DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

July 8, 2026

Adela Flores-Brennan
State Medicaid Director
Colorado Department of Health Care Policy and Financing
303 E. 17th Avenue, Suite 1100
Denver, CO 80203

Dear Director Flores-Brennan:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Colorado's Final Report for the Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Colorado Expanding the Substance Use Disorder Continuum of Care" (Project No: 11 W-00336/8 and 21-W-00079/8). This report covers the demonstration period from July 2020 to June 2021. CMS determined that the Final Report, submitted on June 25, 2025 and revised on June 23, 2026 is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

In accordance with STC #12.11, the approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid and CHIP funds and must fully comply with all applicable Medicaid and CHIP statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX and Title XXI of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid and CHIP services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA

and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We sincerely appreciate the state's commitment to evaluating the Managed Care Risk Mitigation COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the Colorado Expanding the Substance Use Disorder Continuum of Care section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

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Date: 2026.07.08 12:38:06 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Keri Rosenbloom, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Managed Care Risk Mitigation COVID-19 PHE Summative Evaluation Report

June 20, 2025

COLORADO
Department of Health Care Policy & Financing

Contents

I. Introduction

In 2020, the Department intended to launch a new inpatient and residential substance use disorder (SUD) benefit for the SFY 2020-21 behavioral health managed care contract. The Public Health Emergency (PHE) for COVID pushed the implementation of the benefit until January 2021. This delayed start for the benefit coincided with the middle of the existing SFY 2020-21 contract period.

Due to the nature of the benefit launch and the inherent risk to both the Medicaid program and the Medicaid managed care providers, the State elected to add a risk mitigation proposition to the contract. The risk mitigation being added during the middle of the contract period would have violated 42 CFR 438.6(b)(1) and, as such, the Department applied for an 1115 Managed Care Risk Mitigation COVID-19 PHE demonstration.

The demonstration, approved on February 18, 2022, allowed the Department to implement a retroactive risk corridor for the services inherent in the new inpatient and residential SUD benefit within the SFY 2020-21 contract. The risk corridor provided risk protection to both the Department and to the managed care plans with regards to utilization of these services.

This report evaluates the demonstration using the same data sources and collection methodology described in the approved Evaluation Design. No additional methodological limitations were encountered beyond those related to the qualitative analysis outlined in the Evaluation Design.

II. Hypothesis 1: The demonstration will facilitate attaining the objectives of Medicaid

What retroactive risk sharing agreements did the state ultimately negotiate with the managed care plans under the demonstration authority?

The Department entered a two-sided risk corridor with the managed care plans specific to the inpatient and residential substance use disorder (SUD) benefit, based on a per member per month (PMPM) calculation. The risk corridor was structured as a two-tier mechanism. The first mechanism related to the payments allowable within the structure of the risk corridor. The second mechanism was the corridor itself,

which shared varying levels of risk depending on the difference between the Target PMPM and the actual Aggregated PMPM.

For the first mechanism, the managed care plans submitted the total days and total dollars spent for each level of residential or inpatient SUD service under the benefit. This amount was then checked against the Department's internal proposed fee schedule for the same level of utilization on an aggregate basis. If the total dollars spent exceeded 5% above what the Department would have paid, any additional dollars would be excluded from the risk corridor.

For the second mechanism, the total dollars from the first mechanism were converted to an Aggregated PMPM using the enrollment for the effective period. This Aggregated PMPM was then matched against the Target PMPM, weighted by cohort, for the portion of the paid capitation rates built in for the residential and inpatient substance use disorder services.

The risk corridor had the following share structure:

Corridor	Risk Corridor Min	Risk Corridor Max	Managed Care Plan Share %	State/Fed Share %
A	0.00%	94.99%	0%	100%
B	95.00%	98.99%	50%	50%
C	99.00%	100.99%	100%	0%
D	101.00%	104.99%	50%	50%
E	105.00%	+	0%	100%

The Target PMPM would be set at the 100% mark of the risk corridor. For the Aggregated PMPM, within one percent difference from the Target PMPM, the managed care plans would be at 100% risk (corridor C). For the next four percentage points difference from the Target PMPM, the managed care plans would be at a 50% risk (corridors B and D). For anything outside of five percent difference from the Target PMPM, the managed care plans would have zero risk (corridors A and E).

What problems may have been caused by the application of 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid, and how did the exemption address or prevent these problems?

During the PHE, the launch of the SUD residential services was slow due to uncertain capacity, limits on the beds that could be used due to COVID restrictions, and

contracting issues. This created a very clear and serious unknown risk for both the managed care plans and the Department.

Without the appropriate risk corridor in place to mitigate risk, the managed care plans would have been slower and more cautious in seeking out contracts for these services. That additional caution would have greatly hindered the provision of these services. This could have left many people without bedded substance use care in a time when anxiety, depression, and substance abuse were up, directly correlated to the PHE and COVID.

Additionally, the Department is very serious about its mission as stewards of taxpayer dollars. The uncertain nature of the availability of services meant that in the end, the state had overestimated the initial utilization of services. Without the risk corridor in place, the managed care plans would have been able to keep larger shares of taxpayer dollars as profit. This will be laid out explicitly under Hypothesis 2 on the accuracy of payments.

What were the principal challenges associated with implementing the retroactive risk mitigation strategies from the perspectives of the Department and Medicaid managed care plans?

Due to the PHE, the rollout of the new benefit was delayed to the middle of the state fiscal year. The biggest challenge from the perspective of the Medicaid managed care plans was the contracting of new providers to provide this service. Given the uncertain nature of who would be providing the service, when they would become registered as a Medicaid provider, and when they would be available to begin billing for services, the levels of risk mitigation needed were unclear. Managed care plans expressed concern with the ability to contract with the providers in a timely manner.

From the perspective of the Department, the biggest challenge implementing the retroactive risk corridor was to balance incentives and outcomes. The Department did not want to disincentivize the managed care plans from providing care or to encourage the use of narrow networks due to overly strict or stringent risk arrangements. On the other hand, the Department did not want to make the risk arrangements so generous as to create an incentive for poor contracting and utilization management to generate excessive benefit for the plans.

In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?

The demonstration allowed the Department to add a needed risk sharing mechanism to the SUD residential and inpatient services. Since the rollout of the services was effective in the middle of the state fiscal year and therefore an existing contract period, the Department was free to keep the risk of the new services from interfering with the rest of the existing capitated services. The existing risk mitigation strategy, in the form of a Medical Loss Ratio (MLR) with remittance, was not adversely affected by the addition of these services.

III. Hypothesis 2: The demonstration allowed the State to implement a much-needed inpatient and residential SUD benefit during the COVID PHE

To what extent did the retroactive risk sharing implemented under the demonstration authority result in more accurate payments to the managed care plans?

The retroactive risk sharing allowed the Department to segment out the risk of the new services from the existing MLR. In the year for which the Department included the retroactive risk corridor, the Department recouped $30.85 million in total funds in the risk corridor and an additional $6.9 million in total funds in the MLR reconciliation. Absent this risk mitigation tool, the Department would have recouped $22.2 million in the MLR reconciliation for the same level of service. This resulted in a more appropriate recoupment of an additional $15.6 million in total funds. This allowed the State to better manage both the State and Federal funds attached to this new benefit.