Integrated Pediatric Behavioral Health Care

A Connecticut Solution to Improve Access, Outcomes, and System Efficiency

Presented by

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Too Many CT Children Reach Care Only in Crisis

11,000+
Youth behavioral health ED visits

1 in 5
Adolescents experienced depression

3.5 Days
Average psychiatric boarding time

1 in 3
return to the ED two or more times in the same year

70%
of ED visits involve treatable conditions

(e.g., anxiety, depression, traumatic stress)

Earlier access prevents later emergencies.

Many Children Are Carrying More Than We See

Children may be coping with:

- Abuse or neglect
- Violence at home or in the community
- Caregiver mental illness or substance use
- Loss of a parent or loved one
- Housing instability and poverty
- Chronic stress and uncertainty

LifeBridge Data:

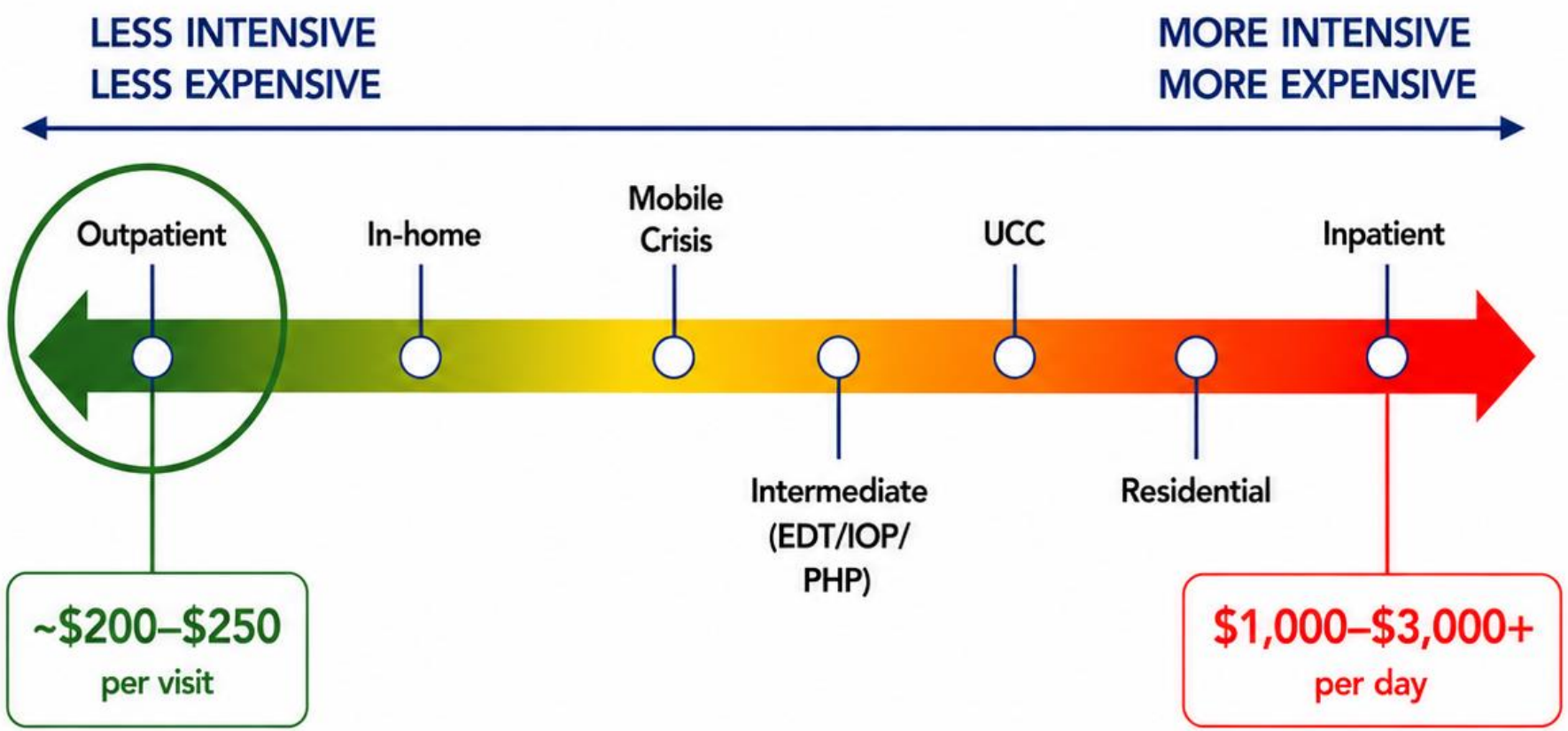
53%

of youth receiving services met the clinical threshold for trauma-related symptoms.

Making Matters Worse:

Bridgeport is a Mental Health Professional Shortage Area.

Earlier Care Prevents Later Crises—and Costs Less



When outpatient care is delayed or unavailable:

- Symptoms worsen
- ↓
- Crises repeat
- ↓
- Emergency department visits increase
- ↓
- Hospitalizations increase
- ↓
- Family stress and disruption increase

Outpatient counseling is not simply one option among many—
it serves the largest number of people and
provides the greatest value to the healthcare system.

Integrated Care Works

Research published in *Pediatrics* and *Health Affairs* shows:

- Improved access to care
- Increased engagement in treatment
- Better clinical outcomes
- Reduced emergency department utilization
- Improved system efficiency and value
- Lower total cost of care

Integrated care is not a theory.
It is an evidence-based model.

LifeBridge Community Services

PHA Pediatric Healthcare Associates

- 30+ years providing community behavioral health care
- Serves Greater Bridgeport families
- Established behavioral health workforce and clinical supervision infrastructure
- Serves many Medicaid-insured children and families
- Member of the National Child Traumatic Stress Network

- 34,000 children served annually
- 60 years serving Fairfield County families
- Four Fairfield County locations (Fairfield, Shelton, Stratford, Trumbull)
- Serves many Medicaid-insured children and families
- Prioritizes youth mental health

Together, these organizations combine pediatric reach with behavioral health expertise to bring integrated care to children who might otherwise go without treatment.

Traditional Referral

Pediatrician provides referral

↓

Weeks or months before treatment begins

↓

Families may never connect with services

- ✗ Multiple handoffs
- ✗ High unkept appt. risk
- ✗ Limited communication between providers

↓

Pediatrician may never know the outcome

LifeBridge-PHA Integrated Care Model

Pediatrician makes direct electronic referral

↓

Access to care within 24 hours

↓

Treatment begins immediately

In a trusted pediatric setting

↓

Pediatrician remains informed and involved throughout treatment

Ongoing communication and care coordination

> *"A child will have the longest relationship with their parents and pediatrician."*
>
> — Anonymous

Pediatric Practice Role

Creates and sustains the integrated-care environment through:

- Screening
- Identification of needs
- Referral coordination
- Shared workflows
- Team communication
- Space and infrastructure
- Multidisciplinary collaboration

Embedded Partnership

LifeBridge clinicians are embedded within:

- PHA Stratford
- PHA Fairfield
- PHA Trumbull

Behavioral Health Provider Role

Brings mental health expertise and provides:

- Clinical assessment
- Therapy
- Care coordination
- Family engagement
- Consultation
- Treatment planning
- Ongoing behavioral health management

MORE THAN HALF THESE ACTIVITIES ARE INELIGIBLE FOR REIMBURSEMENT

Transforming Access to Care

Over the past two and a half years:

393%

increase in youth accessing treatment

More than one-quarter of total access growth was achieved through the integrated-care partnership.

Families are not being handed a list of providers.
They are entering treatment.

Early Results Show Promise

Emotional Regulation *(Self-Control)*

Integrated Care:	48% ↑
Agency Average:	48% ↑

Persistence *(Effort)*

Integrated Care:	51% ↑
Agency Average:	40% ↑

Children accessed care more quickly and received outcomes comparable to, or better than, traditional outpatient services—even during the first 6–8 months of implementation.

Missed Appointment Rates	
Integrated Care Sites	27%
Agency Average	29%
National Medicaid/Community Behavioral Health Benchmark	25–40%

The Economics of Outpatient Mental Health No Longer Work

Actual Cost per Session	**~ $240**
Medicaid Reimbursement	**~ $105**
Unreimbursed Cost	**~ $135**
LifeBridge Annual Loss *(From Unreimbursed Cost)*	**~ $370,000** per year

As workforce costs rise faster than Medicaid reimbursement, the gap continues to grow.

PHA Annual Loss *(Lost Net Revenue)* — **~ $800K** per year

in lost net revenue for PHA from using exam rooms for therapy services instead of pediatric care (3 offices).

Estimate excludes care coordination staff time associated with referrals and follow-up, making the true cost higher.

Connecticut's Own Rate Study Supports Action

Independent Findings

- Behavioral health clinic rates benchmarked 116.9% below target
- Many behavioral health methodologies rely on historical calculations
- Some rates had not been updated in over a decade

Sustainability Findings

- No routine mechanism for annual updates
- Workforce costs rise faster than reimbursement
- Current approaches require repeated legislative intervention

State Recommendations

- Rebase rates
- Establish regular update schedules
- Expand alternative payment models
- Tie investments to access and outcomes

Connecticut has already diagnosed the problem.
The next step is implementing the solution.

Other states reimburse for integrated care to expand access and improve whole-child care. Connecticut can too.

	Massachusetts	Colorado	Connecticut Proposal
Primary Focus	**Sustainable payment** for integrated care	**Embedded behavioral health** in pediatric practices	✓ **Combine both approaches**
Payment Approach	Collaborative Care codes, sub-capitation, and PMPM payments	Traditional reimbursement supplemented by integration initiatives	✓ **Dual reimbursement for integrated pediatric behavioral health partnerships**
Behavioral Health Presence	Behavioral health integrated into primary care teams	Embedded clinicians working within pediatric practices	✓ **Embedded clinicians working within pediatric practices**
Pays for Primary Care Integration Activities	✓ Screening, care coordination, team case review	Limited support through local initiatives	✓ **Enhanced reimbursement for screening, warm handoffs, workflow integration, case review, and infrastructure**
Pays for Behavioral Health Integration Activities	✓ Care management and psychiatric consultation	Limited support for embedded behavioral health	✓ **Enhanced reimbursement for embedded therapy, assessments, care coordination, consultation, and family engagement**
Who Receives Enhanced Payment?	Primarily primary care teams	Varies by initiative	✓ **Both pediatric and behavioral health partners**
Result	Integrated care becomes financially feasible	Behavioral health becomes more accessible	✓ **Sustainable, scalable pediatric–behavioral health partnerships statewide**

Policy Recommendations

TIER 1

1 Partnership Incentive Payments

Incentivize pediatric–behavioral health partnerships statewide through grants, infrastructure payments, technical assistance, and workforce supports.

Children should receive behavioral health services where families already seek care.

2 Integrated Payment Model

Establish an integrated pediatric behavioral health partnership payment model that reimburses both therapy and care coordination.

Integrated care requires two providers doing work beyond the therapy session. A sustainable payment model should reimburse both.

TIER 2

3 Demonstration Waiver

Authorize a Medicaid demonstration waiver to evaluate the effectiveness and cost savings associated with integrated pediatric behavioral health partnerships.

Test and learn what works to improve outcomes and reduce costs.

4 Outpatient Medicaid Rates with COLA Indexing

Increase Medicaid reimbursement rates for outpatient behavioral health to reflect the true cost of care and implement annual Cost-of-Living Adjustments (COLAs).

When workforce costs rise faster than reimbursement, access erodes over time—even after one-time rate increases.

The Cost of Doing Nothing

The cost differences are dramatic.

Level of Care	Typical Cost
Outpatient therapy session	**$200–$250** per visit
Intensive Outpatient Program	**$250–$500** per day
Partial Hospitalization	**$350–$800** per day
Residential treatment	**$500–$1,500+** per day
Psychiatric inpatient hospitalization	**$1,000–$3,000+** per day

These are estimated costs based on typical Medicaid reimbursement rates in Connecticut. Actual costs may vary.

Connecticut is already paying for children's mental health.

The question is whether we pay earlier through prevention—or later through crisis.

One psychiatric hospitalization

can cost as much as months—or even years—of outpatient counseling.

- Connecticut already has the partners.
- Connecticut already has the evidence.
- Connecticut already has the need.

Now Connecticut needs the payment model.

Thank you. | Questions?

Contact Information

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SLIDES 2–5

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