Report to
The Vermont Legislature

Centers for Medicare and Medicaid Services: Institutions of Mental Disease Funding Phasedown

In Accordance with Act 200, Sec. 10 (2018)

Submitted to:	House Committee on Health Care Senate Committee on Health and Welfare
Submitted by:	Emily Hawes, Commissioner, Department of Mental Health
Prepared by:	Ashley Berliner, Director of Medicaid Policy, Department of Vermont Health Access Nicole DiStasio, Director of Policy, Department of Mental Health
Report Date:	January 15, 2023

VERMONT
Department of Mental Health
Agency of Human Services
280 State Drive, NOB-2 North Waterbury, VT 05671
www.mentalhealth.vermont.gov

Legislative Language

Act No. 200 (2018). An act relating to systemic improvements of the mental health system.

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:

(1) a status update that shall provide possible solutions considered as part of the State's response to the Centers for Medicare and Medicaid Services' requirement to begin reducing federal Medicaid spending due on or before November 15, 2018; and

(2) 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

(a) (E) alternative solutions, including alternative sources of revenue, such as general funds, or opportunities to repurpose buildings designated as IMDs.

Executive Summary

The Agency of Human Services (AHS) is required by the Centers for Medicare and Medicaid (CMS) to phasedown federal financial participation for all excluded stays provided in Vermont institutions for mental diseases (IMDs) by December 2029. CMS requires the phasedown to bring Vermont into compliance with federal "IMD exclusion" that prohibits 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.

Since the IMD phasedown requirement was established, Vermont has amended its 1115 waiver three times. Each of these amendments have decreased, though not eliminated, the loss of federal Medicaid funding to Vermont's IMDs. Vermont has explored various potential solutions in this report, such as eliminating IMDs, mergers with larger facilities, and creating smaller community-based sites. However, it is essential to note that the weighted evaluation of solutions 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.

The Legislature must backfill the elimination of the remaining IMD investment federal funding through General Funds to prevent the closure of critical psychiatric inpatient beds that would have ripple effects throughout the continuum of care, reducing access to all levels of mental health care.

Contents

Legislative Language 2
Executive Summary 3
Introduction 5
Background from Previous Reports 6
2022 Waiver Renewal Impacts 7
Institution of Mental Disease (IMD) Phasedown Schedule 7
Phase-down Options and mitigation efforts 9
Conclusions 12

Introduction

This is the fifth annual report required under Sec. 10 of Act 200 of 2018. The following report is broken into five parts to provide a description of Vermont's evaluation of the impact of federal Institutions for Mental Disease (IMD) spending on persons with serious mental illness (SMI) or substance use disorders (SUD), including: (1) Background (2) 2022 Waiver Renewal Impacts, (3) IMD Phase-down Schedule (4) Phase-down Options, and (5) Conclusions.

Background from Previous Reports

As discussed in previous Act 200 reports dating back to November 15, 2018, the Agency of Human Services (AHS) was required to submit to the Centers for Medicare and Medicaid (CMS) a phasedown schedule of funding for Vermont institutions for mental diseases (IMDs) that ended federal Medicaid funding by 2026, as required in Vermont's 2017 Global Commitment to Health 1115 Demonstration Waiver. This phasedown requirement was 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]. Up until this phasedown requirement was put into Vermont's 1115 waiver in 2017, Vermont Medicaid was authorized to pay for IMDs using its 1115 investment authority. 2017 marked a consequential CMS policy shift that no longer allowed federal investment funding to be used for IMDs.

Since the IMD phasedown requirement was established, Vermont has amended its 1115 waiver three times. Each of these amendments have decreased, though not eliminated, the loss of federal Medicaid funding to Vermont's IMDs. In 2018, Vermont amended its Global Commitment to Health 1115 Demonstration waiver to receive authority to pay for IMD treatment of primary substance use disorders (SUD). In 2019, Vermont again amended its 1115 waiver to become the first state in the country to receive Medicaid funding for short-term (60 days or fewer) IMD stays provided to otherwise-eligible Medicaid beneficiaries with diagnosis of serious mental illness (SMI) and/or severe emotional disturbance (SED). With both the SUD and SMI IMD waiver amendments, the IMD phasedown required by the State's 1115 waiver was limited in scope to only three remaining IMDs: Lund Home (26 beds), Brattleboro Retreat (87 Beds), and the Vermont Psychiatric Care Hospital (VPCH) (25 beds).

In its most recent waiver renewal, Vermont requested that CMS provide IMD waiver authority to:

(1) cover stays longer than 60 days,

(2) apply to a narrower interpretation of "forensic" that would authorize Medicaid coverage for individuals not in the custody of Department of Corrections, and

(3) provide an IMD exemption and sustained Medicaid funding for Lund Home due to its unique care model, positive outcomes, and focus on maternal child health.

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

2022 Waiver Renewal Impacts

On June 28, 2022, CMS approved a five- and half-year renewal of Vermont's Global Commitment to Health 1115 demonstration[2]. This renewal marked the first-in-nation CMS approval of an IMD in the form of expenditure authority for Lund Home, an IMD focused on maternal health and SUD/SMI treatment services for pregnant women and new mothers. This precedent-setting approval eliminates Vermont's need to phasedown Medicaid funding to Lund Home, so long as other IMD requirements and assurances are maintained. While not successful in obtaining approval of its other two IMD requests (covering stays longer than 60 days; authorize Medicaid coverage for individuals not in the custody of Department of Corrections), the State was successful in arguing for a three-year extension of Vermont's phasedown requirement. Three additional years to phase out federal funding of non-qualifying stays at Brattleboro Retreat and VPCH, from 2026 to 2029, will provide Vermont adequate time to thoughtfully adjust its mental health system of care.

Institution of Mental Disease (IMD) Phasedown Schedule

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

2028: 10% of 2019 spending[3]

2029: 0% of 201 spending

[2] 2022 Global Commitment to Health Section 1115 Demonstration

[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.

Facility	Type and Target Group(s)	Treatment Focus	# of Beds	CY23 Gross Est.
Brattleboro Retreat *Brattleboro, Vermont* *Ineligible dollars due to combination of stays over 60 days and forensic stays.*	Inpatient stabilization for adults	Psychiatric, Co-occurring SUD	87	$4,968,779
Vermont Psychiatric Care Hospital (VPCH) *Berlin, Vermont* *Ineligible dollars due to combination of stays over 60 days and forensic stays.*	Inpatient stabilization for adults	Psychiatric, Co-occurring SUD	25	$24,500,000
Total				**$29,468,779**

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:

1. IMD stays for non-Medicaid patients.
2. IMD stays over 60 days.
3. IMD stays for individuals defined as "forensic" under the terms of the IMD waiver:
    a. Individuals who are awaiting a psychiatric evaluation as part of a trial.
    b. Individuals who have been found incompetent to stand trial.
    c. Individuals who have been found to be insane at the time of the crime were tried and found not guilty by reason of insanity.
    d. 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 $29.4M in investment spending that is subject to phasedown is attributed to forensic care in IMDs, care for persons 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.

Phase-down Options and mitigation efforts

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. Research shows that new parenthood is apt for intervention, with promising return on investment if appropriate treatment can occur with pregnant and parenting women and their young children. Loss of such treatment capacity would place significant strain on Vermont's entire system of care, including emergency departments, community mental health providers, general inpatient hospitals, and the Department for Children and Families as they continue to deal with devasting results that the escalating opioid and mental health crises, alongside a global pandemic, are wreaking on children.

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 Certification of Needs, 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 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. Transactions of this magnitude, like the other scenarios explored above, would require a Certificate of Need. There is no guarantee that such certificates would be granted absent compelling arguments anticipating improved quality, of which the State finds no such evidence to support.

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 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.

Conclusions

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 playments for SUD IMD treatment and SMI IMD treatment up to 60 days, expediture 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 by the Legislature through General Funds. Vermont does not have the infrastructure, staff resources, or geographic attributes needed to further decentralize its systems of care. 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.

AHS believes Vermont must continue to make efforts to achieve an integrated and holistic health care system. However, working towards establishing a 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.