Designing Systems That Work for Children

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Mental Health – Costliest Health Condition of Childhood

BILLIONS of Dollars

$30.00
$25.00
$20.00
$15.00
$10.00
$5.00
$0.00

Mental Health Disorders
Asthma
Trauma Related Conditions
Acute Bronchitis
Infectious Diseases

Faces of Medicaid: Children’s Behavioral Health

- Illuminates patterns of use and expense
  - Behavioral health (BH) services and psychotropic medications
  - Physical health services
  - *Special analyses*: foster care, state trends
- Establishes baseline for monitoring trends over time: 2005 v. 2008 v. 2011
- Serves as national benchmark for individual state analyses
- Provides context for undertaking quality improvement initiatives
Children in Medicaid: Behavioral Health Penetration and Total Expense

Children in Medicaid using behavioral health care:

- Represent under 10% of children enrolled in Medicaid
- Account for an estimated 38% of total Medicaid child expenditures

Children in Medicaid using behavioral health care are an expensive population

- Mean expenses almost 5x higher than for Medicaid children in general:
  - TANF-enrolled: 3x higher
  - Foster care: 7x higher
  - SSI-enrolled/disabled: nearly 9x higher

- Children in the top 10% of BH expense are nearly 18x more expensive than Medicaid children in general

Behavioral health drives expense for high-cost children

<table>
<thead>
<tr>
<th></th>
<th>Mean Expenditures</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Children in Foster Care</td>
<td>Children representing top 10% of BH Service expense</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>$7,018</td>
<td>$27,654</td>
<td></td>
</tr>
<tr>
<td>Physical Health Services</td>
<td>$5,921</td>
<td>$10,429</td>
<td></td>
</tr>
<tr>
<td>Total Health Services</td>
<td>$12,939</td>
<td>$38,083</td>
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</tbody>
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Medicaid Enrollment, Behavioral Health Service Use and Expense by Aid Category

- TANF: 92% All Children in Medicaid*, 67% Behavioral Health Service Use**, 44% Behavioral Health Service Expense**
- SSI: 5% All Children in Medicaid*, 18% Behavioral Health Service Use**, 27% Behavioral Health Service Expense**
- Foster Care: 3% All Children in Medicaid*, 15% Behavioral Health Service Use**, 29% Behavioral Health Service Expense**
Medicaid Enrollment and Behavioral Health Service Use by Race/Ethnicity

All Children in Medicaid*  Behavioral Health Service Users**

- **All Children in Medicaid:**
  - White: 39%
  - Asian: 22%
  - Black or African American: 26%
  - Hispanic or Latino: 8.7%***
  - Native Hawaiian or Pacific Islander: 8.6%***
  - American Indian or Alaska Native: 0%
  - Other/Unknown: 20%

- **Behavioral Health Service Users:**
  - White: 52%
  - Asian: 25%
  - Black or African American: 12%
  - Hispanic or Latino: 8.6%***
  - Native Hawaiian or Pacific Islander: 8.7%***
  - American Indian or Alaska Native: 0%
  - Other/Unknown: 10%

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Behavioral health services most likely to be used

- Outpatient Therapy (primarily, individual): 48.2%
- Screening and Assessment: 45.2%
- Psychotropic Medication: 43.7%
- Medication Management: 24.3%
- Family therapy/Family education and training: 23.2%
- Wraparound: 1.1%
- Therapeutic Foster Care: 0.9%
- Respite: 0.3%
- Peer Services: 0.1%
- Multisystemic Therapy: 0.1%
## Differences in Child Behavioral Health Penetration Rates and Mean Expense by State Management and Payment Arrangement

<table>
<thead>
<tr>
<th>Payment/Delivery Structure</th>
<th>Average Penetration Rate</th>
<th>Penetration Range</th>
<th>Mean Expenditure</th>
<th>Mean Expenditure Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>All FFS</td>
<td>10.4%</td>
<td>2.5% - 17.3%</td>
<td>$5,542</td>
<td>$2,099 to $14,803</td>
</tr>
<tr>
<td>Primarily FFS</td>
<td>7.5%</td>
<td>0.3% - 10.4%</td>
<td>$4,709</td>
<td>$1,862 to $9,172</td>
</tr>
<tr>
<td>Primarily Capitated*</td>
<td>5.1%</td>
<td>1.6% - 8.9%</td>
<td>$3,684</td>
<td>$1,193 to $9,377</td>
</tr>
</tbody>
</table>

*May understate utilization depending on completeness of encounter data submitted to state agencies. May overstate expenditures, which are extrapolated from FFS expenditures.

Chronic Physical Health Conditions Among Children in Medicaid Using Behavioral Health Services*

- 38% of children with BH claims also had claims for at least one chronic medical condition
- Pulmonary diseases were the most common physical health condition (overall mean expense of $1,091)
- High-cost medical conditions (e.g. cancer at $19,065) had low frequency

*Using Chronic Disability Payment System (CDPS) Methodology

Trends: Integration at the Payer (Medicaid) Level

Research has shown that...

- When physical and behavioral health dollars are integrated, there is a risk of behavioral health dollars being absorbed by physical health services.
- When adult and child behavioral health dollars are integrated, there is a risk of child behavioral health dollars being absorbed by adult services.

Especially in the absence of customization within the design for children with serious BH challenges, risk-adjustment strategies, strong contractual performance measures and monitoring mechanisms.

See publications and issue briefs published by the Health Care Reform Tracking Project at: [http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm](http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm)
Trends: Integration at the Practice Level – Medical Home Services for Children

“All behavioral health conditions except ADHD associated with difficulties accessing specialty care through medical home”

“The data suggest that the reason why services received by children and youth with behavioral health conditions are not consistent with the medical home model has more to do with difficulty in accessing specialty care than with accessing quality primary care”.

Suggests need for more customized, intensive care coordination approaches for children with significant behavioral health challenges.

Cost Drivers for Children in Medicaid Using Behavioral Health Services

- Residential treatment and therapeutic group homes:
  - #1 cost driver in 2008 and 2005 – represents about 20% of all BH expense for under 4% of children using BH care

- Psychotropic medications:
  - 2nd highest cost driver in 2008
  - 3rd highest in 2005
What Especially Drives Medicaid Costs (and often poor outcomes)?

• Use of emergency room for regular care
  ✓ Strategy: Medical home, WI Medicaid

• Use of emergency room e.g., for asthma-related issues, for primary care

• Inappropriate Use of Psychotropic Medications
  ✓ Strategies: Red flag monitoring (too young, too many, too much) and consultation to/education of prescribers as in OR and WY; Psychiatric consultation to primary care docs as in MA (MCPAP); Informed consent supported by access to psychiatric consultation- IL and VT

• Duplication of Services (e.g., multiple assessments, multiple care coordination)
  ✓ Strategies: common screening/assessment tools; fidelity Wraparound approach with dedicated care coordinator, low ratios (1:10)
What Especially Drives Medicaid Costs (and often poor Outcomes)?

• Use of traditional outpatient therapies
  “Based on current evidence of the effectiveness of interventions in community mental health settings, there is no reason to assume that the outpatient mental health services provided to foster children are effective in improving outcome” (James, S., Landsverk, J., Slymen, D. and Leslie, L. Predictors of Outpatient Mental Health Service Use—The Role of Foster Care Placement Change Ment Health Serv Res. 2004 September; 6(3): 127–141)

• Use of Residential Treatment (and Day Treatment)
  ✓ Strategy: Effective home and community-based alternatives and intensive care coordination using fidelity Wraparound as in MA, NJ, WI

“Results indicate that children who have experienced long-term foster care do not benefit from the receipt of outpatient mental health services” (Bellamy, J., Gopala, G., Traube, D A national study of the impact of outpatient mental health services for children in long-term foster care. Clin Child Psycholog Psychiatry 2010 Oct;15(4):467-79)

✓ Strategy: Evidence-based practices
Use of Child Behavioral Health Services by Service Type: 2008 v. 2005

- Appreciable increases (20% or greater) in percent of children using:
  - Emergency room: 0.1 to 6% (**590% increase**)
  - Substance use inpatient/residential: 0.3 to 1.7% (**467% increase**)
  - Psychosocial rehab: 12.4 to 18.4% (**48% increase**)
  - Partial hospitalization/day treatment: 3.3 to 4.6% (**39% increase**)
  - Residential treatment/group care: 3.6 to 4.8% (**33% increase**)
  - Family therapy/family education and training: 19.4 to 24.3% (**25% increase**)
  - Substance use screening and assessment: 2.9 to 3.5% (**21% increase**)
Use of Child Behavioral Health Services by Service Type: 2008 v. 2005

• Appreciable decreases (20% or greater) in percent of children using:
  – Psychological testing: 9.3 to 4.5% (52% decrease)
  – Behavioral management/therapeutic behavioral supports: 4.7 to 2.6% (45% decrease)
  – Targeted Case Management: 7.1 to 5.6% (21% decrease)

• Use of emerging best practices (e.g., Multisystemic Therapy, wraparound, peer support, in-home services) remained roughly the same as in 2005, with 1% or less of children using each type
Total Behavioral Health Expense: 2008 v. 2005

14% increase in total expenditures

- 57% increase in proportion spent on 0-5 year olds
- 11% increase in proportion spent on 6-12 year olds
- 7% increase in proportion spent on SSI/disabled
- 4% increase in proportion spent on TANF

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- 11% decrease in proportion spent on adolescents
- 14% decrease in proportion spent on foster care
Care Coordination Continuum

- **All Children**: Screening, Information and Referral on an as Needed Basis/ During Well Child Visits
- **Children With a Behavioral Health Need**: Service Coordination and System Navigation To Support Effective Response to the BH Need
- **Children With Complex Behavioral Health Needs**: Intensive Customized Care Coordination To Provide Extended Support To Multi-Modal Needs
Customized Care Coordination

- 2013 CMCS and SAMHSA Informational Bulletin

- Incorporate intensive care coordination using Wraparound approach for children with serious behavioral health challenges (growing number of states – MA, LA, NJ; PRTF Waiver Demo; CHIPRA Care Management Entity Quality Collaborative states)
  - Intensive care coordination rates for this population range from $780 pmpm to $1300 pmpm (CHCS Matrix)
  - In fidelity intensive care coordination/Wraparound approaches, all-inclusive cost of care (e.g., admin, care coord, placements, clinical treatment, informal supports) averages $3700-$4200 pmpm (about $2100 is Medicaid)– compare to $9,000 pmpm in PRTFs, higher in psych inpatient

- Require that every child has a designated primary care provider and coordination between physical and behavioral health care providers

- Require coordination with child welfare system and with Part C, CSHCN

Milwaukee County, WI

- **CHILD WELFARE**
  - Funds thru Case Rate
  - (Budget for Institutional Care for Chips Children)
  - 10.0M

- **JUVENILE JUSTICE**
  - Funds Budgeted for Residential Treatment and Juvenile Corrections Placements
  - 10.0M

- **MEDICAID CAPITATION**
  - (1923 per Month per Enrollee)
  - 24.0M

- **MENTAL HEALTH**
  - CRISIS BILLING
  - HTI GRANT
  - HMO COMMERCIAL INSUR
  - 8.0 M

**WRAPAROUND MILWAUKEE CARE MANAGEMENT ORGANIZATION (CMO)**
- 52.0M

- **FAMILIES UNITED**
  - $525,000

- **CHILD & FAMILY TEAM OR TRANSITION TEAM**

- **PLAN OF CARE OR FUTURES PLAN**

- **CARE COORDINATION OR TRANSITIONAL SPECIALIST**

- **PROVIDER NETWORK**
  - 210 Providers
  - 60 Services
New Jersey

Department of Children and Families
Division of Children's System of Care (CSOC)

Contracted Systems Administrator-
PerformCare – ASO for child BH carve out

Family Support Organizations
- Family peer support, education and advocacy
- Youth movement

*Care Management Entities- CMOs
- Lead non profit agencies managing children with serious challenges, multisystem involvement

Provider Network

Mobile Response & Stabilization Services

Dept. of Human Services
Division of Medical Assistance and Health Services (Medicaid)

UMDNJ Training & TA Institute; Rutgers
- • 1-800 number
- • Screening
- • Utilization management
- • Outcomes tracking

BH, CW, MA $$ - Single Payor

Adapted from State of New Jersey 2010
Strategizing Who Can/Will Fund What

**Medicaid & Medicaid MCOs**
- Intensive in-home services
- Crisis response
- Wraparound
- Peer support
- TF-CBT, FFT, MST, MDTFC, PCIT
- Substance use disorder treatment
- Screening and assessment
- Workforce development

**MCO Reinvestment Dollars**
- Workforce Development
- CANS Implementation
- EBP Capacity Development
- Psychotropic Med Consultation

Examples:
- Magellan funded kinship navigators to help prevent placement disruption due to child’s behavioral health challenges
- Value Options funded training for providers in the Incredible Years

**Child Welfare**
- Team Decision Making
- Family Finding
- Strengthening Families
- Permanency Roundtable
- Workforce Development
- CANS Implementation
- Psychotropic Med Consultation

**Other Systems (e.g. BH, TANF, JJ)**
- Workforce Development
- CANS Implementation
- Non-Medicaid families
- Psychotropic Med Consultation
- Nurse Home Visiting
- Housing supports
- Transportation