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Mental Health Advocacy Network

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

Position Statement on IMD Exclusion and the IMD Exclusion Waiver

Mental Health Advocacy Network opposes any proposal to repeal 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) Funds expended toward that purpose 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 Certified Community Behavioral Health Clinics (CCBHCs) and the 1915(i) will lead to 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

[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

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. 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. Unless the state of North Dakota has unlimited funds, it would be funneling preciously needed resources away from community-based services into institutional care; something that would be tantamount to pursuing the exact opposite of the recommendations from every major research report funded by the legislature and the Department since the late 1980s.

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.

When we pull back to consider the enormity of the problem, we have to consider that we have to ensure that North Dakota meets its legal obligation to provide community-based mental health services to *all* of the adult SMI. That is nearly 39,000 North Dakotans by the Department of Health and Human Services' own figures. We are nowhere near that mark. That is the problem North Dakota must solve in order to justify pursuing an IMD Exclusion Waiver. That is why Renee Schulte said to the last Interim legislative body that the state of North Dakota was nowhere near being ready

to contemplate an IMD Exclusion Waiver. Simply put, as it stands now, the North Dakota mental health system cannot withstand an IMD Exclusion Waiver.

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 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.

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