Behavioral Health Planning Council (BHPC) Annual Meeting

October 16, 2024
Meeting Minutes

Council Members in Attendance

Emma Quinn (Consumer - Individual in Recovery MH); Carlotta McCleary (ND Federation of Families for Children's Behavioral Health); Andrea Hochhalter (Consumer, Family Member of an Individual in Recovery); Denise Harvey (Protection and Advocacy); Matthew McCleary (Mental Health America of ND); Brenda Bergsrud (Consumer Family Network); Melanie Gaebe (Consumer, Individual in Recovery SUD); Kristi Kilen (Private Mental Health Provider); Kurt Snyder (Consumer - Individual in Recovery); Pamela Sagness (Principal State Agency: DHHS Mental Health); Jennifer Henderson (Principal State Agency: Housing); Mark Schaefer (Private Substance Use Disorder Treatment Provider); Michelle Masset (Principal State Agency: Social Services; Robin Lang (on behalf of Amanda Peterson, Principal State Agency: NDDPI Education); Cheryl Hess Anderson (DHHS, Vocational Rehabilitation); Lorraine Davis (Consumer, member at large);and Paul Stroklund (Consumer, Family Member of an Adult with SMI).

Council Members Absent: Michelle Gayette (DHHS Aging Services); Dr. Amy Veith (Principal State Agency/Criminal Justice); Brad Hawk (Indian Affairs Commission); Tim Wicks (Consumer, Veteran); Heather Call (ND National Guard); Dan Cramer (DHHS Behavioral Health Delivery System); Mandy Dendy (Principal State Agency: Medicaid); Michael Salwei (Healthcare Representative); Dr. Lisa Peterson (Consumer, Family Member of a Veteran); Tania Zerr (Consumer, Family Member of a Child w/SED); and Glenn Longie (Tribal Behavioral Health Representative).

Staff: Tami Conrad (DHHS Behavioral Health Representative)

Facilitator: Janell Regimbal of Insight to Solutions

Call to Order

Chair Lorraine Davis called the meeting to order at 10:00 AM CT, via videoconference and in-person at the ND Job Service office in Bismarck.

Quorum

A roll call was conducted, confirming a quorum with majority attendance. The Chair declared a quorum and welcomed members.

Approval of Minutes

KURT SNYDER moved to APPROVE THE JULY 17, 2024; MEETING MINUTES AS PRESENTED. PAUL STROKLUND seconded the motion. The motion passed unanimously.

Approval of Agenda

A motion to APPROVE THE AGENDA WITH AMENDMENTS (moving the 1915(i) report to the afternoon session to be provided by Sarah Aker) was made by CARLOTTA MCCLEARY and seconded by MELANIE GAEBE. The motion passed unanimously.

BHPC UPDATES

Membership

Tami Conrad announced two positions remain open: a family member of a child with SED and an individual in recovery with MH. The Governor's office is currently reviewing applications for these roles. Members were encouraged to recommend applicants if they knew of interested individuals.

Election Results

Facilitator Janell Regimbal presented the results of the electronic voting held from September 30 to October 7. Melanie Gaebe was elected as Vice Chair, and Kurt Snyder was appointed to the Executive Committee. A MOTION TO APPROVE THESE ELECTION RESULTS WAS MADE BY ANDREA HOCHHALTER and seconded by MATTHEW MCCLEARY. The motion carried unanimously.

Slate of 2025 Meeting Dates of the BHPC

A MOTION TO APPROVE THE SLATE OF DATES AS PRESENTED FOR 2025 WAS MADE BY CARLOTTA MCCLEARY and seconded by KURT SNYDER. The motion was carried unanimously with dates adopted of May 14, July 16, October 15 (Annual Meeting) and December 17.

Introduction of BHPC Policy and Procedures Proposed Actions, the following key points were discussed, and actions were recommended as it relates to how policies and procedures would be added, deleted, or revised. It was noted that while the council had previously moved from a bylaw-driven structure to one guided by a policy and procedures manual, there were gaps identified regarding how amendments or new policies would be proposed and approved.

- **Feedback on Supermajority Requirement**: Members discussed whether changes to policies should require a simple majority or a supermajority (e.g., two-thirds of the membership). Feedback leaned towards favoring a supermajority to ensure that significant changes reflect a strong consensus. The language of the policy will be revised to include a supermajority vote requirement for adopting or amending policies. The policy should clarify that the process applies not only to amendments but also to the adoption of new policies.
- **Formal Procedure for Policy Introduction**: Members proposed assuring a step for reviewing new policy suggestions before the final vote, potentially allowing for initial feedback at one meeting followed by formal adoption at the next.

The **discussion on the formation of a conflict-of-interest policy** included the following points and recommendations:

- **Need for a Formal Policy**: The importance of having a clear conflict of interest policy in place to guide council members on when and how to declare conflicts

was discussed. This was seen as essential for maintaining transparency and integrity during meetings, especially when decisions involve potential conflicts related to funding or policy positions, however it was noted the authority of this group is quite limited.

- **Draft Policy Overview**: A proposed conflict of interest policy was presented, detailing procedures for council members to declare conflicts during meetings. This included steps for identifying potential conflicts and a formalized process for recusal from discussions or votes when necessary.
- **Feedback on Specificity**: Some members noted that the draft policy was detailed, outlining several types of conflicts and the appropriate responses. This level of detail was seen as beneficial for providing clear guidance but prompted questions about whether such detail might be overly prescriptive. Members agreed that the draft policy should undergo further review to ensure it is practical and aligns with the council's needs. This review would involve considering feedback about the policy's specificity and any potential adjustments.
- There was a recommendation to include a designated agenda item for members to declare any conflicts at the beginning of meetings and again before voting on specific items. Adopting such a policy would strengthen the council's governance framework yet this needs to be balanced with the role of the group and assuring it is not taken further than needed so that we lose the ability of those with lived experiences etc. to share their views and experiences freely.

These recommendations and discussions reflected a shared goal of ensuring robust and transparent governance within the Behavioral Health Planning Council. The revised policy is expected to be brought back for further review and potential adoption at the December meeting.

Summary Report on ND Behavioral Health Strategic Plan (PPT slides provided)

Bevin Croft from the Human Services Research Institute provided a summary of the ND Behavioral Health Strategic Plan's status and ongoing activities. Updates on goals and progress across strategic initiatives were discussed. Highlights included:
 - **Aim 1:** New updates on behavioral health dashboard metrics with work progressing on quarterly releases.
 - **Aim 4:** Continued implementation of school-based behavioral health programs, with a focus on the Behavioral Health in Education (BHERO) model.
 - **Aim 7:** Workforce initiatives including a new position focused on addressing workforce shortages, particularly through partnerships with local universities.
 - **Aim 10:** Increased emphasis on involving individuals with lived experience in behavioral health initiatives across the state.

Council members were encouraged to participate in these aims through ongoing liaison roles. Ms. Croft noted that the System of Care work and the establishment of Certified Community Behavioral Health Clinics (CCBHCs) will require advocacy during the legislative session to ensure continued support and funding.

Member Feedback: BHPC Prospective Legislative Advocacy Agenda (PPT slides provided)

Facilitator Regimbal provided information about activities of the last session by way of review. Members provided feedback emphasizing the importance of ensuring that key legislative priorities align with the current needs in behavioral health. It was noted that there might be a need for advocacy around comprehensive care frameworks, particularly for programs that support families and community-based mental health services. Members also highlighted the relevance of supporting initiatives that focus on improving access to behavioral health services, integrating peer support, and reinforcing financial sustainability through state funding. There was agreement to consider setting priorities for advocacy for the BHPC ahead of the session so we can provide a priority document versus testimony. We can be broad in what is needed to move things forward. The December agenda will allow for discussion and planning to take place for the Executive Committee to move forward during the session.

Consumer Family Network Report (PPT slides provided)

The Consumer Family Network overview, presented by Matthew McCleary, included updates on initiatives supporting families dealing with children's mental health challenges. The report covered ongoing efforts to provide resources, support, and advocacy for families. It was noted that the network has been engaging in outreach activities aimed at improving family involvement in behavioral health service planning and policy discussions. The need for continued collaboration with state agencies to ensure that family voices are incorporated into decision-making processes was raised as well as highlighting recent success stories from the network's outreach programs.

Adjourned for lunch at 11:55 AM

Chair Lorraine Davis reconvened the meeting at 1:00 PM.

1915i Provider Status & Clients Served Update (PPT slides provided)

Sarah Aker, Executive Director of Medical Services of DHHS, presented updates on the 1915i program, which included changes aimed at improving service delivery and reducing administrative barriers for providers. Key updates included:

- Removal of service authorization requirements for most services, effective November 1, 2024, to streamline access.
- Implementation of post-payment audit processes to ensure accountability without delaying care.
- Simplification of the provider enrollment process to encourage new providers to join the 1915i network.

Acre shared that enrollment had increased rapidly, doubling to over 700 clients in the last quarter, highlighting significant growth and increased access to behavioral health services. Until a new point of contact for the 1915i program is named, it was recommended to use the general 1915i program group email for inquiries until further updates are provided.

Institution for Mental Disease and the Managed Care in Lieu of Authority (PPT slides provided)

Sarah Aker provided information on the topic of Institutions for Mental Disease (IMD) and the Managed Care in Lieu of Authority. Key points included:

- **Definition and Regulations**: Aker explained that IMDs are facilities with more than 16 beds that primarily provide care for individuals with mental health or substance use disorders. Federal financial participation for Medicaid services at these facilities is restricted for individuals under 65 unless for inpatient psychiatric services for individuals under 21.
- **Current Payment Practices**: The presentation detailed how North Dakota manages payments for Medicaid services, including the process of suspending eligibility during IMD stays, affecting both fee-for-service and managed care models.
- **Managed Care In Lieu of Authority**: Aker discussed the option under Medicaid to use managed care plans for providing certain alternative services. She highlighted the benefits and limitations, such as the 15-day limit on stays and the potential impact on Medicaid expansion populations.
- **Challenges and Considerations**: The session included insights into how this authority could address current payment gaps but also raised concerns about its applicability, especially given the average length of stays for treatment being around 45 days, far exceeding the 15-day limit.

Aker responded to several questions including:

- **Extension of Stay Payments**: Aker clarified that service authorization payments for Prairie St. John's could extend past 14 days if a transfer to the state hospital is planned and delayed. In such cases, payments continue until the transfer is completed.
- **Funding for Extended Stays**: Payment for stays longer than 14 days requires specific conditions, such as approval for a transfer, and cannot generally use other funding like the SUV voucher to supplement Medicaid payments during those stays.
- **"In Lieu of" Authority**: The "in lieu of" option could be used to provide managed care alternatives, but it has limitations, notably the **15-day cap** on stays. Aker noted that this option could create differences in service access between Medicaid expansion members and traditional Medicaid members, potentially influencing provider choices.
- **Federal Guidance and Limitations**: Aker emphasized that solutions beyond waivers or the "in lieu of" option require changes to the **Social Security Act**, which restricts payments for IMD services. She mentioned that CMS's role is limited, and substantial changes would require congressional action.
- **CMS's Solutions**: CMS has provided options like the **30-day state plan amendment** and 1115 waivers, but these have not yielded consistently strong outcomes across states. Aker mentioned that initial results were mixed and noted that COVID-19 affected outcome reliability.

- **Unintended Consequences**: Aker expressed concern about potential disparities between populations eligible for managed care (Medicaid expansion members) and those using fee-for-service Medicaid, which might lead to shifts in providers' willingness to serve certain groups.
- **Inpatient vs. Residential Care**: Aker acknowledged that there has been some discussion at the federal level about differentiating between inpatient and residential settings. She noted that the burden falls on states to demonstrate that a residential setting is community-based, which complicates policy definitions and funding.

Panel Discussion

A panel comprised of representatives of provider organizations of Dave Marion, Business Development Director of Prairie Recovery, Kurt Snyder, Executive Director of Heartview Foundation, and Jeremy Traen, President/CEO of ShareHouse provided information and insights, and shared field examples of challenges and needs related to serving clients.

- **Advocacy for Flexibility**: Marion advocated increased flexibility in Medicaid policies, suggesting that states should be allowed more leeway to use federal funds for IMD services. He stressed that without such flexibility, states face significant hurdles in providing comprehensive care for individuals with serious mental health and substance use disorders.
- **Impact on Service Providers**: Kurt Snyder emphasized the operational difficulties that service providers experienced due to the IMD exclusion. He explained that suspension of Medicaid eligibility for patients during their stay at IMDs complicates continuity of care and burdens both patients and providers.
- **Recommendations for Waiver Utilization**: Snyder recommended that North Dakota explore the use of 1115 waivers more extensively to mitigate some of these challenges. He noted that while the waivers have limitations, they could offer a pathway to support care for individuals in IMDs, especially when services extend beyond short-term stays.
- **Concerns about "In Lieu of" Authority**: He also expressed caution about relying solely on the managed care "in lieu of" authority due to its 15-day stay limitation. This constraint, he argued, does not align with the typical duration needed for effective residential treatment, which often exceeds this period.
- **Financial and Administrative Concerns**: Jeremy Traen focused on the financial and administrative implications of the IMD exclusion. He pointed out the strain on funding mechanisms and the need for innovative approaches to ensure financial sustainability.
- **Coordination of Services**: Traen suggested that better coordination between state and federal resources could help bridge gaps created by the IMD exclusion. He mentioned that while some states have successfully used combinations of state funding and Medicaid waivers to extend coverage, this requires careful planning and robust state-level advocacy.

- **Outcome Monitoring**: He recommended implementing strong outcome monitoring if waiver programs were expanded or adopted. This would ensure that the programs meet intended goals, such as reducing emergency department use and improving treatment outcomes.

Recommendations and Next Steps:

- The panel collectively recommended that North Dakota should consider applying for or expanding existing 1115 waivers to address the IMD payment issue while ensuring coverage continuity for patients needing long-term care. Advocacy at both state and federal levels was deemed necessary to push for policy changes that could provide more funding flexibility and bridge existing gaps. Strengthening coordination between state and service providers and establishing rigorous monitoring frameworks were suggested to support the sustainable implementation of waivers and alternative payment structures.

The discussion underscored the complexity of the IMD waiver issue and highlighted the importance of pursuing multifaceted strategies to enhance behavioral health service delivery in North Dakota. Plans were made for the providers to have further discussion with Ms. Aker on the various items and she offered to join the BHPC again to share further information.

DHHS BEHAVIORAL HEALTH DIVISION UPDATES & RELATED DISCUSSIONS

System of Care Grant Update (PPT slides provided)

Katie Houle, Clinical Administrator at DHHS, discussed the ongoing System of Care (SOC) Grant activities aimed at supporting children and families in need of behavioral health services. Key points included:

- Expanding family peer support services within the SOC framework.
- Addressing service delivery gaps in rural and underserved areas.
- Integrating care coordination efforts for youth with serious emotional disturbances She also reviewed the recent granting process in each area of service. They recently awarded eight grantees in each region and three that will be provided in both regions. Houle emphasized the importance of community partnerships in achieving SOC objectives and welcomed Council feedback on expanding family-centered care practices.

NDPMHCA (PPT slides provided)

Sara Kapp explained that the PMHCA grant is designed to enhance pediatric mental health services by improving the integration of primary and behavioral health care for children and adolescents. The goal of the program is to strengthen the support available to primary care providers who manage mental health needs in younger populations. One of the primary successes of the grant has been in providing training programs for primary care providers. These sessions focus on identifying and managing mental health conditions such as anxiety, depression, and behavioral disorders in pediatric patients. The grant has facilitated the development of added resources that assist primary care clinics in managing pediatric mental health cases effectively. This includes access to consultation and collaborative care models that allow healthcare providers to consult

with child psychiatrists and other mental health specialists. The grant has fostered stronger collaborations within the medical community, enabling a networked approach to mental health care for children. These efforts aim to reduce barriers to accessing specialized care and enhance the overall capacity of primary care settings to address mental health needs. A challenge noted in Kapp's report was the sustainability of grant-funded initiatives beyond the grant period. She stressed the importance of developing plans for continued funding and integration to maintain the momentum achieved through the PMHCA. Moving forward, Kapp mentioned that efforts would focus on expanding the reach of the program to more rural and underserved areas where access to pediatric mental health services remains limited. Preliminary data was shared showing that the grant has improved early identification and treatment outcomes for pediatric patients with mental health needs. She highlighted positive feedback from primary care providers who have benefited from increased support and training, leading to more confident and effective management of mental health cases in their practices.

MHBG/SUPTRS (PPT slides provided)

Shauna Eberhardt and Lacresha Graham from the DHHS Behavioral Health Division provided updates on the Mental Health Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS). Notable items included:

- MHBG initiatives aimed at expanding access to crisis services and peer support programs.
- SUPTRS funding allocations toward community recovery services and support for addiction treatment facilities.
- Status updates on contract renewals and funding disbursements to support continued service provision statewide.

Eberhardt and Graham underscored the importance of these grants for maintaining essential services and encouraged Council members to participate in discussions regarding program improvements and provider feedback.

Regional Service Expectations Discussion & CCBHC Implementation Update

Pamela Sagness, Executive Director of the Behavioral Health Division, provided an update on division initiatives, specifically Certified Community Behavioral Health Clinics (CCBHCs). The CCBHC model is designed to offer comprehensive, coordinated care for individuals needing mental health and substance use disorder treatment. The model focuses on integrating services to ensure a holistic approach to behavioral health care providing accessible and person-centered services that include crisis intervention, treatment, and support. She highlighted ongoing efforts to expand the reach of these clinics and increase their capacity to serve diverse populations, leading to improved access to services and better integration of care. All eight regions are working on this. Minot was the first to declare and be approved. Fargo and Williston have submitted. Dickinson is nearing their submission. We were reminded it is a two-to-four-year process. A significant focus has been on maintaining compliance with federal and state guidelines to secure necessary funding and support for CCBHC operations. Sagness

shared that an increase in service has been seen in every Human Service Center. As an example, there has been a 36% increase in Badlands, getting more people service and access.

With regards to an interim legislative update there will be new legislation related to behavioral health priorities, including potential policies to enhance community-based care and initiatives and budget allocations to support workforce development, crisis intervention, and community programs. Sagness also discussed interim findings on Medicaid funding improvements and encouraged Council input on priorities for the upcoming legislative session especially as it relates to "What's the right level to bring forward a proposal to say to policy makers, to government agencies, these are the services that we believe should exist in the state in every region for all ages. This would assist policymakers in having full vision and understanding what pieces may be missing and where. Sagness emphasized the importance of setting clear service expectations for different regions to ensure that residents have equitable access to quality care. She discussed the need for tailored approaches that consider the unique needs and resources of each region. There was also an acknowledgment of the challenges faced by more rural or underserved areas, where building the infrastructure for comprehensive services can be more difficult. Sagness noted that targeted efforts were being made to bridge these gaps through strategic partnerships and resource allocation. Sagness outlined several challenges in implementing the CCBHC model, including workforce shortages and the logistical complexities of expanding services to rural areas. She mentioned that recruiting and retaining qualified staff remains a significant barrier that affects service delivery. Funding sustainability was also highlighted as a key concern, with the need for ongoing advocacy to ensure state and federal support for the CCBHC model. Continued collaboration between state agencies, local service providers, and community stakeholders will be needed to support the expansion and effectiveness of CCBHCs. Enhancing the tracking of patient outcomes and service delivery metrics to demonstrate the value of the CCBHC model will be needed with this data helping to support future funding requests and program adjustments. Addressing workforce shortages through training programs and incentives was recommended as a critical step to ensure the sustainability of regional services.

Sagness agreed to bring this conversation back to the BHPC at the December meeting, to discuss what we think is foundational, to share what is in the current budget before the legislature, and the bills legislators are planning to bring forward.

Public Comments

Chair Davis invited public comments; none were provided.

Adjournment

A MOTION TO ADJOURN THE MEETING WAS MADE BY CARLOTTA MCCLEARY AND A SECOND BY MATTHEW MCCLEARY passed unanimously. The meeting was adjourned at 4:00 PM CT. The group will next convene on December 11, 2024.

Respectfully submitted by Janell Regimbal, facilitator of Insight to Solutions