup 4.2% of the United States adult population, and account for an estimated 7.2% of hospital expenditures and 8.5% of ED expenditures[59]. Those individuals with SUD diagnosis are 80% more likely to recidivate. A disproportionate number of incarcerated individuals are minorities, specifically Black, Hispanic, and Indigenous[60]. The disproportionate number of incarcerated Black individuals compounds existing health disparities affecting these underserved populations. The justice-involved population and the minority populations' healthcare outcomes are interconnected.

In January 2023, California received federal authority from CMS to cover certain pre-release services to Medicaid and CHIP eligible justice individuals for up to 90 days immediately prior to their expected date of release from incarceration in institutions such as county jails, state prisons, and youth correctional facilities. In April 2023, CMS

[55] Social Security Act,42 U.S.C. § 1396d 1905 (a)(A). Retrieved from: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

[56] Binswanger et al (2007)

[57] Prison Policy Initiative (2023) Colorado profile. Retrieved from: https://www.prisonpolicy.org/profiles/CO.html

[58] Criminal Justice Federal Authority Project: Specifications for Different Federal Authority Solutions, 2023-8. April 2023

[59] US Department of Justice Medical Problems of State and Federal Prisoners and Jail Inmates, 2011–12. January 2015. Available at: https://bjs.ojp.gov/content/pub/pdf/mpsfpji1112.pdf

[60] Binswanger et al (2007)

shared with state guidance on how to develop a plan for Medicaid coverage of pre-release individuals in a carceral setting.[61] Colorado seeks the federal authority to provide certain prerelease services with FFP.

Serious mental illness (SMI) and serious emotional disturbance (SED)

The Medicaid IMD exclusion[62] has been in place since the Medicaid program began in 1965. The IMD exclusion prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases." The statutory provisions relating to IMDs include two categories of covered services and a broad payment exclusion that excludes FFP[63] for any medical assistance under title XIX for services provided to any individual who is between the ages of 21-64 and who is a patient in an IMD. Conversely, the original Medicaid legislation included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. In 1972, the policy was expanded to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22.

The exclusion was designed to assure that states, rather than the federal government, have principal responsibility for funding inpatient psychiatric services. The law was enacted during a time when states maintained large psychiatric hospitals, which served as the primary providers of psychiatric care to patients who often experienced long lengths of stay (LOS). The IMD exclusion followed the Community Mental Health Act of 1963,[64] which provided grants to states to establish community mental health centers in an effort to deinstitutionalize individuals with mental illness as well as developmental. FFP is the portion paid by the federal government to states for their share of Medicaid expenditures.

At present, CMS provides two options for states to receive FFP for short-term IMD stays. First, states may use "in lieu of authority" through its managed care contracts to reimburse IMD stays of up to 15 days in a calendar month. Second, under 1115 waiver authority, states may reimburse for IMD stays of up to 60 days if an average statewide length of stay of 30 days or less is maintained. Currently, Colorado utilizes "in lieu of" authority through its managed care contracts with RAEs to provide IMD reimbursement for stays of up to 15 days in a calendar month. This authority provides sufficient coverage for most acute psychiatric inpatient stays. However, there remain IMD stays that exceed the 15-day limit due to issues such as patient acuity and additional time needed to ensure a safe and appropriate transition to community-based services. Stays that exceed the 15-day LOS rule are not eligible for any reimbursement for services rendered.

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[61] Tsai, D. (2023) SMD# 23-003 RE: Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals Who Are Incarcerated. DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services. Retrieved from: https://www.medicaid.gov/sites/default/files/2023-04/smd23003.pdf

[62] Social Security Act,42 U.S.C. § 1396d 1905 (a)(B). Retrieved from: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

[63] Federal financial participation (FFP) is the portion paid by the federal government to states for their share of Medicaid expenditures.

[64] Community Mental Health Act of 1963, Pub. L. No. 88-164, § 406, 761 Stat. 77 (1963) Retrieved from: https://www.govtrack.us/congress/bills/88/s1576

Through this amendment, HCPF seeks authority to reimburse up to 15-days each calendar month even if a stay exceeds the current limit under "in lieu of authority." This will permit Colorado to modify its current practice through which a prorated capitation payment is made to the RAE for the days within the month that the enrollee was not in an IMD and the RAE's subsequent payment recoupment from the IMD for the entire stay. It will also address the clinical decision making challenges in which providers are choosing between discharging a patient and receiving 15 days of reimbursement, and recognizing that some clients may have extended LOS due to discharge barriers such as housing, transportation, access to step down or psychiatric care, or physical safety in the home.

Health First Colorado (Colorado's Medicaid Program)

The Medicaid program in Colorado, known as Health First Colorado, covered approximately 1.6 million people in Colorado during 2022. This means roughly 26.9% of Colorado's population was enrolled in Health First Colorado[65]. Of those enrolled, over 37% were children and adolescents (covered by Health First Colorado and Child Health Plan *Plus*)[66]. These programs covered 43% of all births in the state of Colorado in calendar year 2021.

Health First Colorado is a Medicaid insurance program that provides access to physical and behavioral health care, hospitalization, nursing facility care, prescription drugs, dental care and other benefits for qualifying adults and children. Physical health services are paid for through the traditional fee-for-service structure through HCPF. While behavioral health and care coordination services are capitated and provided by RAEs through contracts with HCPF. The RAEs have data sharing agreements with the Department of Corrections to better support members as they transition to community.

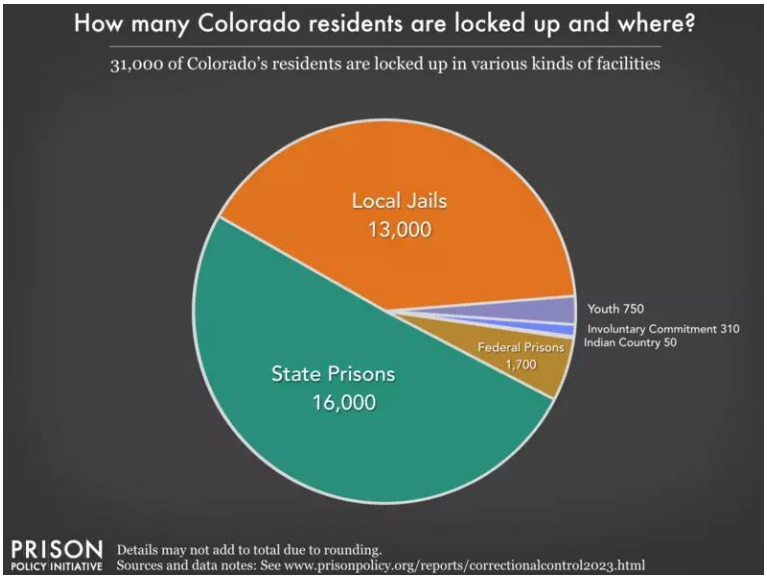
Since 2011, the Accountable Care Collaborative (ACC) has served as the core vehicle for delivering and managing member care for Health First Colorado. All full-benefit Health First Colorado members are enrolled in the ACC except for members enrolled in the Program for All Inclusive Care for the Elderly. The ACC integrates managed fee-for-service physical health care and managed care for behavioral health. The ACC's regional model allows it to be responsive to unique community needs. Key components of the ACC include care coordination and member support.

Colorado is seeking to ensure continuous Health First Colorado coverage for children during the first three years of their lives. Colorado covers Health First Colorado children up to 215 percent Federal Poverty Level (FPL) with Medicaid funds and up to 260 percent FPL with CHIP funds through the Child Health Plan Plus. The proposed continuous enrollment policy will apply to Medicaid-enrolled children with incomes up to 215 percent FPL, CHP+ children with incomes up to 260 percent FPL, and children

[65] Health Care Policy & Financing (HCPF) (2023) *State of Colorado Fact Sheet*. Colorado Department of Health Care Policy & Financing. Retrieved from: https://hcpf.colorado.gov/sites/hcpf/files/Statewide%20Fact%20Sheet.pdf

[66] Health Care Policy & Financing (HCPF) (2023) *Health Care Policy & Financing Report to the Community Fiscal Year 2021-2022*. Colorado Department of Health Care Policy & Financing. Retrieved from: https://hcpf.colorado.gov/2022-report-to-community

who would be eligible for medical assistance coverage but are not because of their immigration status. Colorado estimates that in 2019 there were 43,984 children who lost eligibility or had a gap in eligibility before 12/31/2019 or before they turned 4. The continuous enrollment initiative would have prevented these children from churning off coverage. On average, 31,000 young children will receive continuous enrollment through this initiative. It is estimated that approximately 31,000 Colorado residents are incarcerated in local jails, federal and state prisons, and other criminal justice facilities (see figure below for breakdown)[67]. As of 2023, there were over 17,000 individuals incarcerated in 21 state prisons.[68] The average stay in state prisons is 33 months, and over 94% of prisoners are male.[69] There are approximately 5,883 releases per year, with 4,070 – 5,295 of those released are likely eligible for Medicaid.[70]



Proposed Amendment requests

Colorado is seeking authority for the below through an 1115 waiver amendment request of Colorado's current 1115 waiver: Expanding the Substance Use Disorder Continuum of Care, Waiver #: 11-W-00336/8.

- Continuous eligibility for ages 0-3 and adults leaving Colorado correctional facilities;
- Pre-release services for individuals transitioning from correctional settings; and
- Reimbursement for acute inpatient and residential stays in IMD for individuals diagnosed with a SMI or SED.

Continuous coverage for children to age three

Colorado is seeking new federal authority to provide continuous enrollment in Medicaid or CHIP for young children who have incomes below 215 percent FPL for Medicaid and 260 percent FPL for CHIP at the time of application through the end of the month their third birthday falls. A Medicaid or CHIP eligible child shall remain continuously eligible without regard to family income. Eligibility will continue to be monitored by the State. Children who have moved out of state will not retain

67 Prison Policy Initiative, 2023

68 Thomas-Henkel, C., Williams, C., Costa, J., White, J., Kelly, T., Moore, T. (2023) Federal Authority to Support Health-Related Reentry Services for Incarcerated Populations. Retrieved from: https://hcpf.colorado.gov/sites/hcpf/files/Federal%20Services%20for%20Incarcerated%20Populations%20SB%2022-196-B_0.pdf

69 Thomas-Henkel, et al. 2023

70 Thomas-Henkel, et al. 2023

coverage. When the family has requested voluntary disenrollment coverage will not be retained.

Adults leaving a Colorado Department of Corrections (DOC) facility

Colorado is seeking new federal authority to provide continuous enrollment in Medicaid for adults who have been released from a Colorado Department of Corrections facility. A Medicaid-eligible adult shall remain continuously eligible for Medicaid without regard to income for a period of 12 months beginning on the date of release. Eligibility will continue to be monitored by the State. Eligible adults who have moved out of state will not retain coverage. When an adult has requested voluntary disenrollment, the state determines eligibility was erroneously granted, or the individual is deceased coverage will not be retained.

Colorado is seeking to implement continuous enrollment requests by January 1, 2026. This continuous eligibility request is contingent on the receipt of FFP to the maximum extent allowed under federal law.

Pre-release services for individuals transitioning from correctional settings

In alignment with Senate Bill 22-196, this amendment request would authorize Medicaid-funded reentry services to incarcerated individuals across several settings, including state prisons and youth in correctional facilities. The 90-day reentry services would include:

- Case management (care coordination) services that include physical and behavioral health clinical screenings and consultation services;
- A 30-day supply of prescription medications and medication administration post release; and
- MAT for all FDA-approved medications (including counseling and long acting injectables).

Colorado seeks to implement prerelease services for individuals transitioning from state-run facilities (operated by the Colorado Dept. of Corrections an the Colorado Dept. of Human Services Office of Children, Youth and Families) by January 1, 2026. This prerelease request is contingent on receiving FFP to the maximum extent allowed under federal law and Colorado. The request is also to include all 51 jails in Colorado the following year, recognizing that since each facility is operated by a different local government, there is a lot of stakeholder engagement and financial and program alignment that is required, whereas with the state run facilities that work is consolidated with one accountable agency.

Serious mental illness (SMI) and Serious emotional disturbance (SED)

Colorado seeks to expand the authority to reimburse for acute inpatient and residential stays in IMDs for individuals diagnosed with SMI or SED by January 1, 2025. This request is contingent on the receipt of FFP to the maximum extent allowed under federal law and Colorado.

New Waiver Authorities

Colorado is requesting the following three authorities be added as an amendment request to Colorado's existing "Expanding the Substance Use Disorder Continuum of Care" 1115 demonstration waiver (Waiver #:11-W-00336/8).

Continuous coverage for children to age three and adults leaving Colorado a Department of Corrections (DOC) facility

42 CFR 457.343: to enable the state to waive the annual redetermination requirements, including required procedures for reporting and acting on changes (other than a change in residence to out of state, voluntary disenrollment, erroneously granted enrollment).

Pre-release services for individuals transitioning from correctional settings

Waiver of Section 1905(a) of the Social Security Act "inmate exclusion rule", as necessary to implement the state's pre-release services to justice involved individuals in state prisons, county jails and youth correctional facilities for up to 90 days prior to release.

HCPF requests expenditure authority under Section 1115 for otherwise covered Medicaid services furnished to otherwise eligible individuals, who are receiving services in a carceral setting. No additional waivers of Title XIX or Title XXI are requested through this amendment application.

Serious Mental Illness and Serious Emotional Disturbance

Waiver of Section 1905(i) of the Social Security Act "institutions for mental diseases (IMDs) exclusion rule", as necessary to implement payment for services provided to individuals in IMDs.

HCPF requests expenditure authority under Section 1115 for otherwise covered Medicaid services furnished to otherwise eligible individuals, who are primarily receiving treatment for an SMI/SED who are short-term residents in facilities that meet the definition of an IMD. No additional waivers of Title XIX or Title XXI are requested through this amendment application.

Financing

Colorado proposes to finance the non-federal share of expenditures under this request using state general funds. Expenditures under this amendment will be treated as "pass-through" for the purposes of budget neutrality.

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