Medicaid Section 1115 Substance Use Disorder Demonstrations
Monitoring Report Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) demonstration or the SUD component of the broader demonstration

The title page is a brief form that the state completed as part of its monitoring protocol. The title page will be populated with the information from the state's approved monitoring protocol. The state should complete the remaining two rows. Definitions for certain rows are below the table.

State	Colorado
Demonstration name	Expanding the Substance Use Disorder Continuum of Care
Approval period for section 1115 demonstration	*Automatically populated with the current approval period for the section 1115 demonstration as listed in the current special terms and conditions (STC), including the start date and end date (MM/DD/YYYY – MM/DD/YYYY).* *Start Date:* 01/01/2021 *End Date:* 12/31/2025
SUD demonstration start date[a]	*Automatically populated with the start date for the section 1115 SUD demonstration or SUD component if part of a broader demonstration (MM/DD/YYYY).* 01/01/2021
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*Automatically populated with the SUD demonstration implementation date (MM/DD/YYYY).* 01/01/2021
SUD (or if broader demonstration, then SUD - related) demonstration goals and objectives	*Automatically populated with the summary of the SUD (or if broader demonstration, then SUD- related) demonstration goals and objectives.* Under this demonstration, the State expects to achieve the following Objective 1. Increa
SUD demonstration year and quarter	*Enter the SUD demonstration year and quarter associated with this monitoring report (e.g., SUD DY1Q3 monitoring report). This should align with the reporting schedule in the state's approved monitoring protocol.* *SUD DY* 2 *Q* 4
Reporting period	*Enter calendar dates for the current reporting period (i.e., for the quarter or year) (MM/DD/YYYY – MM/DD/YYYY). This should align with the reporting schedule in the state's approved monitoring protocol.* *Start Date:* 10/01/2022 *End Date:* 12/31/2022

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Executive summary

The executive summary should be reported in the fillable box below. It is intended for summary-level information only. The recommended word count is 500 words or less.

Milestone 1: The State began producing retrospective Part A monitoring reports with metrics using sub-populations beginning DY1Q1. The Behavioral Health Authority (BHA) was established and began operating in 2022. Collaboration between BHA and HCPF continued to identify opportunities to improve access to medication assisted treatment, specifically for Opioid Use Disorders (OUD) through leveraging mobile Opioid Treatment Program (OTP) units and grant opportunities to support exploration and infrastructure building.

Milestone 2: All contracts with MCEs require providers and MCEs to provide assessments to ensure appropriate placement using the American Society of Addiction Medicine (ASAM) criteria and for MCEs to utilize ASAM criteria to authorize SUD residential and inpatient stays. Managed Care Entities (MCEs) provide ASAM criteria training as part of the provider orientation process.

Milestone 3: All SUD providers are licensed by ASAM level and required to annually re-certify their license through BHA. All residential SUD providers in the State have been licensed since 2021, and the licensure requirements reflect the ASAM level of care requirements. HCPF and BHA have been jointly charged to support increasing the number of licensed facilities delivering adolescent residential SUD treatment providers.

Milestone 4: Work continued on the implementation of the Behavioral Health Capacity Registry, including a partnership with Dimagi to upgrade the original Behavioral Health Capacity Registry platform to allow providers to send push notifications to other providers when they are searching for a bed for an individual. Several bills were enacted, expanding access to evidence based substance use treatment, expanding the substance use workforce with a special focus on expanding Peer Support Specialist capacity, establishing a license for peer-led organizations, increasing access to behavioral health services through interstate licensed professional counselor compacts and leveraging telehealth, ensuring staff working in crisis services are trained to support individuals with SUDs, investing in care coordination, ensuring students have information on how to access behavioral health crisis services, requiring reimbursement for hospitals that provide opiate antagonists to individuals at risk for unintentional opioid overdose, and requiring use of the PDMP.

Milestone 5: The Colorado Opioid Abatement Council facilitated the first Opioid Abatement Conference August 15 through August 16, 2022. The Naloxone Project selected the Colorado chapter to launch the MOMs (Maternal Overdose Matters) Initiative. The State provided $1.8 million in funding for local agencies in the State to obtain naloxone for free and hosted a free yearlong SUD Learning Collaborative for Outpatient and Inpatient Perinatal Providers with the goal of reducing maternal death due to suicide and accidental overdose.

Milestone 6: BHA published recommendations for development of care coordination infrastructure and two related bills were signed into law.

3. Narrative information on implementation, by milestone and reporting topic

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.	**Assessment of need and qualification for SUD services**			
1.1	**Metric trends**			
1.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to assessment of need and qualification for SUD services	X	Metric #3- Medicaid beneficiaries with SUD Diagnosis (monthly) Metric #4- Medicaid beneficiaries with SUD Diagnosis (annually) for SUD	
1.2	**Implementation update**			
1.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1.a The target population(s) of the demonstration	X		
	1.2.1.b The clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration	X		
1.2.2	The state expects to make other program changes that may affect metrics related to assessment of need and qualification for SUD services	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2.	**Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)**			
2.1	**Metric trends**			
2.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1	X	Metric #6 Any SUD Treatment Metric #7 Early Intervention Metric #8: Outpatient Services Metric #9: Intensive Outpatient and Partial Hospitalization Services Metric #10: Residential and Inpatient Services Metric #11 – Withdrawal Management	

			Metric #12 – Medication Assisted Treatment Metric #22- Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	
2.2	**Implementation update**			
2.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1.a Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g., outpatient services, intensive outpatient services, medication-assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)			DY2Q4: The State began producing retrospective Part A monitoring reports with metrics using sub-populations beginning DY1Q1. BHA and the State are expanding access to OTPs in several key areas: • BHA and the State are making final determinations on mobile OTP service regions. • BHA announced five new competitive grants to fund start up costs for OTP medication units in rural areas. • BHA secured and announced grant funding to partner with an in-state research entity to conduct and analyze OTP patient satisfaction surveys. These surveys will help BHA determine if more rigorous rules around culturally responsive,

				respectful, and trauma-informed care training requirements are needed. DY2Q3: Even though Milestone 1 is complete under the Demonstration, the State continues to improve access and understanding of SUD treatment services across the continuum of care for Medicaid beneficiaries. This quarter, the Colorado BHA implemented OwnPath, a new care directory, to improve access to all behavioral health including SUD. This directory is accessible to both providers and Medicaid members, and identifies providers by zip code, services offered, and insurance type(s) providers are in network for. Individuals can see full details about providers, including location, hours of operation, services offered, populations served, accessibility, languages spoken, and telehealth options. DY2Q2: The Fentanyl Accountability and Prevention Legislation requires that public and private facilities proved MAT and other withdrawal management treatment to individuals with SUD through the duration of the person's incarceration, as medically necessary, by July 2023.
2.2.1.b	SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication-assisted treatment services provided to individual IMDs	X		
2.2.2	The state expects to make other program changes that may affect metrics related to Milestone 1			DY2Q1: The new Regional Accountable Entity contract modified the data collected and submitted to the Colorado Department of Health Care Policy & Financing (HCPF). Starting with the date, January 1, 2022 and submitted the second week in May 2022, the transaction date will be

			omitted from the encounter data. This could affect the State's ability to calculate metrics.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3.	**Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)**			
3.1	**Metric trends**			
3.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2	X	Metric #5- Medicaid beneficiaries treated in an Institute for Mental Disease (IMD) for SUD. Metric #36- The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	
3.2.	**Implementation update**			
3.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes: 3.2.1.a Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria			DY2Q4: All contracts with MCEs continue to have language ensuring all new and existing providers have training on ASAM criteria. All contracts with MCEs continue to require providers and MCEs to provide assessments to ensure appropriate placement using ASAM criteria and for MCEs to utilize ASAM criteria to review SUD residential and inpatient stays.

				DY2Q3: HCPF staff initiated the use of a new data collection template this quarter that supported tracking sub-population utilization. Information and instructions regarding the new form was communicated via a recurring newsletter developed by HCPF for SUD providers. HCPF anticipates being able to report on sub population specific trends by December 2022. The August 2022 SUD Stakeholder Newsletter included a reminder that SUD placement evaluations must include an American Society of Addiction Medicine (ASAM) level of care determination.
3.2.1.b	Implementation of a utilization management approach to ensure (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, or (c) use of independent process for reviewing placement in residential treatment settings			DY2Q4: All MCE contracts continue to prohibit prior authorization for non pharmaceutical components of MAT, require the use of ASAM criteria to determine the medical necessity of residential and inpatient stays, require the prior authorization of residential and inpatient stays, and require review (but prohibit prior authorization) of withdrawal management.
3.2.2	The state expects to make other program changes that may affect metrics related to Milestone 2	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.1 Metric trends			
4.1.1 The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3 Note: There are no CMS-provided metrics related to Milestone 3. If the state did not identify any metrics for reporting this milestone, the state should indicate it has no update to report.	X		
4.2 Implementation update			
4.2.1 Compared to the demonstration design and operational details, the state expects to make the following changes to: 4.2.1.a Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards			DY2Q3: HCPF continued to work closely with BHA on licensing for substance use service providers. Currently all SUD treatment licenses are required to identify the service level(s) provided as well as any specialized populations the agency serves. Milestone 3, part 1, is complete effective DY2Q3. DY2Q2: HCPF updated the SUD provider manual. The manual contains an overview of SUD processes, links to additional resources, and the most current versions of forms and tools. The SUD Residential Provider Manual covers member eligibility, provider requirements, provider enrollment procedures, SUD benefit policies, and the roles of MSOs and MCEs in benefit

				management
4.2.1.b	Review process for residential treatment providers' compliance with qualifications			DY2Q3: All licenses require annual renewal, and BHA conducts periodic audits and reviews of facilities as part of the licensing process. Milestone 3, part 2 is complete effective DY2Q3.
4.2.1.c	Availability of medication-assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site			DY2Q3: HCPF and BHA ensured licensure language aligned with the ASAM Criteria's best practices regarding individuals' access to Medication-Assisted Treatment (MAT) when receiving services at a residential treatment program effective January 2021. Current licensure rules require that: Agencies shall continue individuals on their MAT regimen and will only detox individuals from medications treating opioid use disorders (OUDs) at the individual's request or if it is deemed medically necessary. Agencies shall inform individuals receiving services about access to MAT. Upon the individual's consent, agencies shall provide MAT directly, if the agency/provider is appropriately licensed to do so. If the agency/provider is not licensed for MAT, an agency shall refer the individual to an agency that provides MAT.

			WM programs must continue patients on their MAT treatment regimen when available and will only detox individuals from medications treating OUDs at the patient's request or if it is deemed medically necessary. Milestone 3, part 3 is complete effective DY2Q3.
4.2.2 The state expects to make other program changes that may affect metrics related to Milestone 3	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.	**Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)**			
5.1	**Metric trends**			
5.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4	X	Metric #13- SUD Provider Availability Metric #14- SUD Provider Availability- MAT	
5.2	**Implementation update**			
5.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care			DY2Q4: All MCE contracts require MCEs to submit annual network adequacy plans regarding the provider type and expertise of providers, including SUD providers. State quality leadership meets with each MCE to review the Network Adequacy Report. BHA has begun work to upgrade the Behavioral Health Bed Tracker. Dimagi, an award-winning technology company that helps organizations deliver quality digital solutions for a variety of sectors, has been selected to help lead this effort. Developments planned for the registry include the ability for providers to send push notifications to other providers when they have a client for whom they are trying to find a bed. This work is a significant step towards tracking availability for mental health and SUD treatment beds, and BHA's broader goal to create a centralized platform for integrating and simplifying behavioral health data across the State. The Governor signed HB22-1214 on April 27, 2022,

			effective July 1, 2022. It requires BH crisis providers to be properly staffed to provide crisis services and supports to individuals with SUD. The Governor signed SB22-077 on June 8, 2022. The Interstate Licensed Professional Counselor Compact allows professionals that are licensed professional counselors in their state of residence to practice professional counseling in the State if they reside in a compact state under a privilege to practice. It also allows the use of telehealth in the provision of services. The Governor signed HB 22-1052 on June 8, 2022. This act, Promoting Crisis Services to Students, requires that each public school student is provided an identification card that must contain the phone number, website address, and text talk number for State crisis services and the Safe2Tell program to ensure all students are aware of resources if they are experiencing a behavioral health crisis (inclusive of substance use/misuse.) The State must notify each public and private school annually in August of the resources in the State behavioral health system, inclusive of the possibility of peer-to-peer counseling as part of the offered services. The State must also provide awareness and educational materials to each public and private school in the State. The Governor signed SB 22-226 on May 18, 2022. This act, Programs to Support Health-Care Workforce, requires the State establish a practice-based health education grant program to increase practice-based training opportunities necessary for enrolled students to complete degree requirements and become licensed to practice, or program participants to complete residency requirements and gain hands-on experience. It is not profession or practice specific. Funds can be used to provide assistance with tuition, fees, and course materials (for eligible programs), and support experiences like apprenticeships and work

			based experiences that can lead to credentialed professions. DY2Q3: BHA continued to facilitate stakeholder meetings and engagement to support the roll out and use of the Behavioral Health Capacity Registry. The Behavioral Health Bed Capacity Tracker continued to provide free resources for training as well as Frequently Asked Questions to support providers in using the site. In September 2022, BHA published the 2022 Workforce Strategic Plan: An Approach to Community Partnership. This plan was required by SB22-181 Behavioral Health Care Workforce (signed June 8, 2022) and includes funding to meet the goals identified in the SB. BHA continued to support work on the Behavioral Health Workforce Strategic plan required by SB22-181 by scheduling public stakeholder meetings on August 10, 2022 and August 11, 2022. SB22-181 requires the BHA to develop a plan that expands, strengthens, and invests in the behavioral health care provider workforce. SB22-181 also required a plan be developed that specifically addresses expansion of the Peer Support Professional workforce, and that the Department of Regulatory Agencies (DORA) provide recommendations that support expanding credentialing requirements through telehealth. The July 2022 SUD Stakeholder Newsletter informed providers about House Bill 21-1021 (HB21-1021), which created a license type for peer led organizations that provide non clinical recovery support services to

			individuals with SUD. The article provided links to additional information and resources, including an introduction to the Recovery Support Services Organization (RSSO) license and a RSSO LADDERS Licensing Platform walk-through. DY2Q2: BHA is working on updates to the Behavioral Health Capacity Registry, including the ability for providers to send push notifications to other providers when they have a client for whom they are trying to find a bed. The Fentanyl Accountability and Prevention Act requires that by January 2023, Managed Care Organizations (MSO) must contract to provide short-term residential placement for withdrawal management, crisis stabilization, or medication-assisted treatment for those requiring detoxification and stabilization services, with licensed providers. DY2Q1: To facilitate sufficient provider capacity, the Behavioral Health Capacity Registry collects daily bed capacity updates from providers. HCPF is collaborating with OBH to create an enhanced Behavioral Health Capacity Registry tracker system, anticipated to roll out in the Fall of 2022. The system will better track withdrawal management and residential beds. Additionally, HCPF requires bed counts to be included as part of Medicaid enrollment and facility renewals. The first quarterly provider forum discussed how to count bed days and how to correct errors in the system

5.2.2 The state expects to make other program changes that may affect metrics related to Milestone 4			DY2Q2: The Fentanyl Accountability and Prevention Bill will require MCEs to report the number of providers trained to provide medication-assisted treatment, withdrawal management, recovery services at public high schools, and recovery residences by January 2023. HCPF drafted the BH Rates report per the State Legislative request. The report includes an examination of the landscape of State BH billing, specifically in regard to Community Mental Health Centers and the independent provider network. SUD outpatient services were included in the BH rates analysis. The report findings include modifications to allow more safety net providers, which CO anticipates will impact members receiving SUD services. Billing for comprehensive MAT services currently requires providers to bill for therapy codes covered under capitation, and medication management is billed under fee for service. The State is exploring aligning the MAT payment structures to better and more efficiently align.

Prompt		State has no trends/update to report (place an X)	Related metric(s)	State response
6.	**Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)**			
6.1	**Metric trends**			
6.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 5	X	Metric #18- Use of Opioids at High Dosage in Persons Without Cancer Metric #21- Concurrent Use of Opioids and Benzodiazepines Metric #23- Emergency Department Utilization for SUD per 1,000 Medicaid beneficiaries Metric #27- Overdose Deaths (rate)	
6.2	**Implementation update**			
6.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 6.2.1.a Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD			DY2Q4: Through an American Rescue Plan Act (ARPA) funded project, the HCPF Department of Pharmacy is partnering with the Colorado Consortium for Prescription Drug Abuse Prevention (CO RX Consortium) on a pain management initiative designed to help primary care providers manage necessary opioid use for pain. The ARPA team facilitates meetings with care managers/ coordinators from every MCE to provide a detailed overview of their initiatives addressing opioid prescribing policies and share contact information between MCEs. A

			current CO RX Consortium initiative offers a HCPF pharmacy resource to provide assistance with finding available benefits, with finding new primary care providers for pain treatment, and with prior authorization eligibility and questions. The MCE care manager/care coordination group was informed of an upcoming 2023 initiative that will provide peer to peer consults for primary care providers with a pain specialist for complex pain needs. DY2Q3: The first Opioid Abatement Conference was held August 15–16, 2022. The conference was organized and supported by the Colorado Opioid Abatement Council, which is tasked with providing oversight of the opioid funds and ensuring the distribution of those funds comply with the terms of both national and State opioid settlement guidance. This two day conference highlighted best practices for addressing the opioid crisis, how opioid settlement funds will be distributed, information to leverage State and national resources, and practical information about receiving and utilizing funds. Information regarding the conference was shared in the August 2022 SUD Stakeholder Newsletter and included a link to the organizers' website for providers and individuals that were unable to attend the conference. The interim Medicaid Director and Director of Population Health facilitated a session titled "Braided Funding and Sustainability: Maximizing Medicaid Dollars". The September 2022 SUD Stakeholder Newsletter informed providers that non emergent medical transportation (NEMT) services are a covered benefit for Medicaid members that can be leveraged to support ongoing engagement in MAT services. The newsletter included a link to additional information on NEMT services.

			Several provider specific policies have been supported by HCPF, and implemented in support of the Colorado Consortium for Prescription Drug Abuse Prevention: Morphine Milligram Equivalent (MME) — Prior authorization is required for any RX exceeding 200 MME. Short acting opioid pill quantity limits — 120 pills per 30 days for chronic (non naïve) short acting opioids. Opioid Naïve Policy — members identified as opioid naïve if they have not had an opioid Rx filled within 180 days will have their days supply limited to seven days (56 pills, short acting opioid only) after three fills of seven day supplies are written. The provider may be required to complete provider provider consult with a pain management specialist. Dental Provider Limit — quantity is limited to four days (24 pills, short acting opioid only). Provider to-Provider Consults — HCPF provides provider to-provider consults with a pain management specialist for providers and members free of charge to ensure there is access to expert evaluation of safety and efficacy of members' pain management regimens.
6.2.1.b Expansion of coverage for and access to naloxone			DY2Q4: The Colorado Prescription Drug Consortium held their annual meeting on October 27, 2022. The Naloxone Project announced the State as its first state

			chapter for the MOMs initiative. MOMs is focused on providing hospital-based overdose education and naloxone directly into the hands of pregnant and parenting patients and their families. DY2Q3: HB20-1065 was signed into law and addressed the coverage and access for naloxone by requiring that a carrier that provides coverage for opiate antagonists must reimburse a hospital if the hospital provides a person with an opiate antagonist upon discharge. It also requires pharmacies dispensing prescriptions for opiates to notify the individual about the availability of opiate antagonists. Finally, this HB also allows a non-profit organization to operate a clean syringe exchange program without needing local board of health approval, and requires these organizations report out data and information annually. DY2Q2: The Fentanyl Accountability and Prevention legislation provides Medicaid reimbursement to hospitals and emergency departments (EDs) for the cost of dispensing naloxone at discharge. According to Colorado's Naloxone Project, from January 2021 through April 2022, providers dispensed 4,294 Naloxone kits to at-risk patients leaving the hospital. The number of Colorado facilities dispensing naloxone tripled since March 2021. Over 85% of Colorado hospitals, EDs and clinics have joined the Naloxone Project. Six labor and delivery hospital units are participating in pilot programs that dispense naloxone to mothers with SUDs.

			DY2Q1: In January 2022, the State announced $1.8 million in funding for local agencies working with high-risk individuals to obtain naloxone for free. The funding was made available through the American Rescue Plan Act.
6.2.2 The state expects to make other program changes that may affect metrics related to Milestone 5			DY2Q1: As part of the Hospital Transformation Project, the Colorado Perinatal Care Quality Collaborative (CPCQC) began hosting a free yearlong SUD Learning Collaborative with the goal of reducing maternal death due to suicide and accidental overdose. Outpatient as well as inpatient perinatal providers are supported by CPCQC in implementing the Alliance for Innovation in Maternal Health (AIM) patient safety bundle for Obstetric Care for Women with Substance Use Disorder.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
7.	**Improved Care Coordination and Transitions between Levels of Care (Milestone 6)**			
7.1	**Metric trends**			
7.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 6	X	Metric #15-Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) Metric #17(1)-Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) Metric #17(2)-Follow-up After Emergency Department Visit for Mental Illness (FUM-AD) Metric #25-Readmissions Among Beneficiaries with SUD	
7.2	**Implementation update**			

7.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports			DY2Q3: "Bridging the Gaps: Policy Recommendations to Implement a Cohesive Statewide Care Coordination Infrastructure" was published and provides recommendations to inform the BHA on implementation of statewide care coordination. SB22-177 Investments in Care Coordination Infrastructure was signed into law. This new law requires improved care coordination infrastructure. This SB also included use of a cloud based platform to ensure providers that are not using electronic health records can actively participate in the care coordination process and infrastructure. This act also ensures navigators are available through the statewide care coordination infrastructure via website and mobile applications, and that BHA services ensure individuals and families can initiate timely access to services. DY2Q2: The Fentanyl Accountability and Prevention legislation requires jail-based behavioral health services to develop policies by January 2023 describing the provision of medication-assisted treatment and other withdrawal management care upon release from jail.
7.2.2	The state expects to make other program changes that may affect metrics related to Milestone 6	X		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
8.	**SUD health information technology (health IT)**			
8.1	**Metric trends**			
8.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics	X	Total Number of PDMP Users Number of Opioid Prescriptions in PDMP Tracking MAT with Use of Counseling and Behavioral Therapies	
8.2	**Implementation update**			
8.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes to: 8.2.1.a How health IT is being used to slow down the rate of growth of individuals identified with SUD			DY2Q3: SB22 027 was signed into law and addresses the Prescription Drug Monitoring Program (PDMP). The new law clarifies that each prescriber of prescription drugs must register/maintain a user account with the PDMP and must query the program prior to filling an opioid or benzodiazepine prescription. DY2Q2: The Colorado Office of eHealth Innovation's (OeHI) Consent Management Workgroup has drafted two forms: Consent to Share: Substance Use Disorder Information and Substance Use Disorder Information Sharing Revocation. They plan to finalize the forms in English and Spanish by the middle of September 2022 and pilot the project. The Fentanyl Accountability and Prevention Act funds a study on the use of the internet, including retail, payment, and social media platforms, for the purpose of trafficking fentanyl, synthetic opiates, and counterfeit prescription

				drugs by March 1, 2023. DY2Q1: The Colorado Office of eHealth Innovation's (OeHI) Consent Management Workgroup plans to contract with a business analyst to further explore requirements for a statewide consent system that aligns the consents required for sharing all types of health data. Recommendations are being drafted for a standardized behavioral consent form and streamlining consent in Colorado.
8.2.1.b	How health IT is being used to treat effectively individuals identified with SUD	X		
8.2.1.c	How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD			DY2Q2: The Fentanyl Accountability and Prevention Act allows emergency medical service providers, emergency departments, state and local law enforcement agencies, sheriffs' offices, and coroners to participate in the web-based Overdose Detection Mapping Application Program to report incidences of fatal and non-fatal drug overdoses and synthetic opiate poisonings.
8.2.1.d	Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels			DY2Q2: The Fentanyl Accountability and Prevention Act allows emergency medical service providers, emergency departments, state and local law enforcement agencies, sheriffs' offices, and coroners to participate in the web-based Overdose Detection Mapping Application Program to report incidences of fatal and non-fatal drug overdoses and synthetic opiate poisonings.
8.2.1.e	Other aspects of the state's health IT implementation milestones	X		
8.2.1.f	The timeline for achieving health IT implementation milestones			DY2Q1: The Telehealth and Broadband Initiative aims to increase the use of telehealth and provide reliable and affordable broadband access for health organizations and consumers. Recently, a letter was sent to the Federal Communications

			Commission (FCC) requesting attention to technology/connectivity issues in rural areas to support data sharing. OeHI's Rural Health Information Exchange (HIE) Connectivity project aims to increase affordable access to health IT, information exchange, and analytics for rural safety-net providers. An Advanced Planning Document to fund the next phase of rural analytics work was submitted to CMS in December 2021, and contracts to expand the current analytics strategy are in the review and approval stages.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
8.2.1.g	Planned activities to increase use and functionality of the state's prescription drug monitoring program			DY2Q4: The total number of active PDMP user accounts in DY2, as of December 31, 2022, rose to over 50,278. The number of dispensers reporting at least one prescription to the PDMP was roughly steady at 1,166. DY2Q3: The total number of active PDMP accounts in DY2Q3 increased to 48,678 active PDMP user accounts as of September 30, 2022. The number of dispensers reporting at least one prescription remained roughly steady at 1,158 at the end of September 2022. DY2Q2: As of June 30, 2022, 46,987 active PDMP user accounts exist, a 2.02% increase since the prior quarter. The number of dispensers reporting at least one prescription to the PDMP rose to 1,152 for the quarter. DY2Q1: As of March 31, 2022, 46,036 active PDMP user accounts exist, a 1.8% increase since the prior quarter. The number of dispensers reporting at least one prescription to the PDMP remained stable for the quarter at 1,130.
8.2.2	The state expects to make other program changes that may affect metrics related to health IT	X		
9.	**Other SUD-related metrics**			
9.1	**Metric trends**			

9.1.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics	X		
9.2	**Implementation update**			
9.2.1	The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to other SUD-related metrics		Metric #33: Grievances Related to SUD Treatment Services Metric #34: Appeals Related to SUD Treatment Services	DY2Q4: The State was able to report Grievances and Appeals related to SUD treatment services for this quarter. This information will be provided in the Part A for DY2Q4 data when it is submitted. DY2Q3: The State was able to report Grievance and Appeals related to SUD treatment services for the first time this quarter. This information will be provided in the Part A for DY2Q3 data when it is submitted.

4. Narrative information on other reporting topics

Prompts		State has no update to report (place an X)	State response
10.	**Budget neutrality**		
10.1	**Current status and analysis**		
10.1.1	If the SUD component is part of a broader demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole. Describe the current status of budget neutrality and an analysis of the budget neutrality to date.		DY2Q2: The budget neutrality calculation template has been submitted with this monitoring report. The State has been working on an actuarial correction. DY2Q1: The budget neutrality calculation template has been submitted with this monitoring report. There was an error on the last budget neutrality report; the report has been resubmitted to CMS.
10.2	**Implementation update**		
10.2.1	The state expects to make other program changes that may affect budget neutrality	X	

Prompts		State has no update to report (place an X)	State response
11.	**SUD-related demonstration operations and policy**		
11.1	**Considerations**		
11.1.1	The state should highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively affect beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.		DY2Q2: Legislation to formally establish the Behavioral Health Administration (BHA) was signed into law in May 2022. BHA is a new cabinet member-led agency within the State, housed within the Department of Human Services, and is designed to be the single entity responsible for driving coordination and collaboration across State agencies to address behavioral health needs. The Fentanyl Accountability and Prevention Act adds entities and their employees that are immune from liability for administering naloxone, including jails, religious organizations, libraries, institutions of higher learning, and local public health agencies, as well as mental health professionals. The legislation also makes possession of over 1 gram of fentanyl a crime. The bill further funds an independent entity to conduct a study about the health effects of criminal penalties and implementation of the Act. DY2Q1: The State is still on track to reform the behavioral health system and implement the new Behavioral Health Administration by July 2022.
11.2	**Implementation update**		
11.2.1	Compared to the demonstration design and operational details, the state expects to make the following changes: 11.2.1.a How the delivery system operates under the demonstration (e.g., through the managed care system or fee for service)	X	

11.2.1.b	Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes)	X	
11.2.1.c	Partners involved in service delivery		DY2Q4: During DY2Q4 the State continued to collaborate across divisions, with MCEs, and with providers to support the implementation of the 1115 SUD Demonstration Waiver. Information regarding upcoming meetings, archived newsletters, and resources can be found on HCPFs website dedicated to the 1115 SUD Demonstration Waiver implementation — Ensuring a Full Continuum of SUD Benefits.

Prompts	State has no update to report (place an X)	State response
11.2.2 The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities	X	
11.2.3 The state is working on other initiatives related to SUD or OUD		DY2Q4: The Governor signed SB22-191 on June 8, 2022. This act requires BHA to create and implement a plan addressing the behavioral health workforce shortage. One task focuses on expanding the peer support professional workforce. SB22-191 also requires DORA to make recommendations on expanding credentialing requirements through telehealth. BHA will have to provide an overview of their progress towards implementing this bill in 2023. DY2Q3: The State held a quarterly virtual SUD provider forum through Zoom on Wednesday, July 6, 2022. The forums are open to providers and other stakeholders to learn about issues SUD providers face and initiatives to increase SUD service access. Registration is managed through a link available on the public facing SUD web page, so anyone is able to sign up and attend. The July 2022 Provider Forum included a presentation on Contingency Management. This presentation reviewed data supporting use of contingency management, population specific evidence and outcomes, cost benefit analysis compared to other best practices, perceived barriers to implementing contingency management, current grant opportunities that could be leveraged to support the implementation of contingency management, and available resources through the Colorado Rx Consortium. The slide deck used for this presentation is available on the HCPF website — Ensuring a Full Continuum of SUD Benefits. DY2Q2: Through a joint effort between multiple State agencies, including HCPF and the Department of Local Affairs' Office of Homeless Initiatives, the State plans to open SUD recovery campuses. Funding to re-purpose the

		Ridge View campus into a Supportive Residential Community will provide ASAM-informed SUD treatment, temporary housing and a vocational training program. This bill was signed in May 2022. DY2Q1: As a result of joint effort between multiple State agencies, including HCPF and the Department of Local Affairs' Office of Homeless Initiatives, the State plans to open SUD recovery campuses. Senate Bill 22-211 will provide funding to re-purpose the Ridge View campus into a Supportive Residential Community that will provide ASAM-informed SUD treatment, temporary housing and a vocational training program.
11.2.4 The initiatives described above are related to the SUD or OUD demonstration (The state should note similarities and differences from the SUD demonstration)	X	

Prompts		State has no update to report (place an X)	State response
12.	**SUD demonstration evaluation update**		
12.1	**Narrative information**		
12.1.1	Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this monitoring report is due to CMS and the timing for the demonstration. There are specific requirements per 42 Code of Federal Regulations (CFR) § 431.428a(10) for annual [monitoring] reports. See Monitoring Report Instructions for more details.		DY2Q4: A list of all new and renewed SUD licensed providers is shared with HCPF staff monthly and indicates all ASAM levels of care an agency is licensed to provide. This list supports HCPF in ensuring Medicaid enrollment for levels of care correspond with the licensure that has been issued. DY2Q2: Through a joint effort between multiple State agencies, including HCPF and the Department of Local Affairs' Office of Homeless Initiatives, the State plans to open SUD recovery campuses. Funding to re-purpose the Ridge View campus into a Supportive Residential Community will provide ASAM-informed SUD treatment, temporary housing and a vocational training program. This bill was signed in May 2022. DY2Q1: The Evaluation Design was updated after receiving comments from CMS and was resubmitted to CMS in DY2Q2. CMS approved the Evaluation Design May 23, 2022. There are no anticipated barriers to achieving the goals and time frames related to the Demonstration Evaluation.
12.1.2	Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs		DY2Q3: The State's independent evaluator has begun work on the mid point assessment. DY2Q2: Expected timelines are being met. DY2Q1: DY1Q4 Report: submitted on time (March 2022). Revised Monitoring Protocol: submitted to CMS in January 2022; approved by CMS May 23, 2022.

		Expected timelines are being met.
12.1.3 List anticipated evaluation-related deliverables related to this demonstration and their due dates		DY2Q3: The assessment is anticipated to be completed in July 2023 and delivered no later than 60 calendar days after July 1, 2023, consistent with Special Terms and Conditions (STC) 38. DY2Q2: • DY2Q3 Report: due December 29, 2022 • DY2Q4/Annual Report: due April 30, 2023 • Mid-Point Assessment: due September 1, 2023 • Draft Interim Evaluation Report: due June 30, 2024 • Final Interim Evaluation Report: due 60 days after receipt of CMS comments • Draft Summative Evaluation Report: due 18 months after the end of the approval period (June 30, 2027) • Final Summative Evaluation Report: due 60 days after receipt of CMS comments DY2Q1: • DY2Q1 Report: submitted on time (by May 30, 2022) • Acceptance of Monitoring Protocol by CMS May 23, 2022 • Acceptance of Evaluation Design by CMS May 23, 2022 • DY2Q2 Report: due September 29, 2022* • DY2Q3 Report: due December 29, 2022* • DY2Q4/Annual Report: due April 30, 2023* • Mid-Point Assessment: due September 1, 2023 • Draft Interim Evaluation Report: due June 30, 2024 • Final Interim Evaluation Report: due 60 days after receipt of CMS comments • Draft Summative Evaluation Report: due 18 months after the end of the approval period (June 30, 2027) • Final Summative Evaluation Report: due 60 days after receipt of CMS comments * Dates have been shifted forward one month (see 13.1.3 below).

Prompts		State has no update to report (place an X)	State response
13.	**Other SUD demonstration reporting**		
13.1	**General reporting requirements**		
13.1.1	The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol	X	
13.1.2	The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes		DY2Q1: The State continued to set up processes to prepare for the calculation of the metrics after the Monitoring Protocol is approved. CMS agreed to allow for a 6-month data lag and a 1-month reporting lag based on State reporting requirements. Consistent 3-month claims run-out for all data will be used.
13.1.3	Compared to the demonstration design and operational details, the state expects to make the following changes to: 13.1.3.a The schedule for completing and submitting monitoring reports		DY2Q3: CMS indicated they would provide feedback and comments in the draft Evaluation Design. The first round of data is being finalized for submission to CMS, and the annual forum is in the planning stages. DY2Q2: In May, CMS agreed to allow for a 6-month data lag and a 1-month reporting lag based on State reporting requirements. Consistent 3-month claims run out for all data will be used.
	13.1.3.b The content or completeness of submitted monitoring reports and/or future monitoring reports	X	
13.1.4	The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation		DY2Q4: There were issues with data and retrospective performance metric report submissions for DY1Q1 through DY2Q2. HCPF will continue to review the updated programming based on the new technical standards and engage the MCEs that have experienced difficulty submitting data. DY1Q1 through DY2Q1 will be submitted in the first half of 2023. DY2Q2 through DY3Q1 data continues to have some issues that could impact Part A deliverables.

		DY2Q3: HCPF worked with MCEs to identify a way to obtain Grievance and Appeals information that reflects the total number of grievances and appeals received, as well as how many grievances and appeals were for SUD services specifically. DY2Q2: There were no issues submitting deliverables during the current quarter. Deliverables during DY2Q2 included • DY2Q1 Quarterly Monitoring Report • Monitoring Protocol • Evaluation Design DY2Q1: There were no issues submitting deliverables during the current quarter. Deliverables included DY1Q4/Annual monitoring report and the draft Evaluation Design.
13.1.5 Provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, per 42 CFR § 431.428(a)5	X	

Prompts		State has no update to report (place an X)	State response
13.2	**Post-award public forum**		
13.2.2	If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual monitoring report.		DY2Q4: The second annual SUD stakeholder forum was held virtually in October 2022. During the annual forum, the Department reviewed the Annual Report for Demonstration Year 1, provided an update about the 1115 Waiver "Expanding the Substance Use Disorder Continuum of Care", and provided an opportunity for participants to ask questions. There were four opportunities for the public to attend. Forums were held on the following dates and times: • Friday, October 7, 2022, 12:00 pm–1:00 pm MST • Thursday, October 13, 2022, 9:00 am–10:00 am MST • Tuesday, October 18, 2022, 4:00 pm–5:00 pm MST • Thursday, October 27, 2022, 2:00 pm–3:00 pm MST Summary Cumulative number of registrants: 71 Cumulative number of attendees: 39 Note: There were several people who registered for multiple webinars but did not attend all the webinars. Q&A Question #1: Will utilization management be more standardized for residential services to align with ASAM standards, as services that weren't required in residential level of care previously are now? Utilization management reporting under 21-137 is standardized and uses ASAM criteria for making authorization and denial determinations. Question #2: Is funding available to be able to enhance crisis services or to start these services to have this available across the state? Yes, there are funding opportunities for crisis services through both BHA and HCPF ARPA grants. Information can be found on the respective webpages by searching funding opportunities. Question #3: For clarification, does this demonstration include young people under 18 years?

		Yes, all Medicaid members are included in the demonstration regardless of age. Question #4: Is there a list of those organizations/facilities who are taking part in this waiver and have this continuum of care available? All organizations who are Medicaid providers of SUD services are required to deliver care in accordance with 1115 requirements as outlined by the Department and overseen by the MCEs. The SUD Benefits web page does list providers by level of care that are licensed by BHA, enrolled with Medicaid and contracted with an MCE. Question #5: What is happening right now with residential? Residential LOC services as defined by ASAM are licensed by BHA, enrolled with Medicaid and then contracted with one or more MCEs to deliver those levels of care to members. Question #6: There is an insufficient number of residential settings to address substance misuse. With this waiver, are there funds that would allow them to build out this type of service within their own practice or in coordination with other organizations? The 1115 waiver does not provide funds for building infrastructure, it allows for SUD residential services to be delivered in settings with 16 or more individuals for more than 14 days and ensures all levels of care including outpatient level 1 and 2 and inpatient level 4 are provided to members in the State. Question #7: Can I get information about requirements for harm reduction or peer support services in rural areas? If a community is interested in starting a program, what are the requirements for someone to start a program? More information about peer organizations across the State, including in rural areas, can be found through the BHA webpage and specifics about enrolling as a peer service organization with Medicaid and contracting with MCEs can be found on the Department Peer Services webpage. Harm reduction would be an approach to service delivery that SUD providers of services in the area may engage in and reviewing provider sites would be necessary to identify those providers. For a community interested in starting a program, connecting with BHA would be a good starting point to determine what licensing requirements would need to be met to set up the program. Once a program is licensed,

		discussing with the Department to determine enrollment steps would be next. DY2Q3: The State continued to prepare for the Second Annual SUD Stakeholder Forum, which is scheduled for a series of community meeting to be held across the month of October 2022. DY2Q2: The State is planning to hold four post-award public forums to take place during October 2022.

Prompts		State has no update to report (place an X)	State response
14.	**Notable state achievements and/or innovations**		
14.1	**Narrative information**		
14.1.1	Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.	X	

*The state should remove all example text from the table prior to submission.

Note: Licensee and states must prominently display the following notice on any display of Measure rates:
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