Faces of Medicaid Data Analysis: Identifying Opportunities to Improve Children's Behavioral Health

Analysis Question & Answer[1]

METHODOLOGY

1. **Are children with autism included in this data?**
   Yes, children who received a diagnosis of autism, a diagnosis of pervasive developmental disorder (PDD), and/or services with Current Procedural Terminology (CPT) codes related to autism are included in this study. However, these data are not presented separately from the larger category of children with developmental disabilities in which children with autism are represented.

2. **Can you explain the difference between children on SSI/disability and children with developmental disabilities, per your study methodology?**
   The Supplemental Security Income (SSI) group includes all children eligible for SSI or state-specific disability criteria who received behavioral health care (services and/or psychotropic medications). Within the SSI group are children with any type of disability (e.g., physical disability, mental health disability, and developmental disabilities) who received behavioral health care. In addition to the SSI group, we looked at a subset of children who had a specific diagnosis of developmental disability on a Medicaid claim or were served in an Intermediate Care Facility for Individuals with Mental Retardation. While over 60 percent of this subset were enrolled in Medicaid through SSI, nearly 28 percent were enrolled through TANF eligibility, and 10 percent were enrolled through foster care.

FINDINGS

3. **Can you explain the difference between the number/percent of children in Medicaid who are in foster care and the number/percent of children in foster care receiving behavioral health care services?**
   Children in foster care comprised 3.2 percent of the overall Medicaid child population in 2005 (919,590 children in foster care out of 29.1 million total children in Medicaid). Children in foster care comprised 15 percent of all children who used behavioral health services in 2005 (293,885 children in foster care used behavioral health services out of 1,958,908 children overall using behavioral health services). This translates to a penetration rate for behavioral health service use for the foster care population of 32 percent (i.e., the percent of children in foster care who used behavioral health services out of all children in foster care). Twenty-three percent of the foster care population in Medicaid—212,176 children—received psychotropic medications (with or without behavioral health services).

4. **Could you speculate on who the children in the study population are who did not have a psychiatric diagnosis, yet used behavioral health services or medications?**
   Forty percent of children receiving behavioral health services in 2005 did not have a psychiatric diagnosis. Some of these children may have been prescribed psychotropic medications by a primary care provider, without an accompanying diagnosis documented; or, the medication may have been prescribed for a non-psychiatric condition, such as "assaultiveness." Children without a psychiatric diagnosis may have also been included in the study population due to their service use, for example, use of "group therapy," without a documented diagnosis.

BEHAVIORAL HEALTH SERVICE USE

5. **Does this study account for behavioral health services that are not billed to Medicaid although the child is covered by Medicaid, such as child welfare preventive services?**

[1] These questions were originally posed during a Center for Health Care Strategies webinar held on November 20, 2013.

This study only analyzes Medicaid claims, not those of other payers or programs. However, such data are important to gather to help with estimates of total expenditures for children and youth with complex behavioral health issues, who often are involved in multiple systems.

6. **What is psychosocial rehabilitation?**
   Psychosocial rehabilitation services are an optional service within Medicaid. They include various types of services that can be provided in natural environments (non-clinic-based) such as at home or in school. Interventions may include skills training, vocational, social, educational, or personal care, and education to youth and their families about emotional management and positive coping mechanisms. A definition of psychosocial rehabilitation is provided in the full analytic report.

7. **Where can we find the specific data for our state's Medicaid expenditures on behavioral health services?**
   CHCS is not releasing state-specific data in the 2005 analysis, but is considering whether or not to do so in subsequent analyses, depending on the completeness of individual state data. State Medicaid agencies typically have contracts in place with data vendors, which may be a source of data in your particular state.

PSYCHOTROPIC MEDICATION USE

8. **Who might be prescribing medication for children receiving more than two classes of medications, who are not receiving other behavioral health services?**
   This is a very important question that requires additional study. Based on available information, the researchers' hypothesis is that these prescriptions are originating in primary care.

9. **Were you able to look at polypharmacy, or co-pharmacy, within the same class?**
   No, in this study, concurrent medication prescription was defined as the prescription of more than one psychotropic medication across medication classes during the study year (2005).

10. **Was the prescription of medications broken down by type of provider (e.g., nurse practitioner, family practice, pediatricians, and psychiatrists)?**
    Information on the prescribing provider was not available for this analysis.

MANAGED CARE

11. **Can you elaborate on a "flexible benefit" as a recommended practice for states' behavioral health managed care models?**
    A flexible benefit refers both to the coverage of a broad service array, including home- and community-based services, as well as the flexibility to allow child and family care planning teams to develop and revise service plans as needed, based on the individualized strengths and needs of the child.

12. **Can you describe the relationship between the degree of managed care capitation, and the use of evidence based practices?**
    Our study did not analyze utilization of specific service types by degree of managed care capitation. It examined overall penetration rates and expense in states with capitated managed care versus states with fee-for-service or hybrid arrangements.

IMPLICATIONS

13. **How do you see this research meshing with the trauma-informed care models?**
    This study does not include any specific data on trauma-informed care, and it is difficult to identify specific service practice models within Medicaid claims data. One can identify, for example, screening and assessment, but not whether it was trauma-informed. With the exception of Multisystemic Therapy, there are no discrete billing codes for evidence-based practices that may include trauma-informed elements. The subsequent analysis of 2008 data will, however, track the extent to which home- and community-based services are used.

14. **Do you have specific policy recommendations for states and/or for health care management organizations?**
Policy recommendations are included in the overview brief and full analytic report. Some of the key recommendations are as follows:

- To improve the quality and cost of care, states should consider covering—and incentivizing Medicaid managed care plans to offer—evidence-informed home- and community-based services, such as home-based services, peer support, and mobile response and stabilization services, as alternatives to restrictive, expensive care, such as residential treatment and group care.
- Evidence suggests that children with serious behavioral health challenges benefit from a more customized approach to care coordination, including intensive care coordination using the wraparound approach. States should consider incorporating these approaches into their health system reforms, through the health homes and 1915(i) home- and community-based services provisions of the Affordable Care Act.
- Children in foster care are an especially high-need group. States should consider incorporating trauma-informed policies and practices into their children's behavioral health systems and implementing partnerships between Medicaid and the child welfare system to create coordinated programs.
- States should strengthen their systems for monitoring and oversight of psychotropic medications, particularly antipsychotic use, concurrent prescription, and use among vulnerable children (e.g., very young children and children in foster care).
- States and their managed care partners can address quality and cost issues by implementing more effective policies and practices for adolescent males, an especially high-utilizing and expensive subset of children in Medicaid who use behavioral health care. Recommended approaches include evidence-based practices like Multisystemic Therapy, supported employment, and youth peer support.

15. **What are the implications of the findings from the 2005 analysis for more current trends such as the expansion of managed care to serve children with complex needs?**
We are analyzing the Medicaid MAX data over time to obtain an understanding of how changes in the larger health care environment, including ACA and state Medicaid re-design initiatives, are affecting child behavioral health utilization and expense. Questions we are interested in include the following:

- As more states enroll all of their child populations and behavioral health services into capitated managed care arrangements, will we continue to see lower penetration rates and mean expenditures relative to former FFS systems, as the 2005 data suggest?
- Or, with states implementing ACA options such as health homes and 1915i state plan amendments, will we see greater use of home- and community- based services?
- As states strengthen their monitoring and oversight of psychotropic medications, will we see reduced use of antipsychotics or among particularly vulnerable children such as the very young or those in foster care?

For More Information
For further questions about *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*, please contact Roopa Mahadevan at rmahadevan@chcs.org.