CCAP COMCARE
The County Managed Care Resource

INSIGHT

An Information Resource from COMCARE

Volume 3, Issue 1

Students with Mental Illness Find Treatment at School | Opinion

By Scott Suhring, Chief Executive Officer of the Capital Area Behavioral Health Collaborative

Originally published in Penn Live, Patriot News; November 14, 2019

Educators have long recognized that mental illness is a disease that can impact many students in many different ways throughout the school day, including suicidal thoughts, depression and anxiety.

The recent report from the state's Safe2Say program, a platform for anonymously potentially unsafe activities, provided a stark reminder of how these challenges are mounting. The program received roughly 28,500 safety tips in the first six months of 2019, and more than 90 percent of the tips dealt with mental health issues.

INSIGHT is published monthly by COMCARE, a program of the County Commissioner's Association of Pennsylvania (CCAP). If you wish to provide comments or feedback, please forward your comments to Lucy Kitner or Michele Denk at COMCARE at the following email addresses: lkitner@pacounties.org; mdenk@pacounties.org. Thank You.

We also know and understand much more clearly that adverse experiences at home such as abuse, or neglect have a tremendous impact on students. If a parent is absent or incarcerated, for instance, their children might need additional mental health support.

Growing numbers of students have family members impacted by the opioid crisis or are facing housing or food insecurities. There are any number of factors that can impact students as they enter the classroom.

Against this backdrop, it is critically important that parents and students are aware that help is available for their children and family in many schools throughout our region. Under the innovative statewide Medicaid Behavioral HealthChoices (BHC) program, county and school leaders are helping families address these challenges.

Currently, there are 239 satellite mental health outpatient clinics in schools throughout Cumberland, Dauphin, Lancaster, Lebanon and Perry counties. In the last fiscal year, 3,661 students enrolled in the Medicaid BHC program received counseling by a licensed clinician in one of these satellite mental health programs. The age of students who received this treatment is telling:

- **Ages 0-5:..... 114**
- **Ages 6-12:..... 2,288**
- **Ages 13-17:..... 1,434**

This effort would not be possible without the BHC program, which was created more than 20 years ago and has continued to evolve over the years to address consumers' needs.

Under BHC, each county has the opportunity to manage the Medicaid BHC program as the primary contractor or to work with other counties and form collaborative partnerships. Counties can identify what innovative approaches can best meet the unique needs of their constituents.

We started embedding these outpatient clinics in schools a decade ago. Putting these resources in schools makes sense for several compelling reasons, starting with the obvious fact that we know where these young people are every Monday – Friday. This is a captive audience.

In addition, we know from our experience that parents seeking help for their children and families are sometimes more comfortable going into a school building than an outpatient clinic. Our society has come a long way in accepting that mental health challenges are pervasive, yet we need to recognize that some families, and young people especially, can be fearful of the stigma that can be associated with mental health challenges. By offering these services in the school, this barrier can be removed.

We also know that families live close to their schools, so these services are more accessible. Consider a family, for instance, being able to drive to their school in Duncannon for counseling, rather than having to drive to Carlisle or Harrisburg.

I encourage parents to ask their school leaders if these services are available in their children's school building or in the district.

Scott Suhring is the CEO of the Capital Area Behavioral Health Collaborative, a private, not for profit company formed among Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties' Mental Health and Drug and Alcohol programs.

Human Behavior

Human behavior is the source of complexity that may arise from the interplay of conducts, demeanors, and attitudes of people. These behaviors may be the result of factors such as changing power relationships, political influence, and individuals' experiences and perspectives. These factors may hinder the clear identification of goals and objectives.[1]

Teams of people working together to accomplish a project or goal can be very rewarding and productive, however, these relationships very often are the source of some of our greatest professional challenges!

Program and project work consist primarily of the combined efforts of many individuals to accomplish established objectives. It is rare that one person's efforts are isolated from those of team members and other stakeholders. While effective interactions among stakeholders contribute to success, the diversity, influence, and number of stakeholders involved in those interactions contribute to the complexities encountered in the program or project.[2]

The Project Management Institute® has outlined a profile of human behaviors that introduce complexity and significant challenge for teams pursuing a project or program initiative. Maybe you have encountered some of these conditions:

- Participant stakeholders may set unrealistic and unachievable expectations as the new project or program begins.
- Key stakeholders (both internal and external) indicate significant misunderstanding of, and/or disagreement with, goals, benefits, decision processes, and outcomes.
- Clear, cohesive, visible, and active executive and organizational support is not adequate.
- Unstated or concealed agendas drive decision making.
- Key stakeholders' representatives are being replaced during the duration of the program or project.
- Senior executives or governance boards do not give program or project managers and team leaders the requisite authority to take acceptable risks, make key decisions, or provide a process for expediting those decisions.
- The organization and its human resources have insufficient experience in the work being undertaken by the program or project.
- The program or project team has not effectively addressed interdisciplinary process integration.
- The program or project is underfunded or lacks adequate reserves.
- Critical information is knowingly withheld, postponed, or not acknowledged in a timely manner.

[1] Navigating Complexity: A Practice Guide; Project Management Institute ®; 2014; pg 13.
[2] Ibid.

If you have encountered any of the conditions described above, you know well how challenging it is for a project leader to successfully accomplish the goal. Different expectations may create openings for disagreements and unwritten or tacit agreements.

When individuals act, they do so both on their own behalf and on the behalf of the groups and organizations that they represent or with which they identify. Below are more examples of individual behavior that add complexity and challenge to accomplishing operational project or program goals:

- Sometimes individuals leading project initiatives have an ***"optimism bias"*** – the natural tendency for a person to believe that they are less likely than others to experience a negative outcome. This bias often causes individuals to plan unwisely, underestimating real costs, time, and risks – and over-estimating the potential benefits of the time and money spent.
- ***"Anchoring"*** is a bias that occurs when great significance is attached to information acquired early in programs or projects when the least amount of information about the work is clearly understood. This lack of clear understanding affects estimates, requirement assumptions, and overall scope, time, and effort.
- A material impact on decision making is ***"how the project or program is framed"***. The manner in which information is presented and who presents that information affects how that information is perceived or interpreted. Project or program leaders must assure that all alternatives are presented as objectively as possible.
- ***"Loss Aversion (the sunk cost effect)"*** is when a great deal of emotion, energy, and resources are invested in a troubled program or project, people are reluctant to terminate it despite clear indications that recovery may be impossible. This is very clearly seen in the illustration where an organization invests large amounts of time and money into an information technology solution that underperforms and does not

Safe2Say Something' tops 40,382 tips

Monday, February 10, 2020
by The Press in Local News

On the one-year anniversary of the Safe2Say program, Attorney General Josh Shapiro today announced Pennsylvania's anonymous reporting system for schools, students and community members, "Safe2Say Something PA" has reached over 40,000 tips from across the commonwealth. Safe2Say Something was created following the governor's approval of Act 44 in 2018. The anonymous reporting system came online Jan. 14, 2019.

Pennsylvania was the first to deploy Safe2Say statewide and to train students and staff in all of the commonwealth's 500 public school districts, including private, charter, and parochial schools.

Students and community members can submit tips via PA's website, www.Safe2Saypa.org; through the Safe2Say Something PA app; or via telephone at 844-Safe2Say (844-723-2729). Most of the 40,382 tips were received through the app (32,998), while 6,512 tips came through the website, and 872 tips were telephoned into the crisis management center.

The top five categories of tips received during Safe2Say's first year:

1. 1.Bullying/Cyber Bullying,
2. Cutting/Self-Harm,
3. Suicide/Suicide Ideation,
4. Drug Use/Distribution/Possession
5. Depression/Anxiety.

"We need additional funding to ensure there is at least one mental health counselor in every school building in PA," Shapiro said. "We must expand mental health services in our schools."

– Attorney General Josh Shapiro

meet their expectations. Often the organization will continue using the poor performing product because of what they have already invested.

- All programs and projects cause change. ***"Resistance to change"*** is a constant barrier that managers must address effectively. Transitioning from one state to another involves letting go of the familiar (with it's known consequences, good or bad), and accepting something new (with unknow consequences, good or bad). It involves changes in human behavior and occasional changes in institutional (enterprise) culture.

Effective leaders and managers in every discipline of life (military, industry, technology, healthcare, government, sports, or entertainment) face many challenges in the pursuit of their respective goals. The greatest of these is the ability to overcome the weaknesses of human behavior – in ourselves, and collectively in teams.

"One can have no smaller or greater mastery than mastery of oneself" – Leonardo da Vinci.

Portions excerpted from: Navigating Complexity: A Practice Guide; Project Management Institute ®; 2014

Implications of the IMD Exclusion

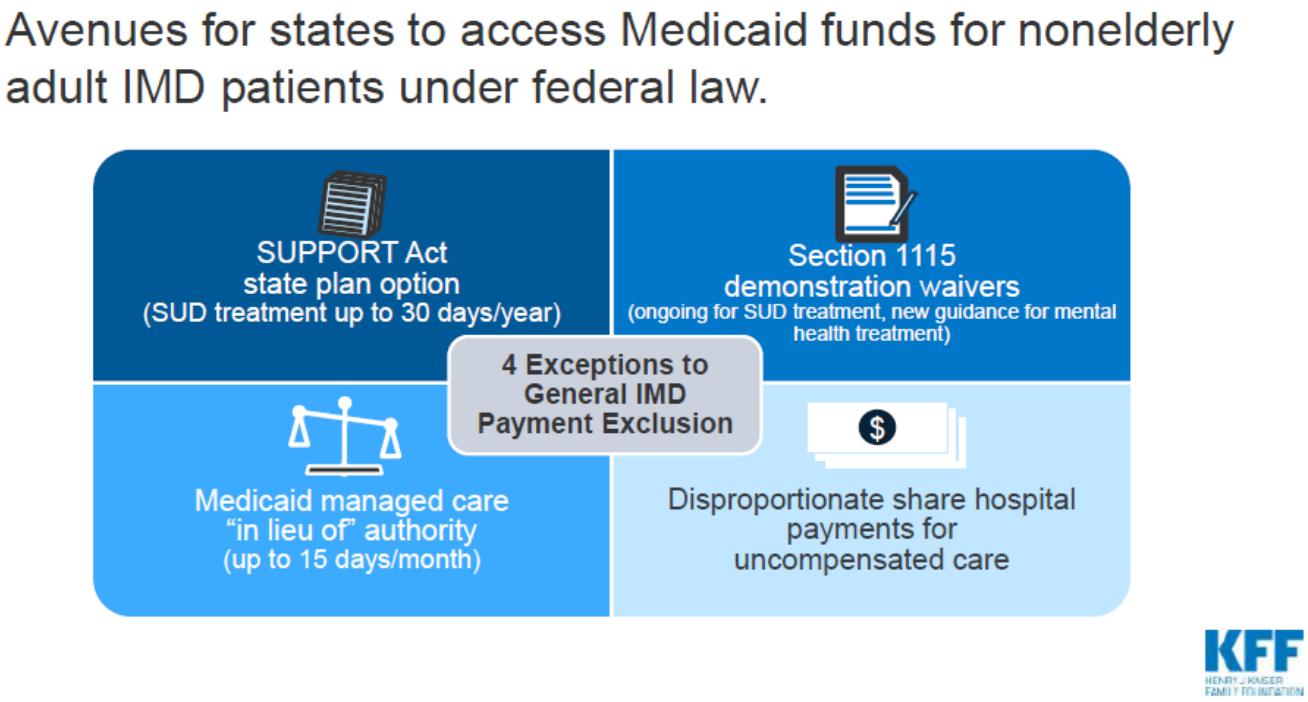
Since Medicaid's inception, federal law has generally prohibited states from using Medicaid funds for services provided to nonelderly adults in "institutions for mental disease" (IMDs). The IMD payment exclusion was intended to leave states with the primary responsibility for financing inpatient behavioral health services. However, the lack of federal funding may limit access to needed inpatient services and contribute to high levels of unmet need.

"The term 'institution for mental diseases' means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." (SSA §1905(i).)[3]

Medicaid's IMD exclusion limits the circumstances under which federal Medicaid funding to states is available for inpatient mental health care. Policymakers have concerns about access to mental health care, and, in recent years, federal guidance and the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 115-271) have amended the IMD exclusion.

In recent years, the federal government has provided new mechanisms for states to finance IMD services for nonelderly adults through Medicaid in certain situations. There are now four options for states to cover these services: Section 1115 demonstration waivers, managed care "in lieu of" authority, disproportionate share hospital payments, and the SUPPORT Act state plan option.

[3] For the definition of IMDs, the term *mental disease* includes diseases listed as mental disorders in the International Classification of Diseases, with a few exceptions (e.g., mental retardation). (See Centers for Medicare & Medicaid Services [CMS], *State Medicaid Manual*, Part 4, §4390.) Under this definition, substance use disorders (SUDs) are included as mental diseases. If the substance abuse treatment follows a psychiatric model and is performed by medical personnel, it is considered medical treatment of a mental disease.



What Is the IMD Exclusion?

The IMD exclusion is a long-standing policy under Medicaid that prohibits the federal government from providing federal Medicaid funds to states for services rendered to certain Medicaid-eligible individuals who are patients in IMDs (§1905(a)(30)(B) of the Social Security Act [SSA]). **When a Medicaid-eligible individual is a patient in an IMD, he or she cannot receive Medicaid coverage for services provided inside or outside the IMD. The IMD exclusion applies to individuals aged 21 through 64. In 1988 the IMD Exclusion was further defined with the addition that facilities with 16 beds or fewer were exempted (so small facilities could continue to receive Medicaid funding.**

The Impact on Managed Care Coverage

The SUPPORT Act enacted in October 2018, Section 1013 codified the regulation allowing states to make monthly payments to managed care organizations for enrollees aged 21 through 64 who are patients in an IMD **as long as the length of stay in the IMD is no more than 15 days during the month of the payment**.

Treatment Communities Raise Concerns

Treatment communities highlight that CMS interprets "institution" within the IMD statute to include community-based substance abuse non-hospital residential treatment facilities (i.e., treatment communities). The law disallows the use of federal Medicaid financing for services provided to individuals in IMDs with more than 16 beds. Community-based treatment communities require a census for the treatment model to be effective. Facilities with 16 beds or less do not achieve fidelity to the treatment community model. In addition, the 16 or less bed restriction makes economic survival impossible for community-based treatment providers while complying with licensure requirements for addiction treatment including staff-to-patient ratios, counseling and coverage hours, etc. Moreover, a new federal IMD rule limits treatment to 15 days in facilities with more

than 16 beds. The majority of individuals in residential SUD treatment programs require treatment for more than 15 days to achieve and maintain their recovery consistent with their clinical diagnosis.[4]

Waivers Results Emerging and Yet to Be Seen

Many people with behavioral health diagnoses report unmet treatment needs, with substantial shares of nonelderly adults with SUD and any mental illness reporting an unmet need for drug or alcohol treatment. Though treatment utilization among nonelderly Medicaid adults with behavioral health needs is greater than the privately insured, treatment rates are low across all payers.

Enabling states to access federal Medicaid funds for inpatient SUD and mental health treatment could help to address some of this unmet need and help states to cover services that reflect current evidence-based treatment standards. Additionally, providing federal matching funds for IMD services can free up state dollars previously spent on inpatient treatment to instead fund corresponding expansions in community-based services across the behavioral health care continuum.

By law, state initiatives to expand behavioral health services cannot solely focus on inpatient services and instead also must consider community-based services, given states' community integration obligations under the Americans with Disabilities Act. Thus, state expansion of behavioral health services under efforts to fund IMDs may also address demonstrated unmet treatment needs for outpatient behavioral health services.

Policymakers reported that receiving federal Medicaid funds for IMD services under the waivers can allow state and local funds to be used to expand community-based service options, increase provider payment rates, and develop other necessary program features that Medicaid does not fund, such as housing.

Given the widespread use of SUD waivers, and the notable policy change now allowing mental health waivers, states, health plans, providers, and enrollees will be interested in evaluation results assessing the waivers' impact. Key questions include how allowing states to use federal Medicaid funds for IMD services affects access to and utilization of inpatient and outpatient care, health outcomes, care quality, costs, IMD day limits, discharge planning and care transitions, and the continued evolution of evidence-based best practices for SUD and mental health treatment.

While some waiver evaluation results are emerging, most are not expected until 2024 or 2025. In the meantime, states' quarterly and annual waiver reports to CMS and interim evaluation findings can provide important information about the waivers' impact to inform whether CMS makes further Medicaid IMD policy changes and/or whether Congress acts to amend the statute.[5]

Final Thought…

When we try to pick out anything by itself, we find it hitched to everything else in the universe. – John Muir

[4] IMD Exclusion; Treatment Communities of America; https://www.treatmentcommunitiesofamerica.org/advocacy/imd-exclusion/;

[5] Looking Ahead summary provided by: Musumeci, M. et.al., State Options for Medicaid Coverage of Inpatient Behavioral Health Services, https://www.kff.org/report-section/state-options-for-medicaid-coverage-of-inpatient-behavioral-health-services-report/; Kaiser Family Foundation; November 6, 2019.