Health Plan Innovations: Improving the Behavioral Health of Children, Youth & Young Adults

July 26, 2018
Suzanne Fields, University of Maryland

Earlie Rockette, Amerigroup, Georgia

Tad Gary, Mercy Maricopa, Arizona

Katherine Hobbs-Knutson, Alliance Behavioral Health, North Carolina
AGENDA

10:30-10:40  Welcome, Introductions, Setting the Stage  
10:40-11:00  Amerigroup, Georgia  
11:00-11:20  Mercy Maricopa, Arizona  
11:20-11:40  Alliance Behavioral Health  
11:40-12:00  Q & A
Who Do We Have In the Session?
Children in Medicaid Who Use Behavioral Health Care Are An Expensive Population

• 11% of children in Medicaid use behavioral health care and account for 36% of all Medicaid child expenditures

• Mean expense is 4x higher than for children who don’t use behavioral health services

• Expense for top 10% most expensive children = $47,000 – expense driven by use of behavioral health care, not physical health

Chronic Physical Health Conditions Among Children in Medicaid Using Behavioral Health Services*

• 38% of children with BH claims also had claims for at least one chronic medical condition

• Pulmonary diseases were the most common physical health condition (overall mean expense of $1,091)

• High-cost medical conditions (e.g. cancer at $19,065) had low frequency

*Using Chronic Disability Payment System (CDPS) Methodology
Distribution of Psychiatric Diagnoses among Children in Medicaid Using Behavioral Health Services

### Changes in Top Three Child Behavioral Health Expense Drivers

<table>
<thead>
<tr>
<th>Year</th>
<th>Res/GH (Expense)</th>
<th>OP (Expense)</th>
<th>Psyc Meds (Expense)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$1.5B</td>
<td>$1.3B</td>
<td>$1B</td>
</tr>
<tr>
<td>2011</td>
<td>$2.5B</td>
<td>$2.1B</td>
<td>$1.9B</td>
</tr>
</tbody>
</table>

- **67% ↑** in residential treatment/group homes expense
- **90% ↑** in psychotropic medication expense
- **39% ↑** in psychosocial rehab expense

---

Changes in Mean Expense of Top Three Child Behavioral Health Expense

2005
- Res. treat./group homes: $21,671
- Outpatient: $1,275
- Psych meds: $1,267
- Psychosocial rehab: $3,416

2011
- Res. treat./group homes: $22,711
- Outpatient: $827
- Psych meds: $1,640
- Psychosocial rehab: $3,412

- 29% ↑ in psychotropic medication
- 5% ↑ in residential treatment/group homes
- Psychosocial rehab unchanged
- 35% ↓ in outpatient mean expense

One Size Does Not Fit All: Designing a Care Integration Continuum

- 75% of children with diagnosed mental health disorders are seen in the primary care setting.
  - Racially and ethnically diverse families especially feel less stigma in pediatric settings than with specialty behavioral health providers.
  - Pediatricians play a key role in early detection for children enrolled in Medicaid through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive screening and health care services for children under age 21.
  - The persistent shortage of behavioral health specialty providers further contributes to the increased role of primary care.

- Yet, numerous studies have found that primary care practices often struggle with managing child behavioral health conditions and access to a medical home is uneven.
  - One study found that “all behavioral health conditions except attention deficit hyperactivity disorder (ADHD) were associated with difficulties accessing specialty care through the medical home.”
  - A 2013 study in *Pediatrics* found that youth of color, lower-income youth, youth from households with limited English proficiency, and those with mental (as opposed to physical) health conditions were less likely to have a medical home where they could obtain routine, family-centered care. There have been similar findings with respect to Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) youth.
One Size Does Not Fit All: Designing a Care Integration Continuum

• Much of the literature examining integrated care approaches has been devoted to adults with SMI or co-morbid conditions with less known about which methods or models of yield optimal clinical and functional outcomes for children, youth, and young adults.
  • For example, the Collaborative Care Management model has shown promise with adolescents with depression receiving treatment in office-based settings and Intensive care coordination using fidelity Wraparound has proven effective for children and youth with serious behavioral health challenges who often have multi-system involvement.

• Much knowledge is still needed to understand which children could benefit from which integrative approach, including those with brief, moderate, and intensive treatment needs, those with mild, moderate and/or complex behavioral health conditions, very young children to transition-age youth, children and youth involved with multiple child-serving sy/systems such as child welfare, and diverse racial and ethnic groups.
Children and Youth - Distinct Population from Adults

- Do not have the same high rates of co-morbid physical health conditions
- Have different mental health diagnoses from adults with SPMI (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar) and diagnoses change often
- Two-thirds are also involved with child welfare and/or juvenile justice systems and 60% may be in special education – systems governed by legal mandates
- Coordination with other children’s systems – child welfare, juvenile justice, schools – and among behavioral health providers consumes most of care coordinator’s time, not coordination with primary care
- To improve cost and quality of care, focus must be on child and family/caregiver(s) – takes time

UNIVERSITY OF MARYLAND, BALTIMORE
TRAINING INSTITUTES
JULY 25-28, 2018 | WASHINGTON, D.C.

Q & A

ssw.umaryland.edu/traininginstitutes
Care Management Organization’s Innovations to Improve BH Services to Youth in the Child Welfare System

Earlie Rockette, RNP, MN
Regional Vice President, Special Populations
Amerigroup Community Care - Georgia
Technology Supported Pediatric ER BH Crisis Re-Direction Program
• Focus on behavioral health crisis
• Assist members with connecting to providers from the comfort of their homes
• Deliver services via telehealth
• Redirect from PH to BH facilities and providers
• Engage primary care BH provider in crisis care
• Increased sharing of information between facilities, members and providers
• Enhance EMS Transport system engagement
Integrated One-Stop-Shop Mobile Clinics
Single location benefits foster parents and child welfare workers in accessing healthcare, transportation, referrals and services to children.

Range of health care services (Behavioral, physical, and dental healthcare services)

Increased continuity of care – all records posted to centralized state operated health information exchange network

Enhanced exchanged of clinical information

Care coordination of clinical services

Member and provider incentive program
Concierge Services

Exception to the rule of where traditional medical services are delivered

Personalized and not bulk-service driven Integration of Behavioral and Physical healthcare

Positive impact on health care expenditure and member experience

“House Calls”
Behavioral health services delivered in least restrictive environment
Appointment set based on availability and convenience of the member
Assessment and therapeutic services
Improved care and decreased member cost (transportation, child care etc.)
Completed within 10 days of request, as indicated

ssw.umaryland.edu/traininginstitutes
Addressing the Behavioral Health Needs of Children in the Child Welfare System

Tad D. Gary, MEd, MA, CRC, LPC
Administrator/Chief Operating Officer
Who is Mercy Care?

Ascension Care Management

St. Joseph’s Hospital and Medical Center, a Dignity Health member

dba Mercy Care & Mercy Care Advantage

Managed by Aetna Medicaid Administrators, LLC through a Plan Management Services Agreement
As of 2016, in the United States there were 437,465 children in foster care. (Children’s Bureau, 2017)

Studies suggest that up to 80% of children in foster care have significant mental health issues. (Dore, 2005 and Pecora et al., 2009)

Approximately 18% to 22% of children in the general population have significant mental health issues. (Dore, 2005)

2013 SAMHSA report: Adjustment disorders, mood disorders, anxiety disorders, and attention-deficit, conduct, and disruptive behavior disorders were commonly comorbid with each other across all ages.
Brief overview of Arizona system: Child Welfare and Behavioral Health

- Department of Child Safety (DCS)
- Regional Behavioral Health Authorities (RBHAs)
- Jacob’s Law
- Child welfare data
Arizona DCS data

- **Total children in DCS care (9/30/17): 15,840**
  - Decrease of 16% Since March 2016
  - Ages 0-5: 43% of total children in care

- **Total children entering DCS care April 2017 to September 2017: 4,331**
  - 23.6% decrease from previous year
  - Removals in Maricopa County: 2,498 (58% of statewide removals)

![Pie chart showing Child Removals April 2017 - September 2017](chart.png)

- 58% of all DCS Removals occurred in Maricopa County
- Other AZ Counties N=1,833
- Removals in Maricopa County N=2,498
Trended quarterly Mercy/CMDP penetration rate (October 2015 to December 2017)
Four-pronged approach

- Network Development
- Provider & Community Training
- Collaboration
- Stakeholder Engagement
Network development

• Developed comprehensive clinical model, inclusive of parent support services and case management for all youth and addressing both physical and behavioral health needs

• Focus on evidence-based practices
  o Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
  o Dialectic Behavioral Therapy (DBT)
  o Multi-Systemic Therapy
  o Transition to Independence Program

• Specialized programs specific to the child welfare system needs:
  o Healthy Connections, Substance Exposed Newborn Services Program
  o Foster Care stabilization program inclusive of respite, coaching and therapeutic services
  o Family Center of Excellence
Provider and community needs

- On-site community trainings for DCS offices, group home and foster care providers

- Monthly Foster/Adoptive/Kinship “Navigating Behavioral Health” Forums

- Training
  - Foster/Adoptive/Kinship Caregiver Training Series Infant-Toddler Mental Health Training Series
  - Evidence Based Practice Training (TF-CBT, TIP, CBT-SUD)
References


Thank You
Q & A

ssw.umaryland.edu/traininginstitutes
Q & A

ssw.umaryland.edu/traininginstitutes
Suzanne Fields  
sfields@ssw.umaryland.edu

Earlie Rockette  
earlie.rockette@amerigroup.com

Tad Gary  
garyt@mercymaricopa.org

Katherine Hobbs-Knutson  
khobbs-knutson@alliancebhc.org