

Addressing Behavioral Health Needs Through Sustainable Medicaid Investment and Integrated Care Partnerships

Presented by

Edith Boyle, LCSW

President & CEO,
LifeBridge Community Services



Too Many CT Children Reach Care Only in Crisis



11,000+

Youth behavioral
health ED visits



3.5 Days

Average psychiatric
boarding time



1 in 5

Adolescents experienced
depression



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:

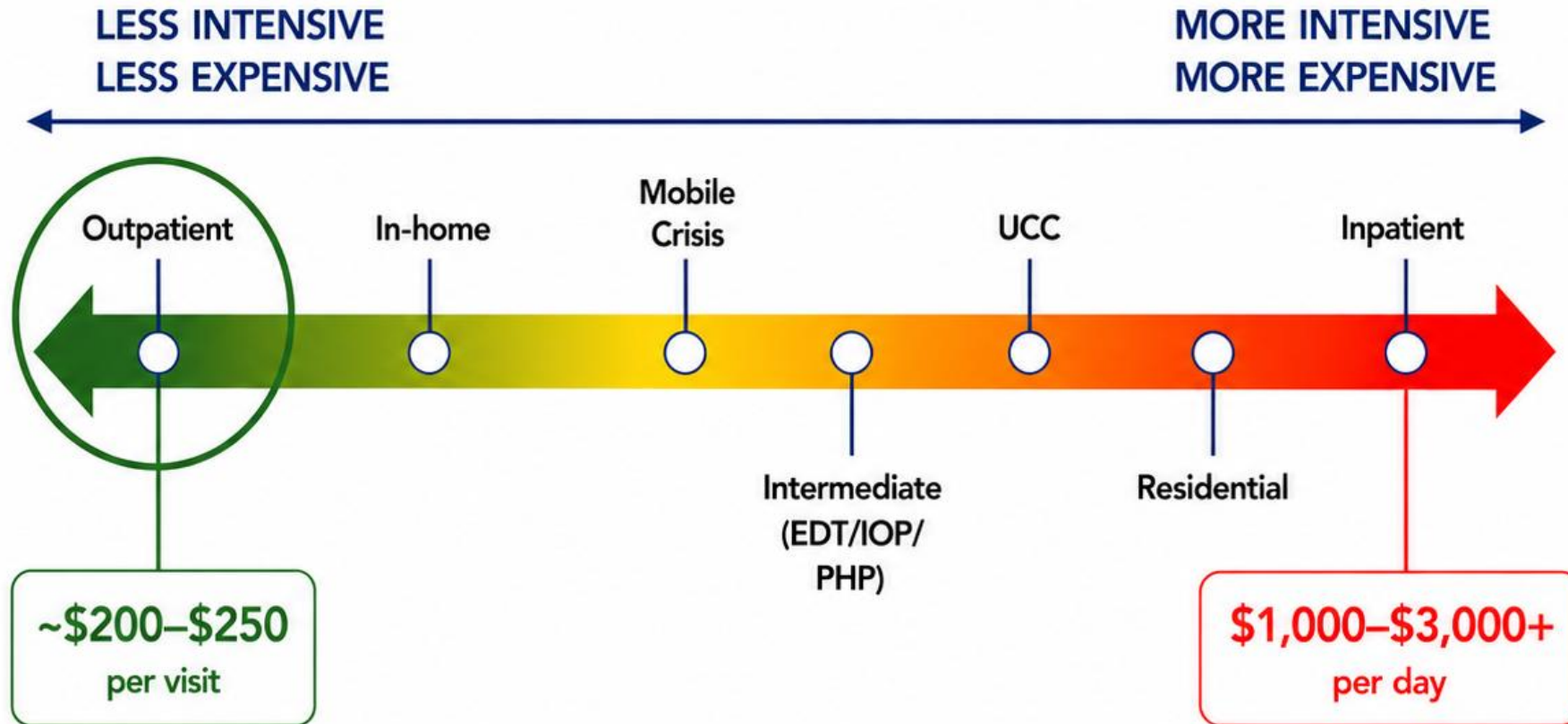


Making Matters Worse:

Bridgeport is a Mental Health 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



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



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.



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

- ✓ **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



Edith Boyle, LCSW
President & CEO



203-368-5550



eboyle@LifeBridgeCT.org



www.LifeBridgeCT.org



Pediatric Healthcare Associates

Andrea Hagani, MD
CEO



203-452-8322



ahagani@phagroup.com



www.pha4kids.com

SLIDES 2-5

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