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

January 25, 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 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.

Through this amendment, HCPF seeks authority to reimburse the first 15-days of stays that exceed the current limit under "in lieu of authority." 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 early development and strengthens overall mental health through regular connections with

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

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*)[4]. These programs covered 43% of all births in the State in calendar year (CY) 2021.

Health First Colorado is a Medicaid insurance program that 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 (divided into seven RAEs) 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 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

[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

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.

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.

[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

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]

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

[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.

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.

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

[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.

- 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 to increase 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.

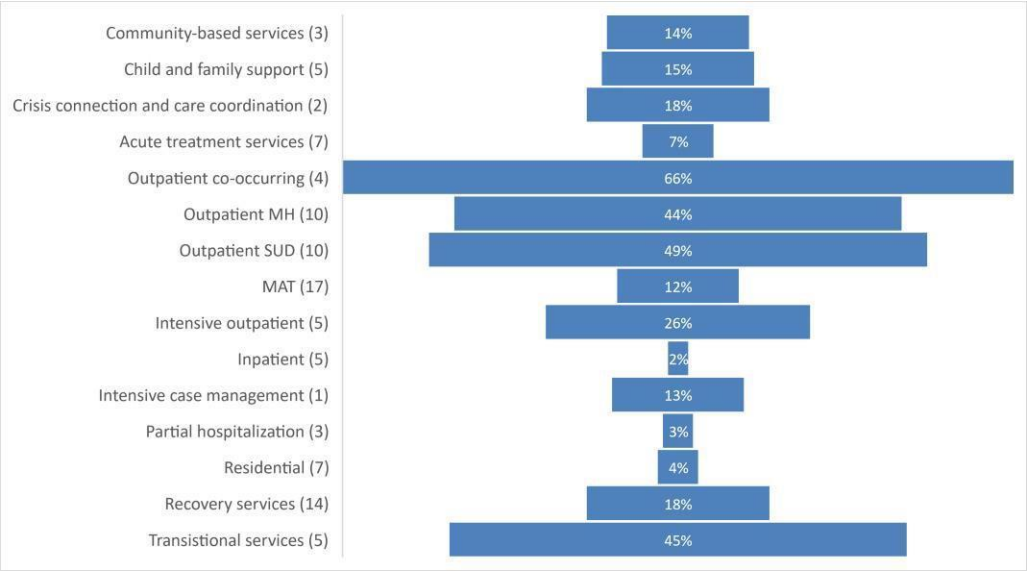
In addition to these Health First Colorado initiatives, the State is in the process of consolidating BH networks for its safety net system into one behavioral health administrative services organization (BHASO) per region. BHASOs are intended to help individuals and families initiate BH care and ensure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



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 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

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

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[17]. 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[18]. 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[19]. 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[20].

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.

[17]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
[18]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
[19]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
[20]Child First (2023) *Home-Based Intervention. Child First.* Retrieved from: https://www.childfirst.org/our-work/home-based-intervention

Goals and Objectives

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. 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 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 on or after 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 provides 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.[21] A detailed description of the background and benefits of the continuous coverage request is found in the overview paper included in Appendix A.

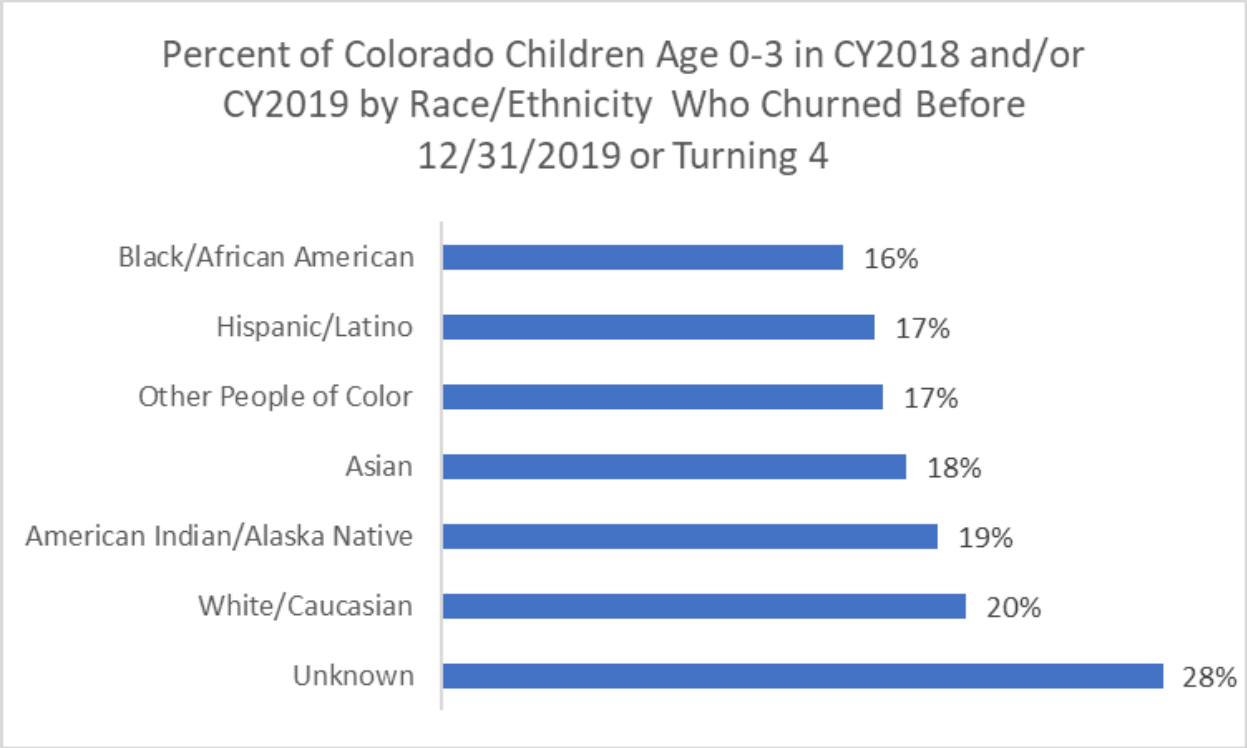
The State is seeking to implement both continuous coverage requests by January 1, 2026. These continuous coverage requests are contingent on the receipt of FFP to the maximum extent allowed under Federal law.

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 the charts below for coverage gaps broken out by race and ethnicity.

[21] 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



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[22]

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 2. 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[23]	5,883	33 months	4,070–5,295
Youth Population in 15 Youth Corrections Facilities	173[24]	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 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)

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

[23] 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.

[24] 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.

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 3. 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.

Reimbursement will be limited to the first 15-days of stays that exceed the current limit under "in lieu of authority."

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.

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 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

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

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 1 presents the current demonstration periods; Table 2 presents the proposed Amendment demonstration periods.

Table 1: 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 2: 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 3 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 3: Demonstration Proposal Effective Dates

Demonstration Proposals	Effective Date
FFP for the first 15 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)

Table 4 presents information by proposed Medicaid Eligibility Group (MEG) for the estimated caseload, (member months), projected per capita and 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 4: Caseload and Total Computable Expenditure Projections (Hypothetical Expenditures)

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)

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 15 days for stays that exceed 15 days. The state will not receive FFP for the portion of non-SUD IMD stays that exceed 15 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 1 - Non-Expansion Adults					
Demonstration Member Months	3	6	6	6	6
Per Capita (PMPM)	$39.79	$41.81	$43.95	$46.19	$48.54
Projected Demonstration Expenditures	$124	$263	$279	$296	$315
MEG 2 - Expansion Adults					
Demonstration Member Months	38	78	78	79	80
Per Capita (PMPM)	$56.82	$59.72	$62.76	$65.97	$69.33
Projected Demonstration Expenditures	$2,182	$4,633	$4,918	$5,221	$5,542
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 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 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.

	DY5	DY6	DY7	DY8	DY9
MEG 3 –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 4 - 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 5 - 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.

	DY5	DY6	DY7	DY8	DY9
MEG 6 – 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.

	DY5	DY6	DY7	DY8	DY9
MEG 7 –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 8 - 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 9 - 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 table 4 through estimated number of member months (months of eligibility) for each MEG impacted by the demonstration proposal over the five-year demonstration period.

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).

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	3	6	6	6	6
MEG 4 – SMI Expansion Adults	38	78	78	79	80
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	$124	$263	$279	$296	$315
MEG 4 – SMI Expansion Adults	$2,182	$4,633	$4,918	$5,221	$5,542
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 3 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 4 based on SFY2021–SFY2022 reconciliations.

Table 3: 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 4: 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 SMI/SED to community-based	• 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
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.

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
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.
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.

Hypothesis	Evaluation Questions	Evaluation Parameters/Methodology
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 3 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

The State has two federally recognized tribes, the Southern Ute Tribe and the Mountain Ute Tribe. The State will solicit 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 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. Additional information regarding the tribal consultation will be updated after that process has been completed.

Section X. Demonstration Amendment Contact

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Section XI. Appendices

ATTACHMENT 1

- **Compliance with Budget Neutrality Requirements**

ATTACHMENT 2

- **Public Notice Requirements**

ATTACHMENT 3

- **Public Notice Comments**

ATTACHMENT 4

- **Tribal Consultation**