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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

December 18, 2020

Tracy Johnson
Medicaid Director
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Dear Ms. Johnson:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Colorado's Substance Use Disorder (SUD) Implementation Plan (IP) for the state's approved section 1115(a) demonstration, titled "Expanding the Substance Use Disorder Continuum of Care" (Project Number 11-W-00336/8). With the state's submission received on November 2, 2020, CMS has now determined that the revised IP is consistent with the requirements outlined in the Special Terms and Conditions (STC); therefore, CMS is approving the SUD demonstration's IP. With this approval, the state may begin receiving federal financial participation as of the demonstration's effective date for the provision of inpatient, residential and other services provided to otherwise-eligible Medicaid beneficiaries while residing in institutions for mental diseases for primary diagnoses of SUD. A copy of the approved SUD IP is enclosed and, hereby, incorporated into the STCs as Attachment C.

If you have any questions, please do not hesitate to contact your project officer, Mr. Jack Nocito. Mr. Nocito can be reached at (410) 786-0199 or Jack.Nocito@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2020.12.18 15:13:07 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Curtis Volesky, State Monitoring Lead, Medicaid and CHIP Operations Group

COLORADO
Department of Health Care Policy & Financing

Colorado Substance Use Disorder Section 1115 Waiver Implementation Plan

Submitted to the Centers for Medicare & Medicaid Services on November 2, 2020

COLORADO
Department of Health Care Policy & Financing

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Introduction

Over the past two decades, Colorado, like the rest of the country, has felt the impact of the opioid epidemic and has experienced an increase in the rate of SUD diagnoses. Data collected by the Colorado Department of Public Health and Environment between 1999-2017 show that:

- An estimated 500,000 Coloradans are dependent on alcohol or have used illicit drugs, defined as cocaine (including crack), marijuana, heroin, hallucinogens, inhalants, and prescription drugs used non-medically. Nearly 30 percent (142,000) are Medicaid members[1];
- Between 2000-2019, 14,512 Coloradans died due to a drug overdose[2];
- The number of overdose deaths has increased from 351 deaths in 2000 to 1,062 deaths in 2019[2]; and
- Opioid use is leading the overdose epidemic, accounting for over half of the overdose deaths in 2019.[2]

While opioid overdoses in Colorado rose between 2000 and 2019, other drugs including alcohol and methamphetamine also drive the rate of admissions for addiction treatment in the state. In 2017, alcohol was responsible for the majority of treatment admissions, followed by methamphetamine. From 2013 to 2017, methamphetamine-related admissions increased by 63%.[3]

In order to address this crisis, the State of Colorado enacted legislation in 2018 that directed the Department of Health Care Policy and Financing (Department) to seek all necessary federal authority to ensure coverage of the full continuum of Substance Use Disorder (SUD) services for Coloradans covered by Medicaid. In response, the Department submitted an 1115 demonstration application in 2019 to authorize federal financial participation for payment of residential and inpatient SUD treatment and withdrawal management services in Institutes for Mental Disease (IMDs). The state is also in the process of adding residential and inpatient treatment and withdrawal management as covered services under the State Plan. This Implementation Plan is being submitted in conjunction with the state's 1115 demonstration to

[1] Colorado Health Institute. Exploring Options for Residential and Inpatient Treatment of Substance Use Disorder in Health First Colorado. November 2017. https://www.colorado.gov/pacific/sites/default/files/HCPF%202017%20Inpatient%20SUD%20Treatment%20Report.pdf

[2] Colorado Drug Overdose Data Dashboard. https://cohealthviz.dphe.state.co.us/t/PSDVIP-MHPPUBLIC/views/DrugOverdoseDashboard/PoisoningDeathFrequencies?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no&%3Aorigin=viz_share_link

[3] Russell, S. "Colorado Drug Trends." Drug/Alcohol Coordinated Data System (DACODS), Colorado Department of Human Services Office of Behavioral Health. 2018.

detail how coverage of the full continuum of SUD services, including residential and inpatient services authorized under the 1115 demonstration, will be implemented.

This Implementation Plan describes the Department's strategies to ensure access to care, utilize the American Society of Addiction Medicine (ASAM) Criteria for patient placement and provider qualifications, address capacity, conduct prevention efforts and improve care coordination. The Implementation Plan that follows also discusses efforts to gather information from the public through stakeholder outreach and regional meetings. This information influenced the plans and actions that address each of the six milestones included in this plan.

Goals and Milestones to be addressed in Colorado's Implementation Plan Protocols

CMS is committed to working with states to provide a full continuum of care for people with opioid use disorder (OUD) and other SUDs and in supporting state-proposed solutions for expanding access and improving outcomes in the most cost-effective manner possible.

Goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to and retention in treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD 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 level of care where readmissions is preventable or medically inappropriate for OUD and other SUD; and
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones:

1. Access to critical levels of care for substance use disorders;

2. Widespread use of evidence-based, SUD-specific patient placement criteria;

3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications;

4. Sufficient provider capacity at each level of care, including medication assisted treatment (MAT);

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and opioid use disorder (OUD); and

6. Improved care coordination and transitions between levels of care.

Partners

These plans were developed collaboratively with other state agencies and stakeholders. State agencies that participated actively include the Colorado Department of Human Services Office of Behavioral Health, Department of Regulatory Agencies and Department of Public Health and Environment. In addition, this plan describes ongoing work conducted by two workgroups comprised of state agency, Regional Accountable Entity, and Managed Service Organization representatives. As discussed in the state's 1115 demonstration application, Regional Accountable Entities (RAEs) administer the Department's Accountable Care Collaborative Program and are responsible for promoting physical and behavioral health of Medicaid members in each of the regions of the state that they serve. The Managed Service Organizations (MSOs) contract with the Office of Behavioral Health to deliver a continuum of SUD care that includes residential and inpatient services through state and federal block grant funding.

Milestone #1: Access to Critical Levels of Care for SUD Treatment

CMS Specifications:

Coverage of a) outpatient, b) intensive outpatient services or partial hospitalization, c) medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state), d) intensive levels of care in residential and inpatient settings, and e) medically supervised withdrawal management.

Colorado's Response:

Colorado currently covers outpatient SUD treatment services under the Medicaid state plan. The state plan includes coverage of early intervention, outpatient, medically acute inpatient, and some withdrawal management services. State Plan Amendments (SPAs) are in process to add new services and modify current service definitions as detailed below.

Table 1 below identifies each ASAM level of care, the service and service description, whether the service is currently Medicaid-covered, the authority used to cover it, and any changes that are being proposed under the state plan or this demonstration.

Table 1

ASAM	Service	ASAM Service Definition	Current Coverage	Future coverage

Level of Care			Authority	under Waiver or State Plan
.5	Early Intervention	Full screening, brief intervention and referral to treatment	State Plan Attachment 3.1-A, Item 13.c Preventative Services	Continuation of current state plan coverage
1	Outpatient Services	Substance abuse assessment, individual and family therapy, group therapy, alcohol/drug screening counseling, medication assisted treatment	State plan Attachment 3.1-A, Item 13-d Rehabilitative Services	Continuation of current state plan coverage
2.1	Intensive Outpatient Services	The Colorado state plan does not distinguish between outpatient and intensive outpatient.	State plan Attachment 3.1-A, Item 13-d Rehabilitative Services	Currently covered as "outpatient services;" the state submitted a SPA for this change in October 2020.
3.1	Clinically Managed Low-Intensity Residential Services	Supportive living environments (SLE) with 24-hour staff and close integration with clinical services provided when determined to be medically necessary and in accordance with an individualized treatment plan. Program services of five or more hours of services weekly may be offered in a (usually) free-standing, appropriately licensed facility located in a community setting.	Not covered	The state submitted a SPA in October 2020 to add this service and requests 1115 demonstration authority for provision of services in IMDs.
3.3	Clinically Managed Population-	Clinically managed therapeutic rehabilitation facilities for adults with	Not covered	The state submitted a SPA in October 2020

	Specific High Intensity Residential Services	cognitive impairment including developmental delay or traumatic brain injury that provides rehabilitation services to recipients with an SUD when determined to be medically necessary and in accordance with an individualized treatment plan. High intensity clinical services are provided in a manner to meet the functional limitations of patients with cognitive impairment so significant and the resulting level of functional impairment so great that outpatient motivational strategies and/or relapse prevention strategies are not feasible or effective. Staffed by credentialed addiction professionals, physicians/physician extenders, credentialed mental health professionals.		to add this service and requests 1115 demonstration authority for provision of services in IMDs.
3.5	Clinically Managed High Intensity Residential Services	Clinically managed therapeutic community or residential treatment facilities providing high intensity services for recipients with an SUD when determined to be medically necessary and in accordance with an individualized treatment plan. Staffed by	Not covered	The state submitted a SPA in October 2020 to add this service and requests 1115 demonstration authority for provision of services in IMDs.

		licensed/credentialed clinical staff, including licensed addiction professionals, licensed social workers, licensed professional counselors, physicians/physician extenders, and credentialed mental health professionals.		
3.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient services provided in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit when determined to be medically necessary and in accordance with an individualized treatment plan. Includes 24-hour clinical supervision including physicians, nurses, addiction counselors, and behavioral health specialists.	Not covered	The state submitted a SPA in October 2020 to add this service and requests 1115 demonstration authority for provision of services in IMDs.
4	Medically Managed Intensive Inpatient Services	Acute care in a general hospital setting, with 24/7 medical management and nursing supervision, and counseling services (16 hours per day). Managed by addiction specialist physician with interdisciplinary team of credentialed clinical staff knowledgeable of biopsychosocial dimensions of addictions.	State plan for acute medical diagnosis only	Continuation of current state plan coverage

3.2-WM	Clinically Managed Residential Withdrawal Management	"Social detox" addressing intoxication or withdrawal in a setting that emphasizes peer and social support in a 24-hour setting.	State plan and 1915(b) waiver	The state currently covers ASAM level 3.2WM which is identified as "social detoxification." It will remain a covered service in the state plan and will be described in a new section titled "Withdrawal Management" on the 13.d Rehabilitative Services page.
3.7-WM	Medically Managed Inpatient Withdrawal Management	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring	Not covered	The state submitted a SPA in October 2020 to add this service (see above) and requests 1115 demonstration authority for provision of services in IMDs.
4-WM	Medically Managed Intensive Inpatient	Medical benefit	State plan	Continuation of current state plan coverage

Summary of Future Coverage Changes

As outlined in the table above, several SUD services are currently covered under the state plan, but new services are being added and updated through SPAs. Specifically, as illustrated in Table 1 above, the state is in the process of modifying the state plan for services at the ASAM level 2.1 and 3.2WM and is adding ASAM levels 3.1, 3.3, 3.5, and 3.7, and 3.7WM as benefits in the

Colorado Medicaid state plan. The state is working closely with the provider community to ensure that they are fully prepared to provide services based on the ASAM Criteria.

The following section summarizes the service coverage changes that will be made under the state plan and 1115 demonstration.

Level of Care: 2.1 Intensive OP SUD Services
Current State: Colorado's state plan does not currently differentiate between outpatient and intensive outpatient (IOP) services. All outpatient SUD services in the state are billed as outpatient services rather than differentiating between outpatient and IOP.
Future State: The state has submitted a SPA that will define IOP services as a distinct service.

Level of Care: 3.1 Clinically Managed Low-Intensity Residential Services
Current State: No coverage.
Future State: The state has submitted a SPA to CMS that adds clinically managed low-intensity residential services as a state plan service. This service meets the requirements of ASAM Level 3.1 by providing at least five hours of low-intensity treatment services per week, including medication management, recovery skills, relapse prevention, and other similar services. This level of care is designed to improve the patient's ability to structure and organize the tasks of daily living, stabilize and maintain the stability of the individual's substance use disorder symptoms, and to help them develop and apply recovery skills. Services are provided by allied health professional staff including counselors, group living workers, and some clinical staff knowledgeable about biological and psychosocial dimensions of SUD and psychiatric conditions.

Level of Care: 3.3 Clinically Managed Population-Specific High-Intensity Residential Services
Current State: No coverage.
Future State: The state has submitted a SPA to CMS that adds clinically managed population-specific high-intensity residential services as a state plan service. This service meets the requirements of ASAM Level 3.3 by providing services for individuals with temporary or permanent cognitive limitations that make it unlikely for them to benefit from other residential levels of care that offer group therapy and other cognitive-based relapse prevention strategies. This level of care is designed to improve the patient's ability to structure and organize the tasks of daily living and recovery, to stabilize and maintain the stability of the individual's substance use disorder symptoms, and to help them develop and apply recovery skills. Services are provided by 24-hour allied health professional staff who supervise the residential component with access to clinicians competent in SUD treatment.

Level of Care: 3.5 Clinically Managed High-Intensity Residential Services
Current State: No coverage.
Future State: The state has submitted a SPA to CMS that adds clinically managed high-intensity residential services as a state plan service. This service meets the requirements of ASAM Level 3.5 by providing comprehensive, multifaceted treatment to individuals with psychological problems, chaotic or unsupportive interpersonal relationships, criminal justice histories, and

antisocial value systems. Services will include a range of cognitive, behavioral and other therapies administered on an individual and group basis and provided by an interdisciplinary team comprised of appropriately credentialed clinical staff including addiction counselors, social workers, and licensed professional counselors, and allied health professionals who provide residential oversight.

Level of Care: 3.7 Medically Monitored Intensive Inpatient Services
Current State: No coverage.
Future State: The state has submitted a SPA to CMS that adds medically monitored intensive inpatient services as a state plan service. This service meets the requirements of ASAM Level 3.7 by providing services to patients with biomedical, emotional, behavioral and/or cognitive conditions that require highly structured 24-hour services including direct evaluation, observation, and medically monitored addiction treatment. Medically monitored treatment is provided through a combination of direct patient contact, record review, team meetings and quality assurance programming. These services are differentiated from Level 4.0 (which is currently covered by Colorado Medicaid) in that the population served does not have conditions severe enough to warrant medically managed inpatient services or acute care in a general hospital where daily treatment decisions are managed by a physician. The care team will include physicians credentialed in addiction who are available on-site 24 hours daily, registered nurses, and additional appropriately credentialed nurses, addiction counselors, behavioral health specialists, and other clinical staff.

Level of Care: 3.2 WM Clinically Managed Residential Withdrawal Management
Current State: This service is currently covered through 1915(b) authority and under the state plan.
Future State: The state has submitted a SPA that outlines withdrawal management as a covered service at both the 3.2 WM and 3.7 WM levels of care. This service will continue to meet the ASAM 3.2 WM level of care criteria by providing 24-hour structure, support, supervision, and observation for individuals who are intoxicated or experiencing withdrawal symptoms. Services are supervised by a qualified medical professional who must be available by telephone or in person 24 hours per day. These facilities will be required to demonstrate that they are licensed to provide this level of care by the Colorado Office of Behavioral Health (OBH).

Level of Care: 3.7 WM Medically Managed Residential Withdrawal Management
Current State: Not covered.
Future State: The state has submitted a SPA to CMS that adds medically managed residential withdrawal management as a state plan service. This service meets the ASAM 3.7 level of care criteria by providing 24-hour medically supervised evaluation and withdrawal management. This level of care is for individuals whose withdrawal signs and symptoms are sufficiently severe to require care by medical professionals but not an inpatient hospital level of care. Services are supervised by a medical director who must be on site seven days a week and available for consultation or onsite recipient monitoring 24 hours per day.

Actions Needed to Achieve Milestone #1 Across All Service Levels

Action Needed	Timeline
SPA revision of 2.1 Intensive OP SUD Services	Pending approval of SPA; proposed effective date January 1, 2021
Implementation of 3.1 Clinically Managed Low-Intensity Residential Services	Pending approval of SPA; proposed effective date January 1, 2021
Implementation of 3.3 Clinically Managed Population-Specific High-Intensity Residential Services	Pending approval of SPA; proposed effective date January 1, 2021
Implementation of 3.5 Clinically Managed High-Intensity Residential Services	Pending approval of SPA; proposed effective date January 1, 2021
Implementation of 3.7 Medically Monitored Intensive Inpatient Services	Pending approval of SPA; proposed effective date January 1, 2021
Implementation of 3.7 WM Medically Managed Residential Withdrawal Management	Pending approval of state plan amendment; proposed effective date January 1, 2021
Develop and implement Regional Accountable Entity (RAE) rate methodology that reflects continuum of additional and modified services	October 2019 – Current; anticipated contract updates in effect prior to January 1, 2021
Execute RAE contract amendments that reflect updated capitation rates that include new and modified services	By January 1, 2021
Billing system changes to allow for claim submission for new services (residential and inpatient) and changes to existing service billing rules (IOP)	November 2020

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

CMS Specifications:

- Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g. the ASAM Criteria or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Implementation of a utilization management approach such that a) beneficiaries have access to SUD services at the appropriate level of care, b) interventions are appropriate for the diagnosis and level of care, and c) there is an independent process for reviewing placement in residential treatment settings.

Colorado's Response:
Colorado Medicaid requires evidence-based level of care determinations that utilize the ASAM Criteria.

The state will require treatment providers to conduct assessments that allow them to gather information about the patient that allows for rating of the six ASAM dimensions, and the use of the ASAM Criteria for matching to an appropriate level of care. For residential treatment admissions, the RAEs will review those recommendations through a prior authorization process to ensure that medical necessity exists for the level of care recommended. RAE contracts that will be effective January 1, 2021 contain language pertaining to utilization management of residential and inpatient SUD services. The RAEs have submitted draft utilization management policies and procedures to the Department that are aligned with the Department's requirements related to the management of these services.

Colorado will require the RAEs to conduct a utilization review process to ensure that beneficiaries have access to the most appropriate level of care depending on their individual needs. RAEs will also be responsible for ensuring that the continuum of care is surrounded by recovery supports that promote sustained recovery and minimize readmissions.

The state will also conduct monitoring activities when the benefit is in place to review prior authorization documentation of medical necessity and level of care decision making.

A. Patient Placement Assessment

Current State: The state requires that ASAM Criteria be used for SUD-related assessments. Specifically, Office of Behavioral Health licensing requirements state that SUD providers at all levels of care, including outpatient, intensive outpatient and residential levels, conduct assessments in accordance with the following requirements:

- Use the ASAM Criteria as a guide for assessing and placing individuals in the appropriate level of care;

- Assessments shall include information gathered on all six (6) dimensions outlined in the ASAM criteria; and,

- Level of care shall be determined utilizing the decisional flow process as outlined in the ASAM criteria.

During site visits to SUD provider facilities, the Office of Behavioral Health reviews patient charts to verify that the ASAM criteria was used to appropriately place the client in the level of care.

Contracts with RAEs direct the RAEs to conduct evaluations that are "designed to determine the most appropriate level of care, based on criteria established by ASAM, the extent of drug/alcohol use, abuse or dependence and related problems, and the comprehensive treatment needs of a member with a drug or alcohol diagnosis."

In addition, in its role as regulator, the Colorado Office of Behavioral Health (OBH) licenses all SUD providers in the state. In August 2020, OBH completed the rule revision process to fully align its licensure requirements with the ASAM Criteria. The new licensure rules distinguish providers by ASAM level and describe the levels of care in detail. Providers receiving reimbursement for SUD services by Medicaid must be licensed for the level of care which they are offering.

Future State: The state is updating its contract language with RAEs to strengthen requirements and monitor the RAEs' use of the ASAM Criteria for patient placement. Contract changes include a requirement that the ASAM Criteria be used for level of care determination and to document medical necessity for the level of care the provider is recommending. Contracts with RAEs will also provide guidance on other expectations for RAE relationships with SUD providers. The state is working with the RAEs to develop policies and procedures for aspects of utilization management such as prior authorization and reauthorization practices.

In addition to aligning its licensure rules with the ASAM Criteria, Colorado is also in the process of procuring ASAM-based technology that will facilitate state-of-the-science assessments. Once the technology is made accessible to all residential and inpatient SUD providers, they will be required to use it to assess patients and make level of care determinations. The use of a standardized tool would improve communication between RAEs and providers and increase consistency in the application of ASAM criteria for level of care decision making. Until that system is accessible to providers, the state will require providers to use ASAM-consistent screening and assessment tools that collect data to allow providers to develop risk ratings on

the six dimensions of care and then manually map to an appropriate level of care based on those ratings.

B. Utilization Management

Current State: The OBH licensure process aims to ensure that Coloradans have access to SUD care that is consistent with the levels of care described by the ASAM Criteria. Expectations regarding utilization management practices are set forth in RAE contract requirements.

Future State: The state is strengthening the utilization management requirements for SUD services by the RAEs. The state has convened an Implementation Work Group (comprised of key stakeholders and partners from the Department, OBH, RAEs, and Managed Service Organizations, or MSOs), which is charged with working through the details of 1115 demonstration implementation. RAE representatives on the work group include staff who are focused on utilization management. The State has communicated requirements that pertain to prior authorizations and timeframes for prior authorization reviews that will be implemented uniformly across RAEs. RAEs incorporated those uniform standards into their policies and have operationalized them. The Department has also convened an Initial Monitoring Team that is developing plans to monitor utilization of residential and inpatient services in the early weeks and months after implementation. This team is developing plans for independent tracking of residential and inpatient SUD service utilization across RAE regions and identifying outliers or utilization trends that require management.

Actions Needed to Achieve Milestone #2

Action Needed	Timeline
Update OBH licensing regulations	Completed August 2020
Update RAE contracts to include new services and UM of services	December 2020
Implement training and technical assistance to align providers with ASAM standards	February 2020 and ongoing
RAE development of UM policies and procedures	August 2020
State review of UM policies and procedures and provision of feedback to the RAEs	October 2020
Begin UM process for residential placements	January 2021
Begin internal monitoring of benefit according to initial monitoring plan currently in development	January 2021

Communicate changes to providers	Ongoing

Milestone #3: Use of Nationally-Recognized SUD-Specific Program Standards for Residential Treatment Facility Provider Qualifications

CMS Specifications:

- Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualifications should meet the program standards in the ASAM Criteria or other nationally recognized, evidence-based SUD-specific program standards regarding the types of services, hours of clinical care, and credentials of staff for residential treatment settings
- Implementation of state process for reviewing residential treatment providers to assure compliance with these standards
- Requirement that residential treatment facilities offer MAT on-site or facilitate access off-site

Colorado's Response:

The state recently updated licensure regulations for residential treatment providers to fully align with ASAM standards. Regional Accountable Entities (RAEs), Managed Service Organizations (MSOs), and the state will work together to ensure residential treatment provider compliance with the newly updated regulations and contract requirements, including providing onsite, or facilitating offsite, access to MAT services.

A. Implementation of Residential Treatment Provider Qualifications (in Licensure Requirements, Policy Manuals, Managed Care Contracts, or Other Guidance)

Current State:

Licensure Requirements

The Colorado Office of Behavioral Health (OBH) is responsible for licensing residential treatment providers in the state. Licensing regulations include standards on staffing, admissions, data collection and reporting, quality improvement, application and revocation of a license, license expiration, background checks for staff, use of records, service plans, type of care provided, and rules specific to special populations such as adolescents. These regulations were revised in August 2020 to directly align with ASAM levels of care. Under the new rules, providers are being issued licenses associated with each ASAM level of care they provide.

Managed Care Contracts

Managed care contracts between the state and the RAEs currently include the following provisions:

- RAEs may only enter into written contracts with behavioral health providers that are enrolled as Colorado Medicaid Providers. Note: Providers must be licensed by the OBH in order to enroll as a Colorado Medicaid Provider.

- RAEs shall ensure that all network behavioral health providers are credentialed and that the credentialing process follows NCQA credentialing and re-credentialing standards.
- RAEs must re-credential all contracted providers every three years.

Policy Manuals
The department maintains a Uniform Services Coding Standards Manual, which provides guidance on coding, documenting and reporting on services covered by Medicaid in Colorado. It also aligns coding requirements with those of the OBH for services paid through other funding sources. The manual includes instructions for providers on billing for all behavioral health services including the outpatient SUD services currently covered by Medicaid.

Future State:
Licensure Requirements
The OBH is currently requiring providers to reapply for licenses as they are defined under the new regulations. Providers must be licensed in accordance with the recently ratified rules prior to billing Medicaid for services. RAEs are aware of the rule changes and are in conversation with providers regarding any plans to relicense at a different level of care if a program is not aligned with the current licensing standards.

Policy Manuals
The SUD Residential Provider Manual, released in October 2020, covers: member eligibility, provider requirements, provider enrollment procedures, SUD benefit policies, and the roles of MSOs and RAEs in benefit management. Additionally, an update to the Uniform Service Coding Standards Manual will be published on its regular cycle in January 2021 and will include pages outlining coding instructions for the newly covered SUD services. In order to ensure that providers are informed of the appropriate coding practices for the new services prior to the benefit go-live date, the billing and coding instruction pages for the new SUD services are included in the SUD Residential Provider Manual.

Prior to residential services going live on January 1, 2021, the state will require providers to enroll with Colorado Medicaid based on their licensing level. In November, providers will enroll with the Department's Medicaid Management Information System (MMIS). In order to do so, they will submit their license and enroll under a specialty provider type associated with each level of care they are licensed to provide. Billing rules require providers to code services by level of care which must match the specialty provider type for that level of care.

Other Guidance
In addition to communicating provider requirements through policy manuals, the Department conducted two provider trainings in October 2020. The trainings included content on: Medicaid coverage across the SUD continuum, ASAM Criteria and medical necessity, utilization management procedures, provider requirements, SUD provider licensing, provider enrollment, the roles of the RAEs and MSOs and MAT requirements. These trainings were recorded and are being made available online to providers to reference in the future.

Managed Care Contracts
Managed care contracts currently only allow RAEs to contract with providers enrolled with Medicaid. In order to enroll with Medicaid, providers must be licensed under the current rules. With the recently ratified OBH rules for SUD providers, RAEs will only be contracting with providers that are licensed according to rules that align with the levels of care as defined by ASAM.

B. Implementation of State Process for Reviewing Residential Treatment Provider Compliance with Standards

Current State: In order to license as an SUD Provider, providers submit an application to the OBH. After review of the application, the OBH conducts a site visit, which involves review of policies and procedures, touring the facility, reviewing local fire inspections to assure compliance with fire and safety codes, and examining local zoning ordinances to ensure compliance.

Licensure of facilities by the OBH also involves verification of credentialing for individual medical or counseling practitioners who work in these facilities. Colorado uses federal standards for screenings based on provider type risk level. The OBH verifies licenses and conducts site visits for moderate- and high-risk providers. The state also requires a fingerprinting process for provider owners with more than 5% ownership.

SUD Provider licenses are valid for two years. The OBH investigates critical incident reports and complaints, which can result in licensure status changes such as revocation or probation. Provider compliance with current regulations is enforced through the OBH, that takes appropriate actions when residential treatment providers have complaints filed against them or fall short of meeting requirements.

Future State: Since the ratification of licensing rules that align with ASAM Criteria, the OBH licensure process will ensure that providers are offering services consistent with the levels of care. Programs will be further reviewed for compliance with those licensure standards through the RAE credentialing process. Contracts between RAEs and providers will include specifics pertaining to ASAM requirements.

C. Implementation of Requirement that Residential Treatment Facilities Offer MAT Onsite or Facilitate Access Offsite

Current State: The state currently has 26 opioid treatment programs (OTPs) that offer methadone, with most also offering buprenorphine. This is an increase of 15 providers compared to four years ago. The state also has 1,200 new X-waivered providers and is working to create more. There are roughly 7,000 people receiving MAT through a state licensed OTP and another 9,300 people receiving MAT through an X-waivered provider. The OTP statewide

census and those receiving MAT through X-waivered providers have both increased more than 50% since January 2017.

MSOs currently direct residential treatment providers to be "MAT-friendly." RAEs do not have any requirements regarding residential treatment providers and MAT services, as residential treatment is not a covered service at this time.

Future State: Contract language effective January 1, 2021 pertaining to MAT in residential facilities requires RAEs to review policies and procedures of inpatient SUD services and residential SUD services programs to ensure that they provide onsite access, or facilitate offsite access to medication assisted treatment services. The state is currently developing a toolkit to support providers in facilitating access to MAT.

Actions Needed to Achieve Milestone #3

Action Needed	Timeline
Relicensing of providers based on updated OBH regulations; OBH responsible	December 2020
Implement training and technical assistance to align providers with ASAM standards	October - December 2020
Update RAE contracts to reflect residential provider requirement changes, including requirements related to providing access to MAT.	Draft revisions complete. Contracts will be in place by November 2020.
MMIS system changes to allow for enrollment of providers by ASAM level	Complete
Colorado Medicaid enrollment portal opens for SUD providers	Complete (Opened November 5, 2020)
Publish SUD Residential Provider Manual	Complete (October 2020)
Publish updated Uniform Services Coding Standards Manual with billing and coding requirements for new services	January 2021

Milestone #4: Sufficient Provider Capacity at Critical Levels of Care, Including MAT

CMS Specifications:
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients at the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT.

Colorado's Response:
The State has completed a provider capacity assessment and is actively developing strategies to further expand provider capacity in the state.

Current State: In preparation for submission of the state's 1115 SUD demonstration application, the Department undertook a provider capacity assessment in 2018 to assess the availability of providers across the state to deliver the expanded set of SUD treatment services. The surveys helped inform state planning and preliminary discussions of the waiver.

In 2019, the State:

- Developed a series of maps depicting the current demand for SUD services, represented by SUD diagnoses among Medicaid members and the existing treatment programs across the state. Those maps appear on the following pages.
- Conducted 12 regional meetings across the state to gather qualitative data about the accessibility of SUD treatment in various regions.
- Convened the SUD Capacity Workgroup comprised of RAEs, MSOs, OBH, and Department representatives to review the available information on SUD service capacity and develop a plan for addressing capacity deficiencies where they exist across the SUD continuum.

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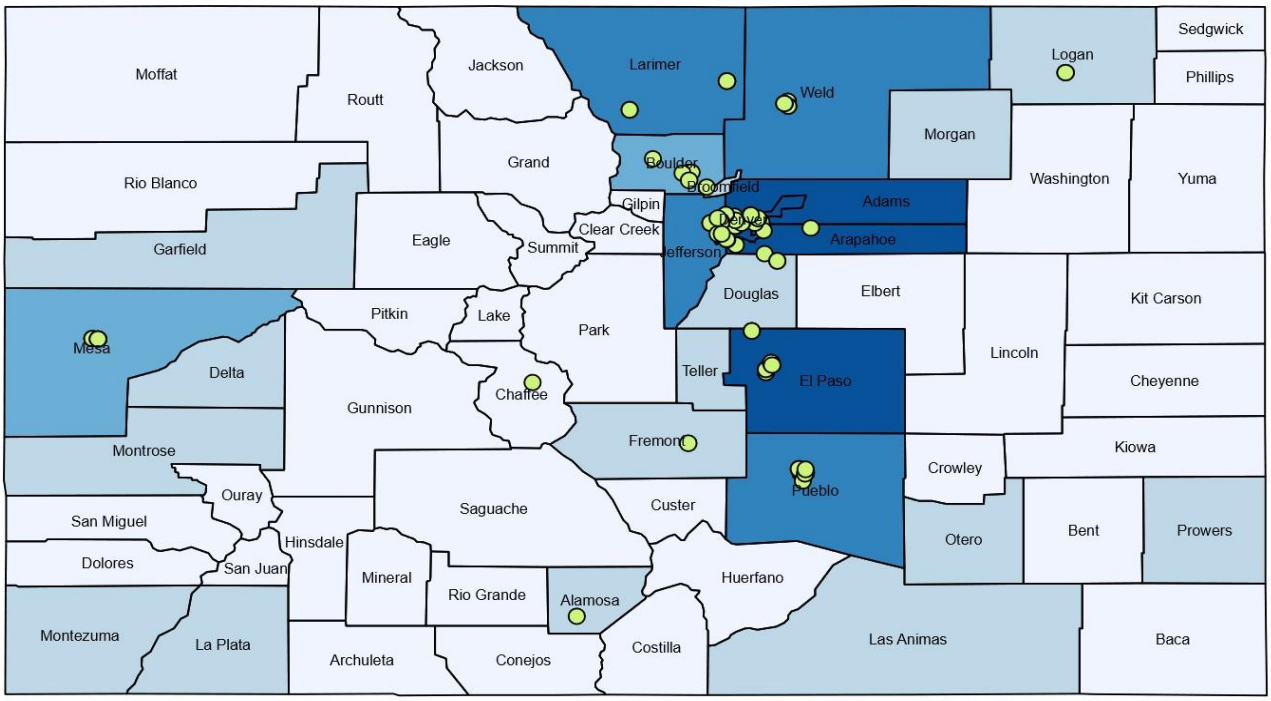
COLORADO
Department of Health Care Policy & Financing

Number of Unique SUD Clients by County and All SUD Providers for Levels 3.1, 3.5 and 3.7 State Fiscal Year 2018-2019



The client data represented in this map was retrieved from the Department of Health Care Policy and Financing Department Decision Support System. SUD Clients are defined by the presence of an SUD related Primary or Secondary Diagnosis code on a claim at least once during the 2018 - 2019 State Fiscal Year.

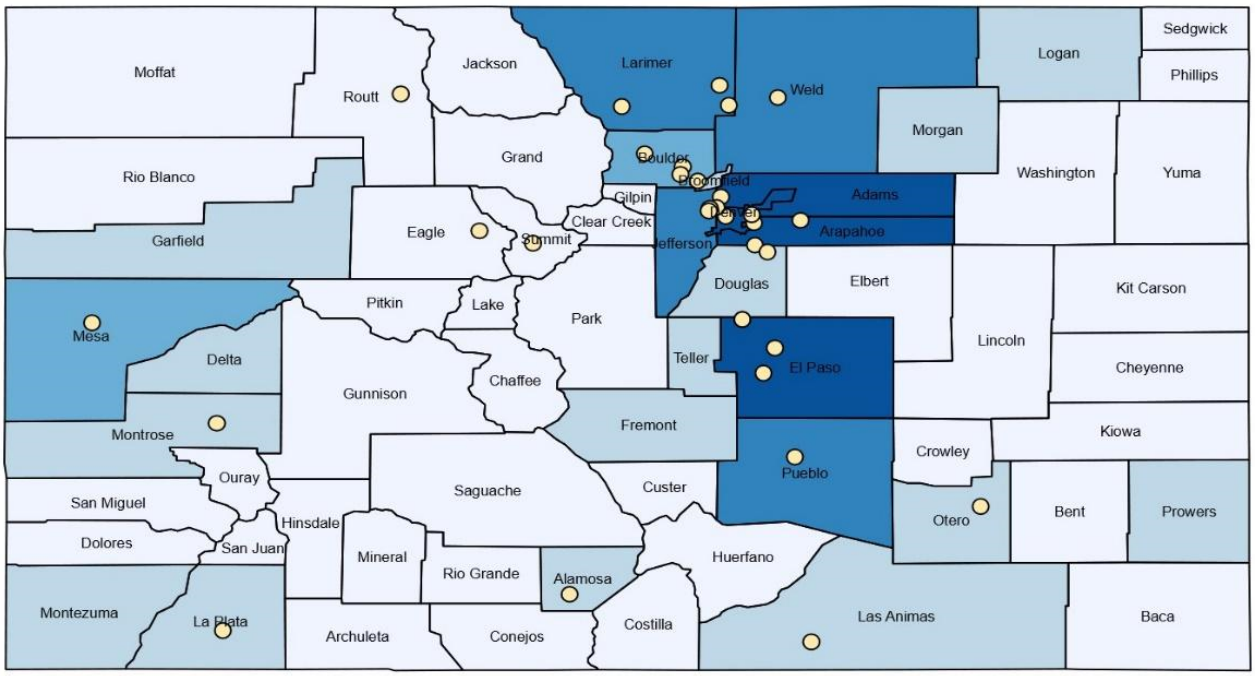
Project Tracking #: 8555 Map Created on: 6/3/2020

In Colorado, there are approximately 1,180 community-based residential substance use treatment beds and another 416 correctional beds. That estimate equates to one bed per 2,750 individuals. In addition, there are another 629 withdrawal management, or detox, beds. Treatment provider facilities are represented as yellow dots on the map above.

	Treatment Capacity by ASAM Level						
ASAM Level	**3.1**	**3.3**	**3.5**	**3.7**	**3.2 WM**	**3.7 WM**	**Correctional**
Number of Beds	323	0	603	252	423	206	416

COLORADO
Department of Health Care Policy & Financing

Number of Unique SUD Clients by County and All SUD Providers for Levels 3.2WM and 3.7WM State Fiscal Year 2018-2019



The client data represented in this map was retrieved from the Department of Health Care Policy and Financing Department Decision Support System. SUD Clients are defined by the presence of an SUD related Primary or Secondary Diagnosis code on a claim at least once during the 2018 - 2019 State Fiscal Year.

Number of SUD Clients

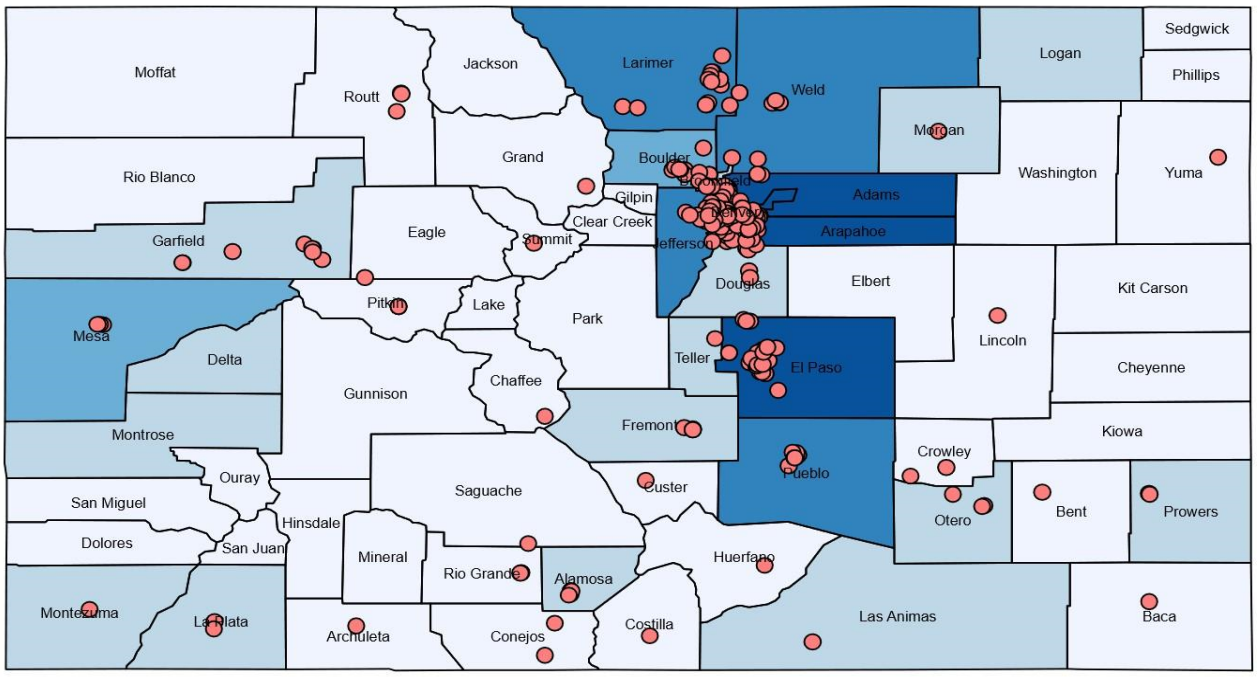
0 - 500
501 - 2,500
2,501 - 5,000
5,001 - 10,000
10,001 - 20,000

Project Tracking #: 8555 Map Created on: 6/3/2020

Colorado has 629 withdrawal management beds, with a 2:1 ratio of 3.2 WM to 3.7 WM. The majority of these Level 3.2 WM beds, about 380, are available to Colorado Medicaid members. Of the 23 Level 3.2 WM facilities, ten facilities comprising almost 100 beds lie outside the Front Range. While there are facilities outside of the I-25 corridor, access to those facilities is limited for several reasons including: several programs do not accept Medicaid members, several do not accept unscheduled admissions, the facility in Frisco has operated intermittently.

COLORADO
Department of Health Care Policy & Financing

Number of Unique SUD Clients by County and NonCorrectional SUD Providers for Level 2.1 State Fiscal Year 2018-2019



The client data represented in this map was retrieved from the Department of Health Care Policy and Financing Department Decision Support System. SUD Clients are defined by the presence of an SUD related Primary or Secondary Diagnosis code on a claim at least once during the 2018 - 2019 State Fiscal Year.

Project Tracking #: 8555 Map Created on: 6/3/2020

The map of IOP providers shows that they are more evenly distributed across the state than residential providers. While the map demonstrates this, stakeholders reported during regional meetings that IOP capacity is lacking throughout the state, even in populated areas. Stakeholders noted that maintaining IOP programs in less populated areas is a challenge due to workforce shortages.

Future State:

The State and its SUD Capacity Workgroup are currently in the process of reviewing findings and developing a plan to facilitate capacity expansion where needed. RAEs will be a critical part of the effort to expand provider networks and grow capacity. The Department's contracts with the RAEs require them to comply with network adequacy requirements, and those requirements are independently audited through a contract with Health Services Advisory Group (HSAG). These requirements will include having a complete continuum of SUD care, across all ASAM levels, for members attributed to their region. We also anticipate that a new, sustainable payor for these services will drive existing providers to increase available beds and new providers to enroll in Medicaid. In addition to Medicaid payments for residential and

inpatient SUD care driving expansion of capacity for these services, several other resources may be utilized to support capacity expansion. These are discussed below.

First, the state has an initiative underway to improve bed tracking capabilities. The 2019 legislature passed HB 19-1287, a bill that creates an electronic bed tracking system which will allow for real-time bed availability in the state. The system will initially be updated through provider self-reporting, and site visit audits will validate alignment with reported bed numbers and revised rules. HB 19-1287 also created a Care Navigation Program and assigns OBH and the Department the responsibility for ensuring care transitions.

Second, this same state bill also appropriated $5 million in funding for OBH to support rural and frontier SUD capacity expansion. While funding was disbursed in 2019 to awardees for expansion of treatment services, the program was suspended for fiscal year 2020-21 because of state budget shortfalls resulting from COVID-19. Budget assumptions pertaining to the Medicaid SUD benefit were adjusted at the same time to account for a slower ramp-up of capacity.

Third, through the state's Hospital Transformation Program, a rural hospital fund has been created. One of the allowable uses of funds is to expand bed capacity specifically for SUD services, especially in areas where there are no services available at a particular level of care. HTP will begin in February 2021, coincident with the SUD benefit program launch.

Fourth, the state has undertaken an X-waiver provider recruitment program entitled "IT MATTTRs." Colorado used SAMHSA State Targeted Response (STR) to the Opioid Crisis and State Opioid Response (SOR) grant funding to expand the MAT capacity of the state. The program has provided X-waiver training at no cost to providers. Funds also support onsite practice implementation training at participating health clinics. Nationally, a barrier that impedes MAT expansion is provider apprehension about initiating MAT in their practice. In order to address this issue, IT MATTRSs offers regular telephonic training forums where an experienced MAT provider offers real time support to newly waivered providers across the state. To date, there have been 244 participants in these forums.

Finally, in addition, legislation passed in 2019 will expand MAT access. HB 19-001 provides grant funding for MAT expansion pilot programs specifically targeted in communities with limited access, targeting the 15 out of 64 counties in the state that do not currently have a MAT provider.

Actions Needed to Achieve Milestone #4

Action Needed	Timeline
Convenings of the Provider Capacity Work Group	September 2019 – Ongoing

OBH go-live of electronic bed tracking system	January 2021
Hospital Transformation Program bed capacity expansion	Application opens February 2021
IT MATTrs (X-waiver training)	Ongoing

Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies

CMS Specifications:

- Implementation of opiate prescribing guidelines along with other interventions to prevent opioid abuse;
- Expanded coverage of, and access to, naloxone for overdose reversal; and
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs.

Colorado's Response:

Colorado has numerous efforts underway to address opioid abuse and OUDs, including state and federal partnerships and the state's Consortium for Prescription Drug Abuse Prevention (the Consortium), which facilitates a robust public/private partnership centered around a variety of prevention and treatment strategies. The Department leverages its sister agencies and other statewide community organizations to achieve the goals and milestones of this section.

Colorado's efforts that are most relevant to Milestone #5 are summarized below.

A. Implementation of Opioid Prescribing Guidelines Along with other Interventions to Prevent Opioid Abuse

Current State:

Opioid Prescribing Guidelines

Colorado Medicaid has taken a number of steps over the past five years that have resulted in a more than 50% reduction in the number of opioid pills prescribed and a 44% reduction in the number of Medicaid members taking opioids. Those policy initiatives have been aimed at reducing the number of opioids prescribed to members, tightening criteria when requesting refills, and reducing the daily Morphine Milligram Equivalents (MME) members can take – all while continually ensuring members receive necessary medications for adequate pain management.

Other state efforts to prevent opioid abuse include:

- A helpful guide containing research and a list of resources is maintained by the OBH and can be found here.
- Colorado's Lift the Label campaign has set a goal of reducing the stigma that prevents those with opioid use disorder from seeking treatment.
- The state's Prescription Drug List (PDL) provides guidelines for all Medicaid-related prescription drugs, including those that require prior authorization.

- A Drug Utilizations Review (DUR) board serves in an advisory role to the Department and makes recommendations on drug utilization, provider education, and application of standards. A pain specialist sitting on the DUR board determines the prior authorization criteria for drugs with special prescribing guidelines such as those that don't make the state's PDL.[4]

One of the recent initiatives of the DUR was to inform providers of how they compare in Medicaid opioid prescribing patterns to those of their peers.

Other Interventions to Combat SUDs
To date, Colorado has received two grants from SAMHSA for purposes of combatting the SUD crisis:[5]

State Targeted Response (STR) Grant
SAMHSA provided $15.7 million to the state for the period May 2017 - April 2019. The state used the STR grant to:

- Conduct a state SUD needs assessment that identified areas where opioid misuse and its harms are most prevalent, what existing activities and funding sources are in place to address the opioid crisis, and gaps in the existing system that need to be addressed;
- Provide MAT services to 1,947 individuals, 481 of whom received MAT before or upon release from jail;
- Train 530 prescribers to provide buprenorphine;
- Connect 596 individuals to Peer Recovery Coaches; and
- Distribute 27,027 naloxone kits throughout the state.

State Opioid Response (SOR) Grant
SAMHSA provided $41 million to the state in a second round of funding for the period September 30, 2020 - September 29, 2021. The state will utilize these funds for the following purposes:

Prevention

- Implement family services utilizing the Community Reinforcement and Family Training (CRAFT) model
- Implement culturally responsive prevention programming for American Indian/Alaska Native students

Treatment

- Increase MAT access for uninsured and underinsured Coloradans
- Expand evidence-based treatment program for stimulant use disorder

[4] https://www.colorado.gov/pacific/hcpf/drug-utilization-review-board
[5] https://www.colorado.gov/pacific/cdhs/colorado-state-targeted-response-opioid-crisis

- Place mobile health units for MAT induction in rural areas
- Fund residential treatment services for underinsured and uninsured
- Employ peer navigators to connect clients to treatment
- Provide tools to Colorado hospitals to support MAT initiation within emergency departments as well as disseminate protocols to reduce the use of opioids for treatment of pain
- Implement Practice Improvement Program to support X-waivered prescribers
- Support staff for the Colorado Crisis Hotline
- Implement services identified through a needs assessment for three tribal communities
- Implement MAT in jails

Recovery

- Implement employment services utilizing Individual Placement and Support (IPS) model
- Increase access to peer recovery services at Recovery Community Organizations
- Expand Recovery Housing funding
- Incorporate recovery-based questions on the Behavioral Risk Factor Surveillance System

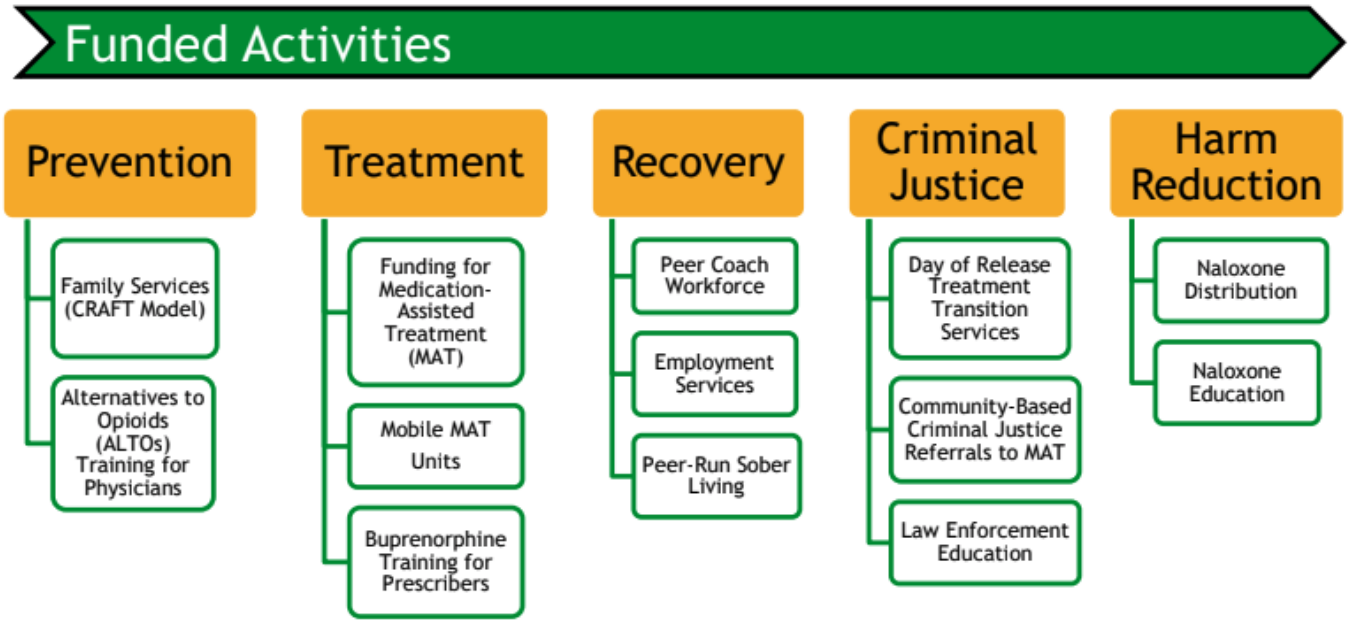
Harm Reduction

- Naloxone distribution
- Increase access to STI/HIV/HCV testing and syringe exchange for people who inject drugs

Communications and Outreach

- Lift the Label and Colorado Crisis Line marketing campaigns to refer people to treatment
- Community outreach about resources available to address the opioid crisis and community concerns

A visual summarizing SAMHSA grant-funded activity is below:



Marijuana Tax Revenue

Since authorizing medical marijuana use in 2000 and personal marijuana use in 2012, Colorado has collected three types of taxes on marijuana: the state sales tax, a special sales tax, and an excise tax. The taxes generate millions of dollars in revenue for the state, which is used for a variety of health, human services, public safety, and higher education programs and initiatives. Some funds are specifically dedicated to SUD treatment and services, including:

- Training for health professionals who provide Screening, Brief Intervention, and Referral for Treatment (SBIRT) services for individuals at risk of substance abuse;
- Increasing access to effective SUD services, including evaluation of intensive residential treatment (the study conducted in conjunction with the authorizing legislation for this demonstration);
- Implementing programs for adults with co-occurring mental health conditions and SUDs;
- Providing behavioral health services for individuals in rural areas with co-occurring mental health conditions and SUDs;
- Implementing community prevention and treatment for alcohol and drug abuse;
- Providing SUD services at mental health facilities; and
- Promoting substance abuse prevention through public awareness campaigns.

Colorado Consortium for Prescription Drug Abuse Prevention

In addition to the activities above, Colorado is working to continue to reduce opioid prescriptions and reduce stigma. During his tenure as governor, Governor John Hickenlooper led an effort to create a workgroup focused on cross-agency ways to address the opioid epidemic. The resulting Colorado Consortium for Prescription Drug Abuse Prevention (Consortium) has grown with a wide range of stakeholders participating in numerous work

groups designed to address the opioid crisis. The Consortium's 2019 Annual Report outlines the accomplishments and future projects which include the placement of 162 safe medication disposal boxes throughout the state, training medical providers on safe opioid prescribing, tracking prescriptions through the PDMP and increasing access to naloxone and MAT.

Future State: The Department has contracted with OpiSafe to provide the opioid risk metric tool for Medicaid providers, which includes:

- Easy access to Prescription Drug Monitoring Program (PDMP) data,
- Identification of Opioid Use Disorders (OUD),
- Educational tools with access to evidence-based treatment,
- Tools for overdose prevention, and
- Provides tracking for health systems and states.

The opioid module will be operational in January 2021. Additionally the Department is initiating a subsidy program where 5,000 user licenses will be provided free of charge to qualified Medicaid prescribers. In collaboration with OpiSafe, HCPF will identify and reach out to high impact prescribers for the subsidy program. HCPF is also partnering with external stakeholders, such the Colorado Pain Society and the Colorado Hospital Association to further identify high impact prescribers suitable for the subsidy program. Any Medicaid prescriber will be able to apply for a subsidized license via an online request form which will be activated by the end of December 2020.

In addition, the state will continue to build on all activities described in the current state section, with an emphasis on monitoring and improving prescribing guidelines based on the latest science and informed by the state's DUR.

B. Expanded Coverage of, and Access to, Naloxone for Overdose Reversal

Current State: In April 2015, Colorado passed Senate Bill 15-053, expanding access to the life-saving drug naloxone, which is used to reverse overdoses to narcotic drugs, such as certain prescription medications and heroin. As a result of the 2015 law, a physician — or any medical professional with prescriptive authority — can write a standing order for naloxone that can be dispensed by other designated individuals (such as pharmacists and harm reduction organizations).

With these standing orders, pharmacists and harm reduction organizations can provide naloxone to those who might benefit from it the most, including:

- A family member, friend, or other person in a position to assist a person at risk of overdose
- An employee or volunteer of a harm reduction organization
- A first responder
- An individual at risk of overdose

Pharmacies can contact the Colorado Department of Public Health & Environment (CDPHE) to request a standing order for naloxone prescriptions. These standing orders are intended for pharmacies that do not have their own medical providers. Those who do have affiliated medical providers should use their prescriptive authority and signature to create their own standing orders.[6]

Colorado has other efforts underway that facilitate access to overdose reversal medications, led by the Consortium, who:

- Through a partnership with OBH, purchased 6,500 naloxone kits with nearly 3,600 kits distributed through October of 2018;
- Facilitated reporting of 439 successful naloxone reversals through the OpiRescue smartphone app since May 1, 2017;
- Trained and equipped 183 law enforcement departments in Colorado to administer naloxone;
- Equipped five county jails to dispense naloxone to inmates upon release;
- Increased the number of pharmacies with standing orders to distribute naloxone;
- Increased collaboration with Walmart, King Soopers, and Walgreens pharmacies;
- Trained AmeriCorps members to become trainers to provide overdose awareness and naloxone education and distribution in their assigned regions;
- Travelled extensively around state for community coalition building and overdose awareness education; and
- Received $335,000 from the Colorado Legislature to expand community-based naloxone education and expand programs for law enforcement.

In addition, the OBH provides Community Reinforcement and Family Training (CRAFT) “train the trainer” classes to help spread this model of support for family members which emphasizes building resilience and teaching treatment strategies. At the end of the training, newly-trained facilitators are issued naloxone kits.

As part of the state’s SOR grant, the OBH also facilitates naloxone distribution programs in jails and schools. OBH has supported the distribution of naloxone in various ways for the past four years. Initially, OBH dedicated state funding aimed at jail-based SUD treatment services to provide naloxone training and medication to at-risk people upon release from incarceration. SAMHSA STR and now SOR funds have been used to expand this to many other high-risk populations. Colorado has standing orders laws that are operationalized through the Colorado Department of Public Health and Environment (CDPHE). The OBH worked with their MSOs to make Narcan Nasal Spray available to all syringe access programs, withdrawal management providers, and treatment programs serving those with opioid use histories. Other organizations, such as first responders or schools, and even public libraries have also utilized this program. More recently, the Naloxone for Life program that was established in 2017 by the State Attorney General Cynthia Coffman, has been supported with OBH funding. This program

[6] https://www.colorado.gov/pacific/dora-pdmp/resources-pdmp

provides Narcan Nasal Spray to law enforcement agencies throughout Colorado. The initial supply of naloxone was from the Attorney General's office, but since the Spring of 2019, OBH has supported replacement doses, or initial supplies for newly adopting law enforcement agencies. Since the beginning of the STR grant, OBH has distributed nearly 40,000 naloxone kits, and had over 1,500 overdose reversals reported using naloxone purchased with SAMHSA grant funds.

Future State: The Consortium's Harm Reduction Work Group has several initiatives underway in 2020, related to developing naloxone training videos, planning educational trainings for pharmacists around safe opioid prescribing, overdose awareness, and naloxone dispensing, and broadening syringe access throughout Colorado.

In addition, the 2019 Colorado legislature created a statewide naloxone bulk purchasing program through SB 19-227. This fund established by CDPHE will allow organizations to buy naloxone at discounted rates. The legislation also appropriated funding to defer the cost for most organizations, such as syringe access programs, law enforcement, or treatment programs. The OBH will dedicate future SAMHSA grant funds into this program to streamline the process for organizations looking to distribute naloxone to at risk people.

C. Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs

Current State: The states' Prescription Drug Monitoring Program (PDMP) is a program run through the Department of Regulatory Agencies (DORA) and governed by the Board of Pharmacy. The PDMP helps prescribers and dispensers reduce prescription drug misuse by allowing them to make more informed decisions when considering prescribing or dispensing a controlled substance to a patient. The PDMP is comprised of controlled substance prescription data uploaded every regular business day through pharmacies across the state.

Historically, access to the state's PDMP has been limited to prescribers and pharmacists with registered accounts. More recently, the Colorado Department of Public Health and Environment (CDPHE) has been granted authority to access information in the PDMP to pilot provider report cards showing prescribers' opioid prescribing practices and comparing them to their peers. The report care pilot has been successful: 83% of prescribers felt that the information was new and 81% found it useful.

Future State: Enhancements and improved participation in the PDMP continues with new pharmacies and medical systems added each year and increased rates of prescriber and pharmacy use. Data from the PDMP will continue to be utilized to inform prescribing guidelines. The Board of Pharmacy is also interested in improving PDMP capabilities and participation to include state-to-state connections to the PDMP. Currently, Colorado's PDMP is connected to all contiguous states except NE and WY. The board also employs surveys and key informant interviews soliciting ideas for improving the PDMP.

Summary of Actions Needed to Achieve Milestone #5

Action Needed	Timeline
Identify opportunities for expanding PDMP functionality and use; DORA responsible	Ongoing
Increase the use of PDMP by providers and pharmacists; DORA responsible	Ongoing
Continue implementing SOR grant activities; OBH responsible	Ongoing
Continue implementing marijuana tax revenue SUD prevention-related activities; OBH responsible	Ongoing
Consortium work groups; Consortium responsible	Ongoing
Statewide naloxone bulk purchasing program; CDPHE responsible	Ongoing

Milestone #6: Improved Care Coordination and Transitions between Levels of Care

CMS Specifications:
Implementation of polices to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.

Colorado's Response:
Colorado is working to ensure that there is a full continuum of care in place in order to effectively serve beneficiaries with SUDs. The Department is working closely with the RAEs and other state agencies to ensure that members receive services along the continuum that are appropriate to their needs and that transitions between levels of care are supported through care coordination.

Current State: The RAEs administer a continuum of outpatient SUD services and facilitate care coordination for members receiving SUD treatment services. Care coordination is overseen by the RAEs and MSOs utilizing a variety of care providers and support services.

Managed Care Contracts and Policies
Current RAE contracts require coordination of services for members between transitions of care and collaboration with MSOs and other agencies to reduce duplication of services and improve member experience.

Under the current system, even though RAEs are not responsible for coverage of residential or inpatient SUD services, they are responsible for facilitating care coordination for members as they leave those levels of care. These services may include:

- Outreach while still in placement or immediately after;
- Arranging for follow-up appointment within seven days of discharge;
- Establishing an initial connection with care coordination staff at community-based facility;
- Medication reconciliation to prevent errors; and
- Provision of clinical information to care coordinator for follow-up and continuity of care.

Other care coordination services provided by RAEs varies by region, though all RAEs report to the state on their specific activities. Generally speaking, RAE care coordination activities include:

- Co-location of care coordinators in behavioral health facilities;

- Availability of coordinators via phone (call and text), email, mail, or in-person;
- Facilitation of needs assessment and individualized goal-setting;
- Referral to health providers and community resources addressing social determinants of health;
- Appointment reminders;
- Medication follow-up;
- Education about navigating systems, coping skills, crisis management, etc.;
- Attending appointments (health and non-health) with members when necessary;
- Safety planning with high-risk members;
- Attending operations meetings at provider locations to talk through complex cases; and
- Care managers that work with individual care coordinators.

Other State Efforts
In addition, both the Medicaid benefit and the OBH-funded services for uninsured include coverage for Peer Recovery Support Services. Peer support services provide needed support to individuals working to maintain their recovery and can be especially helpful to those transitioning between levels of care.

Future State:
Managed Care Contracts and Policies
As the RAEs transition to managing the full continuum of SUD services for all members, they will be in an optimal position to coordinate care during transitions from one level to another. In addition to current RAE contract language that outlines expectations for care coordination, the state has also directed the RAEs to develop policies that outline how they will conduct care coordination for the following:

- Members discharging from residential or inpatient SUD services receive comprehensive support as they transition to lower levels of care and;
- Members awaiting treatment at a facility where no bed is available at the time of referral are provided with interim services.

RAE care coordination policy drafts are currently under review by the Department. The Department has an existing process for monitoring the RAEs care coordination activities through deliverables. The Department is in the process of ensuring that the population of members receiving SUD services are incorporated into that monitoring strategy.

Additionally, the SUD Implementation Workgroup is exploring opportunities for care coordination activities to address gaps and needs in treatment and recovery support.

Other State Efforts
Legislation enacted in 2019 specifically addresses the need for improved care coordination and navigation services for individuals with SUD. HB 19-1287 creates a Care Navigation Program and assigns OBH and HCPF responsibility for ensuring care transitions, including the hiring of a staff person to facilitate implementation of the law. Legislation includes a requirement for a 24/7

crisis hotline, encourages the use of peer support specialists, and creates mechanisms for ensuring that individuals receive care coordination through the staff person hired to implement the initiative. Due to state budget impacts related to COVID-19, implementation of HB19-1287 is subject to available appropriations.

Additionally, the state will be implementing a new care coordination program through the OBH, the Hospital Follow-Up Program. This program will work with hospitals across the state to identify individuals who have experienced a mental health or substance use crisis involving suicidal ideation and could benefit from additional support. Individuals will be paired with a trained crisis or peer support specialist to ensure they continue care, begin outpatient treatment and receive support during a period of heightened risk.

Summary of Actions Needed to Achieve Milestone #6

Action Needed	Timeline
Collaboration with the RAEs to enhance care coordination activities through the Implementation Work Group	January 2021 – Ongoing
RAE policy development to ensure adequate care coordination across the SUD continuum	October - December 2020
Certify recovery residences; Office of Behavioral Health	January 2020 – Ongoing

Attachment A – Template for SUD Health Information Technology (IT) Plan

The following table is a component of Milestone 5, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP.

Prescription Drug Monitoring Program (PDMP) Functionalities			
Milestone Criteria	**Current State**	**Future State**	**Summary of Actions Needed**
Enhanced interstate data sharing to better track patient specific prescription data	Colorado shares data with 33 states through the PMP InterConnect hub, including contiguous states Kansas, Oklahoma, New Mexico, Arizona, Utah and Wyoming. Colorado also shares data through the RxCheck hub with Kentucky, Utah (both hubs), Washington (both hubs) and is in progress with Nebraska. Currently, healthcare organizations with an integrated (API using PMP Gateway) connection to the PDMP have more limited interstate access. Each integrated entity must be approved by other states' PDMPs for access.	Data sharing with additional states will be pursued, but data sharing agreements are contingent on other states' processes and policies for interstate data sharing.	Security enhancements for Colorado's integrated users are being pursued, which will require all integrated users to be validated against the CO PDMP (PMP AWARE) user account list to successfully access the PDMP through an integrated connection (direct EHR connection, e-prescribing software, HIE connection). Expanded interstate access for integrated healthcare entities leveraging reciprocal agreements with other states to approve out of state healthcare entities for PMP Gateway access will be pursued once the security enhancements are implemented.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	Direct PDMP integrations with EHRs, pharmacy management systems and e-prescribing software allow the user to query the PDMP directly within their workflow. All major Colorado pharmacies and approximately 5,000	Prescribers and pharmacies will continue to integrate their electronic health technology with the PDMP.	Integration mini-grants will be offered in fall 2020 to cover the planning and/or implementation costs of PDMP integration, funded by Overdose Data to Action grant (CDPHE is recipient,

	prescribers currently have integrated access through the PMP Gateway. Those without an integrated connection must log in to the PMP AWARE website to query the PDMP. Prescribers and pharmacists can authorize up to three delegates to search the PDMP on their behalf. Delegate access is only in place for the PMP AWARE website.		DORA is sub-recipient through an interagency agreement). The exact number of integration grants is dependent upon available funding with awards anticipated to be at the $5,000, $15,000 and $30,00 level. Organizations in rural or high-burden counties will receive higher priority in the application scoring process.
Enhanced connectivity between the state's PDMP and statewide, regional or local health information exchanges	Pilot projects for QHN and CORHIO funded by CDPHE completed an integrated PDMP connection through PMP Gateway within the HIE portals in March 2018 for CORHIO and in May 2018 for QHN. CORHIO integrated the PatientCare 360 portal for urgent care facilities, QHN implemented an integrated PDMP connection through PMP Gateway for St. Mary's Hospital, which offers single sign-on access to the QHN portal and PDMP can be accessed through the QHN portal. Colorado is sharing data with Nebraska, which operates its PDMP through the state HIE. Access to Colorado PDMP data for Nebraska is currently limited to	Other state HIEs may be considered for interstate access, subject to other states' HIEs requesting access, confirmation that other state HIEs do not download or store PDMP data, and the development of a reciprocal framework for approval of out of state integrated healthcare entities once Colorado implements the aforementioned security enhancements for PMP Gateway integrations.	See "future state" response.

	pharmacists and their delegates because Nebraska law varies from Colorado for prescribers.		
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns (see also “Use of PDMP” #2 below)	Colorado sends prescriber scorecards, which compare a prescriber’s controlled substance prescribing habits to their peers in the same healthcare specialty as well as Patient Alerts, triggered by patients meeting the state’s confidential multiple provider/multiple pharmacy threshold. Section 12-280-404(9), C.R.S. states: Reports generated by the program and provided to prescribing practitioners for purposes of information, education, and intervention to prevent and reduce occurrences of controlled substance misuse, abuse, and diversion are: 1. Not public records under the "Colorado Open Records Act", part 2 of article 72 of title 24; 2. Not discoverable in any criminal or administrative proceeding against a prescribing practitioner; and 3. Not admissible in any civil, criminal, or administrative proceeding against a	Additional enhancements may require legislative or rule changes.	

	prescribing practitioner.		

Current and Future PDMP Query Capabilities			
Milestone Criteria	**Current State**	**Future State**	**Summary of Actions Needed**
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	The PDMP vendor is Appriss, who has shared the patient matching algorithm has a 99.5% success rate.	Further enhancements are not being considered at this time.	

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Milestone Criteria	**Current State**	**Future State**	**Summary of Actions Needed**
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the	HB 14-1283 expanded authorized access to allow a prescriber or pharmacist to authorize up to three delegates to search the PDMP on the prescriber's or pharmacist's behalf. Direct EHR integrations, integrations with electronic prescribing software and integrations with HIEs that also offer single sign-on access to PDMP data, which are dependent on specific	Further enhancements are not being considered at this time, however, PDMP integration mini-grants will reimburse approximately 25-30 healthcare organizations with integration implementation costs.	

issues which follow	businesses/facilities, often allow providers to access the PDMP in a single click within the patient's chart.		
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	This is dependent on the PDMP access method/facility or practice setting for prescribers as described above.	Further enhancements are not being considered at this time; however, expanding PDMP access to delegates allows staff working for prescribers to access PDMP reports on the provider's behalf and competitive PDMP integration mini-grants will reimburse healthcare organizations with integration implementation costs in the near future. Additionally, the Board has approved over 230 PMP Gateway licenses for Colorado healthcare organizations, covering over 700 facilities in their requests for integration, which continues to increase depending on facility/practice needs and funding.	

Master Patient Index / Identity Management			
Milestone Criteria	**Current State**	**Future State**	**Summary of Actions Needed**
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery	Prescriptions for SUD (suboxone, etc.) dispensed by a pharmacy are reported to the PDMP. SUD drugs dispensed by an entity governed by 42 CFR Part 2 are not required to report dispensations to the PDMP. Any DEA-licensed practitioner or their delegate can search the PDMP for any current patient. Clinical	The Board and Division are committed to enhancing the PDMP to best meet the needs of the state. Additional	

	decision support tools can leverage PDMP data with other data sources if connected to the PDMP and other data sets.	enhancements may require legislative or other changes.	

Overall Objective for Enhancing PDMP Functionality & Interoperability			
Milestone Criteria	**Current State**	**Future State**	**Summary of Actions Needed**
Leverage the above functionalities, capabilities, and supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately pay for opioids.	The Colorado legislature is currently contemplating House Bill 20-1085, which aims to curb inappropriate opioid prescribing, amongst other efforts.	The Board and Division are committed to enhancing the PDMP to best meet the needs of the state. Additional enhancements may require legislative or other changes.	