Customizing Medicaid & Managed Care for Children

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Use of Managed Care is Growing

As of July 1, 2011:

U.S. Overall = 51%

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 Drive Significant Portion of Expenditures
Children in Foster Care and Children With Disabilities Drive Costs & Utilization
Behavioral Health Accounts for Majority of Expenditures Even Among Children With Chronic Physical Conditions

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Ages 0–5</th>
<th>Ages 6–12</th>
<th>Ages 13–18</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Children in Medicaid*</td>
<td>41%</td>
<td>34%</td>
<td>25%</td>
</tr>
<tr>
<td>Behavioral Health Service Use**</td>
<td>11%</td>
<td>44%</td>
<td>45%</td>
</tr>
<tr>
<td>Behavioral Health Service Expense**</td>
<td>5%</td>
<td>36%</td>
<td>59%</td>
</tr>
</tbody>
</table>

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

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Adolescents Have Particularly High Costs
Access & Utilization Varies Significantly By Race & Ethnicity
Services in Medicaid Continue to Be Traditional Services

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

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Percent of Children Using Behavioral Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient treatment (primarily individual)</td>
<td>53%</td>
</tr>
<tr>
<td>Psychotropic medications</td>
<td>44%</td>
</tr>
<tr>
<td>Screening/assessment/evaluation</td>
<td>41%</td>
</tr>
<tr>
<td>Medication management</td>
<td>22%</td>
</tr>
<tr>
<td>Wraparound</td>
<td>1%</td>
</tr>
<tr>
<td>Therapeutic foster care</td>
<td>1%</td>
</tr>
<tr>
<td>Respite</td>
<td>0.2%</td>
</tr>
<tr>
<td>Supported housing</td>
<td>0.2%</td>
</tr>
<tr>
<td>Peer services</td>
<td>0.1%</td>
</tr>
<tr>
<td>Home-based (e.g., in-home services)</td>
<td>0.1%</td>
</tr>
<tr>
<td>Activity therapies</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

* 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.

Children in Medicaid Continue to Use High Amounts of Residential & Group Care
<table>
<thead>
<tr>
<th>All Children Using Behavioral Health Care</th>
<th>TANF</th>
<th>Foster Care</th>
<th>SSI/Disabled**</th>
<th>Top 10% Most Expensive Children Using Behavioral Health Care***</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Health Services</strong></td>
<td>$3,652</td>
<td>$2,053</td>
<td>$4,036</td>
<td>$7,895</td>
</tr>
<tr>
<td><strong>Behavioral Health Services</strong></td>
<td>$4,868</td>
<td>$3,028</td>
<td>$8,094</td>
<td>$7,264</td>
</tr>
<tr>
<td><strong>Total Health Services</strong></td>
<td>$8,520</td>
<td>$5,081</td>
<td>$12,130</td>
<td>$15,123</td>
</tr>
</tbody>
</table>

* 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
## 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.


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

• 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
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
Selected Resources

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

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

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
Selected Resources

Financing Youth & Family Partners

Customize Health Homes for Children