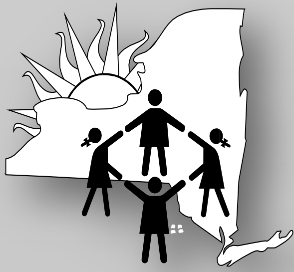

New York State Coalition for Children's Mental Health Services

Business Case for Children's Mental Health Specialty Managed Care

Why should government consider investing in a differentiated model of children's behavioral health specialty managed care program?

In New York State, children's behavioral health care stakeholders are making the case for adapting the Health Home and Accountable Care Organization models to address the unique needs of children and families.

First, decades of research and studies by reputable sources confirm early intervention and prevention of emotional disturbances result in cost avoidance in special education, juvenile justice, child welfare, behavioral health, and in the case of the Adverse Childhood Experiences study (ACEs) by Kaiser Permanente, chronic health expenses in adulthood. Unlike adults, it is not primarily the complex health care needs that drive up the extraordinary public spending on high-needs children and adolescents, it is their complex lives and the complex lives of their families. To bend the cost curve, the multitude of problems must be addressed.

Conclusively, the investment in a differentiated child and adolescent Health Home must be predicated on the understanding that the benefits will accrue in out-year State budgets. However, the savings will not be confined to health care or behavioral health care. The savings will accrue in the form of reduced social services expenditures and through increased tax-paying productivity when the individuals served enter the workforce better-educated, capable of parenting and emotionally well.

__Our Mission:__ To promote quality mental health services for New York's children with serious emotional disturbance and their families by leading the service provider community in identifying effective practices and participating in planning and implementing a continuum of services that are family-focused, comprehensive, cost-effective, culturally responsive, coordinated and appropriately funded.

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Compelling Reasons for Child and Adolescent Specific Health Homes

1. Behavioral health care for children must be coordinated across organizational boundaries. Millions of dollars are spent in the education, social services, and juvenile justice systems by federal, state, and local agencies to address child and adolescent behavioral health issues. Often the funding is intended to achieve similar goals. However, it is usually spent without reference to the efforts of the other systems. Childhood Medicaid expenditure is only part of all the system expenditures, therefore we have to organize both the Medicaid spending and the "silo" systems spending.

- In 2011-12, New York State allocated $436 million to support the Foster Care Block Grant and $101.5 million to support juvenile detention programs;
- In 2011-12, New York state allocated $133 million in Medicaid for child and adolescent psychiatric hospitalizations and $90 million for residential treatment for severe emotional disturbances and $16.6 million for residential substance use treatment;
- The average annual cost to support one child in special education in New York State is $210,000.00 (Hevesi, *Building Foundations: Supporting Involvement in the Child's First Year*; City of New York Office of the Comptroller, 2001)
- In 2011-12, New York State allocated $34.6 million to support 18% of the residential cost of the placement of youth by school district Committees on Special Education. Local governments contributed another $82 million or 43% of residential special education placements.
- In 2011-12, New York State allocated $76 million to fund state-operated schools at OMH psychiatric centers and residential OPWDD centers and $19.5 million to fund state-operated educational programs for incarcerated youth.
- "Approximately 48 percent of youth (429) who were screened at intake to OCFS operated facilities in 2007 had mental health needs and 70 percent (625) had substance use issues. . . .OCFS does not publicly report similar, aggregate data on the service needs of youth placed at private agencies**." (*Charting a New Course: A Blueprint for Transforming Juvenile Justice in New York State,* December 2009 *)

2. Interventions provided—or not provided—in early childhood have a compounding effect over a lifetime. Nobel Prize winning economist James Heckman, and others, have demonstrated the economic advantage of investing in young children (Heckman, Wall Street Journal, 2006). It is clear that behavioral health dollars spent on prevention, cross-systems support, and therapy during this period are, by and large, more powerful than dollars spent during other life-cycle periods.

- Unemployment and lower earnings, resulting from high school non-completion, also has a substantial bearing on an individual's reliance on public programs. Levin (2007) reports that graduating from high school is associated with a lower probability of receiving TANF (-40%), housing assistance (-1%), and food stamps (-19%). These reductions have the potential to produce significant cost-savings at all levels of government
- For every $1 spent on home visiting, there is a $5.70 return on investment (Karoly, Cannon; *Early Childhood Interventions: Proven Results, Future Promise;* Rand Corporation, 2005)
- The number of children in foster care in New York has dropped from 25,700 in July 2007 to 23,380 in July 2010, yet the rate of recurring child abuse and maltreatment remains around 12% (11.4% in March 2007 and 11.9% in March 2010). **OCFS Trend data*
- Improved high school graduation rates may produce a reduction in the cost of crime. If the male graduation rate in New York State was increased by only 5%, the State would experience an annual savings of $286 million in crime-related costs (Alliance for Excellent Education, 2006)

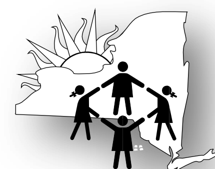
3. Nurturing and permanency support healthy development. The transition from dependent child to independent adult is necessarily protracted in our species. This is especially true for young people whose course of behavioral development has been distorted by organic, environmental, or experiential factors. Caring adults and service systems must be able to "be with" children over time and through phases of growth, the care coordination elements must focus on establishing this "permanency" of relationships as a priority, including, but certainly not focused upon the permanency of a primary care physician.

- The average annual cost for a child in non-residential foster care is $45,000 (NYS Citizen Review Panels for Child Protective Services; *2008 Annual Report and Recommendations*)
- Home visiting decreases confirmed child abuse cases for young first-time mothers who receive services prenatally by 50%. (Dumont, et al; *Effect of Health Families New York on Maternal Behaviors;* July 2008)

- The contribution of family connectedness to promoting adolescent health was demonstrated clearly and convincingly through the National Longitudinal Study on Adolescent Health. The study indicated that family connectedness is protective against emotional distress, suicidal thoughts and behaviors, violence, . . . and young age at sexual debut. (Hillis, Anda, Dube, Felitti, et al; *The Association Between Adverse Childhood Experience and Adolescent Pregnancy;* Pediatrics, February 2004)
- In 2011-12, New York State fought to maintain $23 million to support Home Visiting, an evidence-based approach to support early nurturing because of economic conditions. The funding was sustained.

4. Children's behavioral health services need to be provided by children's behavioral health specialists. The need for specialization should not be sacrificed for efficient generalization. Specialization is clearly needed as the severity of challenges has increased and the science behind specific treatments has improved. The rise in understanding the effects of trauma on childhood emotional disturbances is a good example. Behavioral health care must apply its own recognized approaches, like trauma-informed techniques, for children with serious emotional disturbances to ensure quality services are not generalized to the extent that harm occurs.

- Profile data of 57 youth in RTF care in New York State (2010) show low to moderate IQs and low math and reading levels. Adjusting treatment to correspond to developmental levels is just one aspect of appropriate specialization.
- The same 2010 survey of 57 youth at a New York RTF reveals no availability of the father for over 1/2 the residents and approximately 1/3 without availability of the mother. 36 residents have not lived with their bio parent in 6 or more years. Providing trauma informed treatment is effective and necessary.
- The 2009 Patient Characteristic Study (PCS) by OMH shows that 23,323 children had contact with mental health clinics but only 7,108 receive mental health supportive services such as family support services, mobile mental health services, respite, school-based mental health, case management and advocacy services. Developing and supporting a specialty workforce that can provide lower-cost support services is key to successful system redesign.
- The 2009 PCS showed over 2,000 children either hospitalized or receiving RTF care, yet only 1,004 children received crisis services, such as crisis intervention, home based crisis intervention, extended observation days, crisis outreach and crisis residence services. The ability to build up services that are responsive and assist in avoiding hospitalization or residential placement requires specialists who can correctly identify ambulatory care responsive conditions.



Making the Business Case with Data

To make the case in a manner that can be generalized, attempts should be made to correlate state Medicaid data to available national prevalence data. Both federal and state officials must be reassured that the identified populations and problems are pervasive, here to stay and need focused attention for an extended time period.

Regardless of the specific cost data or even aggregate cost date across systems, the complex needs of the youth are evident in existing data sources. With constant educational and relationship interruptions, the youth who need specialty managed care and care coordination are not only struggling to recover from their mental illnesses, they are struggling to strive, to learn, to love and to maintain hope that those positive outcomes will remain an option for them.

These data snapshots support our attestation that children's Health Homes and Accountable Care Organizations MUST be designed and differentiated from the adult models. The funds spent on treatment and prevention will bend the cost curve of entire families and futures.

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