HMA

HEALTH MANAGEMENT ASSOCIATES

Options for Medicaid Coverage of Institutions for Mental Diseases

PREPARED FOR
COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Executive Summary

In response to Senate Enrolled Act 19-222, the Colorado Department of Health Care Policy and Financing (Department) is exploring options for securing federal financial participation (FFP) from the Centers for Medicare and Medicaid Services (CMS) for adults with serious mental illness (SMI) who require stays in Institutions for Mental Disease (IMDs). Until recently, states were prohibited from securing FFP for inpatient psychiatric stays within an IMD for adults between the ages of 21 and 64. However, today there are two avenues to securing FFP for IMD stays for individuals with SMI (and children with serious emotional disturbance or SED): 1) states may use federal "in lieu of" authority through managed care contracts, or 2) states may use an SMI/SED 1115 demonstration waiver. Both authorities allow FFP for individuals with SMI/SED receiving care in an IMD.

The primary difference between the two authorities is the length of stay (LOS) eligible for reimbursement. A stay is defined as a single episode of inpatient care, from admission to discharge. The "in lieu of" authority, codified in the 2016 Medicaid Managed Care Final Rule, covers IMD stays for up to 15 days per month. It is important to note that the LOS is calculated cumulatively by member by month; if a member has one stay or three, the cumulative total of all days during that calendar month count towards the LOS and must not exceed 15 days. The SMI/SED 1115 waiver, available since November 2018, offers FFP for individual stays of up to 60 calendar days per admission, although the waiver requires states to maintain an average statewide LOS of no more than 30 days. Additionally, the "in lieu of" authority is only available to states with managed care delivery systems.

Currently, Colorado uses federal "in lieu of" authority to cover stays for up to 15 days within a calendar month in an IMD. Due to federal Medicaid managed care regulations, stays exceeding a total of 15 days (whether consecutive or separate) within a calendar (capitation) month are not eligible to receive FFP. Therefore, the Department must recover any payments made when a Health First Colorado member stay in the IMD exceeds the allotted 15 days. In accordance with federal requirements, if a stay or combination of stays exceeds 15 days within a calendar month, the Department does not require managed care entities that administer the capitated behavioral health benefit ("managed care entities"), such as the Regional Accountable Entity (RAE) or Denver Health Medicaid Choice (DHMC), to reimburse the IMD. In alignment with federal regulations, the Department recoups all payments made for IMD stays that exceed 15 days, including any capitation or per-member per-month payments made by the Department. The Department provides prorated capitation payments to the managed care entity for the days within the month that the member was not in an IMD.

At a high level, the decision for states to pursue a waiver comes down to a set of key criteria, including the degree of need for an SMI/SED 1115 waiver to accomplish state service goals and the cost-benefit of using the waiver versus "in lieu of" authority. Additionally, in making the decision on whether to pursue a waiver, states weigh the following criteria:

- The need to minimize disparities between the fee for service (FFS) and managed care populations. States with a significant percentage of Medicaid enrollees in a FFS delivery system

may wish to leverage the waiver to assure the FFS and managed care populations have the same coverage.

- Average length of stay (ALOS) and the number of people who require longer lengths of stay. Specifically, those who exceed the 15-day benchmark and the state ALOS.
- Breadth of the community-based behavioral health system of care and service continuum.
- Availability of alternative approaches to manage the LOS and specifically, considering the state's service delivery system, the availability of the "in-lieu of" option.
- Cost and resources to manage waiver requirements, including developing the waiver as well as meeting monitoring and reporting requirements.

Most states continue to provide reimbursement to IMDs via "in lieu of" authority. This may be due to the decreased administrative burden as compared to an SMI/SED 1115 waiver paired with the fact that these states' managed care programs include a significant portion of enrollees who have a psychiatric inpatient benefit. However, states using "in lieu of" authority must ensure that the total days of a member stay do not exceed 15 days in a calendar month. To date, four states (DC, ID, IN, VT) have received approval for an SMI/SED 1115 waiver. Of these, Indiana and the District also had access to the "in lieu of" option under managed care. However, both states chose to pursue the SMI/SED 1115 waiver to address coverage disparities between their FFS and managed care populations.

According to data on one of these key criteria, the 15-day (consecutive or not)limit for FFP under "in lieu of" authority is sufficient for the majority of Health First Colorado members' individual stays. Based on Length of Stay (LOS) data provided by the Department, 7,781 unique enrollees had a stay in an IMD in state fiscal year (SFY)19 and the first half of SFY20, with 27,117 unique stays. The vast majority of stays (97.2 percent) were less than 15 days, and therefore eligible for reimbursement under the "in lieu of authority." A total of 2.7 percent, or 743 stays, exceeded the maximum length of stay eligible for reimbursement under the "in lieu of" authority. Nine of the 743 stays exceeded the SMI/SED 1115 waiver 60-day limit and would also have been ineligible for FFP.[1]

All Colorado objectives beyond allowing the state to receive FFP for Health First Colorado member IMD stays that exceed 15 days, including quality and service delivery improvement, may be achieved under "in lieu of" authority. These include:

- **Improving Quality Outcomes**. The opportunity for Colorado to achieve or improve quality outcomes is influenced by the scope of activities, programs, and services included in the state's waiver demonstration. States, like Colorado, that already have a robust continuum of prevention, crisis, and treatment services may focus on expanding access to existing services, such as inpatient stabilization, through an expanded network of providers (e.g. IMDs), rather than adding new services to their state plan or through the demonstration waiver.
    - While states must demonstrate expanded access to community-based behavioral health services where gaps currently exist to operate an SMI/SED 1115 waiver, the expansion of these benefits is not typically authorized through waiver authority. Therefore, the

[1] HCPF Rate Section Data delivered to HMA June 12, 2020.

SMI/SED 1115 waiver is not necessary to expand or modify the current behavioral health service array; these modifications can be made in the absence of the waiver.
    - Waiver activities to improve quality of care, such as requirements that IMDs follow up with individuals within 72 hours of discharge, can be implemented in the absence of an SMI/SED 1115 waiver.
    - Waiver quarterly and annual data collection and measurement requirements are significant under the SMI/SED 1115 waiver. Although they may lead to earlier identification of areas where practice improvement is needed, Colorado could undertake data improvement efforts without a waiver.

- **Leveraging Community Based Behavioral Health Services**. The SMI/SED 1115 waiver emphasizes the importance of the community-based continuum of care, but it does not require the state to add community-based behavioral health supports to the extent there is already a robust service continuum in place. Colorado can expand the continuum of community-based services, using alternative approaches to enhance access to services for individuals with SMI, and can provide intensive treatment and transitional supports without the SMI/SED 1115 waiver. This includes expanding programs currently utilized by the state, such as intensive care management and tailoring these approaches to the specific populations with longer stays.
- **Managing the Length of Stay in an IMD**. Although the waiver allows for FFP for stays that exceed the current 15 day limit under "in lieu of" authority, the SMI/SED 1115 waiver does not specify how states should manage LOS, although it does contain requirements intended to support a shorter LOS. Colorado does not require an SMI/SED waiver to implement new or enhanced mechanisms currently in place to manage LOS, such as value-based payment or episode of care reimbursement strategies. Further, the availability of FFP for additional IMD days may act as a disincentive to transition individuals to community-based care as soon as is safely possible. Notably, both the SMI/SED 1115 waiver and "in lieu of" options require managing a beneficiary's LOS, leaving a continued Medicaid reimbursement gap for longer term stays in an IMD. As noted above, Department data indicates the vast majority (97.2 percent) of individual stays in an IMD are currently reimbursable under "in lieu" of authority as they fall below the maximum allowable 15-day stay.
- **Achieving Cost Effectiveness**. Because only three states have recently approved SMI/SED 1115 waivers, data is unavailable to demonstrate if this option is cost effective, or results in greater costs or cost savings for states. While all 1115 waivers must demonstrate costs are not greater than in the absence of the 1115 waiver, because psychiatric inpatient stays may be covered under the Medicaid State Plan, CMS treats SMI/SED 1115 waiver costs as hypothetical and does not require the state to demonstrate savings. Potential cost drivers associated with the SMI/SED 1115 waiver include expansions of community-based services necessary to meet SMI/SED 1115 waiver milestones and access requirements (the state must demonstrate in the application and annually thereafter that the provider network and service array is adequate to ensure geographic and service access standards are met), and administrative costs of implementing and monitoring an 1115 waiver.

A comparison of the SMI/SED 1115 waiver and the in-lieu of option, including potential strengths and weaknesses of each, is provided in Table 4.

To date, the states that have pursued the SMI/SED 1115 waiver do not enroll their entire Medicaid population in a managed care delivery system. These states are thus unable to utilize the "in lieu of" authority across all populations, creating disparate access to IMD services between those Medicaid beneficiaries enrolled in managed care and those enrolled in FFS. This concern does not apply to Colorado because under the state's 1915(b) waiver, all full-benefit Health First Colorado members are enrolled in managed care entities, allowing the Department to utilize the "in lieu of" authority across all populations. Therefore, pursuit of the SMI/SED 1115 waiver would not expand access to the IMD benefit.

Finally, pursuing the waiver may require dedication of additional Department resources and new state costs to address the significant CMS monitoring and implementation requirements. These costs, along with federal maintenance of effort requirements to maintain community-based behavioral health treatment services funding for the duration of the waiver, may pose challenges in light of anticipated and severe state budgetary constraints stemming from the COVID-19 public health emergency.

The IMD Exclusion

Historical and Regulatory Context

The Medicaid Institutions for Mental Disease (IMD) exclusion[2] has been in place since the Medicaid program began in 1965. The IMD exclusion prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases." The statutory provisions relating to IMDs include two categories of covered services and a broad payment exclusion that excludes federal financial participation (FFP)[3] for any medical assistance under title XIX for services provided to any individual who is between the ages of 21-64 and who is a patient in an IMD. Conversely, the original Medicaid legislation included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. In 1972, the policy was expanded to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22.

The exclusion was designed to assure that states, rather than the federal government, have principal responsibility for funding inpatient psychiatric services. The law was enacted during a time when states maintained large psychiatric hospitals, which served as the primary providers of psychiatric care to patients who often experienced long lengths of stay (LOS). The IMD exclusion followed the Community Mental Health Act of 1963,[4] which provided grants to states to establish community mental health centers in an effort to deinstitutionalize individuals with mental illness as well as developmental

[2] Pub.L. 89-97
[3] Federal financial participation (FFP) is the portion paid by the federal government to states for their share of Medicaid expenditures.
[4] Pub.L. 88-164

disabilities, and was intended to further incentivize treating persons with mental health issues in the community.

Institutions for Mental Disease Definition

An IMD is defined as a hospital, nursing facility, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care for persons with mental diseases, including medical attention, nursing care, and related services. The term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases (ICD), except for intellectual disabilities, neurocognitive disorders, and organic brain syndrome. Because the ICD system classifies alcoholism and other chemical dependency syndromes as mental disorders, some substance use disorder (SUD) treatment settings can be classified as IMDs.

In addition to SUD treatment facilities, CMS recently clarified through guidance to states that the "psych under 21" exception to the exclusion is limited in its application.[5] Specifically, the guidance applies to inpatient psychiatric hospital services for individuals under age 21 furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility, commonly referred to as a "Psychiatric Residential Treatment Facility" (PRTF), that meet certain requirements. Therefore, therapeutic residential treatment settings, including Qualified Residential Treatment Programs (QRTP) defined under the federal child welfare statute, can be considered IMDs and fall under the exclusion.[6]

The CMS State Medicaid Manual provides guidance to states in determining when a facility may be considered an IMD.[7] Of note, facilities with more than 16 beds providing services other than inpatient and residential mental health and substance use services, such as personal care services, may also be considered IMDs because a key IMD determination criterion is based on whether more than half of the individuals in the facility are there because of their mental health or substance use condition. If any of the criteria laid out in the State Medicaid Manual are met, a thorough IMD assessment must be made to determine the applicability of the exclusion from payment.

The facility may be considered an IMD if:

- The facility is licensed as a psychiatric facility.
- The facility is accredited as a psychiatric facility.
- The facility is under the jurisdiction of the state's mental health authority. This criterion does not apply to facilities under mental health authority that are not providing services to persons with mental illness or SUD.

[5] CMS, Qualified Residential Treatment Programs (QRTP) and Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers, September 20, 2019 at https://www.cwla.org/wp-content/uploads/2019/09/IMD.pdf

[6] Ibid.

[7] See Part 4, Part 4, §4390 CMS State Medicaid Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927

If a facility specializes in providing psychiatric/psychological care and treatment but does not meet the criteria above, it may still be considered an IMD if:

- The facility has an unusually large proportion of staff who have specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and
- If the current need for institutionalization for more than 50 percent of all patients in the facility results from mental diseases (according to the International Classification of Diseases (ICD)).

Despite ongoing criticism of the exclusion policy, it is not likely to be repealed in the near future. In 2015, Congress considered, but did not pass, legislation to fully lift the IMD exclusion. The Congressional Budget Office (CBO) estimated at that time that doing so would cost the federal government $40-60 billion over 10 years (2016-2025).[8]

As Colorado considers the impact of the IMD exclusion on Health First Colorado (Medicaid) enrollees, providers, programs, and services, it is important to recognize the broad applicability of the exclusion and the challenges it brings in order to determine the best path forward for Colorado.

SMI/SED 1115 Waiver Overview

Between 1993 and 2009, CMS approved Section 1115 waiver demonstrations in nine states which allowed federal funds to cover behavioral health services in IMDs, essentially granting authority to "waive" the IMD exclusion. However, the IMD waivers within some of these demonstrations were largely phased out by 2009.

Following this initial wave of 1115 waivers, in March 2012, CMS selected 11 states to participate in the Medicaid Emergency Psychiatric Demonstration (MEPD), established in accordance with Section 2707 of the Patient Protection and Affordable Care Act (ACA).[9] The MEPD provided FFP for psychiatric inpatient stays in an IMD for enrollees aged 21-64. The demonstration was intended to test whether IMD reimbursement would increase the quality of care for individuals with mental illness at a lower cost. The MEPD ended on June 30, 2015. The final independent evaluation of MEPD "found little to no evidence of MEPD effects on inpatient admissions to IMDs or general hospital scatter beds; IMD or scatter bed lengths of stays; emergency department (ED) visits and ED boarding; discharge planning by participating IMDs; or the Medicaid share of IMD admissions of adults with psychiatric emergency medical conditions (EMCs). Federal costs for IMD admissions increased, as expected, and costs to states decreased. The

[8]Congressional Budget Office, *Direct Spending Effects of Title V of H.R. 2646, Helping Families in Mental Health Crisis Act of 2015, Cost Estimate* (Nov. 3, 2015).
[9] Pub Law 111–1482, U.S.C. § 18001 et seq. (2010).

extent to which these findings were driven by data limitations, were affected by external events, or reflect true effects of MEPD is difficult to determine."[10,11]

In July 2015, following the end of the MEPD, CMS announced a SUD 1115 waiver demonstration opportunity that would allow states to use Medicaid funds to cover SUD services in IMDs[12]. At this time, the guidance was clear that CMS would not consider requests for a waiver of the IMD exclusion for psychiatric stays. As of June 2020, CMS had approved SUD 1115 waivers in 28 states. In 2018, Colorado signed HB 18-1136 into law, giving the Department authority to add SUD inpatient and residential treatment benefits, including withdrawal management services, to the continuum of SUD services available to Medicaid members.[13] On October 31, 2019, Colorado submitted a SUD 1115 waiver application to CMS which is pending approval as of the date of this report.

In 2016, Section 12003 of the 21st Century Cures Act (Cures Act)[14] mandated that CMS make the SUD waiver opportunity available to states for adults with serious mental illness or children with serious emotional disturbance (SMI/SED) with an overarching goal to improve care for this population. In November 2018, CMS issued guidance on a new Section 1115 demonstration opportunity targeted at improving access to and quality of treatment for Medicaid beneficiaries with SMI/SED.[15] This SMI/SED 1115 waiver opportunity permits states, upon CMS approval of their demonstrations, to receive FFP for services furnished to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings qualifying as IMDs. As part of the demonstration, states must ensure quality care in IMDs and improve access to community-based behavioral health services.

As of June 1, 2020, there were four approved SMI/SED 1115 waivers (DC, IN, ID, VT). This report is focused on the SMI/SED 1115 waiver opportunity, as opposed to the SUD 1115 waiver demonstration. States may apply for a combined SUD/SMI/SED waiver; however, each of the two demonstration opportunities have separate goals, milestones, monitoring and evaluation requirements, and Implementation Plan structures. In Table 1, we lay out approved and pending state IMD Payment Exclusion waivers.

[10]Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report, August 18, 2016 at https://innovation.cms.gov/files/reports/mepd-finalrpt.pdf

[11] Application, implementation, and monitoring for the MEPD was different than current requirements under 1115 waivers, therefore similar costs and outcomes should not be assumed under an 1115waiver option.

[12] CMS SMD 15-003, New Service Delivery Opportunities for Individuals with a Substance Use Disorder, July 27, 2015, at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/SMD15003.pdf.

[13] Medicaid Section 1115 Waiver Demonstration Expanding the Substance Use Disorder Continuum of Care application. Accessed on May 6, 2020. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/co/co-continuum-care-pa.pdf

[14] Pub. L. 114-255

[15] CMS SMD 18-011 Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, November 13, 2018 at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf

Table 1: States with Approved or Pending 1115 Waivers with IMD Provisions[16]

1115 Waiver Provision	States with Approved 1115 Waivers	States with Pending 1115 Waivers
IMD Payment Exclusion for SUD Treatment	28 States: AK, CA, DC, DE, ID, IL, IN, KS, KY, LA, MA, MD, MI, MN, NC, NE, NH, NJ, NM, OH, PA, RI, UT, VA, VT, WA, WI, WV	Pending: 5 States: AZ, CO, ME, TN, OK*
IMD Payment Exclusion for Mental Health Treatment	4 States: DC, ID, IN VT	1 State: OK*

**Oklahoma has posted a combined SUD/SMI/SED waiver for public comment but has not officially applied to CMS.*

Federal Requirements

The SMI/SED 1115 waiver opportunity includes requirements intended to support states in achieving the goals of the demonstration program as well as specific milestones that must be achieved within the first two years of the demonstration. The waiver cannot be approved beyond an initial five-year period. States must apply for renewals prior to their waiver expiration dates to continue their demonstrations.

Populations and Facilities Excluded under the SMI/SED Waiver Demonstration

The SMI/SED 1115 waiver allows states to receive FFP for services for beneficiaries who are short-term residents in IMDs and who are primarily there to receive mental health treatment. However, the SMI/SED 1115 waiver continues to exclude FFP for the following services:

- Room and board payments in residential treatment settings unless they qualify as inpatient facilities under section 1905(a) of the Act. This limitation is a long-standing CMS policy based on statute and regulations.
- Services provided in nursing homes that qualify as IMDs. CMS guidance states that nursing homes do not specialize in providing mental health treatment and may not have staff with appropriate credentials and training to provide good quality treatment to individuals with SMI/SED.
- Services provided in treatment settings for individuals 21 years of age or younger if those settings do not meet CMS requirements to qualify for the Inpatient Psychiatric Services for Individuals under Age 21 benefit.[17]
- Services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in the facility by operation of criminal law.

Average Length of Stay and 60-Day Maximum Stay Requirements

Under the SMI/SED 1115 waiver, states are required to achieve a statewide average length of stay (ALOS) of 30 days for beneficiaries receiving care in IMDs. This is consistent with the ALOS requirement

[16] Source: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/ accessed on May 6, 2019.

[17] Of note, this prohibition appears to conflict with CMS guidance issued on September 20, 2019, indicating waiver authority is available to reimburse QRTPs which are determined to be IMDs. However, CMS continues to describe this setting limitation for children under 21 since issuing the QRTP guidance.

of the SUD 1115 waiver opportunity. States may claim FFP for stays up to 60 days if the state demonstrates that it is meeting the requirement of a 30 day or less ALOS at its mid-point assessment. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for individual stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. States must assure that they will provide coverage for stays that exceed 60 days with other sources of funding if it is determined that a longer LOS is medically necessary for an individual beneficiary. Stays in IMDs that exceed 60 days for a single stay (not during a calendar or fiscal year) are not eligible for FFP under this demonstration.[18,19] The demonstration guidance does not place a limit on the number of distinct admissions for an individual that are eligible for FFP.

CMS SMI/SED 1115 Waiver Milestones

States participating in the SMI/SED demonstration opportunity are expected to take several actions to improve community-based behavioral healthcare services and ensure quality care within IMD settings. These actions are intended to align with a set of SMI/SED demonstration goals and milestones.

CMS's five goals for the SMI/SED 1115 waiver are:[20]

1. Reduce utilization and LOS in emergency departments (EDs) among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings.
2. Reduce preventable readmissions to acute care hospitals and residential settings.
3. Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.
4. Improve access to community-based services to address the chronic mental health care needs of individuals with SMI/SED including through increased integration of primary and behavioral health care.
5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

States are expected to demonstrate achievement of the following milestones through successful completion of the related demonstration requirements:

[18] CMS updated guidance in 2019 to limit coverage under the demonstrations for stay under 61 days, emphasizing waiver of the IMD exclusion for short-term stays only.
[19] Summarized from STCs from Indiana's approved SMI/SED amendment to the Healthy Indiana Plan Waiver, December 20, 2019.
[20] CMS SMD 18-011 Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, November 13, 2018 at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf

Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Ensure that participating hospitals and residential settings are licensed or otherwise authorized by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity, including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), prior to receiving FFP for services provided to beneficiaries.

- Establish and maintain an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements.

- Leverage a utilization review entity (e.g., a managed care organization (MCO) or administrative service organization (ASO) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and to ensure only individuals who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities.

- Ensure participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers. Under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues.

- Implement a requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and SUDs, and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in these treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

Improving Care Coordination and Transitions to Community-Based Behavioral Healthcare Services

- Implement a process to ensure strong support during care transitions. Specifically, psychiatric hospitals and residential treatment settings must provide intensive pre-discharge care coordination services to help transition beneficiaries out of IMD settings and into appropriate community-based behavioral health outpatient services. Community-based providers must participate in these transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings or by hiring peer support specialists to help beneficiaries follow through with discharge plans and navigate the system to engage in community-based behavioral health service and supports, including providing employment and independent housing supports when appropriate).

- Implement a process to assess the housing stability of individuals upon admission to a psychiatric hospitals or residential treatment setting, and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available upon discharge.
- Implement a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made with each beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities. This should occur by contacting the individuals directly and by contacting the community-based provider the person was referred to for follow-up after discharge.
- States must implement strategies to prevent or decrease the LOS in EDs among beneficiaries with SMI/SED. This can be achieved through expanded crisis services or by leveraging peers as system navigators to support linkage or engagement into ongoing treatment.
- States must implement strategies to develop and enhance electronic health record (EHR) interoperability, including electronic referral and electronic consent sharing between primary care, SUD, and inpatient and outpatient mental health providers with the goal of enhanced care coordination through real time access to clinical information.

Increasing Access to Continuum of Care Including Crisis Stabilization Services

- Conduct annual assessments of the availability of mental health services throughout the state. CMS has provided a template for reporting the initial assessment and requires states to update this assessment annually.[21] (A more detailed description of this template and reporting requirement is provided in the Application Requirements section of this report.)
- Commit to a financing plan approved by CMS that is focused on community-based behavioral health crisis services, such as mobile crisis and diversion programs with law enforcement. The financing plan must be implemented within the first two years of the demonstration. States must commit to expanding outpatient services such as Assertive Community Treatment (ACT) and services provided in integrated care settings such as the Certified Community Behavioral Health Clinic model.[22] States are strongly encouraged to include implementation of evidenced based practices when proposing to add services through the waiver demonstration.
- Implement a strategy to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible.
- Implement an evidence-based, publicly available patient assessment tool, preferably one endorsed by a mental health provider association, such as LOCUS or CASII. Providers and

[21] Monitoring template, including the Mental Health Availability Assessment, and a list of quantitative 1115 SMI/SED monitoring metrics is available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html

[22] https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-impl-plan-template.pdf

Medicaid managed care entities may be required to utilize the chosen tool(s) for treatment planning, level of care decision making, and utilization management (UM) activities.

Earlier Identification and Engagement in Treatment Including Through Increased Integration

- Implement strategies for early identification and engagement in treatment for individuals, especially adolescents and young adults with SMI. This must include linking individuals to supported employment and education programs.
- Increase integration of behavioral healthcare in a variety of care settings, including schools and primary care practices, to improve early identification of emerging mental health conditions and improve awareness of and engagement with specialty treatment providers.
- Establish specialized settings and services, including crisis stabilization services, which target the needs of young people with SMI/SED.

State Decision Points & Impacts

The level of state effort necessary to meet the waiver milestones will be dependent upon the degree to which the Department can demonstrate requirements are already met. At minimum, the following should be considered:

- The extent to which current IMD licensure and accreditation standards align with CMS requirements.
- Whether current IMD oversight and auditing processes align with new CMS expectations, including requirements for unannounced site visits.
- Whether IMDs are currently meeting clinical expectations established under the waiver such as screening for comorbid conditions and housing insecurity, conducting discharge planning and following-up within 72 hours of discharge.
- The extent to which the state's health information technology (HIT) infrastructure supports the waiver expectations.

Depending on the outcome of this analysis, a series of changes may be necessary to enforce new requirements on IMDs. For example, the state may need to implement administrative rule changes and new oversight procedures. HIT improvements may also be necessary to support increased interoperability across the care delivery system. Many of these modifications will necessitate cross-collaboration with other state agencies and non-state entities including the Colorado Department of Human Services, Office of Behavioral Health, the Colorado Department of Public Health and Environment, the Department of Corrections, and the Office of Information Technology, as well as the state health information exchanges.

Application Requirements

To request authority to waive the IMD exclusion, states must submit to CMS an SMI/SED 1115 waiver demonstration application, consisting of multiple documents (links to the waiver application package can be found at the end of this Report). The application includes a narrative that specifies the demonstration's goals, including how the state's demonstration program will achieve the goals outlined

by CMS. The application must also confirm the state's commitment to achieving the milestones outlined in the demonstration guidance and include an Implementation Plan utilizing the CMS template. States are strongly encouraged to include implementation of evidenced based practices when proposing to add services through the waiver demonstration. CMS initially recommended and then later required that states perform an assessment of their current behavioral health system of care and include a summary of this assessment within their application. To assist states with this requirement, CMS created an 1115 SMI Currently Available Assessment Template that provides a format for providing information on both provider and service availability within the state.

Implementation Plan

CMS provides a template for states to use in submitting their Implementation Plans.[23] CMS does not require this component to be submitted with the state's application; however, states cannot receive FFP for services provided to individuals within IMDs who are under the exclusion until the Implementation Plan has been approved. The Implementation Plan template is organized by the CMS goals and associated milestones. States must provide a summary of their status related to each of the requirements associated with the four milestones. If gaps in meeting the milestone exist, states must identify how they will satisfy each requirement shortfall, including providing a timeline for completion. The plan must also address financing and HIT strategies the state will use to meet CMS goals for the demonstration. The financing plan section prompts states to include current or future strategies to expand community based mental health services and supports, including crisis services and intensive outpatient programs aimed at reducing the need for inpatient stabilization. The HIT plan section prompts the state to share current and future strategies for leveraging technology, and specifically health information exchange (HIE) systems, to support care coordination, information sharing, and collaboration across behavioral health and primary care providers.

1115 SMI Currently Available Assessment

States must complete the 1115 SMI Current Availability Assessment template as part of the waiver application. The template includes a Narrative Description, to be completed once at the beginning of the demonstration, and the Availability Assessment portion, to be submitted with the application and then annually updated and submitted as part of the monitoring protocol. In the Availability Assessment, states must report on the prevalence of SMI and SED broken out by region or county using the following data points:

- Number of adult Medicaid beneficiaries (18-20)
- Number of adult Medicaid beneficiaries with SMI (18-20)
- Number of adult Medicaid beneficiaries (21+)
- Number of adult Medicaid beneficiaries with SMI (21+)
- Number of Medicaid beneficiaries (0-17)
- Number of Medicaid beneficiaries with SED (0-17)

[23] The Implementation Plan template can be found at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-impl-plan-template.pdf. Links to all waiver documents can be found at the end of the Report.

States must also report the availability of specific providers within the state, including the number of those enrolled as Medicaid providers, and of this subgroup, the number of providers accepting new patients. Specific provider types include:

- Psychiatrists and other practitioners who are authorized to prescribe
- Other practitioners certified or licensed to independently treat mental illness
- Community Mental Health Centers (CMHCs)
- Intensive Outpatient/Partial Hospitalization providers
- Residential Mental Health Treatment Facilities (adult); number of facilities and beds
- Psychiatric Residential Treatment Facilities (PRTF); number of facilities and beds
- Psychiatric Hospitals
- Psychiatric units in acute care hospitals
- Psychiatric units in Critical Access Hospitals; number of units and beds
- Total number of licensed psychiatric hospital beds (psychiatric hospitals + psychiatric units)
- Residential Mental Health Treatment Facilities (adult) that qualify as IMD
- Number of psychiatric hospitals that qualify as IMDs
- Number of crisis call centers
- Number of mobile crisis units
- Number of crisis observation /assessment centers
- Number of crisis stabilization units
- Number of coordinated community crisis response teams
- Number of FQHCs that offer behavioral health services

The narrative section also requires a response to five questions intended to provide a summary of the state's analysis of the Availability Assessment data:

1. Describe the mental health service needs at the beginning of the demonstration.
2. Describe the organization of the state's Medicaid behavioral health service delivery system.
3. Describe the availability of mental health services for Medicaid beneficiaries with SMI/SED and at minimum, explain any variations across the state.
4. Describe any gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment.
5. Describe any gaps in the availability of mental health services or service capacity NOT reflected in the Availability Assessment.

Maintenance of Effort on Community Based Services

In addition to budget neutrality requirements, states are expected to meet maintenance of effort (MOE) requirements under the demonstration. As part of their SMI/SED demonstration application, states must describe the level of state appropriations and local funding for outpatient community-based behavioral health services for the most recently completed state fiscal year as of the date the state submits its SMI/SED demonstration application. States must maintain this same level of funding for the duration of the demonstration.[24]

[24] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/faq051719.pdf

State Decision Points & Impacts

- The Implementation Plan's milestone (action) requirements will require, at minimum, an investment in health information exchange and staff time, depending on what the state chooses to include in Colorado's demonstration and Implementation Plan.
- Completion of the Availability Assessment is a significant administrative task for states. Provider level data on licensure, bed availability, and acceptance of new patients are often tracked by different state agencies and utilize unaligned data definitions. This can provide challenges for data aggregation and accuracy, requiring significant state coordination and resources to complete.
- It may be difficult to meet community-based behavioral health services MOE requirements, particularly in the current environment where Colorado may need to address budget shortfalls over the next few years due to COVID-19.
- In developing this waiver, CMS assumed that states have inadequate community-based behavioral health services, which may make it difficult for Colorado to get waiver authority approval unless the state can demonstrate the milestones are already met. Service additions may be cost prohibitive, particularly in the current economic environment.
- Additionally, it remains unclear if CMS will accept the significant effort currently underway at the state to review and address behavioral health system strengths and challenges or require an additional parallel process. Strengthening access and delivery of the existing comprehensive continuum of services may not equate to milestone achievement under the guidance. However, attention to the current service array as opposed to adding services may be in the best interest of Coloradans and their system of care.

Post-Submission Deliverables and Requirements

Once approved, there are several ongoing steps states must take to maintain the waiver:

Ongoing Monitoring

States must submit quarterly and annual monitoring reports throughout the demonstration. These reports include qualitative and quantitative data about the state's progress implementing the demonstration and an annual reassessment of the availability of mental health providers and settings in the state, including information regarding the state's efforts to implement improvements in the availability of mental health providers. States are also required to provide an update on all aspects of the Implementation Plan, including the financing and HIT plans within its monitoring reports. Additional performance and quality measures included in the monitoring protocol must also be included in these reports.

Data Collection Necessary for Ongoing Monitoring

The SMI/SED 1115 waiver includes significant ongoing monitoring requirements. This includes annual completion of the Availability Assessment, which will require collaboration across state agencies to compile data from multiple sources. The requirements also include approximately 40 SMI/SED quantitative metrics that must be reported on a quarterly or annual basis. Many of these metrics must

be reported separately by subpopulations such as age, Medicare dual eligibility, criminal justice status, co-occurring SUD, and physical health conditions. This level of data analysis will require significant investments, staff resources, and collaboration across state agencies responsible for tracking associated data. For example, interfaces with the Department of Corrections or Department of Human Services, Office of Behavioral Health may be required, to the extent data sources necessary to report upon subpopulations are not currently accessible to the Department.

Independent Evaluation

CMS requires states to have an independent evaluation of the demonstration. States will need to contract with a vendor who must submit an evaluation design within 180 days of the demonstration approval. The evaluation design must include hypotheses and evaluation questions, data sources, measures, collection and analysis approaches, and reporting details, and will be subject to CMS review and approval. The state will need to submit an interim evaluation one year before expiration of the demonstration or when the state submits a proposal to renew the demonstration. The state will need to submit the summative evaluation 18 months after the demonstration period ends.

Cost Implications of the SMI/SED 1115 Waiver

Pursuing the SMI/SED 1115 waiver, as with any waiver, will require expenditure of additional state resources. At minimum, completion of the waiver application would require Department staff resources. In the absence of sufficient staff capacity, contracting with an external vendor is an option, but poses additional costs. Requirements to complete budget neutrality documentation may require contracting with an actuarial vendor if in-house financial expertise is unavailable. Following the initial waiver application, the Department would be required to contract with a third party to conduct the required Independent Evaluation. Further, if ongoing monitoring functionality is not outsourced to the independent evaluator, internal Department resources would be necessary, likely through dedication of at least two full-time staff members (one for data monitoring and one for overall demonstration project management). Notably, administrative costs are shared by the federal government and are eligible for 50 percent federal match.[25]

State Decision Points & Impacts

- Data collection requirements necessary to meet the demonstration's monitoring and evaluation requirements pose a substantial lift. Because some metrics are federally defined, Colorado is likely not currently collecting all of the data points required and may not find all required metrics helpful in achieving the state's specific goals. Additionally, data collection alone is insufficient to move the needle toward improved outcomes. Effective quality improvement will be dependent upon the availability of Department staff resources to act upon findings. Such activities will likely require cross-agency collaboration and buy-in to address behavioral health services across the care continuum which are not under the purview of the Department. For example, the crisis services continuum, which is under the Department of Human Services, Office of Behavioral Health is a key part of the continuum for the SMI/SED 1115 waiver and

[25] 42 CFR 433.15

development and monitoring of the services would require close collaboration between the two departments.

- The significant ongoing monitoring and reporting requirements may pose challenges with access to data. The Department would need to work with other state agencies to access non-Medicaid provider and services data. This will require cross-agency buy-in and resources and may require additional staff resources for those other agencies to meet the added requirements.
- The SMI/SED 1115 waiver also requires contracting with an independent evaluator. Dedication of two Department FTEs is also likely required to ensure effective data collection, monitoring, and quality improvement activities.

State Practices: Strategies to Manage Length of Stay

As noted previously, states with approved SMI/SED 1115 waivers are required to achieve a statewide ALOS of 30 days for beneficiaries receiving care in IMDs. Additionally, because stays in IMDs that exceed 60 days are not eligible for FFP, states must assure CMS that they will provide coverage for stays that exceed 60 days with other sources of funding if it is determined that a longer LOS is medically necessary for an individual beneficiary.

States must document the actions they will take to manage Medicaid enrollees' LOS in the Implementation Plan which accompany waiver applications.[26] Notably, although states may submit the Implementation Plan after submitting the waiver application, they cannot receive FFP until the Implementation Plan is approved, prompting some states to submit the Implementation Plan concurrently with the waiver application.

In the Implementation Plan, states must identify milestones (or actions) for making progress towards the goals outlined in the November 2018 State Medicaid Director Letter (SMDL), including to achieve a "statewide ALOS of 30 days for beneficiaries receiving care in IMDs." The SMDL further requires that "providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association, e.g., LOCUS or CASII, to help determine appropriate level of care and length of stay."

Below we discuss the structure of the state Medicaid programs for those states with SMI/SED waivers. Table A-1, located in Appendix A, presents state utilization management (UM) strategies, which can be found in Milestone 1c of the SMI/SED 1115 waiver application Implementation Plan.

District of Columbia Behavioral Health Transformation

The District's Medicaid program is administered by the Department of Health Care Finance (DHCF), whose 1115 waiver allows DHCF to reimburse IMDs for inpatient and residential services provided to Medicaid-enrolled patients with SMI/SED and/or SUD. The waiver was approved on November 6, 2019.

[26] The Implementation Plan template can be found at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ce-implementation-plan-template.pdf

Authority for waiver oversight is divided between DHCF, Medicaid MCOs, and the DC Department of Behavioral Health (DBH).

The District's primary delivery system for Medicaid beneficiaries is capitated managed care, with almost 65 percent of the District's Medicaid beneficiaries receiving care through four MCOs.[27] DHCF reimburses for clinic services, FQHCs, hospitals, and outpatient services. Medicaid MCOs contract with a behavioral health network to provide low-acuity, primary, behavioral health services, while more intensive services are carved out of MCO contracts and delivered by other providers administered by the DBH. In addition, the District has implemented health homes targeted to serve individuals with SMI and co-occurring chronic health conditions, specifically adding care coordination and transition support elements in addition to other services and supports.

The District has historically utilized the "in lieu of" authority through its managed care contracts to reimburse for short term stays in an IMD. However, not all populations are enrolled in managed care, making a portion of the District's Medicaid enrollees ineligible for stays in an IMD. Its waiver application referenced this concern, stating "the disparate access to Medicaid coverage of IMD services between managed care and fee-for-service (FFS) programs unfairly disadvantages FFS beneficiaries."

Idaho Behavioral Health Transformation

Idaho's Medicaid program is administered by the Idaho Department of Health and Welfare (IDHW). IDHW, like DHCF, received authority from CMS to reimburse IMDs for inpatient and residential services provided to Medicaid-enrolled patients with SMI/SED and/or SUD. Idaho's demonstration was approved on April 17, 2020. Notably, in addition to receiving waiver approval, Idaho expanded its Medicaid program on January 1, 2020, putting more pressure on IDHW to control costs.

Idaho Medicaid uses a mandatory enhanced primary care case management (ePCCM) delivery system (Healthy Connections) in which primary care providers (PCPs) receive a per member per month (PMPM) per capita payment ranging from $2.50 to $10 based on patient characteristics to coordinate and manage care for their Medicaid patients. The program covers nearly all of Idaho's 266,030 Medicaid enrollees.[28] The state pays for Medicaid services on a FFS basis, including a range of behavioral health services. The IDHW's Division of Behavioral Health (DBH) and Division of Public Health, along with the Division of Medicaid, oversee behavioral health services.

Ambulatory behavioral health services, including services provided to the SMI/SED population, are managed through the Idaho Behavioral Health Plan (IBHP), Medicaid's behavioral health managed care program. In 2013, Optum was selected to administer the plan and continues to do so today. Although IBPH currently only covers ambulatory behavioral health services, during the waiver period, it will be transitioned to a prepaid inpatient health plan (PIHP) and all behavioral health services will be carved into the managed care contract, including inpatient and residential services.

[27] D.C. Medicaid Managed Care Information, https://www.dc-medicaid.com/dcwebportal/nonsecure/managedCareInfo, accessed May 13, 2020.
[28] HMAIS, December 2019 enrollment data.

Indiana SMI/SED Waiver Amendment

Indiana's Medicaid program is administered through the Family and Social Services Administration (FSSA). Indiana's Healthy Indiana Plan amendment for individuals with SMI/SUD was approved on December 20, 2019. FSSA received authority from CMS via an amendment to their SUD 1115 waiver to reimburse IMDs for inpatient and residential services provided to Medicaid-enrolled patients with SMI/SED. Of note, Indiana's waiver application indicated state mental health hospitals will not be classified as IMDs eligible for reimbursement under this waiver.

Indiana's FSSA, Office of Medicaid Policy and Planning (OMPP), and Division of Mental Health and Addiction (DMHA) oversee Medicaid behavioral health services, which are provided through both FFS and managed care delivery systems. Indiana's managed care delivery system includes three programs: 1) the Healthy Indiana Program (HIP) for the new adult group, as well as most non-dual, non-disabled adults, which serves 452,603 beneficiaries through four MCOs;[29] 2) the Hoosier Healthwise (HHW) program, which includes 607,463 children up to 19 years of age, CHIP, and pregnant women, and whose members receive services via the same MCOs as HIP members; and 3) the Hoosier Care Connect (HCC) program, which serves 91,057 aged, blind, and disabled members via two MCOs. Dual eligible, long term services and supports (LTSS), and those with retroactive eligibility, presumptive eligibility, and limited benefits receive services through the FFS program. Behavioral health benefits are carved in to all MCO contracts.

Indiana pursued the SMI/SED 1115 waiver opportunity to address individuals enrolled in FFS without access to services in an IMD. In particular, the state wished to address access gaps created when the state transitioned its presumptive eligibility population from managed care to FFS.

Vermont Global Commitment to Health

The Agency of Human Services (AHS) is Vermont's Green Mountain Care (Medicaid) single state agency. The Department of Vermont Health Access (DVHA) is designated by AHS to administer the Medicaid program. Vermont's SMI/SED demonstration waiver was approved on January 1, 2020.

Currently, all Vermont Medicaid beneficiaries receive care through a FFS delivery system. However, under the demonstration, AHS will enter into an agreement with the Department of Vermont Health Access (DVHA) to deliver services covered through the demonstration via a "managed care like" non-risk PIHP. The AHS will develop a PMPM capitation rate and oversee the PIHP. All Medicaid beneficiaries will be enrolled in the non-risk PIHP.

State Practices: Strategies to Leverage Community-Based Behavioral Health Services

The SMI/SED 1115 waiver opportunity is part of a broader movement towards community-based behavioral health care. The SMI/SED 1115 waiver is intended to provide opportunities for states to prevent institutionalization of individuals with SMI/SED through requirements that states maintain current funding levels for outpatient care, increase access to community-based behavioral health

[29] HMAIS, March 2020 enrollment data.

services, and improve care coordination and continuity of care for individuals transitioning to the community. It is expected that over the course of the demonstration, access to community-based behavioral health services for individuals with SMI/SED will improve. Sub-regulatory guidance expands on this by discussing how states can leverage existing authorities to expand services, including by increasing screening for mental illness in schools or through more robust transitions to community-based behavioral health care. Ultimately, leveraging and building on community-based behavioral health services is linked to achieving the goals and milestones of the waiver.

Below, we provide highlights of state actions to leverage community-based behavioral health care, as detailed in their demonstration waiver applications. More detail on state actions to leverage community-based behavioral health services are provided in Table A-2 in Appendix A.

District of Columbia Behavioral Health Transformation

The District contractually obligates Medicaid MCOs to reduce preventable hospital admissions and low acuity ED visits, as well as reduce 30-day readmission to receive full capitated payment. FQHCs receive incentives to improve care coordination and transitions and the FQHC alternative payment methodology (APM) includes a bonus for achieving benchmarks. In the future, the District plans to leverage its existing Health Home programs to improve care coordination and connect beneficiaries to community-based behavioral health services. In addition, like Idaho, the District will add Medicaid reimbursement to the State Plan for discharge planning.

Idaho Behavioral Health Transformation

Idaho currently has few discharge planning requirements. Because inpatient services are under the FFS system and outpatient services are managed by the IBHP, the state collaborates with IBHP to manage transitions. By 2022, Idaho plans to lessen system fragmentation by changing IBHP contracts to include inpatient service as well as outpatient services. The new contract will also include provisions intended to strengthen coordination with community-based healthcare providers, including increased discharge planning requirements, requirements to coordinate with community-based providers, and enhanced case management for all hospitalized members. Idaho will also add reimbursement for discharge planning to the State Plan. Finally, Idaho will continue to enhance (via telehealth) and leverage its continuum of crisis services, including crisis intervention teams and mobile crisis teams, to prevent inappropriate ED use and hospital admissions and readmissions.

Indiana SMI/SED Waiver

Indiana plans to continue to leverage discharge planning and care coordination requirements to connect individuals with community-based healthcare providers. Indiana will also use MCO contracts and requirements via the State Medicaid Manual to obligate providers to follow-up with members within 72 hours of discharge. Indiana is evaluating their MCO networks to identify gaps in behavioral health services providers and inform provider recruitment activities to reduce inappropriate ED utilization and reduce lengths of stay in an ED.

Vermont Global Commitment to Health

Like other states, Vermont's discharge planning standards support community-based healthcare. Vermont plans to enhance its current discharge planning and care coordination strategies and improve connection with community-based behavioral health services via a "Collaborative Network Approach" or open dialogue practice; increase awareness of community support for staff and individuals in psychiatric hospital care; host employment groups; and develop ways for local rehabilitation counselors and employment specialists to meet with patients and staff prior to discharge. Vermont DMH also employs a housing coordinator who works with landlords in securing housing for homeless or members in unstable housing. Vermont's approach to reducing ED usage includes building inpatient and residential capacity; using telepsychiatry and peer-to-peer support services; and increasing Screening, Brief Intervention, and Navigation to Services (SBINS); and positioning Vermont Psychiatric Survivors (VPS) in EDs to support people in crisis. Finally, Vermont is using an All-Payer Accountable Care Organization Model to support payments to community providers for complex care coordination.

Colorado Considerations & Assessment of 1115 Opportunity

Assessment of Opportunity to Achieve Quality Outcomes

The CMS goals for the SMI/SED demonstration include assuring quality care in hospitals and positive clinical outcomes resulting from improved care coordination and early identification of need and access to mental health services and supports. The opportunity for Colorado to achieve or improve quality outcomes is influenced by the scope of activities, programs, and services included in the state's waiver demonstration. The demonstration requires states to consider service gaps within their continuum of care. States that already have a robust continuum of prevention, crisis, and treatment services may focus on expanding access to existing services, such as inpatient stabilization, through an expanded network of providers (e.g. IMDs), rather than adding new services to their state plan or through the demonstration waiver.

Of note, while states must demonstrate expanded access to community-based behavioral health services where gaps currently exist to operate an SMI/SED waiver, the expansion of these benefits is not typically authorized through waiver authority. Therefore, the waiver is not necessary to expand or modify the current behavioral health service array. The SMI/SED waiver is purely a vehicle to receive federal authority for IMD stays that exceed the LOS permitted under the "in lieu of" option.

In cases where waiver authority to reimburse IMDs is the primary focus of the waiver, the state is less likely to see a measurable impact on outcomes, especially in the case of Colorado, where IMDs are currently receiving reimbursement under the "in lieu of" option.

Specific to IMDs, CMS guidance for the SMI/SED waiver opportunity emphasizes the expectation that states have strong oversight of these providers. Required oversight includes accreditation by a nationally recognized organization and annual onsite visits to ensure both state licensure and national accreditation standards are met. These activities cannot be assumed to improve member outcomes or quality of care. There are no measures associated with care within IMDs as metrics focus on the community-based behavioral health system of care, such as engagement in treatment and follow-up after an admission. One exception to this is the waiver requirement that individuals be screened for

substance use disorder, housing stability, and physical health conditions upon admission. For states where these quality measures already exist, the waiver quality assurance measures do not drive additional quality improvement. Further, if these requirements intended to assure quality were in place prior to the waiver, there will not likely be a notable impact with continuation under the demonstration.

Required activities under the waiver specific to care transitions may improve quality outcomes if fully implemented and enforced. For example, the requirement that all IMDs follow-up with individuals within 72 hours of discharge may serve to improve continuity of medication adherence and continuity of care, which could result in a reduction in avoidable readmissions or ED utilization. However, Colorado could opt to mandate these provider follow-up requirements in the absence of the 1115 waiver.

Colorado's participation in the SMI/SED demonstration opportunity would require extensive reporting of both quantitative and qualitative metrics on a quarterly and annual basis. The required metrics include measures that align with outcomes associated with established practice guidelines, such as *Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication* and *Follow-up after an Emergency Department Visit*. However, it is important to note that collecting and reporting the data alone is not associated with achieving or improving outcomes. The state will need to commit to activities intended to improve clinical and other interventions, likely through adoption of evidenced-based practices, to achieve quality outcomes. Because the state is required to submit baseline data for required metrics, participation in an SMI/SED demonstration *will* allow the state to review quality outcome measures, at minimum, on a quarterly and annual basis. This may lead to earlier identification of areas where practice improvements are needed, allowing the state the opportunity to act.

Assessment of Opportunity to Leverage Community-Based Behavioral Health Services

While the SMI/SED demonstration opportunity does not require or authorize the state to add community-based behavioral health services and supports, or authorize additional payment for behavioral health care services, it does emphasize the importance of the community-based continuum of care. States are required to maintain the same level of financial support to community-based behavioral health services throughout the demonstration. This includes annual financial reporting on MOE. In addition, the demonstration requires that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and LOS. A valid and reliable assessment tool that informs level of care could assist in ensuring individuals are served in community-based settings whenever appropriate and inpatient stays are only utilized when medical necessity is met. Monitoring requirements also allow states to identify fluctuations in behavioral health providers and services which may trigger enhanced provider enrollment and or expansion outreach when gaps are identified.

The SMI/SED 1115 waiver focuses on states' crisis continuum of services. Specifically, the demonstration is intended to test the CMS hypothesis that if individuals have access to a robust set of crisis services, they may be diverted from inpatient stays. However, the demonstration does not measure the effectiveness of these programs specific to their ability to divert individuals from inpatient stays, a gap in the monitoring protocol that could result in a missed opportunity to understand if these expensive services are producing the intended outcomes or merely serving as a feeder for hospitals.

Colorado could expand the continuum without the waiver using alternative approaches to closing gaps in the existing system. Based on data provided by the Department, the longer lengths of stay in the state represent a small subset of the population (2.7% of all IMD stays), with social determinants of health barriers (e.g., housing) and legal status (e.g., guardianship), contributing to discharge delays. The need for more transitional services to provide a structured step down for high risk individuals may be a gap within the current continuum for this subset of the population. Colorado could add elements to the continuum to address these barriers without the demonstration, and it is noteworthy that some barriers, such as guardianship policies and procedures are outside the purview of Medicaid authority. Programs focused on transitions of care could include a health home model, intensive care management for high risk populations with longer lengths of stay and barriers to discharge (leveraging comprehensive care management or programs such as Assisted Outpatient Treatment) or other programs tailored to improve inpatient transitions.

Assessment of Opportunity to Manage Length of Stay

The SMI/SED 1115 waiver limits the coverage of stays within an IMD to short term stays. Specifically, the guidance requires a statewide ALOS of no more than 30 days and bans FFP for any stay exceeding 60 days. While a longer LOS permitted under the waiver versus "in lieu of" authority may address some additional enrollees with greater clinical needs, it may also create perverse incentives for increasing the ALOS in IMDs when community-based resources may be available and clinically appropriate.

Additionally, managing the LOS requires continuous monitoring due to the risk of a reduction in the overall LOS eligible for FFP when the ALOS milestone is not met. The guidance is also clear that CMS will not provide FFP for any portion of a stay that exceeds 60 days. Furthermore, the 60-day cap on FFP suggests that a state may need to identify, upon admission, which individuals may require a longer-term stay to prevent claims payment and FFP collection for stays which ultimately exceed the 60-day cap.[30]

The waiver does not specify how states must manage to the LOS and states with approved SMI/SED 1115 waivers delegate managing the ALOS to MCOs or FFS fiscal intermediaries. However, the SMI/SED 1115 waiver does have certain requirements intended to support a shorter LOS in an IMD, including:

- Supporting collaborative discharge planning between inpatient and outpatient providers.
- Maintaining a robust continuum of outpatient services intended to maintain community-based living.
- Providing intensive, preventative outpatient services.
- Providing step-down services to allow for supported transitions to the community.

[30] There is no singular way that this is done. States will have to monitor ALOS and prevent FFP going to stays greater than 60. States we have worked with feel they should identify likely long stays at admission and be proactive to ensure they do not receive Medicaid reimbursement. This is especially true when there are not designated facilities for long term stays such as a state hospital that are not eligible for FFP with that understanding up front. If Colorado pursued the waiver, the Department would have to contemplate how they would identify these longer stays early on.

Availability of partial hospitalization and Assertive Community Treatment (ACT) providers and services are among the outpatient services monitored throughout the demonstration.

Existing approved SMI/SED 1115 waivers do not provide an example of value-based or alternative payment strategies, but these strategies may provide a mechanism for incentivizing only medically necessary LOS and the development of alternatives to inpatient care. For example, Colorado could consider reimbursing for an episode of care that incentivizes providers to efficiently stabilize and support discharge as opposed to daily per diems that reward longer lengths of stay. The state could also implement incentive payments for outpatient providers with low admission rates, readmission rates, and high percentages of community tenure for clients with SMI to encourage outpatient providers to use evidence-based practices and creatively partner with housing and other social services providers to assist in reaching goals. An SMI/SED 115 waiver is not required for Colorado to implement value-based incentive payments.

Given the recent implementation, data is not yet available regarding ALOS in states that are utilizing the waiver authority. However, outcomes from the MEPD may provide insight. Of note, the SMI/SED 1115 waiver imposes a 60-day limit which was not a component of MEPD; this may create incentives among states to ensure a shorter ALOS in the SMI/SED 1115 waiver. Overall, the ALOS under MEPD was 8.6 days. The states' median LOS were lower and close to the ALOS. When considering the maximum ALOS, it appears the majority of stays were well within the 15-day maximum LOS required under the "in lieu of" option. However, as illustrated in Table 2, some stays were substantially longer.

Table 2: MEPD Length of Stay for IMD Admissions[31]

State	Number of Admissions	Median Length of Stay	Average Length of Stay	Standard Deviation	Minimum	Maximum
AL	1,112	7	10.0	8.0	1	70
CA	3,152	7	8.5	6.6	1	71
CT	855	6	7.6	5.0	0	46
DC	857	7	7.6	4.5	1	66
IL	336	7	9.5	6.8	1	55
ME	681	7	10.6	10.8	1	83
MD	4,169	7	9.5	9.8	1	147
MO	2,065	5	6.2	4.5	1	72
NC	635	8	9.4	6.5	1	53
RI	245	6	7.4	6.8	1	61
WA	715	8	10.2	8.5	1	97
WV	1,909	7	7.6	5.5	1	105
Total	**16,731**	**7**	**8.6**	**7.6**	**0**	**147**

Data on IMD stays provided by the Department aligns with the MEPD findings suggesting the majority of stays fall below the 15-day maximum permitted under "in lieu of" authority. As further illustrated in Table 3, 97.2 percent of stays in an IMD are currently reimbursable under "in lieu" of authority.

[31] Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report, August 18, 2016 at https://innovation.cms.gov/files/reports/mepd-finalrpt.pdf

Assuming the trends from SFY19 and the first half of SFY20 remain consistent, SMI/SED 1115 waiver authority would have permitted FFP for an additional 734 stays, representing 2.7 percent of all IMD stays.

Table 3: Colorado IMD Stays[32]

Length of Stay	Total Stays	ALOS
15 days or less	26,374	2.9
Between 16 & 30 days	501	22.15
Between 31 & 60 days	233	33.48
More than 60 days	9	78.67
TOTAL UNIQUE STAYS	27,117	3.55

Assessment of Cost Drivers & Cost Effectiveness via the SMI/SED 1115 Waiver

Because only three states currently have approved waivers, data is unavailable to demonstrate if this option is cost effective or results in greater costs or cost savings for states. At least one state, Indiana, will have access to cost data to compare the SMI/SED demonstration option with the state's previous use of the "in lieu of" option. Cost drivers will include the administrative costs of waiver implementation, including monitoring, reporting and the cost of an independent evaluator.

CMS requires that all 1115 waivers meet federal budget neutrality requirements, meaning states must demonstrate the costs to the federal government are not more than they would have been in the absence of the waiver. However, CMS has determined the costs under the SMI/SED 1115 waiver may be treated as "hypothetical" as psychiatric inpatient stays may be authorized under the Medicaid State Plan and "hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services."[33] Therefore, meeting federal budget neutrality requirements would not be of concern. However, this also means state costs may be higher under the waiver. Potential areas driving cost increases include expansions of community-based behavioral health services necessary to meet waiver milestones, access requirements, and the additional administrative costs associated with implementing and monitoring the waiver, such as contracting with an independent evaluator.

Implementation Strategies

States with approved SMI/SED 1115 waivers have focused on authority to waive the IMD exclusion and compliance with milestones associated with oversight of IMD providers. All states have worked closely with their respective state behavioral health authorities to support implementation strategies, especially in implementing required regulatory, licensure, or contractual changes. In some cases, states have delegated these monitoring activities to behavioral health authorities. If Colorado pursues a waiver, it will require significant cross-agency collaboration and buy-in from the Department of Human Services Office of Behavioral Health.

[32] HCPF Rate Section Data delivered to HMA June 12, 2020.
[33] Centers for Medicare and Medicaid Services, *State Medicaid Director Letter #18-009*, August 22, 2018.

Managed Care "in lieu of" Overview

In May 2016, CMS overhauled the regulations governing Medicaid managed care. As part of this update, the agency codified a long-standing policy commonly referred to as the "in lieu of" authority. Under this option, managed care entities are permitted to provide Medicaid covered services in alternative settings as well as services "in lieu of" State plan[34] covered services. To utilize this authority, the following general conditions must be met:[35]

- The state must determine the alternative setting or service is a "medically appropriate and cost-effective substitute for the covered service or setting under the State plan."
- Use of the alternative setting or service must be at the option of both the enrollee and the managed care entity.
- The state's contract with the managed care entity must explicitly identify and authorize the "in lieu of" services or settings.
- In developing capitation rates for managed care entities, the utilization and actual cost of the "in lieu of" services must be taken into account.

At least 17 states, including Colorado, utilized the "in lieu of" authority to authorize stays in an IMD prior to the 2016 federal regulatory changes. The new regulations impose a 15-day limit not previously implemented by these states, however.

States have the option to utilize the "in lieu of" authority to cover short term stays in an IMD for Medicaid enrollees ages 21-64. This option was finalized in the May 2016 regulatory update to address inpatient psychiatric access and availability concerns.[36] Section 1013 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act,[37] passed in October 2018, codified these regulations. In addition to meeting the general requirements applicable to all "in lieu of" services, there are additional federal requirements specific to short-term IMD stays, as discussed further below.

Federal Requirements

Under the "in lieu of" authority, states are permitted to receive FFP for monthly capitation payments made to managed care entities for enrollees ages 21-64 receiving inpatient treatment in an IMD. To exercise this authority, the facility must be a "hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services." Further, to be eligible for FFP, these IMD stays must be short term, as described further below. In setting capitation rates, states may include IMD utilization, but may not consider IMD costs.

[34] The Medicaid State plan is the agreement between a state and the federal government describing how the state administers its Medicaid program. For example, it describes federally allowable benefits covered by the state.
[35] 42 CFR §438.3
[36] 81 FR 27853, May 6, 2016
[37] Pub.L. 115–271

Rather, the costs of settings authorized under the State plan must be utilized (i.e., non-IMD inpatient psychiatric settings).[38]

15-Day Length of Stay Maximum

Federal "in lieu of" authority limits IMD stays to no more than 15 days per calendar month per member. This monthly limit is a cumulative total by member; members may have multiple stays during the month but the total LOS of these combined days per stay cannot exceed 15 days. CMS imposed this monthly time limit under the premise that managed care entities are paid monthly capitation rates to assume the risk of covering that month's Medicaid-covered services. If an enrollee is an IMD inpatient for the full month to which the capitation payment applies, this enrollee would be ineligible for any Medicaid covered benefits due to the IMD exclusion. Therefore, CMS indicates the managed care entity should not be eligible for any capitation payment in that month.[39] However, if an IMD stay is for less than one month, the managed care entity would still be at risk for Medicaid covered services received during the portion of the month in which the enrollee is not in the IMD. CMS has indicated the 15-day maximum is further supported by data from the MEPD, which had an average LOS of 8.6 days, while also accounting for variability in acute inpatient LOS.[40]

Of note, stays in an IMD under the "in lieu of" authority can exceed 15 days when the admission spans two consecutive months if the stay is less than 15 days in each month. For example, FFP is available for an individual admitted to an IMD on June 29th and discharged on July 15th even though the total days in an IMD equals 17. This is because the 15-day limit is tied to the monthly capitation payment period. Additionally, the 15-day LOS is cumulative; enrollees may have multiple stays within one month if the total inpatient days do not exceed 15.[41]

Contract Requirements

States utilizing the "in lieu of" authority to reimburse for IMD stays must reflect this policy in contracts with managed care entities, which are subject to CMS review and approval. Contracts must reflect the following:[42]

- IMD stays are limited to 15-days within the capitation month in addition to the state's policy for handling stays which exceed 15 days.
- Monthly capitation payments will only be made for stays in IMDs which are hospitals providing psychiatric or substance use disorder inpatient care or sub-acute facilities providing psychiatric or substance use disorder crisis residential services.

[38] 42 CFR §438.3(e)
[39] 80 FR 31097, June 1, 2015
[40] The Medicaid Emergency Psychiatric Demonstration (MEPD) was a demonstration project established under the Patient Protection and Affordable Care Act. Conducted from 2012 through 2015, it enabled states to receive FFP for stays in an IMD for enrollees otherwise subject to the IMD exclusion.
[41] Centers for Medicare and Medicaid Services, *Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions – Section 438.6(e)*, August 2017.
[42] Centers for Medicare and Medicaid Services, *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval*, January 20, 2017.

- The enrollee may not be required by the managed care entity to receive inpatient psychiatric services in an IMD versus State plan covered inpatient setting.
- The ability to reimburse for IMD stays is at the option of the managed care entity.

Capitation Recoupment

Under the "in lieu of" authority, if a stay exceeds the 15-days per month standard and FFP is not available, states have the following options, in accordance with federal regulations, to address these stays:

- A prorated capitation payment may be made to cover the days in which the enrollee was not an inpatient in the IMD. For example, if an individual is an inpatient for 20 days in a calendar month, a state may pay the managed care entity for the other 10 days in the month. FFP would be available for the prorated capitation payment.[43]
    - Colorado currently utilizes this arrangement under its 1915(b) authority.
- Recoupment of the entire month's capitation payment when the 15-day limit is exceeded.
- Payment using state-only funds for any stays exceeding 15 days.
    - This is not an option for Colorado. The Department is statutorily required to administer its programs in accordance with Title XIX of the Social Security Act (25.5-4-104, 25.5-4-105). The Department's appropriations are reduced proportionately for any services for which federal match cannot be claimed. This precludes the Department from spending state-only funds, except when expressly authorized by the General Assembly.

State Decision Points & Impacts

States will need to have a process for monitoring LOS to ensure FFP is only provided for stays of 15 or fewer days in a calendar month. When stays exceed this LOS, federal regulations require states to have a process in place for capitation recoupment. This requires states to implement administrative processes, including both capitation recoupment and ensuring federal match is not claimed.

State Practices

Colorado currently uses "in lieu of" authority to cover Health First Colorado member stays in IMDs for up to 15 days (42 CFR 438.6(e)). This policy was implemented in July 2018. Prior to this, Colorado allowed reimbursement for IMD services without limit on the number of days as federal regulations did not impose a maximum LOS at that time.

Colorado leverages managed care entities (e.g., RAE, DHMC) under the state's 1915(b) waiver to manage LOS. The Department does not make any payments for member stays that exceed 15 days total, whether they are consecutive or separate stays, in a month as the Department cannot claim FFP for those days. However, the Department gives the managed care entities, via their contracts, flexibility in using payment arrangements, including value-based payment arrangements, to incentivize IMDs to limit member LOS to 15 days. In accordance with federal requirements, for stays that exceed 15 days, the Department recovers FFS, capitation, or per member per month (PMPM) payments, as well as dental capitation payments for that member for the days when the member resided in an IMD during the

[43]Centers for Medicare and Medicaid Services, *Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) Frequently Asked Questions – Section 438.6(e)*, August 2017.

month.[44] The Department provides prorated capitation payments to the managed care entities for the days within the month that the member was not in an IMD.

In addition to Colorado, 32 states use Medicaid managed care "in lieu of" authority to cover inpatient treatment in an IMD (SUD and/or mental health services) for nonelderly Medicaid adults. States may require managed care entities, including Medicaid MCOs and PIHPs, cover inpatient and residential care. In these instances, states use contracts to define the state and the managed care entity's financial responsibilities for covering stays up to 15 days per month, as well as those that exceed the 15-day requirement. Most contracts explicitly define and note the "in lieu of" authority, cite federal regulation, and require plans to report on all IMD stays or stays exceeding 15 days. Examples of contracting language are provided below.

Indiana

Indiana's Hoosier Healthwise RFP Scope of Work (incorporated into the contract) notes "Plan may cover services or settings "in lieu of" services or settings covered under the State Plan, including short-term stays no more than 15 days in a calendar month…" The state provides a list of IMD providers to the plans and prohibits the plan from creating any incentives for the member to receive services in an IMD versus "a setting covered by the State Plan." If a member's stay exceeds 15 days in a calendar month but the member is awaiting placement in a state hospital for treatment, the member is disenrolled from the plan and enrolled in FFS (though the plan must ensure a smooth transition). Any other stays exceeding 15 days become the financial responsibility of the plan. Notably, the contract explicitly requires the plan to provide care coordination for enrollees. The state then recovers the enrollee's monthly capitation rate.[45]

Michigan

Michigan Medicaid MCOs do not cover inpatient mental health services, which are covered by a PIHP (though the MCO is required to coordinate with the PIHP). The PIHP contract simply states "The PIHP is responsible for providing the covered services in an IMD up to 15 days per month per individual".[46]

Ohio

Ohio's Medicaid MCO contract provides a brief statement of the "in lieu of" authority and the method used for determining the rate. If an MCO enrollee exceeds 15 days per calendar month requirement, the Ohio ODM will recover "a percentage" of the MCO's monthly capitation payment based on the total number of days the member was in the IMD. The percentage is not provided. MCOs may provide

[44] Department of Health Care Policy and Financing, FY 2019-20 Joint Budget Committee Hearing, December 19, 2018 at https://www.colorado.gov/pacific/sites/default/files/2018%20Health%20Care%20Policy%20and%20Financing%2C%20BH%20Hearing%20Responses%20-%20DEC%2019%2C%202018.pdf. Accessed May 28, 2020

[45] Indiana Professional Services Contract, at http://www.state.in.us/fssa/files/MHSSTIND_00000000000000000000032139_0.pdf. Accessed May 15, 2020.

[46] Agreement Between Michigan Department of Health and Human Services And PIHP at https://www.michigan.gov/documents/mdhhs/PIHP_Contract_Bundle_670950_7.pdf. Accessed May 15, 2020.

services for more than 15 days, but Medicaid will not reimburse the MCO. MCOs are required to report quarterly on any MCO stays that exceed the 15 day per calendar month requirement. [47]

New Jersey

New Jersey's managed care contract also defines "in lieu of" services and requires Medicaid MCOs to cover residential treatment up to 15 calendar days. For private IMDs, if the MCO exceeds the 15 day requirement, the enrollee stays in the plan but "no [FFP] will be claimed for the capitation paid to the Contractor for any month in which the enrollee is resident for more than fifteen (15) days." The state requires private IMDs to track the number of days of all enrollee stays in IMDs. For public IMDs, MCOs must also track the number of days of an enrollee resides in an IMD; however, if the stay exceeds 15 days in a calendar month, the MCO must notify the state and the state disenrolls the enrollee from the MCO's plan and is enrolled in FFS and is covered by state funds. The MCO does not receive FFP for the month in which the enrollee's stay exceeds 15 calendar days, or for subsequent months when the enrollee is disenrolled. MCOs must provide the state with a monthly report identifying the number of enrollees receiving services in an IMD and the LOS. [48]

Washington State

Washington State's contract includes IMD services for no more than 15 days in the contract as an "in lieu of" service. The contract allows the Health Care Authority (HCA) to recoup any premium payments and retroactively terminate an individual's enrollment in the plan if the enrollee resides in an IMD for more than 15 days in a calendar month (except for SUD admissions). Contractors must submit an annual report of all IMD long-stay months.[49]

Colorado Considerations & Assessment of "in lieu of" Authority

Assessment of Opportunity to Achieve Quality Outcomes

The "in lieu of" option does not have the same reporting requirements as the SMI/SED 1115 waiver. States are not required to formally report on outcomes, and there are no requirements specific to other components of the service delivery system. Therefore, this option is not likely to directly impact quality outcomes in the absence of state-initiated quality monitoring and improvement activities.

Assessment of Opportunity to Leverage Community-Based Behavioral Health Services

The "in lieu of" option does not incorporate any components of the community-based behavioral health continuum within its design. Colorado has sought to develop incentives for transitioning enrollees to outpatient, community-based healthcare through contractual requirements for managed care entities to

[47] The Ohio Department of Medicaid Ohio Medical Assistance Provider Agreement for Managed Care at https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/03_2020_MMC_COVID%20Amendment_Final.pdf. Accessed May 15, 2020.

[48] Contract Between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and … Contractor at https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf. Accessed May 15, 2020.

[49] Washington Apple Health Integrated Managed Care Contract at https://www.hca.wa.gov/assets/billers-and-providers/ipbh_fullyintegratedcare_medicaid.pdf. Accessed May 15, 2020.

develop value-based payment agreements with IMDs. This is intended to create an incentive for the development and reliance upon community-based behavioral health services.

Assessment of Opportunity to Manage Length of Stay

States using "in lieu of" authority may leverage their managed care entity contracts to enforce the ALOS requirement. The "in lieu of" authority has a stricter LOS requirement that must be managed at the beneficiary level. Because this authority can only be leveraged under managed care arrangements, states delegate the utilization management to their contracted managed care entities. Managed care entities typically have greater financial incentive to manage utilization and appropriate LOS. This incentive is further increased under the "in lieu of" authority whereby monthly capitation payments are recouped for any member whose stay exceeds 15 days in a month. Nationwide data is not currently available regarding current ALOS among states utilizing the "in lieu of" authority.

Colorado leverages the state's 1915(b) waiver to manage LOS using contract requirements under the capitated behavioral health benefits, which encourage the managed care entities to offer private IMDs value-based payment agreements which incentivize quality outcomes and serving members in the "least restrictive environment"; engage members in care management; and support the "timely" transition to community-based healthcare. The Department reviews all value-based payment agreements, including metrics.

Assessment of Cost Drivers & Cost Effectiveness via "in lieu of"

The maximum LOS requirement can help manage Medicaid spending associated with psychiatric stays. However, the state will need to identify funding sources for stays exceeding the 15-day maximum. Other states rely on general funds due to the prohibition against using Mental Health Block Grant funds for inpatient services. However, Colorado prohibits the use of state general funds to pay for Medicaid covered services, except when expressly authorized by the General Assembly; this limits the methods through which the state can pay for stays exceeding 15 days.[50]

Implementation Strategies

Colorado is currently utilizing the "in lieu of" authority; therefore, there are not strategies necessary for implementation. However, this does not necessarily mean that the state cannot realize additional opportunities from the existing program. The shorter LOS requirement, as compared to the SMI/SED 1115 waiver, allows for continued reinforcement for serving individuals in the least restrictive environment. This includes assuring availability of step-down services intended to support smooth transitions in care. Although not required, additional strategies available under the SMI/SED 1115 waiver to monitor outcomes and service availability are also available to the Department while leveraging the "in lieu of" option, with the added flexibility to tailor the metrics and consider services necessary to meet the Department's goals.

[50] The Department is statutorily required to administer a program in accordance with Title XIX that qualifies for federal funds (25.5-4-104, 25.5-4-105). Appropriations are restricted by the "M headnote" (described in the long bill introduction) which essentially means that if the Department cannot get a federal match, General Fund funding is reduced proportionately. This precludes the Department from spending state-only funds except when expressly authorized by the General Assembly.

Conclusion

While the longstanding IMD exclusion has prohibited FFP for psychiatric inpatient stays in an IMD for individuals aged 21-64, states now have two options for reimbursing IMD providers for short-term psychiatric inpatient stabilization stays. Because FFP is limited to short-term stays, both the SMI/SED 1115 waiver and "in lieu of" authority options require monitoring and when possible, managing a beneficiary's LOS within these limits. Likewise, both of these options leave a continued Medicaid reimbursement (FFP) gap for longer term stays in an IMD.

At a high level, the decision for states to pursue a waiver comes down to a set of key criteria, including the degree of need for a 1115 SMI/SED waiver to accomplish state service goals and the cost-benefit of using the waiver versus "in lieu of" authority. Additionally, in making the decision on whether to pursue a waiver, states weigh the following criteria:

- The need to minimize disparities between the FFS and managed care populations. States with a significant percentage of Medicaid enrollees in a FFS delivery system may wish to leverage the waiver to assure the FFS and managed care populations have the same coverage.
- ALOS and the number of people who require longer lengths of stay. Specifically, those who exceed the 15-day benchmark and the state ALOS.
- Breadth of community-based behavioral health system of care and service continuum.
- Availability of alternative approaches to manage the LOS and specifically, considering the state's service delivery system, the availability of the "in-lieu of" option.
- Cost and resources to manage waiver requirements, including developing the waiver as well as meeting monitoring and reporting requirements.

Most states continue to provide reimbursement to IMDs via "in lieu of" authority. This may be due to the decreased administrative burden as compared to an SMI/SED 1115 waiver paired with the fact that these states' managed care programs include a portion of enrollees who have a psychiatric inpatient benefit. However, these states may only receive FFP for stays up to 15 days within a calendar month versus the 60-day maximum stay allowable under the SMI/SED waiver. To date, four states (DC, ID, IN, VT) have received approval for an SMI/SED 1115 waiver. Of these, Indiana and the District also had access to the "in lieu of" option under managed care. However, both states chose to pursue the SMI/SED 1115 waiver to address coverage disparities between their FFS and managed care populations.

For Colorado, these considerations suggest the state can more effectively use public dollars by continuing to utilize "in-lieu of" authority. Colorado's LOS is already low, with minimal use of longer-term stays according to data provided by the Department. Specifically, 97.2 percent of all individual stays in an IMD are currently reimbursable under "in lieu of" authority as they fall below the maximum allowable 15-day stay. Colorado's outpatient continuum of care is the priority for the state and most public investments are made at the community level. Colorado also has the "in-lieu of" authority option to reimburse for all short-term IMD stays, as all full-benefit Health First Colorado enrollees are in managed care.

Consideration of state data points and goals recommends ongoing engagement of "in-lieu of" authority. This does not prevent the state from continuing to explore alternative community-based investments to support individuals and to reduce LOS based on specific barriers to discharge, such as community transition. Nor does it prevent the state from consideration of other payment options for IMDs (as outlined above).

CMS' clear and strong guidance related to both the waiver and "in lieu of" options' LOS requirements do not make a presumption that all psychiatric stabilization episodes will fall within the required LOS parameters. States will have to determine the best options for covering intermittent and long-term stays within IMDs, as they did prior to the availability of waivers of the IMD exclusion. At the time that the IMD exclusion was created, the majority of psychiatric inpatient stabilization was provided within long-term state psychiatric hospitals. Over time, as medication and other interventions have been introduced, psychiatric units able to stabilize patients within a short-term stay became more common and available in community hospitals. Some states have even transitioned state operated beds to provide short-term stabilization. However, these options and variances among inpatient providers pose a challenge for states, when at the time of admission, the length of time needed for stabilization may not be clear. Under both the waiver and "in lieu of" options FFP may not be leveraged for reimbursement when the stay exceeds the applicable guidance. The data provided by the Department suggests the volume of long-term stays in IMDs is limited, with only 0.03 percent of all individual stays in SFY19 and the first half of SFY20 exceeding 60 days.

It is possible for an individual in any psychiatric inpatient setting (IMD or non-IMD), to exceed the LOS allowable under the waiver and "in lieu of" options for FFP and continue to meet medical necessity for the covered benefit. In some instances, this scenario requires that an individual be transferred to a long-term psychiatric care setting, traditionally a state hospital, which are largely funded by state general fund dollars. It is worth noting that this option is only available in states who have retained bed capacity for non-forensic (e.g. civil) populations.

In summary, when considering options for FFP reimbursement within an IMD setting, it is important to note that the SMI/SED 1115 waiver allows states to pay for stays or combined stays within a month exceeding 15 days, as compared to the "in lieu of" option; however, the state is still required to maintain a statewide ALOS of 30 days. All other stated Colorado objectives, including quality and service delivery improvement, can be achieved under both the waiver and "in lieu of" authority. Pursuit of the waiver would impose new state administrative costs and require dedication of additional Department and cross-agency resources. These costs, along with federal maintenance of effort requirements to maintain community-based behavioral health services funding for the duration of the waiver may pose challenges considering anticipated state budgetary constraints stemming from the COVID-19 public health emergency. A closer look at the pros and cons of each of these options is provided in Table 4.

Table 4: 1115 SMI/SED Demonstration and In-Lieu of Option Comparison Chart with Potential Strengths and Weaknesses of Each

STATE CONSIDERATIONS	1115 WAIVER	IN-LIEU OF OPTION
Maximum Average Length of Stay	▪ Statewide ALOS of 30 days	▪ No ALOS requirement
Limitation on FFP	▪ Short term stays; FFP only available for stays ≤60 days. ▪ This strategy would not expand access to IMD services for a new population beyond the current "in lieu of" scope.	▪ Stays ≤ 15 days within calendar month; state must recoup PMPM for a stay or combined stays > 15 days in calendar month. ▪ FFP not available to populations enrolled in FFS programs or outside of managed care arrangements. This limitation does not impact Colorado as all enrollees eligible for full benefits are enrolled in a managed care entity.
Administrative burden tied to initial CMS approval	▪ Extensive application process that includes completion of waiver application, SMI availability assessment, Implementation Plan, and required financial reporting.	▪ Implemented through current managed care contracting arrangements versus extensive waiver application process. ▪ Requires no additional Department resources.
Maintenance of IMD reimbursement	▪ Federal approval period is limited to a maximum of five years & renewal application required for ongoing operations. ▪ CMS must continue to determine the goals of the demonstration opportunity further the objectives of Medicaid. This determination may be impacted by changes in federal leadership as well as outcomes data gathered by states during the initial waiver term. ▪ Extensive federal compliance obligations which will require additional Department resources and a contract with an independent evaluator including: ○ Quarterly monitoring reports	▪ Ongoing federal compliance obligations are limited to ensuring capitation recoupment and federal match refund for any stays > 15 days. This is significantly less than required under 1115 authority and would not require additional allocation of Department staffing or fiscal resources. ▪ Federal authority is not time limited. The "in lieu of" authority was codified by the SUPPORT Act; therefore, congressional action would be required to terminate this option.

STATE CONSIDERATIONS	1115 WAIVER	IN-LIEU OF OPTION
	○ Annual monitoring reports ○ Budget neutrality reporting ○ Annual public forum ○ Independent evaluation	
Policy levers for managing longer LOS	▪ 30-day average LOS compared to 15 day for in-lieu of option. ▪ No option for coverage of longer-term stays. ▪ Requires MOE and monitoring of access to community based services intended to divert from inpatient as well as allow for successful stepdown; access to step-down services such as ACT and partial hospitalization may serve to decrease LOS with proper community supports in place to maintain stability. ▪ While a longer LOS allowed under the 1115 option may address some additional enrollees with greater clinical needs, it may also create perverse incentives for increasing the average LOS in IMDs when community-based resources may be available and clinically appropriate. ▪ Continuing to put the managed care entity at financial risk for these services continues incentive for management to appropriate lengths of stay and may mitigate some of this risk.	▪ Recoupment of PMPM from the managed care entity in accordance with federal guidance. ▪ No option for coverage of longer-term stays.

Appendix A: State Approaches to SMI/SED 1115 Waivers

Table 1A: State Approaches to Managing Length of Stay in SMI/SED Waivers

State	Current	Future
DC (FFS)	▪ QIO (Qualis) conducts UM to monitor appropriateness and quality of care. ▪ QIO must authorize hospitalizations at specialty hospitals. ▪ QIO oversees LOS by conducting concurrent utilization reviews during hospitalizations at specialty hospitals to determine clinical appropriateness of current and proposed LOC. ▪ QIO uses InterQual BH Criteria for authorization and concurrent utilization review decisions.	▪ QIO will authorize hospitalization in psychiatric hospital settings. ○ QIO will also provide oversight LOS by conducting concurrent utilization reviews ○ Timeline: 12-24 months.
DC (MCO)	▪ MCOs must develop UM Program. ▪ Stays in psychiatric and residential treatment settings are allowable for MCO beneficiaries under the ""in lieu of" services" provision. ▪ MCOs must conduct independent utilization reviews of hospitalizations and inpatient stays, based on standards such as InterQual BH Criteria and Milliman Care Guidelines.	▪ MCOs will continue to conduct independent utilization reviews of stays in psychiatric hospitals and residential treatment settings. ▪ If new RTFs wish to participate in the demonstration, DC will establish a utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on LOS.
ID (FFS)	▪ QIO (Qualis) authorizes inpatient treatment. ▪ The QIO conducts UM reviews to ensure beneficiaries have access to the appropriate inpatient LOC and LOS. ▪ For inpatient psychiatric stays, the QIO conducts prospective PA as well as reviews during the hospitalization for continued stays to provide oversight on LOS.	**ID FFS and MCO** ▪ In 2021, Idaho Medicaid will rebid the IBHP contract and make several changes to improve coordination, including transitioning to a PIHP. ○ 1 contractor will provide UM activities for all inpatient, residential, and outpatient behavioral health services. ○ The goal of the UM and review processes will be to ensure beneficiaries have access to appropriate levels and types of care, provide oversight on LOS, and provide transitions between LOCs. ▪ The IBHP will utilize state approved, nationally informed best practices. ▪ IBHP staff will work closely with state oversight staff as well as UM counterparts and discharge planners in hospitals and residential programs. IBHP will employ UM staff and use policy and procedures to implement effective UM and review processes. The state will work with IBHP to assure UM procedures align with state standards. ▪ The IBHP contractor will be required to employ staff in each of the state's seven regions who will be responsible for care coordination, ensure enrollees are placed at the appropriate LOC, and link Medicaid members with available programs.
ID (MCO)	▪ Since inpatient care is handled through FFS, and outpatient treatment is delivered through the Idaho Behavioral Health Plan (IBHP) managed care carve-out, the state and QIO work closely with IBHP staff to monitor transitions and discharges among inpatient and outpatient LOC. ▪ The IBHP contractor employs a statewide team of Field Care Coordinators (FCCs). These FCCs are licensed clinical professionals and assist with facilitating transitions across the continuum of care. As members transition from inpatient or residential to community-based care (or vice versa), FCCs assist to promote seamless transitions in care.	

State	Current	Future
IN (FFS)	▪ All inpatient psychiatric, substance abuse, and rehabilitation admissions require PA to ensure the appropriate LOC. ○ Medical necessity reviews are completed by state's PA entity, which uses Milliman Care Guidelines. ▪ Reimbursement is available for inpatient care only when the need for admission has been certified. ○ Emergency and nonemergency admissions require telephonic precertification review followed by a written certification of need through completion of a state form and a written plan of care. ▪ All requests for PA are reviewed on a case-by-case basis to determine whether the requested acute inpatient services meet medical necessity. ▪ Reimbursement is denied for any days the facility cannot justify a need for inpatient care. If the provider fails to complete precertification, reimbursement will be denied from the admission to the actual date of notification. ▪ All private mental health institutions (PMHIs) must have policies and procedures that govern the intake and assessment process to determine eligibility for services. Each admitted Medicaid enrollee must have a preliminary treatment plan formulated within 60 hours of admission on the basis of the intake assessment at admission, which must specify the services necessary to meet the consumer's needs and contain discharge or release criteria and the discharge plan. Further, progress notes must be entered daily and the consumer's treatment plan must be reviewed at least every seven days.	▪ OMPP will develop a report to monitor ALOS for all Medicaid programs. All reporting will follow CMS monitoring guidance. Additionally, OMPP will review timeline requirements for submission of the 1261A form.
IN (MCO)	Same practices as FFS, however: ▪ Medical necessity reviews are completed by the MCO. ▪ OMPP reviews the MCO's UM practices. ▪ All requests for PA are reviewed on a case-by-case basis. The MCO (not PA vendor) reviews each submitted State Form (44697).	▪ OMPP will develop a report to monitor ALOS for all Medicaid programs. All reporting will follow CMS monitoring guidance. Additionally, OMPP will review timeline requirements for submission of a state form (1261A).
VT (FFS only)	▪ DVHA conducts numerous UM and review activities to ensure that "quality" services, (increase the likelihood of desired health outcomes and are consistent with prevailing professionally recognized standards of medical practice), are provided to members and that providers are using the program "appropriately, effectively, and efficiently".	▪ No changes anticipated

State	Current	Future
	▪ DVHA and DMH staff utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence. ○ In 2012, DMH and DVHA collaborated to create a unified, consistent UM system for all Vermont Medicaid-funded inpatient psychiatric and detoxification services. ○ In addition to the joint DMH/DVHA Utilization Review Team, DMH formed an expanded Care Management Unit to actively support the system of care in Vermont and facilitate flow throughout the highest LOC. ▪ Medicaid holds utilization review calls weekly with the Brattleboro Retreat, an inpatient mental health facility for children and adolescents in Vermont, to coordinate care.	

Table 1B: State Practices to Leverage Community-Based Healthcare Services

State	Action
Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions	
DC	▪ Discharge planning and care coordination requirements on psych hospitals and community-based providers. ▪ MCOs must coordinate care and assist in discharge planning. ▪ Added 2703 Health Home model. ▪ Future: Reimburse for discharge planning services.
ID	▪ Discharge planning requirements. ▪ Inpatient care is an FFS benefit, outpatient care is via the IBHP managed care benefit. State will work closely with IBHP to monitor transitions. IBHP uses Field Care Coordinators for care coordination who work directly with members and community providers. ▪ Future: 7/1/2022 IBHP contract will include inpatient services, as well as intensive pre-discharge planning and inclusion of community-based providers in care transitions. ▪ IBHP contract to require: (i) tracking of hospital follow-up with members within 72 hours, 7 days and 30 days after discharge; (ii) case management for all patients hospitalized related to SMI/SED or SUD and continuing at least 30 days post-discharge; and (iii) minimum standards for discharge planning, including full access to robust discharge plans even in rural areas of the state. ▪ Will add Medicaid reimbursement for transition planning services provided by behavioral health providers, including community-based managers.
IN	▪ Discharge planning requirements. ▪ All MCOs must document a post-discharge and care coordination plan. ▪ CMHCs must be involved in treatment and discharge. ▪ MCOs are contractually obligated to provide case management services for at least 90 days post discharge and must connect members with follow up care within seven days of discharge.
VT	▪ Discharge planning requirements. ▪ Contracts with CMHC providers to participate in transition efforts and discharge planning. ▪ Future: Enhance discharge planning and care coordination strategies and improve connection with community-based services via a "Collaborative Network Approach" (open dialogue practice); increase awareness of community support for staff and individuals in psychiatric hospital care; host employment groups; and develop ways for local rehabilitation counselors and employment specialists to meet with patients and staff prior to discharge.
Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available	
DC	▪ Housing included in discharge planning.
ID	▪ Currently no requirement for psychiatric hospitals and residential settings to assess beneficiary housing situation. By January 1, 2021, all psychiatric hospitals participating in the demonstration will be required to assess beneficiary housing situation and coordinate with housing providers. This will be included in the IBHP contract. This will be included in discharge planning.
IN	▪ MCO contracts must provide case management for at risk or members discharged from inpatient psychiatric settings, including "must make every effort to assist members in navigating community resources and linking members with community-based services such as Connect2Help211, food pantries, housing and housing supports, legal, employment and disaster services."

State	Action
	▪ CMHCs must provide advocacy and referral including helping individuals access entitlement and other services. ▪ In the future, Indiana will explicitly require psychiatric hospitals to have protocols in place to assess for housing insecurity as part of the discharge planning process.
VT	▪ Currently assess member's housing situation and community supports and clinical needs during referral, assessment and evaluation, and treatment planning. ▪ Discharge planning includes social work staff working with CMHCs to coordinate care, including housing and residential step-down services. ▪ DMH housing coordinator works with Vermont landlords to secure affordable housing for homeless or those in unstable housing. ▪ Future (2021): Implement state policy to support housing coordination and alignment across IMDs.
State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	
DC	▪ Notification requirements. ▪ MCOs are responsible for coordinating access. ▪ Future: Reimbursement for discharge planning; requirement that residential treatment and hospital settings initiate contact with the beneficiary and community-based provider within 72 hours of discharge.
ID	▪ Currently no requirement in place. New IBHP contract will include inpatient services and incorporate these requirements that IBHP network providers contact beneficiaries. ▪ New managed care contract will include enhanced case management requirements regardless of type of hospitalization. IBHP contractor staff will be required to work with members through at least 30 days post discharge.
IN	▪ MCO contractual obligations for follow up within seven days of discharge. ▪ Indiana Medicaid covers bridge appointments if no outpatient appointment is available in 7 days. ▪ 2020: Indiana will update State Medicaid Manual to require psychiatric hospitals to have protocols in place to ensure member is contacted within 72 hours of discharge and follow-up care is accessed.
VT	▪ These practices are not currently in place. In the future the state will promulgate administrative rules to meet requirement 2c.
Strategies to prevent or decrease lengths of stay in EDs	
DC	▪ Discharge planning + MCOs must reduce preventable hospital admissions and low acuity ED visits, as well as reduce 30-day readmission to receive full capitated payment.
ID	▪ Leverage current continuum of crisis services, including crisis intervention teams and mobile crisis teams.
IN	▪ MCOs must identify high ED users and ensure care coordination for members who are at least three standard deviations from the mean. ▪ Future: State will monitor network capacity and identify underserved areas for provider recruitment. ▪ Currently piloting mobile response stabilization services.
VT	▪ Building inpatient and residential capacity; using telepsychiatry; using peer-to-peer support services, including expanding peer run crisis and stabilization units; increasing Screening, Brief Intervention, and Navigation to Services (SBINS); and positioning Vermont Psychiatric Survivors (VPS) in EDs to support people in crisis. ▪ In the future, Vermont will maintain and enhance current efforts, as well as issue an RFP for peer workforce development that incudes reviewing certification standards and funding methods.

State	Action
	▪ DMH conducted a stakeholder engagement effort in 2019 which resulted in a 10-year plan for holistic and integrated system of care, which will be provided to the Legislature to inform financial and policy priorities.
Other State requirements/policies to improve care coordination and connections to community-based care	
DC	▪ Discharge planning and care coordination requirements. ▪ Medicaid Health Home program requirements. ▪ Incentivize FQHCs to improve care coordination and transitions; APM includes bonus for achieving benchmarks. ▪ Future: Build off Health Homes program.
VT	▪ Technical assistance grants from the National Governor's Association and Actionable Intelligence for Social Policy to enhanced interoperability and data sharing on SUD and mental health providers, among other matters. ▪ All-Payer Accountable Care Organization Model to make payments to community providers for complex care coordination, including to Home Health agencies, Designated Mental Health Agencies, and Areas Agencies on Aging. ▪ Brattleboro Retreat, an inpatient mental health facility for children and adolescents, helps coordinate care during weekly calls.

Appendix B: 1115 Demonstration Waiver Documents

The CMS template is available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html under "Serious Mental Illness/Serious Emotional Disturbance." For direct links, see:

- The CMS November 13, 2018 guidance can be found here.
- The Implementation Plan template can be found here.
- The Monitoring Report Template can be found here.
    - The Mental Health Availability Assessment (excel) can be downloaded here.
    - The 1115 SMI/SED monitoring metrics can be found here.
- Evaluation Design Guidance
    - Master Narrative can be found here.
    - Appendix specific to SMI/SED can be found here.
- Appendix C, which details methods to calculate changes in total costs and examines cost drivers, can be found here.

Appendix C: Acronyms & Terms

Acronym or Term	Definition
ALOS	Average length of stay (ALOS) or length of stay (LOS) refers to the number of days that patients spend in a hospital (IMD). To determine the ALOS, states divide the total number of days stayed by all inpatients during the time period by the number of admissions or discharges.
EMC	[Psychiatric] emergency medical conditions. Defined by the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."
EMTALA	Emergency Medical Treatment and Active Labor Act of enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). EMTALA requires anyone coming to an emergency department to be stabilized and treated, regardless of insurance status or ability to pay.
FFP	Federal financial participation defined under 42 CFR 431.250 is the federal government's share of a state's expenditures under the Medicaid program.
FMAP	Federal Matching Assistance Percentage is used to calculate the federal share (FFP) of state expenditures for services. FMAP is based on a formula that takes into account the average per capita income for each state relative to the national average; it cannot be less than 50%. Colorado's current FMAP is 50%. The highest in the country is Mississippi's, at 76.39%.
ILO	"In lieu of authority" was established by the 2016 Medicaid Managed Care Final Rule. It permits states to allow health plans to cover services "in lieu of" those available under the Medicaid state plan. States may receive FFP for capitation payments on behalf of enrollees aged 21-64 who receive inpatient psychiatric or substance use disorder (SUD) treatment or crisis residential services in an IMD for no more than 15 days per calendar month.
Managed Care Entity	Managed care entities include the seven Regional Accountable Entities (RAEs) and the RAE Medical Choice (DHMC) which operate under 1915(b) authority - The Colorado Medicaid Accountable Care Collaborative: Primary Care Case Management and Prepaid Inpatient Health Plan Program; Accountable Care Collaborative: Limited Managed Care Capitation Initiative and Special Connections: Postpartum Months Three through Twelve
MEPD	The Medicaid Emergency Psychiatric Demonstration established by §2707 of the Patient Protection and Affordable Care Act (ACA). 11 states participated from 3/2012 – 7/2015. Provided FFP for psychiatric inpatient stays in an IMD for enrollees aged 21-64. The demonstration was intended to test whether IMD reimbursement would increase the quality of care for individuals with mental illness at a lower cost.
RAE	Seven Regional Accountable Entities (8, if you include the DMHP) are responsible for coordinating member care, connecting members with primary and behavioral health care, and developing regional strategies to serve Colorado Medicaid members. RAEs are paid a PMPM by the Department and manage capitated payments for behavioral health services.

SED	Serious emotional disturbance refers to a child under age 18 with a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities (SAMSHA).
SMI	Serious mental illness is defined as someone over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities (SAMSHA).
State Plan	A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities (CMS).
SPA	A State Plan Amendment must be submitted if a state wants to change its Medicaid program policies or operational approach. SPAs are used to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information. CMS must review and approve all SPAs before they can take effect. A SPA takes effect on the day specified in the SPA. The effective date for Medicaid SPAs may not be earlier than the first day of the quarter in which it is submitted (42 CFR 430.20). The effective date for a CHIP SPA must be no earlier than the date on which the state began to incur costs to implement the SPA (42 CFR 457.65).
SUD	Substance use disorder is when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home (SAMSHA).
1115 Waiver	Section 1115 Medicaid demonstration waivers allow states to test new approaches in Medicaid different from what is required by federal statute. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services the discretion to let states waive certain Medicaid requirements to carry out "experimental, pilot or demonstration project which, in the judgement of the Secretary, is likely to assist in promoting the objectives of the Medicaid program" (CMS). Colorado currently has one pending 1115 waiver (Colorado Adult Prenatal Coverage and Premium Assistance CHP+) and two pending 1115 waivers (Colorado Hospital Transformation Program and Expanding the Substance Use Disorder Continuum of Care).
1915(b) Waiver	1915(b) waivers are a federal authority vehicle for Medicaid managed care programs. Colorado's Accountable Care Collaborative currently operates under 1915(b) authority. The current waiver period is July 1, 2018 - June 30, 2023.