INVESTING IN IDAHO YOUTH MENTAL HEALTH:

Our Current Broken Systems and Direct Strategies To Improve

AUTHORED BY

Rachel Blanton, MHA • Caroline Messerschmidt, MPH, RD • Elise Winbrock, MPH
Ashley Anderson, BS • Monica Mispreta, PhD

SUPPORTED BY

Blue Cross of Idaho | Foundation for Health, Inc.

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EXECUTIVE SUMMARY

PURPOSE:
This paper was developed to highlight actionable opportunities for significantly improving access to and quality of mental health care for youth in Idaho.

METHODS:
The development team conducted over 250 hours of interviews with stakeholders across the state in the areas of clinical care, education, policy, payors, and more. These key stakeholder interviews were complemented by extensive quantitative data analysis and reporting. Detailed reports are available upon request.

RECOMMENDATIONS:
Based on this information discovery and synthesis, the following recommendations have been determined.

1. Enhance reimbursement for masters-level clinicians with an emphasis on Medicaid
2. Decrease burden of paperwork for Medicaid clients and providers
3. Specifically bolster capacity for care in rural communities across the state
4. Significantly increase the funding for schools to implement evidence-based prevention resources and support coordination of services for students
5. Create a state level interagency workgroup to coordinate and communicate changes to youth mental health services between Medicaid, Division of Behavioral Health, Youth Corrections, State Board of Education, Division of Public Health, etc.

INTRODUCTION

There is a youth behavioral health crisis (American Psychological Association, 2023). This is not a new statement or observation. **Children and youth, their families, and their communities are struggling and dying because there is not a system in place to meet their needs related to behavioral health.** Idaho is no exception to this trend and, in fact, represents an even more extreme manifestation of the alarming trends at the national level. Over the past 20 years, Idaho has consistently ranked at or near the bottom of 50 states for youth mental health. In 2022, Idaho ranked last (Mental Health America, 2022).

This paper should be considered a review of conditions in Idaho. While some details are in flux given the political, economic, and healthcare environment, the paper's main points remain valid. They are part of an evolving and complex ecosystem of services. As such, Blue Cross of Idaho Foundation for Health welcomes discussion, collaboration, and updates to the content. These updates provide opportunities to improve youth mental health.

BACKGROUND

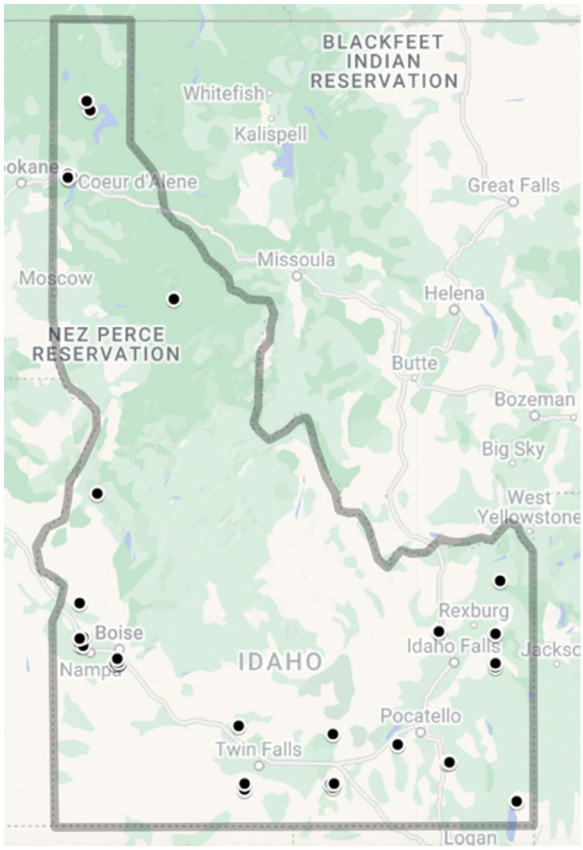
YOUTH MENTAL HEALTH

Youth mental health conditions such as depression, anxiety, and behavioral disorders are among the leading causes of illness and disability in adolescents. While many cases go unrecognized, the World Health Organization estimates that 1 in 7 (14%) of 10 to 19-year-olds experience mental health conditions (WHO, 2021). Unfortunately, the number experiencing mental health conditions continues to increase. Over the past two decades the Disability Adjusted Life Years (DALYs) due to mental health disorders have increased from 80.8 million in 1990 to 125.3 million in 2019 (Ferrari et al., 2022). Further, the proportion of DALYs attributed to mental health disorders has also increased from 3.1 to 4.9 (Ferrari et al., 2022). Estimates suggest people with a mental health disorder have a reduced life expectancy of 10 years (Ripoll et al., 2022).

Among high school students, there has been an increase in mental health disorders and the COVID-19 pandemic only worsened this trend. In December 2021, U.S. Surgeon General Vivek Murthy issued an advisory about youth mental health, saying the pandemic accelerated and exacerbated existing mental health struggles for children whose daily lives were upended by school closures and social isolation. In 2021, 4 in 10 (42%) high school students felt persistently sad or hopeless, a dramatic increase over the last 10 years, up from 28% in 2011. Among females, the data is even more dire, with nearly 60% reporting feeling sad or hopeless (YRBS). In 2021, 41% of female and 18% of male high school students reported having poor mental health (YRBS). Far too many high schoolers have thought about suicide, often an indicator of trauma and mental health conditions. In 2021, 30% of females and 14% of male high schoolers seriously considered suicide, and overall, 18% made a plan for how they would attempt suicide (YRBS). Data for emergency department visits for self-harm further demonstrates the disparity and higher risk among girls and young women, with the rate of emergency

department visits nearly double that of young boys and men (females: 514.4 vs. males: 200.5 per 100,000) (CDC). With suicide on the minds of many youth and 10% attempting suicide, death from suicide is a harsh reality. Overall, youth deaths account for 15% of all suicides (CDC WISQARS). Suicide is the second leading cause of death for youth aged 10-24, accounting for 7,126 deaths in the US in 2021. Like the rise in mental health conditions, the rate of suicide deaths has increased, with a 52.2% increase from 2000 to 2021 among youth aged 10-24 (CDC). Tragically, this means that almost every community in Idaho has been directly impacted by youth suicide (Figure 1).

Figure 1. Idaho Resident Suicide Deaths Age 15-17 (2019-2021)



> *If there was a disease in the Treasure Valley that has taken 7 teens in the last few weeks, we would desperately want to know about it to protect our own children.*
>
> **BOISE SCHOOL DISTRICT PARENT, 2023**

IDAHO DATA

The prevalence of mental health conditions in Idaho is close to the national average, however suicide rates are much higher, possibly due to the rural nature of the state. In 2021, 20.7% of adolescents aged 12-17 reported having a major depressive episode in the past year (US: 20.1%; NSDUH, 2021), 12.6% of youth aged 3-17 had anxiety or depression (U.S.: 11.8%; NSCH,2020), and 8.5% of 12-17-year-olds were diagnosed with a substance use disorder (U.S.: 8.6%; NSDUH). Fewer Idaho high schoolers reported seriously considering suicide than students across the US, 21.3% vs 22.2%. However, more Idaho high school students made a plan about how they would attempt suicide, 19.7% vs 17.6%. Additionally, more Idaho youth attempted suicide than youth nationally (10.9% vs. 10.2%) and more attempts resulted in injuries that needed to be treated by a doctor or nurse (3.4% vs 2.9%) (YRBS, 2021). In rural communities, there is a higher risk of suicide with nearly twice as many suicides in the most rural counties compared to urban areas (Mack et al., 2022). Data suggests that the rural-urban disparities in suicide rates are increasing over time. From 2000 to 2020, the rate of suicide in rural counties increased 46% in non-metro areas compared to 27% in metro areas (CDC). In Idaho, 35 of 44 counties are rural, thus the impact of suicide reaches all areas of the state. In 2021, Idaho had a suicide death rate of 20.5 per 100,000 population, ranking it twelfth among all 50 states (US rate: 14.1 ,CDC, 2021). Over the last decade (2007-2009 to 2016-2018), the rate of suicide deaths among youth ages 10-24 has increased 47.1% on average nationally and 55% in Idaho (CDC). Nationally, the suicide rate in 2020 was 10.49 per 100,000 for youth ages 10-24 as compared to 18.16 in Idaho. However, rates substantially differ when looking at smaller age ranges. When comparing Idaho junior high to high school students, suicide rates are more than double the rates among high school students. For youth ages 10-14, the rate per 100,000 is 7.1 vs. youth aged 15-17 the rate per 100,000 is 16.5 (DHW vital statistics). Among Idaho youth ages 15-19, suicide Is the second most frequent cause of death (CDC WISQARS).

Trends in Idaho Medicaid data also show a substantial increase in mental health diagnoses among youth over time. This is particularly pronounced through 2018-2021 (see Figure 2, Figure 3). At the same time, services have not increased at a matched rate. This would suggest the system has not kept pace with the rapid rise in demand for services in the state. Thus, one can assume children are going untreated in the state (full Medicaid data set available by request).

Figure 2. Behavioral Health Services utilized for youth experiencing mental health disorder (2018-2021)

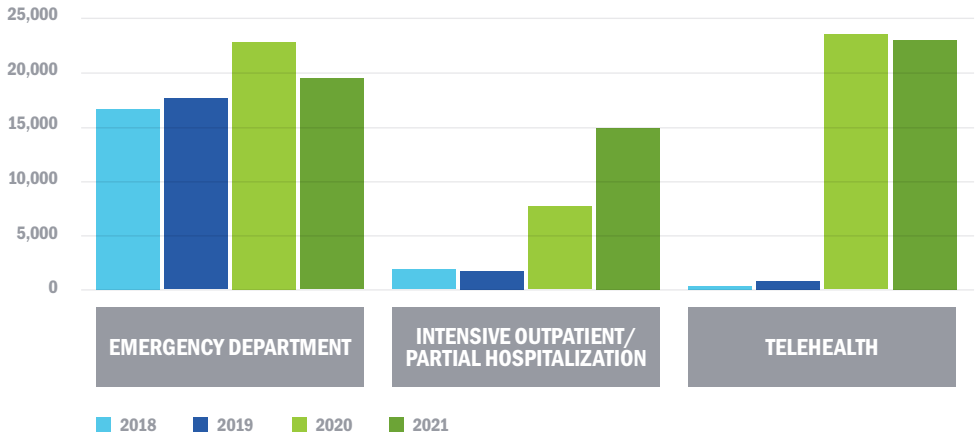
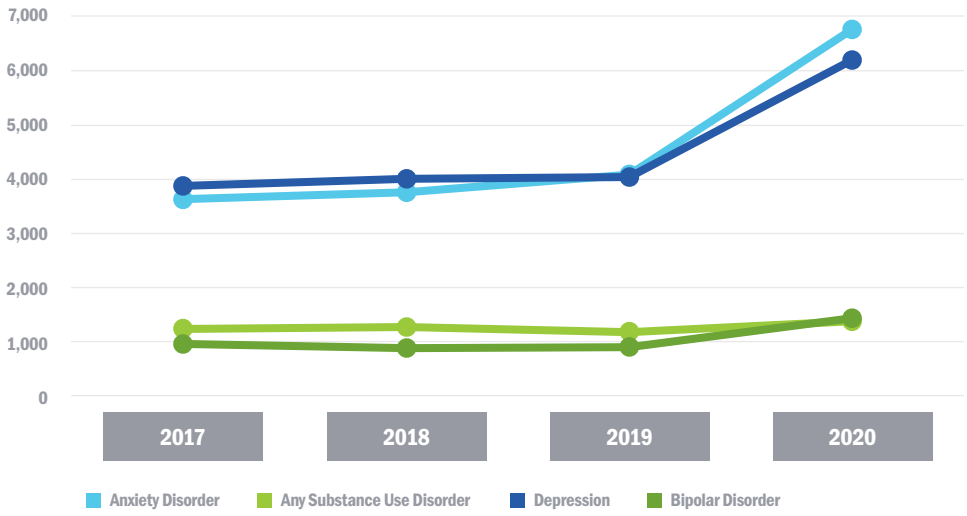


Figure 3. Idaho Youth Medicaid Beneficiaries Diagnoses by Year (2017-2020)



MENTAL HEALTH DISPARITIES

While the burden of mental health conditions reaches all portions of the globe, populations who have historically been marginalized are disproportionately affected. Youth experiencing poverty, food insecurity, exposure to violence, racism, and discrimination are at increased risk for depression, trauma-related disorders, aggressive and disruptive behaviors, anxiety, substance use, and eating disorders. For example, among American Indian/Alaska Native teens, a historically marginalized group, the rate of suicide is three times higher than that of white teens (38.9 vs. 12.7 per 100,000) (CDC Wonder). Further, people experiencing poverty are more likely to experience mental health conditions and negative outcomes. Youth who are unhoused report higher rates of depression and are 2-3 times more likely to misuse alcohol and other substances than their peers (Grant, 2022). Additionally, they are at higher risk for suicide, with 29.1% of unhoused youth reporting self-injury (Barnes, 2018).

Over the past twenty years, there has been growing interest in understanding what role childhood risk behaviors play in predicting the leading causes of death. In exploring behaviors in childhood, a relationship was found between more exposures to childhood emotional, physical, or sexual abuse and household dysfunction, known as Adverse Childhood Experiences (ACEs), and the leading causes of death among adults (Felitti, 1998). Research suggests five of the top ten leading causes of death are associated with ACEs (CDC). It has been estimated that youth who have four or more ACEs have a four to twelve times increased risk of developing substance use disorders, depression, and attempting suicide, compared to those who have experienced none (Harris et al., 2020). Nationally, 17.2% of youth have experienced two or more ACEs, compared to Idaho's 18.7% (NSCH, 2021). Physical abuse, in the form of sexual violence, was reported in 25% of Idaho high school girls, higher than the national average of 18% (YRBS, 2021). Another ACE is household dysfunction, which includes substance use or mental illness. More Idaho children live with someone who is mentally ill, suicidal, or severely depressed than their peers nationally, 12.1% vs. 8% (NSCH, 2021). Additionally, more Idaho children live with someone who has had a problem with alcohol or drugs (ID: 9.8%, US: 8.2%) (NSCH, 2021). This data underscores the impact social determinants of health and ACEs have on adolescents' mental health outcomes and the disparities that exist for many Idaho youth. It also provides evidence for the risk factors to address for prevention (Harris et al., 2020).

100%
OF THE STATE IS CONSIDERED A BEHAVIORAL HEALTH PROVIDER SHORTAGE AREA

ACCESS TO CARE

Across the US, there is a shortage of mental health professionals (HRSA map). This shortage is likely to be more apparent in rural areas, which account for the majority (two-thirds) of the mental health professional shortage areas (Mack et al., 2022). For example, in a rural state like Wyoming, 96.4 percent of residents live in a mental health professional shortage area versus an urban state like New Jersey, where only 0.4 percent of residents lack adequate mental health providers (Mack et al., 2022). Similar to Wyoming, 100% of the state of Idaho is designated as a mental health professional shortage area (DHW). In Idaho, 30.4% of the need for mental health professionals is met as compared to 27.4% in the US (HRSA, 2023). In further exploration of the data, 52.5% of Idaho youth aged 12-17 who have depression did not receive any care in the past year (National Alliance on Mental Illness, 2021). A recent survey of caregivers in Idaho found that many caregivers find it challenging to find care. Nearly 3 out of 10 caregivers (29%) indicated they could not easily access the mental health services their child or youth needs (YES). With access to care being limited across the state, finding innovative solutions to increase access to mental health resources is vital to reducing morbidity and mortality and improving health outcomes.

EARLY INTERVENTION MATTERS

Early intervention is critical to ensuring youth have every opportunity to thrive and develop into fully functioning adults. When left untreated, mental health disorders can negatively impact society and the economy in various ways. In the short term, educational outcomes are worse, which has been connected to increased risk for substance use, higher dropout rates, and higher rates of unemployment (NSDUH, 2021, Dupere, 2022). The impact of untreated mental illness can carry into adulthood with higher rates of incarceration, homelessness, and premature death. The rise in mental health diagnoses has also increased the number of individuals on Social Security Disability Insurance. Individuals with a mental health disorder diagnosis now account for 29% of all cases. While this safety net is necessary, earlier treatment can reduce the number of individuals relying on this resource and improve one's overall ability to fully contribute to society (White House, 2022). Further, the impact of untreated mental health can be passed on to the next generation. One in 14 children has a parent with poor mental health (NSCH, 2018). Children with parents who have poor mental health are more likely to have poor general health, increased exposure to ACEs, and mental, emotional, or developmental disabilities (Wolicki et al, 2021). Intervening early can both improve outcomes for the individual and positively impact the lives of generations to come.

WHAT IS IDAHO DOING?

Prompted by the Jeff D. Settlement that was reached in 2015, Idaho has made some major progress in addressing youth mental health over the last decade. Recently, there has been a renewed commitment to improve mental health in Idaho with Governor Brad Little's allocation of $50 million to expand behavioral health resources. Using funding and recommendations from the Idaho Behavioral Health Council, improvements are starting to take shape. Idaho state agencies and community organizations have been working together to establish a better system of care that includes the following:

1. **Development of the YES (Youth Empowerment Services) Program:**
   The Jeff D lawsuit was initially filed in 1980 against the Governor, the Idaho Department of Health and Welfare, the Idaho Department of Juvenile Corrections, and Idaho State Department of Education for failure to adequately treat children with severe emotional disturbance (SED). In the 1980s when the lawsuit first began, youth with SED, including Jeff D, were often placed alongside adults at the state hospital and then incarcerated for criminal behavior. The lawsuit drew attention to the lack of state treatment and community-based support to treat youth mental health, and the need to improve how youth mental health is treated in Idaho. The settlement agreement requires Idaho and the above agencies to overhaul the treatment of youth mental health. To be more effective, services changed to include a more collaborative approach to care across agencies and to incorporate families as part of the care team. Therefore, the YES Program was established in Idaho as part of the mental health system to aid children with SED, both at home and in the community. It incorporates a family-centered approach to care to identify the strengths of the child and family to better support their needs. Through collaboration with agencies and the family, youth with mental health needs are identified as early as possible to ensure they are linked to the services they need no matter which agency is their starting point. Additionally, there is an increased focus on making more community-based services available to address the unique needs of children and their families. Treatment plans and services have shifted to be more outcome-based. The agreement also includes a commitment to policy development to improve care.

2. **Establishing Youth Crisis Centers and Assessment Centers:**
   Crisis centers are a quick and easy way for youth experiencing a crisis due to serious mental illness or substance use disorder to quickly get help when they need it. The operating and planned crisis centers will be open every day of the year and provide services from mental health professionals. Youth will be able to stay at the center for 23 hours and 59 minutes. While at the center, youth will be given time to stabilize, develop a plan of care, and will be provided with other services such as medical assessment, community-based referrals, and access to the 24-hour crisis hotline. These centers have been shown to reduce hospitalization, criminal charges, domestic violence, child abuse, and the need for residential treatment among those served (IDJC). These centers are funded by a one-time $4.42 million general fund appropriation (now under the purview of IDHW).

Crisis Center Sites

- RISE UP Teen & Child Crisis Center of East Idaho - Idaho Falls
- ProActive Youth & Family Support Center - Twin Falls
- Pathways Youth Community Support Center - Boise
- Western Idaho Youth Support Center - Nampa

The assessment centers are complementary to the crisis centers and are designed to serve as a place to triage a variety of needs for children, ranging from basic supports (housing, food, transportation, etc.); to mental healthcare; to social concerns and resources. These centers are based on a national model with demonstrated efficacy in reducing trauma, criminal charges, hospitalization, expulsions, and family separation (NAC). One of the primary goals of the assessment centers is to promote diversion from law enforcement and Family and Community Services (FACS) involvement, thus are typically characterized by more law enforcement and youth corrections association as compared to the crisis centers. These centers are also funded by a time-limited appropriation with supplemental support provided in FY24 (IDJC). Current funding emphasizes access in rural communities across the state.

Assessment Center Sites

- Children's Village - Coeur D'Alene
- LC Valley Youth Resource Center - Lewiston
- YouthROC - Caldwell
- The Bridge Youth and Family Resource Center - Boise
- Twin Falls Youth Service Center - Twin Falls
- Simply Hope Safe Teen Assessment Center - Burley
- The Village County Assessment Center - Pocatello
- Safety Prevention and Resource Center - Idaho Falls

3. **Opening the Idaho Youth Ranch Residential Center for Healing and Resilience:** Recently opened in July 2023, in Caldwell, ID, this adolescent psychiatric residential treatment center has 64 beds and the ability to serve 100 kids a year. With no in-state option previously available for Idaho families on Medicaid, this center will reduce the burden on families to get the care they need. The facility offers youth 24-hour nursing and psychiatric care using proven therapeutic models. Additionally, the center offers year-round school, individual and group therapy, indoor and outdoor recreation areas, a health center, and aftercare for children and their families. The center is designed to support the whole child including the physical, educational, and emotional needs of the children and teens who live there (Idaho Youth Ranch).

FINDINGS

> *"I want to be clear that our division [pediatric behavioral health] does not make money for the hospital. Outpatient mental health ultimately saves the system money in the long run as a prevention measure."*
>
> **MENTAL HEALTH CLINICAL DIRECTOR**

The research team conducted an extensive review of existing data, special data review requests, and key informant interviews to identify current gaps, resources, and opportunities in the youth behavioral health landscape in Idaho. While this is by no means exhaustive, it is meant to highlight the most salient and critical issues that impact schools, clinicians, families, communities, corrections, public health, and other sectors. Findings have been grouped by primary theme and implication/recommendation.

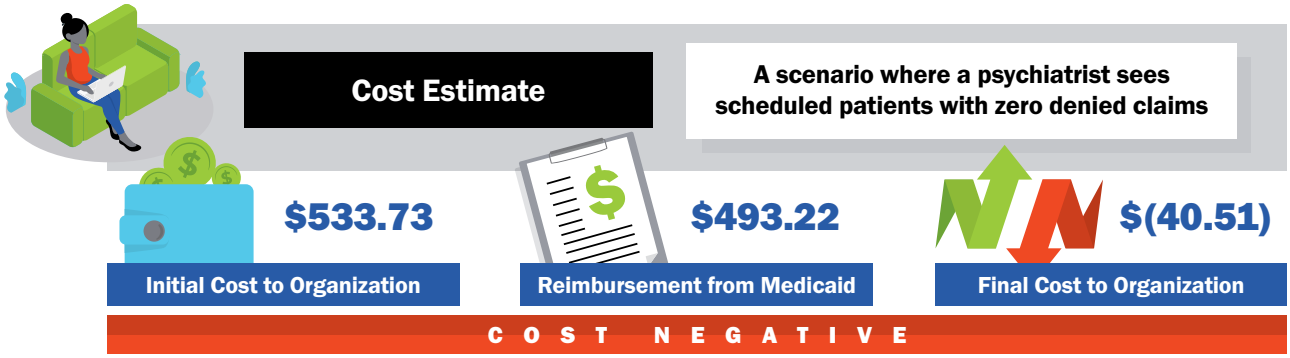
1. ENHANCE REIMBURSEMENT FOR MASTERS-LEVEL CLINICIANS WITH AN EMPHASIS ON MEDICAID

The limited Medicaid reimbursement combined with the burden of paperwork (CANS assessment and documentation) creates a system in which there is very little incentive for providers to accept Medicaid. Given that 36% of children in Idaho are covered by Medicaid, this results in a massive availability gap for clinical services. If Medicaid were able to set rates at a higher reimbursement level (particularly for masters level clinicians) this would create the conditions for more children to receive much needed clinical care.

Among all clinicians interviewed for the purposes of this paper, the single leading issue driving low access to care for youth in Idaho was low reimbursement by Medicaid. Whether private for profit, private nonprofit, community health center, integrated setting, or other, all agencies reported that they were limited by the Medicaid fee schedule and that often they were losing money by accepting Medicaid clients.

The math is simple and consistently in the red for all types of mental health providers. If a clinical social worker makes an average of $42 per hour plus 38% fringe and benefits, the hourly cost for clinical services is approximately $58 per hour just for the direct personnel time. This does not include administrative costs, paperwork, technology, scheduling or care coordination, billing services, office space lease, etc. Therefore, the total hourly expense with these additional costs included is closer to $75 per hour if one considers all the supports needed to deliver services beyond a simple hourly wage (fringe benefits, office costs, billing software, etc). Thus, on these costs for an 8-hour day in which a clinician sees 9 of 13 scheduled patients (due to no-shows) and completes paperwork, patients would cost an organization just below $679. This is compared to the $602 in revenue from Medicaid. As a result, costs are not covered. This is not to say that every day is a money-losing day, but the margins are so tight that for many clinicians and agencies, it is not worth the risk. The same is true for LPCs, LMFTs, psychiatrists, and PsyDs (see Figure 4).

Figure 4. Financial Feasibility Sample *(See Medicaid reimbursement model in Appendix)*



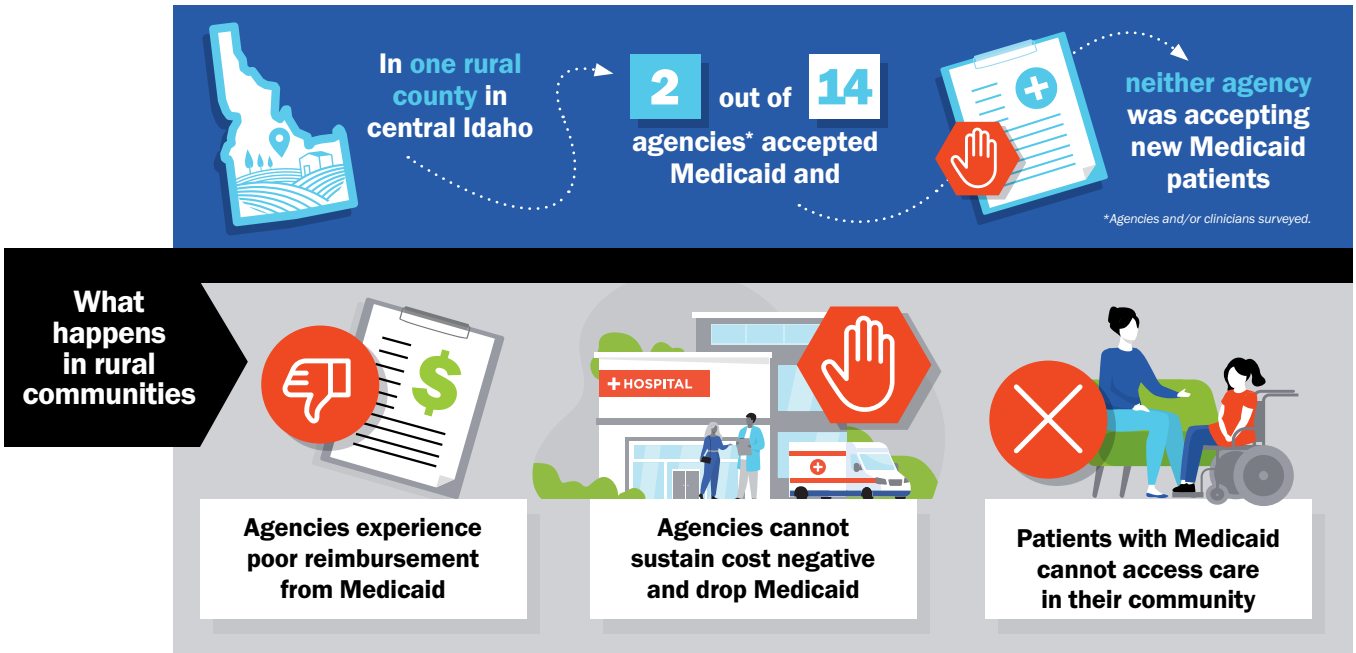
The result has been a mass exodus of clinicians from agencies that take Medicaid and agencies accepting Medicaid. In one rural county in central Idaho, out of 13 agencies and/or clinicians surveyed, only two accepted Medicaid and neither of these were accepting new patients. Therefore, there is **no capacity in this county for families and children seeking services.** Unfortunately, this is not an extreme example. This is not aided by the limitations on types of providers who can bill Medicaid for a variety of encounter types (Table 1), resulting in less available clinical workforce to serve children in Idaho.

TABLE 1		BILLABLE UNDER ID MEDICAID				
CPT Code	Definition	Psychiatrist	PsyD	LCSW	LPC	LMFT
90791	Psychiatric Diagnosis Evaluation Without Medical Services	X	X	X	X	X
90792	Psychiatric Diagnosis Evaluation With Medical Services	X	1	1	1	1
90832	Psychotherapy, 30 Minutes	X	X	X	1	1
90846	Family or Couples Psychotherapy With/Without Patient	X	X	X	X	X

An "x" indicates billable. A "1" indicates allowable at a community behavioral health organization. There is no standard definition for a community behavioral health organization, however they are typically described as organizations that provide behavioral health services to underserved communities.

Rural communities are hit particularly hard by low reimbursement as they lack the presence and scale of larger hospital systems that can offset the cost of accepting Medicaid (Figure 5). There are more private, small agencies in rural areas and as they opt out of accepting Medicaid, children and their families lose access. This is supported by data at the national level showing worse mental health outcomes for children in rural areas, largely driven by issues in access to care (Morales, 2020).

Figure 5. Rural Access to Care



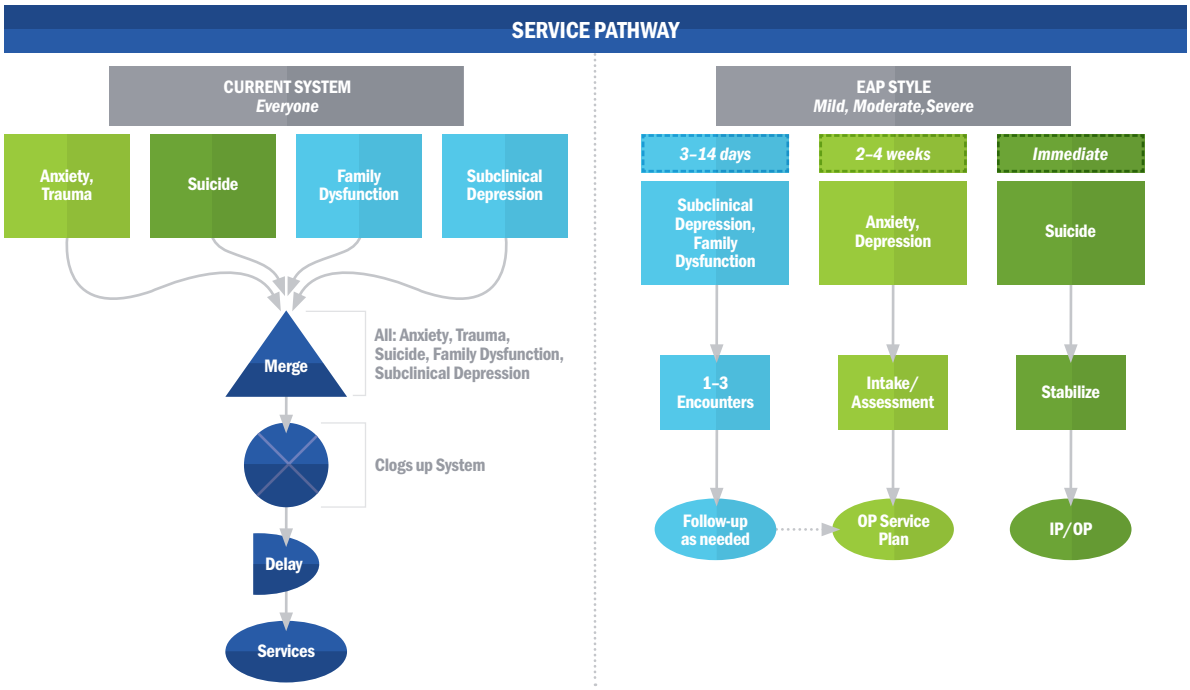
RELATED ISSUES:

- **Prevalence of High-Deductible Plans in Rural Areas:** Idaho's population has proportionally more community members covered by nongroup/"Exchange" plans as compared to the national average (8.7% vs. 6.2%). This coverage plan is more common in rural areas where large, employer-sponsored plans are less prevalent. Almost exclusively, the "cheaper" plans are high-deductible, meaning that they function as emergency plans as routine care is still prohibitively expensive. Unfortunately, this intersects with the fact that nearly half of families in high-deductible health plans whose members have a chronic condition face a substantial financial burden due to healthcare costs. As a result, children in Idaho are more likely to be in families who must make significant decisions between their access to behavioral health services and other family costs and resources.

- **Intersection of Healthcare Coverage and Special Healthcare Needs:** 82,235 children in Idaho (18.6% of the pediatric population) have a special healthcare need. There is little access to specialty behavioral health services trained to provide care to these children who are caught in a tension between non-specialized care in their communities and travel to more specialized care in population centers.

- **Lack of Mental Health Employee Assistance Program (EAP)-Style Options for Children and Adolescents:** As discussed in later sections, there is little diversity in the level of care and entry points for children and adolescents in the mental health system. This means that brief care for lower acuity/intensity issues is routed through the same care pathway as children with serious mental illness. The cost (time, financial, stigma) to access the care may not be worth it for many families who see some behavioral health complaints as "not that serious" or subclinical. Idaho Medicaid and commercial payers should explore opportunities to diversify service types for lower acuity behavioral health conditions to reduce the burden of accessing care (see Figure 6).

Figure 6. Current Systems vs. Alternative Access Pathways



- **Conduct a Feasibility Assessment to Optimize Codes for Billing to Medicaid:** There are a variety of types of billing codes available to states for Medicaid encounters. However, Idaho has utilized a small subset of these for payments through the previous contract with Optum Idaho. The new Idaho Medicaid contract with Magellan Health reflects an opportunity to review the open codes for modification/expansion to better reflect the current needs of beneficiaries. See Medicaid reimbursement model in Appendix.

STATE COMPARISON:

Other comparable states pay significantly more than Idaho does in both Medicare and Medicaid. Table 2 clearly demonstrates the higher rates paid in Utah and Montana. Without rate changes, Idaho will continue to lag behind in access to care as detailed above.

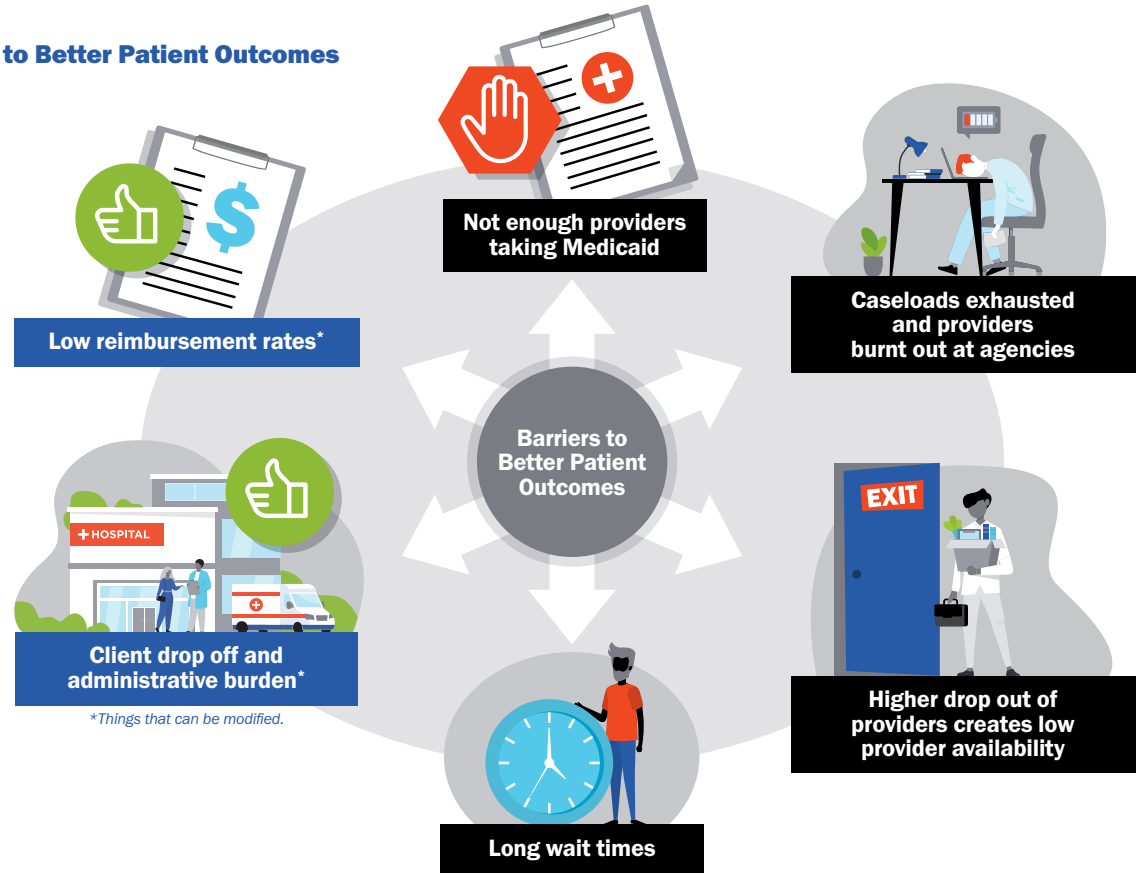
TABLE 2		MEDICARE			MEDICAID		
CPT Code	Definition	Idaho	Utah	Montana	Idaho	Utah	Montana
90791	Psychiatric Diagnosis Evaluation Without Medical Services	$168.53	$171.34	$174.78	$151.68	$165.76	$218.51
90792	Psychiatric Diagnosis Evaluation With Medical Services	$187.83	$192.06	$196.41	$169.05	$165.76	$244.69
90832	Psychotherapy, 30 Minutes	$73.03	$74.16	$75.54	$65.73	$67.95	$95.07
90846	Family or Couples Psychotherapy With/ Without Patient	$92.96	$94.36	$95.91	$83.66	$101.94	$120.02

In Idaho and Montana: Reimbursement rates are based on physician fee schedule. Rates as of 7/1/23.

In Utah: UT reimbursement fees have been multiplied to a 1-hour unit since fee schedule was listed in 15 min increments and inconsistent with other states who simply bill for 90791 or 90792 as a whole. In UT for 90846 it is shown as 45 minutes. Physicians, Psychologists, APPs, LCSW all get reimbursed at the same rate for 90791. 90792 is not billable by LCSW or psychologist. All provider types receive the same reimbursement for 90832 and 90846. Rates as of 7/1/23.

In Montana: MT Medicaid reimburses a percentage of the above depending on who provides services (physician, mid-level, allied health, mental health). Psychiatrists bill at 112% of fee. Mid-levels at 90%. MT fees are listed as office fees. Fees are different when provided at a facility. The conversion factor for physician services is $42.29. The conversion factor for allied services is $25.34. The conversion factor for mental health services is $21.69. Rates as of 1/1/23.

Figure 7. Barriers to Better Patient Outcomes



While enhanced reimbursement does not solve all the related access barriers (see Figure 7, above), it is one of the primary causal factors that causes subsequent systems issues. Thus, raising reimbursement rates is not the singular solution, but it is central to modifying the drivers of poor system function.

2. DECREASE BURDEN OF PAPERWORK FOR MEDICAID CLIENTS AND PROVIDERS

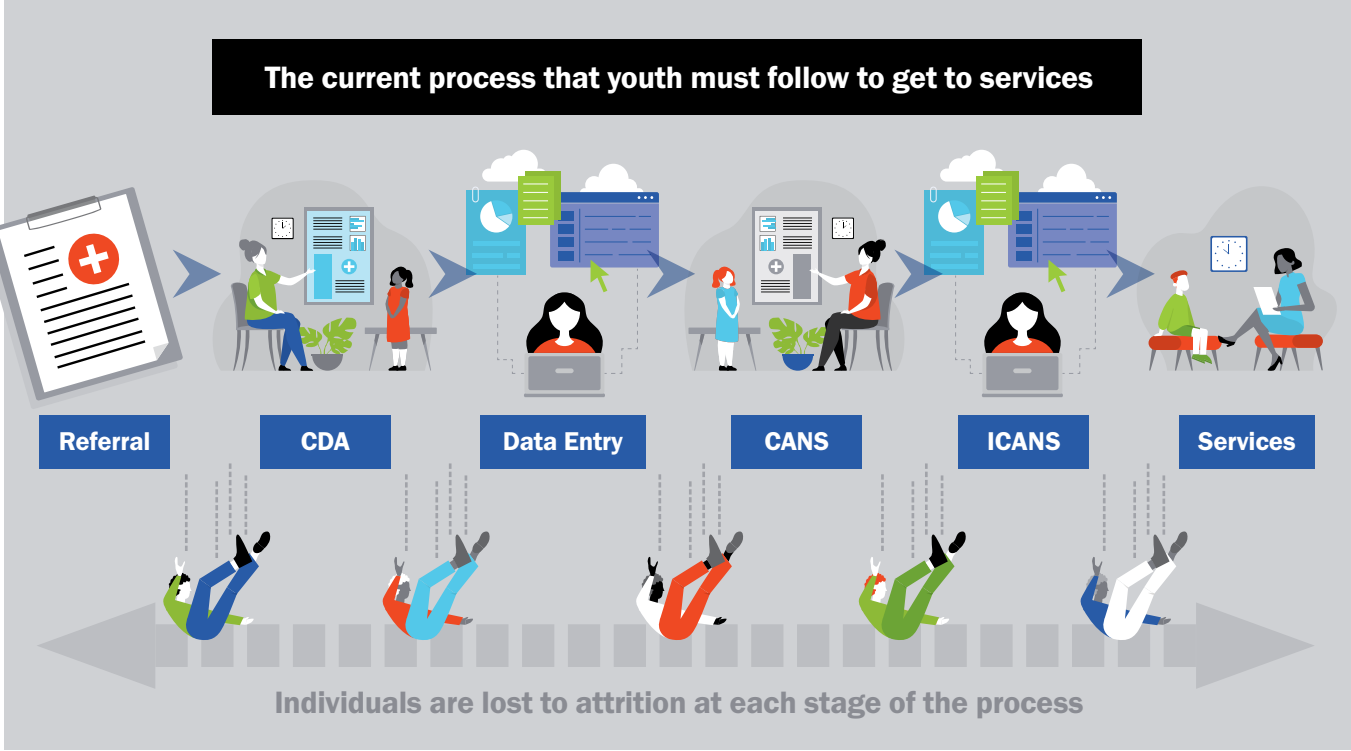
Medicaid paperwork is significantly more burdensome than that of commercial payors. While, in theory, providers are paid to complete assessments and perform relevant administrative tasks, it greatly reduces the total capacity for clinical care among those clinicians who could spend more time in treatment and assessment without such extensive paperwork. In addition, all Medicaid paperwork requires a guardian's signature. This adds another level of administrative burden to seeing Medicaid clients as the parent or guardian must take time off work or other commitments to be on site for the signature. The most significant burden is that of the Child and Adolescent Needs and Strengths (CANS) assessment. A summary of paperwork comparisons by payor is provided in Table 3 below.

TABLE 3	PAYOR PAPERWORK COMPARISONS		
	Commercially Insured	Medicaid	Self-pay
Paperwork Required	Progress note	Annual CDA (Comprehensive Diagnostic Assessment) Treatment plan 90-day review CANS	None
Reported effort (clinician interviews)	Negligible burden	5–10 hours per patient per year	Negligible burden

The CANS assessment was introduced in 2018 by the Idaho Division of Behavioral Health. It is part of the independent assessment process for Medicaid and a tool for the treatment planning process. The CANS is designed for providers to incorporate the family and main caregivers as they identify unmet needs and strengths that are unique to the child and family. The CANS explores many aspects of a child's life including strengths, life functioning, ACEs, culture, behavioral and emotional needs, risky behaviors, and transition into adulthood. Discussing these different aspects with the family ensures any resources the family needs are identified and that treatment planning is family centered.

While the CANS assessment is a highly validated and reliable instrument and is in use in other states, it is rarely used by other state systems for all new intakes and tracking of all patients. Instead, the CANS is utilized for initial screening (screener form); annual care plan updates (short form); and complex care assessment (long form). However, Idaho does not allow for any nuance or flexibility in the assessment system. **A child with mild-moderate anxiety must go through the same CANS process as a child with a history of violence and suicidal ideation.** As a result, the system gets bogged down in required assessments that would be better utilized as a targeted tool based on the intensity/severity of the behavioral health issue. Multiple providers interviewed for the purposes of this report indicated the CANS assessment system (collection, input, frequency) was prohibitively detailed and time intensive as compared to assessment and paperwork for other payers/regulatory bodies (see Figure 8). While a state workgroup is actively exploring ways to reduce the paperwork burden of the CANS, many providers indicated that the assessment needs to be a minimum of 60% shorter to be more tenable. The state is also working on sharing information about how to use the CANS assessment as it is not intended that every question is answered. The assessment is a summary of the information the provider already knows about the client and family. The average time to enter the information into ICANS for the CANS assessment is approximately 15-45 minutes, however, it does not sync within many provider Electronic Health Records. **This creates a system duplication for data entry and billing duplication and ends up costing the state more to monitor a system of paperwork instead of delivering care.**

Figure 8. Medicaid Services Documentation Pathway



> *"It is like having to go through a full head-to-toe physical and bloodwork because you have a sore throat."*
>
> **KEY INFORMANT INTERVIEWEE**

State leaders have two options for reducing this burden and the resulting barriers to care. First, the CANS could become a tool in the toolbox for assessment but be removed as the single-entry point for all children and families. If, however, this is not an option, a second pathway would be to significantly revise the use of CANS. These revision recommendations include:

1. Eliminate the 100-day entry limit for ICANS
2. Reduce frequency of CANS completion
3. Allow for screener and short form depending on intensity and acuity of presentation
4. Allow for flexibility in completion timeframes to facilitate relationship development and nuanced assessment windows
5. Increase training opportunities for incorporating ICANS into the intake process

RELATED ISSUES:

Idaho Medical Care Consent Laws: Parental participation in the intake is mandated for all children. No one who was interviewed suggested parents/caregivers should be barred from the intake, but many stakeholders identified mandatory participation, especially for older children, as a major barrier. Parents should be able to make the choice that access to care within the week is more important for their child as opposed to when the parent can get time from work in three months. While parental/caregiver input in assessment is extremely important, it should be emphasized, not required. When parents/caregivers must attend all intake sessions, it can create a barrier for families with working adults or those without transportation. This is even more of an issue for children who are unaccompanied or have incarcerated caregivers. Often, these are the kids who need the most support from the behavioral health system but cannot access support due to administrative red tape.

School vs. Medical vs. Behavioral Systems of Support and Documentation: Children and families with more moderate to severe conditions are interfacing with a variety of agencies designed to support their care needs. These include schools, Medicaid, IDHW, etc. However, even the professionals in these settings admit confusion over the role, scope, and activities that are within the borders of each service. This means that families are also confused about paperwork requirements, consent, and signatures and are likely having to repeat their history multiple times. When systems aren't talking on the backend or sharing data when they are able, the burden is on individual families and schools.

WHAT OTHER STATES ARE DOING:

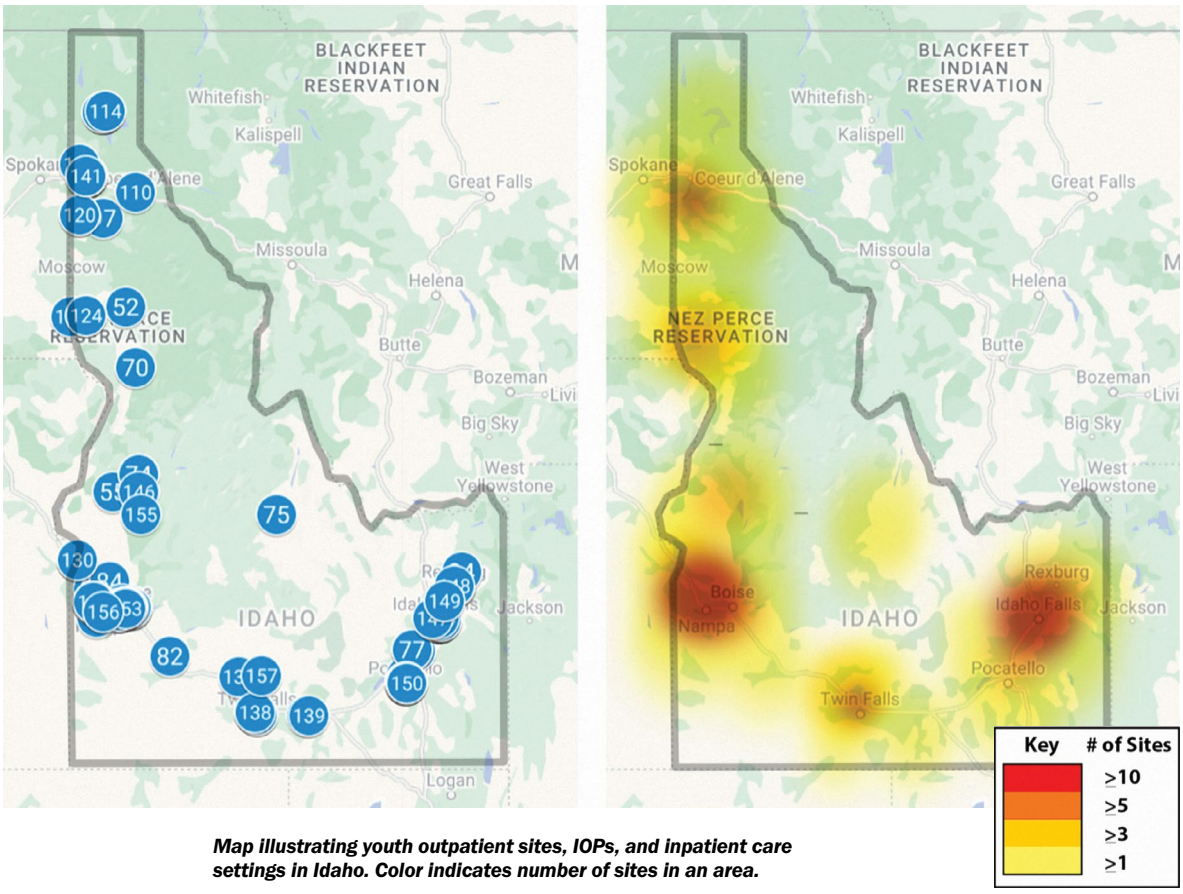
The burden of the CANS assessment is particularly profound when compared with other similar states. As noted in Table 4, Idaho lacks flexibility in staff, length, and period of administration when compared to peer systems.

TABLE 4	STATE BY STATE COMPARISON OF KEY CANS ELEMENTS					
CANS Element	Idaho	Utah	Wyoming	Nevada	Montana	Oregon
Required for all new patients prior to session	Yes	No	No	Yes	No	No
Number of Questions	120	64	60	120	60-120	60-120
Therapist required for administration	Yes — Therapist	No — Self-adminis-tered (parent or screener)	No — Family care coordinator (non-therapist)	No — Trained support staff	No — Trained support staff	No — Trained support staff

3. SPECIFICALLY BOLSTER CAPACITY FOR CARE IN RURAL COMMUNITIES ACROSS THE STATE

Rural children fare worse than their urban and suburban counterparts when it comes to behavioral health outcomes. This is not just the story in Idaho, but also across the country (CDC, 2023). As evidenced in Figure 9, behavioral health resources are concentrated along the highway corridors and population centers in the state.

Figure 9. Map of Youth Behavioral Health Services in Idaho



Map illustrating youth outpatient sites, IOPs, and inpatient care settings in Idaho. Color indicates number of sites in an area.

This leaves huge swaths of the state without care at all levels, from traditional therapy to behavioral health consulting to intensive inpatient care. As an example, over the past four years, the Blue Cross of Idaho Foundation for Health has funded the Healthy Minds Partnership program. This program is designed to facilitate co-location of behavioral health services within schools to increase access for youth by reducing transportation barriers and increasing partnerships between schools and behavioral health providers. Approximately 70% of urban/suburban schools enrolled in the Healthy Minds Partnership have found a provider for co-location. This is in contrast to 30% of rural schools. Multiple counties did not even have one provider available who was currently taking Medicaid. In

the communities of Fairfield and Richfield, partner school districts have been looking for a clinician to serve students for over 30 months. While all levels of care are under-resourced/under-available in most rural communities across the state, there are several key opportunities for increasing capacity in high need areas. These include:

A. SUPPORT FEDERAL LAW CHANGE RELATED TO RURAL CLINICS AND BEHAVIORAL HEALTH ACCESS:

Rural Health Clinics are specially certified primary health clinics located in rural service areas and meet specific criteria to be eligible for federal funding. These sites are essential to care access in rural areas across Idaho. The 50 clinics throughout Idaho provide services from wellness visits to chronic disease care to behavioral health care. It should be noted that these sites cannot do more than 49% mental health services based on statute provisions but often end up being the only source of care within their communities (National Association of Rural Health Clinics). RHCs were established by the 1977 Rural Health Clinic Services Act. This makes it quite antiquated when compared to the rapid acceleration of healthcare delivery and services during the same time period. One of the elements that doesn't reflect the current landscape is the limit on sites where RHCs can bill for services. Currently, as the law stands, RHCs can only bill for services at 1) their clinic sites; 2) a patient's home; 3) a short-term nursing facility; 4) the site of a medical emergency. Notably, schools are missing from this list. As the only behavioral health care providers in many communities, this means kids cannot access critical care from providers in their town. This has come up nearly every year for the Healthy Minds Partnership program and has been identified as an issue in key stakeholder interviews with both schools and rural behavioral health providers. It is an unnecessary barrier and it is not without precedent to make changes to the federal legislation (see Rural Health Clinic Modernization Act).

> *"We don't have providers, we don't have enough hospital beds. A kid has to go down three times before they get seen."*
>
> **IDAHO SCHOOL ADMINISTRATOR**

B. FUND AN INPATIENT CARE SITE IN NORTHERN IDAHO:

Idaho has made immense strides in increasing inpatient care facilities throughout the state in the last two years. However, the Northern Region of the state remains significantly underserved. Key stakeholders report youth being transferred out-of-state 80% of the time. Even when they are treated in an Idaho inpatient program, this can result in a six-hour drive for a family to see their child. Therefore, a critical investment should be opening an inpatient facility in the Panhandle Region. Recent news articles have highlighted the major risks and challenges for Idaho's most vulnerable youth.

C. SUPPLEMENT/SUPPORT FEDERAL RURAL LOAN REPAYMENT:

The National Health Service Corps (NHSC) provides loan repayment to medical, nursing, and mental health/behavioral health providers working in rural communities and is funded by the Health Resources and Services Administration. In addition to practicing within a rural service site, the provider must also work for an agency that meets NHSC criteria and has applied for the designation. This includes a variety of requirements from providing free care to families with low incomes, maintaining a clinician recruitment and retention plan, and adhering to a specific services agreement with HRSA. For many rural sites with provider/owners and maybe one to two staff, this is not feasible. Given the amount of time they are spending seeing clients, running their businesses, and meeting payor requirements, NHSC qualification represents an immense burden due to paperwork and implementation requirements for sliding fee scales. DHW could help these smaller sites — rural agencies with less than four providers — by assisting them in applying for and maintaining NHSC approval or providing supplemental funds to do so.

RELATED ISSUES:

Enhance Telehealth Referral Networks in Rural Areas: Not all communities will have the ability to recruit and keep local behavioral health providers. Fortunately, telehealth can help to supplement gaps in access. Rural communities can work with both traditional care partners (regional providers, independent telehealth networks, etc.) and less traditional partners such as libraries to promote telehealth access where there are gaps in services for families.

Support in Transitions of Care: Children and adolescents in the care system can access various levels of care through their treatment. Whether it is going to the emergency department with suicidal ideation, an intensive outpatient program (IOP), or seeing their therapist for 30 min of art therapy, children often move through different care settings and geographies. However, these care providers are highly fragmented in Idaho and parents and caregivers are often on their own when it comes to navigating care. Creating funded, integrated, and supported positions specific to pediatric mental health care coordination could alleviate these issues.

OTHER STATE COMPARISON:

Idaho has the basic infrastructure to support enhanced resources for rural youth but has not invested sufficiently in pushing resources into those structures. For instance, Montana has utilized its rural health association, major training universities, and primary care association to implement services such as a rural telemental health program, rural mental health clinician training and placement incentives, and rural school-provider partnerships.

4. SIGNIFICANTLY INCREASE THE FUNDING FOR SCHOOLS TO IMPLEMENT EVIDENCE-BASED PREVENTION RESOURCES AND SUPPORT COORDINATION OF SERVICES FOR STUDENTS

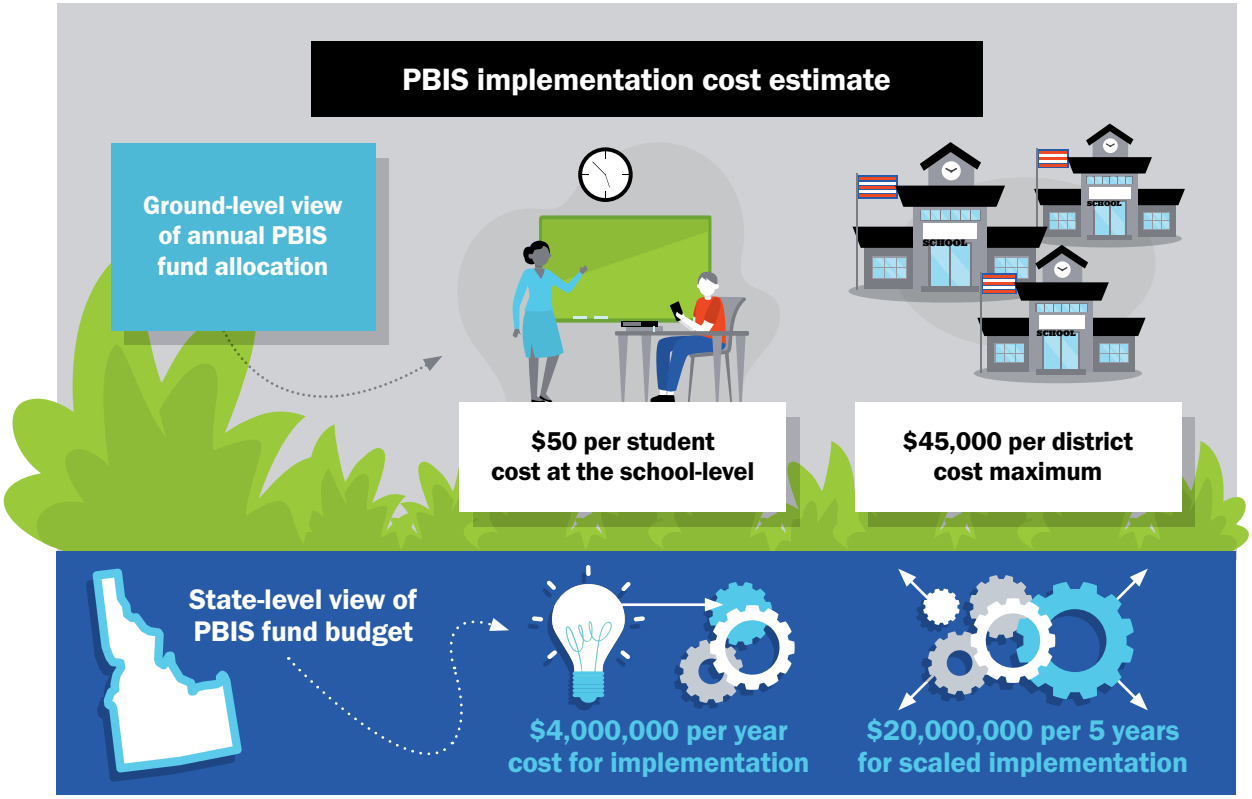
Schools are the functional epicenter of community and support for youth in the United States. They are often where students spend the most time outside of their homes, where they receive meals, and increasingly where they receive mental health care. However, schools are not designed to be specialty mental health centers. As a result, educators and school staff are feeling increasingly untenable stress to manage student mental health without the resources to do so. They are in a sense functioning as a safety net with gaping holes. Currently, there is inadequate funding for suicide prevention in schools. In 2018, recognizing the need to address the high rate of suicides in Idaho, the legislature set aside funding and mandated the development of The Idaho Suicide Prevention Action Council (ISPAC). ISPAC developed the Idaho Suicide Prevention Plan for 2019-2023. One overarching goal of the plan is to reach a 20% reduction in Idaho's suicide rate by 2025. However, funding to support this effort is insufficient. Currently, state funding supports the Idaho Youth Suicide Prevention Program which also relies on federal funding to be fully operational in supporting schools in improving connections and resiliency to prevent youth suicide. In addition, state funding supports the Idaho Suicide and Crisis Lifeline, now 988, and regional coordinators at each of the seven public health districts. If Idaho is serious about its efforts to reduce youth suicide, stable state funding needs to be dedicated to support the Idaho Youth Suicide Prevention Program at the Idaho Department of Education (IDE).

> *"It isn't just a funding problem. It is a time, human capital, and funding problem."*
>
> **IDAHO SCHOOL ADMINISTRATOR**

For years, teachers in many states across the country had few alternatives and training on how to de-escalate crisis situations in the classroom and relied on Restraint and Seclusion (R/S) as a means to control the classroom. In 2009, the Education Department recognized R/S can negatively impact children, and in some cases severely injure children (Nanno et al, 2006), and issued guidance encouraging states to adopt alternative policies to R/S (Kern et al, 2021). Since then, more than 48 states and/or territories have implemented legislation or policies on R/S. Up until the 2023 legislative session, Idaho was one of six states and/or territories with no legislation and one of five with no policy on Restraint and Seclusion (R/S). In 2023, Idaho passed rules around R/S which ban it from being used as a form of discipline or classroom governance but failed to include any guidance offering alternative approaches (Idaho, 2023). One alternative approach is Positive Behavior Interventions and Supports (PBIS). Across the country, as

27,000 schools have implemented PBIS a whole-school approach, which means they have systems of support for all students, ranging from those with minimal behavioral interventions needed to those at the highest level of care needed. While it is not mandatory in all participating schools, 38 of the states with legislation or policies around R/S recommend PBIS as an alternative. Despite Idaho not being a mandatory state and the lack of guidance in alternatives to R/S, more and more schools in Idaho are adopting tenets and practices associated with PBIS. This is due to the extensive data supporting PBIS and the explicit call for increased implementation of the model in national legislation (Individuals with Disabilities Act-1997). There are public and private initiatives in Idaho to support the implementation and assessment of PBIS. There are public (Idaho AWARE) and private (BCIF) initiatives funding implementation and assessment of PBIS in Idaho. However, the state has not directly led or funded PBIS initiatives for schools in the state. This does not include funding or programming from the Idaho Department of Education (IDE), DHW, or the State Board of Education. While this funding is crucial to advancing initiatives, it is clear the state has not taken a leadership role in programming or funding PBIS. The cost per student at a school level is estimated at approximately $50 with the per district cost at $45,000. In Idaho, this translates to approximately $20 million for implementation. With a five-year scaled implementation, this would equate to $4 million per year (Figure 10).

Figure 10. PBIS Implementation Cost Estimate for Idaho



> *Kids are coming to school because of their teachers. They experience the world through us. We want to help them but that isn't our training and we don't have the resources.*

IDAHO EDUCATION ADMINISTRATOR

At the same time, this is not just a funding issue. It is a training and time issue. Parents and families are always children's first teachers and leaders, but many teachers and school staff become anchors in children's lives. Teachers receive minimal to no training in attachment and trauma despite the significant role they play in many children's lives. Thus, when behaviors manifest in the classroom (aggression towards classmates, emotional outbursts, disrespect towards the educators), teachers don't have the skills to support the student or insulate themselves from burnout. In an attempt to increase training for teachers and educators, ECHO Idaho has developed a K12 Behavioral Health Series to support training related to student behavioral health. However, this is not required for continuing education (CE) and only a small percentage of educators have accessed this resource. To address this gap, pre-teacher programs should mandate a minimum of 8 hours in youth mental health content and the State Board of Education should mandate one (1) credit hour per five-year renewal cycle in youth mental health topics (with a minimum of 100 free hours available to teachers per year).

In addition to prevention structures, schools must have additional support to serve as the safety net, a role they currently occupy informally. This means providing and coordinating higher levels of structured coordination. Providing care doesn't mean that schools must employ behavioral health providers but instead can co-locate or better collaborate with community providers. For the past seven years, the Blue Cross of Idaho Foundation for Health has sponsored the Healthy Minds Partnership program. This program supports the co-location of mental health treatment in school settings. However, this program has become less and less effective over time given the challenges in staffing therapist positions and the burden of re-engaging new clinicians. When other solutions introduced in this document have been implemented, this program will become more viable once again. Other strategies should include budgeting for and hiring local school behavioral health coordinators for regional resource and training coordination. Recent discussions with school administrators and counselors indicate they are spending significant amounts of time seeking out care and support resources for students. One school administrator reported spending approximately three hours a day coordinating care for students. Part of this phenomenon is likely driven by needs (more mental health concerns, less care availability) but is also due to a lack of familiarity and bandwidth to liaise with mental health systems. The people attempting to coordinate care for kids (principals, counselors, teachers) are not healthcare professionals. Instead, districts and/or regions (depending on size) could staff school behavioral health coordinators whose job would be to connect students to care resources and connect school staff to training and development resources. These staff would have the training and bandwidth to support schools and students and relieve the pressure on administrators, counselors, and teachers, allowing them to focus on education and development. This level of position (BA/BS degree, some experience) represents a cost of approximately $50,000 in salary per year and $17,000 in fringe per position. **If approximately 15 positions are supported across the state (one per health district region to serve rural communities and one per population center within those health regions, with two for Boise), the cost would be $1 million per year. This could lead to cost savings through increased capacity for academic support and development, as well as improved quality of life and care for all parties involved, compared to informal care coordination performed by administrators, educators, and counselors.** These positions could be staffed in a variety of different agencies but may be best suited to sit at the public health districts as they operate as natural bridges between clinical services, community resources and educational settings.

RELATED ISSUES:

Concerns with Schools and Who Pays for What: If schools identify a behavioral health problem, lack of clarity in what constitutes something that the school ultimately must

manage through an individualized education plan (IEP) vs. providing parents/guardians resources to access care sometimes means that students don't get the right support. This can be due to the financial burden of supporting a child's care based on an IEP but could also be due to simple confusion over who is responsible for what type of care in a system. In addition, many students with very intense needs do not qualify for an IEP or 504. Rural schools are particularly vulnerable given that they lack the economies of scale to support system-level teams to make these determinations. As a result, it could be a flip of the coin for what under-resourced system children end up in. The worst-case scenario is that a child doesn't get any support because administrators and counselors do not know what system to send a child to and fall into the trap of simply not being connected to any resources.

Support Youth Suicide Prevention in Schools by Any Evidence-Based Models: Several key informants indicated there has been an unnecessary politicization over the type/model of suicide prevention implemented at a school or district level. This has caused schools to have "stops and starts," model changes, and other disruptions to the implementation of a systematic and right-size model for them. As long as there is continuity at the school/district level, it shouldn't matter which evidence-based model is selected as long as the approach is appropriate to and tailored to the community. This is akin to the Office of Drug Prevention's (ODP) model of listing approved, evidence-based interventions for funding and allowing communities and providers to select interventions that fit their local needs and resources.

OTHER STATE COMPARISON:

Montana: The school-based health initiative is administered by the Office of Public Instruction (OPI) as part of the Coordinated School Health Program which focuses on whole child skill development. There are 60 sites across the state and services are contracted out because many schools do not have the skillset to provide services. OPI offers technical assistance and training on trauma-informed care, ACEs, and sharing of what services schools can provide. Training is provided in person on professional development days and via the state's professional development platform. Staff at OPI support community-clinical linkages for the schools.

Funding: The Montana Healthcare Foundation, Project AWARE under SAMSHA and Title IX provide funding for the healthcare partners and some of OPI staff time to oversee the program. Medicaid is billable if an IEP is in place, however Montana has realized many students without an IEP also need services. Currently, schools are using ESSER funding provided during the pandemic. As ESSER funding comes to an end, the

state is exploring legislative opportunities, such as expanding Medicaid coverage for more sustainable funding.

Opportunities for Expansion:

- Educators as Advocates: Teachers have been rallying behind more mental health supports in schools. They have seen the impact both the pandemic and years of high suicide rates have had on youth. Educators work with communities and families to support the whole child.
- Reaching Rural Students: To reach remote schools, Montana is exploring developing a hub of providers that would travel from a central location to small, one-room schools in their region. Housing in remote areas has been a barrier to relocating providers and this is their proposed solution to better meet the need.

Other Supports:

- Department of Health and Human Services (DHHS) funding for a Comprehensive School and Community Treatment Program to support students with Severe Emotional Disturbance (SED) which includes a behavioral interventionist, therapist, and individual, family, and group counseling.
- Workforce development is critical to decreasing waitlists. Montana has a Rural Mental Health grant from the Department of Education (DOE) to support the training of 10 mental health student providers at local universities. The goal is to keep the students in Montana once they have been trained to increase the workforce.
- Federal funding also supports the Rural Behavioral Health Institute to screen for ACEs and other behavioral health risk factors. Depending on the risk level identified, a link to care or immediate assistance is offered. A therapist is contracted with the program so that once a child screens as being at-risk, services can be provided. Currently, funding supports 30,000 students.

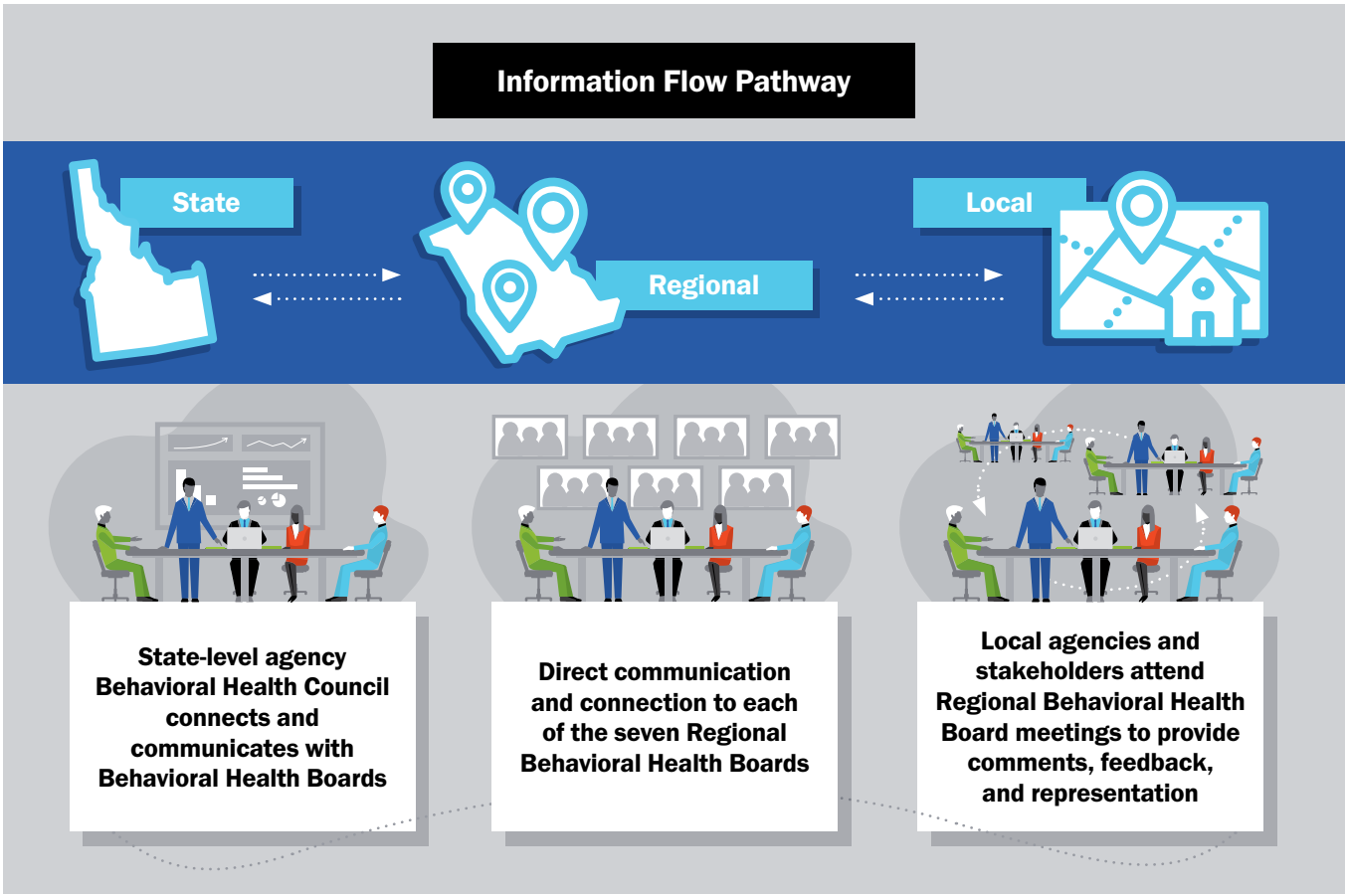
> *"The state as a whole (legislative, state agencies, Medicaid) doesn't talk to each other and agencies providing services have to spend a lot of time telling state agencies what the other one is doing or saying... it is a ton of chaos for people trying to help kids."*
>
> **RURAL BEHAVIORAL HEALTH DIRECTOR**

5. CREATE A STATE LEVEL INTERAGENCY WORKGROUP TO COORDINATE AND COMMUNICATE CHANGES TO YOUTH MENTAL HEALTH SERVICES BETWEEN MEDICAID, DIVISION OF BEHAVIORAL HEALTH, YOUTH CORRECTIONS, STATE BOARD OF EDUCATION, STATE DEPARTMENT OF EDUCATION, DIVISION OF PUBLIC HEALTH, ETC.

Many stakeholders across sectors who were interviewed for this paper indicated a significant sense of frustration with the perceived lack of coordination among state regulatory, compliance, and management agencies. One very well-respected behavioral health director noted, "They don't talk. I ask someone with YES about what needs to happen to coordinate with Medicaid and the schools for a struggling child and I get a different answer from when I ask Medicaid and when I ask the Department of Ed. If they can't see the connections at the state level, how are we [at the local level] going to figure it out?" Others echoed this sentiment, noting that lack of providers was one thing but not feeling like the larger agencies were working together made them feel caught in the confusion.

Theoretically, much of this work is intended to be coordinated by the Idaho Behavioral Health Council (state level) and the Regional Behavioral Health Boards (regional level). While these groups have taken on important communication and strategic planning functions, they have not served as centers of strategic coordination and communication for stakeholders. As a result, there is reduced visibility and transparency regarding significant changes within programs. Ultimately this means kids get lost in a fragmented system where the macro, mid, and micro systems are in silos despite ultimately being functionally interconnected. As in, what happens at the state level regarding programs for youth has profound implications for kids and their families, and the concerns of providers should drive care options and structural supports, but only to the extent that these levels of the system communicate and coordinate with each other.

Figure 11. Proposed Coordination and Information Flow for Idaho Coordination Bodies



To improve these systems, Behavioral Health Council's imperative for program coordination and communication should be strengthened while formalizing pathways for feedback, questions, and concerns to be exchanged between local, regional, state, and national levels. This would also include a direct link to each of the seven Regional Behavioral Health Boards for regional functions (Figure 11). These bodies should use convenings to:

1. Discuss role, scope, authority, and access for new or modified services and programs
2. Develop brief communication regarding functional interface with these programs at the agency level (school, behavioral health provider, law enforcement)
3. Field questions, concerns, and feedback regarding programs and access from the community

Finally, communication and dissemination strategies should specifically and explicitly include considerations for rural and small, independent agencies. Current structures exclude these critical access points from collaboration and development in youth services and even prevent their awareness of key program updates. For instance, most small rural provider groups survive on an encounter-based revenue model that demands they see patients to keep their doors open. In contrast, larger provider groups have the volume and overhead to allow participation in state and regional meetings instead of solely seeing clients. The result is that larger, urban/suburban groups are over-represented in state and regional decision-making. The same could be said for smaller and/or more rural schools. Agencies and stakeholders should not have to commit to attending a three-hour meeting, once a month (plus drive-time for in-person) to stay abreast of key programmatic, process, and resource changes in their areas.

TABLE 5	PROPOSED LEVELS OF COORDINATION IN IDAHO		
	Macro-Level (State)	Mid-Level (Region)	Micro-Level (Patients & Families)
Participants	• Division of Behavioral Health • Division of Public Health • State Board of Education • Department of Education • Division of Behavioral Health • Medicaid • MH MCO • Legislative representative • Commercial payers • Youth Corrections • Training programs	• Division of Behavioral Health • Superintendent • Division of Behavioral Health • Medicaid • MH MCO • Provider representative • Youth probation • Family Advocates • Public health department	• Family and child • Treatment provider • Care coordinator • Family advocate • School coordinator • School counselor • Youth probation • Community programs (after school, faith, etc)
Key Topics	1. Address school-based behavioral health billing gap 2. Develop EAP style access model for children 3. Create recommendations for teacher and administrator BH training content requirements	1. Review regional access data for key gaps and opportunities 2. Identify shared resources and utilization plan related to children's crisis' services 3. Facilitate regional trainings and communication briefs regarding emerging policies and programs	Take care of children based on the best flow of information from the macro and mid levels

Example of Function-New Program to Support Children with Incarcerated Parents Access Care: The state recommends legislation to allow more flexibility in access to care in the absence of a consenting adult due to incarceration. This is based on feedback regarding individual children and families identified at the micro level. These cases have been highlighted at the mid level and subsequently communicated up to the macro level. Once the legislation is passed and enacted, the state determines the roles and responsibilities of schools, providers, adult system, child system, Division of Behavioral Health and other stakeholders. This is reviewed by each regional board for revisions. Feedback is reviewed by the state and finalized. A communication brief is developed for the regional boards. The regional boards develop a communication plan for the new legislation and enact this communication plan. The local schools, coordinators, providers, etc. all know their role in the new system and support kids who need care. Feedback from these agencies is directly solicited by the regional boards and elevated to the state as appropriate. As a result, the state system is supportive of and responsive to the needs of children and their families. This is mirrored and aligned at the regional and local levels.

Thus, state and regional workgroups should require representation from smaller agencies/organizations and provide compensation for meeting attendance. This could be accomplished through a variety of funding structures such as grants (ODP, Office of Suicide Prevention, etc.) or Division budgets at state agencies. However, without these voices at the table, children living outside of population dense areas will continue to lack the supports available to children living in Boise, Twin Falls, Pocatello, Idaho Falls, and Coeur d'Alene. A proposed structure and division of responsibility under this model is highlighted in Table 5.

RELATED ISSUES:

Lack of Data Interoperability: In many situations, schools don't know when a child has been hospitalized and providers don't know when a child has been expelled. It is on the family or even child to communicate between these external supports. As a result, the "ball gets dropped" for services.

Excessive Meetings: Many interview subjects indicated there was significant redundancy in meetings. For example, the State Department of Education was hosting a meeting with the same people as the Division of Behavioral Health in the same week. This dilutes messaging and can confuse collaboration efforts. Collaboration should occur higher in the system to reduce the burden on regional and local agencies to attend multiple meetings and glean, then organize, information from different state agencies.

Fear of Liability: Children's mental health is fraught with liability and for the most part, this is justifiable. Those who take on the responsibility of addressing children's mental health should do it with fidelity and dedication. However, liability can threaten the decision of those who could take on the responsibility of care and support and lead to "passing the buck" to the next agency or just not addressing the issue at all. For

example, a school may not refer a child for behavioral health services for fear of being responsible for a special education plan if the behavioral health condition interferes with their academic performance.

OTHER STATE COMPARISON:

While there is much to learn from programs in other states, ultimately, Idaho is particularly unique in its regional structure to support the specific needs of local communities. This proposed solution is based on consideration of the state's strengths and resources and a thoughtful approach to linking stakeholders to ultimately serve the children and families in communities.

CONCLUSION

In conclusion, it is evident that there is a shared desire among the agencies, organizations, and institutions in the state of Idaho to see children thrive. However, there appears to be a need for greater effort in preventing the suffering of children and mobilizing the resources required to address gaps in prevention, care, and support. We respectfully urge the leaders in Idaho's policy and care delivery to take meaningful action in implementing these recommendations and protecting the health and well-being of children. It is our belief that no single entity can achieve this alone, but by collectively utilizing data, coordination, best practices, and insights from key stakeholders, we can develop new programs and policies that will help us achieve this goal. We must recognize that inaction will result in a disservice to the children and youth of our state. However, The Blue Cross of Idaho Foundation for Health is confident in the leadership, capacity, resources, and creativity of Idahoans. We are aware of your dedication to the well-being of children, and we kindly invite you to join us in taking the next steps towards real change.

INVESTING IN IDAHO YOUTH MENTAL HEALTH:

Our Current Broken Systems and Direct Strategies To Improve

ADDENDUM 1

AUGUST 2024

AUTHORED BY
Rachel Blanton, MHA

SUPPORTED BY
Blue Cross of Idaho | Foundation for Health, Inc.

ADDENDUM 1

> *"There is still a disconnect between the idea that they raised the rates and being five years behind inflation. New grads can either come work for me [agency accepting Medicaid] and make barely enough to scrape by or get 40%-50% more [pay] accepting only cash or commercial."*
>
> **MENTAL HEALTH AGENCY LEADER**

LATEST IDAHO MEDICAID RATE INCREASES AREN'T ENOUGH TO REMOVE BARRIERS TO CARE

Magellan released the new Medicaid rates for behavioral health services in Idaho. These rates, published July 1, 2024, have been updated in the financial model linked below.

[Link to Data Set]

While the small increase is a step in the right direction, it does not cover expenses for many types of service settings where benefits are offered to staff and no-show rates average 20% (Carrico, 2023). The gap between costs and reimbursement has been narrowed for several projected scenarios, with some even achieving a net positive. However, these scenarios leave little room for no-shows, raises, denied claims and much less a lunch break or training. In addition, agencies and providers report that many of the most commonly used codes saw the smallest increases. The current rates continue to lag behind neighboring states (see table below for comparison). This continues to pose a major threat to workforce recruitment and retention alongside overall margins for businesses. Many agencies report state rates for reimbursement as a major concern given the prevalence of telehealth. Providers can live in Idaho and make much more by virtually serving patients in other states (see Table A1.)

TABLE A1	STATE COMPARISON-PHYSICIAN ^RATE (IDAHO MEDICAID RATES UPDATED 7/1/2024)			
CPT Code	Definition	Idaho	Utah*	Montana*
90791	Psychiatric Diagnosis Evaluation Without Medical Services	$158.19	$165.76	$218.51
90792	Psychiatric Diagnosis Evaluation With Medical Services	$186.06	$165.76	$244.69
90832 (30 min)	Psychotherapy, 30 Minutes	$88.24	$67.95	$95.07
90846 (50 min)	Family or Couples Psychotherapy With/Without Patient	$95.77	$101.94	$120.02

^ Rates are shown for physician billing. All rates for masters level providers are billed at a lower rate and are available publicly for review
**** Utah and Montana based on 2023 published rates***

In addition, the rates were unchanged for behavioral health services delivered in Idaho schools. This causes further confusion and negative pressure to shift care sources away from special education supports (see Table A2). For example, there may be a natural push toward care supports outside of the school setting to follow the funding. **This will create additional barriers to care and confusion between school services and community services.**

TABLE A2	SCHOOL-BASED SERVICE VS. DEVELOPMENTAL DISABILITY AGENCY REIMBURSEMENT	
Service	School-Based [Link to Rates]	Developmental Disability Agency (DDA) [Link to Rates]
EBM Professional Intervention	$20.59 per 15 min	$25.71 per 15 min
Behavior Intervention Specialist	$12.91 per 15 min	$16.12 per 15 min

NEW CANS ASSESSMENT STILL BURDENSOME COMPARED TO OTHER STATES

Idaho has released recommendations from a CANS workgroup through Idaho Department of Health and Welfare Transformational Collaborative Outcomes Management (TCOM) Competency Center. The result is the Idaho CANS 3.0 is 30 questions shorter than the previous required CANS form but is still longer (90 questions) than other states in the region (see Table 4 page 19). While the CANS 3.0 reduces the redundancy of some data entry, it still requires a significant burden of paperwork for the therapist as opposed to relying on support staff or self-entry. The TCOM Competency Center has updated language and items to support a more client-centered approach to assessment, which should have substantive impacts on utilization and the development of a therapeutic relationship. However, the sequencing, duration and update requirements remain a burden for providers and care sites. A provider interviewed states (August 2024).

PROVIDERS TELL THEIR STORY

"As a practice owner and provider, it makes no sense for the CANS to be required. Providers who are trained to use measurement-based care should be able to use the assessments and protocols they are trained on and have the freedom to adjust as needed.

Most recently a systematic review of using the CANS showed that there was 'little evidence for improvement over time using CANS-informed services.' As a provider who values evidence-based care, we use assessments that have shown strong evidence of measuring movement and outcomes. Being forced to use the CANS every 90 days for children is not only ineffective, but a complete waste of time and resources. I can understand the need to assess the CANS one time at the intake, which would be justifiably reasonable and could be incorporated with other measurement-based care models. However, taking up time to do this every 90 days limits the actual progress a client can make.

Providers should be allowed to use the training and education gained to provide the best evidence-based care possible. We have moved away from accepting Medicaid clients for this very reason. The other reason we stopped accepting Medicaid is the requirement of conducting a CDA (comprehensive diagnostic assessment). This is far more extensive of an intake assessment than is typically needed to see most clients. That, combined with the CANS and the low reimbursement rates, ***makes accepting Medicaid untenable in providing services to the community."***

— IDAHO PRIVATE PRACTICE OWNER/CLINICIAN

"The Medicaid data entry system is a major barrier to staffing and care related to youth behavioral health. We must double staff the data entry. The therapist enters NOMS (National Outcomes Measures) and CANS into the chart, then a care coordinator puts the data into the required Medicaid portal. It is not possible for a provider to enter in real time due to the slow system. It means we would see less patients every day. My concern for my colleagues in smaller practice is that they don't have care coordinators, and this is going to drive them out of seeing children with Medicaid."

— FQHC BEHAVIORAL HEALTH ADMINISTRATOR

APPENDIX

IDAHO COMPONENTS OF CARE

Intensive Outpatient: In-depth counseling to address mental health disorders that do not require detoxification or 24-hour supervision. They allow a patient to continue with their normal daily activities rather than residing in a residential treatment facility.

Crisis Centers: A no-cost resource for individuals in behavioral health crisis such as suicidal thoughts or withdrawal from drugs. Individuals can stay for up to 24 hours and receive a bed, food, and services from a mental health professional. Referrals and connections are made to community resources to help individuals have a plan once they leave.

Assessment Centers: A 24-hour center for assessment of juveniles who are involved or likely to become involved with the justice system. Youth service providers collocate with juvenile justice agencies at the assessment center to provide basic and in-depth assessments of the youth's treatment needs and coordinate safe placement and access to rehabilitative services once the juvenile is released from the detention center. Juveniles' needs are established upfront to better support the child and point of entry assessments can help to avoid unnecessary detention.

Substance Use Treatment: A program that is delivered by a professional trained in treating substance use disorders and often involves a team including social workers, psychiatrists, nurses, and counselors. Treatment involves an assessment and development of a treatment plan which may include counseling and/or medications. Treatment can occur in a residential facility, inpatient, or an outpatient setting such as a primary care office or methadone clinic.

Integrated Care: The type of care that is delivered when primary care and behavioral health clinicians work together to care for the patient and their family.

Division of Behavioral Health: A state agency under the Department of Health and Welfare. The division delivers treatment and recovery services for Idahoans living with behavioral health disorders.

Medicaid: Provider of health coverage for children who meet certain eligibility criteria and free or low-cost coverage for adults who have a variety of healthcare needs.

School-Based Health Centers: Primary care clinics staffed by physicians, mid-level providers, and counselors located on school premises or off-site centers linked to schools. They provide health care services such as well-child visits, vaccinations, mental health care, and sick visits. They may manage chronic conditions such as asthma, diabetes, and mental health conditions. Most children treated at SBHCs are on Medicaid or are without insurance.

School-Partnered Health Resources: A community behavioral health agency (nonprofit, for profit, CHC, etc.) that partners with the school to offer therapy and other services on site. This is distinct from school-based behavioral health because the school is not responsible for billing and services. This model opens access to students as it reduces transportation and scheduling barriers. The Blue Cross of Idaho Foundation for Health has supported this model since 2017.

Psychologist: (PsyD) Mental health professionals holding doctoral degrees and trained in evaluating an individual's mental health using clinical interviews, psychological evaluations, and testing. They can diagnose and provide individual or group therapy. They cannot prescribe medications.

Psychiatrist: An M.D. or D.O. who specializes in mental health. Psychiatrists are qualified to assess both the mental and physical aspects of psychological problems. They assess, diagnose, and treat the mental health needs of patients including prescribing medications. They have completed a four-year residency in psychiatry.

LCPC: Licensed Clinical Professional Counselors are mental health professionals qualified to deliver psychotherapy, behavioral therapy, and other counseling services. They have completed a master's degree and at least 2,000 hours of supervised direct client contact.

LCSW: Licensed Clinical Social Workers are mental health professionals with specialty clinical knowledge and clinical skills. They are trained in assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions, and addictions. They have completed a master's degree and 3,000 hours of supervised direct client contact.

LMFT: Licensed Marriage Family Therapists are mental health professionals with specialty knowledge within the context of marriage, couples, and the family system. They are trained in psychotherapy and licensed to diagnose and treat mental and emotional disorders. They have completed a master's degree and at least 3,000 hours of supervised direct client contact.

Psychiatric Nurse Practitioner: A Registered Nurse who has completed a graduate training program with specialized training in assessment, diagnosis, and treatment of patients with mental health needs. They are trained to both provide therapy and prescribe medications including controlled substances for their patients with mental health and substance use disorders.

IDAHO RESIDENT SUICIDE DEATHS

NUMBER & RATE PER 100,000 AGED 15-17			
THREE-YEAR AGGREGATE, 2019–2021			
RESIDENCE	DEATHS	POPULATION	RATE
State	42	241,335	17.4
District 1	6	29,370	20.4
District 2	1	11,325	8.8
District 3	12	42,880	28.0
District 4	7	68,166	10.3
District 5	7	29,027	24.1
District 6	4	26,227	15.3
District 7	5	34,340	14.6
Ada	7	63,008	11.1
Adams	1	445	224.7
Bannock	2	11,806	16.9
Bear Lake	1	885	113.0
Benewah	Not reported	1,102	Not reported
Bingham	Not reported	7,657	Not reported
Blaine	Not reported	2,949	Not reported
Boise	Not reported	896	Not reported
Bonner	2	5,062	39.5
Bonneville	2	18,420	10.9
Boundary	Not reported	1,510	Not reported
Butte	Not reported	367	Not reported
Camas	Not reported	140	Not reported
Canyon	7	33,686	20.8
Caribou	Not reported	1,073	Not reported
Cassia	3	4,040	74.3
Clark	Not reported	99	Not reported
Clearwater	1	929	107.6
Custer	Not reported	398	Not reported
Elmore	Not reported	3,151	Not reported
Franklin	Not reported	2,617	Not reported
Fremont	1	2,018	49.6
Gem	3	2,270	132.2
Gooding	1	2,232	44.8
Idaho	Not reported	1,740	Not reported
Jefferson	1	5,302	18.9
Jerome	Not reported	3,748	Not reported
Kootenai	4	20,334	19.7
Latah	Not reported	3,585	Not reported
Lemhi	Not reported	800	Not reported
Lewis	Not reported	502	Not reported
Lincoln	Not reported	838	Not reported
Madison	1	5,884	17.0
Minidoka	1	2,986	33.5
Nez Perce	Not reported	4,569	Not reported
Oneida	Not reported	677	Not reported
Owyhee	Not reported	1,694	Not reported
Payette	1	3,358	29.8
Power	1	1,145	87.3
Shoshone	Not reported	1,362	Not reported
Teton	Not reported	1,419	Not reported
Twin Falls	2	12,094	16.5
Valley	Not reported	1,111	Not reported
Washington	Not reported	1,427	Not reported

FINANCIAL MODEL

A reimbursement-to-cost model was developed based on current published Medicaid rates, published average compensation data, and extensive interviews with providers, supervisors, and agency owners/leaders. The model built out a variety of conditions regarding no-shows, denials, overhead, types of encounters, and other factors. This model is available upon request, but key features are highlighted below.

[Link to Data set]

MEDICAID MODEL

KEY ASSUMPTIONS:

For this model, the team developed various scenarios. Based on provider and agency feedback, the scenario presented in the paper was judged to be the most likely.

Full model available by request.

Model components:

- 8 hours of billable encounters (not training, documentation, scheduling, etc.)
- CPT codes for psychotherapy for established patients, new patients, and CANS assessments
- 38% fringe (health insurance, taxes, unemployment insurance, etc.)
- 30% overhead (office space, admin, liability insurance, technology, etc.)

ABOUT THE BLUE CROSS OF IDAHO FOUNDATION FOR HEALTH

The Blue Cross of Idaho Foundation for Health, Inc., is a nonprofit private foundation established by Blue Cross of Idaho in 2001.

The Foundation is committed to addressing the root causes to some of Idaho's most pressing health issues.

But it always means being a catalytic organization, dedicated to transformational — not simply transactional — approaches that will impact Idaho today and for generations to come.

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