



## Behavioral Health Homes for Children:

# An Opportunity for States to Improve Care for Children with Serious Emotional Disturbance

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A growing number of children and adolescents have behavioral health difficulties, such as attention deficit hyperactivity disorder (ADHD), depression, post-traumatic stress disorder, and conduct disorder. Approximately 20% of children in the United States experience behavioral or mental health disorders, and nearly one in seven children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) have been diagnosed with a behavioral health condition.<sup>1,2</sup> A smaller but significant number—10% of all children in the United States—have a serious emotional disturbance (SED), which is a mental, behavioral, or emotional disorder that substantially interferes with the child's functioning in family life, school, or community activities.<sup>3,4</sup> Furthermore, children's behavioral health services are a prominent driver of health care costs. While only 11% of children enrolled in Medicaid use behavioral health care, behavioral health services account for 36% of total children's Medicaid spending.<sup>5</sup>

Children and youth with SED can have complex needs, and may require care across multiple systems, including primary care, behavioral health care, schools, community-based organizations, and other social service programs.<sup>6</sup> When children's behavioral health needs are not met or services are not coordinated with their other medical and social needs, they are at higher risk for poor health and life outcomes, including unnecessary hospitalizations, lower educational achievement, and involvement in the juvenile justice system.<sup>7,8</sup> For children with serious behavioral health conditions, a systems of care approach, which is a coordinated, comprehensive, and family-centered network of services and supports that is organized to meet the needs of children and youth with special health care needs, has been shown to improve outcomes for children and families and reduce costs.<sup>9</sup> Behavioral health homes (BHHs), which build on a systems of care approach, represent one promising approach that state Medicaid agencies are using to improve care delivery and outcomes for children with serious emotional disturbances (SED) while containing costs.

Health homes are an optional Medicaid benefit established under Section 2703 of the Affordable Care Act, which integrate behavioral and physical health care and social services and provide comprehensive care coordination for those with chronic conditions.<sup>10</sup> (See text box.) The benefit builds on the medical

home model, which is defined as “an approach to providing comprehensive and high quality primary care” that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.”<sup>11,12</sup> As of April 2018, 17 states have active health home programs that are targeted towards individuals with serious mental illness or serious emotional disturbance.<sup>13</sup> Per federal requirements, states must make their BHH programs available to both adults and children.<sup>14</sup>

## Federal Health Home Requirements and Flexibilities

All health home programs are federally required to include the following six core services:

- **Comprehensive care management**
- **Care coordination**
- **Health promotion**
- **Comprehensive transitional care**
- **Patient and family support**
- **Referral to community and support services<sup>15</sup>**

However, states have flexibility in how they define and integrate these core services into their health home programs.<sup>16</sup> Additionally, states also have numerous options for location of BHHs. For example, they can choose to designate specific institutions or providers as BHHs, such as hospitals or community mental health centers, or they can allow other teams of health care professionals that offer the requisite services to participate. These teams can be physically located together, or they can partner together virtually.<sup>17</sup>

States implementing health homes, including a BHH program, receive an enhanced federal matching rate of 90% for health home services provided during the first eight quarters of the program.<sup>18</sup> States have wide latitude in designing their provider payment methodology within their BHH program. They can pay health homes a per member per month (PMPM) rate—a rate that pays a set amount each month for each enrollee; or, they can propose an alternative reimbursement model to the Centers for Medicare and Medicaid Services.<sup>19</sup>

Depending on how the BHH is structured, states may choose which types of staff each health home must have under the Medicaid health home state plan option. Under federal requirements, health homes include, at a minimum, a primary care provider, a nurse, a behavioral health care provider, a social worker, and other providers as appropriate.<sup>20</sup> To ensure a comprehensive approach, states often include multidisciplinary teams on their health home teams; teams may include care managers, family or peer support specialists, and community health workers.<sup>21</sup>

## Pediatric Behavioral Health Home Features and Key Considerations

After meeting the federal requirements detailed above, state Medicaid agencies have significant flexibility in designing their BHH programs to meet the needs of children. While states cannot limit eligibility for the health home option by age, they can choose to tailor their health home plans to offer different treatment approaches to adult versus pediatric populations based on the distinct needs of each age group.<sup>22, 23</sup> They are also able to define which conditions will be served by BHHs.<sup>24</sup> For example, states can choose to target pediatric BHHs to children with certain mental health conditions, or to children with both a mental health condition and certain chronic physical illnesses. States can also target BHHs to certain geographic areas.<sup>25</sup>

While states have flexibility in the design and location of BHH sites, a preliminary review of approved State Plan Amendments finds that many states with BHHs have located them in community mental health centers (CMHCs).<sup>26</sup> Other state approaches to the design of BHHs include the following:

- allowing any qualified team of providers that meet certain requirements to become a BHH, including federally qualified health centers and child health specialty clinics; or
- designating other types of providers, such as existing care coordination entities, as BHHs.<sup>27</sup>

The BHH entity may provide all BHH services, but federal guidance also permits the BHH to facilitate referrals to other providers to provide certain services, such as primary care, or enable outside providers to provide those services onsite at the BHH site.<sup>28</sup>

States can also use a variety of approaches to finance BHHs. Generally, most states with pediatric BHH programs have opted to pay per member per month (PMPM) rates to the health home.<sup>29</sup> States often have tiered PMPM payment rates based on factors such as the acuity of the enrollee's treatment needs and whether the health home is located in a rural or urban area.<sup>30</sup> Some states also offer other additional payments in addition to the capitated PMPM rate or include possible financial penalties. For example, Minnesota offers an initial engagement and assessment payment, which reimburses for the intake and evaluation process when an enrollee joins the health home.<sup>31</sup> In Rhode Island, the state Medicaid agency allows the recoupment of up to 10% of funds if the provider does not meet performance expectations.<sup>32</sup>

In addition to these core components of the behavioral health home, there are a number of additional considerations that states may choose to factor into the design of their BHH programs due to the unique needs of children and adolescents as compared to adults. These considerations include identification and enrollment of children in BHHs, care coordination, and the role of families and caregivers.

For BHHs serving adults, eligibility is typically based on diagnoses, which can be derived from state Medicaid agencies' administrative data and streamlines the identification and enrollment process.<sup>33</sup> However, identifying and determining BHH eligibility among children can be more complex. States may include the duration of the behavioral health condition and functional impairment, in addition to specific diagnoses, in their pediatric BHH eligibility criteria. Determining a condition's duration and a child's functional status typically necessitates the use of a standardized screening tool since this type of information is not captured in states' administrative data.<sup>34</sup>

Children with severe behavioral health needs often receive services from systems beyond the health care system, which can contribute to the complexity of coordinating care for this population. For example, three-fifths of children in one intensive care coordination model were served by special education, and two-thirds were involved with the juvenile justice and/or child welfare systems.<sup>35</sup> Adding to the need for care coordination, many of these systems have legal mandates regarding the treatment of physical and behavioral health conditions for the children in their care. Given these additional care coordination needs, many states with BHHs have significantly lower care coordinator staff ratios for pediatric BHH than those for adults.<sup>36</sup>

Moreover, families play a far more prominent role in care models for children than for adults for numerous reasons g the following:

- children's developmental stage
- children are more likely than adults to live in families
- parents or guardians generally have legal decision-making capacity for medical treatment

Therefore, establishing a family-driven system of care is particularly important in pediatric BHHs, including ensuring families are engaged in the care planning process and integrating family support specialists on care teams.<sup>37</sup>

## Highlights of State Pediatric Behavioral Health Home Programs



### Maine

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Maine launched its Health Home program beginning in 2013. Initially, the State established Health Homes for enrollees with chronic conditions. Then in April 2014, the State rolled out Behavioral Health Homes for adults with serious mental illness and children with Serious Emotional Disturbance (SED).

The BHH program focuses on mental and physical health integration and requires a partnership between a Behavioral Health Home Organization (BHHO) and at least one Department-approved enhanced primary care practice, called a Health Home Practice (HHP). The BHHO is the lead Health Home entity and must be a licensed community-based mental health organization that has been approved by MaineCare. Approval includes meeting ten State-defined Core Standards of care delivery and organization competence.<sup>38</sup> One of the Core Standards for BHHOs is the requirement to implement a family-directed care planning process that uses wraparound principles for children with SED and their families. BHHOs are also required to facilitate, coordinate, and plan for the transition of enrolled youth to the adult system, if necessary.<sup>39</sup> Additionally, BHHOs must establish a care team comprised of the following providers for children with SED: psychiatric consultant, nurse care manager, clinical team leader, family and/or youth support specialist, Health Home coordinator, and medical consultant.<sup>40</sup>

The BHHOs receive a \$394.40 Per Member Per Month (PMPM) payment for services delivered to adult and child enrollees, and they provide pass-through PMPM payments to their partnering HHPs for each BHH client who chooses to enroll in the HHP.<sup>41</sup> The PMPM payment is designed to support care management activities and the coordination of care across service providers.

Since inception, children's BHH enrollment has grown significantly. From 2015 to 2016, the program experienced its largest growth and increased from 300 enrolled members in January 2015 to 2,523 in December 2016. As of June 2018, there were 5,032 children served under this model of care. The program continues to grow steadily in 2018.



### New Jersey

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New Jersey initially launched its BHH program for children and adults in 2014 in one county; it has expanded the program to additional counties since that time.<sup>42</sup> The pediatric BHH program is targeted toward children that have both a SED and a chronic medical condition.<sup>43</sup> The entry point to the state's pediatric BHHs is via a contracted systems administrator (CSA), which manages the program and other state children's mental health services, and serves as the initial point of contact for providers and families. If the CSA finds BHH services are needed, it refers the child to a Care Management Organization (CMO), which provides the BHH services.<sup>44</sup> The CMOs are community-based organizations that serve children with complex needs using the Wraparound model.<sup>45</sup>

The BHH builds on existing CMO services, but with a focus particularly geared toward children with comorbid physical and mental health conditions, emphasizing wellness and the mind-body connection. Each BHH team is composed of the existing CMO staff, along with additional members that provide added medical expertise, including a nurse manager and a health and wellness educator (eg, a nutritionist).<sup>46</sup> To further integrate physical and mental health care, the CMOs are also required to coordinate with primary care practices.<sup>47</sup> Initial results from their pediatric BHH program appear promising. For example, the state has experienced a rapid decrease in children requiring out of home treatment settings. In June 2018 roughly 1,000 children used out of home treatment settings, compared to more than 1,700 in January 2014.<sup>48</sup>



## Oklahoma

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Oklahoma established its BHH program for children with SED, in addition to a BHH program for adults with severe mental illness, in 2015.<sup>49</sup> The BHHs for adults and children are based in community mental health centers, state mental illness service programs, and certain other outpatient behavioral health providers.<sup>50</sup> All BHH care teams must include a care coordinator, nurse care manager, psychiatric consultant, a health home director, and a consulting primary care provider. For the children's BHH program, the care team members also include family support providers, youth peer support specialists, and children's health home specialists.<sup>51</sup>

The BHH program has two levels of care coordination—moderate and high intensity—based on the enrollees' needs.<sup>52</sup> For children, the high intensity program uses the Wraparound approach, which is an intensive, evidence-based model of care planning and management for children with complex needs.<sup>53</sup> In recognition of the high care coordination needs of children with SED, Oklahoma requires far lower client-team ratios for its children's BHH program than its BHH program for adults, and offers a correspondingly higher reimbursement rate for children's BHH providers. Care coordination for children needing moderate intensity services can include up to 25 children per care coordinator. High intensity services have a significantly lower ratio, at a maximum of 10 children per care coordinator.<sup>54</sup>

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