

Developing Health Homes for Children with Serious Emotional Disturbance: Considerations and Opportunities

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The Medicaid health home state plan option is designed to provide a comprehensive system of care coordination across medical, behavioral, and long-term services and supports (LTSS) for Medicaid beneficiaries with chronic physical or serious mental health conditions. Individuals with serious mental illness are commonly targeted by states for enrollment in health homes because of their relatively poor health outcomes, high care coordination needs, and the high costs typically associated with serious mental illness and related comorbidities. To date, 11 of the 14 states with approved health home state plan amendments (SPAs) have included individuals with serious and persistent mental illness (SPMI) and serious emotional disturbance (SED) in the target population.²

Children with SED are a compelling group for health home enrollment considering that mental health conditions are one of the top cost drivers for children and mental health care delivery involves coordination across multiple entities. In fact, while children receiving behavioral health care represent less than 10 percent of the overall Medicaid child population, their care accounts for an estimated 38 percent of total Medicaid child expenditures.³ However, with proper intervention, children with SED can have improved health and social outcomes and lower costs of care.⁴

States cannot develop health home models that target by age (e.g., by focusing only on children with SED instead of across the age continuum for individuals with serious mental illness). However, states can tailor behavioral health-focused health homes to meet the unique needs of both children and adults (see sidebar on Clarifying the Centers for Medicare & Medicaid Services (CMS) Guidance, pg 2).

This brief describes considerations and opportunities for tailoring a health home model specifically to the needs of children with SED. It draws from the Center for Health Care Strategies' (CHCS) work helping states to implement health home programs, as well as from an earlier report by Sheila Pires, Partner, Human Services Collaborative, published in early 2013 by CHCS.⁵

IN BRIEF

Section 2703 of the Affordable Care Act (ACA) created the Medicaid health home state plan option to coordinate primary and acute physical and behavioral health care and long-term services and supports (LTSS) for eligible Medicaid beneficiaries. One potential target population for enrollment in health homes is individuals with serious mental health condition, including children with a serious emotional disturbance (SED). This issue brief highlights health home opportunities for children with SED and presents considerations to help states develop models that address this population's unique needs.

Considerations

Children with SED are different from adults with SPMI in several ways that may affect a state's design of its health home model, such as how the population is identified, provider standards are developed, and services are defined. Just as CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) are working closely to identify and develop the best approaches to care for children with SED, states should consider working across the "silos" of their Medicaid and behavioral health agencies to build a coordinated approach for health homes serving this population. Following are some of the distinctions between children with SED and adults with SPMI that could impact the development of health home components.

Identification of Target Population

Adults with SPMI can often be identified using techniques similar to those for identifying individuals with chronic physical illnesses (e.g., using specific diagnoses to determine health home eligibility). SED determinations for children, however, rely not only on diagnosis (such as anxiety and mood disorders, attention deficit and disruptive behavior disorders, or adjustment disorders), but also on duration of the diagnosed condition(s) and on functional assessment; information that is typically not available in a state's administrative data system. Thus, eligibility

determination for children may need to occur once a provider has screened a child using standardized tools to assess clinical and functional impairment. As a result, more upfront involvement from providers may be required to determine health home eligibility for children with SED than for adults with SPMI.

Development of Provider Standards

The mix of physical and behavioral health conditions in children with SED is different than in adults with SPMI. Children with SED typically have fewer serious medical conditions than adults with SPMI. Approximately one-third of children who use behavioral health care have serious medical conditions (often asthma). In contrast, more than two-thirds of adults with SPMI have chronic medical conditions such as diabetes or heart disease.⁶ As a result, the provider requirements and health home qualifications may need to be tailored more toward children's behavioral health providers and include a family therapist, other youth peer supports, or behavioral modification professionals in addition to a medically-oriented nurse or physician.

Definition of Health Home Services

When defining the six core health home services, states may want to consider shaping service definitions specifically to the needs of children with SED. These include:

Care Coordination. As addressed earlier, children with SED have unique health care needs necessitating a potentially different type of care coordination. As a result, efforts may focus more heavily on coordination of the behavioral health conditions and needs and likely somewhat less on the medical conditions. Although the care coordination for this population might shift to behavioral health needs, connections with primary care remain critical for ensuring overall wellness and access to routine check-ups. Health homes are required to establish strong linkages across primary care and behavioral health.

Individual and Family Supports. For children with SED, family involvement is important not only from the perspective of parents or guardians providing consent for services, but also is critical to achieving positive outcomes. Specifically, strong family involvement can positively impact service delivery for children with SED.⁷ Thus, when defining individual and family supports, states could shape the role of family participation to engage both the individual child and his/her family to create a team that includes family, school, and community.

Community and Social Supports. Children with SED have a different set of social services that should be included in care coordination planning. Care coordinators may need to develop substantive relationships not only with the family, but also with other entities involved in a child's care. Child welfare,

Clarifying CMS Guidance on Targeting Health Homes by Age: Rhode Island's Approach

Since Section 2703 of the Affordable Care Act (ACA) does not explicitly allow states to target health home eligibility by age, CMS has interpreted this to mean that states must develop health home programs that serve individuals of all ages with the targeted chronic conditions. Accordingly, "serious mental illness" as an eligible condition for health homes is interpreted to include both children with SED and adults with SPMI. However, because of the different physical and behavioral needs and social complexities across these two age groups, as well as potential differences in the providers who serve them, states are encouraged to tailor health homes to meet each populations' unique needs.

This tailoring can either be done in the context of one health home state plan amendment (SPA) or through two separate health home models (one targeting adults and another targeting children) as long as they are implemented simultaneously. Rhode Island, for example, has two approved behavioral-health oriented SPAs: one focusing on community mental health organizations (CMHOs) as the health home for adults with SPMI and the other on Comprehensive, Evaluation, Diagnosis, Assessment, Referral and Re-evaluation (CEDARR) Family Centers for children and youth with special health care needs. The two models serve different populations, leverage different provider infrastructure, and have different payment mechanisms. Despite these differences, the models are similar in many ways. Both models address the needs of populations with complex medical, behavioral health, and psychosocial needs; both offer infrastructure that is conducive to the delivery of health home services; and they were poised to pursue additional innovations. Most essential to the approval of these two models is that the state pursued them simultaneously and the effective dates of the two SPAs are the same.

juvenile justice, and special education are all unique to children and indispensable to their care. A model that does not address these social supports is less likely to be effective.

“Chronicity” of Illness in Children vs. Adults

The concept of recovery is important for all individuals with behavioral health needs – and includes the understanding that, regardless of age, individuals have the ability to overcome or effectively manage their behavioral health conditions. That said, it is relevant to note that there are clinically recognized differences in the nature and progression of behavioral health conditions among adults versus children. For example, given the resilience and ongoing development of children, serious behavioral health conditions can often be permanently resolved. In fact, the average length of participation at an *intensive level* of care coordination for children with SED is 16-18 months.⁸ Accordingly, states may want to consider a mechanism for shifting these beneficiaries to a primary care focused health home to the extent behavioral health needs become less significant over time.

How the family is involved, what additional systems should be engaged, and which type of provider standards to require are key distinctions between services designed for children and adults. As a result, health home services, care coordinator qualifications, and reimbursement rates for children with SED may be different from those designed for adults with SPMI.

Opportunities

States have the ability to leverage existing programs or care models for children with SED to develop health home models that are tailored to this population.

Intensive Care Coordination

Two federal initiatives have made substantial contributions to informing how states address the needs of children and youth with significant mental health conditions:⁹

- SAMHSA’s Comprehensive Community Mental Health Services for Children and Their Families Program, or Children’s Mental Health Initiative (CMHI); and
- CMS’ Psychiatric Residential Treatment Facility (PRTF) Demonstration Program.

The CMHI promotes a coordinated, community-based approach to care for children and adolescents with serious mental challenges and their families.¹⁰ The PRTF Demonstration Program was designed to determine the effectiveness of community-based services for youth who are in, or at risk of entering, a PRTF.¹¹ Both programs used intensive care coordination in conjunction with a wide array of other services to meet children’s needs. While Medicaid health homes and their enhanced 90/10 match cover only those aspects of these models that fit within the six core health home services, experiences from these two initiatives show how intensive care coordination can be used to tie together delivery of physical and behavioral health care services. Thus, experience and states’ best practices from these initiatives could be used to inform the development of health homes for children with SED.

Care Management Entities

Several states have existing Care Management Entity (CME) models that could serve as a building block for health homes tailored to the needs of children with SED. A CME organizes and coordinates all care for children with complex behavioral health challenges who are involved in multiple systems and their families. A CME provides: (1) a youth-guided, family-driven, strengths-based approach that is coordinated across agencies and providers; (2) intensive care coordination; and (3) home- and community-based services and peer supports as alternatives to costly residential and hospital care for children and adolescents with severe behavioral health challenges.¹²

The goals of CMEs are similar to those of health homes, specifically to improve clinical and functional outcomes; enhance system efficiencies and control costs; and strengthen families and youth.¹³

Following are states using a CME approach to address behavioral health challenges in children:

- Statewide models: Louisiana, Massachusetts, New Jersey, Oklahoma;
- County-based models: Indiana, Ohio, Wisconsin;
- Regional models: Georgia, Maryland; and
- Emerging models: Colorado, Wyoming.

To date, none of the currently approved health home models build on a CME approach; however, some states in the process of developing health homes are

considering how to best leverage this model when it exists in their state.

Avoiding Duplication of Services and Payment

Depending on how a health home model for children with SED is developed, states should be aware of the potential for duplicating other Medicaid-funded care coordination services. This is a particular risk when other care management programs or care coordination services are already provided in Medicaid. For example, targeted case management, waiver services, and managed care all typically contain elements of care coordination. Additionally, when building on existing infrastructure or programs, it is critical to not only avoid duplication of services, but also to avoid duplication of payment by Medicaid.¹⁴ Flexibility is given to states to describe how this duplication will be avoided in their proposed health home models; however, three options for avoiding duplication include:

1. **Convert services to health home services:** By integrating services within the health home structure, any potential for duplication is eliminated as the existing services would now be provided under the auspices of the health home. An example of this option would be for a state to actively remove a service (e.g., targeted case management) from current authority and place the service within the health home state plan services. Thus, the service would only be available to members participating in health homes and could not be duplicated.
2. **Allow member to choose between services:** Allowing the member to choose between the type of service provider they receive services from is a way to prevent duplication. For example, several states have done this by monitoring and tracking enrollment to ensure that members are not dually enrolled in both targeted case management and health homes offering the similar care coordination/care management services.
3. **Provide adequate differentiation between services:** States can choose to offer care management/care coordination services outside of the health home as long as they are clearly

distinguished from the services being provided within the health home, thereby allowing members to receive both services without duplication. For example, members could receive care management services from both a health plan and the health home, if the nature of the services provided by each entity would be clearly differentiated. In this case, the health home could provide “on the ground” care management/care coordination services, whereas the health plan could be responsible for eligibility determination, referrals, and/or supplying health homes with information regarding health care utilization and community resources.

Additional Resources

Several useful resources are available to support the development of health home models tailored to meet the needs of children with SED. These include:

- CMS/SAMHSA Joint Informational Bulletin 5-7-13: *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Serious Mental Health Conditions*. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html>.
- S. Pires. *Customizing Health Homes for Children with Serious Behavioral Health Challenges*. Center for Health Care Strategies, March 2013. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261488.
- Health Home Information Resource Center website on Medicaid.gov: <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html>.
- N. Marshall. *Integrating Behavioral Health and Primary Care for Children and Youth: Concepts and Strategies*. Center for Integrated Health Solutions / SAMHSA, July 2013. Available at: http://www.integration.samhsa.gov/integrated-care-models/13_June_CIHS_Integrated_Care_System_for_Children_final.pdf.

Conclusion

Medicaid officials at both the state and federal levels recognize that the service needs of individuals within a population may vary. The treatment modalities, protocols, and provider networks needed for children may be different than those for adults. In addition, since final health home regulations have not yet been released, states may have questions as to what requirements and flexibilities exist to develop models for children with SED. Although health home populations cannot be *targeted by age*, states have the opportunity to develop different approaches to coordinating, managing, and monitoring services in

health homes that serve different age groups – to *tailor by age* across the age continuum.

Given the often limited fiscal resources available to states, they should consider using existing programs and initiatives as the basis for developing health home models for children with SED. Flexibility exists for states to tailor health home models to best serve eligible individuals across the age spectrum while still operating within ACA's requirements.

Endnotes

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² The 11 states with approved health home SPAs that include serious mental illness are: Alabama, Idaho, Iowa, Maryland, Missouri, New York, Ohio, Oregon, Rhode Island, South Dakota and Washington.

³ S. Pires, K. Grimes, K. Allen, T. Gilmer, R. Mahadevan. *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*. Center for Health Care Strategies, (forthcoming).

⁴ Center for Medicaid and CHIP Services (CMCS) and U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Joint Informational Bulletin # 5-7-2013. Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Serious Mental Health Conditions. May 7, 2013. Available at: <http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html>.

⁵ This brief summarizes key considerations in developing health homes for children with SED described in: S. Pires. *Customizing Health Homes for Children with Serious Behavioral Health Challenges*. Center for Health Care Strategies, March 2013. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261488#UjNIAPnD-Uk.

⁶ Pires et al., op cit.

⁷ B. Stroul, S. Goldman, S. Pires, and B. Manteuffel. *Expanding Systems of Care: Improving the Lives of Children, Youth and Families*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health, 2012.

⁸ Pires et al., op cit.

⁹ CMCS and SAMHSA, op cit.

¹⁰ U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The Comprehensive Community Mental Health Services for Children and Their Families Program. Evaluation findings—Annual Report to Congress. 2010. Available at: <http://store.samhsa.gov/shin/content/PEP12-CMHI2010CD/PEP12-CMHI2010CD.pdf>

¹¹ For more information on PRTF see: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Alternatives-to-Psychiatric-Residential-Treatment-Facilities-Demonstration-PRTF.html>.

¹² Center for Health Care Strategies. *Care Management Entities: A Primer*. March 2011. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261240.

¹³ Ibid.

¹⁴ Centers for Medicare & Medicaid Services. *Health Home Considerations for a Medicaid Managed Care Delivery System: Avoiding Duplication of Services and Payments*. February 2012. Available at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-Managed-Care-Options-Matrix_020312.pdf.