March 3, 2023

State Board of Human Services
1575 Sherman St., 8th Floor
Denver, CO 80203
Via Email to Kyle Zinth, kyle.zinth@state.co.us

Dear State Board of Human Services:

On behalf of Colorado Hospital Association (CHA) and its 100+ member hospitals and health systems statewide, I am writing to submit comments on **Document 9- Behavioral Health Entity License (22-10-21-02):**

- **Mobile Crisis:** Currently, mobile crisis response provides relief and stabilization to individuals in crisis, including in rural hospital emergency departments. Small rural hospitals face significant budgetary and staffing challenges and rarely employ trained mental health professionals; however, they remain a trusted place for individuals in crisis to go when they need services. To ensure patients experiencing behavioral health crises receive the highest standard of care, rural facilities will call mobile crisis to facilitate a response and sometimes transfer patients to a more suitable location for treatment. The American Rescue Plan Act included additional federal Medicaid dollars to expand mobile crisis services. However, there is a federal prohibition on utilizing those new funds intended for community-based responses in a facility setting, such as a hospital emergency department (ED). While CHA strongly supports expansion of community-based services, there are significant concerns with maintaining access for existing partnerships.
    - ***Problem:*** Due to federal funding options regarding new funding specifically for community-based mobile crisis, the Behavioral Health Administration (BHA) made a concerning decision to prohibit all mobile crisis response to rural emergency departments following an opaque process that did not include safety net providers or hospitals**.** Small rural hospitals do not have the professional staff, expertise, relationships, and placement and referral capabilities that currently exist or resources to develop that expertise. **If crisis response activities are halted in rural hospitals, patients and providers will be put at greater risk, access to behavioral health services will be severely limited in rural Colorado, and the economic viability of the entire crisis response system could be at risk**.

      Colorado's approach is dangerous policy conflicts that with other states. For example, Vermont officially determined that existing crisis programs will still be responsible for EDs and the mobile crisis Medicaid program is exclusively community based. This approach expands access to community-based services while protecting access to existing services.

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Vermont's Request for Proposal: 2.3.1. Must operate and deliver mobile crisis services 24/7/365 in the community. Vendor will not deliver crisis services in emergency departments (ED) or hospital settings. As is the current model, Designated Agencies, will continue to respond to crisis services in ED or hospital settings.

- ***Request:*** Update the Chapter 10: Emergency and Crisis Behavioral Health Services provisions to include the critical, limited facility-based response that is currently funded in Colorado. Without a solution, rural communities will be at severe risk.

- **Safety Net Provider Definition**: Colorado hospitals do not fall into the definition of "safety net provider;" however, this January, hospitals with psychiatric beds inappropriately received so-called enforcement emails regarding compliance with safety net provider standards that are not appropriate or consistent with hospital's separate licensure standards.
  - ***Request*:** CHA requests clarifying language to codify the reality that safety net providers must voluntarily elect to become safety net providers and indicate that they are equipped to comply with all safety net provider requirements and expectations and avoid this misunderstanding in the future.

    "Safety Net Provider" means a behavioral health provider that accepts public funding, voluntarily chooses to serve as a safety net provider, and must be approved pursuant to Chapter 3. Safety net providers include, but are not limited to, essential behavioral health safety net providers and comprehensive community behavioral health providers. (*1.2.88)*

- **Crisis Assessment Form:** Colorado hospitals utilize various electronic health record (EHR) systems with varying degrees of technological sophistication. As reforms to the crisis assessment form occur, it is critically important that the form development includes technical feedback from both behavioral health and EHR experts to ensure a smooth transition that supports patient care.
  - ***Request:*** CHA requests additional language to ensure that the form development includes behavioral health and EHR expertise, and sufficient time once the form is developed to integrate the form into EHRs as those technical changes often take months.

    "(F) ALL AGENCIES PROVIDING ANY TYPE OF CRISIS SERVICE MUST COMPLETE A CRISIS ASSESSMENT IN FULL ON A BHA-CREATED FORM. In development of this form, the BHA must work with both behavioral health and electronic health record (EHR) experts to reduce the administrative burden of changes. Following development, the BHA must provide sufficient time for providers to integrate the form into their EHR."*10.2(f)*

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- **Alignment with HCPF:** While not directly addressed in this rule packet, I would like to draw the board's attention to critically important alignment needed between the Regional Accountable Entities (RAEs) and the Behavioral Health Administrative Service Organizations. As patients switch insurance coverage, it is vital that there is a clear strategy and direct line of sight into the responsibilities of each entity, what they are responsible for communicating and to whom (both patients and providers), and ensuring continuity of care for a patient should they churn on and off Medicaid during a behavioral health crisis. These are significant outstanding questions that I hope will be addressed imminently to ensure patient access to care and a streamlined provider experience. This conversation is especially critical as there are at least four significant ongoing or new regulatory processes underway across HCPF that intersect with BHA rules, including phase III of the Accountable Care Collaborative and the Hospital Transformation Program.
- **Impacts on the Safety Net:** CHA has heard concerns from existing safety net providers regarding unrealistic staffing standards. The Association has concerns about proposals that would threaten the viability of the safety net in Colorado. Hospitals and the communities they serve face significant issues regarding barriers to safe discharge. While not directly impacted by these requirements, CH is concerned about proposals that could limit access to services, in light of the intense need for behavioral health services in Colorado (7.3.4(A)(7)).

At a high level, CHA believes it is crucial to have a robust, informed conversation about the proposed changes being contemplated to avoid unintended consequences that increase administrative burden and decrease patient access to services. These are complex and technical areas of regulation, and I appreciate the board's attention to these topics.

Hospitals play a unique role in the behavioral health system, and CHA looks forward to providing substantive feedback from subject matter experts throughout the regulatory and implementation process.

With thanks for the opportunity to provide feedback,

Megan Axelrod
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