Allegheny County

HealthChoices Program

Medicaid Benchmarking: A Comparative Report

presented by

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

Executive Summary

In June 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a draft report titled "Medicaid Managed Behavioral Health Care Benchmarking Project." This report detailed a study funded by SAMHSA and conducted by Dougherty Management Associates, Inc., under the auspices of The Lewin Group. The purpose of the study was to systematically review and compare data submitted by multiple Medicaid behavioral health programs, identify ways to improve the quality and consistency of data, and determine trends in the ways managed care program performance is measured.

The study included information from telephone interviews and data submissions from 17 states, five counties, and the District of Columbia, all of which have a Medicaid managed care program that includes behavioral health services. The SAMHSA study looked at performance measures based on the Health Employer Data and Information Set (HEDIS) specifications. HEDIS is a highly organized data collection system used by many programs for mandated state reporting. Each HEDIS measure is clearly defined in terms of the diagnostic codes, procedure codes, the content of the numerator and denominator, and the measurement period.

The release of the SAMHSA study draft report provided Allegheny HealthChoices, Inc. (AHCI) with a new way of analyzing Allegheny County's HealthChoices program's performance to standard managed care industry measures. As such, AHCI developed a report that looks at how the Allegheny HealthChoices program compares to data reported by other Medicaid behavioral health programs.

AHCI felt that this comparison would offer the opportunity to explore similarities and differences between Allegheny HealthChoices and other Medicaid managed care programs, as well as determine possible reasons for any differences. Additionally, the hope is that this comparison will help to foster discussion about setting benchmarks or goals for performance in behavioral health systems of care.

As the SAMHSA study acknowledges, however, this type of comparison is not without inherent challenges. The most notable challenge is the fact that most of the standard measures have been adjusted to meet individual program preferences. This includes differences in the methods used to calculate compliance with the performance measures.

Despite the challenges, however, AHCI was able to compare the Allegheny HealthChoices program's performance on a variety of measures to other programs that serve Medicaid eligible individuals through the administration of behavioral health services. The following represents some of the findings:

Of the 20 measures considered, the Allegheny HealthChoices program performed at the mean (average) for the following measures:

- Behavioral health penetration[1];
- Mental health penetration by age (children);
- Inpatient mental health penetration by age (children); and
- Inpatient mental health average length of stay.

The HealthChoices program fell above the average for the following measures:

- Mental health penetration;
- Mental health penetration by age (adults);
- Outpatient mental health penetration;
- Inpatient mental health penetration;
- Inpatient mental health penetration by age (adults);
- Inpatient mental health readmissions within 30 days of discharge;
- Inpatient mental health readmissions by age (children and adults):
- Mental health average cost per consumer;
- Inpatient mental health average cost per consumer;
- Inpatient substance abuse penetration; and
- Inpatient substance abuse discharges per 1,000 members.

The HealthChoices program fell below the average for the following measures:

- Inpatient mental health discharges per 1,000 members;
- Follow up within seven days of an inpatient mental health discharge;
- Substance abuse penetration;
- Inpatient substance abuse average length of stay; and
- Inpatient and non-hospital readmissions within 30 days of discharge.

It is important to note that falling above the mean is not always a positive outcome (i.e., inpatient mental health readmissions within 30 days of discharge) and falling below the mean is not always a negative outcome (i.e., inpatient and non-hospital readmissions within 30 days of discharge). The HealthChoices program's performance needs to be assessed for each measure in the context of the measure's definition, methodology, and the number of other programs with available data for each measure's comparison. As noted previously, the composition of programs' eligible populations and the services included for various measures also affect the outcome.

Despite some of the limitations of this comparison, AHCI found this analysis helpful in confirming areas previously identified as strengths and those with opportunities for improvement. Likewise, it provides a unique and broader perspective on program performance.

[1] Refer to the definition on page seven.

Introduction

Allegheny HealthChoices, Inc. (AHCI) provides stakeholders with information and analysis pertaining to the Allegheny HealthChoices program in the form of quarterly and year end reports. These reports include information on enrollment and utilization of services by level of care. The reports focus on changes and trends over time. Another important perspective to consider is how the Allegheny HealthChoices program compares to data reported by other Medicaid behavioral health programs. The purpose of this report is to compare the performance of the Allegheny HealthChoices behavioral health program to other programs that serve Medicaid members through non-State operated managed care programs on a variety of industry-standard measures.

The comparative information contained in this report was extracted from a 2002 draft report of a study sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).[2] This study was conducted by Dougherty Management Associates, Inc. with the goals of: systematically reviewing and comparing data submitted by multiple Medicaid behavioral health programs, identifying ways to improve the quality and consistency of data, and determining trends in the ways managed care program performance is measured.

The SAMHSA study collected data from the programs through telephone interviews and data submissions on performance measures. For the purpose of this report, comparisons are made using the data submitted to the SAMHSA study and not from the interviews, as this allowed for a quantitative analysis. Additionally, AHCI chose to look at certain measures whose data collection methods most closely matched Allegheny HealthChoices data collection measures. These include:

- Penetration rate for mental health and substance abuse services (overall and by age);
- Utilization of inpatient mental health services (penetration, discharges per thousand, average length of stay, 30-day readmission rates, and follow-up outpatient care after discharge); and
- Utilization of inpatient substance abuse services (penetration, discharges per thousand, and average length of stay).

Other measures, such as day and night utilization of certain levels of care and measures of treatment processes were not used since they do not represent measures for which Allegheny HealthChoices data was available.

The SAMHSA study looked at data from various program models, including: carve-ins (where Medicaid managed care vendors administer both medical and behavioral health services), Medicaid only carve-outs (where managed care vendors administer only the behavioral health services), and blended carve-outs that serve Medicaid and non-

[2] Medicaid Managed Behavioral Health Care Benchmarking Project, June 2002

Medicaid eligibles (where managed care vendors that administer behavioral health services to Medicaid and non-Medicaid eligibles). Collectively, the behavioral health managed care programs in the SAMHSA study represent a variety of characteristics and were selected to participate because they provide a comprehensive cross section for comparison.

This report uses the Medicaid only carve-out and carve-in programs in the SAMHSA study for comparison to the HealthChoices program. AHCI focused on these instead of the blended programs as they more closely match the model of the HealthChoices program. These programs, however, also have unique characteristics that need to be considered when making comparisons. The following is a description of programs from the SAMHSA study that were compared to the HealthChoices behavioral health program.

Medicaid only carve-out programs used for comparison:

- Colorado: a variety of community mental health centers, managed care carve-out programs, and HMOs (utilizing an Administrative Service Organization) that provide mental health services to 288,466 members.
- Florida: a managed care, prepaid, carve-out mental health program that partners with community mental health centers. Of the 57,404 members, 32% were eligible for SSI. The "other" category of aid represents 25% of the total eligible population who were included on the basis of meeting criteria for an expansion program for children.
- Utah: a prepaid, carve-out mental health program that has an arrangement with nine community mental health centers, enrolling 185,122 people.

Medicaid only carve-in programs used for comparison:

- District of Columbia: a program exclusively for Supplemental Security Income (SSI) eligible children and adolescents. It is a Medicaid only carve-in program that enrolls 2,651 children/adolescents.
- Massachusetts: four risk-sharing managed care Health Maintenance Organization (HMOs) programs with a total membership of 192,243 people and a median of 82.5% TANF eligible members. Each of the carve-in programs has an expansion program that focuses on unemployed adults.
- New Hampshire: three managed care carve-in HMO programs with a total membership of 5,812 people.
- New Mexico: three managed care carve-in HMO programs representing 205,387 eligible members and a median TANF eligible population of 81%.
- Oregon: carve-in HMO program providing substance abuse treatment to 323,936 eligible members, the majority (53%) of whom represents categories of aid other than TANF and SSI. Oregon also reported data of carve-out programs for mental health services for a membership of 447,467 people. The mental health program enrolls a smaller percent of children (44%) as compared to the median value of

the other reporting programs (74%). A Children's Health Initiative Program (CHIP) expansion program targets the 83% TANF-eligible population.

- Rhode Island: a carve-in HMO program available to 137,767 members for mental health and substance abuse services. This excludes people eligible for TANF that have a serious emotional disorder or serious mental illness.

By comparison, the Allegheny HealthChoices behavioral health program is a Medicaid only carve-out program that represents over 120,000 Medicaid-eligible people in Allegheny County at any given time. The two highest categories of aid representing the total eligible population are TANF (46%) and SSI (18%). When considering the category of aid by age group, the percentage of TANF for children/adolescents increases to 59% and adults who are SSI eligible represent 26% of eligible adults.

The SAMHSA study found that despite the wealth of data available, there were challenges in making comparisons due to the fact that most of the standard measures have been adjusted to meet individual program preferences. This includes differences in the methods used to calculate compliance with performance measures. The following is a list of some of the other challenges identified when comparing program data:

- Due to the differences in the level of care and the focus on expansion populations, some programs submitted data for specific measures and did not collect/submit data for other measures;
- Expansion population projects also impacted the standardization of data collection, in that some levels of care included in the data specifications were not included in the data reported;
- It was difficult to ascertain the specific service and/or population included/excluded if the programs submitted measures by exception. Examples include: omission of people with serious mental illness, inclusion of respite or non-hospital rehabilitation for target populations. The impact of these inclusions/exclusions made it challenging to evaluate data in terms of the number of people served and the cost of the service;
- Some programs define children/adolescents as 0-20 years and other programs include people 21 years old. The District of Columbia is a program exclusively for children and adolescents through 22 years old; and
- Data was compared in terms of age; however, other demographic factors, such as race, were not considered in the analysis.

Despite these challenges, the comparison of various programs provides some much-needed perspective regarding performance. It also offers the Allegheny HealthChoices program the opportunity to explore areas of difference and reasons for those differences, whether they are due to relevant programmatic distinctions or other issues. Additionally, these comparisons help to foster discussion about setting benchmarks or goals for performance in behavioral health systems of care.

Defining the Data

Study Period

The data represents activity within a 24-month period. Some programs in the SAMHSA study submitted data for the fiscal year beginning July 1, 1999 to June 30, 2000. Others submitted data for the calendar year (CY) 2000, and still others for the fiscal year beginning July 1, 2000 to June 30, 2001. Data from the Allegheny HealthChoices program and the National Committee for Quality Assurance (NCQA) Quality Compass Project, which is used as a benchmark for all programs, was based on the CY 2000.

Methodology

As a rule, the programs in the SAMHSA study submitted data based on the Health Employer Data and Information Set (HEDIS) specifications. HEDIS is a highly organized data collection system used by many programs for mandated state reporting. Each HEDIS measure is clearly defined in terms of the diagnostic codes, procedure codes, the content of the numerator and denominator, and the measurement period. The Allegheny HealthChoices program data is a compilation of claims and authorization data, using the specifications from the HEDIS measures.

The body of the report contains actual data as submitted by the Medicaid only carve-in and carve-out programs in the SAMHSA study and Allegheny HealthChoices data. Unless otherwise specified, the graphic data represents adult and child/adolescent activity. Each bar of the graph represents the measure for a given program. The mean value of the programs submitting data, including Allegheny HealthChoices data, is illustrated as a line graph to help the reader quickly determine how each program's value compares to other programs. In addition, the NCQA mean is provided when available. The NCQA mean is a result of the Quality Compass 2000 Project, which is a collection of commercial and Medicaid data; however, only the mean of the Medicaid data is used in this report.

The following pages illustrate comparisons for various indicators among the programs that submitted data for the SAMHSA study and Allegheny HealthChoices data. The operational definitions are derived from the SAMHSA study, HEDIS specifications, and other information on industry standards. The rationale for each measure as well as observations are also provided to help the reader understand why and how each measure was derived.

Behavioral Health Penetration

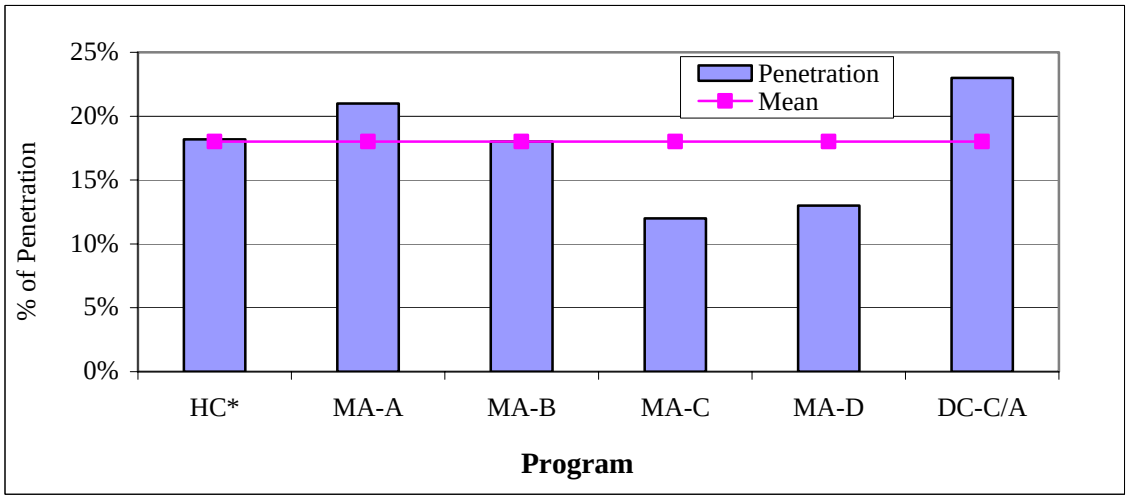
Operational Definition: The percent of people in the Medicaid-eligible population who received publicly funded mental health and/or a substance abuse service during the study period.

Rationale for Use: Penetration provides information about the measure on the number of people who utilized a behavioral health service relative to the total Medicaid eligible population. The overall penetration provides information on the responsiveness of the system to the Medicaid population and allows comparison with other state programs.

Operational Measure: Penetration is determined by dividing the number of people who used at least one unit of any behavioral health service during the study period by the total eligible population. The findings for this measure are illustrated in Chart 1.0.

Chart 1.0

Overall Behavioral Health Penetration



Key:
****** *Indicates carve-out programs. All others are carve-in programs*
HC: HealthChoices *MA-A: Massachusetts HMO-A*
MA-B: Massachusetts HMO-B *MA-C: Massachusetts HMO-C*
MA-D: Massachusetts HMO-D *DC-C/A: District of Columbia child/adolescent program*

Observation: The percent of penetration is the largest for the child/adolescent only (DC-C/A) program. Allegheny HealthChoices penetration is equal to the mean and median at 18% and is within the range of the Massachusetts's HMO Programs.

Data Notes:

- The District of Columbia and Allegheny HealthChoices programs represent data for the calendar year 2000. The Massachusetts programs submitted 2000-2001 fiscal year data.
- Florida and the Allegheny HealthChoices program used an average monthly enrollment. Other programs used a total enrollment in the calculation.

Mental Health Penetration and Utilization

A. Overall Mental Health Penetration

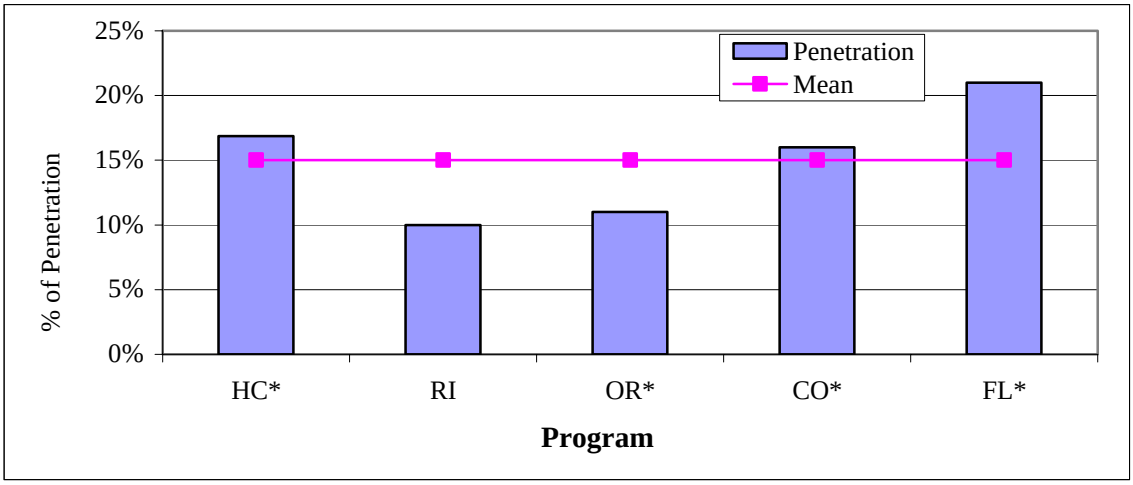
Operational Definition: The percent of people who were Medicaid eligible and accessed a mental health service during the study period.

Rationale for Use: This measure provides information on the number of Medicaid eligible people who received one or more mental health services relative to the Medicaid eligible population.

Operational Measure: Mental health penetration is calculated by dividing the number of people who accessed mental health services during the study period by the total eligible population. Chart 1.1 illustrates the findings.

Chart 1.1

Mental Health Penetration



Key:

****** *Indicates carve-out programs. All others are carve-in programs*

HC: HealthChoices *RI: Rhode Island* *OR: Oregon*

CO: Colorado *FL: Florida*

Observation: Programs such as Florida, with a large SSI eligible population (32%), as a percent of the total eligible population, are expected to have a higher penetration than programs such as Oregon, with 17% SSI eligible population. The category of aid case mix varies considerably by program. The Allegheny HealthChoices program includes 18% SSI eligible members and 46% TANF eligible members.

In addition, Florida provides several mental health services that are not considered in-plan services for the HealthChoices program (see examples below in the Data Notes). The Allegheny HealthChoices program reported data (18%) within the range of the other programs and was between the program mean (15%) and median value of 16%. The NCQA mean was 5.6%.

Data Notes:

- Allegheny HealthChoices data represents the calendar year 2000. Oregon's data was from the fiscal year 1999-2000. All other programs submitted 2000-2001 fiscal year data.
- Florida's program provides services in addition to in-plan Medicaid mental health services such as: crisis stabilization, drop-in centers, respite care, preventive services, partial hospitalization, supported employment, and supported housing.
- Florida and the Allegheny HealthChoices program used an average monthly enrollment. Other programs used a total enrollment in the calculation.

B. Mental Health Penetration by Age

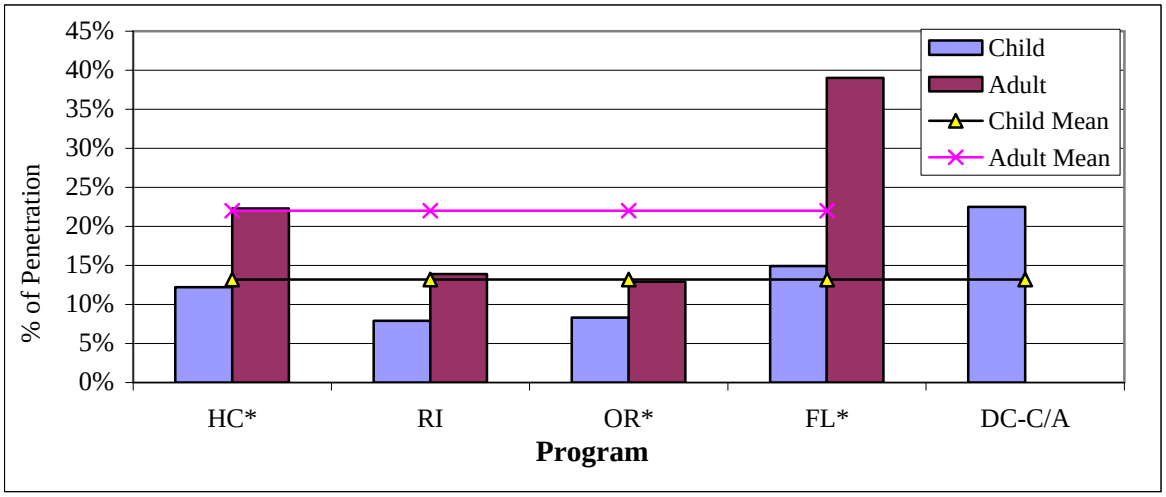
Operational Definition: The percent of children/adolescents (0-20 or 0-21 years old depending on the program) and adults (21 or 22 years and older depending on the program), who accessed mental health services during the study period.

Rationale for Use: This measure provides a comparison of the proportion of Medicaid eligible members by age group being served for each program.

Operational Measure: The numerator represents the number of children/adolescents or adults who accessed treatment during the study period and the denominator is the number of eligible children/adolescents or adults. Chart 1.2 illustrates the mental health penetration by age group.

Chart 1.2

Mental Health Penetration by Age Group



Key:
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Observation: As seen with the overall mental health penetration, the program with the largest SSI eligible population reported the largest penetration of adult mental health services. The District of Columbia's program is exclusive to children/adolescents and would be expected to exceed the penetration of the other programs reporting. Florida's program includes an expansion program for children and additional mental health services, explaining their higher than average penetration. Oregon's program had a higher percent of eligible adults as compared to the age mix of other programs.

Allegheny HealthChoices data by age group is consistent with AHCI quarterly reports in terms of the proportion of eligible members by age group to members who use services. The mental health penetration for the Allegheny HealthChoices program (12.2% child/adolescent and 22.3% adult) was within the range of other programs and was near the child/adolescent mean value of 13.2% and the adult mean of 22.0%. The child/adolescent median value was 12.2% and the adult median was 18.1%.

Data Notes:

- The District of Columbia and Allegheny HealthChoices submitted data for the calendar year 2000. Oregon's data represents the fiscal year 1999-2000. All other program's data represents the 2000-2001 fiscal year.
- The District of Columbia submitted data for children/adolescents through 22 years old and does not have an adult program. Data submitted for Florida's children/adolescents includes people 0-21 years olds and adult members 22+ years. All other programs submitted data for children/adolescents 0-20 years old and adults 21+ years.
- The District of Columbia represents all behavioral health services, not only mental health services as reported by the other programs.

- Florida's program provides services in addition to in-plan Medicaid mental health services such as: crisis stabilization, drop-in centers, respite care, preventive services, partial hospitalization, supported employment, and supported housing.
- Florida and the Allegheny HealthChoices program used an average monthly enrollment. Other programs used a total enrollment in the calculation.

C. Outpatient Mental Health Penetration

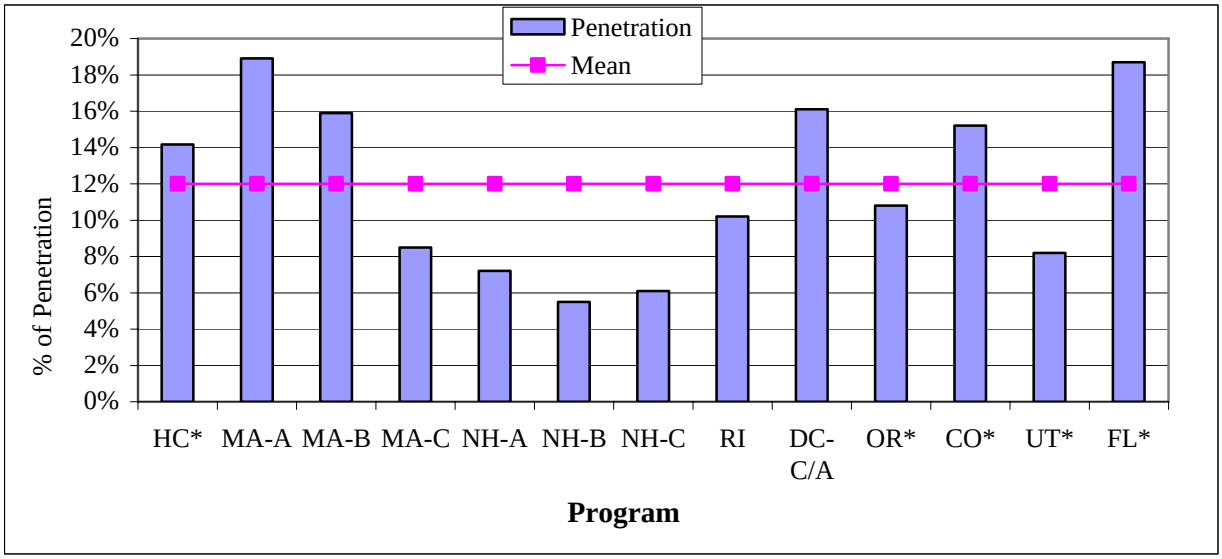
Operational Definition: The percent of people who accessed outpatient mental health services during the study period. Programs reported on the following outpatient services for this measure: individual, family, and group therapy; medication management; and case management.

Rationale for Use: Outpatient penetration provides information on the intensity of the mental health services provided. A high outpatient penetration may indicate maintenance of a condition and may be useful in comparing to inpatient penetration and inpatient readmissions.

Operational Measure: The numerator is the total number of people who accessed at least one outpatient mental health services accessed during the study period. The denominator is the number of HealthChoices eligible members. Chart 1.3 illustrates the findings for outpatient mental health penetration.

Chart 1.3

Outpatient Mental Health Penetration



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NH-C: New Hampshire HMO-C *RI: Rhode Island*
DC-C/A: District of Columbia child/adolescent program
OR: Oregon *CO: Colorado*
UT: Utah *FL: Florida*

Observation: Of the programs that exceed the mean, most include additional services in the outpatient category than those defined by the HEDIS definition for this measure (refer to the Data Notes below for examples). The Allegheny HealthChoices program reported data (14.2%) near the mean and exceeding the median of the programs (10.2%) and the NCQA mean of 5.5%. No explanation was offered in the SAMHSA report for the high penetration for the two Massachusetts's programs.

Data Notes:

- The District of Columbia's data includes mental health and substance abuse treatment.
- Colorado's data includes respite, rehabilitation, and psychiatric testing.
- Florida's data includes in-home therapy and home and community-based services.
- Utah's data includes wraparound service, crisis intervention, day treatment, and respite services.
- Allegheny HealthChoices' data includes consults and electroconvulsive therapy as outlined in the HEDIS specifications.
- Utah's data excludes children/adolescents in foster care.
- Florida, Massachusetts, New Mexico, and the Allegheny HealthChoices programs use an average monthly enrollment. Other programs use a total enrollment in the calculation.

D. Inpatient Mental Health Penetration

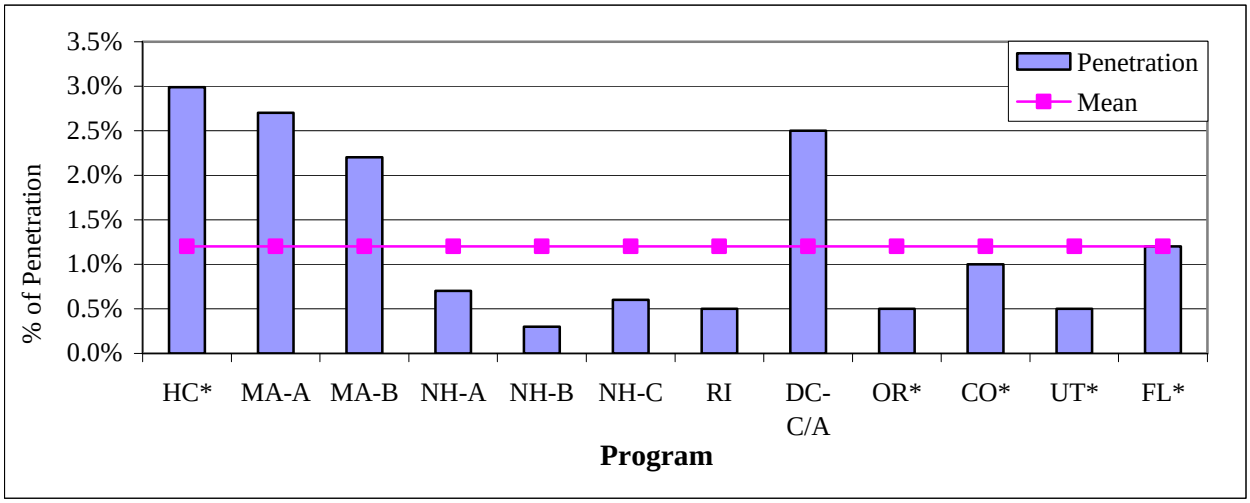
Operational Definition: The proportion of eligible members who received at least one inpatient mental health service during the report period.

Rationale for Use: This measure helps to show the use of more intensive levels of care for mental health services in terms of the eligible population.

Operational Measure: The numerator is the number of people with at least one inpatient episode of care during the study period. The denominator is the total eligible membership. Penetration is expressed as a percent and is illustrated in Chart 1.4.

Chart 1.4

Inpatient Mental Health Penetration



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Observation: Two clusters of penetration values are illustrated; one below the mean and one above the mean. The four programs that exceed the mean have a large percent of TANF and SSI eligible members. The composition of the categories of aid for programs less than the mean was not included in the SAMHSA report. Colorado reported data that includes community and state mental hospital activity. The Allegheny HealthChoices program (3.0%) exceeds data presented in all of the programs as illustrated in Chart 1.4. The high level of inpatient mental health activity is consistent with information presented in previous AHCI reports.

Data Notes:

- Inpatient activity reported by Colorado includes episodes of care at the state mental hospital.
- The District of Columbia includes mental health and substance abuse services.
- New Mexico, the District of Columbia, and Allegheny HealthChoices data represents the calendar year 2000. The Oregon program submitted data for the 1999-2000 fiscal year and the other programs reported for the fiscal year of 2000-2001.
- Florida and the Allegheny HealthChoices program used an average monthly enrollment. Other programs used a total enrollment in the calculation.

E. Inpatient Mental Health Penetration by Age

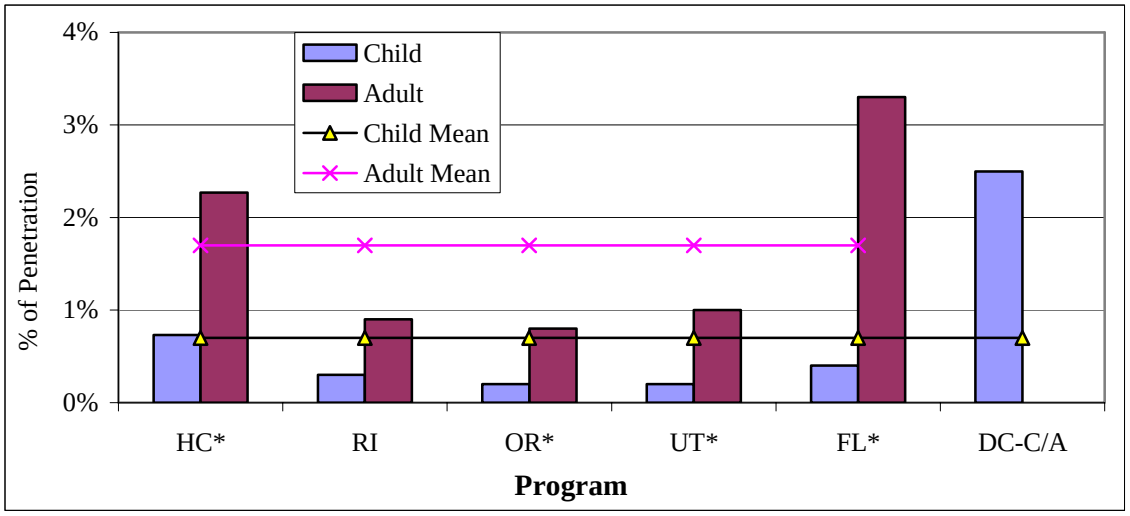
Operational Definition: The proportion of children/adolescents or adults who utilized inpatient mental health services as compared to eligible children/adolescents or adults.

Rationale for Use: This measure provides information on the impact of inpatient mental health treatment by age.

Operational Measure: The numerator is the number of children/adolescents ages 0-20 or 0-21 years old (depending on the program) and adults, ages 21 or 22 years and older (depending on the program), with at least one inpatient stay divided by the total eligible children/adolescents or adult population. The findings for this measure are illustrated in Chart 1.5.

Chart 1.5

Inpatient Mental Health Penetration by Age Group



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Observation: Programs with a high volume of TANF and/or SSI eligible members, such as Florida and Allegheny HealthChoices, have a higher inpatient penetration for adults as compared to programs that have a different category of aid mix and/or do not enroll people with a serious emotional disorder or serious mental illness, such as Rhode Island's program. Inpatient mental health penetration reported for adults in the Allegheny HealthChoices program was 2.3%. This compares to a median penetration of 1.0% and a mean penetration of 1.7%, representing the adult programs. The Allegheny HealthChoices program inpatient penetration for children/adolescents was equal to the program mean of 0.7%. The program median for this age group was 0.35%.

Data Notes:

- The District of Columbia includes mental health and substance abuse services.
- Allegheny HealthChoices and the District of Columbia submitted data for the calendar year 2000. Utah and Oregon submitted data for the fiscal year 1999-2000. All other programs submitted data for the 2000-2001 fiscal year.
- Utah's data includes children/adolescents through 21 years old and adults 22+ years. The District of Columbia submitted data for children/adolescents through 22 years old and does not have an adult program. All other Programs submitted data for children/adolescents 0-20 years old and adults 21 years and older.

Inpatient Mental Health Utilization

A. Inpatient Mental Health Discharges

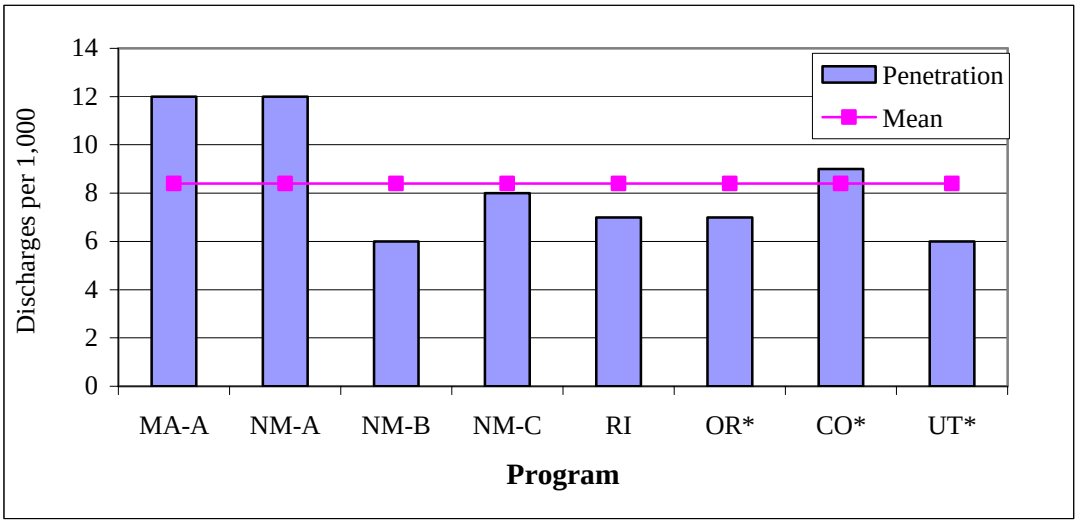
Operational Definition: The number of people per 1,000 members who were discharged from an inpatient mental health facility during the study period.

Rational for Use: Calculating inpatient discharges based on 1,000 members provides an indication of the relative recidivism/frequency of utilization of mental health inpatient care as compared to the total membership.

Operational Measure: The numerator represents the number of people with a discharge and is multiplied by 1,000 (members). The denominator is the average member month equivalent for each program. The discharge measure is illustrated in Chart 1.6.

Chart 1.6

Inpatient Mental Health Discharges per 1,000 Members



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RI: Rhode Island *OR: Oregon*
CO: Colorado *UT: Utah*

Observation: Results for five of the nine reporting programs were below the mean (7.50/1,000 members) and were less than the NCQA mean of 8.6/1,000 members. The program median was 7.5/1,000 members. The findings for this measure reported by the Massachusetts's program are consistent with their high (average 2.5%) inpatient mental health penetration and high (average 12%) discharge per 1,000 members. Seven of the nine programs calculated discharges based on an annual unduplicated number of eligible members. This may distort the value reported because the denominator is larger than the average enrollment for the same period of time. Discharges per 1,000 Allegheny HealthChoices members were the highest of all programs (56.6/1,000 members). This is not included in the graph because of the scale. Allegheny County's high rate of discharge is influenced by a high percent of SSI eligible adults (26.3%) and a large incidence of recidivism (readmission rate 18.9%) as compared to other programs.

Data Notes:

- New Mexico and Allegheny Health Choices reported data for the calendar year 2000. Colorado, Utah, and Oregon reported data for the fiscal year 1999-2000. Data for all other programs represents the fiscal year 2000-2001.
- Massachusetts utilized eligibility for a month-one point in time as the denominator.
- The other reporting programs (minus Massachusetts and Allegheny County) used an unduplicated number of eligible members for the denominator.
- Allegheny HealthChoices program used an average monthly enrollment.

B. Inpatient Mental Health Average Length of Stay

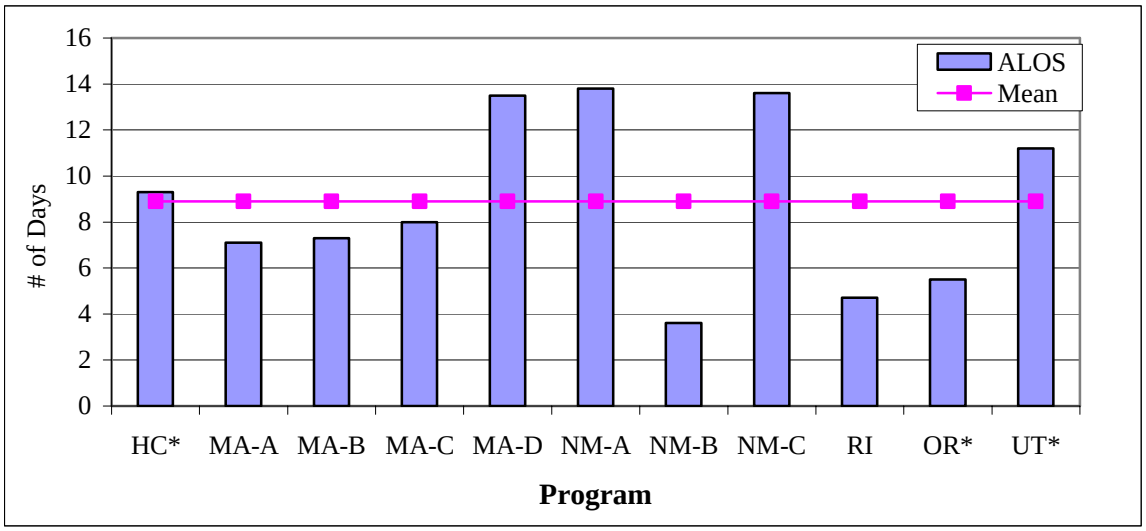
Operational Definition: The average number of days that people are treated in an inpatient mental health facility.

Rationale for Use: The length of hospitalization may be contingent on clinical factors and may indicate practice standards for a provider group or a region as well as the level of utilization management in the system. The average number of days provides a point of reference for comparison.

Operational Measures: The numerator represents the total number of hospital (bed) days for inpatient mental health services. The denominator is the number of members with an inpatient mental health hospitalization within the study period. The ALOS is illustrated in Chart 1.7.

Chart 1.7

Inpatient Mental Health Average Length of Stay



Key;
****** Indicates carve-out programs. All others are carve-in programs*
HC: HealthChoices
MA-A: Massachusetts HMO-A
MA-B: Massachusetts HMO-B
MA-C: Massachusetts HMO-C
MA-D: Massachusetts HMO-D
NM-A: New Mexico HMO-A
NM-B: New Mexico HMO-B
NM-C: New Mexico HMO-C
RI: Rhode Island
OR: Oregon
UT: Utah

Observation: Most of the programs were below the mean of 8.9 days and median of 7.7 days; however, only three programs were below the 6.2 days NCQA mean. No reasons were suggested in the SAMHSA report to explain the large number of days for the Massachusetts's HMO-D and New Mexico HMO's A and C programs. Allegheny

HealthChoices data (9.3 days) was near the mean but exceeded the program median and the NCQA mean by 2-3 days.

Data Notes:

- New Mexico and Allegheny HealthChoices programs submitted data for the calendar year 2000. Utah and Oregon submitted data for the fiscal year 1999-2000. Data submitted by all other programs represents the 2000-2001 fiscal year.

C. Inpatient Mental Health Readmissions Within 30 Days of Discharge

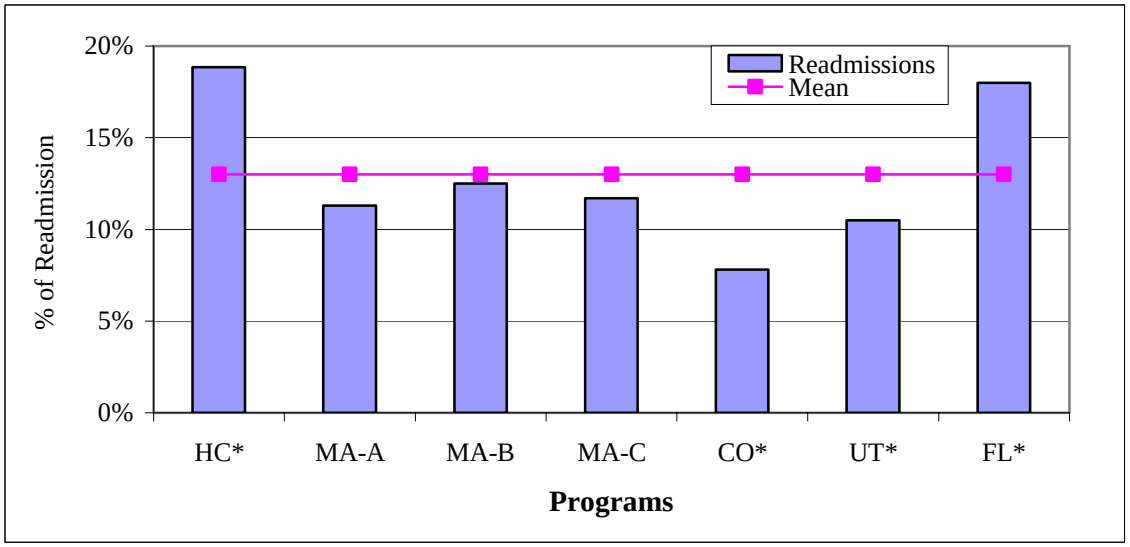
Operational Definition: The percent of people readmitted to the same level of care between 0-30 days following discharge from an inpatient hospitalization during the study period.

Rationale for Use: Readmissions for the same level of care within a 30-day period from discharge shows the relationship between the inpatient care and the outpatient follow-up care. It may indicate the need for a review and improvement of discharge planning procedures, coordination of care processes, and/or support structures available to assist the individual in the community.

Operational Measure: The numerator is the number of people who are readmitted to the same level of care (inpatient mental health services) within 30 days of discharge. The denominator is the number of people with an initial discharge from inpatient mental health services. Readmissions are illustrated in Chart 1.8.

Chart 1.8

Inpatient Mental Health Readmissions Within 30 Days



Key:
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HC: HealthChoices *MA-A: Massachusetts HMO-A*
MA-B: Massachusetts HMO-B *MA-C: Massachusetts HMO-C*
CO: Colorado *UT: Utah*
FL: Florida

Observation: In general, programs reporting a low inpatient penetration seem to be successful at averting readmissions within 30 days following discharge. The inpatient penetration for adults in the Allegheny HealthChoices and Florida programs was substantially higher than the other programs as was the readmission rate. Some of the programs reporting data for readmissions were different from those reporting inpatient penetration and discharges per 1,000 members, impacting the degree of comparison. Allegheny HealthChoices (18.9%) exceeded the program mean of 13.0% and the median percent of readmissions of 11.9%.

Data Notes:

- Allegheny HealthChoices reported data for the calendar year 2000. Colorado and Utah submitted fiscal year 1999-2000 data and the other programs submitted data for the 2000-2001 fiscal year.
- Colorado's data includes state mental hospital data.

D. Inpatient Mental Health Readmissions Within 30 Days of Discharge by Age

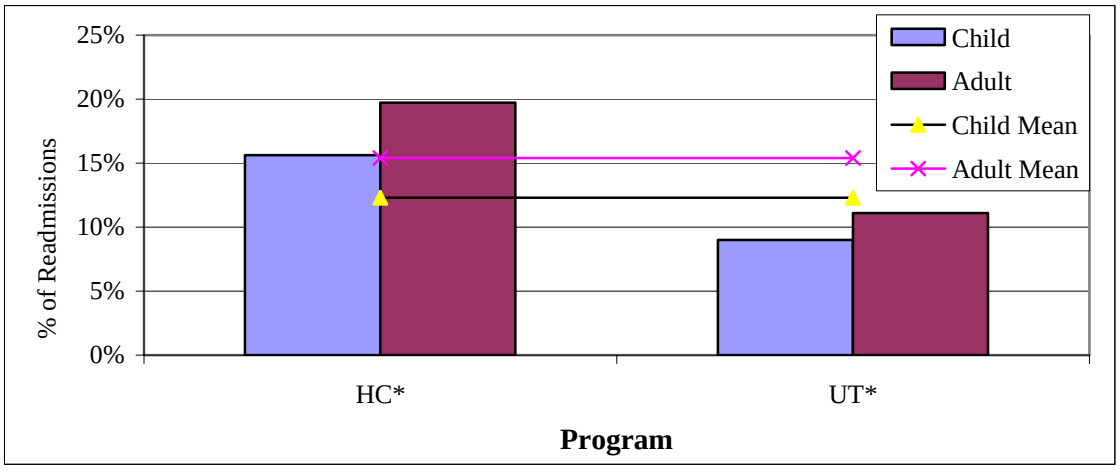
Operational Definition: The percent of people by age group who were readmitted to the same level of care between 0-30 days following discharge from an inpatient hospitalization during the study period.

Rationale for Use: As previously stated, readmissions may indicate the effectiveness of inpatient care and aftercare. This is especially important in terms of age groups because some outpatient services (and providers) are targeted at children/adolescents and different outpatient services (and providers) focus on treatment of adult consumers.

Operational Measure: The numerator is the number of children/adolescents, ages 0-20 or 0-21 years old (depending on the program), and adults, ages 21 or 22 years and older (depending on the program), who were readmitted to inpatient mental health services. The denominator is the number of people who had an initial discharge from inpatient mental health services. Readmissions for adults and children/adolescents are illustrated side-by-side in Chart 1.9.

Chart 1.9

Inpatient Mental Health Readmissions Within 30 Days by Age Group



Key:
***** *Indicates carve-out programs.*
HC: HealthChoices *UT-A: Utah HMO-A*

Observation: Only one Medicaid program submitted data for this measure in the SAMHSA report. Both programs in Chart 1.9 illustrate a lower percentage of readmission for children/adolescents than adults; however, the difference by age is less than other inpatient penetration measures.

Data Notes:

- Allegheny HealthChoices data represents readmissions during the calendar year 2000. Utah submitted data for the 1999-2000 fiscal year.

E. Follow Up After Inpatient Mental Health Discharge

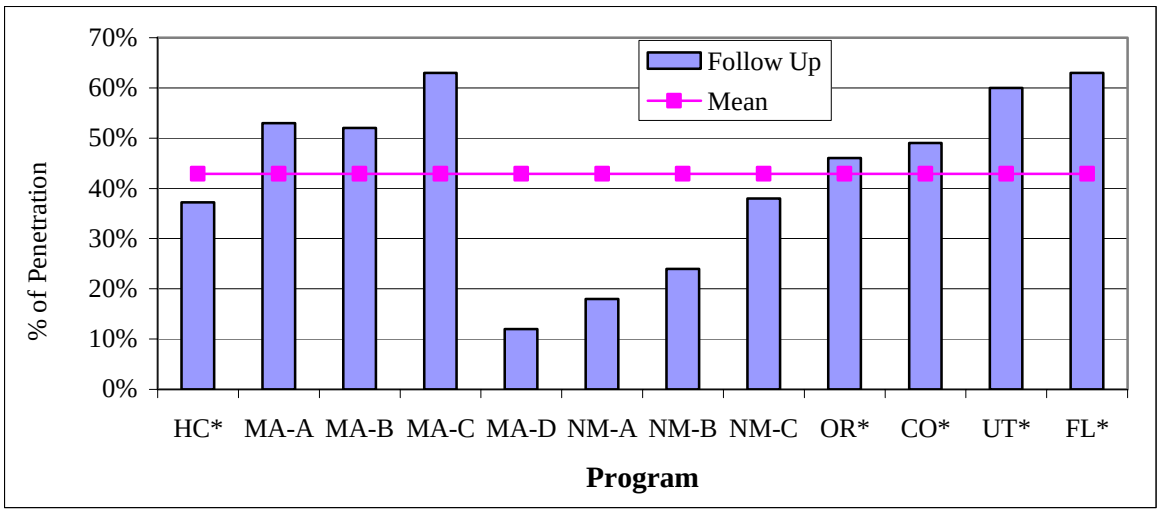
Operational Definition: The percent of people who kept any outpatient follow up appointment within seven days of being discharged from inpatient mental health treatment.

Rationale for Use: This measure shows the impact of coordination of care issues between inpatient mental health and outpatient/follow-up service providers. Discharge planning efforts should address coordination of care issues as the consumer transitions from an inpatient environment to the community. Engagement in outpatient service is most effective when it occurs immediately following an inpatient visit and may help prevent a crisis situation.

Operational Measure: The numerator is the number of people who had an outpatient visit within seven days after discharge from an inpatient mental health facility. The denominator is the number of people with an inpatient mental health discharge minus those who were admitted to a state mental hospital from the inpatient facility. The findings for outpatient follow up are illustrated in Chart 2.0

Chart 2.0

Outpatient Follow Up After Discharge from an Inpatient Facility



Key:

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NM-B: New Mexico HMO-B
NM-C: New Mexico HMO-C
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CO: Colorado
UT: Utah
FL: Florida

Observation: Several programs exceed the program mean of 42.9%, the median of 47.5%, and a NCQA mean of 34%. The percent of follow up reported for Allegheny HealthChoices members was 37.2%, this was lower than average, but within the range of other programs. AHCI has reported this finding in previous reports and Community Care has implemented outreach measures to address this concern.

Data Notes:

- New Mexico and Allegheny HealthChoices submitted data for the 2000 calendar year. Colorado and Utah's data represents activity reported in the 1999-2000 fiscal year and the other programs submitted data for the fiscal year of 2000-2001.
- Colorado's data included people who were transferred to the state mental hospital.
- Utah's data excluded follow up for children.
- Florida reported data for this measure that included crisis intervention as a "planned" follow up service.

Mental Health Expenditure

A. Average Cost per Consumer for Mental Health Services

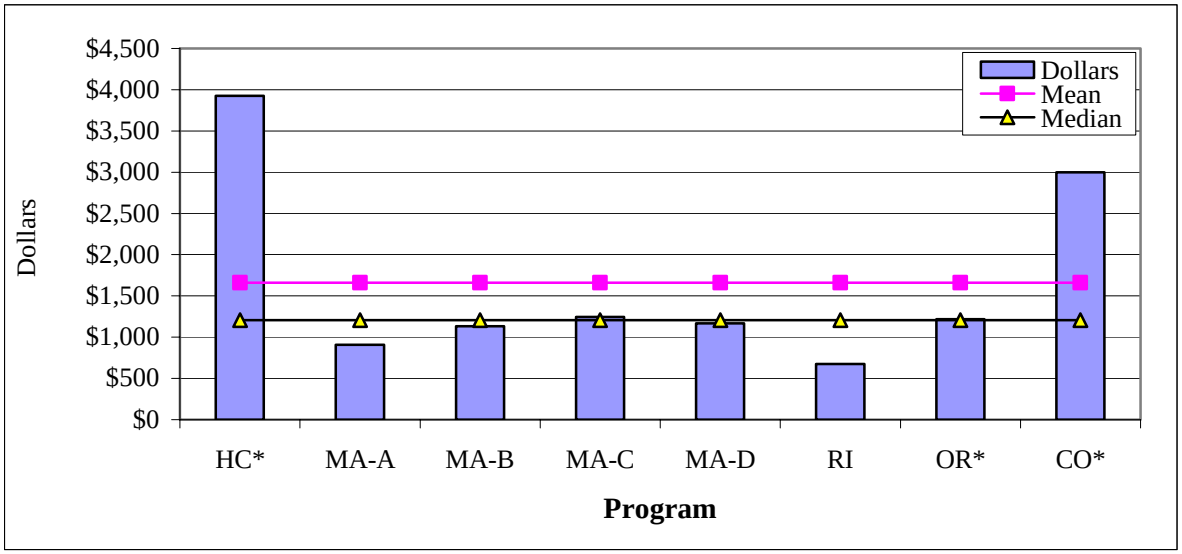
Operational Definition: The average expenditure per person using at least one mental health service during the study period.

Rationale for Use: The average dollar amount spent for mental health services can function as a reference point for comparison and indicates the resources used by the service system.

Operational Measure: The numerator is the total dollars spent on mental health services (inpatient and outpatient). The denominator is the number of people who accessed at least one mental health service during the study period. Chart 2.1 illustrates the average dollars used for mental health services.

Chart 2.1

Average Cost per Consumer for Mental Health Services



Key:
****** *Indicates carve-out programs. All others are carve-in programs*

HC: HealthChoices	*MA-A: Massachusetts HMO-A*
MA-B: Massachusetts HMO-B	*MA-C: Massachusetts HMO-C*
MA-D: Massachusetts HMO-D	*RI: Rhode Island*
OR: Oregon	*CO: Colorado*

Observation: The median cost of $1,205 is substantially different from the average cost containing the two outliers (the Allegheny HealthChoices and the Colorado programs). The average cost excluding HealthChoices and Colorado data was $1,058. The high average cost per person for the Colorado program may be related to services that were reported as part of the standard outpatient services. Average cost reported by Allegheny HealthChoices was impacted by significant total cost for specific in-plan services, such as residential treatment facilities. Likewise, the District of Columbia program reported an average cost of $9,243 per person (not graphed due to the scale). This represents the high cost to treat children/adolescents receiving long term intensive services.

Although the SAMHSA study did not include the following rationale, the high average cost may also be due to the inclusion of children with pervasive developmental disorder. Some programs offer behavioral health rehabilitation services and other programs do not offer this high cost service. The Allegheny HealthChoices program data includes behavioral health rehabilitation services to children regardless of their diagnosis.

Data Notes:

- Colorado's data includes respite care, rehabilitation, and testing services. In addition, state mental hospital costs and MCO administrative costs are included in this measure.
- Massachusetts's expenditure includes mental health and substance abuse services, distributing the cost over all consumers of behavioral health services.

- Allegheny HealthChoices program data includes residential treatment facilities and behavioral health rehabilitation services (annual costs were greater than $10,000 per person for these two services).
- Allegheny HealthChoices data represents expenditure during the 2000 calendar year. Colorado and Oregon reported expenditure for the 1999-2000 fiscal year. All other programs reported for the fiscal year of 2000-2001.

A. Average Cost per Person for Inpatient Mental Health Services

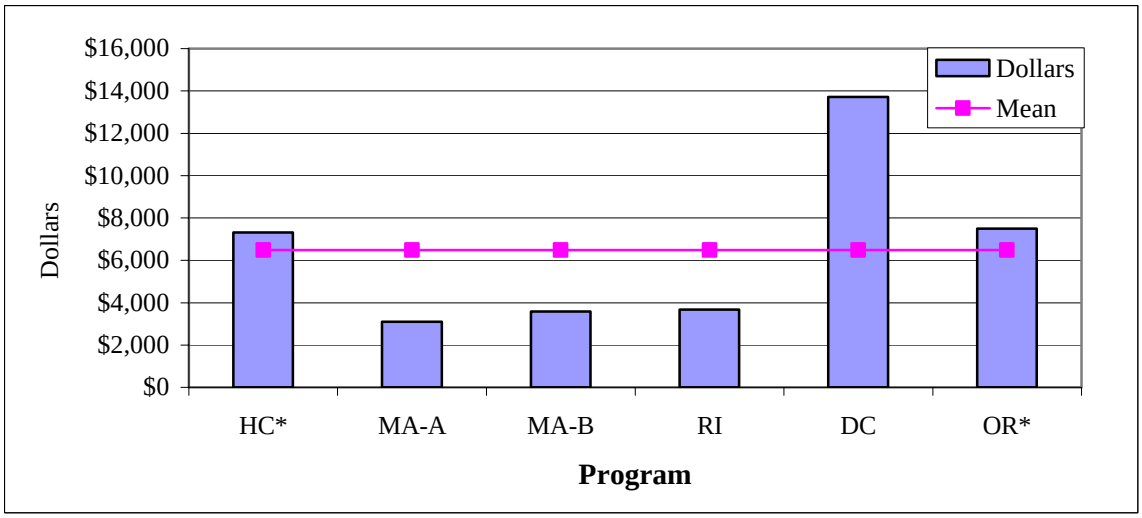
Operational Definition: The average expenditure per person with at least one inpatient mental health hospitalization during the study period.

Rationale for Use: The average dollars spent for inpatient mental health services can be compared to the average cost per person representing all mental health services to determine the proportion allocated to inpatient treatment.

Operational Measure: The numerator is the total expenditure for inpatient mental health services during the study period. The denominator is the number of people with an inpatient mental health hospitalization. The findings are illustrated in Chart 2.2.

Chart 2.2

Average Cost per Consumer for Inpatient Mental Health Service



Key:
****** Indicates carve-out programs. All others are carve-in programs*
HC: HealthChoices *MA-A: Massachusetts HMO-A*
MA-B: Massachusetts HMO-B *RI: Rhode Island*
OR: Oregon *DC-C/A: District of Columbia child/adolescent program*

Observation: The average cost per Allegheny HealthChoices member exceeded the median expenditure by approximately $1,800, but was lower than the cost in the District of Columbia and Oregon programs. The high average cost per person for Allegheny

HealthChoices members ($7,320) was consistent with the findings for inpatient penetration, average length of stay, and readmissions.

Data Notes:

- The District of Columbia and Allegheny HealthChoices programs reported expenditure for the 2000 calendar year. Oregon's expenditure represents the 1999-2000 fiscal year. All other programs reported expenditure for the 2000-2001 fiscal year.
- The average cost reported by the District of Columbia represents mental health and substance abuse services.

Substance Abuse Penetration and Utilization

A. Overall Substance Abuse Penetration

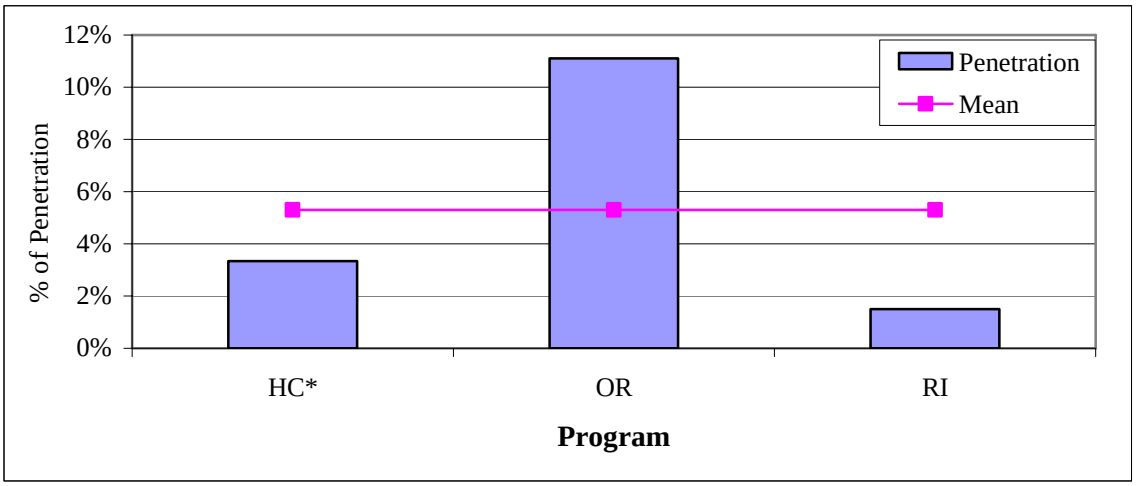
Operational Definition: The proportion of people who accessed at least one substance abuse inpatient, non-hospital, and/or outpatient service during the study period.

Rationale for Use: This measure provides a comparison of the proportion of adults and adolescents being served by each program in comparison with the total eligible membership.

Operational Measure: The numerator is the number of people who accessed at least one substance abuse service during the study period. The denominator is the total number of eligible members. Chart 2.5 illustrates the penetration of substance abuse treatment.

Chart 2.5

Substance Abuse Penetration



Key:
****** *Indicates carve-out programs. All others are carve-in programs*
HC: HealthChoices *R: Oregon* *RI: Rhode Island*

Observation: Two programs, including Allegheny HealthChoices, were below the program mean of 5.3%. The total eligible membership for the Allegheny HealthChoices program represents a large percent of children and adults that received mental health services. A smaller percent of Allegheny HealthChoices members accessed substance abuse treatment than mental health services, reflected in the low penetration as illustrated in Chart 2.5. The program median was 3.3% and the NCQA mean was 0.9%.

Data Notes:

- Oregon's data includes medical services that were related to the individual's substance abuse problem; the majority of which were received in an outpatient setting.
- The Oregon and Allegheny HealthChoices programs represent data for the 2000 calendar year. The Rhode Island program reported for the 2000-2001 fiscal year.

B. Inpatient Substance Abuse Penetration

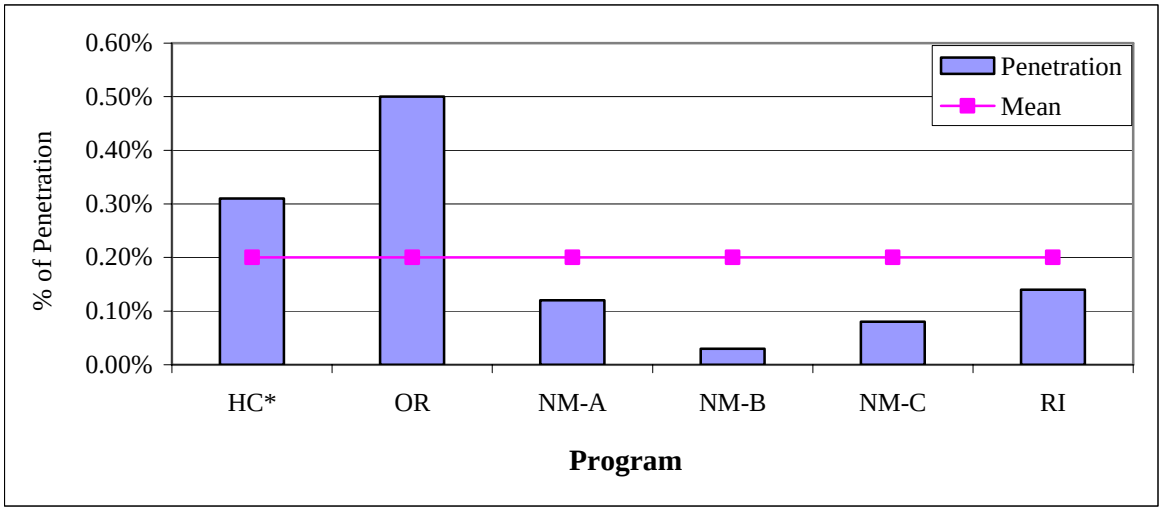
Operational Definition: The proportion of people who received treatment for substance abuse in an inpatient facility during the study period.

Rationale for Use: This measure helps to show the use of more intensive levels of care for substance abuse services in terms of the eligible population.

Operational Measure: The numerator is the number of people with at least one inpatient episode for substance abuse treatment during the study period. The denominator is the total eligible membership. Penetration for inpatient substance abuse is illustrated in Chart 2.6.

Chart 2.6

Inpatient Substance Abuse Penetration



Key:
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HC: HealthChoices *OR: Oregon*
NM-A: New Mexico HMO-A *NM-B: New Mexico HMO-B*
NM-C: New Mexico HMO-C *RI: Rhode Island*

Observation: Two programs exceed the program mean of 0.20%, the median of 0.13%, and the NCQA mean of 0.18%. The proportion of adults to children/adolescents in Oregon's mental health program is nearly 50/50; however, the substance abuse program has substantially more adults. Adults in treatment tend to have used substances for

longer periods than children/adolescents and may require more intensive intervention, which may explain Oregon's high penetration. Likewise, Allegheny HealthChoices data (0.31%) represents almost all adults.

Data Notes:

- Data representing the New Mexico and Allegheny HealthChoices programs was based on an average monthly enrollment. Other programs are based on an annual membership.
- The Oregon and Allegheny HealthChoices programs represent data for the 2000 calendar year. All other programs reported for the 2000-2001 fiscal year.

C. Inpatient Substance Abuse Discharges

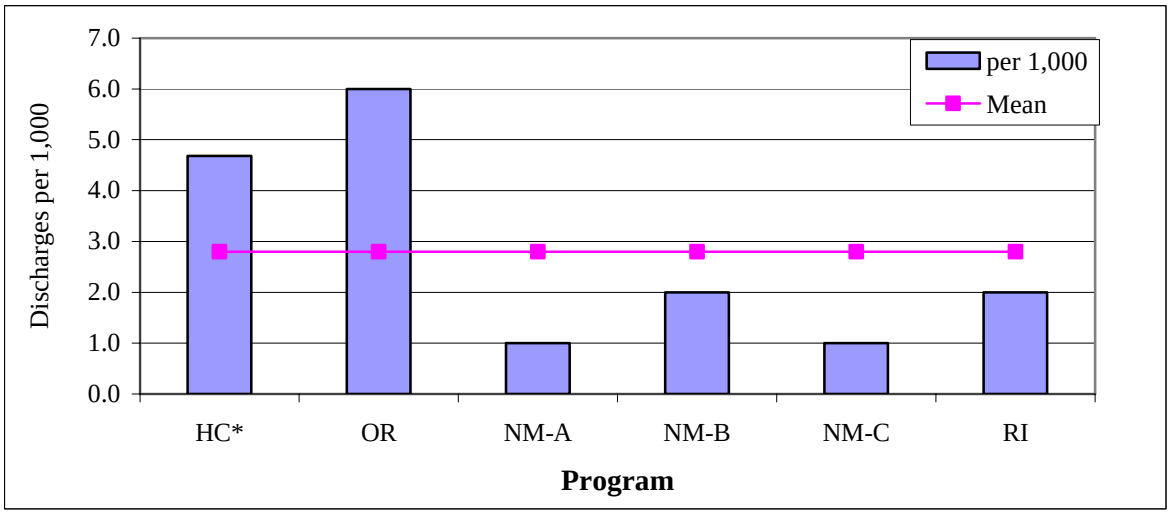
Operational Definition: The number of people per 1,000 members who were discharged from an inpatient substance abuse treatment facility during the study period.

Rational for Use: Calculating inpatient discharges based on 1,000 members provides an indication of the relative frequency of utilization of the inpatient level of care as compared to the total membership.

Operational Measure: The numerator represents the number of people with a discharge from an inpatient treatment facility and is multiplied by 1,000 (members). The denominator is the total eligible membership for each plan. Chart 2.7 illustrates discharges from substance abuse facilities.

Chart 2.7

Inpatient Substance Abuse Discharges per 1,000 Members



Key:

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HC: HealthChoices *OR: Oregon*

NM-A: New Mexico HMO-A *NM-B: New Mexico HMO-B*

NM-C: New Mexico HMO-C *RI: Rhode Island*

Observation: An expansion program targeted at adults with substance abuse problems influenced Oregon's discharge rate. During this report period, less restrictive services such as intensive outpatient were not utilized as often within the Allegheny HealthChoices program. Since the CY 2000, intensive outpatient service is utilized more commonly as an alternative to inpatient treatment. The rate of discharges for Allegheny HealthChoices was 4.7/1,000 members. The program mean was 2.8/1,000 members, the median was 2.0/1,000 members, and the NCQA mean was 2.4/1,000 members.

Data Notes:

- The New Mexico, Oregon, and HealthChoices data represents the calendar year 2000. All other programs reported for the 2000-2001 fiscal year.
- Data representing the New Mexico program was based on an average monthly enrollment. Other programs are based on an annual membership.

D. Inpatient Substance Abuse Average Length of Stay

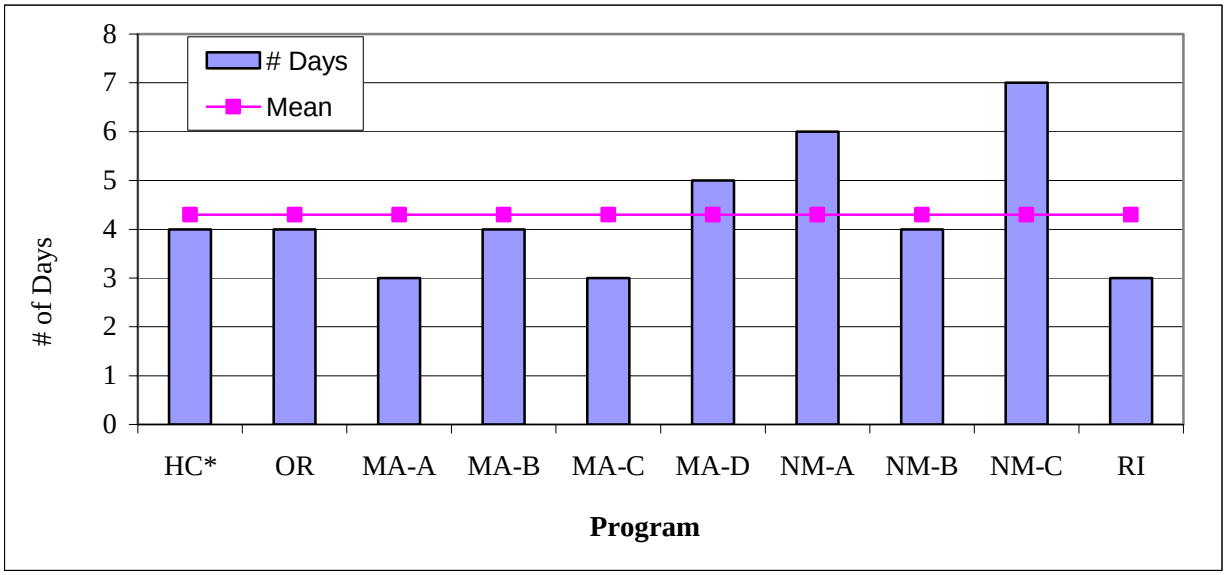
Operational Definition: The average number of days that people who received inpatient substance abuse services used during the study period.

Rationale for Use: The length of stay may be contingent on clinical factors and may indicate practice standards for a provider group or a region as well as the level of utilization management in the system. The average number of days provides a point of reference for comparison.

Operational Measures: The numerator represents the total number of hospital (bed) days for a substance abuse treatment. The denominator is the number of members with an inpatient substance abuse hospitalization within the study period. The average length of stay by program is illustrated in Chart 2.8.

Chart 2.8

Average Length of Stay for Inpatient Substance Abuse Treatment



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NH-C: New Mexico HMO-C *RI: Rhode Island*

Observation: Three of the programs were above the mean number of days. No explanation was provided in the SAMHSA study for the New Mexico program data. The four Massachusetts programs include data for inpatient and non-hospital detoxification treatment. The Allegheny HealthChoices program reported an ALOS of 4.0 days, equal to the program median. The program mean was 4.3 days and the NCQA mean was 4.6 days.

Data Notes:

- The New Mexico, Oregon, and Allegheny HealthChoices programs include data for the 2000 calendar year. All other programs report for the 2000-2001 fiscal year.
- Massachusetts and the Allegheny HealthChoices program used an average monthly enrollment.

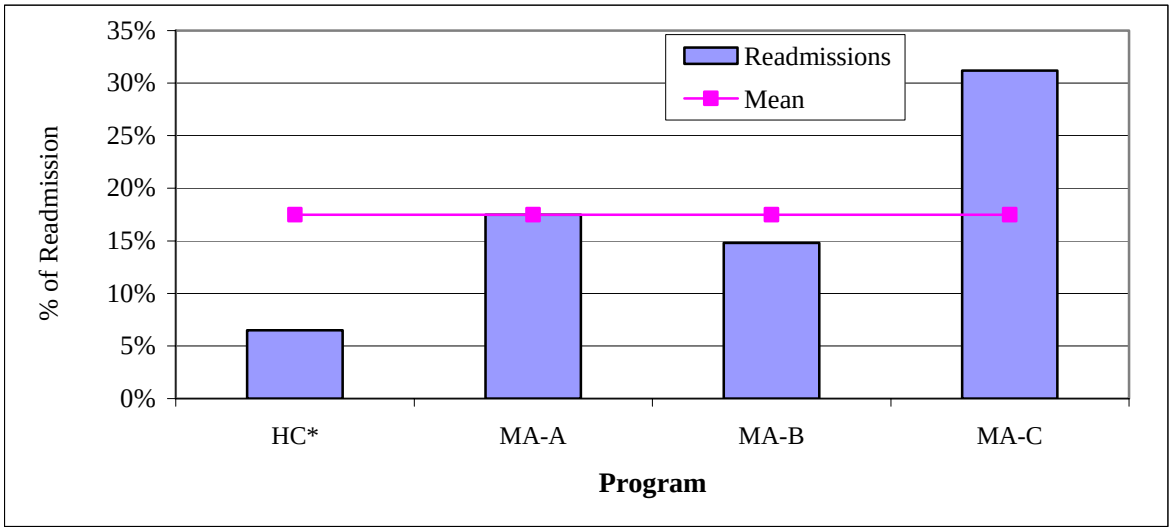
E. Inpatient and Non-hospital Substance Abuse Readmissions Within 30 Days of Service

Operational Definition: The proportion of people who return from inpatient and non-hospital substance abuse treatment to the same level of care within 30 days after discharge during the study period.

Rationale for Use: Readmissions for the same level of care within a 30-day period from discharge shows the relationship between the inpatient care and the follow-up care. It may indicate a review of discharge planning procedures, coordination of care processes, and/or support structures available to assist the individual in the community.

Operational Measure: The numerator is the number of people with a readmission within 30 days of discharge to the same level of care. The denominator is the total number of people with an initial discharge from an inpatient or non-hospital facility. Chart 2.9 illustrates the percent of readmissions.

Chart 2.9
Inpatient and Non-Hospital Readmissions Within 30 Days of Discharge



Key:
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HC: HealthChoices *MA-A: Massachusetts HMO-A*
MA-B: Massachusetts HMO-B *MA-C: Massachusetts HMO-C*

Observation: The Allegheny HealthChoices program data was calculated to include inpatient and non-hospital detoxification services for optimal comparison to the Massachusetts programs. No reason was provided in the SAMHSA study to explain the differences between the Massachusetts programs. The difference between the Massachusetts and the Allegheny HealthChoices programs may be the number of days that are typically authorized for non-hospital rehabilitation and detoxification services.

The Allegheny HealthChoices program authorizes 30units/days for non-hospital treatment and reported a 6.5% of readmissions. This was substantially below the program mean of 17.5% and median of 16.2%.

Data Notes:

- The Massachusetts HMO-C program represents the fiscal year 2000-2001 and HMO-A & B represent the fiscal year 2001-2002. Allegheny HealthChoices data represents the calendar year 2000.

Conclusions

Of the twenty measures presented, the Allegheny HealthChoices program performed comparably to the other Medicaid programs for ten measures. This indicates that the Medicaid programs presented in this report offer similar services to similar populations of Medicaid recipients. The similarities represent measures pertaining to: overall penetration, mental health penetration (total and by age group), outpatient mental health penetration, substance abuse penetration, outpatient follow up after hospitalization, the average length of stay for inpatient mental health and substance abuse treatment, and the average cost per person for inpatient mental health services measure.

The Allegheny HealthChoices program was among the highest of all programs for total inpatient mental health penetration and adult inpatient mental health penetration. Historically, inpatient utilization for HealthChoices in Allegheny County has been higher than other Pennsylvania Counties as reported by the Office of Mental Health and Substance Abuse Services (OMHSAS) in the *HealthChoices Early Warming and Care Monitoring Project.* Likewise, Allegheny HealthChoices program total readmissions within 30 days for mental health inpatient services were the highest of all reporting programs. This was consistent by age group for children/adolescents and adult consumers. Overall and adult mental health penetration (excluding one outlier) also exceeded the program mean. The average cost per person for mental health services for the Allegheny HealthChoices program exceeded all other Medicaid programs in the SAMHSA report. Similarly, the average cost for inpatient mental health services was higher than the program mean. An inpatient service for substance abuse treatment for the Allegheny HealthChoices program was among the highest (with one exception) of all the programs. Similarly, inpatient substance abuse discharges as a rate of total membership were the second highest as compared to other Medicaid programs.

The Allegheny HealthChoices program had the lowest value as compared to all other Medicaid programs in the SAMHSA study for the rate of inpatient mental health discharges based on membership. Outpatient follow up after a mental health admission was below the program mean. Substance abuse penetration for the Allegheny HealthChoices program was below the program mean. The Allegheny HealthChoices program performed below the program mean for the average length of stay for inpatient substance abuse treatment. Readmissions for inpatient and non-hospital level of care for substance abuse treatment were the lowest of all reporting programs.

This report provides confirmation in terms of favorable performance in several areas and identifies some areas for possible improvement. Opportunities exist in terms of education and outreach to members that did not utilize service, the use of less restrictive mental health and substance abuse services, managing high cost services, education and coordination of the continuum of care, and the development of community supports.