

**Review of SoonerCare  
Behavioral Health Services**

September 25, 2009

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## I. INTRODUCTION

### A. Purpose

Over the past several years, Oklahoma has done a great deal through coordinated efforts among multiple agencies to improve access to behavioral health services for children and youth under 21 years of age covered by SoonerCare, Oklahoma's Medicaid program. Expansions in services were necessary, since the system for children's behavioral health was underfunded in the past, but growth in services has led to cost increases that have been much greater than expected. Use of psychiatric residential treatment facilities (PRTFs) for children accounted for the largest portion (53 percent) of the expenditure increase from 2003 to 2008 (Oklahoma Finance Report 2009).<sup>1,2,3</sup> In light of these unsustainable increases in expenditures, the Oklahoma Health Care Authority (OHCA), which oversees SoonerCare, is assessing ways to continue improving the behavioral health system by increasing intermediate levels of care and decreasing the dependency on inpatient psychiatric care. This report is intended to assist OHCA in that endeavor by providing a review of the SoonerCare behavioral health system in Oklahoma, recent changes in the system, costs to the state, current processes within the system, and gaps in services. A separate memo provides recommendations.

### B. Methods

In this evaluation, we use qualitative techniques including semi-structured interviews and document review. During a site visit to Oklahoma in July 2009, Mathematica Policy Research conducted interviews with key stakeholders, including state agency officials, contractors, providers, and a beneficiary advocate. We conducted additional phone interviews to obtain insights from those whom we were unable to meet with in person. In addition, the team reviewed literature and reports on Oklahoma's behavioral health system and on systems in other states, and interviewed national and state experts on Medicaid behavioral health services and financing.

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<sup>1</sup> Since PRTFs provide a costlier level of care, the children receiving those services account for a relatively small portion (4 percent) of the increase in the total number of children receiving behavioral health services between 2003 and 2008 (Oklahoma Finance Report 2009).

<sup>2</sup> Expenditure data for 2009 are available in the table provided in the Appendix.

<sup>3</sup> The Centers for Medicare and Medicaid Services (CMS) defines PRTFs as "any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (psych under 21 benefit). The facility must be accredited by JCAHO or any other accrediting organization with comparable standards recognized by the State" (for more information, see [http://www.cms.hhs.gov/CertificationandCompliance/13\\_PRTFs.asp](http://www.cms.hhs.gov/CertificationandCompliance/13_PRTFs.asp)). However, since conversations with staff at OHCA and other state agencies used the terms PRTF and Residential Treatment Center (RTC) interchangeably, we use PRTF in this report to signify both PRTF and RTC.

## II. EXPANSION OF BEHAVIORAL HEALTH SERVICES AND COST

### A. Expansion of Services

Ten years ago, there was growing concern in Oklahoma that children with behavioral health needs were not receiving essential services and supports (OPCBH 2005 and Oklahoma Financing Report 2009). The state began efforts to improve access to behavioral health care for children. In 1999, child-serving state agencies developed a partnership focused on improvement of the state's behavioral health system for children and families. In 2003, the Oklahoma Partnership for Children's Behavioral Health (OPCBH) was formed and included commissioners and directors of eight child-serving agencies, consumer family representatives, and representatives of the state legislature. Both efforts were intended to work closely together to create a "structure and process for a unified system of behavioral health care for children, youth and their families" (OPCBH 2005).

In an effort to reach the estimated 20 percent of youth in the state who have mental health and/or substance abuse disorders, Oklahoma has in the past several years initiated an array of activities to improve access to and availability of behavioral health services for children (ODMHSAS 2008 and Oklahoma Finance Report 2009). Activities over the past six years include:

- **Increasing the Number of Children Enrolled in SoonerCare.** To address the barrier of lack of insurance, the state increased enrollment by expanding Medicaid eligibility and increasing outreach. From 2003 to 2008, the number of children under 21 enrolled in SoonerCare increased 45.5 percent, from 357,192 to 519,880 (Oklahoma Finance Report 2009).
- **Recruiting New Providers to Serve Specialized Populations.** In 2008, OHCA established new levels of Psychiatric Residential Treatment Facilities (PRTFs) to provide specialty in-state treatment programs (for example, for autism and developmental disabilities). This allowed children that had previously been sent out of state for acute and residential treatment to receive care in-state and for those treated in-state to receive more clinically appropriate services. In 2006, there were 48 children receiving out-of-state care, and as of June 2009, that number was down to 6. At the same time, the number of children overall receiving specialty PRTF services has grown from 48 in 2006 to 248 in 2008, an increase of 416 percent (OHCA report 2009).<sup>4</sup>
- **Capacity and Service Expansion.** Oklahoma has increased the availability of both outpatient and inpatient services and providers. Costs for behavioral health services for children rose by about \$118 million from SFY 2003 to SFY 2008, with the number of children receiving behavioral health services increasing by 35,169. (Oklahoma Finance Report 2009). At the same time, more beds and more PRTF providers were contracted to provide inpatient care and services to children. Based on an OHCA survey of PRTFs

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<sup>4</sup> The numbers may overstate the increase in the number of children receiving specialty services because many of the children now served in specialty PRTFs were served in normal PRTFs before the "specialty" units category was developed. For the past 1.5 years, the state has not approved any new "specialty" rate programs.

in 2006, there were 618 non-specialty PRTF beds in the state in that year. Since then 122 new specialty beds have been added in the state, and an undetermined number of non-specialty beds.<sup>5</sup> The experience of Oklahoma so far with PRTFs is that “however many beds you offer, they will be filled.” Some agency staff believe that too many beds were added. Expenditures for PRTF services grew to \$112 million from \$45 million in the period from 2003 to 2009 (Oklahoma Finance Report 2009 and OHCA SFY 2009 Annual Report).

- **Outreach to Children and Youth.** Statewide Care Coordination Projects assist in getting more children and families into treatment. The increase in numbers of children receiving services is partly a result of efforts by care coordination staff to focus on both inpatient and outpatient programs, coupled with local systems of care wraparound services. These efforts have resulted in referrals averaging 500 children per month into behavioral health services (Oklahoma Finance Report 2009). The number of SoonerCare children who received a behavioral health service increased 151 percent from 2003 to 2008, and the number of children who received PRTF services increased by 61 percent (Oklahoma Finance Report 2009).

These efforts have improved access to behavioral health care for children. A 2009 report by the National Alliance on Mental Illness that grades states on their mental health care systems gave Oklahoma a B (the highest grade awarded, and one of only six given out), up from the D assigned in a 2006 report (NAMI 2009). The grade change “reflect[s] remarkable improvement” in the state (NAMI 2009). The number of children under 21 in SoonerCare receiving behavioral health services increased to 58,412 from 23,243 from 2003 to 2008 (Oklahoma Finance Report 2009). However, there is still a need for additional improvement to services and access. A recent assessment found that more than 40 percent of the youth who need mental health services and 80 percent of youth who need substance abuse services are not receiving them (ODMHSAS 2008).

## **B. Cost Implications**

The improvements in services and access have come with significant cost increases. Costs for behavioral health for children in SoonerCare rose to \$310 million from \$192 million between 2003 and 2008, with the largest portion of the increase attributable to PRTFs, which accounted for 53 percent of the increase in that period (Oklahoma Finance Report 2009). Since costs rose substantially, 2008 expenses were covered only by using money provided by the 2009 economic stimulus package. Our focus for most of this report will be on inpatient services, particularly PRTFs, since they factored heavily in overall increases in expenditure. Reasons for cost increases in the inpatient setting include: (1) increase in number of children receiving services, (2) increase in service use, (3) creation and growing use of in-state specialty PRTFs, and (4) increase in rates for inpatient acute, residential, and community-based providers (see section on payment for inpatient services).

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<sup>5</sup> OHCA obtains information on the number of PRTF beds only from surveys of facilities, the last of which was conducted in April 2006. Since then, at least nine new PRTF providers have entered into contracts with OHCA, none of which was included in the 2006 survey.

### III. CURRENT SYSTEM

#### A. Stakeholders and Roles

Through the Oklahoma Partnership for Children’s Behavioral Health (OPCBH), all state agencies serving children have been able to collaborate to improve the behavioral health system. As one respondent explained it, the OPCBH allows for provision of services and system improvements to be made without agencies “tripping over one another.” As an example of coordinated efforts, OPCBH submitted a coordinated five-year budget request to the legislature in 2008 that outlined what would be needed to “transform the system of care for child behavioral health” and the funding that would be needed for each agency, but progress has been limited due to the economy and resulting fiscal constraints.

The agencies involved in OPCBH include Oklahoma Health Care Authority (OHCA), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma State Department of Health (OSDH), Oklahoma Department of Human Services (OKDHS), Oklahoma Office of Juvenile Affairs (OJA), Oklahoma Commission on Children and Youth (OCCY), State Department of Education, and Oklahoma Department of Rehabilitation Services (DRS) (OPCHB 2005). The Federation of Families is also involved in the OPCBH to ensure input from families of children receiving services. Table III.1 describes the current roles in the behavioral health system for the primary agencies involved in providing and managing behavioral health services for children.

**Table III.1 Agencies and Roles in Behavioral Health System**

OHCA	<ul style="list-style-type: none"> <li>• Purchaser/payer, overseeing the state’s Medicaid program (SoonerCare)</li> <li>• Policy maker for mental health and substance abuse services for SoonerCare beneficiaries</li> </ul>
OKDHS	<ul style="list-style-type: none"> <li>• Gateway for eligibility and certification for Medicaid</li> <li>• Custodian for children in state custody and therefore responsible for locating services</li> </ul>
OJA	<ul style="list-style-type: none"> <li>• Custodian for children in state custody and therefore responsible for locating services</li> </ul>
ODMHSAS	<ul style="list-style-type: none"> <li>• Provider of mental health and substance abuse services through owned or contracted facilities</li> <li>• Source of coverage for people regardless of Medicaid eligibility</li> <li>• Policy maker for mental health and substance abuse services</li> </ul>
OSDH	<ul style="list-style-type: none"> <li>• Regulator for providers of services</li> <li>• Provider of early childhood mental health and substance abuse services (prevention and treatment) through child guidance health department county clinics</li> <li>• Source of coverage for people regardless of Medicaid eligibility</li> </ul>

## **B. Prior Authorization, Management, and Payment for Children’s Behavioral Health**

### **1. Prior Authorization for Inpatient Services**

Children can be identified as Medicaid recipients in need of behavioral health services from multiple places (for example, OKDHS or OJA).<sup>6</sup> Once identified, their cases are sent to APS Healthcare, OHCA’s contracted vendor in charge of authorizing and managing behavioral health services under SoonerCare. Using medical necessity criteria developed in 1995 by the state, APS reviewers assess cases to determine appropriate levels of care. For inpatient services (for example, acute or PRTFs), the reviewer helps find a treatment facility that meets the child’s needs. Once the treatment facility completes an in-person assessment, the facility calls or faxes information to the APS reviewer for prior authorization, confirming that the child meets admission requirements. Based on medical necessity criteria and clinical information submitted by the treating facility—diagnosis, assessment tools, treatment plans—the reviewer authorizes a specified number of days for inpatient stays.

### **2. Management**

Partners in OPCBH have the stated goal of providing appropriate behavioral health services to children in the least restrictive setting possible. For this to occur, children in the system must be managed to ensure they do not receive inappropriate care or stay in inappropriately restrictive settings. OHCA monitors care and progress for children in the system in three main ways—auto-review for length of stay, care management meetings, and inspections of care.

- **Auto-Review for Length of Stay.** OHCA contracts with APS for the authorization for inpatient services like acute care and PRTFs, which are time-limited (up to 5 days for acute and up to 10 days for PRTFs), and providers must receive extensions from APS to keep children in care settings for a longer period. Close to the end of an authorized period, APS reviewers reassess the case to determine if the child should remain in the same level of care or be stepped down to a less restrictive setting. Extension requests must meet medical necessity criteria, otherwise they are denied and the child is moved to a more appropriate setting. In situations where extensions are denied for a child in state custody, the court can order that the child stay in inpatient care. However, if OKDHS wants to keep a child that does not meet medical necessity criteria for inpatient care, OKDHS pays 100 percent state dollars for their care since SoonerCare money cannot be used. This does not happen very often.<sup>7</sup> APS staff said that there are currently only two children in this circumstance. Still, other agency staff expressed concern that PRTFs are sometimes inappropriately used as a placement option for children in child welfare. The

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<sup>6</sup> OHCA is working to implement a No Wrong Door program that will provide an online enrollment process that will allow people to apply and receive Medicaid eligibility no matter where they enter the system. The program will be phased in , and Phase I will include the behavioral health population and children in SoonerCare (OHCA Strategic Plan 2009).

<sup>7</sup> This has become less of a problem over the past five years as staff from DHS, OJA, and OHCA have been meeting weekly on custody children in higher levels of care to focus on discharge planning and inpatient diversion.



most pressing concern is the placement in PRTFs of children in the custody of their parents who cannot access appropriate care through intermediate services in the outpatient setting [See section on Transition/intermediate facilities in IV.B].

- **Weekly Care Management Meetings.** Care management meetings are held weekly by OHCA Care Coordination staff with APS and DMHSAS reviewers to discuss difficult patient cases (for example, children who have come back into inpatient care after discharge or children with long lengths of stay). Often in these difficult cases, the patients' providers are included in meetings by phone to discuss what can be done to improve outcomes.
- **Inspections of Care.** In addition to managing individual cases, OHCA contracts with APS to perform inspections of care (IOC) audits yearly at facilities providing inpatient services. The visits are done without advance notice and involve audits and reviews of a certain percentage of cases. Recoupments and corrective action plans are used to encourage improved quality.

To do the prior authorization, review, and IOC work, APS employs three board-certified psychiatrists and nine licensed mental health workers that are masters level (such as licensed clinical social workers). The licensed mental health workers perform the bulk of reviews for prior authorizations, with constant support from psychiatrists for difficult cases. Staff psychiatrists review cases as well. APS averages about 2,000 prior authorizations a month for PRTFs, about 25 percent of which are for initial PRTF placement and 75 percent for extensions. Reviewers are assigned to specific provider facilities so they become familiar with facility staff and processes, which should create efficiencies in the authorization process. APS has increased the number of reviewers over time because of higher caseloads and level of review required to determine medical necessity. Three psychiatrists will be added to APS staff by the end of 2009 to give reviewers time to be more involved with cases.

### 3. Payment for PRTFs

Two things occurred in 2006 that affected how providers are reimbursed for PRTFs. Before 2006, the per diem rates for PRTFs were calculated using 1990 base year audited costs, updated periodically for inflation. In 2006, the base data were updated using limited utilization and cost information collected through a survey of PRTFs. Updates to the 1990 base data were intended to account for trend updates, changes in federal law regarding seclusion and restraint requirements, direct care staffing, psychiatric professional services, program therapies, prescription drugs, and other medical services. Rates were updated also because of CMS guidelines that appeared to require an "all-inclusive" per diem rate for facilities considered institutions of mental disease (IMDs) that would cover all patient costs.

The other change was the creation of PRTF "peer groups" that grouped facilities based on characteristics such as bed size, licensing requirements, staffing patterns, type of services offered and types of control. Before these peer groups were created, freestanding and hospital-based PRTFs were in one peer group, and community-based PRTFs in another. The per-diem rates in 2005-2006 were \$293 for freestanding and hospital-based PRTFs, and \$180 for community-based PRTFs. The new groups include community based transitional, community based extended, freestanding, provider based, specialized, and public. The different peer groups received different PRTF payment rates starting in October 2006. In 2008, the per-diem rates were \$191 for community based

transitional, \$330 for community based extended, \$348 for standard freestanding, \$357 for hospital based, and \$413 for specialized.

## IV. GAPS IN THE SYSTEM

A key issue with the children’s behavioral health system in Oklahoma is the extensive and growing use of PRTFs. Children who enter this level of care are sometimes caught in the “revolving door” of PRTFs, circling in and out of facilities indefinitely.<sup>8</sup> Staff from various agencies involved in children’s behavioral health explained that gaps in services have contributed to an overreliance on PRTFs. The behavioral health system lacks (1) services to assist in transitioning children out of inpatient settings to less restrictive options, (2) services to divert and keep children from entering inpatient care, and (3) information to monitor and track utilization and outcomes for providers of inpatient services.

### A. Need for Case Management

Case management (also called care management or care coordination) helps patients and their families navigate the behavioral health system and is crucial during transitions from inpatient to outpatient care. In the past, case managers in Oklahoma were present during inpatient treatment or soon after patient discharge from PRTFs to help facilitate connections to outpatient care. One provider recalled that “When a child was discharged from PRTF, a [case manager] would come to the facility and be the face and voice that would help get the child into outpatient care.” These case management services provided during inpatient stay were ended after a CMS notification indicated that reimbursement for such services would be considered duplication of payment.<sup>9</sup> Lack of case management has been a large gap in service that has contributed to children re-entering PRTFs after being discharged.

Understanding the need for case management to help children transition out of PRTFs and stay connected to appropriate care, OHCA and partner agencies recently implemented three initiatives to assist in re-establishing this service.

- **Care Coordination Project for Children’s High End Cases.** This pilot project, which provides intensive case management to high-end users of behavioral health services, is a collaborative effort among various state and advocacy agencies (for example, OHCA, ODMHSAS, and Federation of Families). The pilot, which is being evaluated by Oklahoma University (OU) researchers, will include a control group of 125 children who will receive normal assistance with accessing behavioral health resources and a treatment group of 125 children who will receive intensive case management—involving an initial face-to-face assessment around time of discharge and three telephone follow-ups through the first year. This pilot project is an expanded version of a smaller pilot project recently completed by OHCA that resulted in a 40 percent decrease in PRTF utilization and a 65 percent decrease in time to first outpatient appointment. If the current study

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<sup>8</sup> From 2006 through 2008, 318 children were in a PRTF in all three years, 76 of them in one facility during all three years and the others in more than one (OHCA Comparison Report 2009). While the 318 children represent a small percentage of the total children receiving PRTF services in those years, the appropriateness of their care is still a concern. OHCA staff indicated that most of the 318 children are those with developmental disabilities for whom it is difficult to find alternative community-based service options.

<sup>9</sup> CMS recently reversed this policy and now supports these services.

yields the positive results that are expected, the case management program will likely be expanded.

- **Streamlined DMHSAS Case Manager Certification Training.** Based on feedback from statewide community focus groups, the current Case Manager Certification training has been streamlined from a seven-day training process to a set of web-based training/tests, one- to 2-day in-person training offered throughout the state during multiple times of the year, and annual continuing education units (CEUs). This has substantially decreased the cost of certification, which should increase the number of case managers working in the state.
- **APS Chronic Care Improvement Program/OHCA/DHS/OJA/DMHSAS PRTF Diversion Projects.** Discharge planning for patients leaving inpatient care settings like PRTFs has been poor in past years. Busy providers have not reliably provided good discharge plans and APS has not always enforced the requirement. As a result, some patients have been discharged unsuccessfully, failing to connect to appropriate outpatient care. Starting in January 2009, APS began piloting a program to assign a case management person to children being discharged from inpatient care like PRTFs. APS runs daily searches on its prior authorization system to identify children who are approaching discharge from inpatient care. There are about 30 to 70 discharges per day, which members of the APS team divide up to manage. Case managers look for a discharge plan for each case and follow up with the facility about creating one if no plan is in place. The case managers call the families to discuss follow-up appointments with outpatient providers and make reminder calls. APS staff described the service as short-term case management, with the goal of getting patients involved and active in outpatient care and then stepping out. So far in the pilot, APS has run into some issues with high work volume, especially because every case required an outbound call. However, APS does plan eventually to have 8 to 11 employees staff the program full-time. A larger version of the program will roll out in January 2010 as part of OHCA's broader interagency diversion effort, and will be fully focused on PRTF diversion or early discharge for cases where this is appropriate.<sup>10</sup>

## **B. Need for Full Continuum of Care**

A full continuum of care is the foundation for giving children needed behavioral health services in the least restrictive settings possible. Respondents from several agencies noted gaps in transition facilities that serve as step-downs from PRTFs (intensive therapeutic group homes, for example), facilities that can divert children from PRTFs (such as crisis stabilization centers), and providers in the community that can address special needs and disorders. As one respondent explained, "When we have built a truly accessible community-based set of services and supports, we can greatly reduce the need for acute and residential treatment." However, another respondent warned against adding services without also providing adequate funding and sufficient management and oversight, the lack

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<sup>10</sup> OHCA and APS are also looking at reorganizing the APS reviewer staff into teams to more effectively review outpatient and inpatient cases and coordinate with stakeholders to keep members at the lowest level of care. Reviewers may also be assigned alphabetical segments of the population so they can build knowledge of their members at all levels of care.

of which can lead to “repeating historical failures...[that] start out with a bang but become unsuccessful.”

- **Transition/intermediate facilities** would allow for gradual step-down or diversion from PRTFs to less restrictive settings, but few of these facilities currently exist. Concern that PRTFs sometimes serve as a “placement option for children in child welfare” because “there appear to be no viable alternatives” led some respondents to suggest the creation of more transition facilities like intensive therapeutic group homes. Currently children in the custody of their parents do not have intermediate levels of care to turn to when outpatient services are not adequately intensive. At this point, the only options for these children are inpatient psychiatric care or relinquishment of parental custody to receive intermediate levels of care. From 2003 to 2008, the number of children not in state custody who received PRTF services increased to 2,495 from 1,086, which led to an increase in \$44.5 million in costs related to PRTFs (Oklahoma Financing Report 2009). In the past, the state used to have more group homes but most closed in the 1990s due to changes in funding and regulation. Lack of transition facilities can be a barrier to successfully discharging children from PRTFs. One respondent noted instances where children were discharged to a group home but were left in limbo because there were no beds available. The children may end up in a shelter where they may not receive the treatment they need, leading them to return to PRTFs. Children not in state custody are even more difficult to discharge because Medicaid does not pay for the room and board portion of group homes, which often means that the few beds that do exist are not viable for them. There is also some resistance to creating additional group homes based on belief in the recovery model of care that emphasizes treatment with community wraparound services in the least restrictive setting. However, some respondents noted that a period of transitional care would be helpful, especially for children whose family unit may not be the best place for them to live while receiving wraparound services. “Perhaps a revision of the system [is needed] so we would be in line with what we are seeing socially and culturally.”<sup>11</sup>
- **PRTF/inpatient diversion facilities** such as crisis stabilization centers and mobile crisis units have been shown to be highly effective for intervening with children, stabilizing them and linking them to community-based services so they stay out of PRTFs. The average length of stay for these facilities is five days, with a seven-day maximum, and 75 percent of the children treated go back into the community and stay out of inpatient care. As one respondent noted, diversion from inpatient care is crucial because “once kids are in the inpatient cycle, it is hard to get families to think that they can get out.” Oklahoma currently has two crisis stabilization centers and mobile crisis

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<sup>11</sup> OHCA staff are currently reviewing recommendations for a more tiered PRTF system that were included in a 2008 Mercer report prepared for Pennsylvania. The Mercer report suggested that a more tiered PRTF-level system could include: (1) Crisis Residential Services, (2) Extended Sub-Acute Stabilization, (3) Medium-Term Family Oriented PRTF, (4) Longer-Term (3-12 months) intensive and restrictive PRTF, (5) Small Therapeutic Group Homes/Therapeutic Foster Care Homes closer to the community, and (6) Transition Case Management Services to children and families 14 days prior to discharge (though optimally, management would be provided from date of admission to date of discharge to shorten stays). (Mercer White Paper, 2008)

services available in nine areas of the state. Despite promising results, expansion of these facilities has been halted until new funding is available. In addition to crisis stabilization centers and mobile crisis units, several respondents also indicated that partial hospitalization/intensive outpatient/day treatment, which used to exist in the state, could help keep children out of inpatient care. Changes in payment, inadequate oversight, poorly specified clinical requirements, lack of transportation, and insufficient funding resulted in closure of these programs. If they are brought back, one respondent expressed hoped that stakeholders can learn from past experience. Day treatment “under a new FFS reimbursement methodology along with state-level care coordination/oversight might provide a better outcome [than prior programs].”

- **Expansion to use private providers** was mentioned as another way to build a full continuum of care, providing specialty services that are currently lacking and creating capacity to expand services that work. Currently only licensed behavioral health professionals (LBHPs) who are connected to an agency can treat Medicaid recipients. Advocates for expanding use of private providers said that opening up individual contracts or vendorship to LBHPs would help divert children, especially those with specialized needs, away from PRTFs and keep them from returning. Treatment sessions with LBHPs could limit inpatient stays, these advocates said, because LBHPs are more likely than agency providers to be trained to treat specialized needs (for example, eating disorders) and may be more likely to suggest treatment in the outpatient setting before referring to inpatient care. Advocates of expanding use of LBHPs also believe they would increase access to services, especially for people living in more rural communities. LBHPs could be used to increase the availability of crisis stabilization centers, which are currently only an option for community mental health centers run or contracted by ODMHSAS. To successfully use LBHPs, training and credentialing would be needed to ensure quality of care and use of evidenced-based practices.

OHCA is in the process of presenting its annual budget request to executive staff and intends to include requests previously submitted over the past four years under a package titled “RTC Diversion” that will encompass strategies to address gaps in services and opportunities for improvement—intensive outpatient day treatment services, therapeutic foster care/treatment group homes for non-custody children, respite care for custody children, and individual contracts for LBHPs.

### **C. Need for Information**

Lack of information regarding the behavioral health services providers are giving to patients may hamper OHCA’s ability to oversee facilities like PRTFs. Because all services for PRTFs that are categorized as institutions of mental disease (IMDs)<sup>12</sup> by CMS are bundled into one per diem payment, it is difficult to detect trends in the services providers are giving and how providers compare to one another, which could help identify potential problems or areas of efficiencies. Prescription drugs, for example, are included in the PRTF per-diem in Oklahoma, which means that

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<sup>12</sup> IMD is defined as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services” (USDHHS 1992, 1994).

the state has no direct information on the use of these drugs in PRTFs. OHCA has requested that by December 2009 APS begin running reports that will give care management teams length-of-stay information for all providers, which will help them identify potential facilities and cases on which to focus. OHCA and APS may also be working on additional provider profiling to do further comparisons. Outpatient programs will begin reporting Client Data Core National Outcomes Measures Data (NOMS) into APS each time they request prior authorization. Inpatient programs will begin reporting outcomes data sometime in the spring or summer.

Finally, there is a need for standard clinical information that would support more disease management-type services for patients. OHCA and APS are discussing the possibility of switching to nationally accepted clinical criteria—such as those developed by Milliman—for prior authorizations, which may provide stronger standards for determining medical necessity for PRTFs. APS is also in the process of collecting data on evidence-based outcomes and pharmaceutical information to support active case management.

## **V. CONCLUSION**

Oklahoma has made great efforts to improve the behavioral health system for children, which has been underfunded in the past. The result has been an expansion in coverage, inpatient and outpatient services, and the total number of children that now have access to needed behavioral health care. As the system has grown, however, costs have also increased at an unsustainable rate. Much of the expenditure growth has been related to the use (and possible overuse) of PRTFs, which provide a costlier level of behavioral health care. Addressing gaps in the current system by building case management capabilities, creating more intermediate and transitional services, and collecting information to monitor and track provided services would help OHCA and partnering agencies continue improving the behavioral health system at a more sustainable cost.



**APPENDIX**

**SOONERCARE BEHAVIORAL HEALTH EXPENDITURES FOR CHILDREN UNDER  
21 AND ADULTS IN OKLAHOMA, SFY 2005-2009**

## SoonerCare Behavioral Health Expenditures for Children under 21 in Oklahoma, SFY 2005-2009

	SFY 2005 (\$)	SFY 2006 (\$)	SFY 2007 (\$)	SFY 2008 (\$)	SFY 2009 (\$)	% Increase, 2005-2009	% Increase, 2006-2009
<b>Total Medicaid Expenditures</b>	2,805,599,501	3,111,109,496	3,389,417,548	3,713,543,704	3,959,130,141	41.12	27.26
<b>Total behavioral health expenditures</b>	197,598,258	210,619,966	241,952,090	277,406,711	317,090,312	60.47	50.55
<b>Total behavioral health expenditures as a percentage of total Medicaid expenditures</b>	7.04	6.77	7.14	7.47	8.01	13.72	18.30
<b>Total expenditures for behavioral health services for children under 21</b>	143,467,687	153,064,462	181,308,140	214,973,291	246,223,071	71.62	60.86
Inpatient (acute)	5,095,022	8,269,044	10,146,226	3,969,115	4,396,572	-13.71	-46.83
Inpatient (freestanding hospital and residential treatment centers)	61,823,614	66,984,798	81,689,746	108,742,244	121,645,140	96.76	81.60
Inpatient (freestanding)	--	9,136,235	9,938,183	9,601,340	9,776,053	--	7.00
Psychiatric residential treatment facility (PRTF)	--	57,848,563	71,751,563	99,140,904	111,869,087	--	93.38
Outpatient behavioral health (private)	31,964,512	26,241,326	39,964,827	56,704,674	72,098,025	125.56	174.75
Outpatient community mental health services (public / contracted)	8,458,849	14,025,483	11,816,804	10,077,082	11,054,177	30.68	-21.19
Outpatient community mental health services (public)	--	4,340,419	515,384	428,316	489,558	--	-88.72
Outpatient community mental health services (contracted)	--	9,685,064	11,301,420	9,648,766	10,564,619	--	9.08
Outpatient substance abuse	--	257,718	--	--	--	--	--
Psychologist	2,211,643	3,852,655	4,356,285	4,522,782	3,860,008	74.53	0.19
Psychiatrist	1,481,140	1,545,814	1,765,981	1,274,670	1,531,868	3.42	-0.90
Residential behavior management services (RBMS)	32,172,073	31,763,812	31,122,602	28,865,569	30,648,928	-4.73	-3.51
RBMS (Group)	--	9,593,623	10,308,980	8,688,764	11,777,447	--	22.76
RBMS (TFC)	--	22,170,189	20,813,622	20,176,805	18,871,481	--	-14.88
Targeted case management (TCM)	134,921	123,811	100,292	263,868	962,819	613.62	677.65
Other outpatient behavioral health services	125,913	--	345,379	553,288	25,534	-79.72	--

Source: OHCA Annual Reports, SFY 2005 to SFY 2009.

There are differences in the behavioral health service categories from 2005-2009. After 2005, several services were split into two categories: outpatient community mental health services (public / contracted), RBMS, and inpatient (freestanding and residential treatment center). In addition, 2006 is the only year in which the service category "outpatient substance abuse" was provided.

For service categories that were split into two categories, we summed up the expenditures in years 2006-2009 to allow comparisons with 2005 data.

## SoonerCare Behavioral Health Expenditures for Adults in Oklahoma, SFY 2005-2009

	SFY 2005 (\$)	SFY 2006 (\$)	SFY 2007 (\$)	SFY 2008 (\$)	SFY 2009 (\$)	% Increase, 2005-2009	% Increase, 2006-2009
<b>Total Medicaid Expenditures</b>	2,805,599,501	3,111,109,496	3,389,417,548	3,713,543,704	3,959,130,141	41.12	27.26
<b>Total behavioral health expenditures</b>	197,598,258	210,619,966	241,952,090	277,406,711	317,090,312	60.47	50.55
<b>Total behavioral health expenditures as a percentage of total Medicaid expenditures</b>	7.04	6.77	7.14	7.47	8.01	13.72	18.30
<b>Total expenditures for behavioral health services for adults</b>	54,130,571	57,555,504	60,643,951	62,433,420	70,867,241	30.92	23.13
Inpatient (acute)	8,743,465	10,179,183	9,290,924	8,262,482	9,337,251	6.79	-8.27
Inpatient (freestanding hospital and residential treatment centers)	743,149	508,654	916,047	888,875	880,577	18.49	73.12
Inpatient (freestanding)	743,149	508,654	916,047	887,532	862,739	16.09	69.61
PRTF	--	--	--	1,343	17,838	--	--
Outpatient behavioral health (private)	14,635,863	12,930,856	16,636,519	20,550,528	26,018,888	77.77	101.22
Outpatient community mental health services (public / contracted)	26,839,865	29,413,424	28,541,770	27,022,239	31,004,461	15.52	5.41
Outpatient community mental health services (public)	--	3,465,278	3,699,781	4,623,266	3,381,472	--	-2.42
Outpatient community mental health services (contracted)	--	25,948,146	24,841,989	22,398,973	27,622,989	--	6.45
Outpatient substance abuse	--	706,180	--	--	--	--	--
Psychologist	869,109	914,408	975,256	973,126	1,096,568	26.17	19.92
Psychiatrist	1,314,612	1,602,709	1,590,685	1,531,906	1,534,768	16.75	-4.24
RBMS	--	--	--	--	--	--	--
RBMS (Group)	--	--	--	--	--	--	--
RBMS (TFC)	--	--	--	--	--	--	--
TCM	659,190	736,769	686,354	606,585	665,766	1.00	-9.64
Other outpatient behavioral health services	325,318	563,321	2,006,395	2,597,679	328,962	1.12	-41.60

Source: OHCA Annual Reports, SFY 2005 to SFY 2009.

There are differences in the behavioral health service categories from 2005-2009. After 2005, several services were split into two categories: outpatient community mental health services (public / contracted), RBMS, and inpatient (freestanding and residential treatment center). In addition, 2006 is the only year in which the service category "outpatient substance abuse" was provided.

For service categories that were split into two categories, we summed up the expenditures in years 2006-2009 to allow comparisons with 2005 data.

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