Center for Evidence to Practice

Study Brief (June 2021)

Examining Behavioral Health Services for Louisiana Youth with January 2019 to June 2020 Medicaid Claims Data

Introduction

The Center for Evidence to Practice analyzes Medicaid claims data to understand the behavioral health needs of Medicaid Enrolled Children (MEC) and to track utilization and expansion of evidence-based programs (EBPs). To establish an initial baseline of the state's provider population, the Center has observed claims by providers that deliver children's behavioral health to MECs. Currently, this report looks at the wider array of behavioral healthcare, which may include combinations of psychotherapy, assessment, case management, medication management, psychiatry and nurse practitioner care, laboratory assessments, etc. It also looks at a small subset of providers that are already using codes that show them as unique EBP providers in comparison to the wider array of behavioral healthcare services. Future reports, will narrow analyses to compare providers offering psychotherapy (EBP and non-EBP) to more accurately monitor the Center's mission of expanding EBPs.

As is its mission, in 2020, five new EBP training cohorts were initiated and 12 EBPs had operational service definitions by which providers could bill Medicaid. Despite COVID-19 related challenges, including the precipitous switch to telemental health, the Center achieved a 29% increase in practitioners initiating training in 2020 compared to 2019.

The Medicaid claims analysis of January 2019 through June 2020 produced several key observations described in this report:

- A **ratio of behavioral health providers to Medicaid enrolled children** (MEC) is established as a baseline for future analysis.
- **Covid-19** appears to have impacted the number of EBP clients beginning in the second quarter of 2020 with a **drop of 47%, however, the number of claims did not decrease during the same period—**meaning there was increased frequency and intensity of service to the smaller group of EBP clients who were maintained in EBP services. This may suggest a high service need for those that were maintained in care.
- For providers using EBPs identifier codes, the **average length of care is longer for EBP clients than 'non-EBP clients'. This may suggest higher quality engagement in care**.

Medicaid Claims Analysis 2019-2020

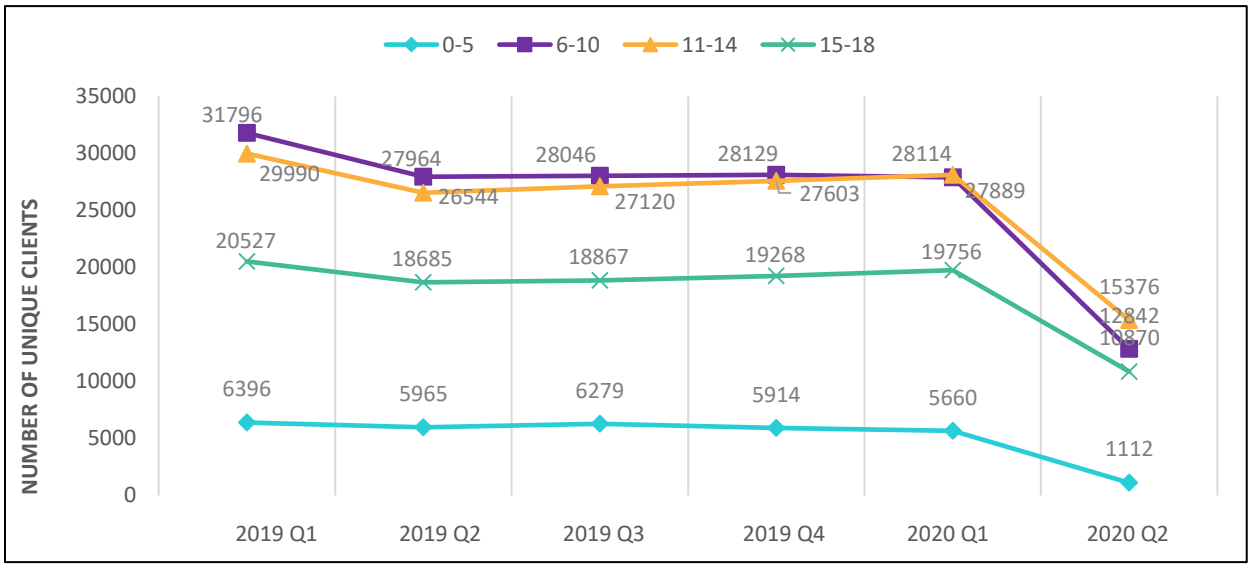
The Center has calculated the number of unique Medicaid clients and providers[1] engaging in behavioral healthcare and EBP care.[2] While Louisiana continues scaling up new EBP utilization, four EBPs are already regularly coded within Medicaid claims: Multi-systemic Therapy (MST), Home Builders (HB), Functional Family Therapy (FFT), and Functional Family Therapy-Child Welfare (FFT-CW). As providers improve EBP reporting in their claims, our analysis of utilization trends will become more accurate, and recommendations related to gaps and needs in services will be better informed.

This brief specifically examines the potential impact of the COVID pandemic on behavioral health and EBP claims following the March 2020 Stay at Home Order. The analysis therefore includes claims data from the first quarter of 2019 through the end of the second quarter of 2020 (i.e., 18 months from January 2019 through end of June 2020).

Behavioral Health Client Dynamics

As seen in Figure 1, the age groups receiving the largest proportion of behavioral healthcare (claims and unique cases) are 6-10 year-olds and 11-14 year-olds. 0-5 year-olds represented the least number of claims. The impact of COVID-19 on claims was observed in the 2nd Quarter of 2020, with a dramatic drop from the 1st Quarter (0-5-year-olds: 80.4% decrease, 6-10-year-olds: 53.9% decrease, 11-14-year-olds: 45.3% decrease, 15-18-year-olds: 44.9% decrease). The rapid loss of both clients and referral networks may account for this reduction in claims. This finding is in line with the loss of both clients and referrals associated with COVID precaution restrictions reported previously.[3]

Figure 1: Unduplicated Medicaid Clients receiving Behavioral Health Care by Quarter and Age Group



[1] Unique clients are identified as deduplicated patients; unique providers are identified as deduplicated rendering National Provider Identifiers (NPI).

[2] Claims include all behavioral health service codes but exclude developmental disorders, including autism diagnoses, and those children who do not have a behavioral health diagnosis and related visit.

[3] see August 2020 Brief: 'Telehealth among Behavioral Health Providers in Louisiana during COVID-19 and a Mandatory Stay at Home Order'. Available at https://laevidencetopractice.com/wp-content/uploads/2020/08/LA-BH-TELEHEALTH-SURVEY-BRIEF.pdf

Behavioral Health Provider to Client Coverage

The ratio of behavioral health providers to MECs is variable across Louisiana. Over 15,000 providers delivered Medicaid behavioral health services of all types during this 18-month period. By comparing the number of providers to the MEC population in each parish, the Center generates a ratio that may reveal gaps in care. This ratio reveals the distribution of coverage as: one provider to '0-200 MECs' in 21 parishes (32.8%) and one provider to '201-400' MECs in 24 parishes (37.5%). The remaining 19 parishes (29.7%) have significantly lower coverage with ratios as low as one provider to 600-800 MECs. The Center is currently working to refine this analysis from the broad array of behavioral providers to one that is more specific to providers offering various psychotherapies, as this is the focus of the Center's EBP expansion work.

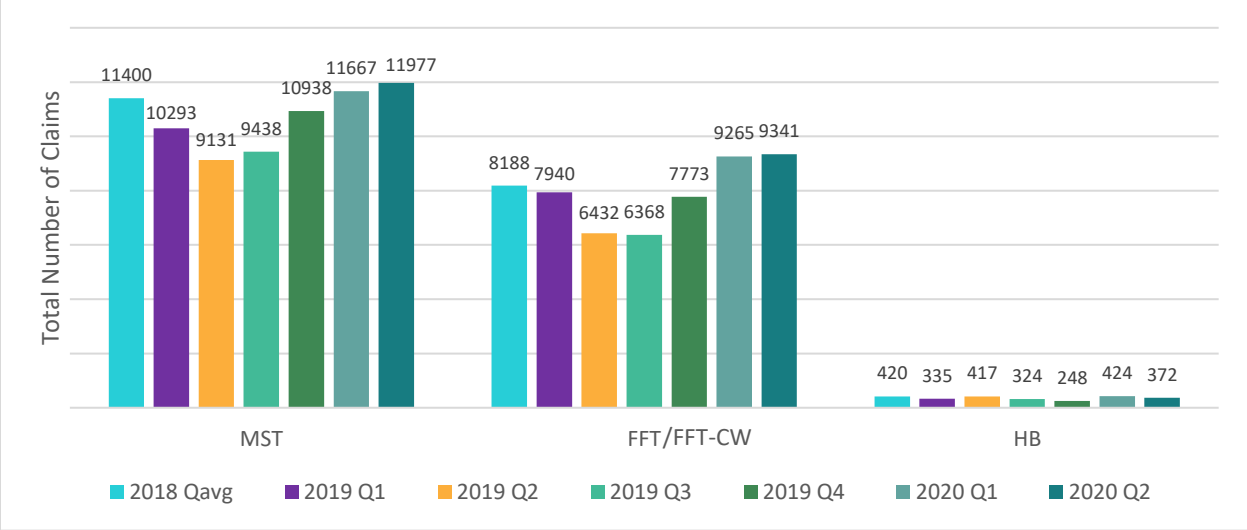
EBP Utilization and Coverage

The Center assesses several key variables: (1) the number and characteristics of EBP providers and clients over time and geography; (2) the ratio of EBP providers to MECs; and (3) the ratio of EBP providers to EBP-recipient MECs; and the comparative length of service across EBP and non-EBP providers. The following represents the finding of these inquiries.

EBP Utilization by Quarter

Four EBPs, MST, FFT, FFT-CW & HB, are currently identifiable in Medicaid claims based on the use of a special modifier code in billing. In 2018, a total of 80,032 of these EBP claims were reimbursed by Medicaid, compared to 69,637 in 2019. As seen in Figure 2, that amount is trending upward the first two quarters of 2020, mostly among MST and FFT claims. The initiation of the Stay at Home Order occurred during the transition from Quarter 1 to Quarter 2, yet there was no significant decrease in claims. If the levels stay the same throughout 2020, it would represent an annual increase of 23.6% from 2019.

Figure 2: Quarterly Trends in EBP Claims by Treatment Model 2019 – 2020, Q2 (w 2018 comparison)

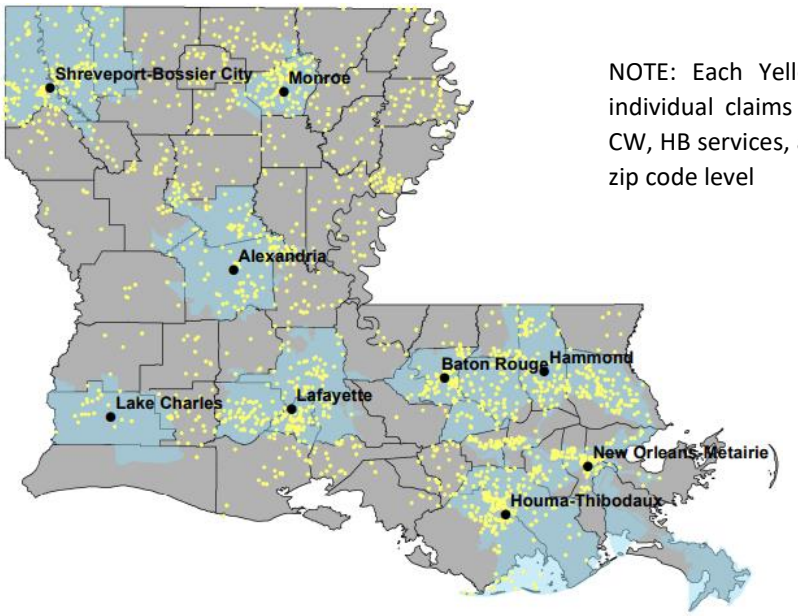


EBP Geographic Coverage

The Center works to increase the availability and utilization of EBP care statewide, including historically underserved rural areas. Claims data showed only 10 parishes out of 64 have more than 100 EBP claims per age group. Of the top 10, the median claims per parish were 483 claims, ranging as low as 104 to as

high as 5,061 claims per parish. Metropolitan Statistical Area (MSA) maps were used to demonstrate the concentration of total claims by population density.[4] This approach uses the delineation of **'Micropolitan'** statistical areas (with populations under 50,000) and **'Metropolitan'** areas (with populations over 50,000).[5] Figure 3 shows EBP utilization is unsurprisingly concentrated in urban centers, but also demonstrates a wide, but less concentrated, dispersion of claims in rural areas. We attribute some of the dispersion in rural areas to EBP models that provide the service in the family home, as many urban centered EBP teams - in fact - travel to rural areas to provide service. Areas of future research will include rural areas that have significant clusters of care to understand what practices and policies promote increased rural coverage.

Figure 3: Total Medicaid Claims of EBPs Geolocated by Rural and Urban Areas



NOTE: Each Yellow Dot represents 4 individual claims of any MST, FFT/FFT-CW, HB services, and are mapped at the zip code level

EBP Provider to Client Coverage[6]

Table 1 below illustrates unique EBP clients in relation to unique EBP providers. The quarterly EBP claims for MST, FFT/FFT-CW, and HB combined, increased 13.7% in 2020 Q1 - Q2, compared to the 2019 quarterly average. This higher number of claims occurred during a substantial decline in individual clients in 2020 from Quarter 1 to Quarter 2, implying that EBP clients in care stayed engaged in care. As seen in Table 1, below, the magnitude of percent decrease in unique clients between the two 2020 quarters was 52.6% for MST, 46.9% for FFT/FFT-CW, and 40.5% for Home Builders.

[4] 1 The Office of Management and Budget (OMB) defines a Metropolitan Statistical Area as one or more adjacent counties or county-equivalents that have at least one urban area of at least 50,000 population, plus adjacent territory that has a high degree of economic and social integration with the core as measured by commuting ties.

[5] OMB defines a Micropolitan Statistical Area as one or more adjacent counties or county-equivalents that have a labor market and statistical areas in the United States centered around a population of at least 10,000 but fewer than 50,000 people

[6] Claims in these analyses go beyond psychotherapy and include a range of provider types (physicians, nurse practitioners, laboratory assessments, etc.). Future analyses will specify only those EBP psychotherapy providers that represent the Center's focus populations.

Table 1: Proportion of MST, FFT/FFT-CW, and HB Clients to EBP Provider by Quarter and Age Group

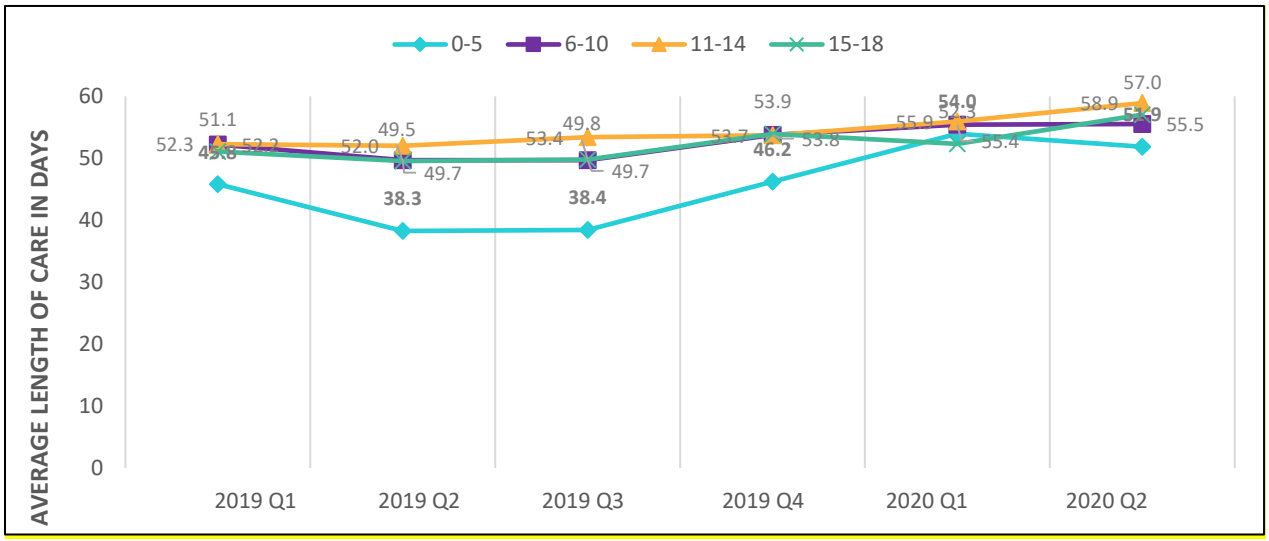
	# EBP Clients			# EBP Providers			Ratio: Proportion		
Variable	**MST**	**FFT/ FFT-CW**	**HB**	**MST**	**FFT**	**HB**	**MST**	**FFT**	**HB**
Overall	2289	3804	162	241	253	14	9.50	15.04	11.57
Quarter									
2019 Q1	760	1321	36	238	249	14	3.19	5.31	2.57
2019 Q2	693	1182	42	238	251	14	2.91	4.71	3.00
2019 Q3	691	984	31	239	253	14	2.89	3.89	2.21
2019 Q4	780	1184	28	240	252	14	3.25	4.70	2.00
2020 Q1	874	1376	42	236	250	14	3.70	5.50	3.00
2020 Q2	414	731	25	235	250	14	1.76	2.92	1.79
Age Group									
0-5	0	326*	21	229	245	14	0.00	1.33	1.50
6-10	6	1048*	47	237	248	14	0.03	4.23	3.36
11-14	1206	1571	61	239	251	14	5.05	6.26	4.36
15-18	1182	1036	37	235	251	14	5.03	4.13	2.64

*FFT-CW targets youth ages 0-10, so all youth in these cells are most likely to be FFT-CW and not standard FFT. Standard FFT targets youth 11 to 18 years old.)

EBP versus non-EBP Length of Service: Provider to Client Coverage[7]

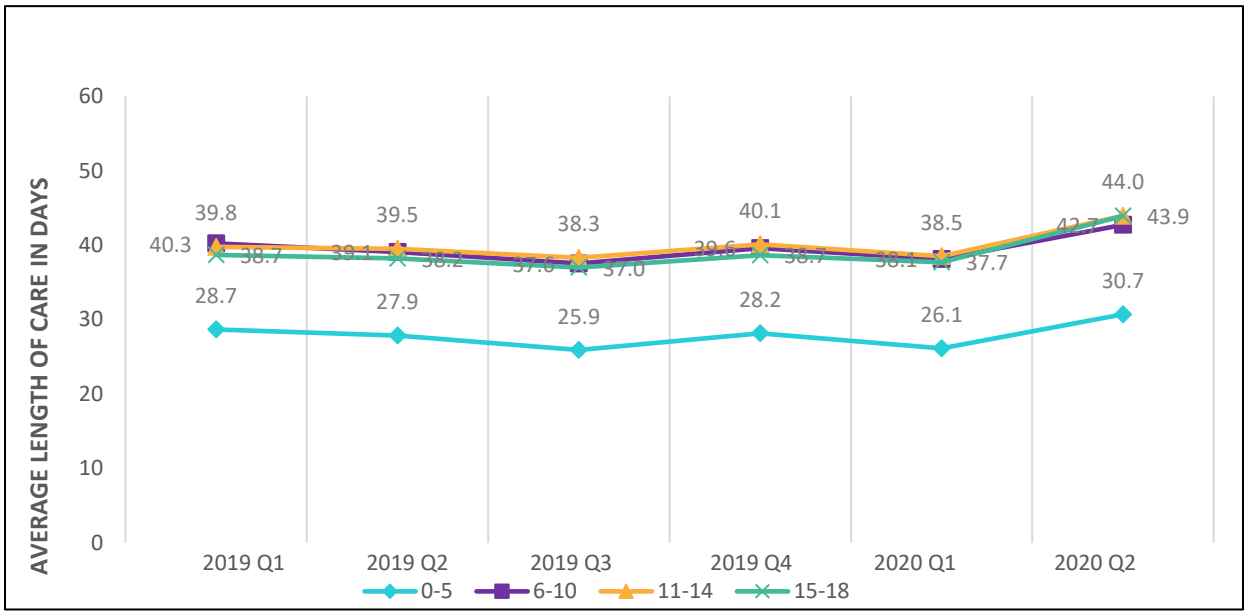
An important characteristic of the EBP claims in this analysis is the length of service. This includes the number of days between the first and last claim within the year and an analysis of the intensity of service-- specifically the total number of visits during the length of service. The average length of service across the six quarters for youth engaged in non-EBP care was 36.1 days (see Figure 5), by contrast, the average length of care for EBP clients was 51.3 days (see Figure 4). These findings were true for all but 0-5 youth where programming averaged 44.1 days.

Figure 4: Average Length of Service for EBP Identified Treatment Claims



[7] Non-EBP care referred to any treatment that was not identified as an EBP by the EBP claims modifier.

Figure 5: Average Length of Non-EBP Treatment (Treatment as Usual) Claims



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The Center's partnership with the state focuses on creating a trained workforce, increasing access to EBPs, and examining improved utilization of EBPs to better serve the behavioral health needs of youth and families throughout Louisiana. More information on the Center is available at https://laevidencetopractice.com/ .