2023 HOUSE HUMAN SERVICES

HB 1261

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1261
1/16/2023

A BILL for an Act to provide an appropriation to the department of health and human services for the implementation of Medicaid plan amendments or Medicaid waivers related to institutions for mental diseases; to provide for a report; and to declare an emergency.

Chairman Weisz called the meeting to order at 10:01 AM.

Chairman Robin Weisz, Vice Chairman Matthew Ruby, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich present. Rep. Prichard not present.

Discussion Topics:

- Opioid epidemic
- Mental health crisis
- Substance abuse
- Options for psychiatric patients
- Resources for behavioral health patients
- Direct access to behavioral health care
- Staffing of behavioral health clinics
- Role of institutional care services
- Community based behavioral health services

Rep. O'Brien introduced HB 1261 with supportive testimony.

Ty Hegland, President of ShareHouse in Fargo, ND, oral testimony in support of bill.

Dr. Joy Froelich, Executive Director and Medical Director of Good Road Recovery Center offered testimony in support of bill (#13458).

Dave Marion, on behalf of the Prairie Recovery Center, testimony in support of bill (#13341).

Carlotta McCleary, Executive Director of the ND Federation of Families for Children's Mental Health, testimony in opposition to bill. (#13505)

Matthew McCleary, Deputy Director of Mental Health America of North Dakota and Deputy Director of the North Dakota Federation of Families for Children's Mental Health testimony in opposition to bill (#13503).

Krista Fremming, Interim Director of Medical Services with the Department of Health and Human Services testimony in opposition to bill (#13457).

Additional written testimony: Tim Blasl, ND Hospital Association # 13370, Michael Dulitz, Grand Forks Public Health # 13406, Andrea Hochhalter, Parent # 13426

Chairman Weisz adjourned the meeting at 11:08 AM.

Phillip Jacobs, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1261
1/16/2023

A BILL for an Act to provide an appropriation to the department of health and human services for the implementation of Medicaid plan amendments or Medicaid waivers related to institutions for mental diseases; to provide for a report; and to declare an emergency.

Chairman Weisz called the meeting to order at 2:53 PM.

Chairman Robin Weisz, Vice Chairman Matthew Ruby, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Brandon Prichard, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich. All present.

Discussion Topics:

- Commuting for behavioral health services
- Substance use disorder
- Distribution of behavioral health beds
- Community behavioral health services implications
- ND Department of Justice cooperation with community-based services.
- Behavioral health services adequacy

Chairman Weisz called for a discussion on HB 1261.

Adjourned the meeting at 3:10 PM

Phillip Jacobs, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1261
2/6/2023

A BILL for an Act to provide an appropriation to the department of health and human services for the implementation of Medicaid plan amendments or Medicaid waivers related to institutions for mental diseases; to provide for a report; and to declare an emergency.

Chairman Weisz called the meeting to order at 5:05 PM.

Chairman Robin Weisz, Vice Chairman Matthew Ruby, Reps. Karen A. Anderson, Mike Beltz, Clayton Fegley, Kathy Frelich, Dawson Holle, Dwight Kiefert, Carrie McLeod, Todd Porter, Brandon Prichard, Karen M. Rohr, Jayme Davis, and Gretchen Dobervich. All present.

Discussion Topics:

- Committee work
- Commuting for behavioral health services
- Substance abuse vouchers
- Distribution of behavioral health beds

Chairman Weisz called for a discussion on HB 1261.

Vice Chairman Ruby moved a DO NOT PASS on HB 1261.

Seconded by Rep. Prichard.

Roll Call Vote:

Representatives	Vote
Representative Robin Weisz	Y
Representative Matthew Ruby	Y
Representative Karen A. Anderson	Y
Representative Mike Beltz	Y
Representative Jayme Davis	N
Representative Gretchen Dobervich	N
Representative Clayton Fegley	Y
Representative Kathy Frelich	Y
Representative Dawson Holle	Y
Representative Dwight Kiefert	Y
Representative Carrie McLeod	N
Representative Todd Porter	Y
Representative Brandon Prichard	Y
Representative Karen M. Rohr	Y

Motion carries 11-3-0.

Carried by Rep. Frelich.

Chairman Weisz adjourned the meeting at 5:16 PM.

Phillip Jacobs, Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1261: Human Services Committee (Rep. Weisz, Chairman) recommends **DO NOT PASS** (11 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1261 was placed on the Eleventh order on the calendar.

TESTIMONY

HB 1261

Testimony on HB 1261

House Human Services Committee

Prepared by: Dave Marion – Prairie Recovery Center

1-16-2023

Chairman Weisz and members of the House Human Services. My name is Dave Marion and work for the Prairie Recovery Center located southwest of Mandan near Raleigh ND. The Prairie Recovery Center serves men and women throughout ND that suffer with addiction and dual diagnosis mental health conditions in a short-term residential setting in rural ND. The Prairie Recovery Center, as a committed ND resource, has made it its mission to answer the call of the severe crisis that ND is facing with its growing needs in substance use disorders and mental health. The Prairie Recovery Center stands in support of HB 1261 and the continued forward movement of the directive in HB1012, section 5 number 6 of the Dept of Human services shall seek Medicaid plan amendments or Medicaid waivers to allow federal funding reimbursement for services provided in Institutions of Mental Disease to Medicaid beneficiaries. We know through past testimony from the Dept of Human Services and Behavioral Health division as well as a 3rd party consultant report (Shulte Report) identifies shortfalls in many areas for some of our sickest individuals seeking help without access or delays or waiting lists to get the services they need and want at the time they need and want it. So, the next steps are in place and now to fund the process to remove limitations on providers that want to do the work and serve a very vulnerable population of North Dakotans afflicted with substance use disorders. With the large number of individuals seeking these life saving services, it makes perfect sense to achieve this and not restrict individuals wanting help and local resources that want to provide it. If the state wants to make greater impacts to this crisis, then getting an IMD waiver will make greater steps and impact to people that need the help as well as decrease the life-threatening waiting lists for our large Medicaid population needing help. If the state wants to get a better handle on this epidemic for this acute population waiting for it to services is life threatening, so it is imperative to support and fund HB 1261. Without moving forward means the opiate crisis continues to rage, acute patients are underserved, waiting lists continue to grow for acute patients and people die. Supporting HB 1261 and taking the steps to an IMD waiver means we join 39 others states who have approved or are finalizing a waiver. It also allows for the utilization of existing resources to do the work, so let us do the work. In-patient behavioral health is delivered in the community in short-term, acute care settings, this is apparent for persons with mental health and substance use disorders. It would not be in the best interest of the people that need the lifesaving services to limit services or resources when the state can take positive steps to address the needs clearly outlined by the Dept of Human Services, Behavioral Health Division and Shulte Report. Taking the steps to support and fund HB1261 is in the best interests of people and families, which serves as the cornerstone to our ND communities. Thank you for your time and consideration and if you have a question please do not hesitate to ask.

Dave Marion

2023 House Bill 1261
House Human Services Committee
Representative Robin Weisz, Chairman
January 16, 2023

Chairman Weisz and members of the House Human Services Committee, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I testify in support of House Bill 1261 and ask that you give the bill a **Do Pass** recommendation.

NDHA supports this bill because it allows for reimbursement for services in institutions of mental diseases (IMDs) for Medicaid beneficiaries between the ages of twenty-one and sixty four.

An IMD is a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. We currently have four facilities within North Dakota that are considered IMDs.

- State Hospital
- Prairie St. John's – Fargo
- ShareHouse – Fargo
- Summit Prairie Recovery Center – Raleigh

NDHA supports eliminating what is called the IMD exclusion in the facilities above which prohibits reimbursement for Medicaid patients (ages 21-64). It makes no sense from a policy perspective to limit the settings where these services are provided.

Limiting access to community behavioral health facilities impacts the costs of care. The days of sending patients to facilities outside their community are no longer acceptable. It shouldn't matter whether a facility has 15 or 30 beds.

Please give the bill a Do Pass recommendation. Thank you for this opportunity.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

Public Health
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Grand Forks Public Health

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January 16, 2023

Chairperson Weisz and Members of the Committee,

I am Michael Dulitz, the Opioid Response Coordinator at Grand Forks Public Health. I am providing testimony in **SUPPORT** of HB 1261.

It is well established that behavioral health services are best provided when the right need matches with the right service at the right time. Providing an excess level of service, or an insufficient level of service leads to poor outcomes for an individual. In other words, behavioral health care is best provided as a *continuum* of care – with most services provided on an easily accessible outpatient basis with the availability of more intensive services when circumstances dictate.

Since the deinstitutionalization efforts of the 1960s, the behavioral health *continuum* has had a tremendous gap – services provided to Medicaid recipients aged 21-64 in facilities considered "institutions of mental disease" (IMD) with more than 16 beds. Medicaid restricted payment for services provided in these larger psychiatric and substance use disorder care facilities. This restriction forces those facilities to make difficult *business* decisions about care provided as opposed to *healthcare* decisions. In many cases, facilities must weigh out the cost of providing uncompensated care, the ethics of restricting care, and the need to keep a facility financially viable.

In recent years, Medicaid has started granting waivers under the section 1115 waiver process for this IMD exclusion. As of December 2022, 34 states have approved waivers for substance use disorder services and 10 states have approved waivers for mental health treatment.

One of the requirements of the 1115 waiver process is a requirement for budget neutrality – a challenging problem when considering providing care for hospitalization. In researching states with approved waivers, a common theme in their budget neutrality plans was improving the behavioral health care *continuum*.

To that end, it is important to consider how the Department of Health and Human Services (DHHS) may be able to achieve the needed budget neutrality and what policies may help ease that pursuit. Establishing the necessary authority for DHHS to establish, certify, and reimburse Certified Community Behavioral Health Clinics may be one opportunity to improve the *continuum* of behavioral health care to help chart that path towards budget neutrality.

The pursuit of Medicaid waivers for the IMD exclusion has the potential to provide timely and needed improvements to the behavioral health *continuum*. I would encourage this committee to consider how to leverage this opportunity to build a stronger behavioral health *continuum* in North Dakota.

Respectfully Submitted,

Michael Dulitz
Opioid Response Coordinator
Grand Forks Public Health
Grand Forks, ND

TESTIMONY OF ANDREA HOCHHALTER

Hearing on HB 1261

January 16, 2023

Written Testimony in Opposition

To the House Committee on Health and Human Services, thank you for the opportunity to provide written testimony regarding HB 1261. This testimony is in opposition to providing an appropriation to the Department of Health and Human Services for the implementation for Medicaid plan amendments or Medicaid waivers for IMDs.

HB 1261, while at first glance sounds like a positive plan and solution to addressing a component of North Dakota's mental health crisis through creating a means for ND to collect federal dollars for services provided to residents of Institutions for Mental Diseases, is not in our best interest. My experience and research tell me an IMD 1115 waiver for ND is the wrong answer and would set back the progress ND is making in mental health services. The waiver does not align with the needs of North Dakotans nor the strategic initiatives of DHHS. Saying yes to an IMD 1115 waiver is saying yes to pulling energy away from what is working and redirecting it toward an initiatve that does support our state's behavioral health vision of investing in community-based services and supports.

First, why do I care? I am a parent of child with serious mental illness. Finding, accessing, integrating services for my family has entailed a great deal of challenges over the years. In particular and related to HB 1261, in 2016 my daughter attempted suicide and following a 9-day stay in a pediatric intensive care unit, fighting for her life, we were informed by the social worker she was going to be relocated to a psychiatric unit at a location not of our choice. What I learned was that the process was to send acute psychiatric cases to wherever there was a bed open in the state or surrounding area outside of ND. Knowing I wanted something better and different for my daughter, believing there had to be another option, I called and called around our state and even out of state for a residential program that would keep her close to home and wrap her in the acute and recovery services she needed. I did not find that solution and with our daughter's safety as the number one priority we admitted her to a facility 100 miles away where she was in residence for 29 days. For these days my husband and I stayed in a hotel to be close to take regular meetings with her medical and care team, to hold regular visits with her, to help her know just how very much she was loved. I can't imagine not being close to our daughter during this traumatic event. Having to be present for her meant added expenses and loss of income for us, an added burden during an already difficult time. Additionally, once released from the hospital we needed to go back to our community and identify providers, wait for providers to be available, and coordinate her care. The navigation of establishing care and support for our daughter, and ourselves, was exhausting and all while we lived in fear of her hurting herself again.

So why do I care? Because my hope is that nobody must experience what we did by sending a family member of any age away for treatment (to an IMD not located near you), to experience added burdens during what may be the most difficult and worst thing in life you ever experience. My hope is for people,

families, to receive treatment where they live surrounded by their family and friends, to have a continuum of services accessible and integrated in their community.

HB 1261 is more than about accessing federal funds for IMDs, it is about prioritizing IMDs over community services. Having the benefit of participating in learnings sessions with four organizations responsible for providing specialty services on health policy, complex state strategies, private/public sector consulting, and legal specialists, all experienced with the IMD 1115 waiver application, planning, demonstration project, implementation, and evaluation process, I am confident pursuing or obtaining the waiver is not in the best interest of North Dakota and our citizens. In these conversations I learned a waiver project is timely, expensive, resource heavy and there is no conclusive data from any of the 8 states approved for mental health IMD waivers that demonstrates added value or positive outcomes.

Separate from the State Hospital, North Dakota has three IMDs that would benefit from a mental health 1115 waiver, two located in Fargo, the other in Raleigh. Channeling Medicaid funds toward two locations does not address the state's mental health crisis, it just adds more of what we already have that is not working for North Dakota. What is working for ND is the current vision, strategy, and initiatives of DHHS with emphasis on community-based services. While the idea of adding new IMDs in ND has been expressed, it is not facilities with 16+ beds we need, we know this. It is getting beds, treatment and services, closer to where people live and work.

There is so much we can do that truly focuses on and addresses ND's mental health crisis without displacing resources toward a waiver. Look for example at what has been accomplished and is continuing to develop with 1915(i) and the ability to receive Medicaid matching funds for mobile crisis and stabilization services. What we focus on expands, let's keep our focus on the existing initiatives that have momentum and are clearly aligned with the needs of the communities and people of our state by not passing HB 1261.

With Regard,

Andrea Hochhalter

. We have the ability to add mental health services to our state's plan, to increase community, program, and care integration, and extend crisis stabilization service all without an IMD 1115 waiver. What DHHS is doing is working. Let's make decisions and investments in the existing vision and strategies that have been well researched, planned, and are working and not get distracted in a shiny waiver that will inevitably become a line in another future Schulte report telling us we are….

Recommendation, focus on continued momentum currently underway by DHHS with emphasis on getting the mental health resources closer to where people are living. Invest in psychiatric care in existing general hospitals and 16 beds or less facilities

- Move attention and resources away from the progress North Dakota has been making with addition and expansion of community based services
- With a waiver comes additional requirements from Centers for Medicaid Services, an additional burden requiring and pulling resources
    - As
- 1915i is taking off and expanding services across the state.

When we choose to invest in communities over IMDs we are demonstrating that we know and understand who ND residents are,are residents of ND are; we are rural, we are

When we invest in IMDs we are enforcing the stigma of mental illness. Mental illness should not be a disease where we ship people off to be housed together like IA waiver on the contrary would have the following negative impacts.

- The waiver provides matching federal funds to the state, for every $1 ND would put toward Medicaid mental health services at an IMB the state receives $0.50. Thus the state is incented to direct funds toward IMD's and away from community based services.
- What we need is not to invest in the bottom line of these facilities but rather to build out community based mental health services across the state and achieving this does not require an IMD waiver nor benefit in anyway from.

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Testimony
House Bill No. 1261
House Human Services Committee
Representative Weisz, Chairman
January 16, 2023

Chairman Weisz and members of the House Human Services Committee, I am Krista Fremming, Interim Director of Medical Services with the Department of Health and Human Services (Department). I appear before you in opposition to House Bill No. 1261.

It is unclear what problem this Bill is trying to solve. Advocates for an IMD waiver have focused on the need for Medicaid to pay for inpatient and residential treatment services for adult Medicaid members with substance use disorders (SUD). North Dakota already has a mechanism to pay for SUD treatment when Medicaid cannot pay – through the state SUD voucher program. In fact, the SUD voucher was established to cover gaps in paying for treatment for low-income North Dakotans, including Medicaid members.

There are only four facilities in the state for which this waiver would enable Medicaid payment for adults that does not currently exist: the State Hospital, Prairie St. John's, ShareHouse and Prairie Recovery Center. Medicaid members are already able to receive outpatient services through these facilities. Medicaid members who need detoxification, inpatient or residential treatment services may receive them through the many other facilities that are 16 beds or less, as well as at hospitals throughout the state.

In addition, there have been several studies conducted in recent years which assessed North Dakota's behavioral health system of care. The findings in these reports support the Department's position against this Bill:

- *Expansion efforts should focus on increased capacity for outpatient treatment that reduces demand for inpatient treatment. A number of states have obtained an IMD exclusion waiver for SUD treatment and more recently mental health; however, this would not address the most important needs in ND and is counter to the thrust of recommendations to reduce inpatient utilization.* (North Dakota Hospital Study, Human Services Research Institute, 2020).
- *North Dakota residential and inpatient facilities are smaller than the US average, but utilization rates are considerably lower. North Dakota's lower utilization rate is further evidence of an adequate supply of substance use residential treatment beds.* (North Dakota Residential Treatment Facility Capacity, Human Services Research Institute, 2020).
- *While some residential and inpatient services are needed to meet the needs of the community, over-relying on these services is problematic for many reasons, which are discussed throughout the report. Chiefly, these arrangements are inefficient from a cost perspective and undesirable from a population health perspective. Our recommendations focus on ways the state might strategically examine utilization patterns and need for services to ensure people receive the right level of care at the right time. Such strategies will allow the state to disinvest from costly and undesirable institutional services and reinvest funding upstream to promote population health and prevent and reduce the need for intensive behavioral*

health services. (North Dakota Behavioral Health System Study, Human Services Research Institute, 2018).

The Department also has concerns that the appropriation in this Bill would not be sufficient to complete the work described. We have consulted with other states that have implemented these waivers and it would take a larger initial investment. In the 23-25 biennium, we estimate the need for $2.5 million in vendor contracts for subject matter expertise, five full-time equivalent positions and $1.15 million to fund those positions.

1115 waivers of this nature are large, complicated and come with a lot of federal requirements and reporting. The Department would need to conduct a gap analysis, develop a phased implementation plan to address the gaps and come back to the 2025 legislature with requests for additional funding to address the gaps. It seems that the gap analysis and related work would be duplicative of work that is already happening or has recently happened. To a large extent, we know what needs to be done to further develop the behavioral health system of care in North Dakota, and we don't believe the answer is more Medicaid payments to institutions.

If we had a legislature that wasn't willing to invest in community-based SUD treatment services, this waiver would be a way to force the hand of the legislature for that purpose. Fortunately, the legislature has seen the need to develop this side of the behavioral health continuum. As the community-based behavioral health system is further developed, the Department is committed to using federal Medicaid resources whenever possible to pay for services and supports, and we would like to work with the legislature to make this happen.

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This concludes my testimony. I would be happy to try to answer any questions the committee may have. Thank you.

MHA Recovery Services
GOOD ROAD RECOVERY CENTER

1308 Elbowoods Lane, Bismarck, ND 58503

Testimony
House Bill No. 1261
House Human Services Committee
January 16th, 2023

Chairman Weisz and members of the House Human Services Committee, my name is Dr. Joy Froelich, and I am the Executive Director and Medical Director of Good Road Recovery Center. I am here today representing Chairman Mark Fox on behalf of the MHA Nation to provide testimony in support of House Bill No. 1261.

The MHA Nation is in full support of this bill along with swift implementation of the IMD waiver to help fight the war on substance abuse and overdose death.

The December 2022 CDC reports in both 2020 and 2021, rates were highest for non-Hispanic American Indians or Alaska Native (AIAN) people (42.5 per 100,000 and 56.6, respectively), and the lowest for non-Hispanic Asian people (4.6 and 4.7, respectively).

Non-Hispanic Native Hawaiian or Other Pacific Islander (NHOPI) and non-Hispanic American Indian or Alaska Native people experienced the largest percentage increases in drug overdose death rates from 2020 through 2021, with rates increasing 47% (13.7 to 20.1 and 33% (42.5 to 56.6), respectively.

Link to CDC data:
https://www.cdc.gov/nchs/data/databriefs/db457.pdf

The MHA Nation is committed to helping enrolled members achieve and maintain long term sobriety. The war on substance abuse is a priority and the MHA Nation has committed resources and infrastructure, but the IMD rule prevents residential treatment services to most members that are in desperate need of residential substance abuse treatment. Most members must leave their home, culture, and family to receive residential services outside of North Dakota.

The MHA Nation has built and utilizes Good Road Recovery Center, a tribally owned and operated treatment facility located in Bismarck ND. The IMD rule limits the bed capacity of this facility to 16 residential clients. Currently MHA Nation has 48 clients in residential treatment outside of Good Road Recovery Center and 35 of these clients are in residential treatment outside of the state of North Dakota due to the limitation of available beds.

Chairman Weisz and members of this committee, the MHA Nation supports House Bill No. 1261 and requests implementation by 2024 not only to help our Nation but to help the epidemic also occurring across the great state of North Dakota.

Chairman Weisz and members of the committee, thank you for the opportunity to testify today and for your attention to the great need of House Bill No. 1261.

I would be happy to answer any questions and again thank you,

Joy Froelich MD
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Mental Health Advocacy Network

Consumer & Family Network
Mental Health America of ND
Youth Move Beyond
The Arc of Bismarck
Federation of Families for Children's Mental Health
Protection & Advocacy Project
ND Association of Community Providers
Fraser, Ltd.
Individual Consumers & Families

House Human Services Committee
HB 1261 Testimony
January 16, 2023
Representative Weisz, Chair

Good morning, Chairman Weisz and Members of the House Human Services Committee. I am Matthew McCleary, Deputy Director of Mental Health America of North Dakota and Deputy Director of the North Dakota Federation of Families for Children's Mental Health. Today I speak on behalf of the Mental Health Advocacy Network (MHAN). MHAN advocates for a consumer/family driven mental health system of care that provides an array of service choices that are timely, responsive and effective. Our vision is for every North Dakotan to have access to the right service—whether it be preventative, treatment, or recovery; at the right time—when the service is needed; and at the right place—as near his or her home as possible.

MHAN is testifying in opposition to HB 1261, the repeal of the IMD Exclusion through an IMD Exclusion waiver. 1) Repealing the IMD Exclusion risks reversing decades of federal legislation and policy designed to help states rebalance their Medicaid spending to support more integrated settings and support the *Olmstead* decision. 2) The $1,500,000 or so much of the sum as may be necessary proposed expenditure could be denied by CMS, particularly because the state of North Dakota has been aware for nearly a decade that it does not have adequate community-based mental health services. 3) The provision of additional community-based mental health services and efforts toward the implementation of the 1915(i) would lead to immediate improvements in the mental health service delivery system in North Dakota and would be a more fiscally sound route for taxpayers.

1) **The *Olmstead* Decision/ Support for Community Integration**

The reason why there is an IMD Exclusion is because of the history of institutionalizing those with mental illness without providing community-based services. As deinstitutionalization was beginning, the argument was that people with disabilities, including those with mental illness deserved to be given community services instead of continuing the reliance on large hospitals to provide institutional level of care. The IMD Exclusion pushes states to focus on community-based services, in integrated environments as opposed to institutional care. Because Medicaid reimbursement is available for mental health and substance use disorder services in the community rather than institutions, the IMD Exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated environments.

To those who say that that was so long ago, and that we are beyond the dangers of the past, people with disabilities say the past is informative about what happens when incentives are stacked against providing community services. Evidence shows that if psychiatric beds are available, they are filled, taking resources from community-based services. When beds are not available, other options meet individuals' needs. Moreover, a large, three-year demonstration program allowing states to claim federal Medicaid reimbursement for services in IMDs found that doing so did not decrease psychiatric emergency room visits or the length of emergency room boarding, and did not increase access to psychiatric hospital services. The only major finding was that

allowing federal financial protection (FFP) to IMDs increased costs to the federal government.[1]

Spending money on more costly institutional settings would very likely result in less funding made available for more cost-effective community-based programs that provide better outcomes. Having fewer resources available for community-based programs would seriously undercut Congress's intent when enacting the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act, and most seriously, the Integration Mandate articulated by the Supreme Court's decision in *Olmstead v. LC.*

The Justice Department has found violations of *Olmstead* and the Americans with Disabilities Act in states across the country due to states' overreliance on psychiatric institutions and insufficient community-based services. As North Dakota is well-aware through the Schulte Report of 2014 and the HSRI report of 2018, North Dakota remains in a mental health systems crisis and that crisis is about North Dakota not fulfilling the requirements of *Olmstead.* Community-based treatment is often more effective and frequently more cost-effective than inpatient or residential care.

2) **Financial Considerations: IMD Exclusion Waiver vs. Community-Based Services**

There are different types of IMD Exclusion Waivers states have applied for. There are Substance Use Disorder Treatment IMD Exclusion Waivers and there are Mental Health Treatment IMD Exclusion Waivers. States also have the option to pursue both. Currently, 28 states have a substance use disorder IMD Exclusion Waiver, with 8

[11] Crystal Blyer et al, Mathematica Policy Research, *Medicaid Emergency Psychiatric Services Demonstration Evaluation, Final Report* (Aug. 18, 2016), https://innovation.cms.gov/Files/reports/mepd-finalrpt.pdf

states pending. There are 10 states with an IMD Exclusion Waiver for mental health services, with 6 states pending.

We need to be clear about what the IMD Exclusion Waiver is and what it is not. It is a means to provide Medicaid reimbursement for inpatient services in facilities with 16 or more beds. There is nothing else it does, and increasing the reliance on institutional care is the exact opposite of what North Dakota-commissioned studies from the last decade said North Dakota needs to do in order to bring an end to this crisis and have a functioning mental health system.

The former Director of the Medical Services Division, Caprice Knapp, testified in front of the legislature in 2021 what it would take to apply for the IMD Exclusion Waiver. While her report was extensive, there are some things that we want to highlight. The required goals and milestones that are required for an IMD Exclusion are extensive, requiring years of planning. There is a high level of administrative costs, post-implementation costs and staffing required for states that seek out this waiver that would remain an ongoing cost requiring millions of dollars.

The $1.5 million or so much of a sum as may be necessary, comes with risks, particularly since all indicators show that the state's level of home and community services are not adequate at this time. Upon approving of this expenditure, CMS would still need to approve any requests for the waiver. If the request is denied, those expenditures would have been for naught.

While larger facilities may seek out more financial reimbursement for care for persons on Medicaid, even upon approval of an IMD there are limitations on the number of days of reimbursement: 15 days per year for inpatient IMD, 30 days per

year for residential IMD. Most crucially, states with an IMD Exclusion Waiver must be "budget neutral" to the federal government, which means that, during the project federal Medicaid expenditures will not be more than federal spending without the demonstration. As a result, community-based mental health services, or the expansion of community-based mental health services as recommended over the last decade, could be in jeopardy.

The state does currently have contracts with hospitals for some in-patient psychiatric hospitalizations as an alternative means to meet the needs of persons who do require inpatient hospitalization and has a substance use voucher available for all levels of care.

The HSRI "ND Residential Treatment Facility Capacity" report states that there is not a shortage of beds, but rather inappropriate utilization, that is beds occupied by people who could be served in less-intensive settings. The most recent report from Renee Schulte Consulting LLC, entitled "The Acute Psychiatric Residential Care Final Draft Report," stated that there are enough acute hospital beds, but many are in the wrong locations and are shared with out-of-state placements. In addition, they found that critical access hospitals must be equipped to assess, stabilize, and transfer mental health and substance use patients to appropriate levels of care as required by federal law. During the interim session, Schulte was specifically asked if they could comment on pursuit of an IMD Exclusion Waiver. Schulte's reply was that she did not address that policy proposal, because North Dakota was so far behind on having a functioning mental health system of care that any energy spent contemplating an IMD

Exclusion waiver would be pointless. In fact, pursuing an IMD Exclusion Waiver was not a recommendation from any previously-commissioned studies.

The state of North Dakota has made great strides in working toward providing community-based services in recent years. While there continue to be considerable needs, through further efforts to implement the 1915(i) and other options available to community services, the state can have a robust mental health delivery system--all without years of planning and high administrative costs related to the application for a waiver of the IMD Exclusion.

3) **Alternatives to IMD Exclusion Waiver/Expansion of Community Based Services**

Investment in community-based services such as permanent supportive housing, mobile crisis teams, assertive community treatment, supported employment, intensive coordinated mobile services, and peer support reduces the need for inpatient beds and allows for more individuals to be served. The 1915(i) State Plan Amendment is an asset North Dakota has and its design has some of the most robust services in the country, but it needs to have better implementation and be given the opportunity to thrive. We had the expectation that it could serve over 11,000 people, but we are nowhere near that total. We need to make it easier for providers to become enrolled and we need to reach more consumers.

The American Rescue Plan Act (ARPA) creates a new state Medicaid option for qualifying community mobile crisis intervention services. States that implement this option can receive 85% federal match for mobile crisis intervention services (MCIS) provided to Medicaid beneficiaries for three years starting on April 1, 2022.

The last decade has seen North Dakota acknowledge that the state has a mental health systems crisis. That crisis has not yet ended. The work to create community-based services remains a top priority for HSRI and DHHS. Consumers and family members are adamant that that work must continue. The pursuit of an IMD Exclusion Waiver jeopardizes that work. Simply put: the North Dakota mental health system of care cannot withstand an IMD Exclusion Waiver.

Thank you for your time and I would be happy to answer any questions you may have.

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HB 1261 Testimony
House Human Services Committee
Representative Weisz, Chairman
January 16, 2023

Chairman Weisz and Members of the Committee, I am Carlotta McCleary, the Executive Director of the ND Federation of Families for Children's Mental Health (NDFFCMH), which is a parent run organization that focuses on the needs of children and youth with emotional, behavioral, or mental health needs and their families. I am also the Executive Director for Mental Health America of ND (MHAND) which is a consumer-run organization whose mission is to promote mental health through education, advocacy, understanding, and access to quality care for all individuals. Today I am testifying as the Chairman of Behavioral Health Planning Council. Members of the North Dakota Behavioral Health Planning Council are appointed by the Governor. BHPC's objective is to monitor, review, and evaluate the allocation and adequacy of mental health and substance abuse services in North Dakota. The BHPC has a focus and vision on wellness and recovery that is consumer and family driven.

The ND Behavioral Health Planning Council is opposed to HB 1261, the implementation of Medicaid waivers related to institutions for mental diseases. The IMD exclusion serves an important purpose, a waiver would risk undermining that purpose. We believe there are numerous ways to improve Medicaid funded behavioral health services without pursing a waiver.

The BHPC has been reviewing IMD exclusion over the last biennium. We have had presentations from ND Medicaid, Karen Kimsey and Tom Betlach from Speire Healthcare Strategies, and finally a presentation from Jennifer Lav, from National Health Law Program and Elizabeth Priaulx, from National Disability Rights Network.

Under Section 1905(a) of the Social Security Act, there is a general prohibition on Medicaid payment for any services provided to any individual who is under 65 and who is residing in an institution for Mental Diseases (IMD). "The term 'institution for mental diseases' means a hospital, nursing facility, or other institution of more that 16 beds, that

is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Under this definition, can have more than 16 beds dedicated to mental health treatment in a general hospital. The purpose of the IMD Exclusion was to clarify it as the states responsibility and to encourage community-based services.

The IMD Exclusion is limited:

- Does not apply to individuals 65 and over
- Does not prevent children under 21 from getting services in the following settings (even if more than 16 beds) psychiatric hospital, psychiatric unit of general hospital, and psychiatric residential treatment facility
- Does not stop managed care enrollees from getting services in an IMD for up to 15 days per calendar month (ND Medicaid Expansion)
- Does not prevent states from asking for a state plan option to allow people to get services for SUD in IMDs (expires 9/30/2023)
- Does not prevent States from getting federal funds for impatient psychiatric care in general hospitals
- Does not prevent federal funding for adult settings that are 16 beds or less.

What do IMD Waivers let states do? IMD waivers allow states to collect federal dollars for services provided to residents of IMDs.

There are certain services, resources, and infrastructure elements that should be in place prior to applying for and implementing a IMD waiver.

- Budget Neutrality Strategy: CMS requires states to have a strategy to offset the costs of the additional services provided so that projects do not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid cost would have likely been absent the demonstration.
- State Plan Services: Meeting CMS milestone requirements might require the provision of serves not currently covered in the state plan.

- Infrastructure Development: New services could require developing adequate provider networks, utilization management protocols, and care management infrastructure to support the access to and the appropriate use of new services.
- Integrating Services: Integrating new services and improving the overall system of care for behavioral health services could require a significant investment of time and resources along with internal and external stakeholder input.
- Management Staff: Additional staff could be needed to assist with planning, execution, and management of the IMD Waiver.

Steps Prior to applying for a waiver:

- Conduct a gap analysis of current to future delivery system
- Determine FTE and resource needs for IMD
- Determine stakeholder demand/appetite and political climate
- Develop a phased implementation plan to address the gaps

We must also consider:

- Discriminatory impact & adverse impact on community-based integration
- Administrative burden
- Opportunity costs

What are the alternatives, North Dakota's 1915(i). Give the 1915(i) time to meet its promise. The service package within the 1915(i) are some of the best within the country. Mobile Crisis Response and Stabilization Services, under American Rescue Plan Act (ARPA), states may apply for and receive an 85% federal match for qualified mobile crisis services, for up to 3 years during a 5-year period, starting April 1, 2022, and increasing access for Assertive Community Treatment.

Through our deliberations, we concluded that we needed to keep the end user and their families at the forefront of our recommendations. The response to the pursuit of an IMD waiver was negative. Consumers and family members have been adamant that the work the council has embarked on to support the HSRI recommendations needs to continue. That work concentrated

on the development of community services for people with behavioral health needs, not increasing our reliance on institutional care and large institutional settings. We also heard from providers that the pursuit of an IMD waiver sends the message to existing providers that their work to play by the rules and build their facilities around smaller bed counts across the state are not rewarded for that work. Instead, bigger providers are going to reap the benefits of such a change.

The IMD waiver does nothing for community-based services that cannot be done by directly improving community-based services. If anything, the IMD waiver jeopardizes the work that we have done over the last few years and the work that remains to be done.

Thank you for your time, I would be happy to answer any question that you may have.

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