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FACES OF MEDICAID SERIES

Children in Medicaid Receiving Behavioral Health Services: Demographics, Utilization, and Expenditures, 2005 and 2008

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IN BRIEF

Although children who use behavioral health services represent a small portion of the overall Medicaid population, Medicaid programs are a major source of funding for children's behavioral health care. This data brief updates the Center for Health Care Strategies' national analysis of 2005 Medicaid claims data for children's behavioral health. It highlights children's behavioral health care service utilization and expenditures based on 2008 MAX data, which may provide helpful insights to guide improvements in care coordination, delivery, and financing for this vulnerable population.

As a significant source of funding for children's behavioral health care, Medicaid programs can advance care coordination and delivery for children and youth with serious behavioral health needs. This brief highlights Medicaid behavioral health service utilization and expenditures, and the demographics of children and youth receiving these services, to inform targeted improvements in care organization, delivery, and financing. This analysis of 2008 Medicaid claims data updates the Center for Health Care Strategies' (CHCS) national analysis of 2005 Medicaid claims data, ***Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures***.[1] Source exhibits for the 2005 and 2008 data referenced here are included in the Appendix.

2008 Medicaid Child Population

The Medicaid child population in 2008 was younger and more racially diverse than in 2005. For the first time, Hispanic/Latino and Hispanic/Latino children of more than one race exceeded representation of African American children. The increasing racial diversity has implications for the cultural and linguistic competence of Medicaid delivery systems (Exhibit A).

Behavioral Health Utilization for Children in Medicaid

Overall Rate of Utilization of Children's Behavioral Health Services

The penetration rate for use of children's behavioral health care remained under 10 percent, with just a marginal increase in 2008 that was due more to a higher rate of use of psychotropic

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medications than to use of behavioral health services. In 2008, a greater proportion of children using psychotropic medications received no identifiable accompanying behavioral health service. The relatively low rate of service use among the Medicaid child population is disconcerting given prevalence estimates.[2] Equally troubling is the increase in the use of psychotropic medications without a concomitant increase in use of services (Exhibit B).

Utilization Rates by Aid Category

Children in foster care and those on SSI/disability — populations with typically higher service needs — continued to use behavioral health services at a higher rate than that of the Temporary Assistance for Needy Families (TANF) child population. However, rates of use declined over 2005 for both the foster care and SSI/disability populations, while the rate increased slightly among TANF-enrolled children (Exhibit C). There was greater enrollment of the foster care and SSI/disability populations in managed care between 2005 and 2008, though most remained in fee-for-service systems.

Utilization Rates by Age

Young children, ages birth to five, experienced a noteworthy (33 percent) increase in their rate of behavioral health service use between 2005 and 2008, although it remains low compared to other age cohorts. The increased rate could be the result of greater national and state-level attention to early childhood mental health screening and intervention. Adolescents continued to have the highest penetration rate (Exhibit D).

Utilization Rates by Race/Ethnicity

While white children continued to use behavioral health services at the highest rate, differences narrowed for most racial/ethnic groups of children, with some racial/ethnic cohorts experiencing notable gains in service use rates. African American, American Indian/Alaska Native, Asian, Hispanic/Latino of more than one race, and multi-racial children all experienced gains in rates of service use. However, Hispanic/Latino and Native Hawaiian/Pacific Islander children experienced decreased rates of utilization between 2005 and 2008 (Exhibit E).

Patterns of Service Use

The top five most frequently used services, defined as those used by 20 percent or more of children, remained largely the same in 2008 as in 2005 (Exhibit F). These services included: outpatient services (largely individual therapy); psychotropic medication; screening and assessment; medication management; and family therapy, which was in the top five for the first time. The use of emerging best practices (e.g., multi-systemic therapy, wraparound, peer support, in-home services) remained very low, with one percent or fewer children using each type. This rate might be an understatement as some of the emerging practices may have been billed under claims for psychosocial rehabilitation, which increased between 2005 and 2008 — though fewer than 20 percent of children used psychosocial rehabilitation services in both years.

Notable changes in service use patterns included:

- An increase in the use of residential treatment and therapeutic group care, which is concerning given national and state efforts to reduce the use of facility-based care for children;
- A decrease in the use of Targeted Case Management (TCM), largely attributable to federal policy changes and greater scrutiny of states' use of TCM during this time period;
- Greater use of screening and assessment, which could be partially attributable to a spike in service use among children aged birth to five years, and/or a greater emphasis in Medicaid managed care systems on screening;
- A significant decrease in use of psychological testing, which may be because psychological testing is more apt to be supported in fee-for-service systems than in capitated managed care, and with more children enrolled in managed care in 2008, a fall-off in testing might be expected.

Behavioral Health Expenditures for Children in Medicaid

Patterns of Service Expense

Residential treatment/therapeutic group homes continued to absorb the largest percent of total expenditures for children using behavioral health services, with a 20 percent increase in expense and a 33 percent increase in utilization in 2008 (Exhibit G). Inpatient psychiatric hospitalization experienced a 77 percent increase in expenditures, although the percent of children using inpatient hospitalization declined slightly. The increase in expense for facility-based care might be partially due to expanded state coverage of psychiatric residential treatment facilities (PRTFs). In 2008, facility-based residential and hospital care accounted for more than 28 percent of total child behavioral health expense for the eight percent of children using these services, compared to 24.6 percent of total expense for 6.9 percent of children in 2005.

In 2008, although spending on psychosocial rehabilitation services and utilization increased considerably (57 percent higher expense and 48 percent increased utilization), these community-based services were still used by fewer than 20 percent of children using behavioral health services, as was the case in 2005. In addition, spending and use of outpatient services fell 44 percent and nine percent, respectively.

Psychotropic medications absorbed the second highest percent of total spending for children who used behavioral health services in 2008, and were used by about the same percent of children as in 2005 (slightly under 44 percent). The 18 percent increase in expense is, in part, due to an increase in the use of antipsychotic medications between 2005 and 2008.

Mean and Total Expense

Mean behavioral health expenditures increased for every age and aid category of children using behavioral health services, as did overall mean behavioral health service expense. Children in foster care continued to have the highest mean behavioral health expenditure among aid categories, with a

mean expense almost three times higher than that of children on TANF and higher than that of children on SSI/disability. Adolescents remained the most expensive age cohort; however, children ages 6-12 saw the biggest increase in mean expenditure. Males continued to have higher mean expenditures than females (Exhibit H).

Total expenditures for behavioral health services increased 14 percent, with significant increases in the proportion of dollars spent on younger children (though still low compared to other age groups) and a lower proportion spent on adolescents (though still the highest compared to other age groups).

Corresponding to changes in the proportion of children using behavioral health services, there were also increases in the proportion of behavioral health service dollars spent on TANF-enrolled children and children on SSI/disability, with decreases in the proportion spent on children in foster care.

Mean overall health expense for the top 10 percent highest-cost children receiving behavioral health services ($38,084) increased by about two percent since 2005 and continued to be nearly nine times higher than mean expense for children in general. Total health costs for these children were driven far more by their use of behavioral health services than of physical health services (Exhibit I).

Implications

The 2008 analysis points to a number of areas that warrant attention, particularly in the context of major changes in the organization and delivery of Medicaid services.

- As the Medicaid child population can be expected to become increasingly more diverse, will the increases in service use rates seen in 2008 for some racially and ethnically diverse groups persist and improve over time? Will certain groups, such as Hispanic/Latino and Native Hawaiian/Pacific Islander children, continue to experience disproportional under-representation in service use?
- Will overall child behavioral health penetration rates remain at about 10 percent, or will changes in the landscape of Medicaid delivery systems lead to changes in usage rates?
- Will there continue to be increases in the use of psychotropic medications, antipsychotics in particular, and in the percent of children who receive psychotropic medications without also receiving treatment services? Will the troubling increase in use of psychotropic medications seen in 2008 by very young children continue?
- What will be the impact of changes in Medicaid systems on utilization rates of high-need populations — children in foster care and those on SSI/disability? Was the slight decline in utilization rates seen in 2008 an anomaly?
- Will there be continued increases in screening rates, particularly for young children ages birth to five, as in 2008, but without concomitant increases in the use of services?
- What will be the impact of health care delivery changes on use of home and community-based services and emerging best practices, such as MST and Wraparound? Will the increased use of residential treatment and inpatient psychiatric hospitalization seen in 2008 continue over time

despite national and state policies to reduce facility-based care, or will innovations in health care begin to show measureable shifts to the use of community-based alternatives?

- Will use of facility-based care and psychotropic medications continue to absorb a significant share of overall child behavioral health spending, particularly compared to spending on home and community-based services?
- Will overall Medicaid spending on child behavioral health care continue to increase, and if so, for which populations of children and for which service types?
- What will be the impact of changes in Medicaid delivery on the top 10 percent most expensive children using behavioral health care? Will their expenditures continue to increase? Will their expenses continue to be driven by use of behavioral rather than physical health care?

Children who use behavioral health services make up a small percentage of the overall Medicaid population; children in foster care, for example, represent only about three percent of the Medicaid child population. Because of their relatively small numbers in the overall Medicaid population and a predominant focus in states on adult populations with comorbid physical and behavioral health problems, the utilization and expense patterns of these children are often not articulated in larger Medicaid analyses. This analysis, which CHCS is updating with 2011 data,[3] helps to give national and state policymakers a more discrete picture of how changes in health care are impacting children served by Medicaid who use behavioral health care.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit **www.chcs.org**.

ADDITIONAL CHILDREN'S HEALTH RESOURCES

Since 2000, CHCS has shed light on the complex needs of Medicaid's most challenging populations through its series of *Faces of Medicaid* data analyses. To explore CHCS' full portfolio of analyses related to children with complex health care needs, visit the Children's Health topic page **www.chcs.org/topics/children/**.

ENDNOTES

[1] S. Pires, K. Grimes, T. Gilmer, K. Allen, and R. Mahadevan. "Examining Children's Behavioral Health Service Utilization and Expenditures." Center for Health Care Strategies. December 2013. Available at: www.chcs.org/resource/examining-childrens-behavioral-health-service-utilization-and-expenditures-3/.

[2] National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml.

[3] S. Pires, T. Gilmer, K. Allen, and J. McLean. "Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures, 2005-2011." Center for Health Care Strategies. Forthcoming Fall 2017.

Appendix: Source Exhibits

Exhibit A: Demographic and Aid Characteristics of the Medicaid Child Population, 2005/2008

Demographic and Aid Characteristics	2005		2008	
	%	N	%	N
Age				
0-5 years	41.3%	12,001,451	46.3%	14,128,316
6-12 years	34.0%	9,889,507	31.3%	9,559,021
13-18 years	24.6%	7,159,347	22.3%	6,816,277
Gender				
Female	48.9%	14,202,259	48.7%	14,860,326
Male	51.0%	14,816,976	51.0%	15,549,420
Unknown	N/A	N/A	0.3%	93,868
Race and Ethnicity				
White	38.8%	11,271,574	36.8%	11,210,800
Black or African American	25.9%	7,537,925	24.9%	7,586,425
American Indian or Alaska Native	1.5%	448,234	1.5%	455,040
Asian	2.2%	644,744	2.2%	678,467
Hispanic or Latino	22.1%	6,413,067	22.7%	6,932,396
Native Hawaiian or Pacific Islander	0.6%	185,598	0.7%	205,304
Hispanic or Latino + one or more races	2.9%	846,083	4.0%	1,231,961
More than one race	0.3%	74,093	0.4%	109,000
Unknown	5.6%	1,628,987	6.9%	2,094,221
Aid Category				
TANF	92.3%	26,812,742	91.6%	27,947,758
Foster care	3.2%	919,590	3.3%	1,005,542
SSI/disabled	4.5%	1,317,973	5.1%	1,550,314
Total Population	**100%**	**29,050,305**	**100%**	**30,503,614**

Exhibit B: Penetration Rates for Use of Child Behavioral Health Care in Medicaid, 2005/2008

	2005		2008	
	N	Penetration Rate	N	Penetration Rate
Children enrolled in Medicaid	**29,050,305**	**100%**	**30,503,614**	**100%**
Children receiving behavioral health care *(services and/or psychotropic medications)*	**2,787,919 (100%)**	**9.6%**	**3,002,796 (100%)**	**9.8%**
Recipients of behavioral health services	1,958,908 (70.3%)	6.7%	2,059,282 (68.6%)	6.8%
Recipients of psychotropic medications and physical health services only*	490,360 (17.6%)	1.7%	536,953 (17.9%)	1.8%
Recipients of psychotropic medications with indeterminate service use**	338,651 (12.1%)	1.2%	406,921 (13.6%)	1.3%
Sub-total of children receiving psychotropic medications	**1,686,387**	**5.8%**	**1,843,734**	**6.0%**

**No identifiable behavioral health services.*

*** Cannot determine based on claims whether behavioral or physical health service.*

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Exhibit C: Child Medicaid Behavioral Health Service Penetration, by Aid Category, 2005/2008

	2005		2008	
	N	Penetration Rate	N	Penetration Rate
Aid Category				
TANF	1,316,635	4.9%	1,404,035	5.0%
Foster care	293,885	32.0%	277,992	27.6%
SSI/disabled	348,338	26.4%	377,255	24.3%
All Children Receiving Behavioral Health Services	**1,958,908**	**6.7%***	**2,059,282**	**6.8%***

**Denominator = total Medicaid child population. In 2005, N = 29,050,305. In 2008, N = 30,503,614.*

Exhibit D: Child Medicaid Behavioral Health Service Penetration, by Age Category, 2005/2008

	2005		2008	
	N	Penetration Rate	N	Penetration Rate
Age				
0-5 years	217,584	1.8%	342,993	2.4%
6-12 years	869,994	8.8%	892,871	9.3%
13-18 years	871,330	12.2%	823,418	12.1%
All Children Receiving Behavioral Health Services	**1,958,908**	**6.7%***	**2,059,282**	**6.8%***

**Denominator = total Medicaid child population. In 2005, N = 29,050,305. In 2008, N = 30,503,614.*

Exhibit E: Child Medicaid Behavioral Health Service Penetration, by Race/Ethnicity, 2005/2008

	2005		2008	
	N	Penetration Rate	N	Penetration Rate
Race/Ethnicity				
White	1,015,126	9.0%	1,014,816	9.1%
Black or African American	496,426	6.6%	541,080	7.1%
American Indian or Alaska Native	28,870	6.4%	34,460	7.6%
Asian	11,458	1.8%	13,075	1.9%
Hispanic or Latino	234,398	3.7%	232,495	3.4%
Native Hawaiian or Pacific Islander	5,702	3.1%	3,275	1.6%
Hispanic or Latino + one or more races	43,521	5.1%	63,480	5.2%
More than one race	5,366	7.2%	9,747	8.9%
Unknown	118,041	7.2%	146,854	7.0%
All Children Receiving Behavioral Health Services	**1,958,908**	**6.7%***	**2,059,282**	**6.8%***

**Denominator = total Medicaid child population. In 2005, N = 29,050,305. In 2008, N = 30,503,614.*

Exhibit F: Use of Child Behavioral Health Services in Medicaid, by Service Type, 2005/2008

Red = Increase in utilization; Green = Decrease in utilization; Yellow = No change

	2005			2008		
Service Type	**%**	**N***	**Rank**	**%**	**N***	**Rank**
Outpatient treatment (primarily individual)	53.1%	1,039,827	1	48.2%	993,580	1
Psychotropic medication***	43.8%	857,376	2	43.7%	900,220	3
Screening/assessment/evaluation	40.9%	801,449	3	45.2%	929,927	2
Medication management	22.3%	436,698	4	24.3%	501,330	4
Family therapy/family education and training	19.4%	379,817	5	23.2%	477,452	5
Psychosocial rehabilitation	12.4%	242,052	6	18.4%	378,598	6
Substance use outpatient	10.5%	206,612	7	9.9%	203,953	7
Psychological testing	9.3%	182,546	8	4.5%	93,039	15
Initial service planning	8.8%	173,194	9	7.9%	162,905	10
Case management	8.7%	170,100	10	9.6%	198,088	8
Group therapy	7.6%	138,749	11	8.5%	175,689	9
Targeted case management	7.1%	138,666	12	5.6%	115,268	12
Behavior management consultation and training/therapeutic behavioral support	4.7%	91,764	13	2.6%	54,316	20
Residential treatment/therapeutic group homes	3.6%	71,003	14	4.8%	97,965	13
Crisis intervention and stabilization (non ER)	3.5%	68,148	15	3.6%	73,237	16
Inpatient psychiatric treatment	3.3%	65,209	16	3.2%	65,140	19
Partial hospitalization/day treatment	3.3%	63,806	17	4.6%	94,303	14
Mental health consultation	3.1%	60,570	18	3.5%	71,724	18
Substance use screening and assessment	2.9%	57,038	19	3.5%	72,710	17
Wraparound	1.1%	22,308	20	1.1%	21,770	22
Therapeutic foster care	0.8%	14,758	21	0.9%	17,531	23
Substance use inpatient/residential	0.3%	5,887	22	1.7%	33,986	21
Respite	0.2%	4,620	23	0.3%	5,162	24
Supported housing	0.2%	3,521	24	0.2%	4,605	25
Transportation	0.1%	2,465	25	0.0%**	38	30
Emergency room	0.1%	2,233	26	6.0%	124,502	11
Peer services	0.1%	1,495	27	0.1%	1,976	27
Home-based (e.g., in-home services)	0.1%	1,193	28	0.1%	1,756	28
Activity therapies	0.1%	1,116	29	0.1%	2,478	26
Telehealth	0.0%**	613	30	N/A	N/A	N/A
Multi-systemic Therapy	0.0%**	102	31	0.1%	1,220	29
All Behavioral Health Services	**100%**	**1,958,908**		**100%**	**2,059,282**	

**Represents unique users, however, counts of children may be duplicated across service categories.*

***Numbers too small to register as percentages.*

**** Includes only children also receiving behavioral health services (i.e. does not include children receiving psychotropic medications and no identifiable accompanying behavioral health treatment).*

Exhibit G: Expenditures for Child Behavioral Health Services in Medicaid, by Service Type, 2005/2008*

Red = Increase in utilization; Green = Decrease in utilization; Yellow = No change

	2005				2008			
Service Type	**Expense***	**% of Total Expense**	**% of Total Users***	**Rank (by $)**	**Expense***	**% of Total Expense**	**% of Total Users***	**Rank (by $)**
Residential treatment/ therapeutic group homes	**$1.5B**	**19.2%**	3.6%	1	**$1.8B**	**19.9%**	4.8%	1
Outpatient treatment (primarily individual)	**$1.3B**	**16.5%**	53.1%	2	**$724.7M**	**8.0%**	48.2%	5
Psychotropic medications***	**$1.1B**	**13.5%**	43.8%	3	**$1.4B**	**15.7%**	43.7%	2
Psychosocial rehabilitation	**$826.9M**	**10.3%**	12.4%	4	**$1.3B**	**14.3%**	18.4%	3
Substance use outpatient	**$749M**	**9.3%**	10.5%	5	**$205.7M**	**2.3%**	9.9%	11
Inpatient psychiatric treatment	**$433.8M**	**5.4%**	3.3%	6	**$768.8M**	**8.4%**	3.2%	4
Partial hospitalization/day treatment	**$366.7M**	**4.6%**	3.3%	7	**$486M**	**5.3%**	4.6%	7
Behavior management consultation and training/therapeutic behavioral support	**$239.2 M**	**3.0%**	4.7%	8	**$194.9 M**	**2.2%**	2.6%	13
Targeted case management	**$233.4M**	**2.9%**	7.1%	9	**$153.4M**	**1.7%**	5.6%	14
Case management	**$209.8M**	**2.6%**	8.7%	10	**$238.4M**	**2.6%**	9.6%	8
Screening/assessment /evaluation	**$175.2M**	**2.2%**	40.9%	11	**$199.7M**	**2.2%**	45.2%	12
Therapeutic foster care	**$165.5M**	**2.1%**	0.8%	12	**$211.5M**	**2.3%**	0.9%	10
Family therapy/family education and training	**$162.6M**	**2.0%**	19.4%	13	**$227.2M**	**2.5%**	23.2%	9
Medication management	**$153.5M**	**1.9%**	22.3%	14	**$124M**	**1.4%**	24.3%	16
Group therapy	**$89M**	**1.1%**	7.6%	15	**$127.3M**	**1.4%**	8.5%	15
Wraparound	**$77.4M**	**1.0%**	1.1%	16	**$99.3M**	**1.1%**	1.1%	17
Psychological testing	**$48.2M**	**0.6%**	9.3%	17	**$35.5M**	**0.4%**	4.5%	20
Crisis intervention and stabilization (non ER)	**$45.5M**	**0.6%**	3.5%	18	**$39.6M**	**0.4%**	3.6%	19
Substance use inpatient/residential	**$28.1M**	**0.3%**	0.3%	19	**$543.9M**	**6.0%**	1.7%	6
Initial service planning	**$26.4M**	**0.3%**	8.8%	20	**$21.1M**	**0.2%**	7.9%	22
Home-based (e.g., in-home services)	**$20.5M**	**0.3%**	0.1%	21	**$21.5M**	**0.2%**	0.1%	21
Substance use screening and assessment	**$14M**	**0.2%**	2.9%	22	**$13.4M**	**0.1%**	3.5%	26
Supported housing	**$8.1M**	**0.1%**	0.2%	23	**$20M**	**0.2%**	0.2%	24
Respite	**$3M**	**0.0%****	0.2%	24	**$14.9M**	**0.2%**	0.3%	25
Emergency room	**$2.6M**	**0.0%****	0.1%	25	**$20.1M**	**0.2%**	6.0%	23
Activity therapies	**$1.9M**	**0.0%****	0.1%	26	**$9.6M**	**0.1%**	0.1%	27
Peer services	**$0.7M**	**0.0%****	0.1%	27	**$4.9M**	**0.1%**	0.1%	29
Mental health consultation	**$0.4M**	**0.0%****	3.1%	28	**$41.8M**	**0.5%**	3.5%	18
Telehealth	**$0.3M**	**0.0%****	0.0%**	29	**N/A**	**0.0%**	N/A	N/A
Multisystemic Therapy	**$0.2M**	**0.0%****	0.0%**	30	**$8.9M**	**0.1%**	0.1%	28
Transportation	**$0*****	**0.0%****	0.1%	31	**$34,638**	**0.0%****	0.0%**	30
Total	**$8.03B**	**100.0%**			**$9.1B**	**100%**		

**Expenditures are based on children in fee-for-service arrangements (1.2 million in 2005 and 850,000 in 2008) and extrapolated to children in capitated managed care.*

***Values are too low to register.*

**** Includes only children also receiving behavioral health services (i.e. does not include children receiving psychotropic medications and no identifiable accompanying behavioral health treatment).*

Exhibit H: Behavioral Health Mean and Total Expenditures for Children in Medicaid Using Behavioral Health Services, by Age and Aid Category, 2005/2008

	2005			2008		
	% of Children Receiving BH Services*	Mean Expenditure	Total Expenditure (% of Total)	% of Children Receiving BH Services*	Mean Expenditure	Total Expenditure (% of Total)
Age						
0-5 years	11.1%	**$ 1,717**	**$373.6 M (4.7%)**	16.7%	**$1,957**	**$671.1 M (7.4%)**
6-12 years	44.4%	**$ 3,353**	**$2.9 B (36.3%)**	43.4%	**$4,083**	**$3.6 B (40%)**
13-18 years	44.5%	**$5,409**	**$4.7 B (58.8%)**	40.0%	**$5,821**	**$4.8 B (52.6%)**
Gender						
Female	39.6%	**$ 3,769**	**$2.9 B (36.3%)**	40.7%	**$3,920**	**$3.3 B (36%)**
Male	60.3%	**$ 4,318**	**$5.1 B (63.8%)**	59.3%	**$4,770**	**$5.8 B (64%)**
Unknown	N/A	N/A	N/A	0.001%	$1,383	$139,657 (0.002%)
Aid Category						
TANF	67.2%	**$2,682**	**$3.5 B (43.8%)**	68.2%	**$2,953**	**$4.1 B (45.5%)**
Foster care	15.0%	**$7,825**	**$2.3 B (28.8%)**	13.5%	**$8,186**	**$2.3 B (25%)**
SSI/disability	17.8%	**$6,234**	**$2.2 B (27.5%)**	18.3%	**$7,125**	**$2.7 B (29.5%)**
Total	100%	**$4,101**	**$8.0 B (100%)**	100%	**$4,424**	**$9.1 B (100%)**

**Includes children with at least one claim for behavioral health services, with or without psychotropic medications use; does not include children with psychotropic medications use and no other behavioral health service claim.*

Exhibit I: Mean Health Expenditures for Highest-Cost Children Receiving Behavioral Health Services, 2005/2008

	2005	2008
	Children Representing Top 10% of Expense for BH Services*	Children Representing Top 10% of Expense for BH Services*
Behavioral Health Services	$28,815	$27,654
Physical Health Services	$8,532	$10,429
Total Health Services	**$37,348**	**$38,084**

** Includes children using behavioral health services, with or without concomitant psychotropic medication use, who are not enrolled in a comprehensive MCO. N = 121,323 children in 2005. N = 84,931 children in 2008.*