Allegheny County HealthChoices Program: Five Year Summary

Presented by

Allegheny HealthChoices, Inc.
444 Liberty Avenue, Pittsburgh, PA 15222
Phone: 412/325-1100 Fax 412/325-1111

September 2004

AHCI is a contract agency for the Allegheny County Department of Human Services' HealthChoices Program

Allegheny County Health Choices Program: Five Year Summary

Executive Summary **.......... 4**

Introduction **.......... 7**

Overview of the HealthChoices Program in Allegheny County 7

Report Contents 7

HealthChoices Enrollment **.......... 8**

Overview 8

How many HealthChoices members are new each year? 8

What are the demographic characteristics of HealthChoices members? 9

Where do most Allegheny County HealthChoices members live? 9

HealthChoices Costs **.......... 11**

Overview 11

How are reinvestment funds spent? 12

Profile of Child and Adolescent Consumers **.......... 14**

What are the characteristics of child and adolescent consumers? 14

Which services do child and adolescent consumers use the most, and how much do these services cost? Have these patterns changed over time? 15

What services are used to treat the most common diagnoses for children and adolescents? 18

Profile of Adult Consumers **.......... 20**

What are the characteristics of adult consumers? 20

Which services do adult consumers use the most, and how much do these services cost? Have these patterns changed over time? 21

What services are used to treat the most common diagnoses for adults? 23

What's next for HealthChoices in Allegheny County? **.......... 26**

Glossary of terms **.......... 27**

Executive Summary

The year 2003 marked the five-year anniversary of the HealthChoices program in Allegheny County. HealthChoices, Pennsylvania's managed care program for Medical Assistance, provides physical health care and behavioral health care services to both children and adults. Under HealthChoices, Allegheny County contracts with the Commonwealth of Pennsylvania to implement the behavioral health services portion of the program. Allegheny County has delegated responsibilities for managing the behavioral health program to two other organizations:

- The County contracts with Community Care Behavioral Health Organization (Community Care) to manage behavioral health services for the HealthChoices program.
- Allegheny County also contracts with Allegheny HealthChoices, Inc. (AHCI) to carry out the County's oversight and monitoring responsibilities required under the HealthChoices program.

When the program began, stakeholders had great hopes for better access to services, quality of care, and the use of less restrictive and more community-based treatment. This five-year milestone provides an important opportunity to review how enrollment and service use have evolved over time to meet these goals.

HealthChoices Enrollment

In 2003, about 125,000 members were enrolled in HealthChoices each month, on average. About 55% of these members were 20 years old or younger.

- From 2000 through 2003, total enrollment in HealthChoices increased by 3.8%.
- HealthChoices membership has been stable over this five year period. Each year from 2000 to 2003, only 15% of HealthChoices members were new members (meaning they had never been enrolled before), and many members were eligible during all five years of the HealthChoices program.
- As a proportion of the total population from the 2000 census, HealthChoices members were more concentrated in several areas of Pittsburgh (i.e. Homewood and the Hill District) and several communities in the Monongahela Valley.

HealthChoices Costs

Pennsylvania's Department of Public Welfare (DPW) pays a fixed amount (a capitation payment) for each person enrolled in HealthChoices no matter if the person actually uses services. Since the HealthChoices program began, total capitation payments have grown 38% to $142.3 million in 2003. These payments have increased because more people are enrolled in HealthChoices and because DPW has raised several payment rates over time, as a result of the analysis of past utilization and service access trends.

The capitation payments are used to pay for claims for services provided, to cover administrative costs incurred by Community Care, the County, and AHCI, and to pay performance standard awards to Community Care. Claims for services provided have increased at a similar rate (37%) as the capitation payments; paid claims in 2003 totaled approximately $120 million. Since 2000, administrative expenses as a proportion of capitation for Community Care, the County, and AHCI have decreased.

The funds remaining at the end of each year after all expenses are paid are required to be invested in services to meet underserved needs. To date, approximately $15.5 million of these reinvestment funds have been allocated for various programs; plans for 2002 and 2003 funds are currently in process.

Child and Adolescent Consumers

Paid claims for child and adolescent consumers increased 36% from 2000 to 2003. A significant increase in the number of consumers (28%), rather than an increase in the average cost per consumer (6%), accounts for this growth in paid claims. The number of child and adolescent consumers grew primarily because *a larger proportion of members chose to access services*.

Despite these increases, the patterns of *who used services* (based on race, gender, and diagnosis) have been constant since 2000. Penetration rates for African-Americans have been lower than rates for Caucasians throughout HealthChoices. Also, the patterns of *services used* have remained stable, both in terms of the proportions of consumers using various services and the total claims paid for various services:

- The largest number of consumers each year used outpatient mental health services (68%), medication checks (32%), and BHRS (26%).
- Three services accounted for 68% of claims paid each year: BHRS (44%), inpatient mental health services (13%), and residential treatment facilities (11%).

Several incremental changes indicate that use of community-based services grew, although the growth was not large enough to affect the overall patterns in the system:

- The proportion of eligible members who used community-based services including BHRS, case management, family-based services, medication checks, and outpatient mental health services all increased from 2000 to 2003.
- A small but growing number of adolescents used substance abuse services; the number of consumers receiving these services increased 77% from 2000 to 2003.

Adult Consumers

For adult consumers, the overall increase of 40% in paid claims was caused about equally by increases in the number of consumers (20%) and the average cost per consumer (17%). Similarly, the number of adult consumers increased 20% from 2000 to 2003; *about 13% of the increase is due to a larger proportion of members choosing to access services.*

As with the child and adolescent consumers, the patterns of *who used services* (based on race, gender, and diagnosis) have been constant since 2000; penetration rates for African-Americans have also been lower than rates for Caucasians. Also, the patterns of *what services* were used have remained stable, both in terms of the proportions of consumers using various services and the total claims paid for various services:

- Since 2000, about 26% of adult consumers used a drug and alcohol treatment service, accounting for approximately 27% of paid claims; 90% of adult consumers used a mental health service, accounting for about 73% of claims.
- Inpatient mental health services accounted for at least 36% of total claims each year. While utilization of inpatient mental health services did not grow as quickly as other services, it is still higher than expected. Rather than decreasing over time, the admission rate increased from 43.06 consumers per 1,000 members in 2000 to 45.73 consumers per 1,000 members in 2003.

Several changes indicate that use of community-based services grew, although the growth was not large enough to affect the overall patterns in the system:

- Community Treatment Team (CTT) services began in 2001. By 2003, about 1% of consumers were on a CTT, and CTT services accounted for about 6% of claims.
- The proportion of members accessing case management services, CTT, medication checks, and outpatient mental health services increased from 2000 to 2003. Growth rates in use of most drug and alcohol services also generally outpaced the growth rates for inpatient mental health services.

Implications and Next Steps

The increasing proportion of members accessing services in both age groups indicates progress towards improving access to services, one of HealthChoices' primary goals. Furthermore, the relatively faster growth rates of community-based services compared to inpatient services indicates that additional resources have been directed towards treating consumers in the community. However, since HealthChoices began in 1999, the expected decrease in inpatient mental health utilization has not occurred.

As the system increasingly moves towards a focus on recovery, additional interventions will need to generate changes toward coordinated, recovery-based, community-focused services. Several current developments should have an impact, including a renewed focus on creating a county housing plan, measurement of performance standards, improvement plans targeting inpatient readmission rates as part of DPW's performance-based contracting, and performance incentives in the new HealthChoices contract. Additional outreach to increase engagement in services, development of crisis services and supported housing, and more assertive coordination of care and discharge planning should be pursued in order to make further progress in meeting the goals of HealthChoices.

Introduction

Overview of the HealthChoices Program in Allegheny County

HealthChoices is Pennsylvania's managed care program for adults and children who receive Medical Assistance (MA). This program includes both physical health care and behavioral health care (e.g., mental health and drug and alcohol services). The goals of Pennsylvania's HealthChoices program are to improve:

- Access to services;
- Quality of care;
- Continuity of the care provided in a multi-system environment; and
- Coordination and distribution of finite Medical Assistance resources.

Allegheny County holds the contract with the Commonwealth of Pennsylvania for the implementation of the behavioral health services portion of the program. As such, the County has the ultimate responsibility and accountability for all aspects of the management of behavioral health services for the HealthChoices program. This includes assuming programmatic and financial risk for all Medicaid-funded behavioral health services provided to HealthChoices members.

Allegheny County has delegated responsibilities for managing HealthChoices in a rather unique way. The County contracts with Community Care Behavioral Health Organization (Community Care) to manage behavioral health services for the HealthChoices program. This includes provider network development, utilization management, quality management, claims management, information systems, reporting, member services, and prevention and outreach. Allegheny County also contracts with Allegheny HealthChoices, Inc. (AHCI) to carry out the County's oversight and monitoring responsibilities required under the HealthChoices Program. This includes overseeing Community Care's administrative and programmatic operations, providing training for providers and stakeholders, and operating Ombudsman services.

Report Contents

This report provides a broad overview of HealthChoices in Allegheny County since the program began in 1999. Enrollment and utilization data highlight the changes and the stability within the system.

For the purposes of this report, the term "members" refers to people who have enrolled in the HealthChoices program. The term "consumers" refers to people who have enrolled in HealthChoices and who used services during the year. Because the enrollment patterns and services provided are different for adults and children, most data is presented separately for children (0-20 years) and adults (over 21 years).

In terms of data used for this report, information related to admissions, readmissions, and length of stay is based on authorizations for services. All other utilization information (including data related to diagnoses) is based on claims paid. Enrollment information is based on data provided by the state. Because 1999 was a start-up year for the program and does not represent a full year of data, most descriptions of change over time use 2000 as the baseline year. A glossary of terms is provided at the end of the report.

HealthChoices Enrollment

Overview

Individuals *apply* for Medical Assistance through Pennsylvania's Department of Public Welfare (DPW) and *qualify* for Medical Assistance because they are eligible for one of the seven broad categories of aid (definitions of these categories of aid are provided in the glossary). DPW determines eligibility for these categories of aid through a complex set of criteria that takes into account the individual's income, assets, and disability status.

People eligible for Medical Assistance could enroll in HealthChoices beginning on January 1, 1999. On July 1, 1999, all Medical Assistance members who were eligible for HealthChoices were required to enroll in the program. Since enrollment was optional for the first half of 1999, 2000 should be considered the first full year of HealthChoices.

When individuals enroll in HealthChoices, they select a physical health managed care organization for their physical health coverage and are automatically enrolled with Community Care for behavioral health care coverage, even if they have not or will not be using behavioral health services. Table 1 shows the average number of members enrolled per month for each of the five years, by age group.

Table 1.

Average Monthly Enrollment for HealthChoices, by Age Group

	Members 0-20 Years	Members 21 Years and Older	Total
1999	55,064	44,190	99,254
2000	64,061	56,300	120,361
2001	64,054	55,236	119,290
2002	65,866	55,371	121,237
2003	68,200	56,779	124,979
% change 2000-2003	6.5%	1%	3.8%

More children and adolescents than adults have been enrolled in HealthChoices. Several of the categories of aid used to establish Medical Assistance eligibility target families with children, so the large number of members under 21 years is expected. From 2000 through 2003, total enrollment in HealthChoices increased by 3.8%. And, average monthly enrollment grew faster for children (6.5%) than for adults (1%).

How many HealthChoices members are new each year?

From 2000 to 2003, about 15% of HealthChoices members each year were new members (meaning they had never been enrolled before). Many members were eligible during all five years of the HealthChoices program:

- For children and adolescents, 46% of African-Americans, 28% of Caucasians, and 21% of those of other races were eligible during all five years of HealthChoices.
- For adults 21 years and older, 43% of African-Americans, 35% of Caucasians, and 26% of those of other races were eligible during all five years.

What are the demographic characteristics of HealthChoices members?

Within each age group, the race and gender characteristics of HealthChoices members have generally remained constant over the five years of HealthChoices:

- For children and adolescents, males and females are enrolled in approximately equal proportions each year. Between 51% and 53% of members are African-American, 44%-46% are Caucasian, and 2-3% are from another race each year.
- For adults 21 years and older, 70% of members are female each year. About 40% of adult members are African-American, 57% are Caucasian, and 3% are from another race each year.

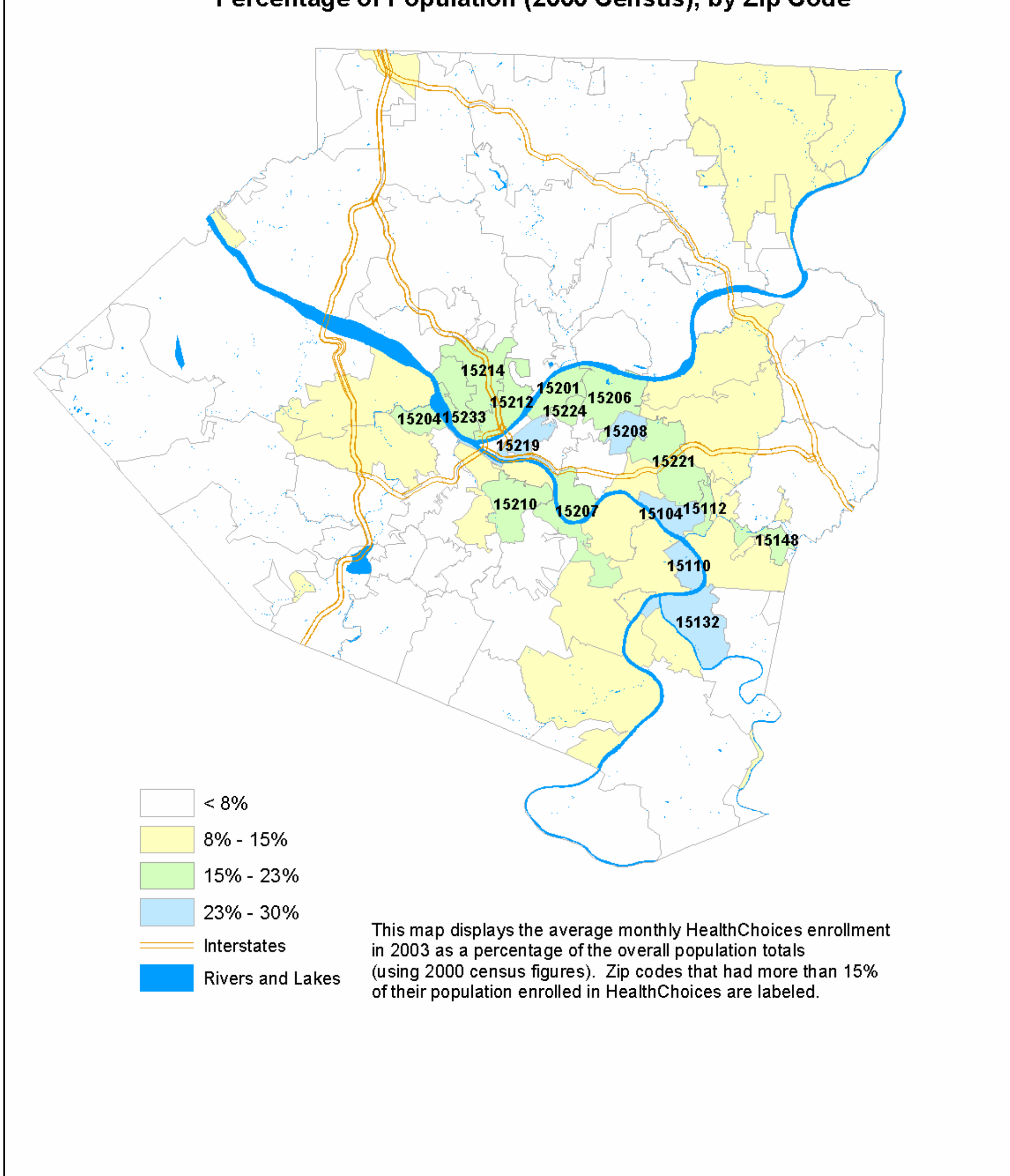
The racial profile of HealthChoices members is quite different from the racial profile of Allegheny County. In the County as a whole, about 12.3% of the population is African-American, and about 83.8% Caucasian;[1] about 52.6% of the population is female, and 47.4% male.[2] Because African-Americans have higher rates of poverty and households headed by single mothers, they are disproportionately eligible to receive Medicaid (HealthChoices) insurance coverage in the County. Similarly, because women have higher rates of poverty and are more often single heads of households, they are more likely to be eligible to receive HealthChoices coverage than males.

Where do most Allegheny County HealthChoices members live?

The map on the following page displays the concentration of HealthChoices members throughout Allegheny County in 2003. Since 1999, the geographic distribution of members has remained stable. HealthChoices members as a proportion of the total population (using 2000 Census figures) varies by zip code, from nearly zero percent in many of the suburban communities to 30% in many areas of Pittsburgh and communities in the Monongahela Valley. Average monthly enrollment by zip code in 2003 varied from 9 to 6,890, with an average of 1,249 members. As expected, the zip codes with the highest concentrations of HealthChoices *members* were the same zip codes that have the highest concentrations of HealthChoices *consumers.*

Pittsburgh zip codes with the highest concentration (more than 23%) of the population enrolled in HealthChoices include the Pittsburgh city neighborhoods of Homewood/Point Breeze, the Hill District, and Bluff, and the municipalities of Duquesne, Braddock, North Braddock, McKeesport, and Rankin. Other city neighborhoods with high concentrations of HealthChoices members (more than 15%) include Bloomfield/Garfield, the North Side, East Liberty and Highland Park, Lincoln-Lemington-Belmar, Larimer, Sheridan and Marshall-Shadeland, Lawrenceville, Hazelwood, Glen Hazel, Carrick, Beltzhoover, Knoxville and St. Clair. Zip codes covering the municipalities of Wilkinsburg and parts of East Pittsburgh, Wilkins, Forest Hills and Braddock Hills also had more than 15% of their population enrolled in HealthChoices. Given the socio-economic make-up of the County, these patterns are expected.

[1] "Black-White Benchmarks Reports." University Center for Social and Urban Research, March 2004. Available at http://www.ucsur.pitt.edu/Benchmarks%202004.htm.
[2] "Women's Benchmarks Reports." University Center for Social and Urban Research, April 2004. Available at http://www.ucsur.pitt.edu/Benchmarks%202004.htm.


2003 HealthChoices Members as a
Percentage of Population (2000 Census), by Zip Code
15214
15201
15212
15206
15224
15204
15233
15208
15219
15221
15210
15207
15104
15112
15148
15110
15132
< 8%
8% - 15%
15% - 23%
23% - 30%
Interstates
Rivers and Lakes
This map displays the average monthly HealthChoices enrollment in 2003 as a percentage of the overall population totals (using 2000 census figures). Zip codes that had more than 15% of their population enrolled in HealthChoices are labeled.

HealthChoices Costs

Overview

As noted above, each person is enrolled in HealthChoices through one of seven general categories of aid. Each month, DPW pays a fixed amount (a capitation payment) to the HealthChoices program for each person enrolled even if the person does not actually use services. Each category of aid has a different capitation rate, so the capitation paid for each individual is determined by the category of aid for which s/he qualified.

Each month, a portion of the capitation goes to Community Care to cover claims for services and administrative expenses. A portion also is released to the County and AHCI to cover administrative operation costs. Funds are also set aside to pay Community Care performance standard awards. The remainder of the capitation is required to be used for reinvestment programs.

From 1999-2003, both revenues (capitation payments) and expenses (claims and administrative expenses) have increased each year. See Table 2. Administrative expenses for Community Care, the County, and AHCI as a proportion of capitation have actually decreased since 2000. Community Care's administrative expenses decreased from 10.3% of capitation in 2000 to 8.4% of capitation in 2003. AHCI and the County's administrative operational expenses decreased from 1.7% of capitation in 2000 to 1.4% of capitation in 2003.

Table 2.

Total Paid Claims and Total Capitation, by Year

Year	Total Paid Claims (millions)			Total Capitation
	0-20 Years	21Years and Older	All Ages	All Ages
1999	$29.4	$26.5	$56.0	$77.2
2000	$48.8	$39.2	$88.0	$103.0
2001	$53.3	$41.1	$94.4	$112.3
2002	$58.7	$46.6	$105.4	$128.8
2003	$66.2	$54.8	$121.0	$142.3
% change 2000 - 2003	36%	40%	37%	38%

As Table 2 shows, total capitation payments have increased by 38% between 2000 and 2003, at about the same pace as total paid claims. Capitation payments increased for two reasons:

1. More people were enrolled in HealthChoices.
2. DPW increased the capitation payments for some categories of aid, based on analysis of past utilization and changes in rates of access.

Each year, claims account for 82% to 85% of the total capitation received from DPW. Two factors account for the 37% increase in claims from 2000 to 2003:

1. More people chose to access behavioral health services, as measured by increases in the number of total consumers and penetration rates[3].
2. On average, consumers used more services and/or more expensive services, as indicated by increases in the average cost per consumer.

[3] Penetration rates are calculated by dividing the number of consumers who *use* behavioral health services by the average number of members *eligible to use* services. Penetration rates increase when a larger proportion of eligible members access services. If the number of consumers increases proportionally with an increase in enrollment, the penetration rate will not change.

Table 3 analyzes how these factors have combined to produce this overall increase in paid claims. From 2000 to 2003, the number of consumers increased 23%, the penetration rate increased 18%, and the average cost per consumer increased 12%.

Table 3.

Total Consumers, Penetration Rates, and Average Cost per Consumer by Year and Age Group

Year	0-20 Years			21 Years and Older			All Ages		
	Total Cons.	Penetration Rate	Cost/ Cons.	Total Cons.	Penetration Rate	Cost/ Cons.	Total Cons.	Penetration Rate	Cost/ Cons.
1999	6,802	7.27%	$4,326	12,211	13.20%	$2,174	18,960	19.10%	$2,952
2000	7,934	7.08%	$6,155	14,045	12.77%	$2,789	21,893	18.19%	$4,020
2001	8,193	7.57%	$6,500	13,985	13.42%	$2,941	22,091	18.52%	$4,272
2002	9,149	7.95%	$6,418	15,458	13.67%	$3,018	24,510	20.22%	$4,299
2003	10,167	8.53%	$6,511	16,838	14.37%	$3,253	26,879	21.52%	$4,501
change 00-03	28%	20%	6%	20%	13%	17%	23%	18%	12%

For child and adolescent consumers, the overall increase in paid claims is primarily driven by the increase in the number of consumers (28%) rather than by an increase in the average cost per consumer (6%). For adult consumers, the overall increase in paid claims was caused about equally by an increase in the number of consumers (20%) and the average cost per consumer (17%).

Because the size of the enrolled population has increased over time, it is important to look at the increase in the overall number of consumers in conjunction with the increase in penetration rates. The proportion of child and adolescent members who used behavioral health services increased 20% from 2000 to 2003. This increase in the penetration rate accounts for most of the 28% growth in the number of consumers. Similarly, the proportion of adult members who used behavioral health services increased 13% from 2000 to 2003. This increase in the penetration rate accounts for much of the 20% growth in the number of adult consumers.

One of HealthChoices' primary goals is increasing access to services. Therefore, the increase in the proportion of members accessing services is a positive trend. Overall, Allegheny County HealthChoices performs well on access to services measures. According to DPW findings, 76% of adults and 68% of youth expected to need services in 2002 did receive mental health services, above DPW's gold standard of 65%.[4] The lower penetration rates for child and adolescents suggest a need for greater outreach and engagement in services.

How are reinvestment funds spent?

Each county is responsible for using any funds that remain at the end of each contract year for reinvestment activities that target unmet or under-met needs, expand capacity, and/or find innovative ways to improve service delivery. Allegheny County, AHCI, Community Care, consumers and family members, and other stakeholders work together to provide input that directs the development of reinvestment initiatives for each year's funding. These initiatives make up the reinvestment plans that are submitted to the state for approval.

To date, the HealthChoices program in Allegheny County has developed reinvestment plans for the nearly $15.5 million available for reinvestment from 1999 through 2002. The 2002 plan has been submitted but has not yet been approved by the state. The 2003 plan will be submitted in September 2004.

[4] "HealthChoices Behavioral Health Baseline Performance Report," Commonwealth of Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (May 2004). Based on 2002 data, Allegheny County also performed well in access rates for adults needing substance abuse services and access rates for the population with serious mental illness. Access rates for African-American youth needing either mental health or substance abuse services and youth needing substance abuse services were below the gold standards set by DPW.

These funds have been used to help develop and expand mental health and drug and alcohol services for adults and children. Reinvestment dollars have funded the following types of initiatives:

- Outreach programs targeting the homeless, African American children, adults with drug and alcohol issues, and people with HIV/AIDS;
- Respite services for adults and children with mental illness;
- Dual diagnosis services for men who were formerly incarcerated;
- Community support services for families with a child needing/using behavioral health services;
- Psychiatric rehabilitation services for adults with mental illness;
- Behavioral health treatment for juvenile offenders;
- Case management for adults with drug and alcohol issues;
- Behavioral health assessments for children in schools;
- Translation services for people attending recovery support services; and
- Community treatment teams for adults and transition-age adolescents with mental illness.

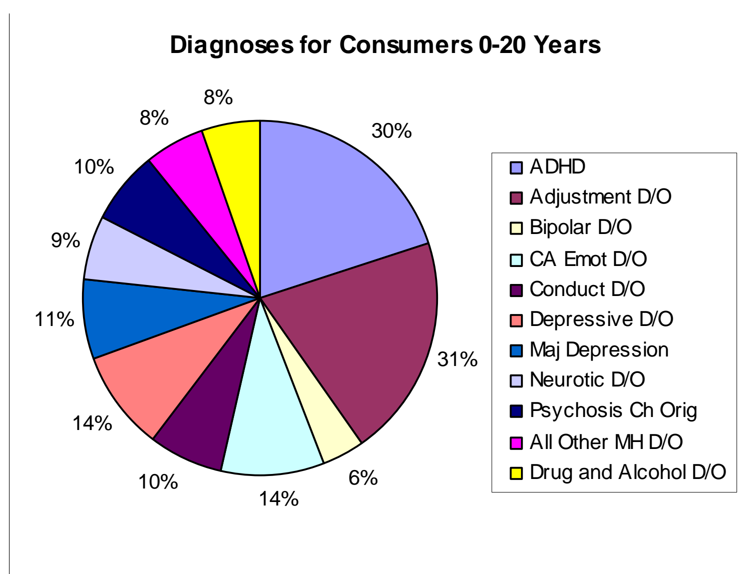
Profile of Child and Adolescent Consumers

What are the characteristics of child and adolescent consumers?

In 2003, over 10,000 children and adolescents received behavioral health services, totaling $66.2 million dollars in paid claims. These 2003 figures represent a 36% increase in claims and a 28% increase in number of consumers from 2000. While the number of consumers has increased, the characteristics of child and adolescent consumers have remained stable over time. In each year since 2000, approximately:

- 40% of consumers are female and 60% are male.
- 40% of consumers are African-American, 58% are Caucasian, and 2% belong to other races.
- Each year, about one third of consumers are *new* consumers, meaning they have not used behavioral health services under HealthChoices previously.
- Chart 1 shows the diagnostic patterns of child and adolescent consumers, which have been consistent year to year since 2000.[5] Attention-deficit/hyperactivity disorder (ADHD) and adjustment disorder are by far the most common diagnoses received. Each year, about 30% of consumers had a claim paid for a diagnosis of ADHD and 31% of consumers had a claim paid for an adjustment disorder diagnosis.[6]
- Diagnoses of emotional disorders, depressive disorders, neurotic disorders, bipolar disorder, and psychosis of childhood origin are given to about the same percentage of consumers each year; each of these diagnoses are for fewer than 20% of consumers. A small percentage (8%) of consumers received a primary substance abuse disorder diagnosis.
- According to their diagnostic histories,[7] about 11-13% of consumers each year have both a mental health and substance abuse diagnosis during their coverage under HealthChoices. The majority of child and adolescent consumers have histories of mental illness diagnoses only (81% to 85%); only 1% of consumers have diagnostic histories of substance abuse only.

Chart 1.



---

[5] A few of the diagnostic categories require clarification. Most consumers with a "child and adolescent emotional disorder" (abbreviated as CA Emot D/O) are diagnosed with oppositional defiant disorder. Diagnoses included in the "neurotic disorder" category include generalized anxiety disorder, dysthymic disorder, obsessive compulsive disorder, panic disorder, and social phobia. Diagnoses included in the "psychosis of childhood origin" category include autism, Asperger's syndrome, and pervasive development disorder.

[6] The percentages total more than 100% because different claims for an individual may use different primary diagnoses. Only diagnoses received by more than 5% of consumers are graphed. The graph represents 10,167 consumers in 2003.

[7] This data is derived from Community Care's care management database. Care managers enter information on consumers based on provider information; this information is not linked to claims for specific services. Based on the combination of diagnoses entered over time, consumers are categorized as having histories of mental illness diagnoses, substance abuse diagnoses, or both mental illness and substance abuse (MISA) diagnoses.

Which services do child and adolescent consumers use the most, and how much do these services cost? Have these patterns changed over time?

As the HealthChoices program has developed, overall patterns of service usage for children and adolescents have remained consistent from year to year. Charts 2 and 3 below illustrate how the different mental health services account for total claims and the total number of consumers.[8] A brief description of each service is provided in the glossary.

Chart 2.

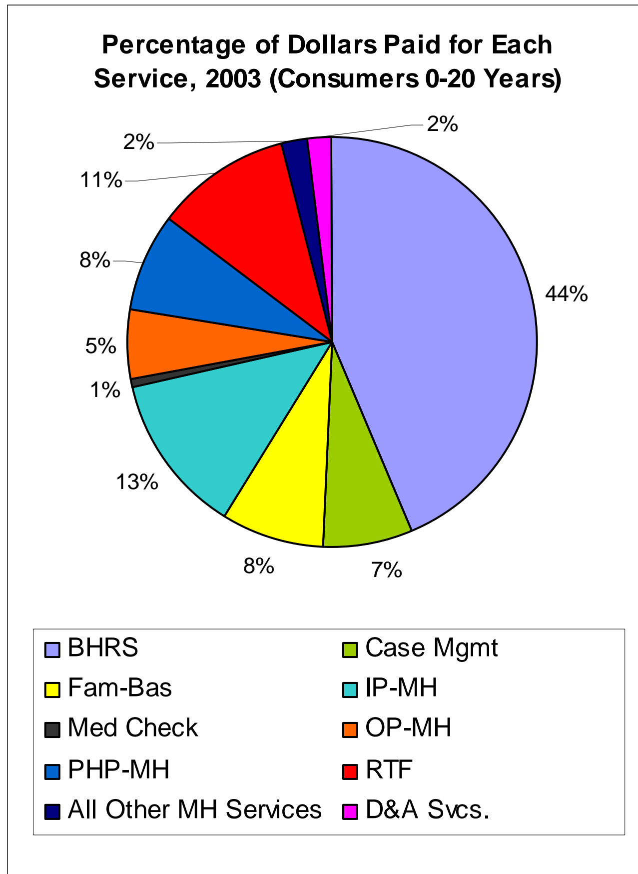
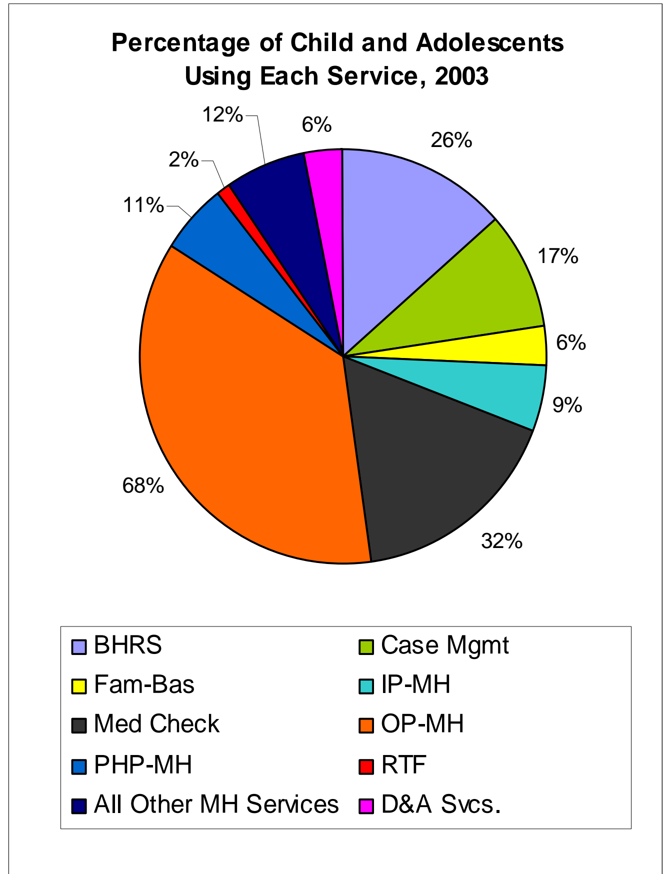


Chart 3.



Key to abbreviations:

BHRS – behavioral health rehabilitation services
Fam-Bas – family-based services
Med Check – medication check
PHP-MH – partial hospitalization mental health program
D&A Svcs – drug and alcohol services
Case Mgmt – case management services
IP-MH – inpatient mental health services
OP-MH – outpatient mental health
RTF – residential treatment facility

Note: the chart legends should be read left to right.

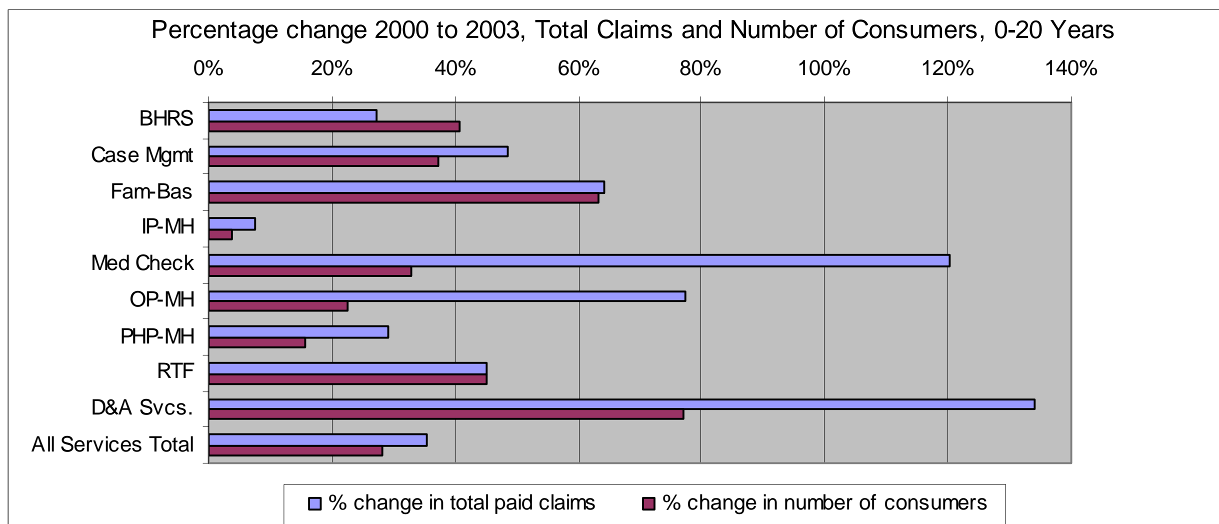
[8] The eight services with the highest paid claims were graphed. Because relatively few children and adolescents used drug and alcohol services, the services were combined.

The largest number of consumers each year used outpatient mental health services (68%), medication checks (32%), and BHRS (26%). Three services accounted for 68% of claims paid each year: BHRS (44%), inpatient mental health services (13%), and residential treatment facilities (11%). It is interesting to note that the proportions of spending and total consumers for each of these services in relation to the total have remained constant since 2000. For example, 26% of children who used services used BHRS, and BHRS has consistently accounted for about 44% of total paid claims. So, although the numbers in Charts 2 and 3 have increased over time, the relative sizes of the pie pieces have remained the same year to year.

Charts 2 and 3 also illustrate the relative costs per consumer for each service. Services that are represented with a small piece of the claims pie and a large piece of the consumer pie are relatively inexpensive (medication checks, outpatient mental health); services represented with a large piece of the claims pie and a small piece of the consumer pie are more expensive per consumer (BHRS, RTF, inpatient mental health services).

While these proportions shown in the charts have not changed over time, the growth in claims paid and number of consumers did not occur uniformly across all services. Chart 4 below shows the percentage increase from 2000 to 2003 for both the number of consumers and paid claims.

Chart 4.



The percentage increase in the number of consumers ranged from a 3% increase for inpatient mental health services to a 77% increase for drug and alcohol services. The percentage change in claims paid varied from a 7% increase for inpatient mental health services to a 132% increase in claims paid for drug and alcohol services. Because the largest percentage increases in the number of consumers occurred in the services with small numbers of consumers (family-based services, drug and alcohol services, and RTF), the increases did not change the overall distribution of consumers using the various services (Chart 2). Similarly, because the largest percentage increases in total claims occurred in the least expensive services (medication checks, drug and alcohol services, and outpatient mental health services), the changes were not large enough to affect the overall distribution of claims spent on children's mental health services (Chart 3).

Assessing the significance of these changes is challenging. Over time, the anticipated results of managed care's authorization and coordination of care processes include increased access to treatment and increased coordination linking consumers to community-based services and support. Therefore, a reduction in the need for more restrictive levels of care is expected. Data presented here leads to several conclusions:

- The proportion of eligible members who used community-based services including BHRS, case management, family-based services, medication checks, and outpatient mental health services all increased from 2000 to 2003. So, access to community-based services has increased. Data from DPW suggests that Allegheny County is providing sufficient access for mental health services for children and adolescents.[9]

  While overall access to community-based services has increased, the increases did not occur uniformly across racial groups. Penetration rates for African-Americans have been lower than Caucasians throughout HealthChoices. For some services, the penetration rates increased more for African-Americans than Caucasians (BHRS, family-based services, partial hospitalization services); for some services, the reverse is true (penetration rates increased more for Caucasians than African-Americans for case management, medication checks and inpatient mental health services). Outreach activities to minority communities, including those funded through reinvestment, need continued support and focus to insure equitable access rates for minorities.

- Since 2000, the proportion of children and adolescents who used inpatient mental health services did not change; admission rates, after a small dip in 2001 and 2002, were the same during 2003 as during 2000 (11.59 admissions per 1,000 eligible members). Each year, about 15% to 18% of children and adolescents discharged from inpatient mental health services were readmitted within 30 days. At the same time, children stayed in the hospital on average for fewer days in 2003 (9.8 days) than in 2000 (10.8 days). These trends indicate that further attention on inpatient utilization and readmission rates is necessary.

- Since 2000, the proportion of children and adolescents who used RTFs increased from .70 to 1.01 admissions per 1,000 eligible members. According to DPW, Allegheny County's admission rates for RTF are reasonable. Furthermore, children stayed in RTFs for fewer days in 2003 (average of 175 days) than in 2000 (average of 265 days). This decreased length of stay suggests that this level of care is being used appropriately to address children's most emergent symptoms and then referrals are made to less restrictive levels of care.

- Fewer adolescents than adults are expected to require substance abuse treatment. However, evidence suggests that only 16% of adolescent consumers who need substance abuse treatment receive it.[10] Therefore, the 77% increase in the number of consumers receiving substance abuse services is an important trend which should be encouraged. Of adolescents who used substance abuse services:

  - Between 53% and 63% used outpatient drug and alcohol services each year
  - About 27% used non-hospital rehabilitation services each year
  - Between 25% and 33% used supplemental drug and alcohol services each year

[9] "HealthChoices Behavioral Health Baseline Performance Report," Commonwealth of Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (released May 2004).
[10] "HealthChoices Behavioral Health Baseline Performance Report," Commonwealth of Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (released May 2004). The report uses 2002 data. Rates for African-American youth accessing substance abuse services were even lower (10%).

What services are used to treat the most common diagnoses for children and adolescents?

Examining the overall patterns of how children and adolescents used services depending on their diagnoses contributes to an understanding of the growth in the utilization of different services shown in the previous section. The diagnosis information presented here is derived from the primary diagnosis field required on each claim that is submitted for payment.[11] Therefore, examining diagnoses from claims provides an indication of the primary reason, or diagnosis, that the consumer needed treatment at that point in time. Table 4 shows the service mix used by child and adolescent consumers in 2003.

Table 4.

Service Use Patterns for Children and Adolescents by Mental Health Diagnosis (using 2003 claims data)[12]

	ADHD	Adjust D/O	Bipolar D/O	CA Emot D/O	Conduct D/O	Depressive D/O	Maj Depr.	Neur. D/O	Psychosis Ch Orig
BHRS	20%	10%	20%	33%	28%	11%	10%	14%	80%
Case Mgmt	18%	8%	28%	14%	14%	15%	16%	14%	15%
Fam-Bas	4%	3%	10%	6%	7%	6%	7%	4%	1%
IP-MH	2%	3%	21%	0%	12%	26%	21%	1%	0%
Med Check[13]	44%	18%	34%	16%	18%	23%	24%	36%	14%
OP-MH	61%	80%	38%	46%	43%	50%	55%	60%	27%
PHP-MH	14%	3%	17%	10%	9%	9%	10%	9%	8%
RTF	1%	0%	7%	1%	4%	2%	3%	1%	1%
Other MH Svcs.	6%	5%	17%	9%	11%	16%	11%	6%	2%
D&A	0%	0%	1%	0%	0%	1%	0%	0%	0%
Total Cons.	3,056	3,109	618	1,469	1,009	1,382	1,146	891	1,006
Total Claims (millions)	$10.5	$5.3	$5.0	$5.6	$5.8	$6.2	$5.2	$2.1	$15.0
Ave. Cost per Cons.	$3,450	$1,698	$8,059	$3,821	$5,714	$4,468	$4,518	$2,379	$14,954

As expected, Table 4 shows that different diagnostic groups have different service utilization patterns:

- Children with ADHD, adjustment disorder, emotional disorders, and neurotic disorders used outpatient mental health services most often. Generally since 2000, growth in the number of consumers using services such as outpatient and medication checks, which are relatively inexpensive, has outpaced the growth in other services. Therefore, the average cost for consumers with these diagnoses has decreased since 2000 (in 2003, ranging from about $1,700 for adjustment disorder, to $3,800 for emotional disorders).

[11] Although accurately diagnosing children is challenging, and diagnoses may change and evolve often as children develop and their environments change, the frequency with which children receive different diagnoses on claims indicates that inconsistencies in the data exist. Furthermore, because only the primary diagnosis is captured on the claim, claims provide an incomplete diagnostic picture of consumers. Without completing reviews of clinical documentation to assess secondary diagnoses and severity of symptoms and resulting impairment, claims-based diagnosis information remains our primary source for completing claims analysis by diagnosis. In the aggregate, diagnoses from claims are a useful tool, but it is important to remember the shortcomings of the data.

[12] The percentages in Table 4 add up to more than 100% because many consumers use more than one service within a year. Because an individual may receive more than one diagnosis within a year, s/he may appear in more than one of the columns above.

[13] Medication checks are under-reported in this data. Consumers may have medication checks with their primary care physician; these claims are not paid for by the behavioral health side of HealthChoices. Also, some services (partial hospitalization, inpatient mental health) include medication checks in their services, so they are not billed separately.

- BHRS accounted for the largest percentage of the dollars spent to treat diagnoses of ADHD, adjustment disorder, emotional disorders, and neurotic disorders. Since 2000, the amount of BHRS each consumer used (especially therapeutic support staff (TSS) services) has decreased, even though more consumers in these groups are using these services. This hopefully is a result of prescribers more accurately prescribing TSS based on client need.
- A larger proportion of children and adolescents with bipolar disorder, conduct disorder, depressive disorder, and major depression used inpatient mental health and RTF services, more costly services. As a result, consumers with these diagnoses have higher average costs per year (in 2003, ranging from over $4,000 for major depression and depressive disorder, to $8,000 for bipolar disorder).
- Children with a diagnosis of psychosis of childhood origin used BHRS almost exclusively. Children with this diagnosis used nearly 50% of the total amount spent on BHRS in 2003, a significant increase from 32% in 2000. Total costs for children with these diagnoses have nearly doubled because of the increase in the number of consumers using BHRS. Each year, the average cost per consumer is nearly $15,000, as a high intensity of services is required to treat consumers with autism and related disorders.
- The overall patterns represented in Table 4 have been consistent from year to year. A few noteworthy changes (of 5% or more):
    - The percentage of consumers with bipolar disorder, conduct disorder, or depressive disorder using inpatient mental health services decreased from 2000 to 2003.
    - The percentages of consumers with bipolar disorder and neurotic disorders receiving medication checks increased 7% from 2000 to 2003.
    - The percentage of consumers with conduct disorder using BHRS increased 8%.
    - Eight percent fewer consumers with an emotional disorder used outpatient services in 2003 than in 2000.
    - The percentage of consumers with a diagnosis of psychosis of childhood origin using case management services increased 5% from 2000.
    - While the proportion of consumers with each diagnosis has remained largely the same year to year, some interesting changes in the quantity of different services used have occurred. Since 2000, the share of total claims paid for consumers for ADHD has decreased by 7% (15.9% of total claims in 2003, $10.5 million); the share paid for consumers with psychosis of childhood origin has increased by 6.5% (22.7% of total claims in 2003, $15.0 million). All other diagnoses account for less than 10% of claims, and fluctuated by less than 3% from 2000 through 2003.

In conclusion, the profile of child and adolescent consumers has remained largely stable since HealthChoices began. The demographics and diagnoses of consumers and service utilization have maintained the same pattern over time. Similar mixes of services have been used by diagnostic groups over time, and consumers with more intensive diagnoses appear to use a more intensive service mix.

The increases in penetration rates for community-based services and in the numbers of consumers using drug and alcohol services are positive trends. Additional outreach, increased engagement in services, and more assertive coordination of care (especially when consumers are discharged from inpatient levels of care) should be completed in order to make more progress in meeting the goals of HealthChoices.

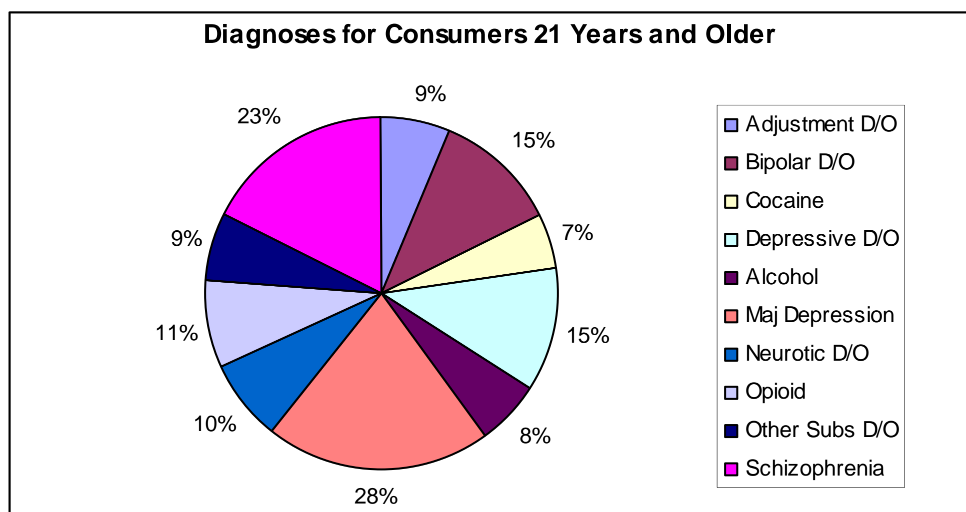
Profile of Adult Consumers

What are the characteristics of adult consumers?

In 2003, nearly 17,000 adults received behavioral health services, totaling $54.8 million in paid claims. These 2003 figures represent a 20% increase in the number of consumers and a 40% increase in claims from 2000. While the number of consumers has increased, the characteristics of adult consumers have remained stable over time. In each year since 2000, approximately:

- 60% of consumers are female, and 40% are male.
- 64% of consumers are Caucasian, 35% are African-American, and 2% are of another race.
- Each year, between 24% and 28% of consumers are new consumers, meaning they have not used behavioral health services under HealthChoices previously.
- The largest number of adults had diagnoses of major depression (27%), schizophrenia (23%), bipolar disorder (15%), and depressive disorders (15%). Chart 5 shows the diagnostic patterns of adult consumers. The percentages of consumers who receive each of these diagnoses have remained consistent from year to year.[14]
- According to their diagnostic histories,[15] about 40% of adult consumers have received both a mental health diagnosis and a substance use diagnosis during their coverage under HealthChoices. About 51% of adult consumers have mental health diagnostic histories only, and 6% have substance abuse/dependence diagnostic histories only.

Chart 5.



Note: The "Other Substance Disorder" diagnostic category includes primarily consumers with poly-substance abuse/dependence diagnoses.

[14] The percentages total more than 100% because different claims for the same individual may use different primary diagnoses. Only diagnoses received by more than 5% of consumers are graphed. About 10% of consumers received a mental health primary diagnosis not graphed, and about 4% of consumers received a drug and alcohol primary diagnosis not graphed.

[15] This data is derived from Community Care's care management database. Care managers enter information on consumers based on provider information; this information is not linked to paid claims. Based on the combination of diagnoses entered over time, consumers are categorized as having histories of mental illness diagnoses, substance abuse diagnoses, or both mental illness and substance abuse (MISA) diagnoses.

Which services do adult consumers use the most, and how much do these services cost? Have these patterns changed over time?

Charts 6 and 7 provide an overview of the total paid claims and number of consumers for the different behavioral health services in 2003.[16] A brief description of each service can be found in the glossary. While paid claims and the number of consumers have increased over time, the *share* or *proportion* of total claims paid and number of consumers for each of these services have remained stable since HealthChoices began, with the exception of Community Treatment Team (CTT) services:

- Since 2000, about 26% of adult consumers used a drug and alcohol treatment service, accounting for approximately 27% of paid claims; 90% of adult consumers used a mental health service, accounting for about 73% of claims.
- Each year, 18% of adult consumers used inpatient mental health services, and claims for inpatient mental health services have consistently accounted for about 36% to 41% of total paid claims.
- Each year, 32% of adults who used services used outpatient mental health services, and claims for outpatient mental health services have consistently accounted for about 8% of total paid claims.
- CTT services began in 2001. By 2003, about 1% of consumers who used services were on a CTT, and CTT services accounted for about 6% of claims.

Chart 6.

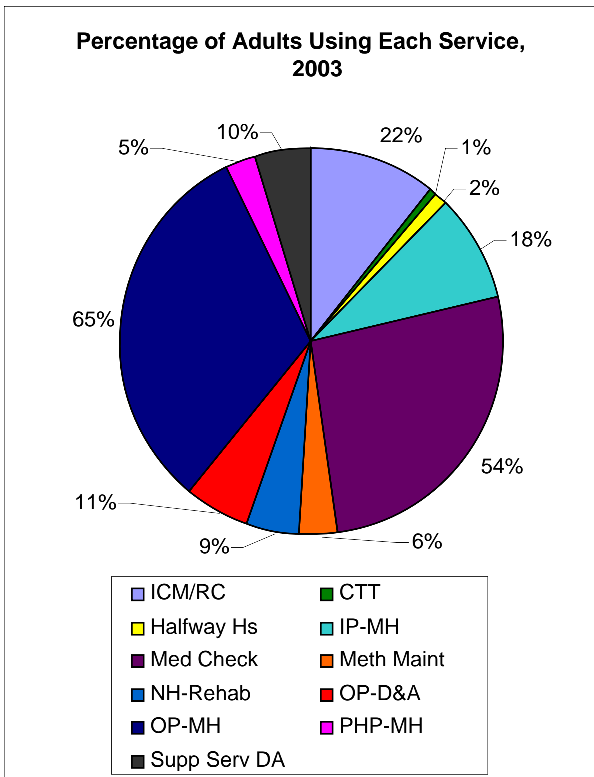
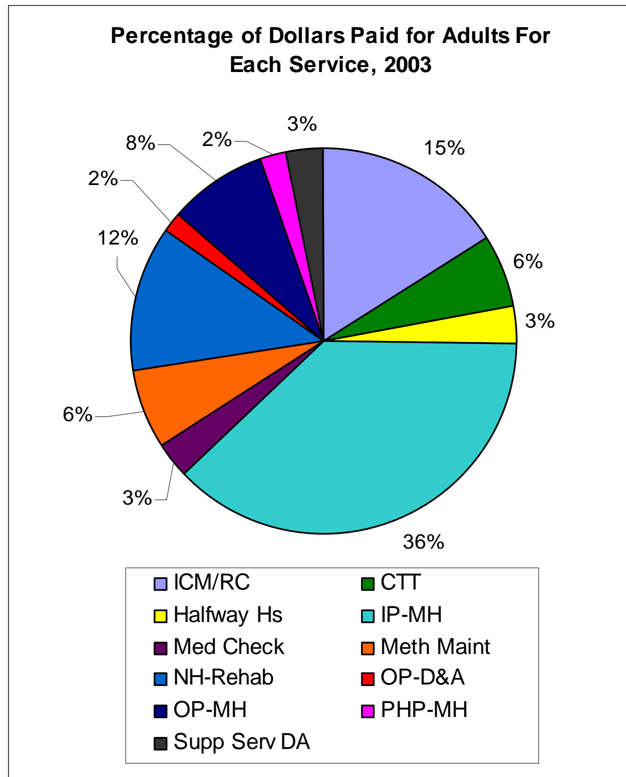


Chart 7.



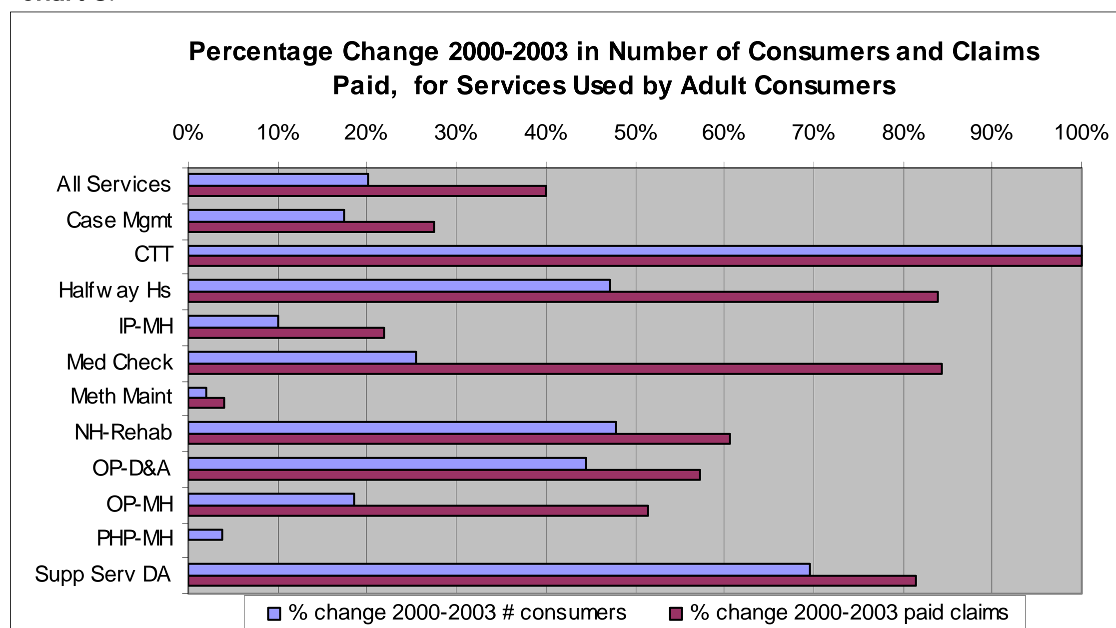
Key to abbreviations: Case Mgmt – case management services; CTT – community treatment team; Halfway Hs – halfway house; IP-MH – inpatient mental health services; Med Check – medication check; Meth Maint – methadone maintenance; NH-Rehab – non-hospital rehabilitation; OP-D&A – outpatient drug and alcohol; OP-MH – outpatient mental health; PHP-MH – partial hospitalization mental health; Supp Serv DA – supplemental drug and alcohol services

[16] Services were included if at least 10% of consumers used the service within a year, and/or the claims paid accounted for at least 3% of total claims paid within a year.

The pie charts also illustrate the relative cost per consumer for each service. Services that are represented with a larger piece of the consumer pie and a smaller piece of the claims pie are relatively inexpensive (medication checks, outpatient mental health, and outpatient drug and alcohol services); services represented with a smaller piece of the consumer pie and a larger piece of the claims pie are more expensive per consumer (CTT, inpatient mental health services, halfway house, non-hospital rehabilitation, and methadone maintenance services).

While the proportions shown in the pie charts have not changed over time, the growth in claims paid and number of consumers did not occur uniformly across all services. Chart 8 below shows how growth in number of consumers and paid claims for individual services compares to the overall 20% increase in number of consumers and 40% increase in total paid claims.

Chart 8.



The percentage change in number of consumers varied from a 2% increase for methadone maintenance to a 70% increase for supplemental drug and alcohol services. The percentage change in claims paid varied from a slight decrease for partial hospitalization services to an 84% increase for medication checks. CTT grew by 100% because the service was not provided until after HealthChoices began. Because the services with the largest rates of growth represent smaller pieces of the consumer and claims pies, the different growth rates did not affect the overall distribution of claims spent as shown in Chart 7 above.

Assessing the significance of these changes is challenging. Over time, the anticipated results of managed care's authorization and coordination processes include increased access to treatment and a shift in resources away from the traditional inpatient services toward community-based services. The data presented above leads to several conclusions:

- The increased proportion of members accessing case management services, CTT, medication checks, and outpatient mental health services is a positive change. Research has shown that consistent use of these services results in positive outcomes for consumers, including an increase in community tenure.

  While overall access to community-based services has increased, the increases did not occur uniformly across racial groups. Overall penetration rates for African-Americans have been lower

than Caucasians throughout HealthChoices. Outreach activities to minority communities, including those funded through reinvestment, need continued support and focus to insure equitable access rates for minorities.

- While utilization of inpatient mental health services did not grow as quickly as other services, it is still higher than expected. Rather than decreasing over time, the admission rate increased from 43.06 consumers per 1,000 members in 2000 to 45.73 consumers per 1,000 members in 2003. The average length of stay has not fluctuated (9.1 days in 2000 and 2003).

  Multiple factors certainly contribute to these higher than expected inpatient utilization rates. Allegheny County's relatively high readmission rate (about 20% of adults discharged from inpatient mental health services are readmitted within 30 days) has received particular attention.[17] In response, Community Care has made significant efforts in connecting consumers with follow-up services within a week of their discharge. To date, these interventions have not affected admission and readmission rates. As the CTTs develop, it is expected that they will contribute to reducing admission and readmission rates. Additional action should be completed to decrease use of, rather than just slow the growth of, inpatient services. For example, further development and utilization of crisis services should be pursued.

- With the exception of methadone maintenance services, the percentage increase in the other drug and alcohol treatment services graphed in Chart 8 was relatively high. Generally, claims for these services increased because more consumers used these services, as opposed to the same number of consumers using increasing quantities of the services. The proportions of Caucasains

  For example, the admission rate for non-hospital rehabilitation services increased from 10.84 consumers per 1,000 members in 2000 to 16.23 consumers per 1,000 members in 2003. At the same time, average length of stay decreased from 27 days in 2000 to 20.8 days in 2003.

What services are used to treat the most common diagnoses for adults?

The diagnostic histories of consumers are logically associated with the services they use. Table 5 shows the number of consumers in each diagnostic category, the costs of services provided, and the average cost per consumer in 2003. The percentage of total claims paid for mental health services and drug and alcohol services are also included. Diagnostic information from Community Care's clinical care management database is examined for each consumer to determine if they have a history of mental health diagnoses, substance abuse diagnoses, or co-occurring mental health and substance use diagnoses.[18]

Table 5.

Number of Consumers, Claims Paid, and Average Cost per Consumer by Diagnostic History, 2003

	Mental Illness Diagnosis	Substance Use Disorder Diagnosis	Both Mental Illness and Substance Abuse (MISA) Diagnoses
Number of Consumers	8,533	1,059	6,749
Ave. Cost per Consumer	$1919	$2522	$5274
Total Paid Claims	$16.4 million	$2.7 million	$35.6 million
% of Total Paid Claims Used for MH Services	99.7%	3.7%	66.3%
% of Total Paid Claims Used for D&A Services	0.3%	96.3%	33.7%

[17] In early 2004, DPW set a 10% readmission rate as the gold standard as part of the performance-based contracting initiative.
[18] Diagnosis data for a very small percentage of consumers (.4% in 2003) is incomplete. Those consumers are excluded from Table 5.

As with the overall utilization patterns, the proportions of consumers and claims for each diagnostic category have been stable year to year. On the whole, treating consumers who have histories of both mental illness and substance abuse requires more resources than treating consumers with a mental health or substance abuse diagnosis alone. About 66% of claims paid for consumers with a MISA history are for mental health services, and 34% for substance abuse services. For consumers with a mental illness or substance abuse diagnostic history only, nearly all claims are paid for mental health services or substance abuse services respectively.

Examining the diagnoses submitted on claims provides an indication of the primary reason, or diagnosis, that the consumer needed treatment at that point in time. By matching the primary diagnosis with the service on the claim, it is possible to examine patterns of service utilization by diagnosis. Table 6 shows the service mix used by adult consumers in 2003 with the six most frequently used mental health diagnoses. Table 7 provides similar data for adult consumers with the most frequently used substance abuse diagnoses in 2003.[19] Because consumers often use more than one service within a year, the percentages total more than 100%. Consumers can also receive more than one diagnosis on their claims within the year, so the same consumer may be represented in multiple diagnostic groups in both Tables 6 and 7.

Table 6.

Service Use Patterns for Adults by Mental Health Diagnosis (using 2003 claims data)

	Adjustment Disorder	Bipolar Disorder	Depressive Disorder	Major Depression	Neurotic Disorder	Schizophrenia
Case Mgmt	9%	26%	14%	18%	9%	45%
CTT	1%	2%	1%	1%	0%	3%
IP-MH	13%	24%	30%	18%	4%	21%
Med Check	27%	51%	30%	51%	56%	72%
OP-MH	70%	58%	58%	67%	71%	63%
PHP-MH	2%	7%	4%	5%	2%	8%
Other MH Svcs.	11%	19%	14%	12%	10%	21%
D&A Svcs.	1%	2%	4%	2%	1%	1%
Total Cons.	1,451	2,568	2,579	4,639	1,673	3,946
Total Claims (millions)	$1.24	$6.13	$4.97	$7.87	$1.23	$15.44
Average Cost per Cons.	$856	$2,387	$1,926	$1,697	$732	$3,914

Consumers within each of the diagnostic groups shown above, for the most part, have a used similar mix of services since HealthChoices began. A higher percentage of consumers with more severe diagnoses (e.g. bipolar disorder and schizophrenia) use a more intensive mix of services. Proportionally more consumers with depressive disorder diagnoses use inpatient mental health services. Therefore, consumers with these three diagnoses had the highest average cost. A few changes to note from 2000:

- The proportion of claims paid for inpatient mental health services for consumers with an adjustment disorder or neurotic disorder diagnosis has decreased since 2000.
- For consumers with a diagnosis of bipolar disorder, depressive disorder, major depression or schizophrenia, the new utilization of CTT services reduced the proportion of claims paid for inpatient mental health services.

[19] As in Chart 5, only diagnoses received by more than 5% of consumers in a year are included for analysis.

As with the mental health diagnoses, consumers within each of the substance abuse diagnostic groups have used a similar mix of services over time. See Table 7.

Table 7.

Service Use Patterns for Adults, by Drug and Alcohol Diagnosis (using 2003 claims data)

	Alcohol	Cocaine	Opioid	Other Subs D/O
Halfway Hs	5%	8%	6%	8%
Meth Maint	0%	0%	60%	0%
NH-Rehab	24%	30%	16%	44%
OP-D&A	43%	41%	15%	33%
Supp Serv DA	32%	47%	11%	30%
All Other D&A Svcs.	12%	2%	19%	22%
Mental Health Svcs.	48%	37%	22%	33%
Total Cons.	1,334	1,110	1,818	1,472
Total Claims	2,249,657	2,777,765	5,521,552	3,482,426
Average Cost per Cons.	$1,686	$2,502	$3,037	$2,366

Note: The majority of consumers with an "other" substance use disorder have a poly-substance use disorder.

For those with alcohol, cocaine, or "other" substance use disorders, non-hospital rehabilitation, outpatient drug and alcohol services, and supplemental drug and alcohol services were used by the largest proportion of consumers. For those with an opioid disorder, methadone maintenance is the most commonly used service, used by 60% of consumers.

Consumers often receive drug and alcohol counseling through their mental health services. As shown above, a large percentage of consumers with substance use disorders used mental health services. The proportions using mental health services ranged from 22% of consumers with an opioid disorder to 48% of consumers with an alcohol use disorder. These consumers predominantly used outpatient mental health services and medication checks.

In conclusion, the profile of adult consumers has remained largely stable since HealthChoices began. The demographics and diagnoses of consumers and service utilization have maintained the same pattern over time. Similar mixes of services have been used by diagnostic groups over time, and consumers with more intensive diagnoses appear to use a more intensive service mix.

The increases in penetration rates for community-based services and in the numbers of consumers using drug and alcohol services are positive trends. Additional outreach, increased engagement in services, innovative programming, and more assertive coordination of care (especially when consumers are discharged from inpatient levels of care) should be completed in order to make more progress in meeting the goals of HealthChoices.

What's next for HealthChoices in Allegheny County?

The data presented in this report clearly shows that progress has been made in reaching the goals of HealthChoices. More child/adolescent and adult consumers accessed services as the HealthChoices program developed. Growth rates for community-based services generally outpaced the growth rates for inpatient services. The overall stability of *who* received services (meaning by age, race, gender and diagnosis) suggests that management of the program has been consistent over time.

However, when examining the overall patterns of service utilization, the HealthChoices program has not evolved significantly since it began. Finite Medical Assistance resources still disproportionately fund inpatient mental health services. As the system increasingly emphasizes recovery and resiliency as goals for its members, additional transfers of resources from inpatient services to community-based services must occur. Several current developments should have an impact, including a renewed emphasis on housing and support services, performance standard measurement, improvement plans associated with DPW's performance-based contracting initiative, a new HealthChoices contract, and a targeted examination of inpatient utilization and readmission rates.

1. Allegheny County recognizes the importance of permanent, affordable housing. As part of its focus on a recovery-oriented system of care, consumer choice, and the benefits of housing stability for consumers, Allegheny County is developing a comprehensive housing plan to address the affordable housing needs of consumers. This is a collaborative effort that will use a variety of funding sources to define and develop the various types of housing and supports that will meet consumers' discreet needs.
2. In collaboration with the County, AHCI, providers, consumers and family members, Community Care has developed performance standards for different levels of care. Community Care has developed alternative reimbursement plans for two services (intensive case management and BHRS prescribers) to reward providers who score well on performance standard measures. Developing additional reimbursement plans for other levels of care to insure quality services and coordination of care should be pursued.
3. The Department of Public Welfare has instituted performance-based contracting. This initiative includes publishing performance reports for all 25 HealthChoices counties. Counties will be developing performance improvement plans to target specific indicators where performance is below the standard. As part of this process, Allegheny County will be focusing on the high rates of readmission to inpatient mental health services as a means to reduce overall inpatient mental health utilization.
4. Community Care, the County and AHCI have negotiated a new contract covering 2004-2006. As part of the contract, new performance standards have been established to provide incentives for changing utilization patterns.
5. In addition, Community Care has established a workgroup composed of providers, the County, and other stakeholders to study and develop interventions to address high readmission rates.

Furthermore, additional outreach to increase engagement in services, further development of crisis services, CTTs, and other community-based services, and more assertive coordination of care should be pursued in order to meet the goals of HealthChoices. As the HealthChoices program continues to evolve, these developments will be necessary to create a recovery-focused, cost-effective system of care.

Glossary of terms

Behavioral health rehabilitation services (BHRS): Treatment and therapeutic interventions prescribed by a psychologist or psychiatrist provided on an individual basis in the person's own environment such as the home, school and community. These services include Therapeutic Support Staff (TSS), Behavioral Specialist Consultants (BSC), Mobile Therapy (MT) and specialized services, as approved. *

Capitation: The method of payment in which the health care provider is paid a fixed amount for each person enrolled no matter if the person actually receives services.

Case management services: Services provided to assist children, adolescents and adults with serious mental illness or emotional disturbance to obtain treatment and supports necessary to maintain a healthy and stable life in the community. Caseload sizes are limited to ensure adequate attention to the person's needs as they change. Emphasis is given to housing, food, treatment services, use of time, employment and education. Intensive case management services are available 24 hours a day, 7 days per week.*

Category of aid: Individuals are eligible for HealthChoices because they qualify for assistance through one of seven different categories of aid. The categories are:

- Temporary Assistance to Needy Families (**TANF**) – assistance to families with dependent children who are deprived of the care or support of one or both parents.
- Healthy Beginnings (**HB**) – assistance for women during pregnancy and the postpartum period, and their children.
- Social Security Income with Medicare (**SSIM**) – assistance for people who are aged, blind or determined disabled for over two years.
- Social Security Income without Medicare (**SSI**) – assistance for people who are aged, blind, or determined disabled for less than two years.
- State Only General Assistance – state funded program for individuals and families whose income and resources are below established standards and who do not qualify for the TANF program. This includes the Categorically Needy (**CATN**) and Medically Need Only (**MEDN**) groups.
- Federally Assisted Medical Assistance for General Assistance Recipients (**FGA**) – federal and state funded program for individuals and families whose income and resources are below established standards and who do not qualify for the TANF program.

Community treatment team (CTT): A CTT functions as the primary provider of services for people with serious and persistent mental illnesses. CTTs provide highly individualized services directly to consumers who are living in the community; services include case management, medication management (prescriptions, administration, monitoring and documentation), counseling, housing support, substance abuse treatment, employment counseling. These services are provided by team members who are on-call 24 hours a day, seven days a week, and 365 days a year.

Consumer: An individual enrolled in HealthChoices who used behavioral health services.

Family-based services: Evaluation and treatment services provided to a specific child in a family, but focuses on strengthening the whole family system to increase their ability to successfully manage their child's behavioral and emotional issues. Services are provided by licensed agencies employing a mental health professional and a mental health worker as a team to provide treatment and case management interventions. Services are provided in the home of the family.*

Halfway House: A residential program to assist people in their recovery from drug and alcohol addictions. Halfway Houses are transitional programs to support people in their re-integration in the community.

---

* Service descriptions are quoted from The Office of Mental Health and Substance Abuse Services (OMHSAS), available at http://www.dpw.state.pa.us/omhsas/omhchoices.asp.

Inpatient mental health services: Evaluation and treatment services provided in a licensed psychiatric unit of a community hospital or a community psychiatric hospital that is not part of a medical hospital. Services are provided to persons with acute illness where safety for self or others is an issue. Services are provided by psychiatrists, nurses and social services staff. Persons may be involuntarily committed for evaluation and treatment.*

Medication check: A service provided for consumers taking medication to treat their mental illnesses or substance abuse disorders. Medication levels are checked, side effects discussed, and adjustments to prescriptions are made as necessary.

Member: An individual enrolled in HealthChoices.

Methadone maintenance: Medication used to achieve stabilization or prevent withdrawal symptoms. Slow withdrawal or outpatient detoxification of the person from the maintenance medication is part of this treatment process.*

Non-hospital rehabilitation services: Treatment services provided in a licensed community residential program where a full range of treatment and supportive services are provided for the addicted person in acute distress. Interventions include social, psychological and medical services to assist the person whose addiction symptomatology is demonstrated by moderate impairment of social, occupational, and/or school functioning. Rehabilitation is a treatment goal.*

Outpatient drug and alcohol services (OP-D&A): Evaluation and treatment services provided at a licensed facility to persons who can benefit from psychotherapy and substance use/abuse education. Services are provided in regularly scheduled treatment sessions for a maximum of 5 hours per week by qualified D&A treatment staff.*

Outpatient mental health services (OP-MH): Evaluation and treatment services provided to persons who may benefit from periodic visits that may include psychiatric and psychological evaluation, medication management, individual or group therapy. Services are provided by licensed facilities under the supervision of a psychiatrist or by private credentialed practitioners.*

Partial hospitalization mental health program (PHP-MH): Treatment services provided from 3 to 6 hours per day up to 5 days per week in a licensed facility. Evaluation, treatment and medication are provided under the supervision of a psychiatrist for persons who need more intensive treatment than psychiatric outpatient. Services are provided for a short duration of time for persons acutely ill and for longer periods for persons experiencing long-term serious mental illness. Services are typically provided in a therapeutic group setting.*

Penetration rate: Penetration rates are calculated by dividing the number of consumers who *use* behavioral health services by the average number of members *eligible to use* services. Penetration rates increase when a larger proportion of eligible members access services. If the number of consumers increases proportionally with an increase in enrollment, the penetration rate will not change.

Residential treatment facility (RTF): Comprehensive mental health treatment services for children with severe disturbances or mental illness. These services are provided in Residential Treatment Facilities (RTF's) which must be licensed by OCY&F under Chapter 3800. The facility must have a service description approved by OMHSAS, be certified by OMHSAS through annual on-site review, have a utilization review plan in effect and be enrolled in the MA program.*

Supplemental drug and alcohol services (Supp Serv DA): This category of services includes drug and alcohol treatment programs that are paid for by Community Care but are not required or covered services under HealthChoices.