HMA

Stakeholder Summary Report IMD Exclusion

Prepared for

Colorado Department of Health Care Policy & Financing

June 2023

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INTRODUCTION AND BACKGROUND

The Colorado Department of Health Care Policy & Financing (HCPF) contracted with Health Management Associates (HMA) to explore options for a 1115 waiver related to the federal institution for mental disease (IMD) exclusion. To support this effort, HMA identified the appropriate scope for a potential 1115 waiver based on Centers for Medicare & Medicaid Services (CMS) guidelines, surveyed other states' solutions, and examined alignment with Colorado's efforts to transform its behavioral healthcare continuum. As part of this engagement, HMA supported HCPF in implementing a stakeholder engagement strategy to seek feedback on current issues and potential opportunities. This report provides an overview of the stakeholder engagement process and feedback received.

The IMD exclusion refers to a federal law that generally prohibits state Medicaid agencies from receiving federal matching funds for stays within an IMD for adults ages 21–64. An IMD is defined as a hospital, nursing facility, or other institution with more than 16 beds that is primarily engaged in diagnosing, treating, or caring for people with mental illnesses. These services include medical attention, nursing care, and related services.[1] In addition, the federal match for enrollees younger than 21 years old is limited to inpatient psychiatric services provided in a psychiatric hospital, general hospital with a psychiatric program, or a psychiatric residential treatment facility (PRTF).

At present, CMS provides two options for states to receive federal financial participation (FFP) for short-term IMD stays. First, states may use in lieu of authority through its managed care contracts to reimburse IMD stays of up to 15 days in a calendar month. Second, under 1115 waiver authority, states may reimburse for IMD stays of up to 60 days if an average statewide length of stay of 30 days or less is maintained. At this time, the HCPF uses in lieu of authority through contacts with its regional accountable entities (RAEs).

At the outset of this project, HCPF was considering use of a 1115 waiver as a vehicle to allow for a continuum of behavioral health programming, including step-down services, on a single campus. This possibility was informed by challenges surrounding the creation and maintenance of standalone behavioral health facilities and programs. Creating standalone facilities and programs that have fewer than 16 beds are not affected by the IMD exclusion but are difficult to sustain because of economies of scale factors. Expansion of existing facilities on a campus with existing inpatient or residential beds may trigger the IMD exclusion from reimbursement, and, therefore, providers avoided it. However, workforce limitations also make creating new facilities and programs a challenge, especially when separate from existing facilities and campuses where staffing can be flexed and maximized, especially in rural areas. This option, to allow for campus expansion without concern for triggering the IMD exclusion, informed the initial stakeholder engagement strategy and feedback was sought primarily on provider interest in expanding capacity if IMD exclusion from reimbursement were waived.

During this initial exploratory phase, CMS confirmed that under existing federal guidance[2] it would be feasible to develop step-down services on a campus without triggering the IMD exclusion. Therefore,

[1] 42 CFR 435.1010
[2] State Medicaid Manual, Section 4390

an 1115 waiver would be unnecessary to implement policies establishing collocated services on a campus. With this guidance, the focus of stakeholder engagement shifted to seeking feedback from IMDs on potential challenges under HCPF's use of the in lieu of policy, including length-of-stay limits that differ in duration from those required under an 1115 waiver authority.

APPROACH TO OBTAINING STAKEHOLDER ENGAGEMENT

As described further below, stakeholder feedback was sought through both provider survey and focus groups. The survey was distributed before the CMS guidance that step-down services on a campus are feasible in the absence of 1115 waiver authority. Therefore, the focus and distribution of the survey centered on broad-based feedback from the behavioral health provider continuum and their willingness and ability to expand crisis stabilization, inpatient, and residential services. Following receipt of CMS guidance, the stakeholder engagement strategy shifted to focus groups with IMDs to better understand how the 15-day length of stay (LOS) limit impacted member care and provider operations.

Surveys

The initial survey was prioritized for providers of mental health services in crisis, inpatient, acute, and long-term settings, as well as community-based services and supports. This feedback was requested through an online survey of providers across the state and service areas. The survey asked providers to share their thoughts and experiences to better understand the capacity for short-term mental health crisis stabilization, inpatient, and residential services in their respective communities. HMA also sought feedback regarding providers' interest in expanding access to needed services and supports. Information from the survey was intended to inform the potential development of a 1115 waiver focused on expanding access to behavioral health services through the development of step-down services on a campus as it was distributed before we received CMS guidance on the ability to leverage a campus solution without waiver authority.

The survey specifically asked questions about a provider organization's:

- **Experience/role in the present system of care,** including population(s) of focus; crisis; short-term psychiatric inpatient and residential services; and geographic service area
- **Perspectives on the availability of crisis, short-term psychiatric inpatient, and residential services**, as well as diversion/stepdown services
- **Considerations for service expansion,** specifically how decisions are made regarding adding, expanding, or removing services
- **Barriers to providers adding services and supports to their service array**, including workforce or other program implementation and reimbursement challenges (such as the IMD exclusion)

Please refer to Appendix B2 for a copy of the survey. In addition, a full analysis of survey results is contained in HMA's January 6, 2023, report, "1115 IMD Waiver Impact Analysis."

Overall, results from the survey indicate a potential need for residential, long-term inpatient, and skilled nursing facility treatment services. However, as Table 1 illustrates, responses were mixed regarding provider interest in expansion of services on a campus if HCPF were granted an IMD

waiver. Qualified residential treatment providers (QRTPs) and psychiatric residential treatment facilities (PRTF) expressed interest, but respondents from skilled nursing facilities (SNFs) and community mental health centers (CMHCs) expressed some hesitancy.[3] The only outpatient substance use disorder (SUD) provider who responded to the survey had no interest in expanding inpatient services. QTRP and PRTF representatives indicated they were providing services in most Colorado counties and were interested in further expansion into all counties. When asked if a provider would consider expanding residential services, one PRTF and one QTRP representative reported that they would consider this option. Additionally, one QRTP respondent stated that if allowed, the facility has space to expand its bed availability and would also add crisis/respite beds. Furthermore, a respondent from a CMHC, CCBHC, or other provider that excludes inpatient treatment responded that the facility is outpatient-only, but the thought of opening an inpatient unit is "in the back of our minds for the future." However, survey participation and response were limited, and not all respondents answered all questions asked, limiting the ability to extrapolate these findings.

Table 1. Survey Responses Regarding Willingness to Expand Services on a Campus

Provider Type	If Colorado were granted a waiver of the IMD exclusion, allowing reimbursement for mental health facilities on a campus with a total number of beds greater than 16, would you consider an expansion of services?		
	Yes	No	Unsure
CMHC, CCBHC, or multi-service provider, excluding inpatient services	-	-	1
PRTF	1	1	-
QRTP	1	-	-
Skilled nursing facility	-	-	4
Outpatient SUD facility	-	1	-
TOTAL	**2**	**2**	**5**

Focus Groups

On March 20, 2023, HCPF and HMA led a virtual presentation on Expanding Access and Reimbursement for Services Provided to Individuals with MH Conditions: Options for Services Delivered in IMDs (Appendix B3a) for individuals at the seven adult psychiatric inpatient IMDs. This presentation provided an overview of the SMI/SED 1115 Waiver Opportunity and HCPF data regarding hospital length of stays (LOS) of more than 15 days. Attendees also were given an

[3] Skilled nursing facilities as a provider group are ineligible under the serious mental illness/serious emotional disturbance 1115 waiver opportunity for an IMD exclusion. However, HCPF included these providers in the survey in case they were interested in developing additional mental health facilities under separate licensure. Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance (medicaid.gov) (page 13).

opportunity to provide initial feedback regarding the scope and impact of the 15-day limit. Attendees described several factors driving LOS exceeding 15 days and associated claims denials. Themes raised included barriers to safe discharge such as homelessness, delays resulting from court-ordered medication treatment timing, and wait lists for state hospital beds when needed for longer LOSs.

This high-level feedback informed the development of additional data requests to further identify the scope and impact of the 15-day limit (Appendix B5). As Table 2 illustrates, data from the IMDs varied regarding the impact of the 15-day LOS. Data from four of the five IMD respondents, indicated the total number of individuals with stays longer than 15 days ranged from two to 80 in calendar year 2020. The range of associated costs for these stays was $30,000−$1.6 million, with the associated bed days ranging from 34 to 1,492. IMDs also were asked to provide data on contributing factors to stays exceeding 15 days. Not all IMDs reported on all fields, and the impact of the contributing factors varied by IMD. This information is summarized in Table 2.

Table 2. IMD Data Regarding Stays of More than 15 Days, Calendar Year 2022

	IMD #1	IMD #2	IMD #3	IMD #4	IMD#5
Stays Exceeding 15 Days					
Total stays	2	Not reported	80	39	54
Associated costs	$30,000	$238,000	$1.6 million	$936,000	$882,000
Associated bed days	34	174	1,492	1,120	964
Contributing Factors to Stays Exceeding 15 Days					
Awaiting state hospital bed (monthly average)	0	1	2	0.5	1
Service received at another IMD in same month	0	6 stays 55 days	11 stays 102 days	11 stays 94 days	17 stays 164 days
Delays in court-ordered medication	0	Not reported	4 stays 136 days	12 stays 300 days	10 stays 333 days
# of stays with safe discharge barriers due to homelessness	7	4	31	15	Not reported

Following the data collection and analysis, the HMA team collaborated with HCPF to convene focus groups with the seven IMDs. HMA facilitated three IMD focus groups, which were organized based on IMD corporate structure (see Appendix B1). Ultimately, five of the seven identified IMDs opted to participate in the focus groups.

Generally, the same questions were posed in each focus group, with some variance in follow-up questions specific to data received from each IMD. The focus group questions sought to gain information about the potential impact of HCPF pursuing an 1115 waiver that permits IMD reimbursement under different requirements related to LOS, specifically the ability to manage to an average LOS of 30 days. This discussion included comments regarding how an 1115 waiver could benefit beneficiaries and providers, the barriers and challenges that a waiver would not solve, and operational/system barriers to discharge that increase LOSs beyond the current allowable 15 days per calendar month.

On April 26, 2023, HCPF and HMA met virtually with the seven IMDs and presented the results of the focus group findings. Several common themes related to reasons for stays beyond 15 days emerged from these discussions, including:

- **Individuals awaiting state hospital beds**: IMDs described the current waiting list for a state hospital bed and the inability to transfer patients within 15 days. Respondents noted that reimbursement for IMD stays beyond 15 days would assist in providing additional time for treatment within the IMD pending transfer but would not affect moving patients off the waiting list or creating additional state hospital beds. As the data in Table 2 indicate, the perceived scope of this issue varied by IMD with one representative noting that the facility has no patients awaiting state hospital placement during an average month, whereas the other participants said their institutions averaged one patient awaiting placement.
- **Patient acuity:** Some IMD representatives noted that their facilities recently have been serving higher acuity patients and encountering recidivism when perhaps a longer initial stay would have prevented the readmission. Several IMD representatives said higher acuity can be a barrier to discharge within 15 days and felt an increase in days available for reimbursement would assist in better addressing patient stabilization that requires a longer stay and discharge planning for complex patients to ensure ongoing stabilization.
- **Delays in obtaining court ordered medication approval:** Some IMD representatives described delays in being able to initiate treatment, sometimes up to 14 days, because of delays obtaining court-ordered medication approval. As Table 2 illustrates, not all IMDs reported experiencing this issue.
- **Admission to another facility in the same month:** In each focus group, IMDs reported being unable to identify patient admissions within the same month at other facilities posed a reimbursement barrier for four of the five participating IMDs; that is, when cumulative days between IMDs was 15 days or more within a month, the second IMD was ineligible for reimbursement. Furthermore, regardless of reimbursement concerns, providers said this lack of transparency creates barriers to accessing information that would benefit treatment planning and continuity of care.
- **Homelessness and care transitions:** IMDs noted a lack of safe discharge settings for unhoused populations, with concerns regarding inability to discharge to shelters

because of ongoing treatment and follow-up care needs. Though increasing the LOS available for reimbursement would not expand access to appropriate housing, some IMD representatives did note a longer permissible LOS would provide additional time to better identify and secure appropriate housing and discharge placement.

- **Continuum of care issues**: Participants generally agreed the continuum of Medicaid covered services is sufficient, but said access is limited. For example, staffing shortages in community-based clinics cause delays and barriers to establish outpatient follow-up care. Moreover, several participants noted issues with service authorizations from regional accountable entities (RAEs); for example, denials for step-down services, such as partial hospitalization programs and approvals for an acute treatment unit (ATU) level of care, but the ATU provider is unwilling to accept the patient.

Focus group participants also described the downstream implications of denials for stays of more than 15 days and the potential for more robust discharge planning with longer LOS under an IMD waiver. Some IMD representatives noted the financial loss associated with stays that exceed 15 days prevents them from being able to invest in step-down services such as intensive outpatient or partial hospitalization. Another negative impact some of the participants identified was the need to reduce bed availability for the adult population seeking inpatient services and instead increase bed capacity for populations without the 15-day restriction, including children/adolescent units or forensic inpatient care. The focus group participants identified positive implications of having an IMD waiver such as ability to pay higher wages that would attract the needed workforce and the ability to develop more comprehensive and clinically appropriate discharge plans if longer LOS were permitted, if lost revenue was realized to support these efforts.

OPTIONS FOR ADDRESSING STAKEHOLDER FEEDBACK

1115 Waiver

Overall, stakeholders identified potential benefits associated with 1115 waiver authority to reimburse IMD stays beyond 15 days in a month. Given the range in the number of stays beyond 15 days, the perception of the potential waiver benefits and scope of impact varied among participating stakeholders.

Survey and focus group participants were supportive of the 1115 waiver to address the following issues:

1. A longer length of stay would provide more time to treat individuals with higher acuity and provide more time to plan for discharge to the most clinically appropriate level of care.
2. Non-payment because of another admission in the same month would no longer be an issue.
3. A longer LOS would be considerate of the additional time necessary to stabilize individuals who require court-ordered medication for treatment and their recovery.
4. One administrative issue identified was when an individual is new to Medicaid and there is a delay in assigning a RAE, the RAE does not reimburse for IMD stays during the initial fee-for-service (FFS) eligibility period. With an IMD waiver, the individual's stay could be covered under FFS.

RAE Contracts

In addition to recouping claims payment for an admission in the same month as admittance to another facility, the IMDs identified several issues with the RAEs that an IMD waiver would not solve. Specifically, the respondents reported inconsistent application of medical necessity criteria (MNC), timely filing limits, and denials of authorization to lower levels of care.

Some suggested solutions to RAE-related issues include:

- The use of an independent review organization (IRO) for denials and appeals to evaluate clinical appropriateness and application of MNC.
- Enforcement of standardized MNC across all RAEs.
- Transparency regarding medical necessity criteria for decision making associated with partial hospitalization, intensive outpatient treatment, as well as ATUs and other stepdown services.

Campus Policy

As previously noted, during the early stages of this engagement, HCPF was focused on potential opportunities to design an 1115 waiver to permit step-down services on a single campus. Results from the initial provider survey indicated a high level of interest among respondents regarding expanding services. However, HMA was unable to determine from survey responses the extent to which providers would be interested in expanding step-down services that still fall under the IMD exclusion, such as ATUs, on a campus. Given CMS's guidance that waiver authority is not required for such policies, at the direction of HCPF, in-depth follow-up stakeholder feedback on this topic was not pursued.

Following formal HCPF issuance of the policy guidance, Parameters for Establishing Step-Down Services on a Behavioral Health Campus: IMD Status Implications (Appendix B7), additional stakeholder feedback may be beneficial, particularly, to identify if providers perceive barriers within the HCPF established parameters. Depending upon feedback received, there may be opportunities to further refine the established parameters for a setting to avoid IMD status, so long as the CMS criteria for determining an adjoining property as a standalone component are maintained.

Other Opportunities under an SMI/SED IMD 1115 Waiver Demonstration

The IMD waiver requires that a state commit to actions that will improve community-based mental health services 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;
- Ensure good quality of care in IMDs;
- Improve connections to community-based care following stays in acute care settings;
- 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.

It is worth noting that the focus group participants identified other opportunities where an IMD waiver could be useful in improving the entire behavioral health system of care, and meeting these CMS requirements, including outpatient services and access to intensive services that can prevent the need for higher levels of care. These include community-based strategies would address the needs of individuals who require intermittent and/or LOSs in state hospitals for treatment-resistant illness, access to timely aftercare appointments with community-based providers, staffing shortages, interoperability of IT systems to share health information across providers, and access to safe and affordable housing for people who are housing insecure. Some solutions stakeholders offered are as follows:

- Investment in the community continuum for more timely access to services and availability of services at discharge
- Consideration of reimbursement rates that allow behavioral health providers to offer competitive salaries and benefits in an effort to combat the current workforce shortages
- Improved interoperability of IT systems, including real-time information from RAEs specific to inpatient episodes of care to inform providers if there was a previous admission and promote continuity of care with original provider

HMA would like to acknowledge the contribution of HCPF staff and the stakeholders who participated in providing this valuable feedback to the State of Colorado. These activities represent a thoughtful process in considering policy options to better serve beneficiaries with behavioral healthcare needs.

APPENDIX A: STAKEHOLDER COMMUNICATIONS PROCESS SUMMARY

Survey

The stakeholder survey was open for four weeks beginning November 11, 2022, and ending on December 9, 2022. After the initial distribution via email, two follow up emails were sent to remind providers and encourage their participation. The survey was sent to more than 293 unique Medicaid behavioral health providers and nursing facilities. The survey answers are confidential, and individual responses were not released. Providers completing the survey were anonymous unless they chose to share their contact information to obtain further feedback.

IMD Forums

In collaboration with HCPF, HMA held two IMD forums for the seven adult inpatient providers in Colorado. HCPF sent email invitations to each IMD for the initial focus group on March 20, 2023. This first forum provided an overview of the IMD waiver, HCPF data regarding LOS exceeding 15 days, and review of the request for additional data from the IMDs. Following the first IMD forum, HMA sent the request for data to each of the seven IMDs and five responded. HCPF and HMA subsequently met with the IMD representatives on April 26, 2023, to present the focus group findings and recommend next steps.

Focus Groups

HMA hosted three focus groups. Ultimately, representatives from five of the seven identified IMDs opted to participate. HCPF sent an email to the IMDs' respective organizations to invite participation. Each of the three focus groups were based on organizational affiliations and took place virtually on April 10–13. Generally, the same questions were posed in each focus group, with some variance in follow-up questions specific to data received from each IMD. Questions centered on gaining information from IMD providers about what challenges the IMD waiver would solve for providers, the barriers and challenges that exist for IMD providers that would not be solved with a waiver, and operational/system barriers to discharge that increase LOSs beyond 15 days.

APPENDIX B: STAKEHOLDER COMMUNICATIONS

B1. Focus Group and Stakeholder Survey Distribution Lists

• CEDAR SPRINGS • CENTENNIAL PEAKS • DENVER SPRINGS • HIGHLANDS BEHAVIORAL HEALTH • JOHNSTOWN HEIGHTS BEHAVIORAL HEALTH • PEAKVIEW BEHAVIORAL HEALTH • WEST SPRINGS

• 1111 BONFORTE OPCO, LLC. • 12080 BELLAIRE WAY OPERATIONS • 656 DILLON WAY OPERATIONS, LLC. • ABLELIGHT • ALLHEALTH NETWORK • ALLISON CARE CENTER • ALPINE LIVING CENTER • AMBERWOOD COURT REHAB AND CARE • ANIMAS EQUITY, INC. • APPLEWOOD LIVING CENTER • ARAPAHOE MENTAL HLTH CENTER • ARBOR VIEW • ARDENT HEALTH AND REHAB • ARVADA CARE AND REHABILITATION • ASIAN PACIFIC DEVELOPMENT CENTER • ASPEN CARE COMMUNITY, LLC. • ASPEN LIVING CENTER • ASPENPOINTE HEALTH SERVICES • ATTENTION INC. • AURORA MENTAL HEALTH CENTER • AUTUMN HEIGHTS HEALTH CARE CENTER • AVALANCHE HEALTHCARE, INC. • AVIVA AT FITZSIMONS • BANNER HEALTH EAST MORGAN COUNTY • BARDWELL HEALTHCARE, INC. • BASELINE HEALTHCARE, INC. • BELMONT LODGE HEALTHCARE CENTER • BENT CNTY MEM NURSING HOME

- BERKLEY MANOR CARE CENTER
- BERTHOUD LIVING CENTER
- BETH ISRAEL AT SHALOM PARK
- BETHANY NURSING AND REHAB CTR
- BETHESDA LUTHERAN COMMUNITIES
- BIJOU HEALTHCARE, INC.
- BOB DAVIS
- BOULDER MANOR
- BRIARWOOD HEALTH CARE CENTER
- BRIGHTON OPERATIONS, LLC.
- BROADVIEW HEALTH
- BROOKDALE ROSLYN
- BROOKSHIRE HOUSE REHAB
- BROOKSIDE INN
- BROOMFIELD SKILLED NURSING AND REHAB
- BRUCE MCCANDLESS CVCLC
- BUSINESS OFFICE MANAGER
- CAMBRIDGE CARE CENTER
- CANON LODGE CARE CENTER
- CASTLE PEAK SENIOR CARE, LLC.
- CASTLE ROCK CARE CENTER
- CEDAR SPRINGS HOSPITAL, INC.
- CEDAR SPRINGS HOSPITAL, INC.
- CEDARS HEALTHCARE CENTER
- CEDARWOOD HEALTHCARE CENTER
- CENTENNIAL HEALTHCARE CENTER
- CENTENNIAL MENTAL HEALTH CENTER
- CENTER AT FORESIGHT, LLC.
- CENTER AT LOWRY, LLC.
- CENTER AT PARK WEST, LLC.
- CENTRE AVENUE HEALTH AND REHAB
- CHANCELLOR HEALTH CARE, LLC.
- CHERRELYN HEALTHCARE CENTER
- CHEYENNE MANOR
- CHI LIVING COMMUNITIES
- CHRISTIAN LIVING COMMUNITIES
- CHRISTOPHER HOUSE REHAB AND CARE
- CLEAR CREEK CARE CENTER
- CO STATE VET'S NURSING HOME
- COLONIAL COLUMNS NURSING CENTER
- COLONIAL HEALTH AND REHAB

- COLORADO LUTHERAN HOME
- COLORADO SENIOR RESIDENCES
- COLORADO WEST PSYCHIATRIC HOSPITAL
- COLORADO WEST REGIONAL MENTAL
- COLOROW CARE CENTER
- COLUMBINE CARE CENTER WEST, INC.
- COLUMBINE COMMONS HEALTH AND REHAB
- COLUMBINE MANOR CARE CENTER
- COMMUNITY REACH CENTER, INC.
- CONSULTANTS FOR CHILDREN, INC.
- CONTINUUM AT SHARMAR, INC.
- COTTONWOOD INN, INC.
- COURTYARD CARE CENTER
- COVENANT VILLAGE OF COLORADO
- CRESTMOOR HEALTH AND REHAB
- CRIPPLE CREEK CARE CENTER
- CROWLEY COUNTY NURSING CENTER
- CVCLC-HOMELAKE
- D&A, LLC.
- DAISY CENTER
- DCMH
- DEEDRA SHEAR
- DENVER CHILDREN'S HOME
- DENVER NORTH CARE CENTER
- DENVER SPRINGS
- DESERT WILLOW HEALTH AND REHAB
- EAGLE RIDGE AT GRAND VALLEY
- EBEN EZER LUTHERAN CARE CENTER
- ELEVATION HEALTH AND REHAB
- ELK RIDGE HEALTH AND REHAB
- ENGLEWOOD POST ACUTE AND REHAB
- EVERGREEN NURSING HOME
- FAIRACRES MANOR
- FALCON HEIGHTS HEALTH
- FOREST RIDGE HEALTH
- FOREST ST LTC LLLP
- FORT COLLINS HEALTH CARE CENTER
- FOUNTAIN VIEW HEALTH AND REHAB
- FOUR CORNERS HEALTH CARE CENTER
- FOWLER HEALTH CARE
- FRANKLIN AVENUE HEALTH CARE

- FRASIER MEADOWS MANOR, INC.
- GA HC REIT II LIBERTY TRS SUB.
- GARDEN TERRACE ALZHEIMER'S CENTER
- GATEWAY RESIDENTIAL SERVICES
- GATEWAY TO SUCCESS, PC
- GLENWOOD SPRINGS HEALTHCARE
- GOLDEN PEAKS CENTER
- GOOD SAMARITAN SOCIETY - BONEL
- GRACE MANOR CARE CENTER
- GRAND JUNCTION REGIONAL CENTER
- GRAND RIVER HOSPITAL DISTRICT
- GREEN HOUSE HOMES AT MIRASOL
- GREENFIELD MANAGEMENT, INC.
- GRIFFITH CENTERS FOR CHILDREN, INC.
- GSS - FORT COLLINS
- GSS - LOVELAND
- GSS - SIMLA
- GUNNISON VALLEY HOSPITAL
- HALLMARK NURSING CENTER
- HARMONY POINTE NURSING CENTER
- HAXTUN HOSPITAL DISTRICT
- HC RESORT OF CO SPRINGS
- HEALTH CENTER AT FRANKLIN PARK
- HEALTH SOLUTIONS
- HEIGHTS HEALTHCARE COMPANY, LLC.
- HERITAGE PARK CARE CENTER
- HIGHLANDS BEHAVIORAL HEALTH SY
- HIGHLINE REHAB AND CARE
- HOLLY HEIGHTS NURSING HOME
- HOLLY NURSING CARE CENTER
- HORIZONS CARE CENTER
- IMAGINE FORT COLLINS
- JEFFERSON CENTER FOR MENTAL HEALTH
- JEWELL CARE CENTER OF DENVER
- JOHNSTOWN HEIGHTS BEHAVIORAL HEALTH
- JULIA TEMPLE HEALTHCARE CENTER
- JUNCTION CREEK HEALTH AND REHAB
- JUNIPER LP
- KATHERINE AND CHARLES HOVER
- KENTON MANOR
- KINDRED NURSING REHAB AURORA

- KIOWA COUNTY HOSPITAL DISTRICT
- KIOWA HILLS HEALTH AND REHAB
- KREMMLING MEMORIAL HOSP. DIST.
- LAKEWOOD HEALTHCARE, INC.
- LAKEWOOD VILLA
- LAMAR ESTATES, LLC.
- LARCHWOOD INNS, INC.
- LAUREL MANOR CARE CENTER
- LCC COLORADO SPRINGS
- LIFE CARE CENTER OF AURORA
- LIFE CARE CENTER OF EVERGREEN
- LIFE CARE CENTER OF GREELEY
- LIFE CARE CENTER OF LITTLETON
- LIFE CARE CENTER OF LONGMONT
- LIFE CARE CENTER OF PUEBLO
- LIFE CARE CENTER OF WESTMINSTER
- LIFE CARE OF STONEGATE
- LINCOLN COMMUNITY HOSPITAL-NH
- LITTLE SISTERS OF THE POOR
- LITTLETON CARE AND REHABILITATION
- MANOR CARE DENVER CO, LLC.
- MCHS-BOULDER
- MEDALION HEALTH CENTER
- MENTAL HEALTH CENTER OF DENVER
- MENTAL HEALTH PARNTERS
- MESA MANOR
- MESA VISTA OF BOULDER
- MIDWESTERN COLORADO MENTAL HEALTH
- MILE HIGH CARE SERVICES
- MIND SPRINGS HEALTH
- MINNEQUA MEDICENTER
- MISSION SAN MIGUEL NURSING
- MONTE VISTA ESTATES, LLC.
- MOUNTAIN VISTA HEALTH CENTER
- NAMASTE ALZHEIMER CENTER
- NATIONAL INSTITUTE FOR CHANGE
- NEURORESTORATIVE COLORADO
- NEXION HEALTH AT CHERRY CREEK
- NORTH RANGE BEHAVIORAL HEALTH
- NORTH SHORE MANOR
- NORTH STAR REHAB AND CARE

- NORTHGLENN OPERATIONS, LLC.
- ORCHARD PARK HEALTH CARE CENTER
- ORCHARD VALLEY HEALTH
- PALISADES LIVING CENTER
- PAONIA CARE AND REHAB CENTER
- PARK FOREST CARE CENTER, INC.
- PARKER SKILLED NURSING FACILIT
- PARKMOOR VILLAGE HEALTHCARE CENTER
- PARKVIEW CARE CENTER
- PEAK MEDICAL COLORADO NO 3 LLC
- PEAK VIEW BEHAVIORAL HEALTH
- PEARL STREET HTH AND REHAB CENTER
- PINE RIDGE EXTENDED CARE CENTER
- PIONEER HEALTH CARE CENTER
- POUDRE CANYON HEALTH AND REHAB
- PRESTIGE CARE CENTER OF MORRIS
- PROGRESSIVE CARE CENTER
- RANGELY HOSPITAL DISTRICT
- RECOVER-CARE COLORADO, LLC.
- REGENT PARK NURSING AND REHAB
- RIO GRANDE INN, INC.
- RIVER VALLEY INN
- RIVERDALE REHAB AND CARE
- RMBH, INC.
- RNCR
- ROCK CANYON RESPIRATORY
- ROCKY MOUNTAIN KIDS
- ROWAN COMMUNITY
- SALIDA HOSPITAL DISTRICT
- SAN JUAN LIVING CENTER
- SAN LUIS CARE CENTER
- SANDALWOOD MANOR, INC.
- SEDGWICK COUNTY MEMORIAL HOSPITAL
- SEDGWICK COUNTY NURSING HOME
- SENEX FOUNDATION INC DBA SANDR
- SERVICIOS DE LA RAZA
- SHADOW MOUNTAIN MANAGEMENT
- SHILOH HOME, INC.
- SIERRA REHAB AND CARE
- SIERRA VISTA HEALTH CARE
- SKYLINE RIDGE NURSING AND REHAB

- SLV BEHAVIORAL HEALTH GROUP
- SNH CO TENANT, LLC.
- SOUTH PLATTE HEALTH AND REHAB
- SOUTHEAST COLORADO HOSPITAL
- SOUTHEAST HEALTH GROUP
- SOUTHWEST COLORADO MENTAL HEALTH
- SOUTHWEST HEALTH SYSTEM
- SPANISH PEAKS VETERANS CENTER
- SPRING CREEK HEALTHCARE CENTER
- SPRINGS VILLAGE CARE CENTER
- SSC DEN S MONACO OPCO
- ST FRANCIS NURSING CENTER
- ST PAUL HEALTH CENTER
- ST VINCENT GENERAL HOSPITAL
- STERLING HEALTH AND REHAB
- STERLING LIVING CENTER
- SUMMIT REHAB AND CARE
- SUMMITSTONE HEALTH PARTNERS
- SUNDANCE SKILLED NURSING
- SUNNY ACRES HEALTHCARE, INC.
- SUNNY VISTA LIVING CENTER
- SUNSET MANOR
- SWEEWATER AURORA OPCO, LLC.
- TANYA MADISON
- TERRACE GARDENS HEALTHCARE CENTER
- THE CENTER FOR MENTAL HEALTH
- THE GARDENS SKILLED NURSING
- THE MEMORIAL HOSPITAL
- THE SUITES AT CLERMONT PARK
- THIRD WAY CENTER, INC.
- TRINIDAD INN, INC.
- TURNING POINT CENTER FOR YOUTH AND FAMILY DEVELOPMENT
- UHS OF CENTENNIAL PEAKS, LLC.
- UNIVERSITY HEIGHTS REHAB
- UNIVERSITY PARK CARE CENTER
- UPTOWN HELATH CARE CENTER
- VALLEY MANOR CARE CENTER
- VALLEY VIEW CARE CENTER
- VALLEY VIEW HEALTHCARE CENTER
- VALLEY VIEW VILLA
- VIBRA HOSPITAL OF DENVER, LLC.

- VILLA MANOR CARE CENTER
- VILLAS AT SUNNY ACRES
- VISTA GRANDE INN, INC.
- WALBRIDGE MEMORIAL WING
- WALSH HEALTHCARE CENTER
- WASHINGTON COUNTY NURSING HOME
- WEST CENTRAL MENTAL HEALTH CENTER
- WEST VAN BUREN HEALTHCARE, INC.
- WESTERN HILLS HEALTH CARE CENTER
- WESTLAKE CARE COMMUNITY
- WESTLAKE LODGE HEALTH
- WHEAT RIDGE REGIONAL CENTER
- WHEATRIDGE MANOR CARE CENTER
- WILLOW TREE CARE CENTER
- WINDSOR HEALTHCARE CENTER
- WOODRIDGE TERRACE NURSING
- WRAY COMMUNITY DISTRICT HOSPITAL
- WRAY COMMUNITY LONG TERM CARE
- YUMA LIVING CENTER

B2.Survey

In collaboration with HCPF, HMA developed the "Colorado HCPF SMI 1115 Waiver Planning Survey" to collect input from various providers on their current service array and interest in expanding capacity if HCPF were to receive waiver approval from CMS.

Survey Introduction

Health Management Associates (HMA) is supporting the Colorado Department of Health Care Policy and Financing (HCPF) to explore the parameters of a Mental Health 1115 Waiver related to the federal IMD exclusion guidelines in order to seek flexibility for a continuum of mental health services on a campus for residential and step-down mental health services. This waiver will not be seeking to waive length of stay limitations but will be considering other barriers to supporting continuum or step-down services such as shared staffing and number of treatment beds on a campus. Health Management Associates (HMA) has contracted with the Department to research and provide support in identifying an appropriate scope for this waiver based on Centers for Medicare & Medicaid services (CMS) guidelines, a survey of other States' solutions for campus continuums, and alignment with Colorado continuum efforts.

The goal of the waiver is to eliminate barriers some providers may face due to the IMD exclusion, including expansion of bed capacity or provision of alternative services and supports to divert or service those stepping down from short term psychiatric stabilization stays. The state wishes to take into consideration the perspective of those who provide mental health services within crisis, inpatient, acute and long-term settings, as well as community-based services and supports.

We invite you to share your thoughts and experiences in this survey so we can better understand the current capacity for short term mental health crisis stabilization, inpatient, and residential services within your community and interest in expansion of access to needed services and supports by providers. Information from the survey will inform the development of demonstration project and related application for an SMI/SED section 1115 waiver to CMS.

We ask that you complete the survey by Friday December 2, 2022.

The survey specifically asks questions about your provider organization's:

1. **Experience/Role in the current system of care,** including population(s) of focus, current crisis, short-term psychiatric inpatient, and residential service array and geographic service area;
2. **Perspective on the current availability of crisis, short-term psychiatric inpatient, and residential services**, as well as diversion/stepdown services;
3. **Considerations for service expansion,** specifically how decisions are made about what services to add/expand or remove; and
4. **Perspective on the barriers for providers to adding services and supports to their service array**, including workforce or other program implementation and reimbursement challenges (such as the IMD exclusion).

Therefore, the survey respondent should be familiar with the organization's service offerings and considerations when expanding your service array or capacity for current services. We anticipate this may include individuals within your executive leadership team.

PLEASE ONLY SUBMIT ONE RESPONSE PER ORGANIZATION (not per service location).

All answers are anonymous. Individual answers will not be released, nor will they be shared with the State or anyone else. We will not be able to identify the people who took the survey unless you choose to share your contact information when prompted. There are no right or wrong answers; it's your opinion that matters! The survey will take approximately 15 minutes to complete.

If you have questions or need help with the survey, please contact Devon Schechinger with HMA at cohcpf.imdpolicy@healthmanagement.com.

Thank you for filling out this survey!

Survey Questions

Organization Information

1. Please provide the name of your facility. This question will only be used to ensure we do not have multiple responses from the same agencies. If we do, only the most complete or earliest response will be kept. Otherwise, this information will not be included to maintain anonymity of responses. (text box)

2. If you are interested in learning more, providing more feedback, and/or being involved in feedback sessions, please write in your email below. This will only be used for general follow-up information; not to identify specific responses from specific people. (text box)

3. Please select the option that *best* describes your organization. Please select just one perspective from which you are responding to questions about the needs of individuals currently served within crisis, inpatient, and residential service settings in Colorado.
   - ☐ CMHC, CCBHC, or multi-service provider including inpatient services
   - ☐ CMHC, CCBHC, or multi-service provider excluding inpatient services
   - ☐ Nursing facility
   - ☐ Skilled Nursing Facility
   - ☐ Psychiatric Inpatient Provider
   - ☐ Substance Use Disorder (SUD) Residential Provider
   - ☐ Psychiatric Residential Treatment Facility (PRTF)
   - ☐ Qualified Residential Treatment Program (QRTP)
   - ☐ Other, please specify (text box)

Licensure/Certification

4. Please check all applicable licenses/designations for your organization. We recognize there may or may not be overlap across multiple service locations.
   - ☐ Mental Health Designated Facility with the Colorado Department of Human Services (CDHS), Behavioral Health Administration (BHA)
   - ☐ Substance Use Licensed Agency with the CDHS, BHA

- ☐ Organizations with Colorado Statute 27-65 Designation from the Colorado Department of Human Services, BHA
- ☐ Crisis Stabilization Unit (CSU)
- ☐ Acute Treatment Unit (ATU)
- ☐ Primary Care Provider license (e.g., Federal Qualified Health Center or other licensure status by the organization)
- ☐ Nursing Facility
- ☐ Skilled Nursing Facility
- ☐ Residential Child Care Facilities (RCCF)
- ☐ RCCF-Psychiatric Residential Treatment Facility (PRTF)
- ☐ RCCF- Qualified Residential Treatment Program (QRTP)
- ☐ Other, please specify. (text box)

5. What are the organization's funding sources? Select all that apply.
   - ☐ Medicaid
   - ☐ State general funds from mental health agency
   - ☐ State welfare or child and family services agency funds
   - ☐ State corrections or juvenile justice agency funds
   - ☐ State education agency funds
   - ☐ County or local government funds
   - ☐ Community Service Block Grants
   - ☐ BHA administered funding from SAMHSA Community Mental Health Block Grants
   - ☐ Tricare
   - ☐ IHS/ Tribal/ Urban funds
   - ☐ Discretionary/time-limited grants
   - ☐ Endowment/other foundation support
   - ☐ Other, please specify. (text box)

6. What is the organization's payer mix (as a percentage) for services provided? (can be an estimate):
   - ☐ Medicaid ____%
   - ☐ Medicare ____%
   - ☐ Commercial insurance ____%
   - ☐ Self-pay ____%
   - ☐ State funds (includes MH/SAPT block grant; do not include state share of Medicaid funded services) ____%
   - ☐ Charity care (no reimbursement) ___%
   - ☐ Other (time-limited grants, United Way/foundation support, etc.) ____%

Service Area

7. Please select the county(ies) in which your organization provides services. Select all that apply. (INSERT LIST OF COUNTIES)

8. Should Colorado receive waiver approval, allowing reimbursement for inpatient, residential and/or crisis stabilization services provided in an IMD, within which counties would you consider expanding these services? (INSERT LIST OF COUNTIES)

Behavioral Health Services

9. Access to a full continuum of services is often necessary to successfully serve individuals in the least restricted setting and support timely discharge from acute treatment settings. Please indicate which of the following services and supports you believe are in need of additional capacity (additional beds and/or units) to meet the needs of individuals within your community.
    - ☐ Crisis Stabilization/walk-in
    - ☐ Crisis Respite
    - ☐ Intensive outpatient programs for substance use (e.g., individuals spend 9-15 hours in treatment per week, then go home at night, and may include therapy, medication management, and support groups)
    - ☐ Intensive outpatient programs for mental health (e.g., individuals 9-15 hours in treatment per week, then go home at night, and may include therapy, medication management, and support groups)
    - ☐ Partial Hospitalization Programs for substance use (e.g., individuals spend most of the day in treatment, then go home at night, and may include therapy, medication management, and support groups)
    - ☐ Partial Hospitalization Programs for mental health (e.g., individuals spend most of the day (six hours) in treatment, then go home at night, and may include therapy, medication management, and support groups)
    - ☐ Inpatient withdrawal management (e.g., provides support and monitoring for people withdrawing from addictive substances at another location other than one's home)
    - ☐ Short-term residential treatment for substance use (e.g., lasting for thirty (30) days or less), with the goal to stabilize and equip a person with the skills necessary to continue recovery in a community-based setting)
    - ☐ Short-term residential treatment for mental health (e.g., ranging from a less than one week to 60 days, with the goal to stabilize and equip a person with the skills necessary to return to independent or supported community living)
    - ☐ Short-term acute psychiatric inpatient treatment (less than 14 days)
    - ☐ Intermittent-stay inpatient psychiatric treatment (14 days-60 days)
    - ☐ Long-term inpatient treatment (e.g., can last from several months to a year or longer, and help people in recovery master a broad range of skills that can help them successfully transition out of residential treatment)
    - ☐ Nursing/Skilled Nursing beds for individuals with co-occurring behavioral health and physical health treatment needs
    - ☐ Assertive Community Treatment (e.g., treatment approach for adults diagnosed with a serious mental illness, including case management, therapy, psychosocial education and rehabilitation, and medication monitoring)
    - ☐ Clubhouse (e.g., provides non-clinical support and opportunities for people with mental illness)
    - ☐ Respite care services (e.g., temporary relief for a primary caregiver, enabling one to take a break from the demands of caring for an individual with a substance and/or mental health issues.
    - ☐ Sober or recovery housing
    - ☐ Permanent Supportive Housing (PSH), Housing First
    - ☐ Therapeutic group home

10. What TWO age groups are most likely to be impacted by any current gaps in capacity for crisis stabilization, inpatient, and/or residential services within your community? Select only two.
    - ☐ Young children (ages 1−5)
    - ☐ School age children (ages 6 to 12)
    - ☐ Adolescents (ages 13 to 17)
    - ☐ Adults (ages 19 to 64)
    - ☐ Older adults (ages 65 and older)

11. Based on your answer above, please select which types of crisis stabilization, inpatient, and/or residential services are needed to improve capacity for those age groups who face access challenges.
    - ☐ Crisis stabilization/walk-in
    - ☐ Crisis respite
    - ☐ Inpatient withdrawal management (e.g., provides support and monitoring for people withdrawing from addictive substances at another location other than one's home)
    - ☐ Short-term residential treatment for substance use (e.g., lasting for thirty (30) days or less, with the goal to stabilize and equip a person with the skills necessary to continue recovery in a community-based setting)
    - ☐ Short-term residential treatment for mental health (e.g., ranging from a less than one week to 60 days, with the goal to stabilize and equip a person with the skills necessary to return to independent or supported community living)
    - ☐ Short-term acute psychiatric inpatient treatment (less than 14 days)
    - ☐ Intermittent-stay inpatient psychiatric treatment (14 days−60 days)
    - ☐ Long-term inpatient treatment (e.g., can last from several months to a year or longer, and help people in recovery master a broad range of skills that can help them successfully transition out of residential treatment)
    - ☐ Nursing/skilled nursing beds for individuals with co-occurring behavioral health and physical health treatment needs
    - ☐ Respite care services (e.g., temporary relief for a primary caregiver, enabling one to take a break from the demands of caring for an individual with a substance and/or mental health issues.
    - ☐ Sober or recovery housing
    - ☐ Permanent Supportive Housing (PSH), Housing First
    - ☐ Therapeutic group home

12. Please indicate any of the following behavioral health services shortages or gaps that apply in your service area that create barriers to timely discharge from a crisis stabilization, mental health inpatient, or short-term residential setting stay within your geographic area.
    - ☐ Intensive outpatient programs for substance use (e.g., individuals spend 9−15 hours in treatment per week, then go home at night, and may include therapy, medication management, and support groups)

- ☐ Intensive outpatient programs for mental health (e.g., individuals 9-15 hours in treatment per week, then go home at night, and may include therapy, medication management, and support groups)
- ☐ Partial Hospitalization Programs for substance use (e.g., individuals spend most of the day in treatment, then go home at night, and may include therapy, medication management, and support groups)
- ☐ Partial Hospitalization Programs for mental health (e.g., individuals spend most of the day (six hours) in treatment, then go home at night, and may include therapy, medication management, and support groups)
- ☐ Long-term inpatient treatment (e.g., can last from several months to a year or longer, and help people in recovery master a broad range of skills that can help them successfully transition out of residential treatment)
- ☐ Nursing/Skilled Nursing beds for individuals with co-occurring behavioral health and physical health treatment needs
- ☐ Assertive Community Treatment (e.g., treatment approach for adults diagnosed with a serious mental illness, including case management, therapy, psychosocial education and rehabilitation, and medication monitoring)
- ☐ Respite care or other caregiver support services (e.g., support and/or temporary relief for a primary caregiver, enabling one to take a break from the demands of caring for an individual with a substance and/or mental health issues.
- ☐ Sober or recovery housing
- ☐ Permanent Supportive Housing (PSH), Housing First
- ☐ Therapeutic group home
- ☐ None/not applicable
- ☐ Other (text box)

13. Please share any recommendations you have for improving opportunities to prevent the need for acute services such as inpatient, and/or support timely discharge from short-term stabilization mental health inpatient and residential settings in Colorado. (text box)

14. Please share any other thoughts or comments regarding additional services and supports that are not part of the current behavioral health service or setting array that would support individuals with chronic and/or intensive substance use and/or mental health needs in Colorado. (text box)

Crisis, Inpatient and Residential Service Offerings

15. Please complete the table below to indicate mental health crisis services currently offered within your organization. For each service please also indicate the number of unique service locations, programs, and locations/beds within each county.

Crisis Services

Crisis Services	We do not offer these services anywhere.	Number of Unique Service Locations	Number of Distinct Programs/Units in each Location	Number of Unique Counties with a Service Location
24/7 Crisis Hotline Services	☐			
Walk in crisis center	☐			
Mobile crisis services	☐			
Co-Response Team	☐			
Peer based crisis services	☐			
23-hour crisis stabilization unit	☐			
Crisis stabilization	☐			
Other (please specify)	☐			

16. Please complete the table below to indicate residential services currently offered within your organization. For each service please also indicate the number of unique service locations, programs, and locations/beds within each county.

Residential Services

Residential Services	We do not offer these services anywhere.	Number of Unique Service Locations	Number of Distinct Programs/Units in each Location	Number of Unique Beds within each unit (if applicable)
Adult short term mental health residential (up to 60 days)	☐			
Adult long term mental health residential (>60 days)	☐			
Permanent Supportive Housing (PSH), Housing First	☐			
Therapeutic group home	☐			
Qualified Residential Treatment Facility (QRTP)-Youth	☐			

Psychiatric Residential Treatment Facility (PRTF)-Youth				
Other children's mental health residential services	☐			
Other (please specify)	☐			

17. Please complete the table below to indicate inpatient services currently offered within your organization. For each service please also indicate the number of unique service locations, programs, and locations/beds within each county.

Inpatient Services

Inpatient Services	We do not offer these services anywhere.	Number of Unique Service Location	Number of Distinct Units in each Location	Number of Unique Beds within each unit
Adult Psychiatric	☐			
Adolescent psychiatric (13-17 yrs)	☐			
Child Psychiatric (6-12 yrs)	☐			
Geriatric	☐			
Other (please specify)	☐			

18. Are your current crisis, inpatient, and/or residential facilities all operating within the same campus (at a single address or on adjoining properties)?
    - ☐ Yes
    - ☐ No
    - ☐ Not applicable, we provide only one or none of these services

19. Do any of the organization's crisis, inpatient, and/or residential facilities qualify as an Institution for Mental Disease (IMD)?
    - ☐ No, we do not have crisis, inpatient, and/or residential facilities
    - ☐ Yes, one, and only one facility and/or location qualifies
    - ☐ Yes, one of multiple facilities and/or locations qualifies
    - ☐ Yes, two or more facilities and/or locations qualifies
    - ☐ Yes, all qualify
    - ☐ Unsure

Clinical Decision Making and Prioritization of Services

20. Please indicate the top FIVE greatest challenges your organization is facing to meet its goals for service access, delivery, and outcomes. Select up to FIVE options.
    - ☐ Available workforce
    - ☐ Inadequate training/preparation for emerging public mental health and/or substance use workforce
    - ☐ Lack client to staff ratios necessary for viable groups or curriculum-based programs
    - ☐ Lack of physical plant capacity (beds, etc.)
    - ☐ Physical separation between primary care providers and behavioral health providers
    - ☐ Support from community stakeholders
    - ☐ Reimbursement administrative burden (prior authorization requirements, denials, and protests)
    - ☐ Reimbursement availability (IMD exclusion)
    - ☐ Data collection and reporting capabilities
    - ☐ Lack of electronic health record (EHR) or insufficient EHR capabilities
    - ☐ Organization/local priorities disparate from those of state authorities or RAEs
    - ☐ I don't know.
    - ☐ Other, please describe (text box)

21. Please choose the top three considerations for adding a service/program within your organization. Select up to three options only.
    - ☐ Payers add/begin reimbursement for a service (Medicaid, Medicare, Commercial)
    - ☐ New licensure or certification requirement
    - ☐ Public funding requirement
    - ☐ Evidenced-based practice
    - ☐ Client demand for service
    - ☐ Community, consumer, or family advocacy
    - ☐ Population disparity
    - ☐ Data on population need
    - ☐ New model/practice aligns with current staffing
    - ☐ Recent assessment of community behavioral health need (i.e., community data, risk stratification)
    - ☐ None of the above.
    - ☐ I don't know.
    - ☐ Other, please describe. (text box)

22. Describe the primary process for making decisions about what services to add / expand or remove. (text box)

23. If Colorado is granted a waiver of the IMD exclusion, allowing reimbursement for mental health facilities on a campus with a total number of beds greater than 16, would you consider an expansion of services?
    - ☐ Yes, would definitely expand crisis beds
    - ☐ Yes, would definitely expand inpatient beds
    - ☐ Yes, would definitely expand residential beds

- ☐ Maybe, would consider an expansion of crisis beds
- ☐ Maybe, would consider an expansion of inpatient beds
- ☐ Maybe, would consider an expansion of residential beds
- ☐ No, would not expand crisis beds
- ☐ No, would not expand inpatient beds
- ☐ No, would not expand residential beds
- ☐ Unsure

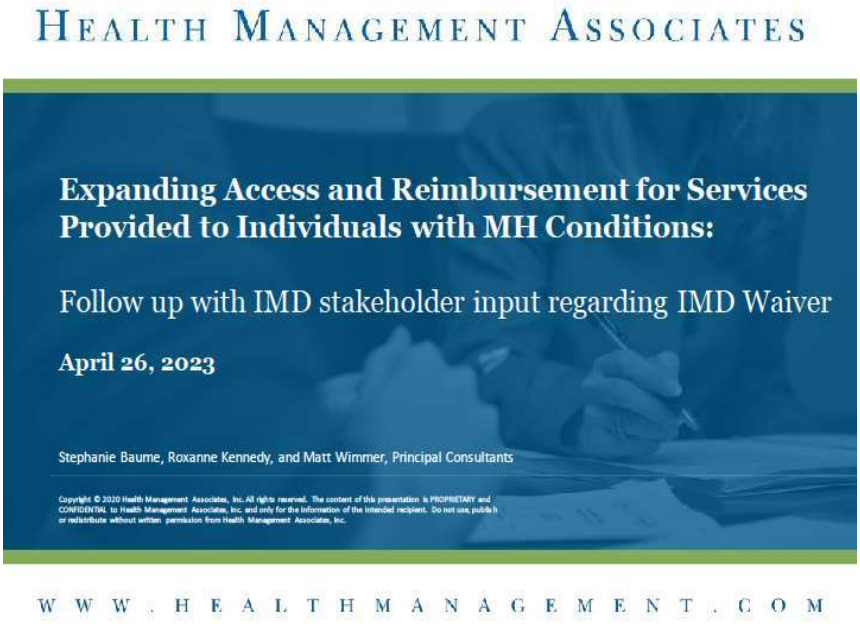
24. Based on your answers to question #23 above, please provide any additional comments to clarify or expand upon your response. (text box)

B3a. Presentation for IMD Forum 3.20.23

(Click image below to view entire slide deck)

B3b. Presentation for IMD Forum 4.26.23

(click image below to view entire slide deck)



B4. Presentation for Stakeholder Forum 6.5.23

(Click image below to view entire slide deck)

B5. Data Request

The questions focus on the state's Health First Colorado (Medicaid) coverage policy for adults aged 21−64 at institutions with more than 16 beds primarily engaged in diagnosis, treatment, or care of people with behavioral health diagnoses (institutions for mental diseases/IMDs).

Data Questions

While we appreciate precise information if available, estimates are also informative. We would appreciate it if you would indicate if the information provided is an estimate.

1. The total number of stays not covered due to exceeding the 15-day limit for your facility in calendar year 2022, including
    a. Costs associated with those stays
    b. The number of bed days associated with those stays

2. The monthly average number of patients awaiting beds at state hospital that your facility served during calendar year 2022.

3. During the IMD forum we heard concerns related to situations where a facility serves a Medicaid member within the 15-day limitation, only to later have their claim denied because the member also received services at a different location which exceeded the 15-day limit across the two facilities.

    a. How many stays were denied in this type of situation at your facility during CY 2022?
    b. How many total days were denied in CY 2022 due to this type of situation?

4. During the IMD forum heard concerns related to the amount of time needed to secure court-ordered medications for Medicaid members who were non-compliant with recommended therapy. For example, a member might be admitted and assessed, but by the time court-ordered medications were approved, 7-10 days or more of the stay had already passed, making it difficult to adequately treat the member within the 15-day limitation.

    a. How many stays were impacted by this challenge at your facility during CY 2022?
    b. How many total days were denied related to this challenge at your facility during CY 2022?

5. During the IMD forum we heard concerns related to challenges serving Medicaid members experiencing homelessness, especially related to safe discharge.

    a. How many stays were impacted by this challenge at your facility during CY 2022?
    b. By what percentage have these challenges increased or decreased during CY 2022 relative CY 2021?

6. If state policy were to change to allow stays up to 60 days,

    a. How many (if any) additional beds would you anticipate your facility to be able to support?
    b. How many more stays beyond 15-days would you anticipate at your facility each year?

c. How many more bed-days billed to Medicaid would you anticipate at your facility each year?

General Questions

7. What were the impacts of 15−day payment limitations for your facility in CY 2022?
8. What challenges associated with existing payment policies limit your facility's ability to provide high-quality service to Health First Colorado (Medicaid) members?
9. Please share any thoughts around how HCPF might address these challenges related to serving Health First Colorado (Medicaid) members.
10. If your organization works in other states, please share any suggestions based on that experience of how they have solved or reduced similar challenges.
11. Please share any other thoughts or feedback on how HCPF can address challenges related to serving Health First Colorado (Medicaid) members.

B6. IMD Campus Policy

Parameters for Establishing Step-Down Services on a Behavioral Health Campus: IMD Status Implications

Background

Federal law prohibits state Medicaid agencies from receiving federal matching funds for stays within an institution for mental disease (IMD) for adults ages 21-64. 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.1 Additionally, federal match for enrollees under 21 is limited to inpatient psychiatric services provided within a psychiatric hospital, general hospital with a psychiatric program, or a Psychiatric Residential Treatment Facility (PRTF).

There are some limited flexibilities available to states that allow them to reimburse for adult IMD stays under managed care authorities. Currently, the Colorado Department of Health Care Policy & Financing (HCPF) has authority to reimburse IMD stays of up to 15 days within a calendar month through its Regional Accountable Entities (RAEs).

The HCPF is issuing this guidance to provide behavioral health providers with options for establishing step-down services on a campus. This guidance outlines parameters for developing standalone services on the same campus with inpatient or residential psychiatric beds in a manner that allows these units and programs to avoid IMD status.

Federal Parameters

The Centers for Medicare and Medicaid Services (CMS) has established criteria for states to determine whether a facility is an IMD. When a facility or campus includes multiple components, there are a series of guidelines that must be applied to identify the facility(s) to which the criteria is to be applied. A campus includes entities that have a shared address or are adjoining properties. Adjoining properties are those less than 750 feet from another property owned and operated by the same governing body. The CMS criteria includes:

1. Are all components controlled by one owner or one governing body?
2. Is one chief medical officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are any of the components separately licensed?
5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

Per CMS guidelines, if the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined there are separate components on the campus, any such units with 16 beds or less would not be considered an IMD, regardless of the bed count of the other units. For any separate components with more than 16 beds, HCPF would need to evaluate the “overall character” of the facility/component to determine if it

meets the definition of an IMD. Additionally, if settings on a campus do not meet the criteria to be considered a separate facility/component, the total number of beds on the campus would need to be counted when determining whether the institution is an IMD.

Any facility/component meeting the definition of an IMD would be subject to the IMD reimbursement exclusion, and in turn, the maximum length of stay (LOS) of 15-days within a calendar month. The following table outlines examples of how the separate component criteria are applied and the associated implications.

Scenario	Setting 1 Implications	Setting 2 Implications
Setting 1 (≤16 beds) & Setting 2 (≤16 beds) on the same campus are determined to be separate components	Not an IMD due to bed count.	Not an IMD due to bed count.
Setting 1 (>16 beds) & Setting 2 (≤16 beds) on the same campus are determined to be separate components	Potentially an IMD due to bed count. If deemed an IMD, held to 15-day LOS maximum.	Not an IMD due to bed count. Not held to 15-day LOS maximum.
Setting 1 (>16 beds) & Setting 2 (>16 beds) on the same campus are determined to be separate components	Potentially an IMD due to bed count. If deemed an IMD, held to 15-day LOS maximum.	Potentially an IMD due to bed count. If deemed an IMD, held to 15-day LOS maximum.
Setting 1 (≤16 beds) & Setting 2 (≤16 beds) on the same campus are determined to NOT be separate components	Potentially an IMD if total beds between the two components exceed 16. If deemed an IMD, held to 15-day LOS maximum.	Potentially an IMD if total beds between the two components exceed 16. If deemed an IMD, held to 15-day LOS maximum.
Setting 1 (>16 beds) & Setting 2 (≤16 beds) on the same campus are determined to NOT be separate components	Potentially an IMD due to total bed count between the two components. If deemed an IMD, held to 15-day LOS maximum.	Potentially an IMD due to total bed count between the two components. If deemed an IMD, held to 15-day LOS maximum.
Setting 1 (>16 beds) & Setting 2 (>16 beds) on the same campus are determined to NOT be separate components	Potentially an IMD due to total bed count between the two components. If deemed an IMD, held to 15-day LOS maximum.	Potentially an IMD due to total bed count between the two components. If deemed an IMD, held to 15-day LOS maximum.

HCPF Criteria

For settings on a campus to be considered distinct for purposes of HCPF determining which facility/component(s) to assess for IMD status, the service settings must be developed as independently as possible. Settings with multiple components on a campus must meet, at minimum, all the following criteria to be considered a separate component for purposes of the IMD assessment.

- **LICENSURE**: Each component on the campus must have separate, distinct license types.
- **MEDICAID PROVIDER ENROLLMENT**: Each component on a campus must be separately enrolled as a distinct Medicaid provider.
- **STAFFING:** While shared staffing would not be prohibited, each facility must ensure sufficient staffing is maintained to meet applicable licensure requirements for each component.

The following are some examples of service arrays on a campus and whether they could potentially be assessed as separate components.

Campus Service Array Scenario	Separate Licensure?	Separate Medicaid Provider Enrollment?	Potential Opportunity to be Assessed as Separate Component?
Qualified Residential Treatment Facility (QRTP) & Crisis Stabilization Unit (CSU)	✓	✓	✓
Psychiatric Residential Treatment Facility (PRTF) & CSU	✓	✓	✓
Psychiatric Hospital & QRTP	✓	✓	✓
Psychiatric Hospital & PRTF	✓	✓	✓
Psychiatric Hospital & CSU	✓	✓	✓
Nursing Facility & Adult Mental Health Transitional Living Home	✓	✓	✓
Nursing Facility & CSU	✓	✓	✓
SUD Residential Facility & CSU	X	X	X

The Colorado Behavioral Health Administration (BHA) is currently restructuring its licensing structure to provide a "cafeteria-style" license, meaning a provider will hold a single behavioral health entity (BHE) license with different endorsements that allow the provider to offer various types of services at multiple locations. This single BHE license with endorsement structure may pose a challenge to meet the separate and distinct licensure criteria for the purposes of the IMD assessment. In anticipation of this challenge, HCPF is currently seeking technical assistance from CMS and will issue updated guidance once the impact of the new BHA licensing structure is determined.

FOR MORE INFORMATION CONTACT
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