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IMD Waiver Implementation Plan Report

Prepared for

Colorado Department of Health Care Policy & Financing

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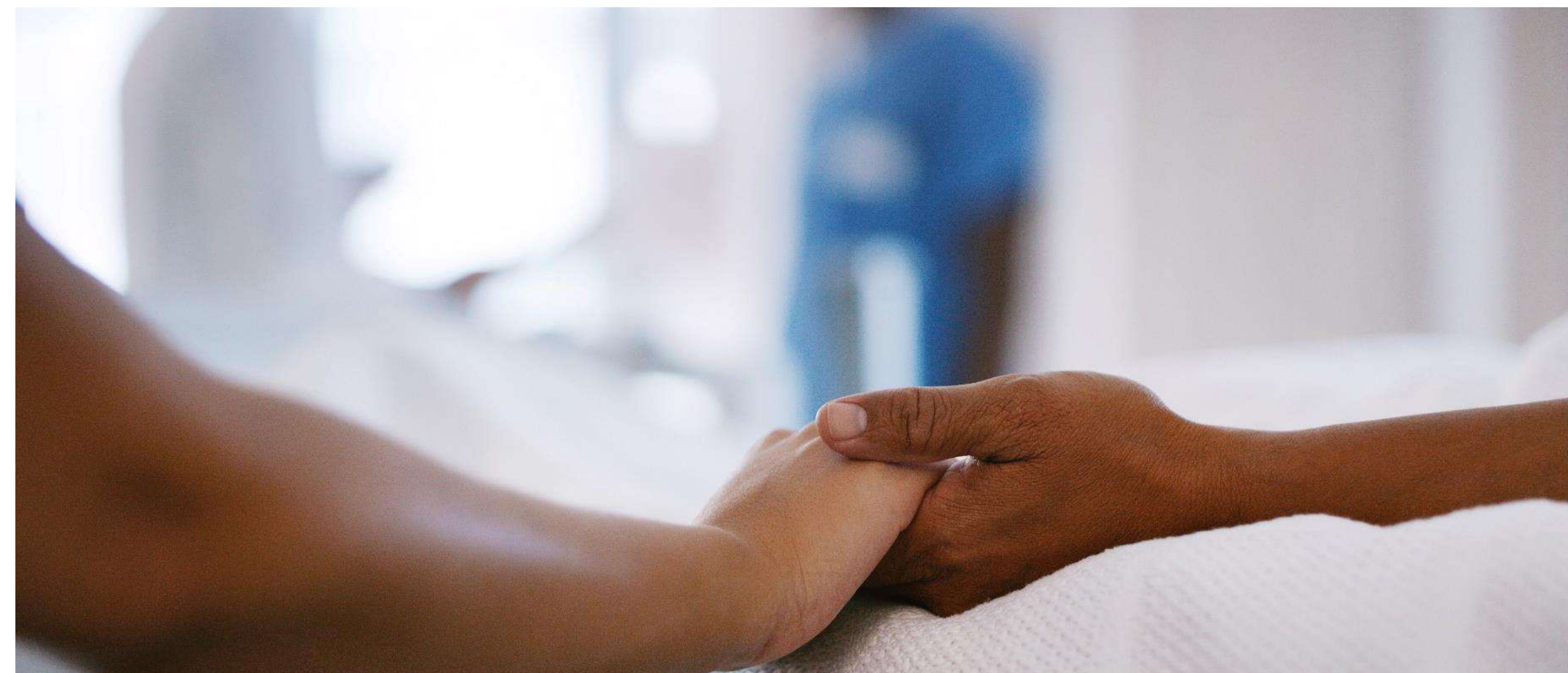

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INTRODUCTION

Background

The Colorado Department of Health Care Policy and Financing (HCPF) received approval under the American Rescue Plan Act (ARPA) to implement 65 projects to improve and enhance Home and Community Based Services (HCBS) within the state. One of the ARPA projects selected by HCPF was to expand access to acute/crisis and step-down facilities. This effort included finding solutions for programs that might operate as components on campuses that would otherwise be classified as Institutions of Mental Disease (IMD). HCPF sought a solution that would allow for program innovation and expansion and would address economies of scale that are currently restricted by IMD considerations.

An IMD is defined as an institution with more than 16 beds primarily engaged in diagnosis, treatment, or care of individuals with behavioral health diagnoses.

For much of the history of the Medicaid program, states have been prohibited from securing federal financial participation (FFP) for inpatient psychiatric stays within an IMD for adults between the ages of 21 and 64.[1] However, more recently the Centers for Medicare and Medicaid Services (CMS) advised states of two pathways to secure FFP for IMD stays for individuals with serious mental illness (SMI) (and children with serious emotional disturbance or SED): 1) states may use federal "in lieu of services" (ILOS) authority through managed care contracts[2], or 2) states may use Section 1115 demonstration waiver authority. States have the option of developing a standalone SMI/SED waiver or incorporating IMD reimbursement within a broader 1115 waiver (e.g., amending an existing 1115 waiver or developing a combined waiver to reimburse for IMD stays for individuals with SMI/SED and substance use disorders). Both authorities allow FFP under certain conditions for individuals with SMI/SED receiving care in an IMD.

Currently, Colorado uses federal "in lieu of" authority to cover stays for up to 15 days within a calendar month in an IMD. According 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, HCPF 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, HCPF does not require managed care entities that administer the capitated behavioral health benefit, such as the Regional Accountable Entity (RAE), to reimburse the IMD. In alignment with federal regulations, 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. In turn, RAEs recoup all payments made for IMD stays that exceed 15 days.

[1] P.L. 89-97
[2] 42 CFR 438.6(e)

In 2020, HCPF contracted with Health Management Associates (HMA) to analyze options for HCPF to secure FFP from the CMS for adults with SMI who require stays in IMDs. HMA evaluated whether an SMI/SED Section 1115 waiver would allow Colorado to accomplish the state service goals and determined the cost-benefit of using this type of waiver versus "in lieu of" authority. To develop our recommendation, HMA considered the following criteria generally used by other states:

- The need to minimize disparities between the fee for service (FFS) and managed care populations.
- 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 length of stay (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.

HMA's research and analysis in 2020 found that pursuit of the SMI/SED Section 1115 waiver would not significantly expand access to the IMD benefit in Colorado. In 2020, like today, all full-benefit Health First Colorado members are enrolled in managed care entities which allows HCPF to utilize the "in lieu of" authority across all populations. According to the LOS data provided by HCPF, 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. Only 2.7 percent (743 stays), exceeded the maximum LOS 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 have been ineligible for FFP.[3]

HMA also determined that pursuing the SMI/SED waiver may require dedication of additional Department resources and new state costs to address the significant CMS monitoring and implementation requirements. These costs were in addition to federal maintenance of effort requirements to maintain community-based behavioral health treatment services funding for the duration of the waiver.

In 2023, building on this previous analysis and recommendations, HCPF contracted with HMA to inform a solution for acute/crisis and step-down facilities operating as components on campuses that would otherwise be classified as an IMD and ineligible for federal financial participation (FFP). Initially HCPF envisioned utilizing a Section 1115 waiver as a vehicle to enhance the state's continuum of behavioral health programming, including step-down services, on a single campus

[3] Health Management Associates, Options for Medicaid Coverage of Institutions for Mental Diseases, June 30, 2020.

as well as to address challenges with creation and maintenance of stand-alone facilities and programs. Components of HMA's work for HCPF included:

- Research of current federal policies related to IMD standards specific to campuses;
- Memorandum addressing considerations and specifications for a SMI/SED Section 1115 waiver proposal that would address the challenges related to the IMD exclusion;
- Landscape analysis of the approaches used in other states to enhance the breadth of mental health services along the continuum of care; and
- Impact of a SMI/SED Section 1115 waiver on the behavioral health provider continuum, including a fiscal analysis, and facilitation of engagement sessions with stakeholders to garner feedback and support.

CMS confirmed for HCPF that under existing federal guidance[4] it would be feasible to develop step-down services on a campus without triggering the IMD exclusion. For example, a provider could have components licensed individually with different license types and sufficiently distinct staff, with recognition that higher credentialed staff could be shared. Therefore, a SMI/SED Section 1115 waiver would not be necessary to implement policies establishing co-located services on a campus.

As a result of CMS' guidance, the focus of HCPF and HMA's stakeholder engagement shifted significantly. Rather than focusing on building out options for acute/crisis and step-down facilities, HMA's focus for the stakeholder forums and data collection requests of IMDs honed in on other concerns. Specifically, HMA structured discussions and analysis on the experience and issues related to the length of stay limits under HCPF's current "in lieu of services" policy. This work explored the range of enrollees' needs and providers' responses to those within the limits of the Medicaid policy and their respective capacity. This work also delved into the potential quality of care, operational, and fiscal impacts in alternative scenarios afforded by the SMI/SED Section 1115 waiver.

SMI/SED SECTION 1115 IMD DEMONSTRATIONS

Scope of Section 1115 Waiver

The SMI/SED Section 1115 waiver requires that a state commit to actions that will improve community-based mental health services for beneficiaries with SMI/SED to receive approval for FFP for services furnished to beneficiaries in inpatient or residential settings that are considered IMDs. CMS advises states to include actions that meet the following criteria:

- Linked to the goals for the SMI/SED demonstration opportunity described in the guidance;
- Ensure good quality of care in IMDs;
- Improve connections to community-based care following stays in acute care settings;

[4] State Medicaid Manual, Section 4390

- Ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED;
- Provide a full array of crisis stabilization services; and
- Engage beneficiaries with SMI or SED in treatment as soon as possible.

Importantly, CMS wants the state's actions to build on opportunities for innovative service delivery reforms the agency has already identified. The SMI/SED Section 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 (See Appendix B).

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 quality treatment to individuals with SMI/SED.
- Services provided in treatment settings for individuals under 21 years of age if those settings do not meet CMS requirements to qualify for the Inpatient Psychiatric Services for Individuals under Age 21 benefit.[5]
- Services in a psychiatric hospital or residential treatment facility for inmates who are involuntarily residing in the facility by operation of criminal law.

Length of Stay Parameters for ILOS Authority Versus Section 1115 waiver

As previously noted, 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 for the full month to which the capitation payment applies, any Medicaid covered benefits provided to this enrollee would be ineligible for FFP due

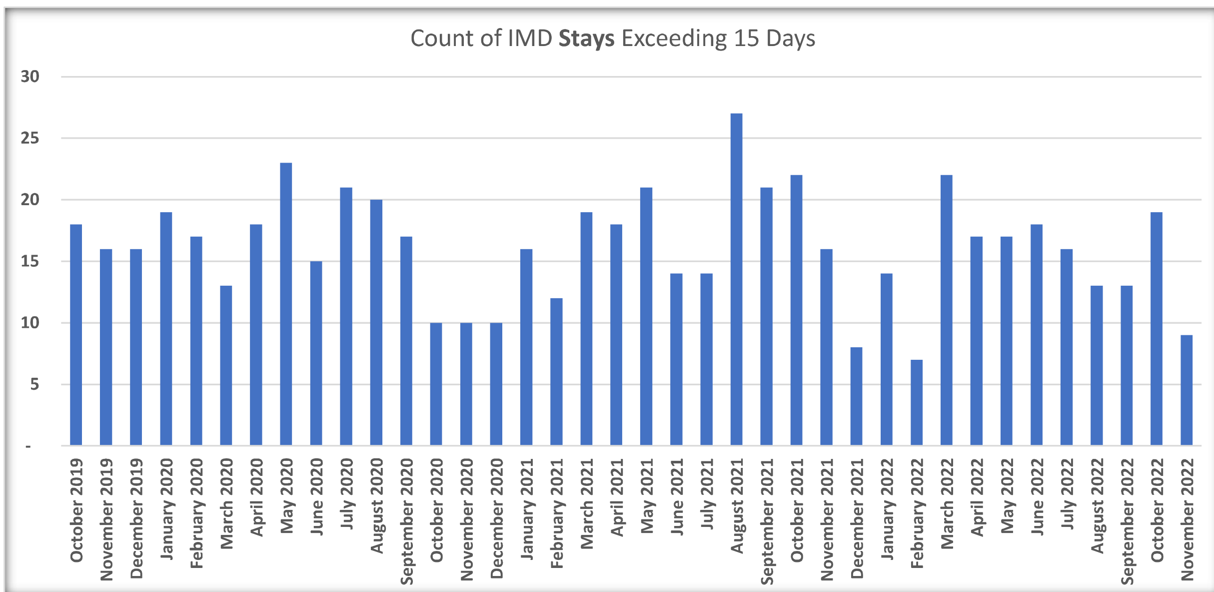
[5] See 42 CFR Part 483 Subpart G

to the IMD exclusion. Therefore, CMS indicates the managed care entity should not be eligible for any capitation payment in that month.[6] 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. In that situation, the managed care entity would be eligible for a prorated capitation payment.

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.[7]

Chart 1 depicts the historical number of stays for IMD visits that exceed 15 days by month based on data provided by HCPF.[8]

Chart 1. Count of IMD Stays Exceeding 15 Days, Oct. 2019-Nov. 2022



[6] 80 FR 31097, June 1, 2015

[7] 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.

[8] HCPF analysis, March 2023

During the period 2019-2022, there was significant variation in the number of stays exceeding 15 days across IMD providers in Colorado (Table 1).[9] This difference is present in the aggregate and annually. In 2022, the number of stays exceeding 15 days ranged from 4 to 62 stays. Under the SMI/SED waiver, Medicaid FFP would be permissible for these stays (provided the state and providers otherwise meet requirements of the waiver).

Table 1. Number of Stays Exceeding 15 Days Per year By Provider

	Cedar Springs	Centennial Peaks	Highlands	West Springs	Peak View	Denver Springs	Johnstown Heights	Clear View
Grand Total	258	166	120	87	70	47	29	6
2019	23	5	11	10	2			
2020	117	30	38	25	23	20		6
2021	56	75	39	35	26	23	6	
2022	62	56	32	17	19	4	23	

In contrast, under a SMI/SED waiver, HCPF 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, HCPF may only claim FFP for individual stays up to 45 days until such time that the Department can demonstrate that it is meeting the 30 day or less ALOS requirement.

Additionally, according to CMS' subregulatory guidance, HCPF would not be permitted to claim FFP for any part of a single stay that exceeds 60 days (not during a calendar or fiscal year) under this demonstration. Based on HMA's review of the Special Terms and Conditions included in previously approved state SMI/SED demonstrations, CMS is likely to require HCPF to assure that the state 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. CMS could seek to apply such a requirement regardless of the limit on the number of inpatient days that HCPF includes in its waiver proposal.[10,11] The demonstration guidance does not place a limit on the number of distinct admissions for an individual that are eligible for FFP.

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[9] HCPF analysis, March 2023

[10] 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. CMS Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers November 4, 2019: https://www.medicaid.gov/federal-policy-guidance/downloads/faq110419.pdf (Accessed May 31, 2023)

[11] Summarized from STCs from Indiana's approved SMI/SED amendment to the Healthy Indiana Plan Waiver, December 20, 2019 and the 2023 STCs: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-healthy-indiana-plan-support-20-ca-03022023.pdf (accessed May 31, 2023)

Administrative Effort for HCPF and Providers

If HCPF were to seek approval for a SMI/SED Section 1115 waiver or amend one of its existing 1115 waivers, the state will need to plan to comply with the federal requirements and ongoing implementation for the waiver, including additional administrative effort and incurred costs by HCPF and providers.

As a first step for determining the costs for developing the waiver, HCPF will need to identify the additional actions needed to meet waiver milestones, such as ensuring health information technology (HIT) initiatives support activities such as closed loop referrals, and tracking of inpatient beds, among others.

HCPF also should consider that 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 or its managed care entities 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. If Colorado pursued the waiver, the Department would have to contemplate how they would identify these longer stays early on. The waiver does not specify how states must manage to the LOS, which means HCPF will need to determine its approach. Many states with approved SMI/SED 1115 waivers delegate managing the ALOS to MCOs or FFS fiscal intermediaries.

The SMI/SED Section 1115 waiver guidance does, however, 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.

Additionally, HCPF would need to consider the administrative activities and costs of waiver implementation, including monitoring, reporting, and contracting with an independent evaluator. States are also required to annually report data on the number of various individual (psychiatrist, psychologist, social worker, etc.) and agency (CMHC, PRTF, hospital) mental health providers licensed in the state, identify those enrolled as Medicaid providers, those with capacity to accept new patients, and indicate if there have been significant shifts in these provider numbers over the course of the demonstration. As with any waiver, HCPF will also have to provide required financial reporting including maintenance of funding allocated to community-based behavioral health services.

Administrative Effort Required of Providers

Providers will also need to undertake additional administrative activities to prepare for and participate in the SMI/SED Section 1115 waiver program. As part of the Implementation Plan that HCPF would need to submit to CMS for approval, HCPF should expect to identify and include new requirements of providers. The Implementation Plan itself must detail how the state currently meets any expectations, any actions required for the state to meet each milestone, and the

persons or entities responsible for completing the actions. Requirements applicable to providers include:

- State requirement that psychiatric hospitals and residential settings screen beneficiaries for comorbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions.
- Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning and include community-based providers in care transitions.
- Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.
- 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.
- State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay.
- Using Health IT to advance the care coordination workflow for patients experiencing their first episode of psychosis.

Implementation Timeline

HCPF will utilize HMA's research and analysis, including information from stakeholder engagement, as it continues to evaluate the SMI/SED demonstration option and its strategy to address gaps in the continuum of services and ensure sufficient provider capacity to meet the needs of Coloradans. In 2023 and 2024, HCPF has committed to continuing its collaboration with providers on specific barriers to care that were identified during stakeholder engagement but that cannot be addressed by a SMI/SED Section 1115 waiver. These issues will be addressed in the IMD provider forums. For example, HCPF will work with providers to ensure there is consistency in the rules and expectations among RAEs and other administrative issues.

Additionally, HCPF is cognizant of the efficiencies gained by aligning work on these issues with the separate workstreams for the design and implementation of Accountable Care Collaborative (ACC) Phase III, where feasible. The ACC features RAEs operating in seven regions. RAEs are responsible for coordinating physical and behavioral health care for members and administering Health First Colorado's capitated behavioral health benefit. Current contracts between HCPF and the RAEs will end on June 30, 2025.[12]

Alignment with ACC Phase III

HCPF created the Accountable Care Collaborative (ACC) in 2011 to deliver cost-effective, quality health care services to its Colorado Medicaid members and to improve the health of Coloradans. As previously noted, the ACC features RAEs operating in seven regions. In preparation for ACC

[12] Colorado's Accountable Care Collaborative Phase III A Brief Overview, February 2023: https://hcpf.colorado.gov/sites/hcpf/files/ACC%20Phase%20III%20Fact%20Sheet%20February%202023.pdf (Accessed May 18, 2023).

Phase III, HCPF developed goals that align with the Department's mission to improve health care equity, access, and outcomes for Coloradans while saving them money on health care and driving value for Colorado. Additionally, the Department identified priority areas for improvement and innovation intended to better align with its mission, advances made by its sister agencies, and stakeholder input received beginning in fall of 2022.[13]

In its ongoing work with providers, and if HCPF pursues a SMI/SED Section 1115 waiver, the Department should consider every opportunity to coordinate and align this work with ACC Phase III, which will be implemented in July 2025. A key element of ACC III is the coordination of behavioral, physical, and community-based services through a regional delivery system. The next phase of the ACC will also continue the state's evolution towards a comprehensive, integrated, and accountable behavioral health benefit that fosters innovation and evolution of the behavioral health infrastructures while holding all critical partners accountable.

IMPLEMENTATION STEPS

Scope of Issues for Colorado

As part of the waiver application HCPF would need to provide a thorough assessment of its current landscape and demonstrate how its strategy for building out the mental health services continuum will lead to improved access to community-based services. Detailed descriptions of the activities HCPF plans must be explicitly linked to the milestones listed in CMS' SMI/SED waiver guidance.

The waiver opportunity will not allow HCPF to alter the criteria used to determine if a facility qualifies as an IMD and whether multiple components are treated as a single IMD. Beyond the exclusion of NFs, the state has flexibility to determine which of its IMDs it includes in the demonstration program. For example, it could opt to exclude state hospitals.

The overall average length of stay must not exceed 30 days. The state would want to work collaboratively with CMS on how this average is calculated.

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, HCPF will need to consider:

- 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.

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[13] Colorado's Accountable Care Collaborative Phase III A Brief Overview, February 2023: https://hcpf.colorado.gov/sites/hcpf/files/ACC%20Phase%20III%20Fact%20Sheet%20February%202023.pdf (Accessed May 18, 2023).

- 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.

Broader Scope of Work for Section 1115

Generally, CMS' November 2018 guidance is focused on providing states a pathway to improve comprehensive, coordinated systems of community-based mental health services. CMS established five goals for state waivers, and the waiver guidance describes 17 milestones (Appendix B) for states to demonstrate progress towards these goals.

The goals are:

1. Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care hospitals and residential settings;
3. Improved 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. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

CMS expects that states will maintain a level of state appropriations and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the demonstration project that is no less than the amount of funding provided at the beginning of the demonstration. This maintenance of effort (MOE) is distinct from the MOE states must demonstrate for the Community Mental Health Services Block Grant.

As part of a SMI/SED Section 1115 waiver application, HCPF would need to describe the state appropriations and local funding for outpatient community-based mental health services provided to Medicaid beneficiaries. The MOE for SMI/SED waivers will be based on the level of state appropriations and local funding for outpatient community-based mental health services for the most recently completed state fiscal year as of the date the state submits its SMI/SED demonstration application.

The guidance letter directs states to include several components in a demonstration application. Table 2 describes the components.

Table 2. Components of SMI/SED Application

Requirement	Description	Reporting Requirement
Comprehensive description of the demonstration	The description must include at least the following: ● The state's strategies for improving access to and quality of mental health care. ● How the strategies will address the goals and milestones for the demonstration. ● A description of the activities the state will undertake to address the milestones. ● A description of state activities to report on progress toward the milestone and performance measures, including proposed data sources and resources for reporting on performance measures.	Included in the application only
Assessment of the current availability of mental health services throughout the state	States must complete an excel template that documents network adequacy, specifically: ● The mental health service needs (e.g., prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration ● The organization of the state's Medicaid behavioral health service delivery system at the beginning of the demonstration ● Availability of mental health services for Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. At minimum, explain any variations across the state in the availability of the following: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning.	● CMS will use this data submitted by the state to set baseline numbers that will be monitored over the course of the demonstration. ● Network adequacy document must be updated annually.

Requirement	Description	Reporting Requirement
	● Gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment ● Gaps in the availability of mental health services or service capacity NOT reflected in the Availability Assessment ● CMS advises states to work with their State Mental Health Planning Councils and other mental health authorities to develop this assessment	
Comprehensive plan to address the needs of beneficiaries with SMI or SED	● The plan must include an assessment of how the demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams ● MOE on funding for SMI/SED demonstrations will be based on the level of state appropriations and local funding for outpatient community-based mental health services for the most recently completed state fiscal year as of the date the state submits its SMI/SED demonstration application	Ongoing reporting of MOE via quarterly monitoring reports
Description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing required of individuals impacted by the demonstration	● A description is required to the extent such provisions would vary from the State's current program features and the requirements of the Social Security Act	Included in the application only
List of proposed waivers and expenditure authorities	State must identify what waivers of Social Security Act requirements it believes to be necessary to authorize the demonstration.	Included in the application only
An estimate of annual aggregate expenditures	Estimates should be provided: ● By population group impacted by the demonstration, including	● CMS provides recommendations for evaluation design and methods to calculate

Requirement	Description	Reporting Requirement
	development of baseline cost data for these populations. ● States' fiscal analysis should demonstrate how the proposed changes will be budget neutral (and not increase federal Medicaid spending).	changes in total costs and examine cost drivers within the Medicaid program[14] ● State must submit cost analyses as part of the interim and summative evaluation reports
Enrollment data	Data should include: ● Historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration	
Documentation of compliance with public comment notice and comment	Documentation must be provided to demonstrate: ● Compliance with the minimum 30-day public notice and comment procedures ● Consultation with Indian tribes and Indian health providers (42 CFR 431.408) ● Report of the issues raised by the public during the comment period and how the state considered those comments when developing the final demonstration application submitted to CMS	Included in the application only
Research hypotheses	● Hypotheses should be related to the demonstration's proposed changes, goals, and objectives ● Provide a general plan for testing the hypotheses including, if feasible, the	● Independent evaluation, including an interim evaluation one year before expiration of the demonstration or when the state submits a

[14] Evaluation Design Guidance For Section 1115 Demonstrations For Beneficiaries With Serious Mental Illness/Serious Emotional Disturbance And Substance Use Disorders, available here: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-1115-eval-guide.pdf; Appendix A: Goals, Research Questions, And Analytic Approaches For Evaluating Section 1115 Serious Mental Illness/Serious Emotional Disturbance Demonstrations, available here: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-eval-guide-appendix-a.pdf and Appendix C: Approaches To Analyzing Costs Associated With Section 1115 Demonstrations For Beneficiaries With Serious Mental Illness/Serious Emotional Disturbance Or Substance Use Disorders, available here: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf (Accessed September 28, 2022)

Requirement	Description	Reporting Requirement
	identification of appropriate evaluation indicators	proposal to renew the demonstration and a final evaluation due 18 months after the demonstration period ends.
Implementation Plan[15]	● Implementation plan can be submitted before or after the demonstration approval. The plan must be approved in order to claim FFP; therefore, submission with the waiver application is recommended. ● Plan must detail how the state currently meets any expectations/ specific activities related to each milestone and any actions needed to be completed by the state to meet all the expectations for each milestone, including the persons or entities responsible for completing these actions. ● Plan must also describe state's planned timelines and activities for meeting milestones (if being submitted at the time of application) or a date by which the state intends to submit this Implementation Plan ● State must use CMS' Implementation Plan template document which includes questions that track with the milestones (Appendix B) ● State may submit additional supporting information and must include a POC for the Implementation Plan ● State must submit a copy of its Memorandum of Understanding (MOU) or other formal agreement regarding coordination with the state mental health authority, if the mental	● State must submit monitoring reports quarterly and annually after demonstration approval ● Must include qualitative and quantitative data about the state's progress implementing the demonstration ● Annual report must include an annual reassessment of availability of mental health providers and settings in the state, identify state efforts to implement improvements in the availability of mental health providers in the state, including a geographic analysis ● Quarterly and annual reports must include reporting on other performance and quality measures that are included in the monitoring protocol ● Reporting on the status of the financing plan is integrated into state's

[15] Section 1115 SMI/SED Demonstration Implementation Plan, July 23, 2019: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-impl-plan-template.pdf (Accessed September 28, 2022)

Requirement	Description	Reporting Requirement
	health authority is not a part of the single state Medicaid agency ● Implementation Plan must include a financing plan that is to be approved by CMS and implemented by the end of the demonstration[16] ● The financing plan must detail how the state plans to support improved availability of non-hospital, non-residential mental health services, including crisis stabilization services, as well as on-going community-based services. ● The financing plan must describe state efforts to increase access to mental health providers throughout the state, including changes to reimbursement and financing policy for the state's mental health systems that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application ● Health IT Plan that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability to support demonstration's goals ● The HIT Plan should address electronic care plan sharing, care coordination, and behavioral health-physical health integration.	quarterly and annual monitoring reports

[16] CMS Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers, May 17, 2019: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf (Accessed September 30, 2022)

Strategy for ACC Phase III

If HCPF were to seek approval for a SMI/SED Section 1115 waiver, RAEs' contracts will need to account for IMD reimbursement under the parameters of the wavier versus "in-lieu of" authority. Specific considerations include the following:

- Making stays in an IMD a mandatory benefit RAEs must cover.
- Prohibiting RAEs from reimbursing for stays over 60 days.
- Requiring RAEs to work with HCPF to manage to a statewide ALOS that does not exceed 30 days.
- Requiring RAEs provide any necessary reporting requested by HCPF or required by CMS.
- Adjusting capitation rates to account for this benefit.

Fiscal Considerations and Estimated Anticipated Impacts

HMA conducted a fiscal analysis to estimate potential new system expenditures that may result in Medicaid FFP for the IMD providers for patient stays that exceed 15 days if HCPF receives approval for a SMI/SED Section 1115 waiver.

HMA worked with HCPF and the IMD providers to obtain general information and historical data that could be utilized as a basis for estimating a potential fiscal impact. Internal HCPF data included historical experience from October 2019 through November 2022 specific to IMD utilization and cost.

In addition to the historical HCPF data, HMA and HCPF met with IMD provider groups in an open stakeholder group forum. During this forum, the discussion focused on the general landscape of today and hopes for how the landscape may look in the future. This included detailed input from the IMDs around current experience and barriers for individuals who exceed 15-day stays. The IMDs were additionally asked to provide their view on historical data in the form of a follow up information request.

The information and data received was aggregated and summarized to utilize for a projection of expense that would be new to the system if stays in excess of 15 days became Medicaid covered services, most likely via an 1115 waiver. The estimate was developed by utilizing components of both HCPF data and IMD information described above. To the extent true historical experience varies from these data sources, the estimate described below would change.

The estimated annual expense for coverage of IMD stays exceeding 15 days is projected to be $7.2M. This figure reduces to $2.5M under the assumption that only the first 15 days of these stays are reimbursed. This estimate represents total expense and may be partially funded with FFP under a SMI/SED Section 1115 waiver. HCPF could determine its preferred policy under a Section 1115 waiver or other approach for reimbursement of these stays including the length of stay to cover.

Several assumptions went into this point estimate. There is a range of expenditures that would be reasonably defendable for this estimate. This analysis utilizes one set of assumptions within that range. To the extent true historical experience varies from the data sources utilized in this analysis, the estimate would change. Note, this estimate represents expenditures for medical services only. As previously discussed, HCPF should expect to incur administrative cost over and

above these figures. Full detail regarding potential fiscal impact is available in the May 24, 2023 report entitled *1115 IMD Fiscal Analysis.*

Submission to CMS and Timeline for Approval

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 in Appendix A). The components include:

- A narrative that specifies the demonstration's goals, including how the state's demonstration program will achieve the goals outlined by CMS.
- Confirmation of the state's commitment to achieving the milestones outlined in the demonstration guidance.
- Documentation of and response to stakeholder feedback. HCPF will need to provide at least a 30-day public notice and comment period specific to the SMI/SED Section 1115 waiver application. The provider forums convened as part of this project will not be sufficient to meet the federal public comment and transparency requirements.
- An Implementation Plan utilizing the CMS template. HCPF would also need to determine if it will include its implementation of evidenced based practices when proposing to add services through the waiver proposals.

Implementation Plan

CMS provides a template for states to use in submitting their Implementation Plans. 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)

HCPF will need to perform an assessment of the state's current behavioral health system of care and include a summary of this assessment within its application. CMS created an 1115 SMI Currently Availability Assessment Template that provides a format for providing information on both provider and service availability within the state. 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.

The Availability Assessment must include the following provider types:

- 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

Table 3 outlines major tasks with timeframes for HCPF to develop and submit a SMI/SED Section 1115 waiver. This may fluctuate based on state specific processes, efforts to align with ACC Phase III, the type and volume of public comment received and other issues that may emerge during the course of this effort.

Table 3. Projected Timeline for Major SMI/SED Section 1115 Steps

	Task/Action	Timeline
1.	Policy meetings to confirm content for waiver application and determine if state will pursue amendment to current 1115 waiver or develop standalone SMI/SED 1111 waiver.	Summer 2023 – Fall 2023
2.	Draft SMI/SED 1115 waiver application or amendment including associated templates.	Summer – Fall 2023
3.	Convene stakeholder engagement forums and provide public comment opportunity; respond to and summarize comments to stakeholder input.	Winter 2023 -- 2024
4.	Revise draft waiver application or amendment, as needed, and review all materials prior to submitting to CMS.	Fall 2023 – Winter 2024
5.	Engage with CMS around waiver approval to address questions and make revisions as necessary.	Spring 2024

Appendix A: 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 B: IMD Waiver Milestones

Milestone	Action to Support Milestone
Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	● 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
	● Establishment of 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
	● Use of a utilization review entity to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure adherence to medically necessary lengths of stay in terms of the clinical need for facility treatment and the time period
	● 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.
	Implementation of a state 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
Improving Care Coordination and Transitions to Community-Based Care	Implementation of a process to ensure: ● Psychiatric hospitals and residential treatment settings provide intensive pre-discharge, care coordination services to help transition beneficiaries out of these settings and into appropriate community-based outpatient services; and ● Requirements that community-based providers participate in these transition efforts
	Implementation of a process that:

Milestone	Action to Support Milestone
	• Assesses the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment setting; and • Connects those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available
	Implementation of a requirement that: • Psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge; and • Follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to
	• Implementation of strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED
	• Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED
Increasing Access to Continuum of Care Including Crisis Stabilization Services	• Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability
	• Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers as well as on-going community-based services
	• Implementation of strategies to improve the state's capacity 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

Milestone	Action to Support Milestone
	● Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association to help determine appropriate level of care and length of stay
Earlier Identification and Engagement in Treatment Including Through Increased Integration	● Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs
	● Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers
	● Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED