

Substance Use Disorder Midpoint Assessment Report

1115 Waiver Demonstration

Colorado Department of Health Care Policy and Financing

July 18, 2023

Updated with metrics through June 2023 on March 13, 2024

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Section 1

General Background Information

Demonstration Name, Approval Date, and Time Period

On November 13, 2020, Colorado (the State) received approval for its application for a section 1115(a) demonstration titled “Expanding the Substance Use Disorder Continuum of Care” (Project Number 11-W-00336/8) effective January 1, 2021, through December 31, 2025.

This Midpoint Assessment Report addresses progress made during the first two full years of the demonstration and the first quarter of demonstration year three (DY3Q1): January 1, 2021, to March 31, 2023. Originally, metrics included for this report were only available through DY2Q2: January 1, 2021, to March 23, 2022. In March 2024, the report was updated to include metrics from January 1, 2021, to June 30, 2023.

Description of Demonstration Policy Goals

The purpose of this waiver is to provide access to residential and inpatient treatment settings, expand the availability of withdrawal management (WM) services, and increase access to medication-assisted treatment (MAT) for members with substance use disorder (SUD). These changes will ensure the most appropriate levels of care (LOCs) are available for patients and improve treatment outcomes.

The State has added American Society of Addiction Medicine (ASAM) levels 3.1 (Clinically Managed Low-Intensity Residential Services), 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services), 3.5 (Clinically Managed High-Intensity Residential Services), and 3.7 (Medically Monitored Intensive Inpatient Services) and 3.7-WM (Medically Managed Inpatient WM) as Medicaid-covered services.

We anticipate this demonstration will accomplish the following goals and objectives, which make up our demonstration hypothesis:

1. Increased rates of identification, initiation and engagement in treatment
2. Increased adherence to and retention in treatment
3. Reductions in overdose deaths, particularly those due to opioids
4. Reduced utilization of emergency departments (EDs) and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
5. Fewer readmissions to the same or higher LOC where the readmission is preventable or medically inappropriate
6. Improved access to care for physical health conditions among beneficiaries.

Expanded Inpatient and Residential Services

The State has revised its Medicaid State Plan to enhance the SUD service continuum under Medicaid. State Medicaid members are now eligible to receive the following ASAM LOCs under their Medicaid benefit: 2.1 (Intensive Outpatient [IOP] SUD Services), 3.1 (Clinically Managed Low-Intensity Residential Services), 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services), 3.5 (Clinically Managed High-Intensity Residential Services), 3.7 (Medically Monitored Intensive Inpatient Services) and 3.7-WM (Medically Monitored Residential WM).

Workforce Development and Training

During DY1, the State created a plan and materials to train all providers working within the continuum of care on utilization management (UM) and ASAM-based assessment to ensure the continuum of care would be applied appropriately and to reduce the under- and/or over-utilization of any of the LOCs. Planned activities in the implementation plan included:

- Ensuring appropriate licensure levels of all sites in the system.
- Defining and training providers on treatment terms to ensure consistency.
- Training providers on evidence-based practices for patient assessment and placement.
- Addressing provider shortages, specifically in rural areas and services for youth.
- Recruiting providers not currently enrolled as Medicaid providers.

Other Implementation Planning Activities

The State is aware of the Centers for Medicare & Medicaid Services (CMS) SUD Implementation Plan requirements and has implemented most activities from the implementation plan that support waiver implementation, as will be described throughout this report. In addition, across the first two demonstration years, the State has identified additional activities to improve services and increase provider capacity. These are reported in the “Progress Toward Demonstration Milestones” section for each milestone, as applicable.

Stakeholder engagement continues throughout the waiver period, which we anticipate will facilitate further discussion of waiver details and inform Health Care Policy & Financing (HCPF) planning for any necessary:

- State regulation changes
- Provider standards and billing manual updates
- Provider engagement and training needs
- Managed Care Entities (MCE) contract policy and payment rate changes.

Population Impacted

There will be no changes to the Medicaid eligibility criteria included as part of this waiver. The demonstration will be open to all Medicaid members with a covered SUD diagnosis. The demonstration will have no enrollment limits.

Section 2

Methodology

This midpoint assessment was conducted by the State's independent evaluator, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits, in May through July of 2023. It includes all data available as of that time period, including quantitative data collected and reported as part of the required metrics monitoring, and qualitative data collected from key stakeholders (MCEs, providers, and members and their families) and progress narratives submitted by the State.

Data Sources

The following table describes the data collected for this assessment.

Data Source	Description
Critical metrics	Critical metrics for this report were taken from regular monitoring reports (through DY2Q1) and include metric numbers #5, #7–14, #16, #17(1), #17(2), #18, #21–23, #27 and #36.
Other metrics	The midpoint assessment also includes a narrative that describes trends in Metric #3 (Medicaid Beneficiaries with SUD Diagnosis [monthly]). Because Metric #4 (Medicaid Beneficiaries with SUD Diagnosis) is only reported annually, no analysis is included, as only baseline data is currently available.
Implementation plan action items	The midpoint assessment documented progress towards the action items associated with each milestone, as described in the State's implementation plan. Progress on action items were documented in narrative monitoring reports (see below).
Qualitative interviews with key stakeholders	A group key informant interview was conducted with two key HCPF staff (n=2) most responsible for demonstration implementation tasks. Additionally, a focus group with MCEs (representing all eight entities) regarding implementation was conducted in June 2023. A provider forum (n=30) and member listening session (n=28) were also conducted via video conference in July 2023 to gather information regarding access to services, provider availability and overall satisfaction with new policies/procedures.
Narrative monitoring or evaluation report data	Narrative information from State monitoring reports was analyzed to assess completion of implementation plan action items and identify any program changes made since demonstration approval.

Analytic Methods

Monitoring metrics were assessed by calculating the change in counts and rates (depending on the metric) over time between baseline (January 2021) and the end of the midpoint assessment data period (March 31, 2022), total change in value, direction of the change (increase/decrease) and magnitude (percent) of change. Changes in absolute values were computed as (time 2 – time 1) and percentages as $([time\ 2 - time\ 1] / time\ 1)$.

Narrative reports and key informant interview/listening session/focus group feedback transcripts were analyzed using a general thematic analysis that identifies and summarizes common themes.

The State has assessed its existing network of inpatient and residential SUD services, managed by MCEs. The State conducted an initial assessment of the availability of inpatient and residential bed capacity, including engaging with a contractor to conduct a provider assessment throughout the State. Results of this assessment are included in the provider capacity assessment findings section of this report (Milestone #4).

Assessment of Overall Risk

Assessment of risk of not meeting milestones is determined by considering three factors:

7. Movement of metrics in the intended direction over the time period for which data is available
8. Review of action items proposed, and new activities planned since demonstration approval and progress made on those to date
9. Stakeholder reports of successes and challenges.

Because complete data on some metrics is available only through March 2022 and only one set of annual metrics are available, metric progress is weighted slightly less in the general review of risk. In cases where metrics indicate movement in the right direction, proposed activities had been implemented, and stakeholder assessment of progress was positive, risk was assessed to be low. In cases where there were stakeholder concerns and metrics were not available, risk was assessed as medium (if there was lack of progress on some implementation activities) or low-medium if implementation activities were largely complete.

Limitations

The primary limitation of this report is the State's ongoing struggles in gathering accurate data from MCEs. The State remains certain that the number of individuals receiving services under the demonstration has increased substantially, based on recent complete submissions from the eight MCEs, but may not be completely reflected in the historical data. Providers must submit their claims data to MCEs, who then submit to the State. MCEs expressed a desire for providers to improve billing and coding practices. SUD reports show that providers may need additional training on coding some services such as Early Intervention/Screening Brief Intervention, and Referral to Treatment. Over the past three years, the MCEs have not been consistent in data reporting efforts. Two of eight MCEs were not reporting data correctly for several months at the start of the waiver, which impacted several quarters of data submission. During a recent transition, one MCE was unable to report complete data due to transitioning to a new claims management platform. Both of these MCE reporting issues have since been rectified. The State is current with CMS performance metric reporting under the SUD 1115 as of July 2023.

Section 3

Mid-Point Assessment Findings

Milestone 1: Access to Critical LOCs for Opioid Use Disorder and other SUDs

The State has revised and/or implemented all ASAM criteria levels 3.x, as proposed in the implementation plan. Currently the State has implemented level 2.1 (IOP) but has not implemented 2.5 (partial hospitalization programs [PHP]). In addition, it is unclear how the State covers levels 1-WM or 2-WM, leaving the continuum of care incomplete. Historically, the State covered outpatient SUD services, which is commonly considered to include outpatient, therapy, group and routine medication management. Intensive ambulatory LOCs are considered to be 2.1 and 2.5 (IOP and PHP) of which the State only covered 2.1. Specialized ambulatory levels of care also include WM and provision of MAT in ambulatory settings. Mercer's review found that it is not clear that the ambulatory withdrawal LOCs (ASAM 1-WM and 2-WM) are explicitly covered by Medicaid. Explicit coverage of 1-WM, 2-WM, and 2.5 requires the State to establish admission criteria, staffing requirements, interventions specific to those ASAM Levels and coding to track each of these services distinct from other services. It is not clear if the State will need to provide policy and coverage clarifications regarding ASAM 1-WM and 2-WM or if the State requires a new authority similar to ASAM 2.5 for coverage of these ambulatory WM services. The State has developed and implemented rate methodologies, MCE contract amendments and billing system changes needed to support all new LOCs. The Behavioral Health Administration (BHA) was established and began operating on July 1, 2022, after the end of the data collection period for this report. The Legislature directed the creation of BHA through HB 21-1097 and established its official duties through HB 22-1278. The BHA is a new cabinet member-led state entity, housed within the Colorado Department of Human Services. It is designed to be the single entity responsible for driving coordination and collaboration across state agencies to address behavioral health (BH) needs, as well as the entity tasked to oversee the rules, regulations and licensing for all agencies and levels of care available in the State. However, ASAM levels 1-WM, 2-WM and 2.5 are not specifically identified in the 1115 Demonstration as being covered services receiving Medicaid reimbursement. Collaboration between BHA and HCPF continued to identify opportunities to improve access to MAT, specifically for Opioid Use Disorders (OUD) through leveraging mobile Opioid Treatment Program (OTP) units and grant opportunities to support exploration and infrastructure building.

Even though activities under the Implementation Plan for Milestone 1: Access to Critical LOCs are complete under the Demonstration, State Medicaid enrollees do not have access to three intensive ambulatory levels of care including ambulatory withdrawal management (ASAM 1-WM and 2-WM) and partial hospitalization (ASAM 2.5). The State continues to improve access and understanding of SUD treatment services across the continuum of care for Medicaid beneficiaries and adding these levels would strengthen that effort and provide access to less costly alternatives to residential LOCs. Recently, the BHA implemented OwnPath, a new care directory, to improve access to all BH, including SUD. This directory is accessible to both providers and Medicaid members, and identifies providers by zip code, services offered and in network insurance type(s) providers. Individuals can see full details

about providers, including location, hours of operation, services offered, populations served, accessibility, languages spoken, and telehealth options.

In order to address availability of critical LOCs to Medicaid populations even before persons become eligible for Medicaid, the State has extended MAT and WM to individuals who are incarcerated and likely to be Medicaid upon release. The Fentanyl Accountability and Prevention Legislation requires that public and private facilities provide MAT and other WM treatment to individuals with SUD through the duration of the person's incarceration, as medically necessary, by July 2023. The result is that individuals are more likely to already be treated with MAT upon release from correctional facilities when Medicaid begins reimbursing for SUD services.

Monitoring Metrics

Metric Number	Updated Monitoring Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Midpoint Risk Assessment
	Base	June 2023 Midpoint	Change	Percentage Change				
6: Number of individuals receiving SUD Treatment Services (original report)	25,973	29,649	3,676	14%	Increase	Increase	Yes	Low
7: Number of individuals receiving Early Intervention Services	38	18	(20)	-53	Increase	Decrease	No	Medium
8: Number of individuals receiving Outpatient Services	19,994	22,003	2,009	10%	Increase	Increase	Yes	Low
9: Number of individuals receiving IOP Services	345	422	77	22%	Increase	Increase	Yes	Low
10: Number of individuals receiving Residential Services	1,196	2,179	983	82%	Increase	Increase	Yes	Low
11: Number of individuals	854	1,727	873	102%	Increase	Increase	Yes	Low

Metric Number	Updated Monitoring Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Midpoint Risk Assessment
	Base	June 2023 Midpoint	Change	Percentage Change				
receiving WM Services								
12: Number of individuals receiving MAT Services	5,039	5,980	941	19%	Increase	Increase	Yes	Low
22: Continuity of Pharmacotherapy for OUD*	0.5758	0.5707	(0.0051)	-0.90	Increase	Decrease	No	Medium

Progress Toward Demonstration Milestones

Action Item Description	Date to Be Completed	Current Status
State Plan Amendment revision of ASAM 2.1 IOP SUD Services	January 1, 2021	Complete
Implementation of 3.1, 3.3, 3.5, 3.7, 3.7-WM	January 1, 2021	Complete
Develop and implement MCE rate methodology that reflects continuum of additional and modified services	January 1, 2021	Complete
Execute MCE contract amendments that reflect updated capitation rates that include new and modified services	January 1, 2021	Complete
Billing system changes to allow for claim submission for new services (residential and inpatient) and changes to existing service billing rules (IOP)	January 1, 2021	Complete

In addition to the completion of each action item, the State has been working to improve access to all LOCs and to MAT, specifically. The State allocated funds to support two grant recipients to build capacity to provide mobile medication management services. The State anticipates the vans would be purchased and upfitted to provide services during DY3Q2 (April 2023 through June 2023). These mobile MAT programs will support the provision of MAT to individuals in rural areas that have limited or no access to MAT.

Stakeholder Input

Stakeholders reported that initial rollout was challenging, with initial provider training being a significant endeavor for both the State agency and the MCEs. MCEs reported that it took time to familiarize providers with new terms and requirements to ensure alignment across the standards and make sure everyone was speaking the same language. Other early challenges reported by MCEs included provider challenges in communicating decisions made around authorizations to members, transitioning thinking to “medically necessary” treatment, and creating and maintaining proper documentation.

All MCE contracts now include a requirement that treatment determinations must be based on ASAM criteria. Health Services Advisory Group (an independent third party) recently completed a review of 30% of all MCE authorization denials and found that reviewers agreed with the MCE denial decisions. In addition, the State reported that denial rates are low, at an average of five percent, which is a good indicator of alignment of treatment service expectations between providers and MCEs.

While MCEs and HCPF staff generally agreed that the current state of implementation is going well and that initial challenges have been overcome, providers were more likely to report ongoing challenges. During a July 2023 provider forum, participants were in general agreement that there is a lack of consistency across MCEs in operations, authorization processes or even ASAM level definitions. Providers reported that different MCEs interpret service definitions and apply those interpretations to individual cases differently. Providers noted that there is often no follow up LOC available once an individual leaves WM. Providers also found it difficult to get both initial and continuing authorizations for 3.7 and 3.7 WM.

During a July 2023 member listening session, many members expressed gratitude for even having an SUD service benefit (one reported being unable to get treatment in other states).

However, there were still many challenges and most forum participants (53%) said they did not feel they had access to the level of needed care. Only about a quarter (26%) said they did have access, while the remaining were unsure or did not respond. Members cited a lack of providers near them that take Medicaid as the primary barrier to accessing needed LOC, others described frustrations and difficulty navigating the system, and some noted they or loved ones had been turned away from services in the past, without fully understanding the reason.

HCPF staff did indicate that the continuum of care currently available in the State may be lacking capacity at needed step-down LOCs to transition members when they no longer need a higher LOC. A lack of ASAM 2.5 (partial hospitalization) options is a limitation to the continuum, as is a lack of ambulatory WM (ASAM 1-WM and 2-WM). This may result in providers requesting authorizations at a higher LOC, because there is not an available step-down option, but MCEs are denying those services because the higher LOC is not medically necessary.

Milestone 2: Use of Evidence-Based, SUD-Specific Placement Criteria

All contracts with MCEs now require providers to provide assessments to ensure appropriate placement using the ASAM criteria and for MCEs to utilize ASAM criteria to authorize SUD residential and inpatient stays. MCEs provide ASAM criteria training as part of the provider orientation process.

HCPF staff initiated the use of a new data collection template in DY2 that supports tracking subpopulation utilization. Information and instructions regarding the new form was communicated via a recurring stakeholder newsletter developed by HCPF for SUD providers and other key stakeholder groups. It is available on the HCPF website.

Monitoring Metrics

Metric Number	Monitoring Metric Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Milestone Risk Assessment
	Base	June 2023 Midpoint	Change	Percentage Change				
5: Number of Medicaid Beneficiaries treated in Institutions for Mental Disease (IMDs)	652	667	15	2.3%	Increase	Increase	Yes	Low

Metric Number	Monitoring Metric Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Milestone Risk Assessment
	Base	June 2023 Midpoint	Change	Percentage Change				
36: (Rate) Average Length of State in IMDs	5.09	9.14	4.04	79.4%	Stabilize, no more than 30 days	Increase	Yes	Low

Implementation Progress

Action Item Description	Date to Be Completed	Current Status
Update Office of Behavioral Health (OBH) licensing regulations	August 2020	Complete
Update MCE contracts to include new services and UM of services	December 2020	Complete
Implement training and technical assistance to align providers with ASAM standards	February 2020 and Ongoing	Complete; Ongoing
MCE development of UM policies and procedures	August 2020	Complete
State review of UM policies and procedures and provision of feedback to the MCEs	October 2020	Complete
Begin UM process for residential placements	January 1, 2021	Complete
Begin internal monitoring of benefit according to initial monitoring plan currently in development	January 1, 2021	Complete
Communicate changes to providers	Ongoing	Ongoing

Senate Bill 21-137 (SB21 137), which was signed into law on June 28, 2021, requires HCPF to produce a quarterly UM report that must be posted for the public the first day of every quarter. The MCE provides residential LOC service utilization data. The report published DY2Q3 had the following summary/highlights:

- Continuing Authorization (CA) denials were appealed 9% of the time. All appeals were for ASAM 3.7-WM LOC. No appeals resulted in the denial being overturned.
- The State recommended continued collaboration with MCEs to better understand youth SUD services and improve member access.
- The State will continue to review the frequency and length of CA requests and approvals to balance efficiency and oversight.
- The State will examine the peer-to-peer process to better understand how it informs decision making for Initial and CAs.

Stakeholder Feedback

As was the case with overall LOCs, stakeholders reported initial challenges with rollout of placement criteria. Currently, all MCE contracts with the State include requirements that ASAM criteria is used for all placement decisions. Both MCEs and providers reported some confusion and disagreement around specific distinctions between 3.5 and 3.7 LOCs, particularly on how much medical oversight is needed. There also remain questions with 3.7-WM placements and whether the treatment could be provided at the lower LOC (3.2-WM). This could be related to a general need for more providers across the continuum and additional ambulatory WM services (e.g., ASAM 1-WM and 2-WM), however, rather than significant disagreements on the requirements for each LOC.

Similarly, MCEs outlined a need for providers to shift to an individualized “treatment model” (how much/what LOC does this member need?) from a “program model” where the provider offers a specific program length and level that is typically applied to all members needing a specific level of treatment.

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

All SUD providers are now being 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 LOC requirements. HCPF and BHA have been jointly charged to support increasing the number of licensed facilities delivering adolescent residential SUD treatment providers.

Monitoring Metrics

There are no CMS-provided metrics related to Milestone 3. The State did not identify any metrics for reporting this milestone.

Implementation Progress

Action Item Description	Date to Be Completed	Current Status
Relicensing of providers based on updated OBH regulations since move to BHA (all licenses require annual renewal)	December 2020	Complete
Implement training and technical assistance to align providers with ASAM standards (includes residential treatment providers)	December 2020	Complete
Update MCE contracts to reflect residential provider requirement changes, including requirements related to providing access to MAT	November 2020	Complete
Medicaid Management Information Systems changes to allow for enrollment of providers by ASAM level	January 2021	Complete
State Medicaid enrollment portal opens for SUD providers	November 2020	Complete
Publish SUD Residential Provider Manual	October 2020	Complete

Action Item Description	Date to Be Completed	Current Status
Publish updated Uniform Services Coding Standards Manual with billing and coding requirements for new services	January 2021	Complete

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.

Stakeholder Feedback

Stakeholders did not report challenges directly related to the use of nationally recognized standards for residential facilities. However, several stakeholders noted a significant lack of overall capacity and no residential capacity (among Medicaid providers) for youth.

This lack of capacity was noted by members participating in the listening session. The number of residential beds available in the State overall, but particularly for adolescents/youth, is a significant barrier to access to appropriate treatment.

Milestone 4: Sufficient Provider Capacity at Critical LOCs including MAT for OUD

Work continues 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 have been enacted since the demonstration began, 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 BH 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 BH crisis services, requiring reimbursement for hospitals that provide opiate antagonists to individuals at risk for unintentional opioid overdose and requiring use of the Prescription Drug Monitoring Program (PDMP).

Monitoring Metrics

Metric Number	Monitoring Metric Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Milestone Risk Assessment
	Base	Mid	Change	Percentage Change				
13: SUD Provider Availability	3,121	2,928	-193	-6.2%	Increase	Decrease	No	Medium

Metric Number	Monitoring Metric Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Milestone Risk Assessment
	Base	Mid	Change	Percentage Change				
14: SUD Provider Availability — MAT	277	278	1	0.4%	Increase	Increase	Yes	Low

Implementation Progress

Action Item Description	Date to Be Completed	Current Status
Convening of the Provider Capacity Work Group	Ongoing	Complete; Ongoing
OBH go-live of electronic bed tracking system (Behavioral Health Capacity Registry)	January 1, 2021	Complete
Hospital Transformation Program bed capacity expansion	February 2021	Complete
IT MATTTs (X-waiver training)	January 2021; Ongoing	Complete; Ongoing

Stakeholder Feedback

Both HCPF staff and MCE representatives reported provider capacity as the primary challenge to providing adequate access to SUD treatment services. In some cases, because there was no prior Medicaid benefit for some LOCs, there were no providers in the State that accepted Medicaid.

The State model of implementation included creation of discrete LOC definitions for providers with specific reimbursements tied to each specific LOC. An unintended consequence of this model is that providers are then incentivized to provide a single LOC, as opposed to multiple LOCs. This creates capacity issues and makes coordination and transitions across LOCs more difficult. MCEs reported they were continuing efforts to support recruiting providers into providing multiple LOCs to improve capacity and care coordination.

MCEs reported ongoing efforts to increase capacity. MCEs, providers and members reported that the State currently does not have adequate capacity to meet all needs. The stakeholders reported specifically about the inability to find SUD treatment for specific populations, such as youth, in more rural areas of the state. MCEs reported struggling with accessibility and trying to develop new contracts to increase availability. MCEs reported working with providers on a notification process when there is a wait list, or if providers are not accepting any new patients. However, even though there is a system for notifications around residential and opioid treatment program capacity, MCEs reported needing a centralized mechanism to monitor capacity in other outpatient programs.

Providers shared similar views of capacity across the State, reporting an overall lack of providers. The biggest capacity gaps identified by providers include WM, residential services, IOP and all services for youth. The Western Slope, in general, has few providers and those that are providing services do not accept Medicaid. While providers noted that Medicaid does not provide any reimbursement for partial hospitalization and ambulatory WM (ASAM 2.5,

1-WM and 2-WM) resulting in a gap in intensive services for individuals to step-down from residential services. MCEs, providers and members also reported that more providers are needed at all LOCs that are funded by Medicaid throughout the state.

Providers reported that the difficulty in obtaining SUD services for youth is being compounded by confusion over Qualified Residential Treatment Program (QRTP) changes happening due to the Families First Prevention Services Act in child welfare. HCPF has met with QRTP providers to explain how to add SUD services to their QRTP license, which would require obtaining a second license. HCPF has also formally issued billing guidance for providers with two licenses. This outreach has been made to address shortages reported by child welfare agencies, who have reported the inability to find appropriate services to keep children safely in their homes/communities.

Some providers suggested that a database of teleservice providers would help to augment areas of the State where there are few or no providers.

Providers also noted significant differences in reimbursement rates across the MCEs and observed that reimbursement rates for outpatient SUD services are significantly lower than outpatient mental health services, which means providers are less likely to want to provide those outpatient SUD services. This could be contributing to the decrease in SUD providers given that residential capacity has increased, as noted below.

There was a consensus that since the demonstration began residential capacity has increased and will continue to, albeit slowly due to workforce shortages and the other challenges outlined here. The stakeholders did not fully discuss access to intensive ambulatory LOCs and the ability of members to access medically necessary, less restrictive interventions such as partial hospitalization and ambulatory WM over residential care. The State has taken recent steps to try to improve the workforce, including adding mechanisms for peer-led recovery support positions/organizations in outpatient settings.

Efforts are also underway to increase OTP providers. Currently, the State has 35 providers, and those numbers continue to grow. MAT is generally accepted as an evidence-based practice for substance use treatment across BH providers in the State, but primary care providers have been slower to implement this treatment option. The number of providers prescribing Methadone has been slower to grow, and there is little capacity in the State.

As discussed previously, all stakeholders, including members, indicated that while the number of providers is slowly increasing, the lack of capacity remains a significant barrier for people seeking treatment in the State. A significant majority (67%) of members participating in the June 2023 listening session identified inability to find a provider in their area that accepts Medicaid as a barrier to accessing care. This was followed by people stating that they could not find a provider in their area that provided the right level and type of care (47%) or that providers in their area did not provide high quality services (43%). One participant specifically cited a need for more providers that can deliver culturally and linguistically appropriate services.

All stakeholders agreed that the biggest capacity gap in the State is in services for youth. Organizations have difficulty finding qualified staff to staff both residential and IOP programs. Depending on region, there are very few (or no) providers that serve youth and accept Medicaid across multiple LOCs.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

The Colorado Opioid Abatement Council facilitated the first Opioid Abatement Conference on August 15–16, 2022. The Naloxone Project selected the State chapter to launch the 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.

Under American Rescue Plan Act funding, HCPF launched a new program in spring 2022 that 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 the safety and efficacy of members' pain management regimens.

Monitoring Metrics

Metric Number	Monitoring Metric Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Milestone Risk Assessment
	Base	Mid	Change	Percentage Change				
18: (Rate) Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	0.09	0.11	0.02NA	NA19.2%	Decrease	Increase	No	Medium
21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	0.13	0.12	-0.01	-10.5%	Decrease	Decrease	Yes	Low
23: ED Utilization for SUD per 1,000 Medicaid Beneficiaries	4.72	5.16	0.44	9.3%	Decrease	Increase	No	Medium
24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	3.07	3.38	0.31	-10%	Decrease	Increase	No	Medium

Implementation Progress

Action Item Description	Date to Be Completed	Current Status
Identify opportunities for expanding PDMP functionality and use; Department of Regulatory Agencies (DORA) responsible	Ongoing	Open/Ongoing

Action Item Description	Date to Be Completed	Current Status
Increase the use of PDMP by providers and pharmacists; DORA responsible	Ongoing	Open/Ongoing
Continue implementing State Opioid Response grant activities; OBH responsible	Ongoing	Open/Ongoing
Continue implementing marijuana tax revenue SUD prevention related activities; OBH responsible	Ongoing	Open/Ongoing
Consortium work groups; Consortium responsible	Ongoing	Open/Ongoing
Statewide naloxone bulk purchasing program	Ongoing	Complete

The State plans to increase use and functionality of the State’s PDMP by integrating PDMP access into the State’s prescriber tool through the OpiSafe opioid risk module. The total number of active PDMP user accounts at the end of DY1, as of December 31, 2021, was 45,230. In DY2, as of December 31, 2022, the number of PDMP user accounts rose to over 50,278.

Overall, activities are going as planned, these will be ongoing throughout the waiver, without being categorized as “complete”. Stakeholder feedback will be gathered as more activities continue and as the peer consults are implemented.

SB22-027 was signed into law on May 27, 2022, and addresses the 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.

Milestone 6: Improved Care Coordination and Transitions between LOCs

As outlined in the Implementation Plan approved by CMS in the Standard Terms and Conditions, HCPF initiated several initiatives to improve care coordination and transitions between LOCs. First, HCPF began a workgroup collaboration with the MCEs to enhance care coordination activities through the Implementation Work Group in January 2020. In the fall of 2022, “Bridging the Gaps: Policy Recommendations to Implement a Cohesive Statewide Care Coordination Infrastructure” was published and provided recommendations to inform the BHA on implementation of statewide care coordination. In the fall of 2021, the State approved updated MCE care coordination policy drafts. Finally, OBH (now BHA) began certifying recovery residences in January 2020 to improve access to a continuum of SUD treatment and housing options.

Monitoring Metrics

Metric Number	Monitoring Metric Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Milestone Risk Assessment
	Base	Mid	Change	Percentage Change				
15: Percentage of beneficiaries 18 years of age and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:								
1. Initiation of AOD Treatment — Alcohol abuse or dependence (rate 1, cohort 1)	0.3378	0.3125	-0.025	-7.5%	Increase	Decrease	No	Medium
2. Initiation of AOD Treatment — Opioid abuse or dependence (rate 1, cohort 2)	0.4064	0.2827	-0.124	-30.4%	Increase	Decrease	No	Medium
3. Initiation of AOD Treatment — Other drug abuse or dependence (rate 1, cohort 3)	0.3687	0.3342	-0.035	-9.4%	Increase	Decrease	No	Medium

4. Initiation of AOD Treatment — Total AOD abuse or dependence (rate 1, cohort 4)	0.3912	0.3571	-0.034	-8.7%	Increase	Decrease	No	Medium
5. Engagement of AOD Treatment — Alcohol abuse or dependence (rate 2, cohort 1)	0.6728	0.6998	0.027	4.0%	Increase	Increase	Yes	Low
6. Engagement of AOD Treatment — Opioid abuse or dependence (rate 2, cohort 2)	0.7085	0.7493	0.041	5.8%	Increase	Increase	Yes	Low
7. Engagement of AOD Treatment — Other drug abuse or dependence (rate 2, cohort 3)	0.6522	0.6774	0.025	3.9%	Increase	Increase	Yes	Low

8. Engagement of AOD Treatment — Total AOD abuse or dependence (rate 2, cohort 4)	0.6045	0.6003	-0.004	-0.7%	Increase	Decrease	No	Medium
17(1a). Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	0.2316	0.2141	-0.018	-7.6%	Increase	Decrease	No	Medium
17(1b). Percentage of ED visits for which the beneficiary received follow-up within seven days of the ED visit (eight total days).	0.1556	0.1511	-0.004	-2.9%	Increase	Decrease	No	Medium
17(2a). Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	0.3402	0.3017	-0.039	-11.3%	Increase	Decrease	No	Medium

17(2b). Percentage of ED visits for which the beneficiary received follow-up within seven days of the ED visit (eight total days).	0.2461	0.2237	-0.022	-9.1%	Increase	Decrease	No	Medium
25. Readmissions among beneficiaries with SUD	0.1875	0.1908	0.003	1.8%	Decrease	Increase	No	Medium

Implementation Progress

Action Item Description	Date to Be Completed	Current Status
Collaboration with the MCEs to enhance care coordination activities through the Implementation Work Group	January 2021, Ongoing	Complete, Ongoing
MCE policy development to ensure adequate care coordination across the SUD continuum	December 2020	Complete
Certify recovery residences; OBH	January 2020, Ongoing	Complete, Ongoing

As part of the efforts to improve care coordination and transitions between LOCs, SUD providers were encouraged to apply for grant funding under HB 22 signed into law on May 18, 2022. Providers were awarded funds under this law to expand their services to offer more integrated care as part of the effort to coordinate appropriate medical care for members. As part of that effort, HCPF facilitated two public webinars in February 2023 to announce the upcoming release of funding under HB 22-1302 Integrated Care Grant Program's Request for Applications. The webinars were recorded and posted on the Integrated Care Grant webpage for viewing.

Care Coordination was also enhanced when SB22-177 Investments in Care Coordination Infrastructure was signed into law on May 25, 2022. This new law requires improved care coordination infrastructure through 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. SB22-177 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.

Stakeholder Feedback

MCEs currently have a responsibility for care coordination in their contracts, but there was a decided lack of consensus that effective care coordination is happening currently. This may be due in part to the siloed nature of providers, which means that individuals have to shift among providers as they need different LOCs. It may also be because capacity issues at specific places in the continuum of care make care transitions more difficult.

State staff noted that HCPF has historically had challenges with care coordination in general, not just in SUD. There is a need to improve care coordination across the board and include other systems (e.g., justice system, child welfare) particularly for people who have high acuity of need, people that have other health related social needs and co-occurring disorders, are multisystem involved, and are typically high utilizers. Challenges have been related to a number of factors, including MCE expectations and their ability to provide care coordination deliverables as specified in contracts.

Both State and MCE staff recognized that to improve coordination the State needs to strengthen the continuum of care. HCPF staff noted that there have been many intensive transformation efforts across the State in the past several years, and transformation fatigue has become an issue that can interfere with any new efforts. However, the State has begun activities to support a new care coordination entity that will be a statewide BH administrative services organization.

Providers participating in the June 2023 forum were skeptical of the MCEs’ capacity to provide good care coordination services. They reported that MCEs were not doing care coordination and did not know what members need. Multiple providers reported that MCEs rarely or never respond when they reach out to try to coordinate patient care.

Other Metrics and Activities

Monitoring Metrics

Metric Number	Monitoring Metric Rate/Count				State Demonstration Target	Direction at Midpoint	Progress (Yes/No)	Milestone Risk Assessment
	Base	Mid	Change	Percentage Change				
3: Medicaid Beneficiaries with SUD Diagnosis (monthly)	74,299	88,051	13,752	18.5%	Increase	Increase	Yes	Low
4: Medicaid Beneficiaries with SUD Diagnosis (annually)	81,928	118,193	36,265	44.26%	Increase	Increase	Yes	Low

Summary Assessment of Overall Risk of Not Meeting Milestones

Assessment of Level of Risk

Milestone	Implementation Plan Action Items	Monitoring Metrics	Stakeholder Feedback	Risk Level
Milestone 1	100%	75% ¹	Stakeholders identified a few concerns, particularly around specific ASAM LOCs (3.5 and 3.7). However, most agreed implementation is improving over time.	Low to Medium
Milestone 2	100%	100%	No stakeholders identified risks. However, providers did express a desire for better consistency across the MCEs.	Low

¹ Based on most recent available data.

Milestone	Implementation Plan Action Items	Monitoring Metrics	Stakeholder Feedback	Risk Level
Milestone 3	100%	N/A	Stakeholders did not identify concerns with national standards but expressed significant concerns regarding the availability of residential treatment beds, particularly for youth.	Low to Medium
Milestone 4	100%	50%	Stakeholders are concerned with capacity overall, although they note that it is slowly improving. Capacity for youth services remains extremely low.	Low to Medium
Milestone 5	100% (One complete, remaining are ongoing)	25%	As more activities progress, more definitive stakeholder perspectives on this milestone will be gathered. Current stakeholders have not identified any concerns with current opioid misuse or OUD treatment strategies.	Low to Medium
Milestone 6	100%	23%	Stakeholders reported continued struggles with care coordination across providers, MCEs and in the State in general. New legislation has been passed to address this, but it is too early to assess the efficacy of those efforts.	Medium

Assessment of State’s Capacity to Provide SUD Services

Overall, the risk of the State not meeting some or all milestones is low to medium, based on the information for this assessment. Most activities proposed have been either completed or remain ongoing and new activities, driven by the State legislature, have the potential to continue improvements in SUD services. The three primary threats to implementation that contribute to some medium risk ratings are as follows:

1. Ongoing struggles for accurate and complete data to create metric reports from MCEs
2. A need to further develop provider capacity, particularly for youth
3. Better cooperation between providers and MCEs in both overall treatment delivery and, in particular, in coordinating care

Section 4

Budget Neutrality

The State has begun preparing the Budget Neutrality reports but is awaiting CMS approval of the Budget Neutrality technical amendment. The State needs that technical amendment approved in order to receive the updated Budget Neutrality Report template with the correct without waiver costs.

At this time, the State is reporting on the CMS-64. The **Schedule C** reports costs through March 31, 2023, on the CMS-64. However, the Schedule C Budget Neutrality, which is an aggregate report of the CMS-64 reports, does not match the State's ad hoc demonstration **Member Months Report**. The **Schedule C** reports expenditures for the Expansion Medicaid Eligibility Group (MEG) of \$1,451,151 and the Legacy MEG of \$190,664, but the **Member Months Report** has expenditures of \$1,297,719 and \$418,432, respectively. The State is continuing to reconcile these reports and hopes to have resolution by July 31, 2023, for the next CMS-64 report.

Section 5

Recommendations

Recommendation 1: HCPF should continue to recruit providers and retain them by better aligning operations across MCEs. HCPF should use the provider forum to identify barriers for providers related to MCE policies and work with these entities to develop solutions.

Recommendation 2: HCPF should explore options within regulatory requirements for creating incentives for existing providers to add more capacity through staff hires and providing multiple LOCs. HCPF should consider training or other workforce or licensing initiatives, consistent with state requirements, to encourage more providers to serve youth. HCPF should consider providing more intensive LOCs (e.g., ambulatory WM ASAM 1-WM and 2-WM as well as partial hospitalization ASAM 2.5) to expand system capacity.

Recommendation 3: HCPF should support MCE and BHA efforts to manage member needs given provider capacity in all LOCs. This could include BHA incorporating provider, MCE, and HCPF considerations into Behavioral Health Bed Tracker upgrades. MCEs could develop interim mechanisms for monitoring and communicating with their own network providers regarding space available at different LOCs to better facilitate access and transitions to lower LOCs.

Recommendation 4: The State should continue to provide training and guidance (including monitoring of new peer-to-peer consultations regarding opioid prescribing and pain management best practices) to providers and encourage increased enrollment in the PDMP.

Recommendation 5: HCPF should continue exploring how to improve care coordination efforts. Providers, in particular, were skeptical of the MCEs' capacity to provide care coordination within the current infrastructure. The State should continue to invest in new infrastructure changes and monitor changes resulting from implementation of new legislation.

Recommendation 6: HCPF should continue working to reconcile the CMS-64 reporting and the ad hoc demonstration reporting. After reconciliation is complete, the CMS-64 reporting should be corrected through prior period expenditures. Once CMS approves the technical amendment and provides the updated Budget Neutrality Report, HCPF should ensure the State completes and submits the report quarterly.



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State's Response to Midpoint Risk Assessment

On Implementation

There have been many intensive transformation efforts across the State in the past several years, including the 1115 SUD waiver, that have transformed behavioral health services. The midpoint assessment, evaluating demonstration progress toward goals, identified some findings for Colorado to address. Health Care Policy and Finance (HCPF) acknowledges these areas of concern and has prepared the following responses to address these areas. Overall, significant progress toward goals has been made and the State is continuing to work toward further implementation and continued progress toward milestones monitoring such progress through the reported metrics. Key findings from the midpoint assessment include:

1. The State overall has low risk for reaching all milestones, except Milestone 6, Improved Care Coordination and Transitions between Levels of Care, which was flagged as medium risk.
2. The State faces the following three challenges with implementation:
 - a. Struggles for accurate and complete data to create metric reports from managed care entities (MCEs);
 - b. A need to further develop provider capacity, particularly for youth; and
 - c. Better cooperation between providers and MCEs in both overall treatment delivery and, in particular, coordinating care.

Colorado continues to make progress toward all milestones; however, Milestone 6, Improved Care Coordination and Transitions between Levels of Care, was determined to be at medium risk of missing the target by the Independent Evaluator. Through the demonstration, Colorado has made progress with implementing all the American Society of Addiction Medicine (ASAM) criteria levels 2 and 3 as proposed in the implementation plan, with likely expansions coming from the legislature in FY24-25. This allows for additional levels of care to be covered by Medicaid and provides additional resources for Colorado Health First members. With the added levels of care now spanning the full ASAM continuum, care coordination is essential to maximize the benefits of offering the full continuum to Members. Colorado Health Institute prepared a report [“Bridging the Gaps: Policy Recommendations to Implement a Cohesive Statewide Care Coordination Infrastructure”](#) which provides recommendations to inform the Behavioral Health Administration (BHA) and other agencies on implementation of statewide care coordination. This report provides a robust look at additional areas of improvement around care coordination. Senate Bill 22-177, Investments in Care Coordination Infrastructure, was also signed into law. This new law requires improved care coordination infrastructure. This act 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. As part of the State's Accountable Care Collaborative (ACC) III implementation, the state is also including a tiered care coordination approach to ensure that members with complex needs, including high utilizers and members with multiple diagnoses receive levels of case management aligned to meet their needs. Through these initiatives, Colorado expects to demonstrate improved progress toward Milestone 6 as indicated through metrics tracked as part of the quarterly and annual reports.



The other area, identified by the Independent Evaluator, for focus and additional attention is how Colorado is ensuring timely collection of accurate and complete data to create metric reports. HCPF has continued to partner with the contracted MCEs through forums and workgroups to resolve identified barriers in reporting. Colorado is now current with CMS performance metric reporting. Colorado continues to discuss data and reporting issues as they occur as well as issues such as systems upgrades which could impact reporting with the MCEs, to ensure any potential data issues are planned for whenever possible.

Colorado continues to further develop provider capacity, particularly for youth, in collaboration across state agencies including Behavioral Health Administration (BHA) and the Colorado Department of Public Health and Environment. Through ARPA grant funds, BHA is supporting the expansion of youth residential SUD services. Grants have been allocated to two providers to build capacity for offering youth residential withdrawal management services. One is open and the other is completing the final steps towards opening. HCPF continues to monitor network adequacy requirements for MCEs, through quarterly reporting. The report includes a narrative report and data file with details about the ability of the MCE's Primary Care Medical Provider network and Specialty Behavioral Health network to meet member needs. Colorado will continue to discuss provider capacity in the youth space as part of the quarterly review process. Colorado Crisis Services is the statewide behavioral health crisis response system offering individuals mental health, substance use or emotional crisis help, information and referrals. The crisis continuum of care is another area of focus for ensuring capacity and access to immediate services, often including substance use disorder (SUD) support, through a partnership between HCPF and BHA.

Colorado is working to facilitate better cooperation between providers and MCEs in both overall treatment delivery and coordinating care through forums and workgroups with MCEs and providers. This area of improvement is also correlated to milestone 6 and making improvements in coordinating care. Through Senate Bill 22-177, Investments in Care Coordination Infrastructure, Colorado is building a care coordination infrastructure to improve treatment delivery and care coordination for members. This bill also includes 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.

On Metrics

The state acknowledges that data delays were significant in the first two years of the demonstration impacting reporting and an accurate overview of the impact of the demonstration. Colorado has successfully worked through MCEs reporting accurate data and brought reporting current with CMS performance metric reporting under the 1115 SUD Waiver. HCPF has been working with MCEs to improve data, billing and coding practices through collaboration and training opportunities. Two metrics are identified in the midpoint assessment as medium risk and not making progress in the direction the State expects. These metrics are: Number of Individuals Receiving Early Intervention Services and ED Utilization for SUD per 1,000 Medicaid Beneficiaries.

Number of Individuals Receiving Early Intervention Services

While it is the expectation through the demonstration that utilization of early interventions services will increase, Colorado metrics are not showing that trend. Colorado continues to work on expanding use of identified service codes for Screening, Brief intervention, and Referral to Treatment (SBIRT) for individuals in the state. Colorado has extensively researched coding for SBIRT services for 15-30 minutes and greater than 30 minutes. Currently Colorado cannot bill for SBIRT services less than 15 minutes. Providers and MCEs have provided feedback that screening for SUD is often less than 15 minutes, which results in alternative codes being billed and the screening not being captured through



the reporting of utilization data. Colorado continues to provide training and information on SBIRT billing through a monthly provider newsletter. Colorado was providing 35 trainings annually and has increased this to 150 SBIRT trainings per year. Proposed Bill 24-047, Prevention of Substance Use Disorders, includes expanding SBIRT training and technical assistance to schools and pediatrics settings to increase SBIRT with adolescents (section 12 and 13). Colorado will continue to monitor this metric and collaborate with providers and RAEs to educate and train on SBIRT.

ED Utilization for SUD per 1,000 Medicaid Beneficiaries

Metrics demonstrate an increase in emergency department (ED) utilization for members with a primary SUD diagnosis, where the demonstration seeks decrease ED utilizations for these members. In efforts to address ED utilization, Colorado continues to work on increasing availability of community based resources such as High Intensity Outpatient (HIOP) services, including Partial Hospitalization Programs (PHP), and Crisis services, including walk-in clinics and Mobile Crisis Response (MCR). Colorado continues to engage with hospitals and the MCEs to discuss opportunities and barriers to reducing readmissions to ED specifically and opportunities to reduce ED utilization in general. The state is also engaging with hospitals on discharge planning for SUD related admissions and HCPF has implemented an associated metric through the Colorado Hospital Transformation Program (HTP). Over the course of the five-year program, provider fee-funded hospital payments will transition from pay-for-process and reporting to a pay-for-performance structure in an effort to improve quality, demonstrate meaningful community engagement and improve health outcomes over time. The goals of the HTP program align with the 1115 SUD Waiver, and the state expects to see an improvement in member outcomes through care design and integration of care across settings. Colorado is also incorporating discharge planning and follow up care coordination, as well as readmissions following ED admissions into performance measures for MCEs under phase III of the Accountable Care Collaboration (ACC), planned for implementation on July 1, 2025. Colorado will continue to monitor these metrics closely and will continue to collaborate with providers and partners to ensure alternative resources are available in the community for Colorado Health First members.

