



UNIVERSITY of MARYLAND  
SCHOOL OF SOCIAL WORK



# Customizing Medicaid & Managed Care for Children

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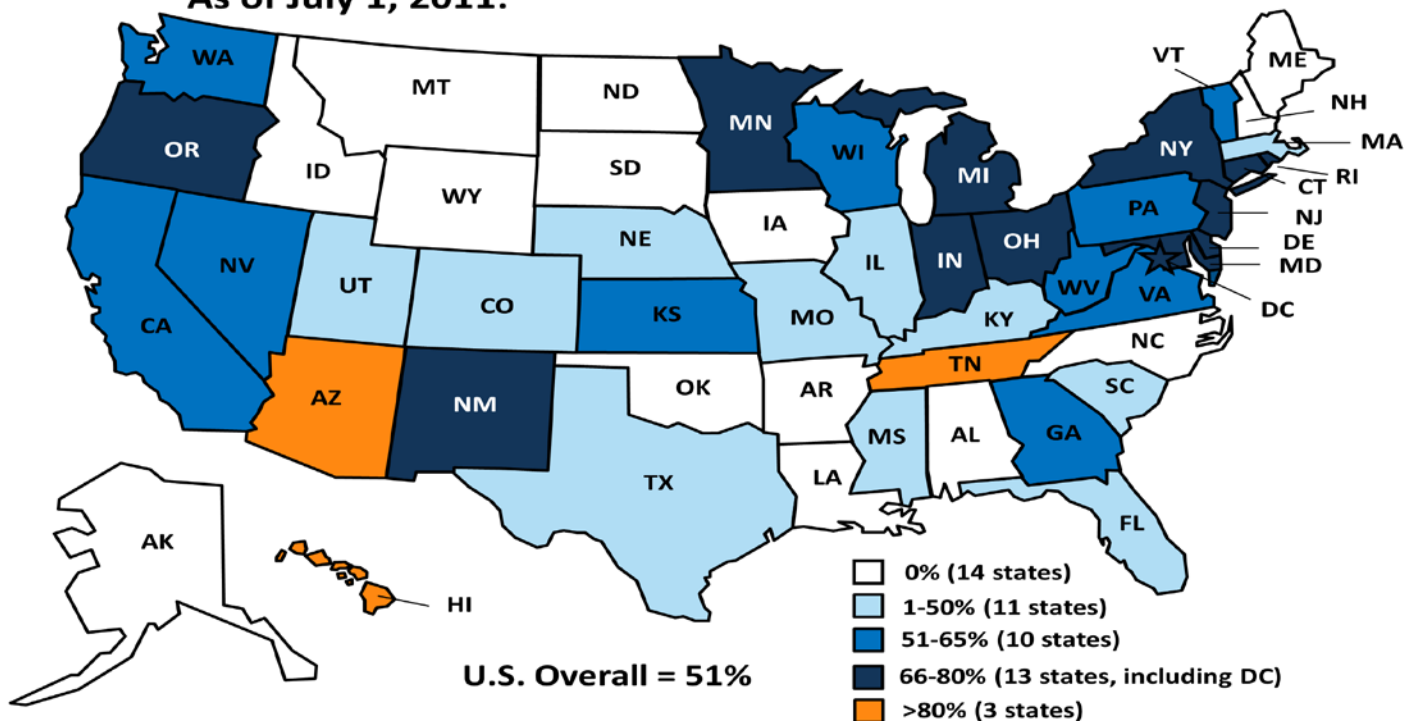






# Use of Managed Care is Growing

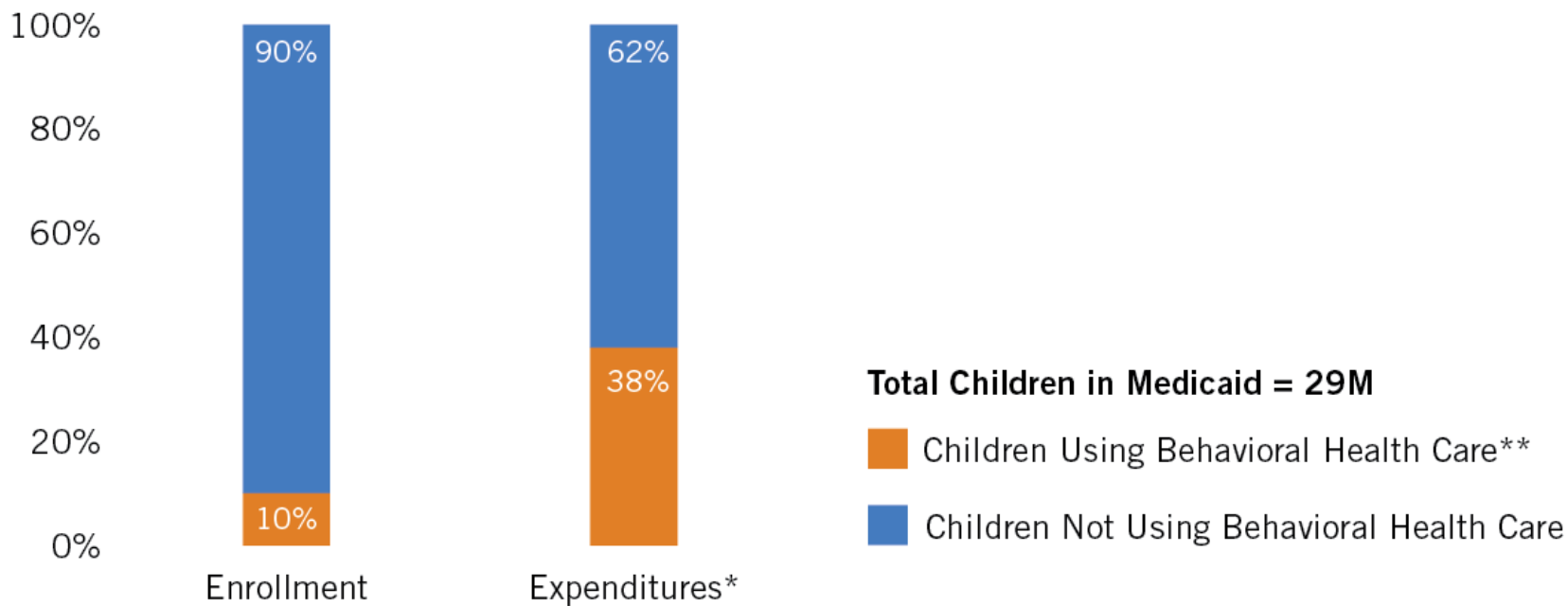
As of July 1, 2011:



NOTE: Comprehensive risk-based managed care includes Health Insuring Organizations (HIOs), comprehensive commercial and Medicaid managed care organizations (MCOs), and Program of All-Inclusive Care for the Elderly (PACE).  
SOURCE: *Medicaid Managed Care Enrollment Report, Summary Statistics as of July 1, 2011*, CMS, 2012.



## CHILDREN USING BEHAVIORAL HEALTH CARE AS A PROPORTION OF TOTAL MEDICAID ENROLLMENT AND EXPENDITURES



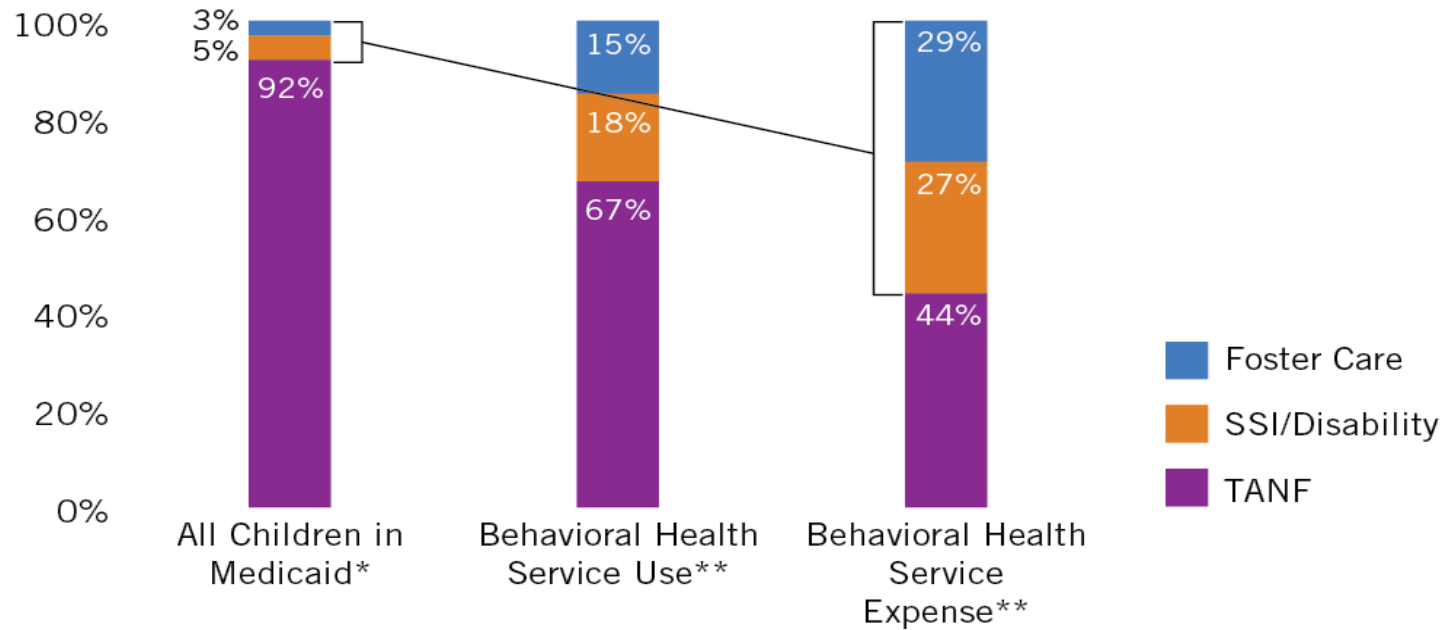
\* Total combined expenditures for all children in Medicaid in 2005 from: Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations: Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services (HCFA 2082), Medicaid and Statistical Information System. 2008 Statistical Supplement.

\*\* Children using behavioral health care in 2005, N= 2,787,919.

**Children Using Behavioral Health  
Drive Significant Portion of Expenditures**



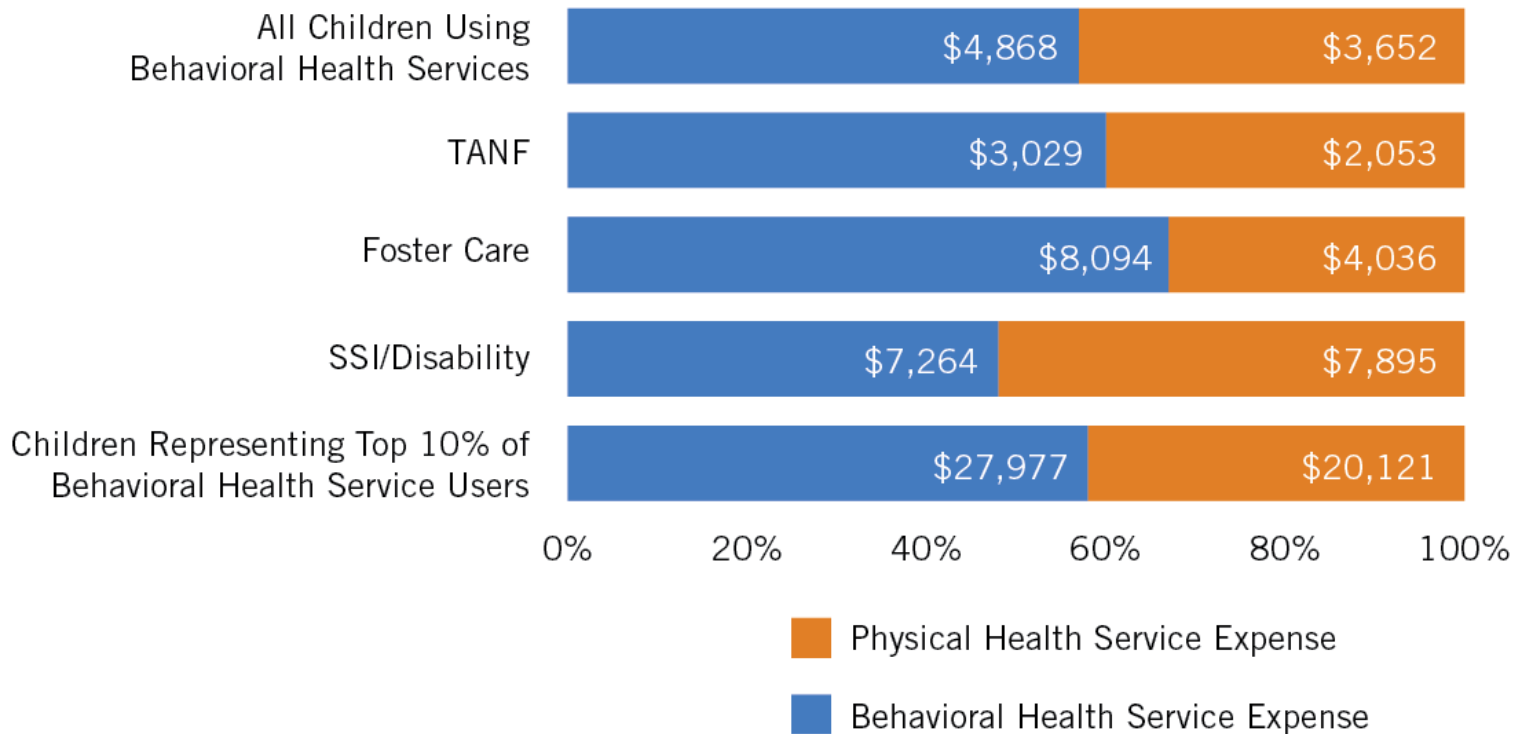
### MEDICAID ENROLLMENT, BEHAVIORAL HEALTH SERVICE USE, AND EXPENSE BY AID CATEGORY



**Children in Foster Care and Children With Disabilities Drive Costs & Utilization**



### MEAN ANNUAL EXPENSE FOR CHILDREN IN MEDICAID USING BEHAVIORAL HEALTH SERVICES\*

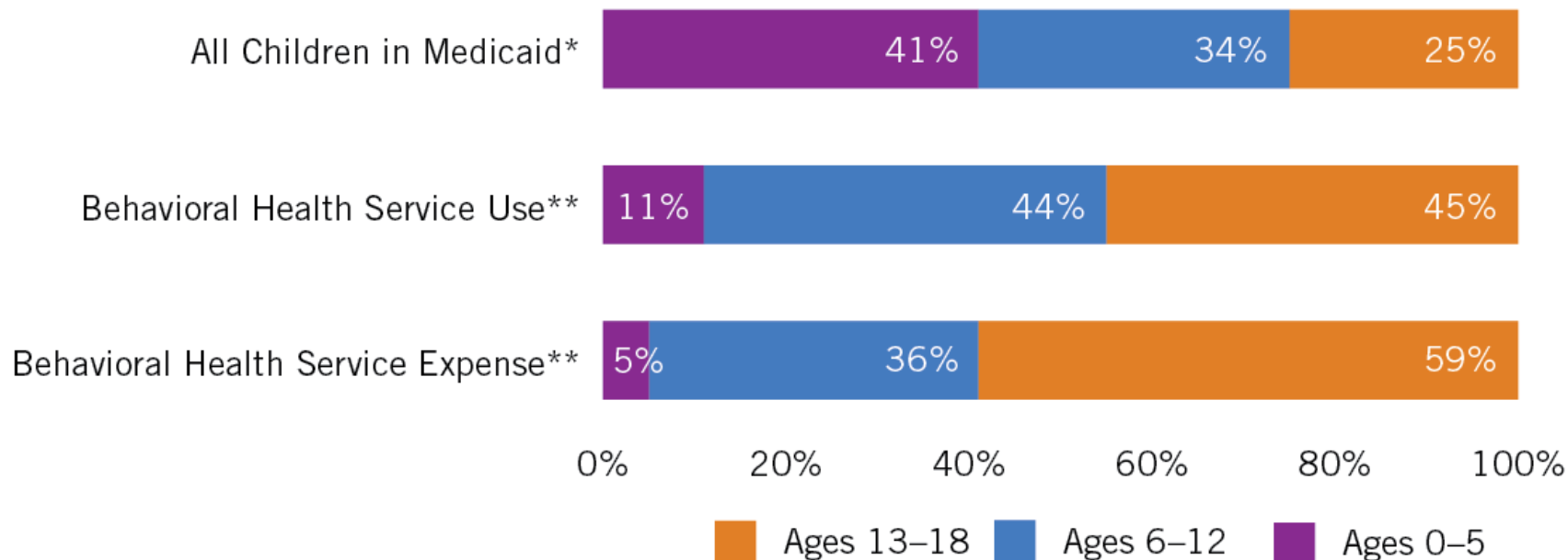


\* Includes children with at least one claim for a behavioral health service in 2005 with or without concomitant psychotropic medication use, N = 1,213,201.

**Behavioral Health Accounts for Majority  
of Expenditures Even Among Children With Chronic  
Physical Conditions**



## MEDICAID ENROLLMENT, BEHAVIORAL HEALTH SERVICE USE AND EXPENSE BY AGE GROUP

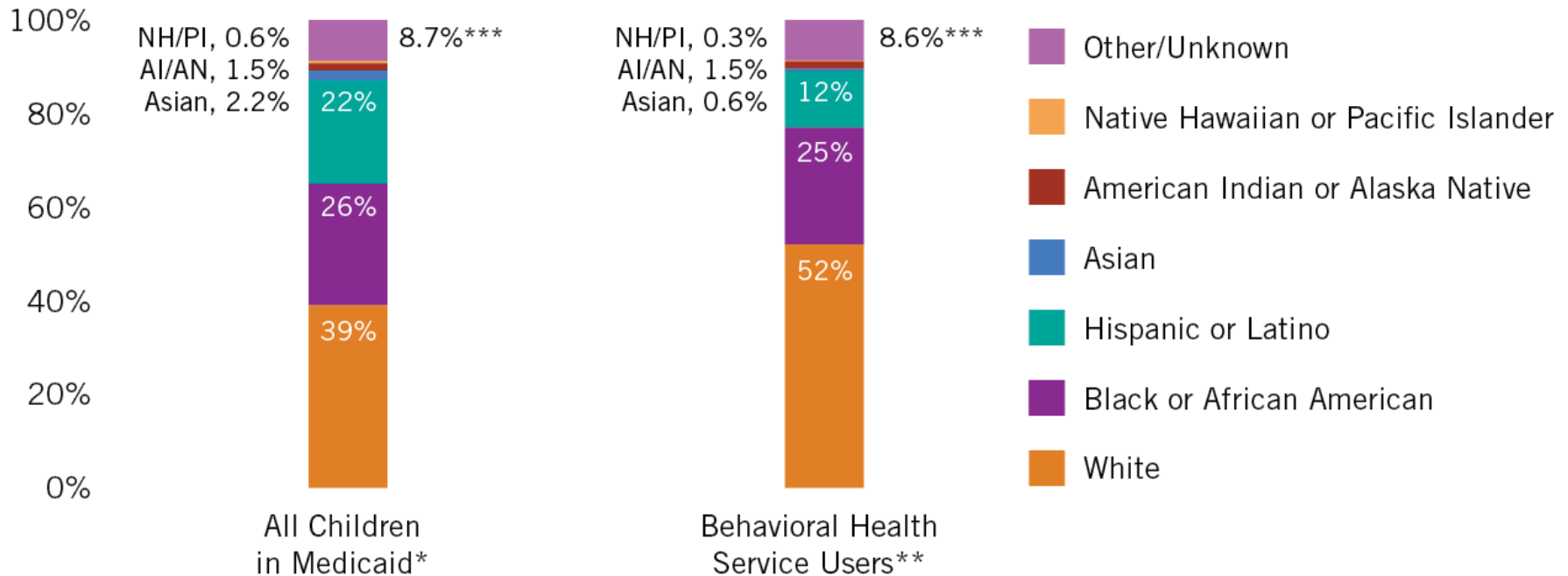


\* All children in Medicaid in 2005. N=29,050,305

Source: G. Flores, R. Collins, T. Gilmer, R. Allen, & R. Mandeville. "Uses of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

**Adolescents Have Particularly High Costs**

## 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.

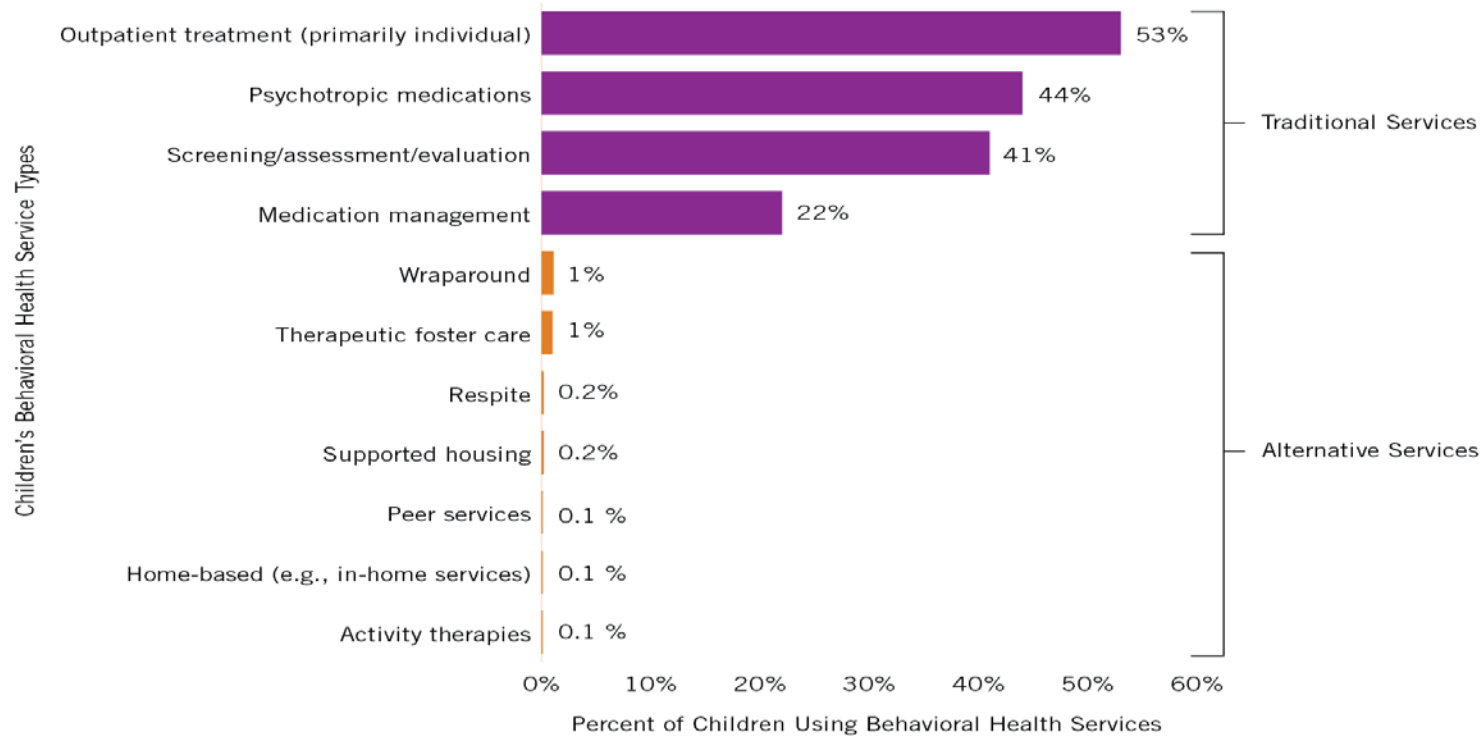
Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

**Access & Utilization Varies Significantly  
By Race & Ethnicity**





USE OF TRADITIONAL SERVICES VS. ALTERNATIVE SERVICES AMONG CHILDREN IN MEDICAID\*



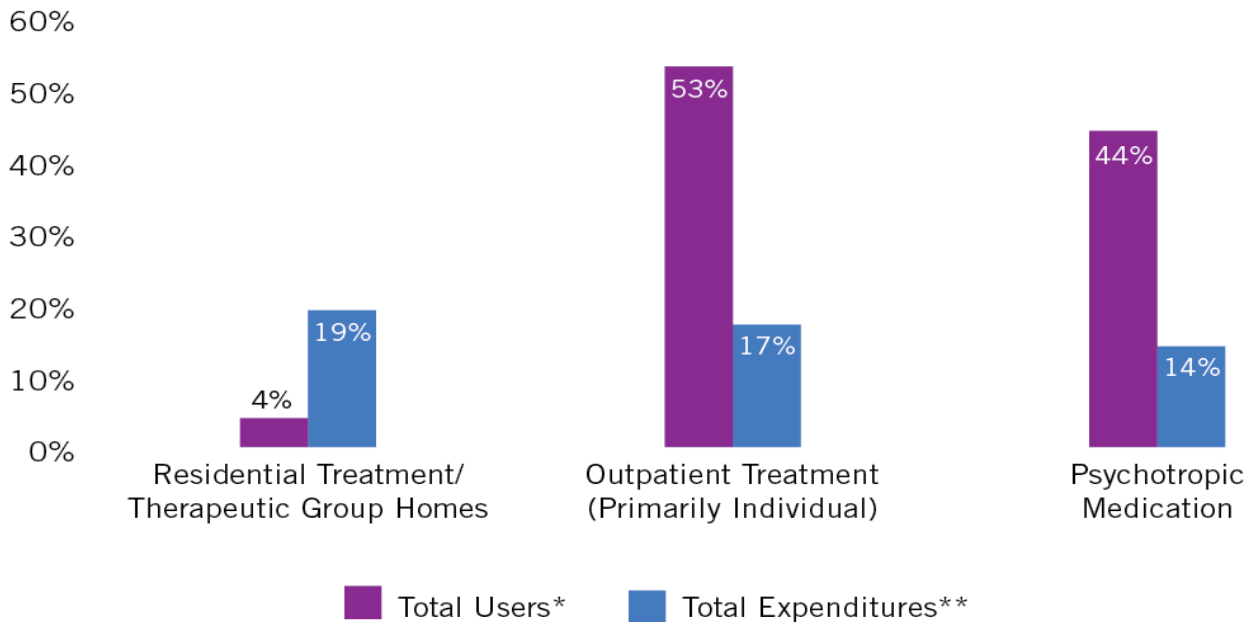
\* Includes children with at least one claim for behavioral health services in 2005, with or without psychotropic medications use; does not include children with psychotropic medication use and no other behavioral health service claim, N = 1,958,908.

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

Services in Medicaid Continue to Be Traditional Services



### COMPARISON OF USE AND EXPENSE FOR CHILDREN'S BEHAVIORAL HEALTH SERVICES IN MEDICAID WITH HIGHEST TOTAL EXPENDITURES



\* Based on all children in Medicaid using behavioral health services in 2005, N=1,958,908.

\*\* Expenditures are based on 1.2 million children in fee-for-service arrangements and extrapolated to children in capitated managed care. 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.

Source: S. Pires, K. Grimes, T. Gilmer, K. Allen, & R. Mahadevan. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies, December 2013.

**Children in Medicaid Continue to Use High Amounts of Residential & Group Care**



	All Children Using Behavioral Health Care	TANF	Foster Care	SSI/Disabled**	Top 10% Most Expensive Children Using Behavioral Health Care***
<b>Physical Health Services</b>	\$3,652	\$2,053	\$4,036	\$7,895	\$20,121
<b>Behavioral Health Services</b>	\$4,868	\$3,028	\$8,094	\$7,264	\$28,669
<b>Total Health Services</b>	\$8,520	\$5,081	\$12,130	\$15,123	\$48,790

\* Includes children using behavioral health services who are not enrolled in a comprehensive HMO, n = 1,213,201  
\*\* Includes all children determined to be disabled by SSI or state criteria (all disabilities, including mental health disabilities)  
\*\*\*Represents the top 10% of child behavioral health users with the highest mean expenditures, n = 121,323

**Opportunity to Redirect Significant Dollars**



## Differences in Child Behavioral Health Penetration Rates and Mean Expense by State Management and Payment Arrangement

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

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

**Reduced Costs But Also Reduce Usage**





## Benefit Design

Intensive Care  
Coordination:  
Wraparound  
Approach

Parent/Youth  
Peer Support  
Services

Intensive In-  
Home & Family  
Based Services

Respite

Mobile Crisis  
Response and  
Stabilization

Flex Funds

Trauma  
Informed  
System

EBPs in  
Outpatient

Substance Use  
Disorder  
Service Array

Prevention & Health Promotion



# Best Examples Of Systems of Care Within Managed Care

## Wraparound Milwaukee

- Reduction in placement disruption rate in child welfare from 65% to 30%
- School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily pop. in residential treatment centers from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days per year to <200



# Best Examples Of Systems of Care Within Managed Care Approaches

## New Jersey

- Savings of \$40 million from 2007 to 2010 by reducing the use of acute inpatient psychiatric services
- Residential treatment budget was reduced by 15% during the same time period, and length of stay in residential treatment centers decreased by 25%





# Best Examples Of Systems of Care Within Managed Care Approaches

## Massachusetts

- Reduced ER, 30% decrease in inpatient psych use and 11% decrease in inpatient expense

## Georgia

- Medicaid annual average cost for a CME youth is \$44,008 less than average annual cost for PRTF youth (CME = \$34,398, PRTF = \$78,406)
- 86% -89% reduction in inpatient hospitalization for youth



# Best Examples Of Systems of Care Within Managed Care Approaches

## CMS PRTF Demonstration Waiver

- 73% reduction in PRTF stays for CME youth meeting PRTF waiver criteria Flex Funds
- 62% reduction in PRTF stays for other high need youth enrolled in CME





# Customization

- Funding across child systems
- Incorporate intensive care coordination using Wraparound  
MA, LA, NJ, WY, PRTF Waiver Demo
- CHIPRA Care Management Entity Quality Collaborative states
  - Rates for this population range from \$780 -\$1300 pmpm
  - All-inclusive cost of care averages \$3700-\$4200 pmpm (about \$2100 is Medicaid) compared to \$9,000 pmpm in PRTFs, higher in psych inpatient



# Customization

- Recognize that physical health needs differ for children than adults
- Recognize that diagnostic trajectories differ for children than adults
- Integration models need to emphasize child coordination with other child systems and with natural supports



# Customization

- Add child welfare requirements
- Urgent response requiring behavioral health screen within 72 hrs of entering care and “fast track” linkage to services
- Liaison to child welfare within managed care
- Train MCO staff in child welfare



# Customization

- Cover EBPs
- Offer in home and family-based approaches
- Train providers in EBPs
- Broaden who can be a provider
- Track psychotropic medications
- Enhanced rates for use of EBPs
- Reinvest savings into EBPs continuously



# Customization

- Care authorizations
- Risk-adjust rates
- Population case rates
- Quality review involves families and youth and other child systems (e.g. child welfare)
- Family organizations as family advocates ; as internal advisors to MCO





# Customization

- Track and monitor outlier use, e.g. too young, too many, too much (growing number of states like WY, MD) – interface with Drug Utilization Review Board
- Provide consultation to prescribers, including primary care providers (MA, VT)
- Orient MCOs to state’s informed consent and assent policies in child welfare
- Provide coverage and training for treatment alternatives (aggression, sleep disorders)



# Customization

- Use of meaningful child data  
Penetration rates and utilization (services and medications) X age, gender, race/ethnicity, aid category, region, diagnosis, service type, medication type.
- Moving beyond HEDIS for performance expectations
  - AZ: PH-access to primary care, adolescent well care visits, annual dental visits, immunization measures; BH-emotional regulation, avoiding delinquency, stability of living situation, substance abstinence, children in psych hospitals awaiting placements
  - MI: BH-reduced use of residential treatment, maintenance in the community, improved functioning using CAFAS
  - NJ: PH-timeliness of assessments and comprehensive exams; compliance with EPSDT guidelines; semi-annual dental checks; immunization measures; access to BH services following assessment; clinical and functional outcomes using CANS





# Design for the Future



*We are now at a point where we must educate our children in what no one knew yesterday, and prepare for what no one knows yet. – Margaret Mead*



# Contact Information



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# Selected Resources

- Informational Bulletins
  - July 2014- Services to Children with Autism
  - May 2013- Coverage of BH Services
  - March 2013 – Prevention and Early Identification of MH & SUD (aka EPSDT)
  - Pending- Coverage of SUD Services
  - <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>



# Selected Resources

**Making Medicaid Work for Children in Child Welfare: Examples from the Field**

[http://www.chcs.org/usr\\_doc/Making\\_Medicaid\\_Work.pdf](http://www.chcs.org/usr_doc/Making_Medicaid_Work.pdf)

**Customizing Health Homes for Children with Serious Behavioral Health Challenges**

[http://www.chcs.org/usr\\_doc/Customizing\\_Health\\_Homes\\_for\\_Children\\_with\\_Serious\\_BH\\_Challenges\\_-\\_SPires.pdf](http://www.chcs.org/usr_doc/Customizing_Health_Homes_for_Children_with_Serious_BH_Challenges_-_SPires.pdf)

**Psychotropic Medications Quality Improvement Collaborative:**

**Improving the Use of Psychotropic Medications Among Children in Foster Care**

[http://www.chcs.org/info-url\\_nocat3961/info-url\\_nocat\\_show.htm?doc\\_id=1261326](http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=1261326)



# Selected Resources

## Financing Youth & Family Partners

<http://www.chcs.org/resource/medicaid-financing-for-family-and-youth-peer-support-a-scan-of-state-programs-3/>

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>

## Customize Health Homes for Children

<http://www.chcs.org/resource/developing-health-homes-for-children-with-serious-emotional-disturbance-considerations-and-opportunities/>

Preventative Services- “The WHO” <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf>