**ND Behavioral Health Planning Council (BHPC)**
**Quarterly Business Meeting**
**December 8, 2021**

**Meeting Minutes**

**Council Members in Attendance:** Emma Quinn, (Consumer), Chairperson; Carlotta McCleary, Vice Chairperson (ND Federation of Families for Children's Mental Health); Brenda Bergsrud (Consumer Family Network), Immediate Past Chairperson; Lorraine Davis (Consumer, Member at Large); Rosalie Etherington (DHS Behavioral Health Service Delivery System); Denise Harvey, Protection and Advocacy Project; Brad Hawk (Indian Affairs Commission); Jennifer Henderson (Principal State Agency: Housing); Cheryl Hess-Anderson, DHS – Vocational Rehabilitation; Andrea Hochhalter (Consumer, Family Member of an Individual in Recovery); Deb Jendro, Consumer, Member; Michelle Massette (Principal State Agency: DHS - Social Services); Matthew McCleary (Mental Health America of ND); Dawn Pearson (Principle State Agency: DHS - Medicaid); Amanda Peterson (Principle State Agency: NDDPI - Education); Lisa Peterson, Conmsumer, Family Member of a Veteran; Pamela Sagness (Principal State Agency: DHS - Mental Health); Michael Salwei (Healthcare Representative); Kirby Schmidtgall (Consumer, ND National Guard); Kurt Snyder (Consumer); Jodi Stittsworth (Consumer, Family Member of a Child with SED); Amy Veith, Principal State Agency, Criminal Justice; Timothy Wicks (Consumer, Veteran); Carl Young (Consumer, Family Member of a Child with SED).

**Presenters and Staff:** Tami Conrad (DHS – Behavioral Health); Kelli Ulberg (DHS - Behavioral Health); Bevin Croft (Human Services Research Institute); Vivian Solomon (Human Services Research Institute); Jennifer Faul (Pediatric Mental Health Care Access Program); Rebecca Quinn (ND Brain Injury Network); LuWanna Lawrence (DHS); Krista Fremming (DHS); Caprice Knapp (DHS); Elle Victoria-Gray, Renee Schulte Consulting.

**Facilitator:** Greg Gallagher, Consensus Council, Inc.; Ann Crews Melton, Consensus Council, Inc.

**Call to Order:** Chairperson Emma Quinn called the meeting to order at 10:04 AM, CT, via video conference. BHPC members and presenters provided self-introductions via video conference sign-in.

**Quorum.** With a majority of BHPC members reporting present, Chairperson Quinn declared the presence of a quorum.

**Approval of Minutes.** Chairperson Quinn called for the review of the October 13, 2021, BHPC meeting minutes. Mr. Gallagher provided a summary of the minutes and supporting attachments.

KURT SNYDER MADE AND CARLOTTA MCCLEARY SECONDED A MOTION TO APPROVE THE OCTOBER 13, 2021, BHPC MEETING MINUTES, AS PRESENTED. THE MOTION PASSED UNANIMOUSLY. CHAIRPERSON QUINN ANNOUNCED THE PASSAGE OF THE MOTION AND DECLARED THE APPROVAL OF THE OCTOBER 13, 2021, MEETING MINUTES.

**Approval of Agenda.** Chairperson Quinn called for the review of the December 8, 2021, meeting agenda prepared by the BHPC Executive Committee. Mr. Gallagher provided an overview of the agenda.

CARLOTTA MCCLEARY MADE AND MICHELLE MASSETTE SECONDED A MOTION TO APPROVE THE DECEMBER 8, 2021, BHPC MEETING AGENDA, AS PRESENTED. THE MOTION PASSED UNANIMOUSLY. CHAIRPERSON QUINN ANNOUNCED THE PASSAGE OF THE MOTION AND DECLARED THE APPROVAL OF THE DECEMBER 8, 2021, MEETING AGENDA.

**Review of BHPC Next Steps Summary.** Greg Gallagher placed into the record the BHPC Next Steps Summary, dated October 13, 2021, reflecting BHPC actions following the October 13, 2021, BHPC meeting. The *Recorded Next Steps* provides a cumulative listing of identified BHPC priorities, outstanding activities, and Council assignments. The *Recorded Next Steps* provides a basis for the development of all BHPC meeting agendas and informs BHPC members of issues that may require specific consideration. No action was required by the BHPC membership.

**Current Status of Behavioral Health Planning Council Membership: Tami Conrad**. Tami Conrad provided an update on current BHPC membership positions. Ms. Conrad reported that the Governor's Office has recently moved to fill or is expected soon to fill the following positions:

- Healthcare Representative
- Family Member of a Veteran
- Principle State Agency: Social Services, pending
- Mental Health America of ND, pending
- Family Member of an Adult with SMI

There currently exist two open consumer positions. The membership of state boards and commissions is managed by the Governor's Office. BHPC membership and governance rules and the application form for BHPC membership are posted for ready public access. Individuals interested in being considered for a designated Council vacancy, including individuals and agency representatives, must submit an application which will be considered by the Governor's Office, leading ultimately to an appointment by the Governor, if accepted. BHPC members are encouraged to reach out to qualified individuals and invite them to apply.

**Seating of BHPC Executive Committee Members**. Greg Gallagher reported that with the recently completed Vice Chairperson election, the BHPC Executive Officers are now formally seated as members of the BHPC Executive Committee: Emma Quinn, Chairperson; Carlotta McCleary, Vice Chairperson; and Brenda Bergsrud, Immediate Past Chairperson.

The BHPC Bylaws also identify two separate slots on the BHPC Executive Committee that remain unfilled: one representative of an Individual or Family Member of an Individual in Recovery - SUD, and one representative of an Individual or Family of an Individual in Recovery – MH. The Executive Committee had agreed previously to defer any election of these two position until the placement of forthcoming new members, which has since been completed. Mr. Gallagher stated that early in 2022 members will be invited to nominate prospective candidates for these two executive committee positions. At that time, an election will be held to fill these two slots, after which the Executive Committee membership will be filled.

**Summary Report of ND Behavioral Health Strategic Plan and Future Activities**, Bevin Croft, Human Services Research Institute

- Emergent Topics of Attention
- HSRI Assessment of Strategic Planning Progress
- Consideration of Future Plan Amendments

Chairperson Quinn recognized Dr. Bevin Croft, HSRI, to provide an update on the status of the state's behavioral health strategic plan. Dr. Croft recognized Vivian Solomon as a technical assistant for the project. Dr. Croft presented a summary report of recent activities implementing the state's behavioral health strategic plan, including updating improvements to the plan's implementation dashboard, implementation of select plan objectives, and management and support of liaison member activities. Dr. Croft's summary report presented several key recommendations for consideration by the BHPC.

Dr. Croft referenced the recently updated *Project Dashboard: North Dakota Plan for Behavioral Health*, which provides a summary update on performance indicators of success within the strategic plan for each of the plan's principal aims, objectives, and activities. The Project Dashboard was released in April 2021 and will continue to be updated as the strategic plan progresses.

Dr. Croft reported on the progress made in engaging select state councils and advisory committees to collaborate on specific issues, and identified BHPC liaison leadership:

- Autism Task Force, Denise Harvey.
- Brain Injury Advisory Council, Denise Harvey.
- Children's Cabinet, Denise Harvey.
- Developmental Disabilities Council, Tami Conrad
- Medicaid Advisory Committee, Brenda Bergsrud.
- Omlstead Commission, Carlotta McCleary.
- Interagency Coordinating Committee, Kelly Ulberg.
- Interagency Council on Homelessness, Jennifer Henderson and Brenda Bergsrud.
- Children in Need of Services, Carlotta McCleary.

Dr. Croft reported that two additional goals have been recently added to the strategic plan, including reducing seclusion and restraint in schools, and expanding peer support navigation in primary care. Carlotta McCleary stated that the North Dakota Disabilities Advocacy Consortium recently voted to assume a leadership position in addressing (1) seclusion and retraint policies and practices, and (2) universal screening practices, and the BHPC might enhance its efforts in these areas by collaborating with the NDDAC. Dr. Croft also noted that two current goals are being reviewed for more precise management, including screening (Goal 3.1), and tribal partnerships (Goal 11.1).

Dr. Croft invited BHPC volunteers to form work groups that would develop strategies to move two issues forward:

- *Peer Support Navigation Services and Workforce.* Volunteers included Denise Harvey, Tami Conrad, Brenda Bergsrud, Emma Quinn, Lorraine Davis, and Matthew McCleary.
- *Seclusion and Restraint.* Carlotta McCleary expressed an interest to help form this effort.

Kurt Snyder recommended that the peer support work group might consider ways to expand peer support services within prison settings and to make peer support as an element of release programming.

Dr. Croft noted that there is an interest in meeting with the Department of Health – Health Equity Office to seek engagement on the strategic plan.

Mr. Gallagher thanked Dr. Croft for her presentation and announced that the afternoon session will allow for further discussion on the strategic plan.

**Screening Guidance and Sustainability, Pediatric Mental Health Care Access Program**, Jennifer Faul, PMHCAP Coordinator. Chairperson Quinn invited Jennier Faul to provide an update on the Pediatric Mental Health Care Access Program. Ms. Faul stated that given recent discussions across multiple councils and advisory committees and activities within Aim 3.1 of the state's behavioral health strategic plan, she would focus her comments on statewide efforts to implement behavioral health screenings, especially school-based screening programs. Ms. Faul reported that many schools attempt to incorporate some forms of behavioral health screening within their Multi-Tiered System of Support programs, exemplified by programs in the Fargo and West Fargo school districts. There has been an emerging interest among some professional educators to institute universal screening practices which would more efficiently and effectively identify students in greatest need for support services. Ms. Faul stated that her discussions with schools have noted many schools do not share common screening tools or discernment practices. Some educators have expressed concern about identifying needs that cannot be addressed because of implied service obligations and financial commitments and constraints, despite the fact that screenings do not constitute assessments.

Ms. Faul discussed an emerging need to cast a wider net in the administration of screenings, akin to vision screenings in schools and adopting a strategy that will allow professional educators to apply their guided discernment to focus on those students most in need. Recent discussions with in the ND Disabilities Advocacy Consortium have identified a similar interest and an awareness that, for a select number of students, such efforts can incorporate Medicaid financial support through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. Universal screening efforts advance a commitment to early intervention, reflecting true fidelity to the continuum of care, where promotion and prevention are highlighted as integral elements of service to individuals in need. Providers are most interested in practices that are time-efficient, cost-effective, and reliable. Uniform practices support a more integrated process of providing services, including carefully documenting medical need for services that opens up more transparent cost coverage by Medicaid and insurance providers. Members expressed an interest in incorporating these observations into the state's behavioral health strategic plan.

Mr. Gallagher thanked Ms. Faul for her presentation.

**Conversation on the Study of the Need for a New State Hospital**, Elle Victoria-Gray, Renee Schulte Consulting. Mr. Gallagher introduced Elle Victoria-Gray, consultant for the Renee Schulte Consulting, to provide an update on the state's study of need for a new State Hospital. Ms. Victoria-Gray provided a formal presentation and reported that Renee Schulte Consulting had been selected by the Department of Human Services to study issues related to providing high-quality psychiatric care statewide, including where service delivery gaps might exist and options concerning the placement(s) and construction of a new State Hospital. Ms. Victoria-Gray stated that Schulte Consulting has conducted initial onsite discussions and tours and will facilitate several virtual townhall type meetings, beginning in January 2022, to gather comments and conduct survey discussions with select stakeholders, since no open public meetings were being considered, at this time. Invitations will be issued to select stakeholders, including BHPC members.

Members stressed the need to expand the list of invitees to these meetings and to market the meetings to ensure that all interests parties across the state, including the general public, will be afforded an opportunity to provide comment on such a critically important matter. Members raised an interest in learning more about any established criteria which might drive the direction of the study. Members stated that the state's behavioral health strategic plan has underscored the importance of considering services across a wide range of special population interests, including jail and prison settings, LGBTQ individuals, adolescents and young adults, children, victims of human trafficking, individuals with brain injury, veterans, individuals experiencing homelessness, refugees and immigrants.

Ms. Victoria-Gray expressed assurances that the study's methods and final reports will address the issues laid forth by the BHPC.

Mr. Gallagher thanked Ms. Victoria-Gray for her presentation.

Chairperson Quinn declared a recess for lunch at 11:55 AM.

Chairperson Quinn reconvened the BHPC back to Regular Order at 1:02 PM.

**Medicaid Reimbursement Practices within Medicaid 1915(i) and Rehabilitative Services,** Caprice Knapp, DHS, Medical Services Division

- Reimbursement Rules, Practices, and Coding Considerations.
- Medicaid Provider Statistics by Service Category.
- Peer Support and Family Peer Support Coverage.
- Provider and Client Navigation Practices.

Chairperson Quinn welcomed Caprice Knapp, Medical Services Director within DHS, to provide a report on general Medicaid reimbursement practices. Ms. Knapp and Dawn Pearson provided a formal presentation of the administration of Medicaid reimbursement practices, with specific attention placed on the Medicaid 1915(i) and Rehabilitative Services programs. [Refer to both presentation hyperlinks for a detailed inclusion of program content.]

Ms. Knapp and DHS staff stated that the state's Medicaid 1915(i) plan, recently approved, is now being fully implemented. The state has submitted an additional amendment to the state plan seeking a change in the WHODAS eligiblity cut score from 50 to 25 to further expand Medicaid coverage for more individuals. The state has been moving quickly to increase the number of providers certified to service Medicaid 1915(i) and has worked to ensure that peer support providers are appropriately trained, certified, and reimbursed. Medicaid provider eligibility applies for both a provider agency and the individual professionals within the agency. The DHS has established an incentive program, offering up to $10,000 grants, to seek and secure additional Medicaid service provider agencies. The DHS provides navigation services for providers and will soon be adding a new navigation coordinator to aid clients through the service application and provision process. Members observed that navigation services are needed for both consumers and providers. Members inquired if DHS might provide technical assistance for Certified Community Behavioral Health Clinic holistic services (evidenced by offering children services, family services, mental health and addiction services, and 24-hour availability) by aiding providers to acquire such a status. Members expressed an interest in inviting Monica Haugan, HCBS Administration for Medicaid 1915(i), to a future BHPC meeting to provide additional information related to the management of client services.

Mr. Gallagher and members expressed appreciation for Ms. Knapp's presentation.

**BHPC Role in Advising DHS on Mental Health and Substance Use Block Grant Management**,Tami Conrad.

- Block Grants' Funding.
- Program Impacts.

Tami Conrad provided a report on the funding priorities of the Mental Health Block Grant (MHBG) and the Substance Use Block Grant (SUBG). The MHBG provides federal funding that supports, in part, the operation of the BHPC including the facilitation services provided by Consensus Council, Inc. and per diem costs and transportation for consumer members. The MHBG funds the BHPC to provide advice to the state on building a comprehensive mental health system. Among its advisory duties, the BHPC conducts the following:

- Prepares an annual letter to the Governor outlining state mental health priorities.
- Supports administrative assistance provided by Consensus Council.
- Assess and guide peer support services across the state, including training for peer support providers and advocating for the development of support materials. Currently, 600 individuals have received peer support training.
- With the inclusion of SUBG funding, MHBG advances Free Through Recovery service capacity to reduce the level of service wait time.
- Provide general advice and guidance to the DHS on all mental health service matters.

The MHBG provides dedicated funding to support serious mental health services, including children's services. The DHS has worked to combine both MHBG and SUBG, under the term behavioral health, to improve service opportunities and to eliminate inefficiencies. The SUBG will be developed further in a future BHPC meeting. Members requested a complete list of contracted services covered by the MHBG and the SUBG. Substance Abuse and Mental Health Services Administration (SAMHSA) will conduct a virtual or onsite monitoring of the state's MHBG activities early in 2022.

**Behavioral Health Division, DHS, Update Report**, Pam Sagness. Pam Sagness reported that during the Special Legislative Session legislators increased the SUD Voucher by $5 Million, funding up to four grants, supporting service providers with 16 beds or less in rural areas and residential SUD programs. HCBS received a $4 Million appropriation in Covid-specific funding for non-congregate service settings. Legislators funded $350,000 for CNA funding to supplement retention incentives. Specific attention is being given to improve service navigation assistance, including care coordination, since there is an identified gap in these services, which requires attention. The number of certified peer support providers has increased significantly, totalling over 100 individuals. The state intends to use national certification standards for children's peer support programs as the basis for ongoing peer support training sessions.

**General BHPC Discussion on State Behavioral Health Strategic Initiatives:** Rosalie Etherington.

- Resolution of Support for a New State Hospital.
- Resolution of Support for the Advancement of Home and Community Based Services and the Appropriate Application of the Medicaid IMD Rule within the State's System of Care.

Mr. Gallagher recognized Rosalie Etherington to provide an update on a draft resolution requested by the BHPC membership during the October 14, 2021, business meeting regarding the future of the State Hospital. Dr. Etherington presented a draft resolution, titled *Resolution of Recognition of Evident Need and Support for the Advancement of a New State Hospital Within the State's System of Care, December 8, 2021*, prepared by the drafting committee.

Members expressed general support for the proposed Resolution but requested certain amendments to the text:

- Members stressed the need to ensure that the resolution's language remove any intimation of regional mini-hospitals and, instead, accentuate regional, community-based service options.
- Members recommended reordering the three bullets on page 2 to progress from (1) supporting the goals of the state's behavioral health strategic plan to (2) noting the vision of a continuum of care to (3) addressing a new State Hospital strategy.

Members expressed uniform approval of the recommended amendments. Members requested that Rosalie Etherington and the BHPC Executive Committee meet, with the assistance of Mr. Gallagher, to prepare a final version of the Resolution. Additionally, given the need for the BHPC to share its final Resolution with certain interim legislative committees, the BHPC instructed the BHPC Executive Committee to prepare and deliver testimony before those interim legislative committees that the Executive Committee deemed most appropriate, principally the Acute Psychiatric Care Committee at its January 20, 2022, meeting, the Human Services Committee at its January 11, 2022, meeting, and the comment meetings for the Schulte Consulting study.

Prior to considering any vote on a resolution, Jennifer Henderson declared that she would abstain from participating in any final vote on a resolution, given the unique responsibilities of the state agency she represents. Mr. Gallagher noted Ms. Henderson's abstention.

ROSALIE ETHERINGTON MADE AND CARLOTTA MCCLEARY SECONDED A MOTION INSTRUCTING THE BHPC EXECUTIVE COMMITTEE TO CONVENE FOR THE PURPOSES OF AMENDING AND ADOPTING A FINAL DRAFT OF THE RESOLUTION OF EVIDENT NEED AND TO PREPARE A PLAN TO PRESENT THIS RESOLUTION TO APPROPRIATE LEGISLATIVE COMMITTEES. THE MOTION PASSED UNANIMOUSLY. CHAIRPERSON QUINN ANNOUNCED THE PASSAGE OF THE MOTION AND THE ADOPTION OF THE RESOLUTION.

[Recorder's note: On January 4, 2022, the BHPC Executive Committee met to amend and approval the final draft of the *Resolution of Recognition of Evident Need and Support for the Advancement of a New State Hospital Within the State's System of Care*, which is attached. The minutes from the January 4, 2022, BHPC Executive Committee meeting record the actions taken by the Executive Committee to move forward with communicating the resolution to designated policymakers.]

- Resolution of Support for the Advancement of Home and Community Based Services and the Appropriate Application of the Medicaid IMD Rule within the State's System of Care.

Dr. Etherington opened discussion on the request by the BHPC during its October 14, 2021, business meeting to consider a resolution of support for the advancement of HCBS and the appropriate application of the Medicaid IMD Rule within the state's system of care. Dr. Etherington noted that the IMD rule is an intricate policy matter that required a concerted analysis

before adopting any specific strategy for the state's consideration. Given the need to carefully study the issue, Dr. Etherington placed before the BHPC a policy summary report on the IMD Exclusion prepared by the Legal Action Center. Dr. Etherington recommended that the BHPC dedicate future meeting time to review the IMD Exclusion and to use this summary report, among others, as a basis for clarifying the state's options before the BHPC adopts any specific strategy.

Members uniformly agreed to receive this summary report as an entry into future discussion on the IMD Exclusion. Members requested that the BHPC Executive Committee consider inviting Caprice Knapp to discuss state IMD capacity issues, and that the Executive Committee should develop, with the assistance of Dr. Etherington, a series of questions that will move this discussion forward in a measured and productive manner.

Chairperson Quinn thanked Dr. Etherington for her presentation and recommendations. Chairperson Quinn stated that the Executive Committee would take this matter under consideration prior to the next BHPC meeting.

**Public Comments.** Chairperson Quinn opened the floor for any public comments. No members of the public came forward to provide comments. Chairperson Quinn closed the period for public comment.

**Review of BHPC Next Steps Summary.** Greg Gallagher revisited the BHPC Next Steps Summary. The BHPC Executive Committee will use the Next Steps Summary to build future meeting agendas.

**BHPC Meeting Dates for 2022.** Mr. Gallagher placed before the BHPC a list of prospective dates for future BHPC meetings throughout 2022. All meetings will be held onsite at the Job Service ND Office – Dakota Room; 1601 East Century; Bismarck, ND, and online via videoconference link.

- April 20, 2022
- July 20, 2022
- October 19, 2022
- December 14, 2022

CARLOTTA MCCLEARY MADE AND TIM WICKS SECONDED A MOTION TO ADOPT THE BHPC MEETING DATES FOR 2022, AS PRESENTED. THE MOTION PASSED UNANIMOUSLY. CHAIRPERSON QUINN ANNOUNCED THE PASSAGE OF THE MOTION AND DECLARED THE ADOPTION OF THE 2022 MEETING DATES.

**Open Comments.** Ms. McCleary recommended that the BHPC Executive Committee distribute copies of *Robert's Rules of Order* and provide instructions to all members regarding the conduct of business, as specified within the BHPC Bylaws. Chairperson Quinn noted this recommendation.

Andrea Hochhalter requested that all BHPC members be forwarded a summary listing of BHPC members, given the recent addition of new members and representative duties. All BHPC members' contact information is provided on the Governor's website for boards and commissions. Chairperson Quinn noted this recommendation.

**Adjournment.** Having completed all agenda items and hearing no further comments from BHPC members, Chairperson Quinn declared the meeting adjourned at 3:52 PM, CT.

Respectfully submitted,

Greg Gallagher
Facilitator,
The Consensus Council, Inc.

**APPENDIX A**

**Resolution of Recognition of Evident Need and Support for the Advancement of a New State Hospital Within the State's System of Care**

**January 4, 2022**

**Resolution of Recognition of Evident Need and**
**Support for the Advancement of a New State Hospital**
**Within the State's System of Care**

January 4, 2022

WHEREAS, the North Dakota Behavioral Health Planning Council assumes its duties as the state's principal advisory body established under Public Law 102-321 (42 U.S.C 300X-4), to monitor, review, and evaluate the allocation and adequacy of behavioral health services in North Dakota and to meet federally mandated requirements, and whose members are duly appointed by the Governor of North Dakota to advise the Governor regarding the administration of the state's behavioral health practices and policies; and

WHEREAS, the membership of the Council represents the diverse voices and interests of the people of North Dakota, bringing forth vast strengths and perspectives from consumers of mental health and substance abuse services, family members, advocates, referral sources, schools, institutional and community-based service providers, the general disability community, and the criminal justice system, and covering an expanse of expertise including a shared knowledge of individual and general consumer situations, Medicaid, service delivery systems, reimbursement issues, housing and community development, legal issues, community resources, recovery, peer mentoring, service delivery, children's issues, and advocacy for mental health and substance abuse issues; and

WHEREAS, the Council has endorsed and guided the development and implementation of the state's current behavioral health strategic plan, covering the breadth of state behavioral health needs, and in so doing, has adopted a Statement of Vision that recognizes *With full regard for the value of each person, appropriate behavioral health services, encompassing the full continuum of care, are readily available at the right time, in the right place and manner, and by the right people, offering every North Dakotan their best opportunity to live a full, productive, healthy and happy life—free of stigma or shame, within caring and supportive communities;* and

WHEREAS, the Council recognizes the inherent value and necessity for a properly sized and situated State Hospital as a critical component of the state's comprehensive system of care, providing specialized care and highly trained staff and ensuring the capacity of the state to provide for its citizens the full expanse of services demanded of a balanced, efficient, and modern continuum of care, documented by multiple studies; and

WHEREAS, the current State Hospital facilities, having served the state for multiple generations, now exhibit profound deterioration, documented by structural, mechanical, electrical, and plumbing deficiencies or failures approximating 76%, significantly evidencing that these facilities have long outlived their expected lifespans; and

WHEREAS, any measured, deferred maintenance budget cannot sustain the volume and cost of needed repairs and systems replacement, and where the current, antiquated facilities lack adequate natural light, healing green space, and pose safety risks for patients and staff, outright

failing to provide for an appropriate setting that will speed recovery, improve patient and staff safety, and improve overall satisfaction of patients and staff; and

WHEREAS, the co-location of the current State Hospital facility with an adjoining prison facility contributes to the stigma, prejudice, and discrimination of individuals with mental illness, denying patients and residents served at the State Hospital the right to receive appropriate and respectful care in a safe and healing environment.

THEREFORE, LET IT BE RESOLVED, that the North Dakota Behavioral Health Planning Council, acting within its assigned charge to provide studied advice to the state on critical issues of care regarding behavioral health services within North Dakota, does endorse

- Adopting and advancing, through policy and funding across all appropriate agencies, the full implementation of all program goals specified within the statewide behavioral health strategic plan; and

- Securing and sustaining a statewide behavioral health system that facilitates an integrated continuum of care across all services, directed to the unique needs of every person served; and

- Building a new, modern State Hospital central facility, located in Jamestown, ND, and providing readily accessible specialized psychiatric care services statewide, securing for all state residents reasonable and ready access to appropriate and specialized behavioral health services.

FURTHERMORE, LET IT BE RESOLVED, that the North Dakota Behavioral Health Planning Council petitions the North Dakota Department of Human Services, the Office of the Governor, the Acute Psychiatric Care Committee, and the full North Dakota 68$^{th}$ Legislative Assembly to authorize and secure sufficient and sustainable financial resources and supporting policies that accomplish each of these stated aims.

**APPENDIX B**

**BHPC Executive Committee**

**Special Meeting**

**January 4, 2022**

**ND Behavioral Health Planning Council (BHPC)**
**Executive Committee Meeting**
**January 4, 2022**

**Meeting Minutes**

**BHPC Executive Committee Members in Attendance:** Emma Quinn (Consumer), Chairperson; Carlotta McCleary (ND Federation of Families for Children's Mental Health), Vice Chairperson; Brenda Bergsrud (Consumer Family Network), Immediate Past Chairperson.

**Staff:** Tami Conrad, DHS Behavioral Health Division.

**Facilitator:** Greg Gallagher, The Consensus Council, Inc.

**Call to Order:** Chairperson Emma Quinn called the meeting to order at 12:03 PM, CT, via video conference. BHPC Executive Committee members and staff provided self-introductions via video conference sign-in.

**Quorum.** With a majority of total current BHPC Executive Committee members reporting present, Mr. Gallagher informed the Committee of the presence of a quorum.

**Approval of Agenda.** Mr. Gallagher reviewed the January 4, 2022, meeting agenda prepared for the BHPC Executive Committee. The Executive Committee members consented to the agenda, as presented.

**Resolution of Support for a New State Hospital**. Mr. Gallagher reviewed the actions taken by the full BHPC during its December 8, 2021, business meeting, where it unanimously adopted a resolution framework, titled *Resolution of Recognition of Evident Need and Support for the Advancement of a New State Hospital Within the State's System of Care.* The BHPC instructed Mr. Gallagher to prepare a final draft of the resolution that rearranged the content of certain components of the resolution to better reflect an expansive attention to the state's system of care and its evolving behavioral health strategic plan. Given the need for the BHPC to share its final Resolution of Support with certain interim legislative committees, the BHPC instructed the BHPC Executive Committee to review, amend as necessary, and approve the final draft of the resolution for use as testimony before those interim legislative committees that the Executive Committee deemed most appropriate, principally the Acute Psychiatric Care Committee at its January 20, 2022, meeting. Mr. Gallagher prepared an interim Resolution, Version 2.0, for consideration by the BHPC Executive Committee.

Mr. Gallagher presented the full text, including marked amendments, of the updated *Resolution of Recognition of Evident Need and Support for the Advancement of a New State Hospital Within the State's System of Care, Version 2.0*. Mr. Gallagher guided Executive Committee members through the amendments to the resolution recommended by the full BHPC during its December 8, 2021, business meeting. Members uniformly expressed support for the resolution's rearranged order of content and refined language, reflecting the BHPC's intentions. Chairperson Quinn invited the formal consideration of the resolution.

CARLOTTA MCCLEARY MADE AND BRENDA BERGSRUD SECONDED A MOTION TO APPROVE AND ADOPT THE RESOLUTION OF RECOGNITION OF EVIDENT NEED AND SUPPORT FOR THE

ADVANCEMENT OF A NEW STATE HOSPITAL WITHIN THE STATE'S SYSTEM OF CARE, VERSION 2.0 AS PRESENTED. THE MOTION PASSED UNANIMOUSLY. CHAIRPERSON QUINN ANNOUNCED THE PASSAGE OF THE MOTION AND DECLARED THE ADOPTION OF THE RESOLUTION.

With the resolution adopted, Executive Committee members discussed how best to disseminate the resolution immediately to policymakers during forthcoming interim legislative committees, prior to the scheduled BHPC business meeting in April 2022. Members agreed that the Acute Psychiatric Care Committee, whose next scheduled meeting is set for January 20, 2022, and the Human Services Committee, whose next scheduled meeting is set January 11, 2022, marked the two committees of principal interest to testify to regarding the adoption of this resolution.

The Executive Committee by consensus agreed that Carlotta McCleary would present the resolution to the Acute Psychiatric Care Committee on January 20, 2022, seeking a slot on the agenda, if possible. If a designated agenda slot should be unavailable, Ms. McCleary would present the resolution to the Committee during the public comment period.

The Executive Committee by consensus agreed that Emma Quinn would inquire into Kurt Snyder's availability to present the resolution to the Human Services Committee on January 11, 2022, seeking a slot on the agenda, if possible. No other Executive Committee members were available to testify on that date. Ms. Quinn will work to finalize the presentation of the resolution to the Human Services Committee, as circumstances allow.

The Executive Committee will continue to consider other interim committees or other organizations with which to share the resolution, going forward.

**Resolution of Support for the Advancement of Home and Community Based Services and the Appropriate Application of the Medicaid IMD Rule within the State's System of Care**. Mr. Gallagher placed before the Executive Committee the background summary on the IMD Exclusion, previously presented to the full BHPC membership during its December 8, 2021, business meeting. Executive Committee members agreed that additional time and extensive discussion would be required to move forward with the development of any final resolution regarding the use of IMD Exclusion. Members agreed by consensus to set aside any further discussion on the IMD Exclusion at this time, but members expressed interest in bringing this issue forward for further consideration during the April 2022 BHPC business meeting.

**Future BHPC Executive Committee Meetings.** Chairperson Quinn stated that no future BHPC Executive Committee meetings need to be scheduled at this time, but members should be alert to any special meeting notifications, going forward.

**Adjournment.** Having completed all agenda items and hearing no further comments from BHPC Executive Committee members, Chairperson Quinn declared the meeting adjourned at 12:30 PM, CT.

Respectfully submitted,

Greg Gallagher
Facilitator,
The Consensus Council, Inc.

**APPENDIX A**

**Behavioral Health Planning Council**
**Executive Committee Meeting**
**January 4, 2022**

**Agenda**

behavioral health
planning council

Address : 600 East Boulevard Ave. Dept. 325
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**Behavioral Health Planning Council**
**Executive Committee Meeting**

**Tuesday, January 4, 2022**
**Video Conference Meeting***
**12:00 PM – 1:00 PM, CT**

**Agenda**

1:00 AM Welcome and Call to Order: Emma Quinn, Chairperson
Roll Call of Council Members via Electronic Sign-in
Quorum

Approval of January 4, 2022, Meeting Agenda
Limited Review of BHPC Next Steps Summary: Greg Gallagher

- **Resolution of Support for a New State Hospital**.
- **Resolution of Support for the Advancement of Home and Community Based Services and the Appropriate Application of the Medicaid IMD Rule within the State's System of Care**.

**Next Steps**

1:00 PM **Adjourn**

**Topic: BHPC Executive Committee, State Hospital Resolution**
**Time: Jan 4, 2022, 12:00 PM Central Time (US and Canada)**

**Join Zoom Meeting**
**https://us02web.zoom.us/j/84438858713**

**Meeting ID: 844 3885 8713**
**Phone Connection Option: 1-346-248-7799**

**APPENDIX B:**

**Resolution of Recognition of Evident Need and Support for the Advancement of a New State Hospital Within the State's System of Care**
**Version 2.0**

**December 10, 2021**

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WHEREAS, the North Dakota Behavioral Health Planning Council assumes its duties as the state's principal advisory body established under Public Law 102-321 (42 U.S.C 300X-4), to monitor, review, and evaluate the allocation and adequacy of behavioral health services in North Dakota and to meet federally mandated requirements, and whose members are duly appointed by the Governor of North Dakota to advise the Governor regarding the administration of the state's behavioral health practices and policies; and

WHEREAS, the membership of the Council represents the diverse voices and interests of the people of North Dakota, bringing forth vast strengths and perspectives from consumers of mental health and substance abuse services, family members, advocates, referral sources, schools, institutional and community-based service providers, the general disability community, and the criminal justice system, and covering an expanse of expertise including a shared knowledge of individual and general consumer situations, Medicaid, service delivery systems, reimbursement issues, housing and community development, legal issues, community resources, recovery, peer mentoring, service delivery, children's issues, and advocacy for mental health and substance abuse issues; and

WHEREAS, the Council has endorsed and guided the development and implementation of the state's current behavioral health strategic plan, covering the breadth of state behavioral health needs, and in so doing, has adopted a Statement of Vision that recognizes *With full regard for the value of each person, appropriate behavioral health services, encompassing the full continuum of care, are readily available at the right time, in the right place and manner, and by the right people, offering every North Dakotan their best opportunity to live a full, productive, healthy and happy life—free of stigma or shame, within caring and supportive communities;* and

WHEREAS, the Council recognizes the inherent value and necessity for a properly sized and situated State Hospital as a critical component of the state's comprehensive system of care, providing specialized care and highly trained staff and ensuring the capacity of the state to provide for its citizens the full expanse of services demanded of a balanced, efficient, and modern continuum of care, documented by multiple studies; and

WHEREAS, the current State Hospital facilities, having served the state for multiple generations, now exhibit profound deterioration, documented by structural, mechanical, electrical, and plumbing deficiencies or failures approximating 76%, significantly evidencing that these facilities have long outlived their expected lifespans; and

WHEREAS, any measured, deferred maintenance budget cannot sustain the volume and cost of needed repairs and systems replacement, and where the current, antiquated facilities lack adequate natural light, healing green space, and pose safety risks for patents and staff, outright

failing to provide for an appropriate setting that will speed recovery, improve patient and staff safety, and improve overall satisfaction of patients and staff; and

WHEREAS, the co-location of the current State Hospital facility with an adjoining prison facility contributes to the stigma, prejudice, and discrimination of individuals with mental illness, denying patients and residents served at the State Hospital the right to receive appropriate and respectful care in a safe and healing environment.

THEREFORE, LET IT BE RESOLVED, that the North Dakota Behavioral Health Planning Council, acting within its assigned charge to provide studied advice to the state on critical issues of care regarding behavioral health services within North Dakota, does endorse

- Adopting and advancing, through policy and funding across all appropriate agencies, the full implementation of all program goals specified within the statewide behavioral health strategic plan; and

- Securing and sustaining a statewide behavioral health system that facilitates an integrated continuum of care across all services, directed to the unique needs of every person served; and

- Building a new, modern State Hospital central facility, located in Jamestown, ND, and providing readily accessible specialized psychiatric care services statewide, securing for all state residents reasonable and ready access to appropriate and specialized behavioral health services.

FURTHERMORE, LET IT BE RESOLVED, that the North Dakota Behavioral Health Planning Council petitions the North Dakota Department of Human Services, the Office of the Governor, the Acute Psychiatric Care Committee, and the full North Dakota 68th Legislative Assembly to authorize and secure sufficient and sustainable financial resources and supporting policies that accomplish each of these stated aims.

**APPENDIX C**

**IMD Exclusion Background Summary**

**December 8, 2021**

LEGAL ACTION CENTER
*Breaking Barriers. Defending Dignity.*

**The Medicaid IMD Exclusion: An Overview and Opportunities for Reform**

The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21, and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.

**What is in the law?**

The IMD exclusion is found in section 1905(a)(B) of the Social Security Act, which prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" except for "inpatient psychiatric hospital services for individuals under age 21." The law goes on to define "institutions for mental diseases" as any "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." The IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services.

The IMD exclusion has been part of the Medicaid program since Medicaid's enactment in 1965, and while Congress has had the opportunity on numerous occasions to amend or repeal the exclusion, it has remained largely intact. In addition, the regulations governing the IMD exclusion have not been updated since 1988.

**What makes a facility an IMD?**

In the State Medicaid Manual, the federal Department of Health and Human Services (HHS) interprets the IMD exclusion to include any institution that, by its *overall character* is a facility established and maintained primarily for the care and treatment of individuals with mental diseases. The guidelines used to evaluate if the overall character of a facility is that of an IMD are based on whether the facility:

- Is licensed or accredited as a psychiatric facility;
- Is under the jurisdiction of the state's mental health authority;

- Specializes in providing psychiatric/psychological care and treatment, which may be ascertained if indicated by a review of patients' records, if an unusually large proportion of the staff has specialized psychiatric/psychological training, or if a facility is established and/or maintained primarily for the care and treatment of individuals with mental diseases; or
- Has more than 50 percent of all its patients admitted based on a current need for institutionalization as a result of mental diseases.

If any of these criteria is met, a thorough IMD assessment will be made. Therefore, a facility is determined to be an IMD based on the character of the institution, including its governance, staffing, and patient population.

**How do the regulations define "mental disease?"**

In interpreting whether an individual's admission to an institution is a result of a "mental disease" for the purpose of applying the "50 percent test," reviewers will consult the International Classification of Diseases (ICD-9-CM), of which the Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subclass. Because the ICD-9-CM system classifies substance use disorders (SUD) as mental disorders, facilities providing inpatient SUD treatment may be considered IMDs under the law. In its discussion of SUD treatment facilities, the State Medicaid Manual says:

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

The State Medicaid Manual also clarifies that facilities that rely on peer counseling and meetings to promote group support and encouragement, and primarily use lay persons as counselors, are not considered IMDs and the services they provide are not eligible for Medicaid reimbursement because they do not provide medical assistance.

**What options might be available to improve the IMD exclusion?**

The IMD exclusion is included in federal Medicaid statute so significant changes to the IMD exclusion would require an act of Congress, and while Congress has had opportunities to change the IMD exclusion it has largely not done so. There are also certain limited administrative options available to HHS to make it easier for facilities to use Medicaid to finance inpatient mental health and/or SUD services. Specifically, the following options are among those that are frequently discussed:

- Congress could fully repeal the IMD exclusion,
- Congress could raise the bed limit above 16 to a number that would allow larger facilities to fall outside of the scope of the IMD exclusion,

- HHS could exclude SUD from the definition of mental disease for the purposes of determining if a treatment facility is an IMD, or
- HHS could allow states to use section 1115 waivers to drawdown FFP for services provided in IMDs.

  There are potential downsides to each approach that would need to be considered by policymakers. For example, potential risks associated with a full or partial repeal by Congress could be to encourage inpatient treatment when outpatient treatment is preferable. Repeal would also be quite expensive for the federal government.

  If HHS were to exclude SUD from the definition of mental disease for the purpose of determining if a facility was an IMD, states could draw down federal funds for SUD treatment provided in inpatient settings with more than 16 beds if less than 50 percent of patients had co- occurring mental illnesses that required an inpatient level of care. However, this approach could promote a separate service delivery system and financing limitations for patients with co-occurring mental health and SUD conditions.

  HHS could also allow states to use waivers to cover services provided in IMDs in some circumstances, which would improve access to inpatient behavioral health services for Medicaid beneficiaries. Waivers must be cost-neutral to the federal government and are time- limited. In addition, waivers are state specific, which would limit the impact of increasing access to residential treatment services using this approach.

  **Other considerations**

  Finally, while the IMD exclusion has remained essentially stagnant for decades, the health care system and disability law in the United States has changed dramatically in that time. These changes must be considered as context for the IMD exclusion and its continued role in the Medicaid program.

  For example, the Affordable Care Act significantly expands Medicaid coverage to low-income adults, and while states have flexibility to determine the benefits that are available to the expansion population, it is likely that beneficiaries in many states will have coverage for inpatient behavioral health services that they will be unable to access because they are only available in IMDs. In addition, as states have continued to move to managed care delivery systems for their Medicaid programs beneficiaries often are covered by the same provider networks as individuals enrolled in commercial coverage that includes facilities that Medicaid considers IMDs, leaving Medicaid enrollees unable to access certain services and leading to disparities.

The IMD exclusion also raises parity issues after the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, since for no other conditions are Medicaid services in certain medical institutions excluded. The requirements of MHPAEA apply to Medicaid managed care coverage and will apply to fee-for-service and managed care coverage provided to those adults gaining Medicaid eligibility under the Affordable Care Act.

Finally, federal law and several key court decisions since the implementation of the IMD exclusion have afforded individuals with disabilities the right to community-based care when

appropriate. The expansion of protections to individuals with disabilities may potentially mitigate some of the concerns Congress had when it established the IMD exclusion.