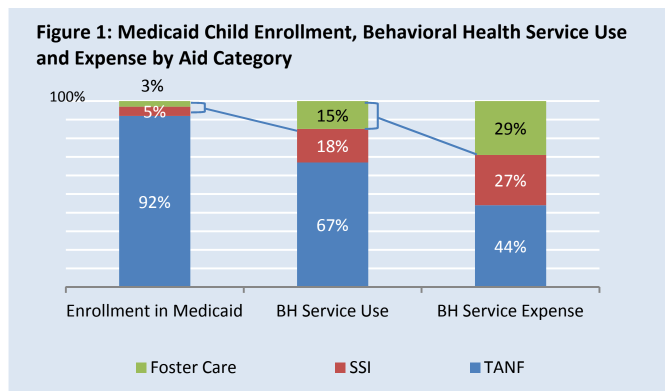
CHCS Center for Health Care Strategies, Inc.

FACT SHEET

Medicaid Behavioral Health Care Use among Children in Foster Care

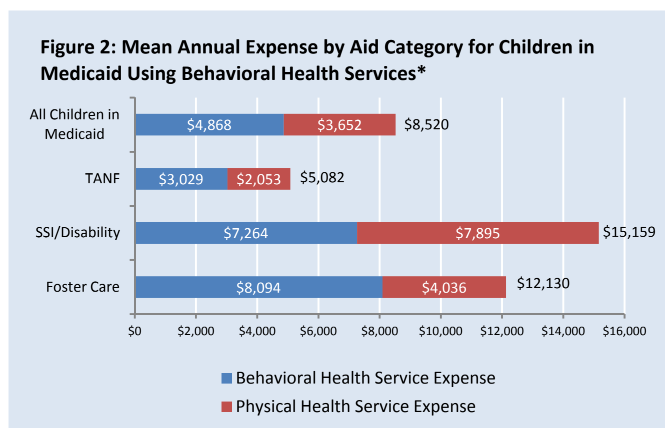
A disproportionate number of children in the nation's foster care system – nearly one in three – use behavioral health services. This population represents only three percent of all children in Medicaid, but 15 percent of those using behavioral health services and 29 percent of Medicaid expenditures for children's behavioral health services (Figure 1).[1]



* All children in Medicaid in 2005, N=29,050,305
** Children receiving behavioral health services in 2005, N=1,958,908

This fact sheet details behavioral health care use and expense for this high-need population, and outlines policy implications. It draws from 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*.[2]

Medicaid expenditures for children in foster care receiving behavioral health services are significantly higher than for other children in Medicaid. Children in foster care have the highest mean behavioral health expenditures at $8,094 per year, compared to other children in Medicaid (Figure 2). Their mean combined physical and behavioral health care costs are also significantly higher than those of the overall Medicaid child population ($12,130 vs. $8,520). For children in foster care, behavioral health expenditures are more than double those for physical 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

Children in foster care are more likely to use restrictive and expensive behavioral health services. Children in foster care use residential treatment/therapeutic group care, inpatient psychiatric treatment, emergency department, and other high-cost, institutional services more often than children in the overall Medicaid population. Residential treatment/therapeutic group care utilization among children in foster care represents the highest mean annual expense among all behavioral health services, at nearly $29,000 per child. Few children in foster care, and Medicaid overall, receive home and community-based services, Multisystemic Therapy, or other effective treatments with an emerging or established evidence base.[3]

Children in foster care are prescribed psychotropic medications at a rate four times higher than the general Medicaid child population, and more often receive multiple psychotropic medications. Children in foster care represent almost 13 percent of the 1.7 million children in Medicaid receiving psychotropic medications, despite only comprising three percent of the Medicaid child population. Close to half (49%) of children in foster care receiving psychotropic medications are prescribed two or more in the same year (Figure 3). Many of these children receive psychotropic medications with no additional identifiable behavioral health supports. Over 42 percent of Medicaid-enrolled children in foster care receiving psychotropic medications are prescribed antipsychotics, compared to about 26 percent of children in Medicaid prescribed psychotropic medications overall. Antipsychotic medications can have significant and undesirable weight and cardio-metabolic impacts, making their overuse among children and youth a particular concern. Expenditures for children in foster care

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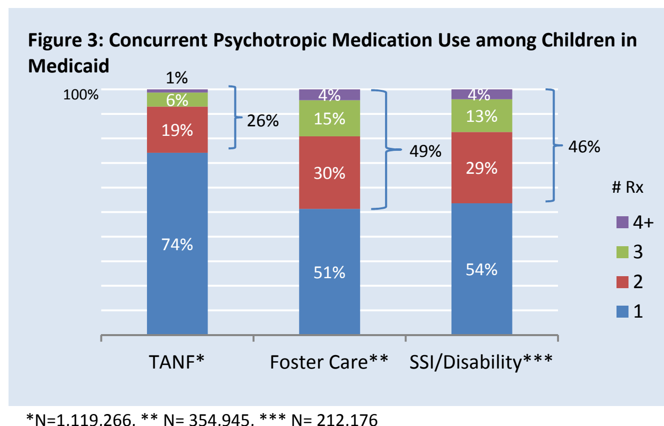
receiving psychotropic medications represent 21 percent of total spending on psychotropic medications among children in Medicaid.



*N=1,119,266, ** N= 354,945, *** N= 212,176

POLICY CONSIDERATIONS

These findings suggest opportunities for states to improve the quality and cost-effectiveness of behavioral health care for Medicaid-enrolled children in foster care. States may consider:

Investing in cross-systems collaboration and care coordination. It is important to ensure that behavioral health care is coordinated between Medicaid and other child-serving systems, including juvenile justice, child welfare, education, and primary care. Some states, including those in CHCS' quality improvement collaborative, *Care Management Entities (CMEs) for Children with Serious Behavioral Health Needs*, are using blended cross-agency funding models to ensure coordination of care.[4] Medicaid health homes, made possible through the Affordable Care Act (ACA), present states with the opportunity to use federal match to cover services for individuals with chronic conditions—including children. States can build on existing intensive care coordination programs – such as CMEs or others developed through the Children's Mental Health Initiative or the Community Alternatives to Psychiatric Residential Treatment Facilities demonstration – to customize health homes for children with serious behavioral health needs.[5,6]

Improving psychotropic medication oversight and monitoring. States can pursue provider and stakeholder engagement and cross-system data-sharing as strategies for effectively managing psychotropic medication use among the foster care population. They can also implement red-flag systems, clinically advised agency consent processes, and telephonic psychiatric consultation to ensure psychotropic medication prescribing among children and youth in foster care reflects nationally-endorsed clinical standards.[7]

Expanding access to appropriate and effective behavioral health services, beyond psychotropic medications. Under the ACA, states can now provide Medicaid coverage up to age 26 for youth involved in the foster care system,[8] many of whom likely have serious behavioral health needs requiring support and/or treatment.[9] States can explore how to use Medicaid and existing provider networks to support intensive care coordination using wraparound; family and youth peer support;[10] in-home services; and other home- and community-based services and supports that can reduce over-reliance on restrictive institutional care or psychotropic medications.

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[1] In the study, Medicaid-enrolled children were designated in one of three Medicaid aid categories: children receiving Temporary Assistance for Needy Families (TANF), children in foster care, and children who are eligible for Supplemental Security Income (SSI)-based Medicaid coverage due to medical and/or mental health disabilities.

[2] 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/.

[3] K.E. Grimes, M.F. Schulz, S.A. Cohen, B. Mullin, S.E. Lehar, and S. Tien. "Pursuing Cost-Effectiveness in Mental Health Service Delivery for Youth With Complex Needs." The Journal of Mental Health Policy and Economics, 14, no. 2 (2011): 73–86.

[4] For more information on Care Management Entities, see: http://www.chcs.org/resource/care-management-entities-a-primer/.

[5] S. Pires. Customizing Health Homes for Children with Serious Behavioral Health Challenges. *Human Service Collaborative*. March 2013. Available at: http://www.chcs.org/resource/customizing-health-homes-for-children-with-serious-behavioral-health-challenges/.

[6] K. Moses, J. Klebonis, and D. Simons. "Developing Health Homes for Children with Serious Emotional Disturbance: Considerations and Opportunities." *Center for Health Care Strategies*, February 2014. Available at: www.chcs.org/resource/developing-health-homes-for-children-with-serious-emotional-disturbance-considerations-and-opportunities/.

[7] American Academy of Child and Adolescent Psychiatry (AACAP). AACAP Practice Parameters. April 2009. Available at: http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Practice_Parameters1.aspx.

[8] Per the ACA rule, former foster youth are eligible for Medicaid until they reach the age of 26, provided that they turned 18 (or older under the state's child welfare plan) and were enrolled in Medicaid while in foster care.

[9] P.J. Pecora, P.S. Jensen, L.H. Romanelli, L.J. Jackson, A. Ortiz. "Mental Health Services for Children Placed in Foster Care: An Overview of Current Challenges." *Child Welfare*, 88, no. 1 (2009): 5–26.

[10] For more information on Medicaid financing for family and youth peer supports, see: http://www.chcs.org/resource/medicaid-financing-for-family-and-youth-peer-support-a-scan-of-state-programs-3/.

For additional resources, visit **www.chcs.org**