Testimony on Behavioral Health Funding for Nursing Facilities and Basic Care
House Appropriations Human Resources Division
February 4, 2025
House Bill 1012

Chairman Nelson and members of the Committee, my name is Nikki Wegner, President of the North Dakota Long Term Care Association (NDLTCA). Thank you for the opportunity to testify. I represent 182 nursing, basic care, and assisted living facilities. I urge support for an amendment to HB 1012, allocating $3 million to implement a specialized behavioral health program for individuals with complex behavioral symptoms in skilled nursing and basic care settings. This proven approach will enhance care while reducing overall healthcare costs.

Background

As Pam Sagness mentioned last week, a diverse group of stakeholders have been working together to identify and address persistent challenges experienced by long term care and hospital providers, some of which were also highlighted in North Dakota's behavioral health studies.

North Dakota Long-Term Care and Psychiatric Facility Collaborative – Behavioral Health

Collaborative members: ND Long Term Care Association, ND Hospital Association, Alzheimer's Association, Health & Human Services-Behavioral Health, Good Samaritan Society, Sanford Health, Prairie St. John's, SMP Health-St. Raphael, Dept of Corrections & Rehabilitation, Altru, Hill Top Home-Killdeer, LTC State Ombudsman, Benedictine Living-Ellendale

Purpose of Collaborative: Identify and address behavioral health specific issues impacting populations served by long term care facilities and psychiatric facilities in North Dakota.

Ongoing Work of the Collaborative:

- Definitions Workgroup (stable, acute, level of care, safety)
- Engage Medicaid
- Data Gathering
- Length of Stay Review
- Strategize Solutions
- State Hospital Role

WHO	**Justice-involved** (DOCR and civilly committed sex offender population)	**Residents with Challenging Behavior** (not specifically gero-psych)	**Gero-Psych**	**Community-Based**
CONSIDERATIONS / PROBLEM STATEMENTS	Individuals who are justice-involved currently or by history remain in state facilities due to a lack of options. • Aging DOCR • Sex-Offenders • Violent Crime History Facility proximity to schools can be an issue in community. Insurance issues for long term care providers. • Case by case review but mostly no.	Medicaid eligibility delays. Medicaid residents under 65 that are hospitalized, SNFs cannot bill for bed hold days. Provider hesitancy to support individuals with difficult behaviors due to concern support won't be available if things escalate. CMS very low risk tolerance for potential harm in SNFs. Lack of care coordination to assist individuals across systems. Need for consulting specialists to assist facilities in maintaining or returning individuals with high need. Reimbursement considerations.	When acute situations arise, the closest inpatient facility isn't necessarily best care for this population (mixed milieu). Neuro-cognitive disorder difficulty. Gero-psych language does not represent current population with many younger individuals. Connecting with peers of similar age is limited in current system. Specialty contracted beds located in existing Long-Term Care facilities are full. (3 providers) Reimbursement considerations. There is a significant delay in discharge/admission to a facility while reapplying for Medicaid which adds cost to the state and reduces revenue for the facility. NDCC 50-24.4-29 edit to avoid NDSH admission prior to Gero-psych admission.	Missing level of service for long term therapeutic interventions? Transitional living facility identity – what is a transitional time frame for a chronic disease? Does ND need Intermediate Care Facilities (ICF) for individuals with mental health conditions? Risk mitigation fund for gero-psych if qualifying issues? "Basic care for SMI"

Regulatory & Discharge Challenges

Nursing (NF) and basic care (BC) facilities and psychiatric providers report major challenges in accessing crisis response services and timely inpatient psychiatric care, creating unsafe situations for both residents and staff. When NF and BC residents experience acute psychiatric episodes—characterized by severe agitation, aggression, or self-harm—facilities often lack the necessary resources to provide effective interventions.

Strict regulations require NFs to maintain an environment free from abuse or the threat of abuse, making it extremely difficult to care for individuals who exhibit or have a history of exhibiting violent verbal or physical behaviors. Facilities risk citations and penalties, creating a barrier to admission for residents with complex behavioral health needs.

LTC facilities and hospitals struggle with delays in transferring patients to the appropriate setting, whether for long term care placement or inpatient psychiatric stabilization. These delays are worsened by Medicaid eligibility delays, and an overburdened State Hospital system, which operates at full capacity due to a lack of step-down options for patients who no longer need hospitalization and cannot safely transition elsewhere. This situation is not only costly but also prevents these individuals from receiving the specialized and consistent care they require in a more home-like setting.

This crisis stems from a shortage of behavioral health specialists and reimbursement barriers. While some necessary services are billable, many essential interventions are not. Facilities must contract for these services, yet current payment structures do not cover these costs.

LTC providers operate under tight financial constraints, making it impossible to fund non-billable but essential behavioral health services, including:

- Training caregivers in behavioral interventions
- One-on-one and group psychosocial activities
- Acute assessment and referrals for uninsured individuals
- Compliance guidance for CMS schizophrenia audits
- Crisis resolution for residents and families

Other states have successfully addressed this gap with add-on payments, ensuring residents receive appropriate care. They've demonstrated that targeted behavioral health programs in long term care facilities can:

- Stabilize residents with behavioral health needs.
- Reduce reliance on emergency departments and hospital admissions.
- Enhance the quality of care and outcomes for residents while decreasing costs to the healthcare system.

Proposed Model

The requested $3 million will provide funding for this biennium to launch and scale a proven care model, demonstrating its effectiveness and cost-saving potential. By starting on a targeted scale, we can fine-tune implementation, gather meaningful data, and build a compelling case for future statewide expansion.

Other states have **proven cost savings** from implementing similar behavioral health support programs. In Nevada, emergency room visits among participating residents dropped **by 72%**, reducing unnecessary hospitalizations and **saving millions in healthcare costs**. A similar approach here in North Dakota will allow us to:

- **Decrease costly acute care transfers** and stabilize residents in lower-cost settings.
- **Equip nursing and basic cares facilities with specialized behavioral health training** to manage complex cases.
- **Reduce staff turnover** by ensuring facilities have the resources to safely care for residents with behavioral health needs.

This isn't just a funding request—it's a solution to a growing problem that, if left unaddressed, will continue to burden **hospitals, emergency departments, and the state's budget**.

To expand on the specifics, I now introduce **Dr. Kristina Kovacs**, who will share data from Behavioral Health Solutions and outline the significant return on investment for implementing targeted behavioral health services in our long term care facilities.

I respectfully urge your **support for this $3 million funding request**, which will **save money, improve care, and prevent avoidable hospitalizations**.

Thank you for your time, and I welcome any questions.

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