Draft SMI/SED Institutions of Mental Disease (IMD) Waiver

Session Law 2023-134, Section 9E.19A

Report to

Joint Legislative Oversight Committee on Medicaid
By

North Carolina Department of Health and Human Services

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Executive Summary

This report details the potential scope and impact of a proposed Medicaid 1115 demonstration waiver to receive federal financial participation (FFP) for services provided to Medicaid members receiving mental health treatment in an institution for mental diseases (IMD), beyond NC Medicaid's current benefit. Through its analyses, the NC Department of Health and Human Services (DHHS) identified that state-operated facilities that qualify as IMDs would not meet the average length of stay requirements to be included in such waiver. Mental health services provided to otherwise Medicaid-eligible individuals in state-operated facilities are entirely state-funded; excluding them from the 1115 demonstration waiver significantly limits North Carolina's ability to generate state savings through new opportunities for federal financial participation. The waiver could only include private facilities, and DHHS estimates that implementation of the waiver would increase annual state spending in these facilities by approximately $7.1M to $11.7M. Based on current assessments of North Carolina's behavioral health delivery system and a review of other states' waiver implementation, new systems of robust oversight would be necessary to ensure quality of care for individuals receiving longer stays in private facilities under such waiver.

Background

Session Law 2023-134 Section 9E.19A. directed DHHS to report on the development of a Medicaid 1115 demonstration waiver focused on adults ages 21 to 64 with serious mental illness (SMI) and/or children with serious emotional disturbance (SED).[1] The goals of the waiver include: receipt of FFP for covered services furnished to NC Medicaid beneficiaries during stays greater than 15 days in a month for acute care in psychiatric hospitals or residential treatment settings that qualify as an IMD; improved access to community-based care, including crisis stabilization services; and improved care coordination and continuity of care following acute hospital and residential treatment facility stays to help reduce emergency department utilization and lengths of stay and avoidable hospital readmissions. An IMD may include 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, including medical attention, nursing care, and related services.

NC Medicaid currently covers and receives FFP for services provided to individuals in an IMD with mental health conditions for stays of no more than 15 days within a month[2] through prepaid health plans or the local management entities-managed care organizations (LME/MCOs) as an "in lieu of service (ILOS)".[3] The 1115 demonstration would provide expenditure authority for stays in IMDs up to 60 days (including the 15 days per month currently authorized as ILOS), and enable the State to receive FFP for covered services for Medicaid beneficiaries for stays in IMDs that exceed 15 days and are no more than 60 days.[4] For the Centers for Medicare & Medicaid Services (CMS) to approve the waiver, the State would be required to maintain a statewide average length of stay in qualifying IMDs of no more than 30 days and commit to an ongoing maintenance of effort (MOE) of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries. This report details the proposed waiver and related financial implications to the State, as well as the necessary process, timeframes and additional resource needs for seeking waiver approval from CMS.

Overview of North Carolina's Mental Health Delivery System

North Carolina has made substantial investments over the past decade in strengthening and improving access to mental health services for adults with SMI and children with SED across the care continuum. As part of its Transitions to Community Living (TCL) Settlement Agreement implementation plan, DHHS has established and strengthened the service infrastructure for adults with SMI in furtherance of the goals outlined in this report, including expanding access to community-based services such as Assertive Community Treatment, Community Support Team, employment supports and housing supports, enhancing institutional discharge and planning processes, and diverting over 4,800 people from institutional care. Through its Tailored Care Management program, DHHS also has established a provider-based, integrated care management model for members with significant behavioral health needs, including adults with SMI and children with SED, and individuals with intellectual/developmental disabilities. With support from the NC General Assembly, DHHS recently implemented significant behavioral health provider rate increases, including increasing

[1] See Appendix A for the full legislative language.
[2] CMS does permit two capitation payments for a member whose stay at an IMD spans two consecutive months and the stay was no more than 15 days for either month.
[3] Per 42 CFR 438.3(e), an in lieu of service or setting is an alternative service or setting that a State determines is a medically appropriate and cost effective substitute for a covered service or setting under the Medicaid State plan.
[4] Per CMS guidance, states cannot claim FFP for any services that are part of a stay in an IMD that exceeds 60 days, including days 0 to 60.

reimbursements to Medicare levels or making inflationary adjustments as applicable. These reimbursement increases extended to IMDs. DHHS will also be submitting a separate legislative report on options for including standalone psychiatric hospitals in the Healthcare Access and Stabilization Program (HASP)[5], which could further increase IMD reimbursement levels if advanced by the legislature. North Carolina also covers and funds a range of outpatient, community-based, crisis, residential, and inpatient services for children with SED, with additional school-based services to support behavioral health treatment. North Carolina's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit ensures children have access to comprehensive physical and behavioral health services, including services not covered under North Carolina's Medicaid State Plan. These system investments and improvements increase access to a range of community-based treatment services for adults with SMI and children with SED in North Carolina. Further analyses are required to fully assess the current mental health system capacity and its ability to meet the current needs of the populations included in this waiver.

Waiver Eligibility and Delivery System Requirements

The scope of this waiver would not include children with SED, because children with SED use inpatient facilities that are not considered excluded IMDs under federal rules. These facilities include Psychiatric Rehabilitation Treatment Facilities (PRTFs) and inpatient psychiatric facilities for children, which are considered Medicaid-covered inpatient psychiatric services for beneficiaries under age 21, and facility-based crisis for children, which have fewer than 16 beds and, therefore, do not qualify as IMDs. As such, inclusion of children with SED in this waiver would not create additional opportunities for receiving FFP, and efforts to improve access to high-quality services for children with SED can be made outside of this waiver.

The scope of this waiver, therefore, could include only adults with SMI. There is a demonstrated need to ensure access to high-quality short-term inpatient and residential mental health services, as well as a strong continuum of community-based mental health services, to this population.

The waiver application could include private inpatient psychiatric facilities that qualify as IMDs. DHHS would not include state-operated facilities in a potential waiver, as the average lengths of stay for these facilities far exceed CMS' 30-day average length of stay requirement. As such, DHHS anticipates that these facilities would not be eligible for federal reimbursement under the waiver.

As noted earlier, for CMS to approve such a waiver, the state would need to commit to an ongoing MOE of state and local Medicaid funding for outpatient community-based mental health services, measured by the most recently completed state fiscal year, for the duration of the demonstration. This means that services authorized by this demonstration request would complement and not replace outpatient services and the state may not reduce, divert or supplant its current state Medicaid funding for community-based mental health services.

The State also would need to assess the current capacity of its mental health system across the care continuum, including crisis stabilization, from the prior two years. DHHS also would need to provide current prevalence data on mental health conditions among Medicaid members. These assessments would need to be updated and submitted to CMS on an annual basis, which will require significant resources for DHHS for the initial assessment and ongoing reporting.

Demonstration Goals and Evidence-Based Strategies for Achieving Goals

The following subsections align with the four milestones included in CMS' SMI/SED Demonstration Implementation Plan. While some goals outlined in Session Law 2023-2024, Section 9E.19A are not specified in the CMS milestones, waiver implementation and monitoring would also address goals related to reducing utilization and lengths of stay in hospital emergency departments for adults with SMI who are awaiting specialty mental health treatment, reducing inpatient and residential readmissions for adults with SMI, improving access to community-based services, including crisis stabilization services, and improving care coordination following stays in acute care hospitals or residential treatment settings.

[5] In compliance with S.L. 2023-134, s. 9E.27

Ensuring Quality of Care at IMDs

The waiver requires IMDs receiving Medicaid reimbursement under an 1115 demonstration to be licensed by DHHS and accredited nationally and meet several federal and state program integrity standards to ensure good quality of care in IMDs. DHHS has established processes and requirements for licensing and accrediting its inpatient psychiatric hospitals under NC General Statute 122C, 10 NC Administrative Code 27G and Clinical Coverage Policy (CCP) 8-B "Inpatient Behavioral Health Services." CCP 8-B also establishes program integrity, medical necessity, utilization management and care management standards for individuals covered under Medicaid managed care and NC Medicaid Direct. Implementation of the waiver could also allow Medicaid members who are enrolled in Tailored Care Management to maintain access to their care manager during a qualifying IMD stay (those under 61 days) to further the goal of improved quality of care.

DHHS notes that existing CCP provisions may need to be reviewed and updated to strengthen clinical standards, utilization management, and program integrity requirements under the waiver. DHHS also would require additional staff resources to meet ongoing monitoring and reporting requirements under the waiver, as well as to establish necessary oversight to ensure appropriate IMD admissions, lengths of stays, and care management.

Improving Care Coordination and Transitioning to Community-Based Care

The waiver requires states to establish care coordination models that focus on transitions between inpatient and residential facilities to community-based settings, and IMDs to perform intensive pre-discharge planning to improve connections to community-based care, including housing. As part of this process, facilities would be required to evaluate enrollees' housing and community-based service needs and connect individuals to those resources and services. DHHS has significantly bolstered housing assessments and linkages to housing for members leaving inpatient psychiatric hospitals through its TCL implementation plan and implementation of Tailored Care Management.

DHHS would be required to implement strategies to decrease emergency department (ED) lengths of stay for individuals with SMI and to promote interoperability and data sharing across physical and behavioral health providers. This would require DHHS to update its CCP 8-B regarding care coordination and care management to meet these requirements as well as develop targeted strategies to address the issue of ED over-utilization.

Increasing Access to Continuum of Care, Including Crisis Stabilization Services

The waiver requires states to enact policies to improve access to a full continuum of care for adults with SMI, including crisis stabilization. It is noted that North Carolina's State Plan and 1915(i) program cover a continuum of mental health services to satisfy this requirement and include network adequacy standards for service types across the care continuum that the state monitors on an ongoing basis. DHHS and LME/MCOs are making a significant investment (~$80M) to strengthen the state's crisis system over the FY24-FY25 biennium and address access issues with Medicaid expansion bonus funds appropriated in Session Law 2023-134. A significant portion of the budget investment will be used to add new mobile crisis teams, MORES teams (child/adolescent funded follow-up following crisis events), behavioral health urgent care centers and facility-based crisis for children and adults. DHHS is also making an investment to expand a Department of Adult Correction SMI program – a care coordination program designed to provide intensive re-entry supports to the most high-needs individuals upon their release from incarceration—using justice budget investments. In addition, DHHS has implemented a statewide behavioral health referral network, the "Behavioral Health Statewide Central Availability Navigator (BH SCAN)," to disseminate mental health and SUD inpatient and outpatient treatment resources to IMDs and other behavioral health facilities in the state. As noted in the above sections, waiver implementation could require updates to clinical coverage policies and other documentation to update service definitions and align with evidence-based standards.

Under the waiver, DHHS would be required to annually evaluate the statewide capacity of mental health services, with a particular focus on crisis stabilization services, and update CMS on efforts to increase access to mental health services. The first assessment would need to be included as part of the initial waiver request. DHHS also would be required to develop and obtain CMS approval for a financing plan to improve availability of non-facility-based crisis stabilization services (e.g., crisis call centers and mobile crisis units) and ongoing community-based services over the life of the waiver based on the baseline initial assessment. While DHHS has made significant investments to strengthen the state's community-based care continuum, including the crisis system, through new mobile crisis teams, Behavioral Health Urgent Care centers, and facility-based crisis for children and adults, the annual assessments and financing plan development would require additional staff and financial resources to implement. CMS requires states to demonstrate strategies to improve its ability to track availability of inpatient and crisis stabilization beds. DHHS also plans to upgrade its crisis system bed registry to provide more real-time updates on a range of bed availability for intensive services, including alternatives to IMDs. DHHS

also notes that housing is a significant resource need as individuals transition from inpatient facilities, as well as a tool to address individuals in crisis. Some of these investments are outside of the scope of DHHS authority.

Earlier Identification and Engagement in Treatment, Including Through Increased Integration

The waiver requires states to promote early identification and engagement of adults with SMI, increase integration of behavioral health care in primary care and other settings, and establish specialized services and supports geared toward young adults with SMI. To date, DHHS has established provisions in the Standard Plan contracts to ensure physical and behavioral health integration, such as requiring that care managers be trained in physical and behavioral health integration and allowing plans to pursue performance improvement projects focused on behavioral health integration. The Advanced Medical Homes program developed by DHHS for its transition to Medicaid managed care similarly ensures all members are screened and assessed for behavioral health needs. DHHS also implemented the Collaborative Care Model to co-locate access to physical and behavioral health care services for members with mild-to-moderate behavioral health needs and substantially increased Medicaid reimbursement rates for a broad range of community-based behavioral health services, all of which could help meet this goal. DHHS already operates an IMD waiver for substance use disorder (SUD) treatment, which has furthered member engagement in mental health treatment by identifying any co-occurring mental health needs of members being provided SUD services under the waiver.

While there have been many efforts to increase primary care and behavioral health integration, DHHS would need to make additional investments in early identification and engagement for adults with SMI to implement the waiver. Specifically, North Carolina lacks and would need to build statewide coverage of Coordinated Specialty Care providers to serve individuals with or at high risk for first episode psychosis through evidence-based care.

Expenditure Authority

DHHS is providing the following draft request for 1115 demonstration expenditure authority for covered services furnished to adults with SMI residing in IMDs that would be incorporated into its waiver application:

> *To improve access to services, North Carolina seeks expenditure authority to make payments to IMDs for otherwise covered behavioral health services for all Medicaid enrollees, either through prepaid health plans (PHPs) or local management entities-managed care organizations (LME/MCOs), or directly to IMDs for fee-for-service enrollees, regardless of whether enrollees are enrolled in managed care or through other delivery systems. Payments will be limited to individuals receiving acute care for behavioral health. Behavioral health services to be covered in IMDs include short-term behavioral health crisis services that aim to stabilize beneficiaries experiencing a psychiatric crisis with the expectation of shifting them to less intensive, community-based setting.*

As described above, DHHS would propose expenditure authority for members in fee-for-service to guarantee maximum waiver flexibility but notes that all populations impacted by the waiver currently are enrolled in Medicaid managed care.

Financing

Federal Budget Neutrality

For CMS to approve a demonstration project, a state must demonstrate it is "budget neutral" to the federal government, meaning that federal Medicaid spending *with* the waiver in place would not be greater than it likely would have been *without* the waiver. Per CMS policy, CMS would consider the costs for the covered populations and services *with* the IMD waiver to be "hypothetical"—meaning they are treated as though the State could have covered them through the Medicaid State Plan *without* the need for a waiver; as such, from the federal perspective, the State would not need to create any waiver savings to offset the waiver costs. However, it is important to note that meeting the federal budget neutrality requirement does not mean implementation of the waiver would be budget neutral to the State (see State Cost Implications below). North Carolina would prepare a detailed budget neutrality model in accordance with CMS guidelines and its budget neutrality template. Additional substantive analyses, which include the development of base year utilization and expenditure data, development of base year per member per month (PMPM) costs, and the development of enrollment and expenditure projections, will be needed to complete the template.

State Cost Implications

As part of the report, DHHS is asked to estimate the cost or savings to the State if the waiver is implemented. An estimate of the financial impact of the waiver on costs or savings to the state should weigh any additional FFP for services that are currently only state-funded with any new program or administrative costs. With the proposed exclusion of state-operated facilities from a potential waiver (as discussed above), there would be no additional FFP generated from state spending in these facilities and, therefore, no expected state savings. Private, community-based facilities do provide services to Medicaid beneficiaries, but the state only contributes to the portion of those stays that is funded through ILOS, as described above, which already receive FFP. New FFP would be generated by services furnished to members with stays between 16-60 days in private, community-based facilities, but the state would need to finance the non-federal share of these expenditures, which would generate new state costs.

Given these parameters, the initial estimated total annual cost (FFP and non-federal share of the cost) of implementing this waiver would be $20.2M to $33.5M (estimated annual cost to the State would be $7.1M to $11.7M annually using the State's regular Federal Medical Assistance Percentage (FMAP) of 65.06%) for increased IMD stays for adults with SMI. This range assumes an increase in adults receiving SMI treatment at private facilities, as well as longer length of stays in these facilities resulting from the waiver. Additional analyses would be needed to refine the calculated assumptions in this estimate and to account for additional costs to the State, such as building out coverage for Coordinated Specialty Care, increased staffing and resources for waiver development and implementation, and other administrative costs.

Next Steps

Additional work is needed to prepare a full and final waiver application that complies with CMS' detailed waiver requirements. DHHS would need to conduct additional analyses on North Carolina's current MOE funding for outpatient mental health services for Medicaid beneficiaries, the mental health system capacity and service availability across the care continuum, the prevalence of adults with SMI across the State, and on the proposed waiver's federal budget neutrality implications. Further analyses would need to be conducted to estimate the cost to the State in order to implement and maintain the waiver. DHHS also would need to develop a final draft waiver application that meets federal and state public notice and comment and tribal consultation requirements. Once the waiver application is submitted, DHHS will enter detailed negotiations with CMS and iterative drafting of the waiver standard terms and conditions (STCs), with an expected timeframe from the waiver's submission to its approval of roughly 9-18 months based on previous 1115 waiver amendments timelines. DHHS would also need to secure funding for any additional staffing or other resource needs to execute this waiver.

Appendix A: North Carolina General Assembly Session Law 2023-134 Section 9E.19A.

SECTION 9E.19A.(a) The Department of Health and Human Services, Division of Health Benefits, shall develop a proposed Medicaid 1115 demonstration waiver focused on adults with serious mental illness (SMI), children with serious emotional disturbance (SED), or both. This proposed SMI/SED waiver shall include all of the following:

(1) Receipt of federal financial participation for covered services furnished to Medicaid beneficiaries during stays greater than 15 days for acute care in psychiatric hospitals or residential treatment settings that qualify as institutions of mental disease (IMDs).

(2) Detailed ways in which DHB shall ensure good quality of care in IMDs.

(3) Methods to address improved access to community-based services for beneficiaries with SMI or SED.

(4) Goals to be achieved through the waiver that include the following:

a. Reduced utilization and lengths of stay in hospital emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.

b. Reduced preventable readmissions to acute care hospitals and residential settings by Medicaid beneficiaries with SMI or SED.

c. Improved availability of crisis stabilization services.

d. Improved access to community-based services to address the chronic mental health care needs of Medicaid beneficiaries with SMI or SED.

e. Improved care coordination and continuity of care following episodes of acute care in hospitals and residential treatment facilities.

SECTION 9E.19A.(b) No later than March 1, 2024, DHB shall submit to the Joint Legislative Oversight Committee on Medicaid a report that provides details on the proposed 1115 waiver developed under subsection (a) of this section, a copy of the draft waiver, and estimated costs or savings to the State were the waiver to be implemented.