MENTAL HEALTH SERVICE ACCESS: USE OF EXISITNG DATA

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SSWR Society for Social Work and Research

Introduction | Methods | Results | Discussion

About 20% of children & youth, ages 3 to 17, experience mental health disorders, but only one in five of affected youth received specialized mental health treatment (Choi & Easterlin, 2018). 25.8% of 18-25 year olds have a mental health disorder (MHD), but only 38.4% received treatment (NIMH, 2019). Without intervention, children & youth with MHD experience long lasting adverse effects (Henning-Smith & Alang, 2016). Increasing access to care is challenging (Callejas et al., 2010; Choi & Easterlin, 2018). Disproportionate access is often found by age, gender, race/ethnicity (language), & geography (CDC, 2019; Gresenz et al., 2000; Chow et al., 2000; Pulsifer et al., 2019.)

Administrative Data Sources

Mental Health Block Grant (MHBG)

"The MHBG program provides funds and technical assistance to all 50 states, the DC, Puerto Rico, the U.S. Virgin Islands, and six Pacific jurisdictions. Grantees use the funds to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system" (SAMHSA, 2019).

Medicaid Claims Data (CDC, 2019)

Medicaid was established as an entitlement program under Title XIX of the 1965 Social Security Act to support health care for individuals with low incomes or living with disabilities. States administer Medicaid, combining federal and state funding. Adhering to federal eligibility criteria, benefits, and payment rates, States design optional services. Federal rules require states to collect person-level eligibility and health service records for each member in electronic files used to manage the program, for surveillance, statistical reports, and research (CDS, 2019).

As part of a state-level system of care initiative (Stroul et al., 2010), this study explored the use of administrative data to examine mental health service (MHS) utilization in order to examine trends and to identify disproportionate access for the purpose of informing program and policy planning and to monitor progress.

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Access was defined as utilization of publically funded mental health services (MHS) for children and youth. Two types of administrative data were examined: Community Mental Health Services Block Grant (MHBG) URS Tables and Medicaid claims.

MHBG URS Data

Using MHBG Uniform Reporting System (URS) Client Level Data, service utilization trends from 2004 to 2016 for transition age youth (TAY, ages 18-20) were traced and the percentage of change calculated.

TAY youth enrollment was disaggregated by gender & race/ethnicity as compared to the state 2015 population.

Medicaid Claims Data

As part of a Child Mental Health Initiative to develop a state-level system of care (Huang et al., 2005), utilization of Medicaid funded child MHS was examined to inform a finance plan. This descriptive analyses compared services by age, gender, race/ethnicity, geography, and language in SFY14. The relationship between language and dispportionate identification of mental health need was also explored.

Mental Health Toolkit (Pires et al., 2018)

A Mental Health Toolkit was applied to claims data to evaluate service utilization and trends. Adapted to fit the state's Medicaid plan, the toolkit framework was utilized to identify MHS categories: **outpatient, supportive, emergent, psychiatric inpatient, wraparound, psychiatric residential treatment, state hospital,** and **pharmacy**. In this study of child/youth's (under age 19) MHS utilization of was compared by gender. MHS access trends between 2014 and 2018 were also compared by race or ethnicity; percent change was calculated. For SFY18, Medicaid costs were reported by service categories and race/ethnicity.

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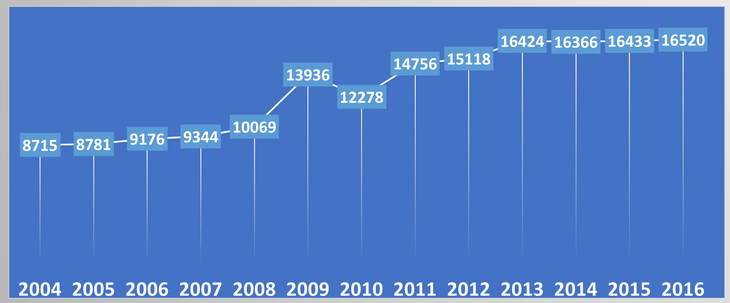
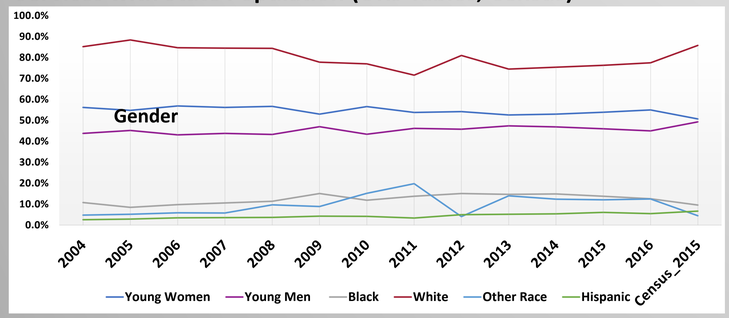
Methods

Growth in MHBG Funded Services for TAY, ages 18-20: 2004-2016 (URS Tables)



Comparison of TAY (18-20) Participation in MHBG Funded Services with State Population (URS Tables, Census)



The number of TAY receiving DMHA funded services increased by 89.56%. A pattern of more young women (55%) receiving services than men remained constant over time although 2015 census population estimates were similar by gender. The pattern of service utilization by TAY of color and white remained consistent. Percentages of participating Hispanic TAY were lower and of Black and Other Race were slightly higher than 2015 State population estimates.

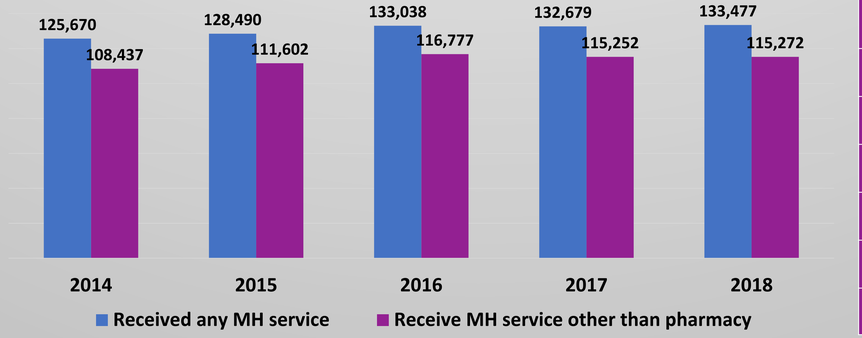
Disparities in Use of Medicaid funded MH Services (Medicaid Claims: SFY 2014)

Age, Gender, Race/Ethnicity. Based on SFY14 Medicaid claims, MH needs were most frequently identified for 12-14 year old boys, but service intensity peaked for adolescents ages 15 -17. In contrast to MHBG data, more young men, ages 18-25, utilized MH services. After age 25, women were more likely to utilize services, but participating boys and men consistently received more MHS. MHS utilization (access and amount) by children of color was lower than by white children.

Language. Most young Medicaid members (90%) lived in English speaking households; other households primarily spoke Spanish (5%), Burmese, or other languages. Children in English speaking households were three times more likely to have MH needs identified than youth in Spanish speaking families. Children in English speaking homes received more than twice the amount services compared to children in Spanish speaking homes.

Geography. MH health needs for children were less often identified in the four largest urban counties than in smaller communities. In contrast to research, the intensity of MHS varied across urban and rural settings.

Children Under 19 Years Receiving Medicaid MH Services



Results

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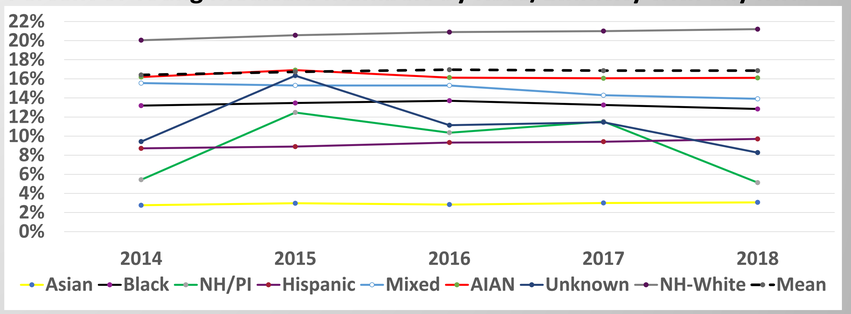
Gender (2014-2018)

Young Medicaid members were consistently about 49% female & 51% male. Overtime time, 13.5% - 14.3% of girls & 19.2 - 19.5% of boys utilized MHS.

Percent of Young Medicaid Members by Race/Ethnicity with any MHS



Medicaid Costs by MH Service Type & Race/Ethnicity SFY18

	Outpatient	Supportive	Emergent	Psych Inpatient	Wraparound	Residential	State Hospital	Pharmacy
Asian n=635	209,297	394,970	16,414	42,207	7,609			291,688
Black n=22222	4,410,213	26,313,779	864,146	3,879,759	2,076,035	1,318,936	1,694,848	18,250,875
Hawaiian n=50	3,940	24,027	10,156	56,325		18,648		34,243
Hispanic n=13109	2,254,947	10,360,647	378,796	2,022,057	715,945	1,317,934	112,102	8,679,665
Mixed n=392	114,566	463,099	12,825	47,531	104,571	61,899		413,586
AINA n=147	20,295	79,249	4,589	33,345	1,700	131,300		133,090
Unknown n=155	14,473	20,004	3,556	109,429	9,467			83,420
NH White n=96765	18,141,042	100,358,271	2,842,068	16,480,607	9,895,870	11,330,334	7,412,168	106,504,823

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Access Trends Reflected Policy Change. URS table documented 90% increase in TAY access to MH services since 2014, plateauing in 2013, coinciding with a Medicaid wraparound demonstration grant (2008-2012). Consistent with implementation of 1915i Medicaid wraparound for children with complex MH needs, statewide access to Medicaid funded MH services (MHS) increased 7.69% from 2014 to 2016, then decreased 1.29% by 2018 as wraparound enrollment plateaued.

Disproportionate Access to Care
Consistent with research, Medicaid claims data revealed disproportionate identification of behavioral health needs and utilization of services by language. Access also differed by race & ethnicity, gender, and geography for children and youth (DuBard & Gizlice, 2008; Duke & Mateo, 2019; Wielen et al., 2015).

Utilizing administrative data , this study found disproportionate identification of behavioral health needs and utilization of services by age, gender, race, ethnicity, language, and geography. Routine review of available data can be useful to inform policy and to better manage MHS access.

Overall, highest 2018 service costs were for Supportive Services (Case Management & Skill Development) and Psychotropic Medication. As with the 2014 analyses, disaggregation of 2018 claims data revealed patterns of MHS utilization. For example:

- For Hawaiian/Pacific Islander children, Inpatient Psychiatric (IP) costs were 2 times higher than outpatient (OP) and supportive costs.
- When race/ethnicity data was missing, IP costs were 3 times higher than OP and supportive service costs.
- Wraparound was utilized by 921 (<1%) young Medicaid members; included were all racial/ethnic groups except Hawaiian/Pacific Islanders.
- Total costs for IP (5793 children), Residential Treatment (450 children), & State Hospital (78 children) reached $46M (10% of total MHS costs).

Claims data documented the need to support equitable access to effective community-based MH services.

Strengths & Limitations

- Administrative data documented MHS utilization.
- URS tables identified transition-age youth, ages 18-20, not 18-25.
- Language data were missing for youth in foster care or adopted.
- Claims data were submitted for billing, not research. Research challenges included identifying acute inpatient psychiatric services from combination of procedure codes, claims forms, service location, and specialty.

Conclusions

Routine utilization of existing data can inform program and policy planning and monitor progress. Periodic analysis of service utilization can assess the impact of policy or programs on access to care (e.g., school based MH services, multi-component policy interventions, telehealth, engaging caregivers; Choi & Easterlin, 2018).

Gender differences between MHBG and Medicaid MH service utilization require further exploration. Additional research is needed regarding factors affecting age, gender, race/ethnic, geographic differences and the effectiveness of routinely using existing data to manage programs and inform policy.

[References available upon request]

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