

# Analyzing Child and Adolescent Expenditures and Service Use Across Systems

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Stakeholders engaged in building systems of care can undertake a strategic financing analysis once they have made preliminary decisions about what they want to finance on behalf of which populations of children and families. This analysis begins with examining child behavioral health expenditures and service use across child-serving systems, identifying:

- which public agencies spend dollars on the populations of focus;
- how much is spent and on which services and supports;
- the types of dollars used (e.g., federal entitlement dollars, such as Medicaid, federal block grants, state general revenue), broken down by service type;
- how many children are served and their demographics (e.g., age, race/ethnicity, gender, and region/county), in total and by service type, and, if available, average lengths of stay by service type; and
- the available outcome data associated with these expenditures.

This type of financial mapping enables stakeholders to identify areas of strength, gaps, duplication, and inefficiencies in spending, as well as disparities and disproportionality in spending and utilization of services – for example, racial and ethnic or geographic disparities and disproportionality. Ultimately, this mapping and analysis supports system builders to identify more effective and efficient use of dollars through development of coordinated cross-agency financing strategies. Undertaking a mapping of expenditures and service use requires the commitment of multiple individuals to support the collection and analysis of the data. There needs to be a commitment across agencies, departments, and organizations to share expenditure and utilization data and a willingness to identify a point person within each department to obtain and help interpret the data.

## **Initial Decisions**

Remember that your financial mapping is guided by your populations of focus. Decide first whether your financial mapping is examining state-level expenditures only, or both state and local. Financial mapping across public agencies can be challenging, because each agency has its

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own data system and captures expenditures and service utilization in different ways. Tackling both state and local level expenditures at once adds to the challenge. Make a decision also as to what fiscal year or years to include for the analysis. Different systems may have data from different fiscal years available; usually, there is a trade-off to be made between taking the most recent data each system has available, recognizing that may include different fiscal years across the agencies, or deciding on a single fiscal year across agencies, recognizing that may not be the most recent data.

### **Relevant Public Agencies**

The following is a listing of state (and local) agency types that typically spend dollars on children with behavioral health challenges. It is not an exhaustive list, simply illustrative, and, of course, your agencies may have different names and organizational homes.

- *Medicaid.* In some states, counties may be providing Medicaid match dollars as well as the state. You will want to look at both Medicaid and State Children’s Health Insurance expenditures and service use. If Medicaid dollars are in a capitated managed care arrangement, you will undoubtedly only be able to capture utilization data, not expenditures. If Medicaid fee-for-service (FFS) expenditures are available, you can extrapolate FFS expenditures to managed care spending, but must include the caveat that this extrapolation may overstate managed care spending (which, in general, tends to be lower than FFS spending).
- *Mental Health, Intellectual Disabilities, and Addictive Diseases.* The state behavioral health agency typically controls block grant and state general revenue dollars for mental health and substance use disorder services and prevention; depending on the state, the behavioral health agency may also have responsibility for Medicaid mental health and/or substance use expenditures. If this is the case, then the state behavioral health agency is spending a significantly larger amount of dollars on children’s behavioral health care than if it is only spending block grant and general revenue monies that are not matched to Medicaid.
- *Child Welfare.* Behavioral health expenditures in child welfare are sometimes difficult to identify, because they may be embedded in larger service contracts or are part of the responsibilities of in-house staff, such as child welfare workers, who have other

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responsibilities. Look at contract expenditures and staff responsibilities and make educated guesses. It is also important to note that, in some states, the child welfare system's budget includes Medicaid match dollars for behavioral health services, including residential treatment expenditures, among others.

- *Rural and Community Health.* Increasingly, rural health clinics and federally qualified health centers (FQHCs) are spending dollars on behavioral health care that might not be entirely captured through Medicaid spending.
- *Maternal and Child Health.* These programs are serving children with special health care needs and often encompass early intervention programs for infants and young children as well.
- *Juvenile Justice.* Juvenile justice systems may be expending dollars for behavioral health care both through contracted services and through in-house staff. In addition, it is also useful to account for detention expenditures in general (not just those for behavioral health), because, by diverting youth with behavioral health challenges to home and community based services, costs often can be saved in detention and diverted to home and community-based behavioral health services, with better outcomes for youth.
- *Education.* It is often difficult to obtain education system expenditures for behavioral health services and supports because there are typically many independent school districts, and state departments of education may be accounting for only some of this spending. Usually, expenditures on special education for students with emotional and behavioral disorders can be tracked at the state level because of federal reporting requirements for these data.
- *Early Intervention Programs.* States organize their early intervention programs for children ages birth to 5 years in diverse ways. For example, the Part C program may be part of the department of education, or the department of mental health, or developmental disabilities, or maternal and child health, or some other arrangement.

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- *Labor.* Departments of labor or employment services may include relevant expenditures through vocational rehabilitation and supported employment for youth with behavioral health problems.
- *Other.* There are other potential funding sources, as well, such as Temporary Assistance for Needy Families, or TANF, dollars through human service agencies, housing supports through housing agencies, and, at a local level, recreation, police, and safety programs and the like.

### Identification of BH Expenditures by Funding Streams

Below is a chart showing the typical universe of funding streams for behavioral health services for children and youth in the public

sector. Again, it is not an exhaustive list; on the other hand, not all states use all of these funding streams for behavioral health services for children, but the chart provides a general framework. For each funding stream, identify:

1. whether the funding stream is used to pay for behavioral health services for children;
2. which state agency controls the funding stream (“controls” refers to responsibility for how the dollars are spent); and
3. the amount of spending on behavioral health services for children within each funding stream.

### Sources of Funding for Children/Youth With Behavioral Health Needs in the Public Sector



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### **Identification of the Types of Behavioral Health Services and Supports Covered by Each Funding Stream/State Agency**

Develop a comprehensive list of behavioral health services and supports to use as a guide for determining which public agencies are spending dollars on which services and supports. It is also important to crosswalk the Medicaid agency's list of covered services with your list, as different terminology may be used for the same service types.

Identify the amount and types of relevant behavioral health services being purchased or provided in-house by the relevant state agencies or their designees (e.g., regional offices). It is also useful to identify the providers (private or public) that public agencies are supporting to provide behavioral health services for children and youth, to guide analysis of overlap across child-serving systems and opportunities for efficiencies such as collaborative training or purchasing.

### **Identification of Number, Demographics, and Severity of Children and Youth Served by Funding Stream/State Agency**

Identify as best as possible the population of children and youth for whom each public agency is purchasing or providing behavioral health services, including numbers of children and demographics (age, gender, race/ethnicity, geographic location, system involvement, average lengths of stay in services, particularly in out-of-home placements such as residential treatment, and level of clinical/functional impairment). Part of this exercise is to identify the extent to which each funding stream/state agency is supporting children with serious disorders, children at risk for serious disorders, and children with brief, short-term needs, as well as children involved in multiple systems.

### **Identification of Service Utilization Patterns by Funding Stream/State Agency**

Identify how much of each service type is being used, supported by different funding streams/state agencies. For example, how much residential treatment (if any) is being used that is purchased by the Division of Medical Assistance using Medicaid dollars versus by the Division of Family and Child Services (child welfare) using state general revenue or Title IV-E funds? And what are the average lengths of stay?

### **Additional Useful Data**

Following are some additional data items to consider.

1. Data on any documented outcomes related to each funding stream or public agency expenditures that are relevant to children and youth with behavioral health disorders and their families. This may include outcomes being tracked by particular systems or

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recent studies or reports associated with particular funding streams that discuss outcomes relevant to children's behavioral health.

2. Information on any legislative or administrative mandates relevant to children and youth with behavioral health disorders; for example, interagency agreements related to pooled funds.
3. Basic demographic data on children and youth in the state (or county, if a local analysis), including:
  - total child/adolescent population, ages birth-21;
  - socioeconomic characteristics;
  - geographic distribution of children at risk (as determined by such risk factors as poverty, minority status, school lunch eligibility, etc.);
  - total numbers of children involved in the following systems (annual and point in time): mental health, substance abuse, child welfare, juvenile justice, special education, and Medicaid; and
  - number of children and youth in out of home placements (annual and point in time), including regular foster care, specialized foster care, regular group home, therapeutic group home, residential treatment facility, inpatient hospital, and secure detention.

### **Caveats about Data**

Some of the data needed for this type of financial mapping and analysis may not be available or may be too time-consuming to find. By the same token, there may be data items not listed above that you might want to add. As noted, public agencies may have data available from different fiscal years, so there may be inconsistency in reporting periods. Don't let perfection be the enemy of the good – collect whatever data each public agency can provide for a complete fiscal year, trying, optimally, for common fiscal year(s) but recognizing that may not be doable. Try to make sense of the data as a whole, with appropriate caveats included, once you have as much data as can be reasonably obtained. Financial mapping and analysis should be viewed as the beginning of an ongoing process, which should get better and easier over time, to account for and improve child behavioral health care spending and utilization.

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