Report to

The Vermont Legislature

# Report on Institutions for Mental Disease

## In Accordance with S.203 of 2018

## Act 200 Section 10§2: An act relating to systemic improvements of the mental health system

**Submitted to:**

**The House Committee on Health Care**

**The Senate Committee on Health and Welfare**

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**Report Due January 15th, 2024**

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# Executive Summary

The Agency of Human Services (AHS) is mandated by the Centers for Medicare and Medicaid (CMS) to implement a phasedown of federal financial participation for excluded stays in Vermont institutions for mental diseases (IMDs) by December 2029. This requirement is in response to CMS's directive to bring Vermont into compliance with the federal "IMD exclusion," prohibiting federal Medicaid funding for patients aged 21-64 in mental health and substance use disorder residential treatment facilities larger than 16 beds.

In response to the IMD phasedown mandate, Vermont has amended its 1115 waiver three times, progressively reducing the loss of federal Medicaid funding to IMDs, although not entirely eliminating it. This report explores diverse solutions, including the potential elimination of IMDs, mergers with larger facilities, and the creation of smaller community-based sites. It is crucial to highlight that the evaluation of these solutions goes beyond monetary impacts and must align with Vermont's vision for a comprehensive, accessible, and high-quality system of care.

To address the elimination of remaining IMD investment federal funding, the Legislature is called upon to provide support through General Funds. This backing is imperative to prevent the closure of vital psychiatric inpatient beds, which could have cascading effects throughout the continuum of care, adversely impacting access to mental health care at all levels.

# Legislative Language

## Sec. 10. REPORT; INSTITUTIONS FOR MENTAL DISEASE

The Secretary of Human Services, in partnership with entities in Vermont designated by the Centers for Medicare and Medicaid Services as "institutions for mental disease" (IMDs), shall submit the following reports to the House Committees on Appropriations, on Corrections and Institutions, on Health Care, and on Human Services and to the Senate Committees on Appropriations, on Health and Welfare, and on Institutions regarding the Agency's progress in evaluating the impact of federal IMD spending on persons with serious mental illness or substance use disorders:

on or before January 15 of each year from 2019 to 2025, a written report evaluating:

(a) the impact to the State caused by the requirement to reduce and eventually terminate federal Medicaid IMD spending;
(b) the number of existing psychiatric and substance use disorder treatment beds at risk and the geographical location of those beds;
(c) the State's plan to address the needs of Vermont residents if psychiatric and substance use disorder treatment beds are at risk;
(d) the potential of attaining a waiver from the Centers for Medicare and Medicaid Services for existing psychiatric and substance use disorder services; and
(e) alternative solutions, including alternative sources of revenue, such as general funds, or opportunities to repurpose buildings designated as IMDs.

# Background from Previous Reports

In the context of the ongoing evolution outlined in the Act 200 reports since November 15, 2018, the Agency of Human Services (AHS) has been mandated to submit a phasedown schedule of funding for Vermont's mental health institutions, known as Institutions for Mental Diseases (IMDs), to the Centers for Medicare and Medicaid (CMS). This obligation, stemming from Vermont's Global Commitment to Health 1115 Demonstration Waiver, aims to phasedown federal Medicaid funding for IMDs by 2029, to bring Vermont into compliance with federal legislation known as the “IMD exclusion” that prohibits the use of federal Medicaid funding for care provided to patients aged 21-64 in mental health and substance use disorder residential treatment facilities larger than 16 beds.[1] Prior to the phasedown requirement, Vermont Medicaid was authorized to utilize 1115 investment authority to fund IMDs. 2017 marked a consequential CMS policy shift that no longer allowed federal investment funding to be used for IMDs.

Over subsequent years, Vermont amended its 1115 waiver three times, mitigating the loss of federal Medicaid funding for IMDs. Notably, in 2018, the state amended its waiver to gain authorization for IMD treatment of primary substance use disorders (SUD). In 2019, Vermont became the first state to secure Medicaid funding for short-term IMD stays (60 days or fewer) for eligible beneficiaries with serious mental illness (SMI) and/or severe emotional disturbance (SED). As a result of these amendments, the IMD phasedown was narrowed down to only

[1] 1905(a)(B) of the Social Security Act

two remaining institutions: Brattleboro Retreat (87 Beds) and The Vermont Psychiatric Care Hospital (VPCH) (25 beds).

In the 2022 waiver renewal,[2] Vermont obtained CMS approval for further IMD waiver authority, extending coverage beyond 60 days, broadening the interpretation of "forensic" to include individuals not in the custody of the Department of Corrections, and granting an IMD exemption with sustained Medicaid funding for Lund Home. This exceptional consideration was based on Lund Home's distinctive care model, positive outcomes, and emphasis on child health.

# Impact of Phasedown

The 1115 Global Commitment to Health Demonstration Waiver renewed in 2022 includes a specified phasedown schedule of the remaining Brattleboro Retreat and VPCH investments in its Special Terms and Conditions (STCs):

- 2022: 70% of 2019 spending
- 2023: 60% of 2019 spending
- 2024: 50% of 2019 spending
- 2025: 40% of 2019 spending
- 2026: 30% of 2019 spending
- 2027: 20% of 2019 spending

[2] 2022 Global Commitment to Health Section 1115 Demonstration

- 2028: 10% of 2019 spending[3]
- 2029: 0% of 2019 spending

The phasedown amounts above reflect the state/federal-combined cost for stays prohibited under the terms of the SMI/SUD IMD waivers. Specifically, the following stays are not eligible for Federal Financial Participation (FFP) under Vermont's IMD waivers:

- IMD stays for non-Medicaid patients.
- IMD stays over 60 days.
- IMD stays for individuals defined as "forensic" under the terms of the IMD waiver:
- Individuals who are awaiting a psychiatric evaluation as part of a trial.
- Individuals who have been found incompetent to stand trial.
- Individuals who have been found to be insane at the time of the crime were tried and found not guilty by reason of insanity.
- Individuals who are pre-adjudication or have been convicted and are in DOC custody who develop the need for acute psychiatric care on either a voluntary or involuntary basis.

The remaining $20.2M in investment spending that is subject to phasedown is attributed to forensic care in IMDs, care for persons

[3] CMS is only authorized to issue STCs that are limited to the duration of the demonstration period for which they apply. Therefore, this STC could not include a phasedown schedule for 2028, as the current demonstration ends in 2027. While changes in federal administrations make future agreements impossible to guarantee, the current administration is committed to authorizing 10% spending of 2018 IMD investment levels in CY 2028.

who are not Medicaid eligible, and care for persons whose length of stay exceeds 60 days. Vermont's phase-down schedule considered the extensive amount of time and resources that will be necessary to adequately plan and implement the large-scale change that is necessary for determining an appropriate financing plan, for the remaining, non-waivered types of care provided in IMDs.

# Psychiatric and Substance Use Treatment Beds

| Facility | Type and Target Group(s) | Treatment Focus | # of Beds | CY24 Gross Est. |
|---|---|---|---|---|
| **Vermont Psychiatric Care Hospital (VPCH)**<br><br>*Berlin, Vermont*<br><br>*Ineligible dollars due to combination of stays over 60 days and forensic stays.* | Inpatient stabilization for adults | Psychiatric,<br><br>Co-occurring SUD | 25 | $20,270,682 |
| **Total** | | | | **$20,270,682** |

# Phasedown Options & Alternative Solutions

While it is important to carefully evaluate all the options utilized by states nationally to address federal funding issues related to IMDs, it is essential to note that the weighted evaluation of these alternatives does not rest exclusively on monetary impacts but

must also align with Vermont's vision for a comprehensive, accessible, and high-quality system of care. In planning for the significant reduction of federal funding to IMDs that primarily treat individuals with severe mental illness, the State is carefully exploring and considering possible treatment alternatives to IMDs or alternative funding mechanisms for existing IMDs. The State's preliminary examination of such alternatives raise serious political, philosophical, and financial issues that will require robust stakeholder engagement and considerable strategic planning by the State, providers, and the legislature to fully explore.

Vermont has evaluated below the elimination of psychiatric IMDs in Vermont. Significant administrative, facility, and geographic shifts in the delivery of mental health from the status-quo to a post-IMD model are necessary to avoid the most significant burdens this reduction in funding will place on Medicaid beneficiaries and the system of care. Vermont's proposed phase down schedule considered the extensive amount of time and resources that will be necessary to adequately plan and implement such large- scale change.

## Eliminate psychiatric IMDs in Vermont

Due to the 60-day length-of-stay limitation in the 1115 mental health IMD waiver, both the Brattleboro Retreat and the Vermont Psychiatric Care Hospital (operating at maximum bed levels) would have a large amount of their services ineligible to receive federal funding for mental health treatment after the phase-down has been implemented.

Reducing the bed count at these two facilities from current levels to 16 beds per facility would result in a net loss of 82 acute adult

inpatient psychiatric beds and 10 residential co-occurring SUD/mental health treatment beds for some of Medicaid's most vulnerable individuals.

Faced with the complete elimination of Medicaid investment funding to Brattleboro Retreat and the Vermont Psychiatric Care Hospital, Vermont has explored the following scenarios aimed at preserving bed capacity.

## Maintain Psychiatric Bed Capacity through Community Hospitals

To maintain psychiatric bed capacity after the elimination of federal IMD funding, 92 new beds would need to be sited across the state. Because of the IMD restrictions, these beds would have to be dispersed across existing community hospital settings or through the creation of new, free-standing psychiatric facilities of 16 beds or fewer. The feasibility of maintaining current capacity achieved through the two IMDs discussed above and placing those beds in a mix of community hospitals and/or standalone facilities would be exceedingly difficult given Vermont's small size, extremely limited work force, and the structure of the current mental health delivery system. Vermont's small population and rural nature presents additional delivery system and workforce barriers that are not present in more populous states.

Of Vermont's 14 community hospitals, four currently have designated psychiatric units and eight are small critical access hospitals (CAHs) of 25 beds or fewer. The small scale of these CAHs makes psychiatric expansion difficult and, if undertaken, expansion in any given facility would be limited to 10 psychiatric beds or fewer due to federal IMD and CAH policy. Additionally, Vermont has been historically challenged by a shortage of

psychiatric professionals (i.e., medical doctors, nurses, psychologists, licensed mental health counselors, and social workers) to staff programs across the state. This already grave shortage in clinical professionals would only be exacerbated by relocating psychiatric beds from current centralized facilities in relatively populous towns to be diffused across Vermont's 14 community hospitals. Beyond the substantial workforce concerns, spreading existing psychiatric bed capacity across the State would present a myriad of other considerable challenges, including: financing the loss of economies of scale inherent in IMDs, capital construction costs, local zoning limitations, obtaining Certificate of Need, and federal and state regulatory licensing and certification requirements.

## Maintain Psychiatric Bed Capacity through Creation of Several 16 Bed Facilities

Separating Vermont's two acute psychiatric inpatient IMDs into independently operated and administered facilities would require the IMDs to split into eight distinct entities in order to maintain critical bed capacity. Vermont is a small state that is already experiencing recruitment and retention issues for clinical professions, particularly in the field of mental health. Consistent with the challenges presented in the community hospital bed model discussed above, the State's current workforce simply could not support the administrative and clinical redundancies that would be necessary for the effective operation of six additional facilities. Such a dispersion of care dramatically reduces the economy of scale enjoyed by larger facilities, as each small facility would require separate and sufficient executive leadership, medical staff, administrative support, and governance.

Significant capital funding would need to be secured in order to develop and build the six new stand-alone inpatient psychiatric facilities necessary to maintain existing capacity achieved through Vermont's current IMDs. Notably, no money can be spent developing any new health care project until a Certificate of Need is granted. Therefore, even at an aggressive pace, the actual provision of care in any of these facilities is at least four years away. During the time it would take to plan, develop, and build new infrastructure, existing IMD capacity must be maintained so not to diminish Medicaid beneficiaries' access to essential psychiatric services.

It is uncertain whether restructuring the mental health system in this way would provide any benefits of increased access from the present state nor improved quality for Medicaid beneficiaries. This, combined with the obvious inefficiencies and increased cost inherent in a dispersed model, greatly limits the viability of such an alternative.

## Merge IMDs with Larger, General Care Hospitals

Transforming Vermont's two inpatient IMDs by merging them with larger acute care facilities (such that the psychiatric beds are less than 50% of total bed capacity—as measured by average daily census) could theoretically allow continued federal financial participation for these necessary services without violating the IMD exclusion. There are several significant challenges with implementing such a solution, many already expressed in detail above.

First, transferring the assets of a state-run hospital (in the case of Vermont Psychiatric Care Hospital) or large non-profits (in the

case of the Brattleboro Retreat) requires a robust operational transformation on the part of both the transferring and the receiving entities.

Second, and not withstanding any other complications, the average daily censuses for the two hospitals most poised (due to both size and physical proximity) to merge with Vermont's existing hospital IMDs are not high enough to absorb the full psychiatric IMD bed capacity without becoming IMDs themselves. Central Vermont Medical Center, already located near the Vermont Psychiatric Care Hospital, estimates it could safely take on 26 non-level-one psychiatric beds without facing IMD characterization concerns, still leading to a significant reduction in level-one inpatient psychiatric treatment capacity for the most acute patients. Although the Brattleboro Retreat has explored several options for partnering with acute care hospitals, only Brattleboro Memorial Hospital presents any viability. Even still, Brattleboro Memorial numbers are inadequate to absorb Brattleboro Retreat's existing 87 adult inpatient beds.

While merging IMDs with larger general hospitals would serve to mitigate some of the lost capacity incurred from complete closure of psychiatric IMDs, as with the other alternatives expressed above it would present difficult-to-overcome capital funding, regulatory, and workforce challenges while still resulting in a destabilized mental health system and significantly decreased access to psychiatric care, particularly for Medicaid beneficiaries.

# Potential of Attaining a Waiver from CMS

AHS has no indication that CMS would grant a waiver or offer extensions to the current phasedown schedule. While there may be ongoing discussions and debates about mental health care and Medicaid policies at the federal level, as of this report, there are no imminent plans or indications that CMS would end the IMD exclusion.

# Conclusion:

Much has been accomplished to mitigate the impacts of the IMD phasedown requirement since it was put into place in 2017, including waivers that authorize payments for SUD IMD treatment and SMI IMD treatment up to 60 days, expenditure authority for Lund Home, and gaining an additional three years of federal investment funding. Despite that, Vermont is still facing a significant loss of federal funding for the most acute components of Vermont's psychiatric system of care, Brattleboro Retreat and VPCH. While the achieved IMD waivers ease Vermont's burden of phasedown planning, their numerous constraints still require the State to carefully assess the system of care and to propose an adequate and proper financing mechanism for sustainability.

As a practical matter, the elimination of the remaining IMD investment federal funding will result in bed closures unless backfilled through General Funds. Vermont does not have the infrastructure, staff resources, or geographic attributes needed to further decentralize its systems of care as a means of complying with IMD requirements. Vermont's mental health and substance use systems of care need to be stabilized and enhanced in order to impact high emergency room utilization for mental health, pervasive opioid use, adverse childhood events and trauma, and suicide rates. With less capacity for delivering the most intensive

treatment, patients with the most complex needs will need to obtain care in psychiatric units of acute care hospitals, creating reduced access for patients who would have otherwise sought care in those settings. Bed closures would have ripple effects throughout the continuum of care, reducing access to all levels of mental health care, and impacting hospital care such as emergency medicine and medical inpatient services.

AHS believes Vermont must continue to make efforts to achieve an integrated and holistic health care system across a continuum of care, from the community to the most acute hospital settings. However, working towards ensuring an appropriate balance between mental health services provided in the hospital, and services delivered in the community, requires time to develop the necessary community supports to ensure all Vermonters have access to the care they need at the time they need it. The State must ensure it is done in a thoughtful way, driven by the needs of Vermonters, and not based on federal funding decisions.