IDENTIFYING OPPORTUNITIES TO IMPROVE CHILDREN'S BEHAVIORAL HEALTHCARE

An Analysis of Medicaid Utilization and Expenditures, The Center of Healthcare Strategies, Dec 2013

Children in Medicaid with serious behavioral health care needs are a complex and vulnerable population. Without access to a broad array of services (both traditional and alternative), care coordination, and collaboration among child-serving systems, they are at risk for poor outcomes and high costs.

To identify ways to improve behavioral health care, the Center for Health Care Strategies (CHCS) conducted a nationwide analysis, *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures (Faces of Medicaid). This study analyzes data from all 50 states to explore: (1) behavioral and physical health service use, expense, and diagnoses; (2) use of psychotropic medications; and (3) service use and expense for children in foster care and those with developmental disabilities.*

This analysis, which uses 2005 data (the most recent data available when the study began), provides a critical baseline for examining child behavioral health utilization and expenses for Medicaid populations. CHCS is pursuing a follow-up study using 2008 data to further explore trends in this area.

State policymakers and other key stakeholders can use the findings to inform quality improvement efforts in children's behavioral health systems, such as:

• Expanding access to appropriate and effective behavioral health care, particularly therapeutic interventions with an existing or emerging evidence base, and home- and community-based services;

• Investing in care coordination models that use a wraparound approach to facilitate delivery of needed supports and services for vulnerable populations; and

• Ensuring collaboration across child-serving systems to increase care coordination and improve oversight and monitoring of psychotropic medication use.

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Expand Access to Appropriate and Effective Behavioral Health Services—Both Traditional and Alternative

Given the higher prevalence of behavioral health needs among children in poverty, the overall use of behavioral health care among children in Medicaid was low, at under 10 percent. Further, variations in use for children of diverse racial/ethnic backgrounds indicate the need to examine how social and cultural determinants of behavioral health impact access to care. To improve access, it is essential to ensure that: (1) a range of behavioral health services is covered by Medicaid; (2) services are culturally and linguistically appropriate; (3) providers are sufficient in number, geographically accessible, and trained in both traditional and alternative services (including home and community-based services); and (4) delivery systems are knowledgeable about Medicaid reimbursement for behavioral health services.

Invest in Care Coordination

Adolescents, children in foster care, and those with developmental disabilities used more behavioral health care, and more expensive services (e.g., residential and group care) than other children in Medicaid. Psychotropic medications were prescribed frequently to children in all age groups, but most often to children ages 6–12 who are typically not able to participate in care decisions. Physical health issues are also a concern for children with behavioral health needs, who are at risk for chronic conditions like asthma and obesity. That reality, plus the health risks associated with psychotropic medication use—especially for very young children, and the high rates of use among those who received no other services, emphasize the need for close coordination between the primary care and behavioral health providers serving these children. Furthermore, children and adolescents with serious behavioral health conditions are often served by other entities such as child welfare, juvenile justice, and special education, making coordination across all child-serving systems especially critical.

Through temporary increased funding authorized by the ACA, states can invest in health homes that facilitate coordination of care for individuals with chronic conditions, including children with serious behavioral health needs. Emerging models of intensive care coordination that use a wraparound approach, such as the Wraparound Milwaukee model, provide many services identical to those required by health homes and have resulted in good quality and cost outcomes for children with behavioral health needs. In some states, including Massachusetts and New Jersey, intensive care coordination using wraparound is financed by Medicaid through Targeted Case Management funds.Health homes may provide a new pathway for expanding access to these services. States like Montana and Maryland are also employing the ACA's 1915 state plan amendment provision to enable access to evidence-informed child behavioral health services, including care coordination approaches.

Improve Collaboration and Coordination between Child Welfare, Medicaid, and Behavioral Health Systems

This Faces of Medicaid analysis supports evidence showing that children in the child welfare system are at greater risk for behavioral health issues, often associated with high levels of trauma and instability, and are more likely to be prescribed psychotropic medications.

Given their frequent involvement with multiple public agencies, broad cross-system communication and coordination are high priorities for this population. Federal legislation like the 2008 Fostering Connections to Success and Increasing Adoptions Act, the 2011 Child and Family Services Improvement and Innovation Act, and some provisions of the ACA, emphasize cross-system collaboration for better oversight and monitoring of psychotropic medications, improved care coordination, and expanded access to medical homes.

Additionally, children in foster care are a priority population for recent federal grants from the Center for Medicare & Medicaid Innovation, boosting recognition of their needs and the role of state purchasers and system partners in improving their outcomes.

Cross-system collaboration and coordination can be achieved in a number of ways, including: (1) data-sharing among child welfare, Medicaid, behavioral health, and other child-serving systems; (2) interagency leadership teams to collectively address system-level issues; (3) training and capacity building across agencies; and (4) shared, family-driven treatment planning. Data-sharing, in particular, is an effective way to coordinate care and boost oversight and monitoring of psychotropic medication use.

Finally, child- and family-driven treatment planning that incorporates all involved agencies and providers, ensures that treatment plans are inclusive, strengths-based, and complete with the necessary information to reduce risk and improve outcomes.

Children using behavioral health care represented **under 10 percent** of the overall Medicaid child population, but an estimated **38 percent** of total spending for children in Medicaid;

Children in foster care and those on SSI/disability together represented **one-third** of the Medicaid child population using behavioral health care, but **56 percent** of total behavioral health service costs; and

Almost **50 percent** of children in Medicaid who were prescribed psychotropic medications received no identifiable accompanying behavioral health treatment.

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An estimated 38 percent of children who used behavioral health services also had a chronic physical health condition; nonetheless, behavioral health costs accounted for the majority of Medicaid expenditures.

Thirty-eight percent of children in Medicaid who used behavioral health services also had at least one chronic physical health condition—most often a pulmonary, skeletal, or central nervous system condition.

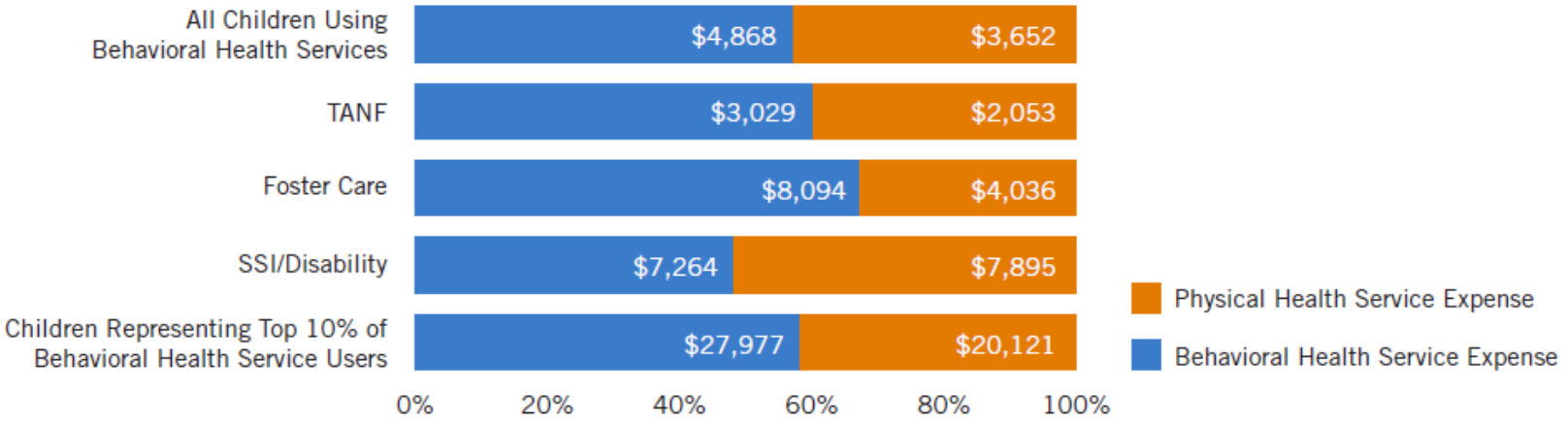
Mean annual behavioral health expenditures for children in Medicaid were nearly $4,900, while their physical health expenditures were about $3,600. Behavioral health expenses outweighed physical health expenses for both children receiving TANF and those in foster care.

Behavioral health expenses for children in foster care were double those of physical health. For children in the SSI/disability aid category, however, mean physical health expenses were slightly higher. The 10 percent of children in Medicaid with the highest behavioral health service use (N=121,323) had mean annual expense of $48,000, with behavioral health expenses of almost $28,000 and physical health expenses of about $20,000 (Figure 3).

These findings contrast with earlier research on adult populations in Medicaid with serious mental illness, who had much higher rates of chronic health conditions and for whom overall expenses were driven more by use of physical health care.

IMPLICATIONS: States that are developing approaches to better identify and address children's behavioral health needs may be able to reduce their overall expenditures—for both behavioral and physical health care. This is an important consideration for states looking into current models for integrating physical and behavioral health care, for which the focus may need to shift to behavioral health—rather than physical health, as in many adult models—to be effective.

Figure 3: **MEAN ANNUAL EXPENSE FOR CHILDREN IN MEDICAID USING BEHAVIORAL HEALTH SERVICES***



* Includes children with at least one claim for a behavioral health service in 2005 with or without concomitant psychotropic medication use, N = 1,213,201.

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Children in Medicaid from racially/ethnically diverse backgrounds were less likely than white children to use behavioral health services.

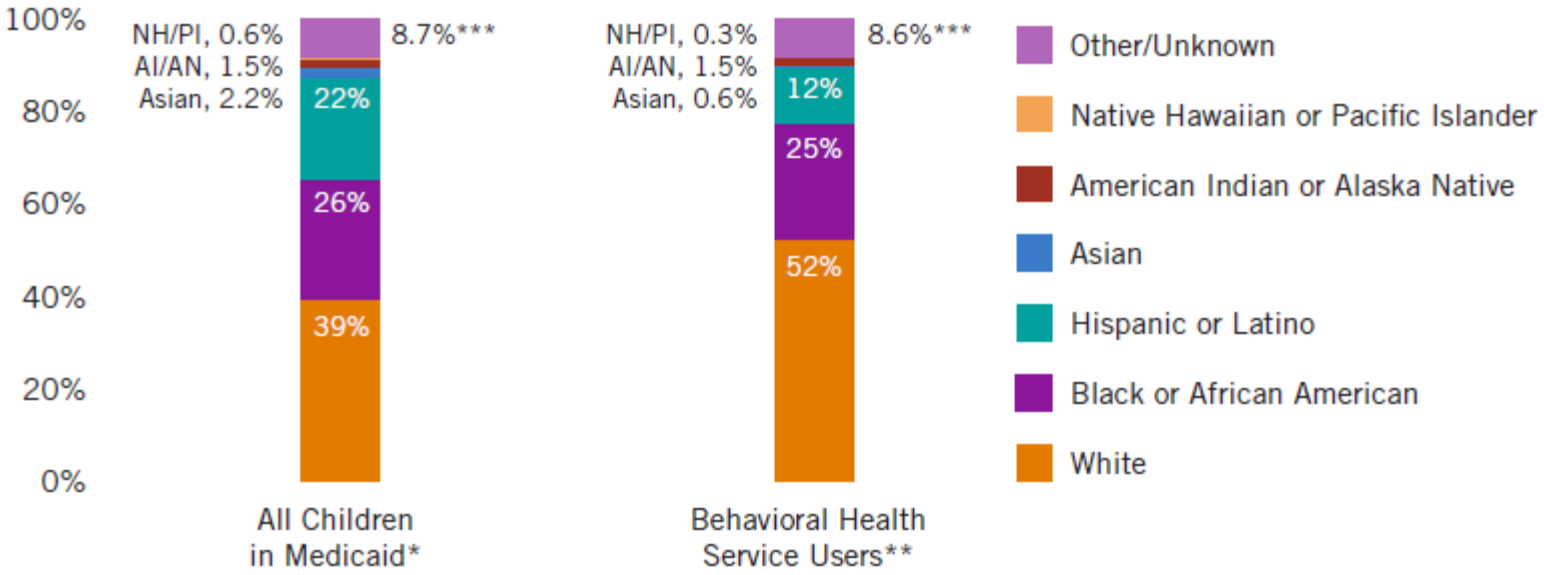
White children represented 39 percent of the Medicaid child population, but 52 percent of the population using behavioral health services. In contrast, while Hispanic/Latino children made up 22 percent of the Medicaid child population, they represented only 12 percent of children using behavioral health services.

Similar trends were seen among Asian and Native Hawaiian/Pacific Islander children, who were also less likely to use behavioral health services. Compared to these children, black or African American and American Indian/Alaska Native children were more likely to use behavioral health services, but still less likely than white children (Figure 4).

IMPLICATIONS: Though certain cultural values may impact the choice to seek behavioral health services, these differences in utilization rates raise questions about possible disparities in access to behavioral health services across racial/ethnic groups.

The availability of culturally and linguistically appropriate behavioral health services may also influence an individual or family's decision to seek care and the quality of that care. Examining the social determinants of health impacting children and youth—such as poverty, social stressors, and environmental hazards—may help Medicaid stakeholders identify root causes of disparities and develop appropriate, community-based interventions involving other public systems such as child welfare, education, and juvenile justice.

Figure 4: **MEDICAID ENROLLMENT AND BEHAVIORAL HEALTH SERVICE USE BY RACE/ETHNICITY**



* All children in Medicaid in 2005, N = 29,050,305.

** Behavioral health service users in 2005, N = 1,958,908.

*** Other category includes: 2.9%, Hispanic or Latino, plus one or more races; 0.3%, more than one race; and 5.6%, unknown.

Adolescents represented one-quarter of children enrolled in Medicaid, but nearly half of behavioral health service users and almost 60 percent of behavioral health expense.

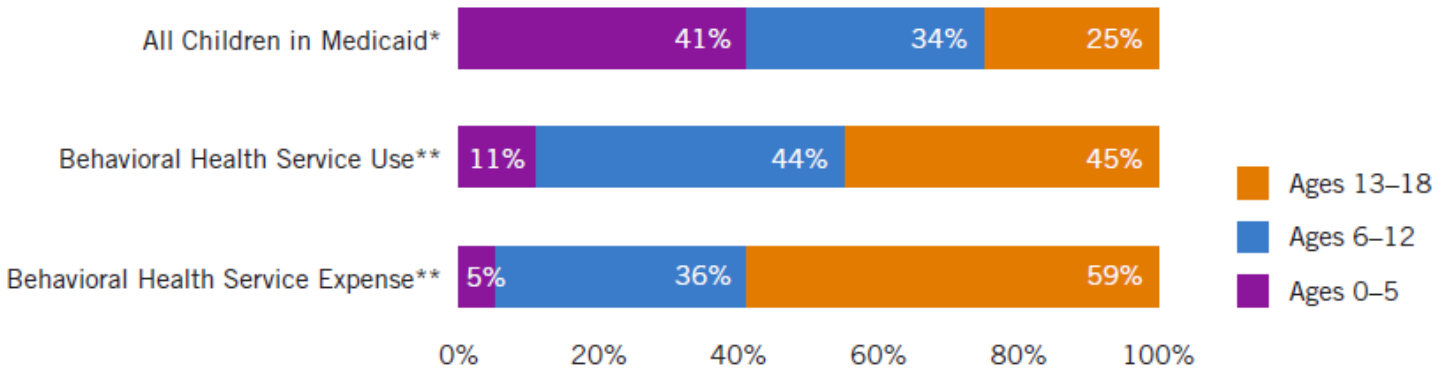
Adolescents, ages 13–18, represented 25 percent of the overall Medicaid child population, but 45 percent of children in Medicaid using behavioral health services (Figure 5).

They were more likely than other children to use all behavioral health service types—particularly more expensive and restrictive services such as residential treatment/group care and inpatient psychiatric treatment. Among children receiving behavioral health services, 19 percent of adolescents—compared with 12 percent of other children— received substance use disorder services. (Overall, 0.8 percent of the Medicaid child population received substance use disorder services.) Consistent with their higher utilization rates across many service types, adolescents had the highest mean ($5,400) and total ($4.7B) behavioral health expenditures, accounting for almost 60 percent of total behavioral health service expenditures for children in Medicaid.

Children ages 0–5, represented 41 percent of the Medicaid child population, and 11 percent of those using behavioral health services. Children in the 6–12 age group used services in slightly higher proportion (44%) than their enrollment in the overall Medicaid child population (34%). Mean expenditures for children ages 0–5 and 6–12 were approximately $1,700 and $3,400, respectively; while total expenditures for these age groups were $373.6M and $2.9B.

IMPLICATIONS: Because adolescents used disproportionately more services—particularly facility-based care—and accounted for more expenditures than other age groups, states may want to focus on cost-effective approaches to care that can be tailored to this age group. States can promote interventions such as Multisystemic Therapy and Functional Family Therapy that include key features such as youth-directed care planning, peer involvement, development of transitional adult skills, and coordination among juvenile justice, child welfare, and substance use service providers, in facilitating improved outcomes for adolescents.

Figure 5: **MEDICAID ENROLLMENT, BEHAVIORAL HEALTH SERVICE USE AND EXPENSE BY AGE GROUP**



* All children in Medicaid in 2005, N=29,050,305.
** Behavioral health service use and expense in 2005, N=1,958,908.

i Rates of use for substance use disorder services are likely overstated, as there is an unknown amount of duplication of children across the substance use disorder service categories of screening and assessment, outpatient, and inpatient.

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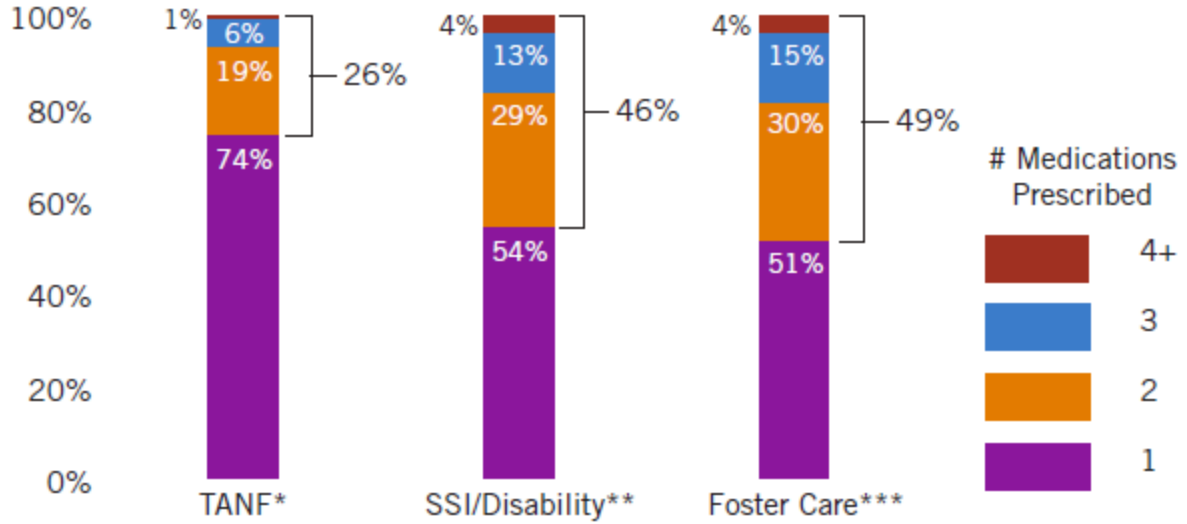
Psychotropic medication prescribing for children in Medicaid revealed high rates of concurrent prescription and antipsychotic use.

Approximately one-third of children in Medicaid receiving psychotropic medications were prescribed two or more medications of different classes, with 11 percent prescribed three or more. About 20 percent of children who received psychotropic medications with no other behavioral health services were prescribed two or more medication classes. Children in foster care who were prescribed psychotropic medications were more likely than children in other aid categories to receive multiple medication types, with 49 percent prescribed two or more, and close to 20 percent prescribed three or more (Figure 10).

Among children in Medicaid who received psychotropic medications, over 26 percent were prescribed antipsychotic medication, although only four percent received a diagnosis of psychosis. This discrepancy between the number of children receiving a medication and the number with an appropriate diagnosis is indicative of “off-label” use. Children in foster care and those on SSI/disability who received psychotropic medications were the most likely to be prescribed antipsychotics—with over 42 percent in each group receiving antipsychotics. Variations in antipsychotic use by age also reveal a concerning pattern, with almost a quarter (23%) of young children, ages 0–5, on psychotropic medications receiving these powerful medications.

IMPLICATIONS: Both concurrent medication use and antipsychotic use among children present significant health risks, including interaction between medications, weight gain, and cardio-metabolic side effects. These trends—and the growing shift of behavioral health treatment into primary care—highlight the need for effective monitoring and a review of current oversight systems. Ensuring appropriate behavioral health provider capacity, as well as access to evidence-based, non-pharmacological interventions, can help to reduce reliance solely on psychotropic medications to treat children with significant behavioral health needs.

Figure 10: **CONCURRENT PSYCHOTROPIC MEDICATION USE AMONG CHILDREN IN MEDICAID**



*N=1,119,266 **N= 354,945 ***N= 212,176

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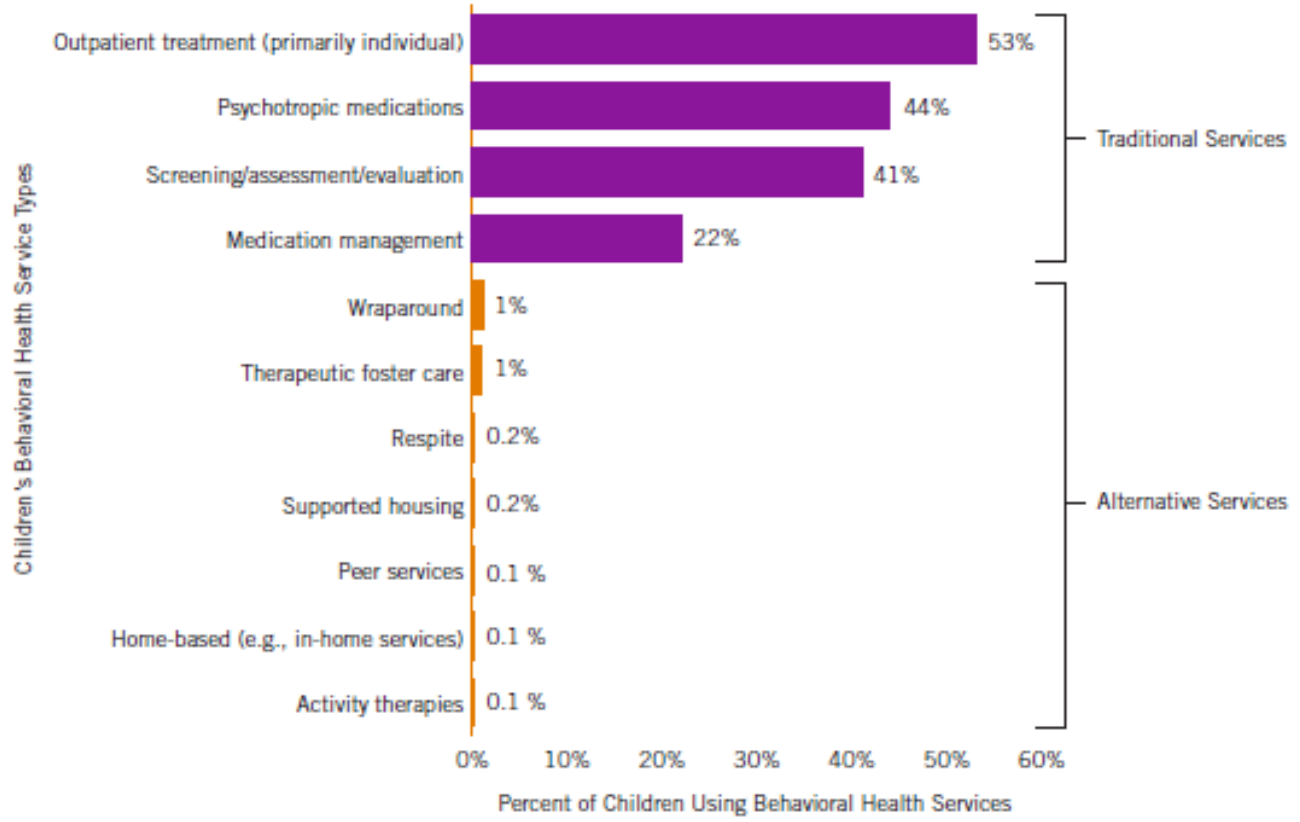
Children in Medicaid were more likely to receive traditional behavioral health services, including outpatient treatment and psychotropic medication, versus alternative approaches, even those with an emerging or established evidence base.

One percent or fewer children using behavioral health services received alternative services that have an existing or emerging evidence base, such as wraparound (1%), supported housing (0.2%), peer services (0.1%), or home-based services (0.1%). This may be due to: inadequate knowledge among stakeholders about effective interventions; a dearth of trained providers to deliver the services; inconsistent coverage of these services in Medicaid; insufficient reimbursement rates; and/or lack of access to these services, even when covered (e.g., due to transportation or child care barriers).

IMPLICATIONS: To expand access to more appropriate and cost-effective behavioral health services and supports, states may need to examine whether their state Medicaid policies allow for coverage and adequate reimbursement of these treatments. States should also determine the geographic availability and level of awareness among providers regarding evidence-informed and home- and community-based services for children. States can look to funding sources outside of Medicaid, for example child welfare, education, or behavioral health, to facilitate co-financing and coordinated delivery of these services.

Figure 8: **USE OF TRADITIONAL SERVICES VS. ALTERNATIVE SERVICES AMONG CHILDREN IN MEDICAID***



* Includes children with at least one claim for behavioral health services in 2005, with or without psychotropic medications use; does not include children with psychotropic medication use and no other behavioral health service claim, N = 1,958,908.

ii The utilization rates for these alternative services may be understated, as they may have been coded to different service categories, such as *psychosocial rehabilitation services*; however, only 12 percent of children in Medicaid used any type of psychosocial rehabilitation service.

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