Allegheny County HealthChoices Program

2002 Year-In-Review

presented by

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

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Executive Summary

The HealthChoices program is Pennsylvania's managed care program for adults and children who receive Medical Assistance/Medicaid. This report reviews the third full year of mandatory implementation of the behavioral health component of the HealthChoices program in Allegheny County.

In the calendar year (CY) 2002, HealthChoices enrollment remained steady for an unduplicated total of 121,000 persons, of which 25,209 individuals used behavioral health services. Claims payment totaled $104.6 million. Utilization patterns by race, gender, age, and service did not change substantially during CY 2002.

Additionally, there were several positive initiatives that began in 2002 in an effort to enhance the Allegheny County HealthChoices program. These included the following:

- A quality review program that evaluates access to behavioral health rehabilitation services provided to children and adolescents;
- An ambulatory follow-up and outreach plan for consumers discharged from inpatient mental health facilities;
- Implementation of dual diagnosis assessments for all consumers accessing HealthChoices services; and
- Services funded through reinvestment dollars, including community treatment teams (CTT), psychiatric rehabilitation services, outreach to special populations, and enhanced community-based support services for women with substance abuse issues who have children.

The fifth year (CY 2003) of the Allegheny County HealthChoices program will provide an opportunity for greater improvement in the choice and quality of services for HealthChoices consumers. The system will focus on:

- Monitoring the implementation of reinvestment-funded services to assess their benefit to consumers and the continuum of care;
- The initiation of performance-based contracting under the guidance of the Department of Public Welfare; and
- The development of performance standards for a variety of HealthChoices services.

Introduction

AHCI has been monitoring the status of the HealthChoices Program since its inception. The purpose of this report is to highlight annual findings on enrollment and service utilization and to summarize program operations. This includes presenting information on claims processing, complaints, grievances, denials, critical incidents, education, outreach, and ombudsman activities.

The design of the Year-In-Review Report was revised to include operational definitions, the rationale for the examination of specific variables, and the operational measures to explain the calculations used to obtain the data, in addition to the usual discussion of the findings. Findings are presented in both table and graph form to allow the reader to compare the actual numbers with the graphic presentation.

Defining the Data

During calendar year (CY) 2002, the third year of full enrollment in the HealthChoices program, AHCI reported on changes related to the volume of activity, cost patterns, practice patterns, and system changes.

In terms of data used for this report, information related to admission, readmission, and length of stay is based on authorizations for services. Other utilization information, (including statistics related to diagnoses), is based on claims paid during the study period.

Additionally, since a consumer may access different levels of care concomitantly and more than one service during the study period, the consumer would be counted once (unduplicated) and each service would be counted as a unique episode. Therefore, the number or the annual percent of enrollees and consumers in this report represents an unduplicated count during each calendar year.

Enrollment and Utilization

A. General Population

Operational Definitions:
Enrollment is defined as the number of persons in the Medicaid population who were eligible for and enrolled in the Allegheny County's HealthChoices program during the calendar year.

Utilization represents the number of persons enrolled in HealthChoices who had at least one paid claim for HealthChoices behavioral health services during the calendar year. Utilization indicates the volume of services provided based upon paid claims. Values can be expressed in units, total dollar amount, average cost per consumer, and the number of unduplicated recipients.

Rationale for Use:
Enrollment and utilization figures provide information on the number of persons who are eligible for and who used HealthChoices behavioral health services, respectively. Specific characteristics are also examined to delineate the differences in enrollment and utilization by race, gender, age group, and category of aid.

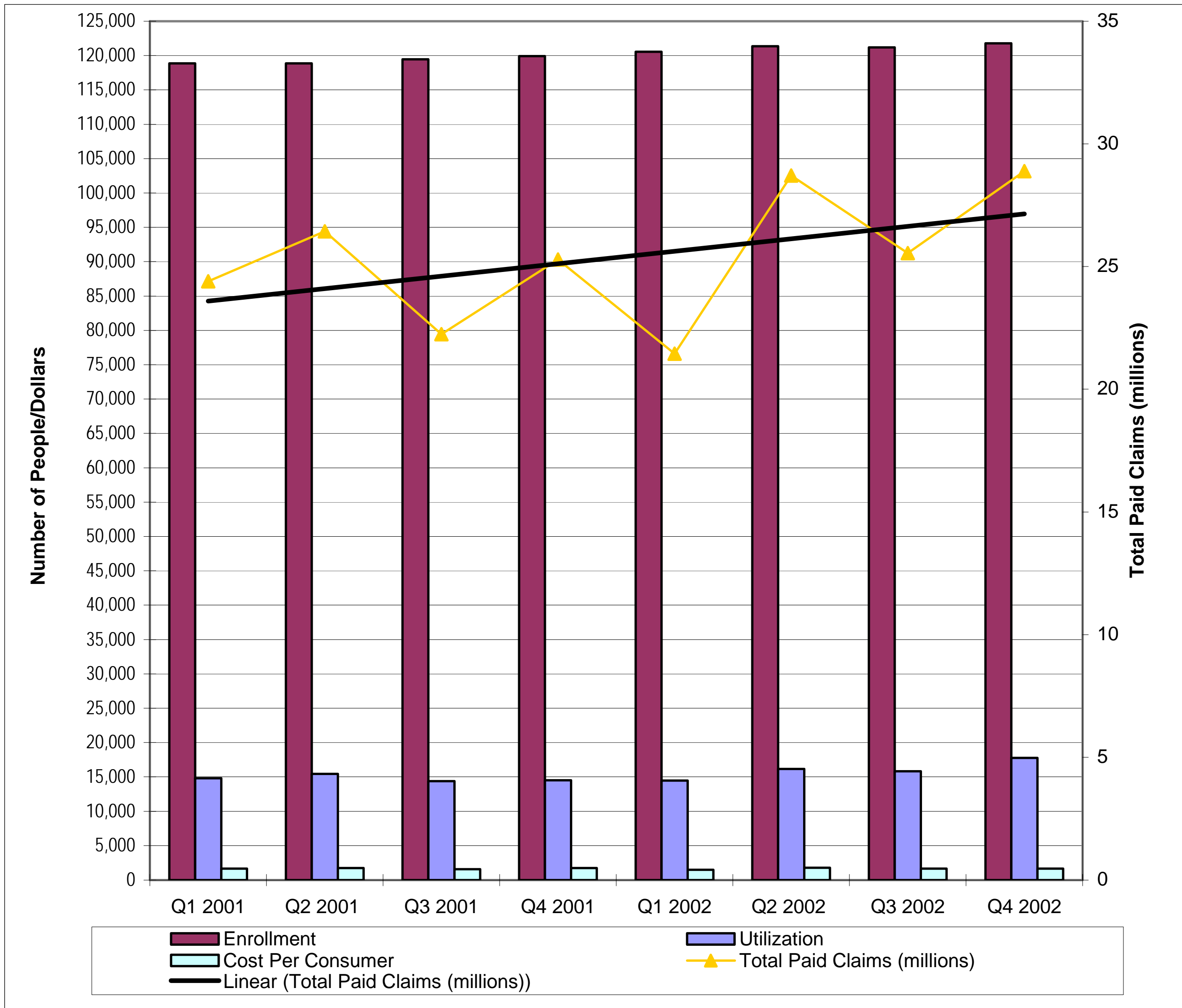
Operational Measures:
Enrollment is derived from the capitation data supplied by the Department of Public Welfare. Annual enrollment for CY 2001 and 2002 was computed by adding the member-month equivalent (MME) values for all 12 monthly periods and dividing the result by twelve. MME is calculated by dividing the number of days between the beginning and ending dates of eligibility by the total number of days in the month. Thus, a member eligible for the whole month would be 1.0 MME.

Utilization rate is calculated by dividing the number of unduplicated persons who had at least one paid claim for behavioral health services by the number of persons enrolled in the HealthChoices program. One measure of utilization is the average cost per consumer. The average cost per consumer is calculated by dividing the total paid amount by the total number of unduplicated recipients.

Discussion:
- In CY 2002, 121,226 individuals were enrolled in the HealthChoices program. This is a slight increase from CY 2001 enrollment (119,280).
- The total unduplicated number of consumers was 25,209 in CY 2002, an increase of approximately 1,700 consumers from CY 2001.
  - Approximately 7,000 consumers received HealthChoices services for the first time (these individuals had no previous paid claims prior to CY 2002). Of this, 2,211 people were new enrollees in the HealthChoices program.
    - In CY 2002, the average cost per consumer was $4,209, a negligible increase from $4,195 in CY 2001.
- The total dollars in paid claims increased from $98.6 million in CY 2001 to $104.6 million in CY 2002.
- Enrollment and utilization data are also stratified further by race, gender, age group, and category of aid on the following pages.

The Number of Enrollees, Consumers, Total Paid Claims, and Average Cost per Consumer per Quarter for CY 2001 and 2002

	Q1 2001	Q2 2001	Q3 2001	Q4 2001	Q1 2002	Q2 2002	Q3 2002	Q4 2002
Number of Enrollees	118,862	118,886	119,479	119,937	120,557	121,374	121,187	121,785
Number of Consumers	14,807	15,428	14,381	14,526	14,466	16,144	15,837	17,762
Total Paid Claims (millions)	$24.40	$26.44	$22.24	$25.29	$21.45	$28.71	$25.55	$28.89
Average Cost Per Consumer	$1,646	$1,726	$1,555	$1,741	$1,484	$1,775	$1,664	$1,669



Enrollment and Utilization

B. Race and Gender

Operational Definitions:
Statistics on race and gender provide information on the number of persons who were eligible for HealthChoices services and who had at least one paid claim for behavioral health services during CY 2001 and 2002. The average cost per consumer represents the average amount of funds expended for each consumer who had at least one paid claim for behavioral health services during the calendar year, stratified by race and gender.

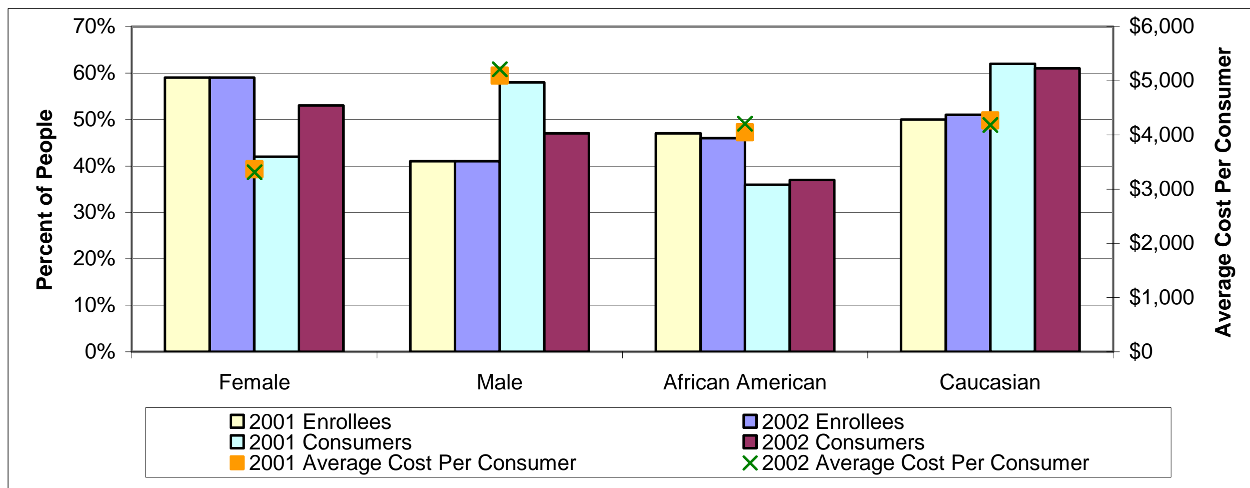
Rationale for Use:
Comparison by gender and race provides information on the differences between African American, Caucasian, male, and female individuals who are eligible for and who had at least one paid claim for HealthChoices behavioral health services. Comparisons between enrollment and utilization by race and gender are made to analyze proportionate access to services.

Cost indicators can be used to understand trends in resource allocation, demonstrate relative levels of access and utilization, and can be combined with other indicators to understand trends in system-level changes longitudinally. Specifically, the analyses for this report included differences in the average cost per consumer by race and gender.

Discussion:
- In CY 2001, females represented a higher percent of enrollees and males represented a higher percent of consumers. However, females represented the majority of both enrollees and consumers in CY 2002.
  - The number of female consumers increased by 11% from CY 2001 to 2002.
  - Towards the end of CY 2001, Community Care initiated an outreach program to consumers with depression. In CY 2002, 10% more female consumers were identified with a diagnosis of depression than in CY 2001 (4,540 in CY 2001 and 5,042 women in CY 2002).
- In CY 2002, Caucasian members represented a slightly higher percent of enrollees, but a much higher percent of total consumers than African American consumers. This is consistent with CY 2001.
- The figures for average cost per consumer by race and gender are consistent for both CY 2001 and 2002:
  - The average cost per consumer for African American and Caucasian males was higher than the average cost for total consumers.
    - The 9% increase in the average cost per consumer for African American males is associated with the introduction of community treatment team (CTT) services in CY 2002. Thirty-three African American male consumers utilized CTT services at an average cost per consumer of $7,639.
  - The average cost per consumer for African American and Caucasian females was lower than the overall average cost per consumer.

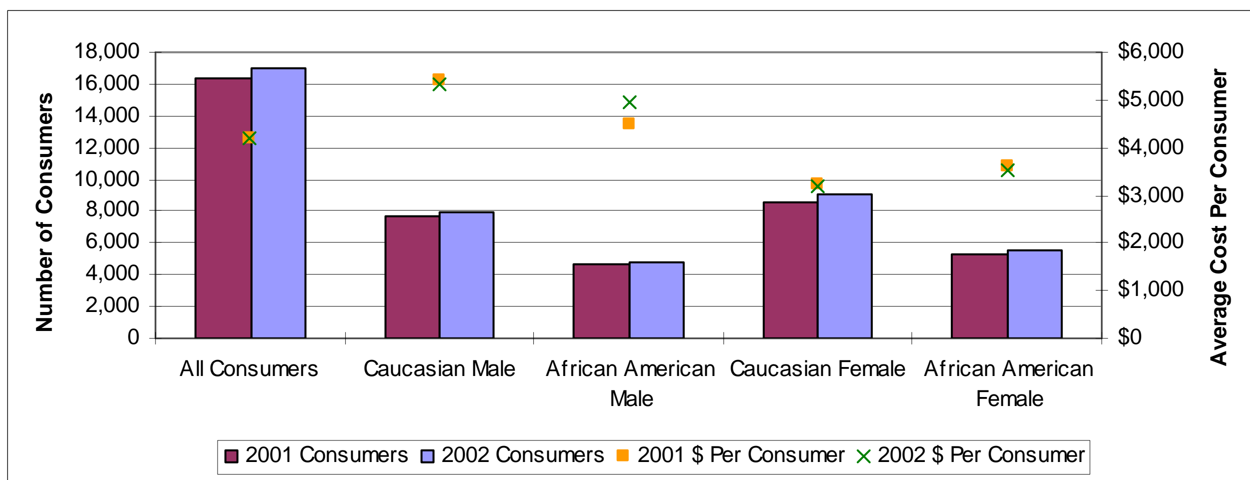
Comparison of Demographic Characteristics between Enrollees and Consumers for CY 2001 and 2002

	2001 Enrollees		2002 Enrollees		2001 Consumers		2002 Consumers	
Female	59%	70,253	59%	70,917	42%	11,283	53%	13,306
Male	41%	49,027	41%	50,309	58%	12,231	47%	11,903
African American	47%	56,912	46%	56,326	36%	8,728	37%	9,351
Caucasian	50%	59,846	51%	61,403	62%	14,365	61%	15,401



Comparison of the Average Cost per Consumer by Race and Gender for CY 2001 and 2002

	2001 Consumers	2002 Consumers
All Consumers	$4,195	$4,209
Caucasian Male	$5,406	$5,328
African American Male	$4,509	$4,948
Caucasian Female	$3,221	$3,170
African American Female	$3,620	$3,543



Enrollment and Utilization

C. Age Group

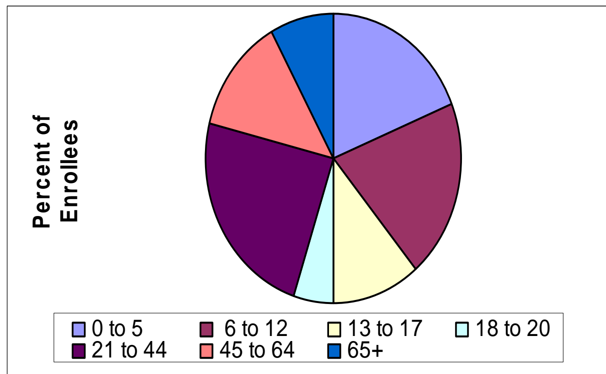
Operational Definitions:
Statistics by age group provide information on the number of persons in each age group who were eligible for, enrolled in, and/or had at least one paid claim for HealthChoices behavioral health services during CY 2001 and 2002. Utilization indicates the volume of services provided based upon paid claims. Values can be expressed in units, dollars paid, and the number of unduplicated recipients.

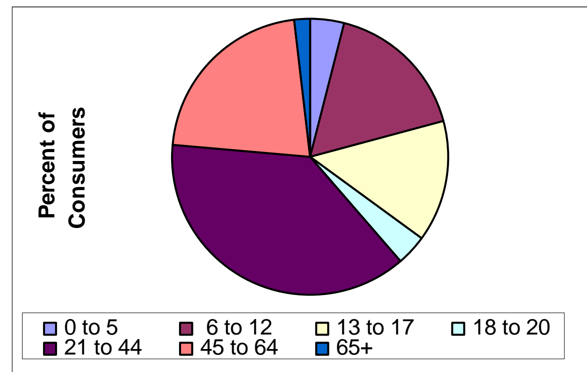
Rationale for Use:
Enrollment and utilization figures provide information on the number of children and adults who are eligible for and who had at least one paid claim for HealthChoices behavioral health services. Consumers in these age groups have different types of behavioral health needs that require specialized services that vary in cost and intensity. For example, some children's services, such as behavioral health rehabilitation services, are costly and intensive, while case management, which is used by many adults, is less costly and less intensive.

Discussion:
- Overall, there were minimal to no changes in the percents of enrollees and consumers by age group reported for CY 2001 and 2002.
- The highest percent for both enrollees and consumers were people in the 21-44 year age group.
  - An especially large difference between the percent of enrollees and the percent of consumers existed for members ages 21-44 years old for both CY 2001 and 2002.
- Three age groups, 13-17, 21-44, and 45-64 years, represented a larger percent of consumers than enrollees for both CY 2001 and 2002.

Comparison of Percent of Enrollees and Consumers within Each Age Group for CY 2001 and 2002

Age Group	2001 Enrollees		2002 Enrollees		2001 Consumers		2002 Consumers	
0 to 5	19%	22,180	19%	22,757	3%	1,060	4%	1,122
6 to 12	20%	24,075	20%	24,026	18%	4,779	18%	4,991
13 to 17	11%	12,745	11%	13,682	14%	3,585	15%	4,084
18 to 20	5%	5,049	4%	5,394	5%	1,090	4%	1,241
21 to 44	24%	29,425	24%	29,310	40%	10,831	40%	11,085
45 to 64	13%	16,002	14%	16,616	23%	6,099	23%	6,353
65+	8%	9,804	8%	9,441	2%	987	2%	816





Data Notes:

- The age groups are divided in the following years:
  - 0 to 5
  - 6 to 12
  - 13 to 17
  - 18 to 20
  - 21 to 44
  - 45 to 64
  - 65 and over
- The percents are calculated based on the total number of enrollees and consumers, respectively.
- The percent of consumers may exceed 100% due to people with birthdays that cross into the next age group during the calendar year.

Enrollment and Utilization

D. Category of Aid

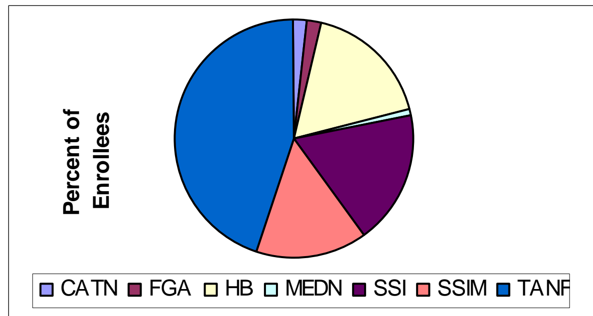
Operational Definitions:
Statistics by category of aid provide information on the number of persons in each category of aid that were eligible for, enrolled in, and/or had at least one paid claim for HealthChoices behavioral health services during the calendar year. Utilization indicates the volume of services provided based upon paid claims. Values can be expressed in units, dollars paid, and the number of unduplicated recipients.

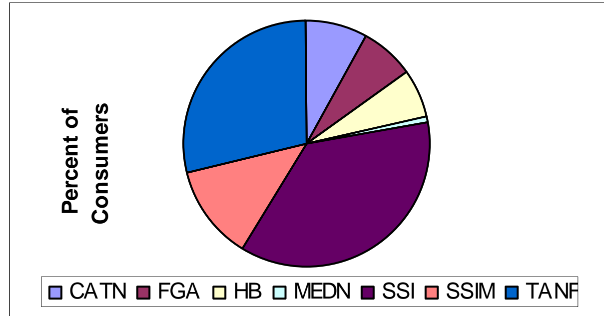
Rationale for Use:
Enrollment and utilization figures provide information on the number of persons by category of aid who are eligible for and who have had at least one paid claim for HealthChoices behavioral health services. Category of aid can indicate some of the characteristics of the eligible population and the intensity of their potential need. Because different categories of aid represent different capitation rates, there is also a fiscal impact.

Discussion:
- Overall, there were minimal to no changes in the percent of enrollees and consumers by category of aid reported for CY 2001 and 2002.
- The Temporary Assistance to Needy Families (TANF) category of aid represent the highest percent of enrollees and the second highest percent of consumers, while the Supplemental Security Income without Medicare (SSI) category represented the highest percent of consumers in both CY 2001 and 2002.
- The Supplemental Security Income without Medicare (SSI) category of aid also represents the highest average cost per consumer ($5,878). The Temporary Assistance to Needy Families (TANF) category of aid represented the second highest average cost per consumer ($3,048). This is consistent with CY 2001 figures.
  - A majority of consumers within the Supplemental Security Income without Medicare (SSI) category of aid are adults with severe and persistent mental illness.
  - A majority of consumers within the Temporary Assistance to Needy Families (TANF) category of aid are children and young mothers.

Comparison of Percent of Enrollees and Consumers within Each Category of Aid for CY 200l and 2002

Category of Aid	2001 Enrollees		2002 Enrollees		2001 Consumers		2002 Consumers	
CATN	2%	2,446	2%	2,585	9%	2,333	9%	2,475
FGA	2%	2,198	2%	2,129	8%	2,140	8%	2,105
HB	17%	20,604	18%	22,326	7%	1,971	8%	2,214
MEDN	1%	1,023	1%	946	1%	238	1%	202
SSI	18%	21,712	19%	22,735	40%	10,193	40%	10,675
SSIM	15%	18,270	15%	18,106	14%	4,433	14%	4,386
TANF	45%	53,026	43%	52,400	32%	8,536	32%	8,857





Data Notes:

- The percent of consumers may exceed 100% due to people who change eligibility categories within the calendar year.
- The following are definitions of the categories of aid:
  - 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
  - Healthy Beginnings (**HB**) – assistance for women during pregnancy and the postpartum period.
  - Supplemental Security Income without Medicare (**SSI**) – assistance for people who are aged, blind, or determined disabled for less than two years.
  - Supplemental Security Income with Medicare (**SSIM**) – assistance for people who are aged, blind, or determined disabled for over two years.
  - 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.

Expenditure

A. Claims

Operational Definition:
Claims are the vehicle by which providers submit information to Community Care on the services rendered and in turn receive payment. Providers are held to timeframes for submission of filing claims, and Community Care must adjudicate (pay or reject) those claims within contractual timeframes.

Rationale for Use:
The review of claims data is important for a number of reasons. This information provides details as to what services are being utilized; which providers are receiving payments for services rendered; the timeframes associated with submission of claims and turnaround time for payments. Paid claims information also helps to predict trends and utilization patterns, as well as helps to develop capitation rates for future periods. Claims data is the foundation of most analysis, review and reporting of statistics and findings related to the HealthChoices program.

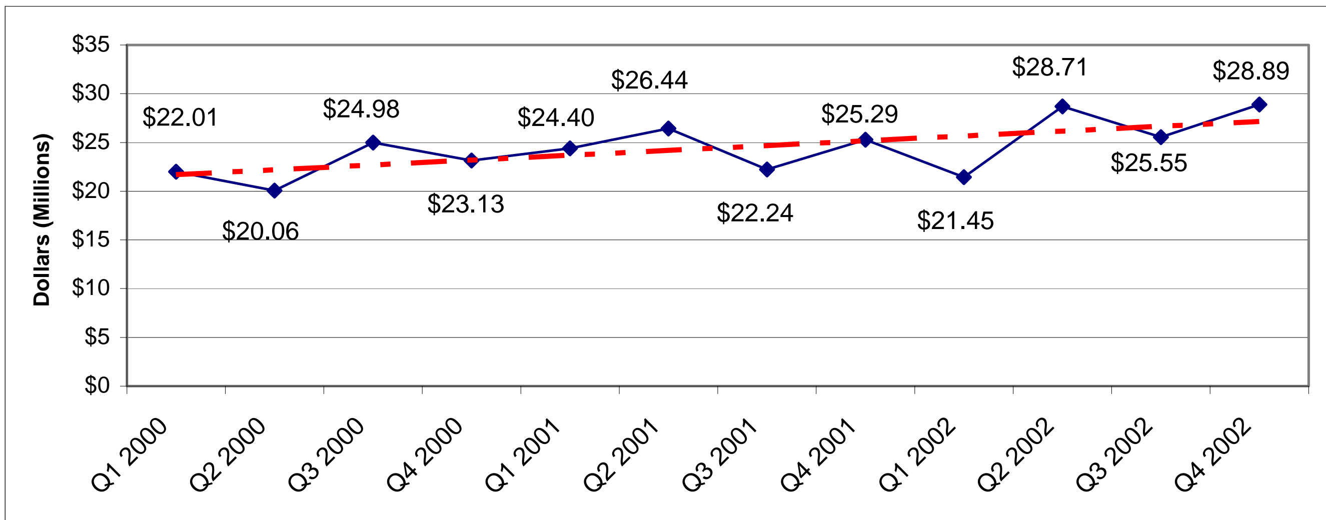
Operational Measures:
For purposes of contractual compliance and Act 68 standards:
- 90% of all clean claims received must be adjudicated within 30 days;
- 100% of all clean claims received must be adjudicated within 45 days;
- 100% of all claims must be adjudicated within 90 days.

It is assumed that all paid claims are clean. Clean rejected claims are those which are not expected to be resubmitted, such as claims that were erroneously mailed to Community Care, i.e., dental claims or claims for a non-HealthChoices member.

Discussion:
- During 2002, Community Care paid $104.6 million in claims, an increase of over six million dollars and 6% than paid in 2001.
- According to the monthly financial reports, Community Care adjudicated an average of 95.4% of clean claims within 30 days in 2002. Nearly all (99.5%) claims (clean and unclean) have been adjudicated within 45 days.
- Community Care's performance in claims processing fluctuated from a low of 78.47% in March 2002 to a high of 99.96% in October 2002.
    - In December 2002, Community Care notified AHCI that a problem with the logic in determining the claims received date existed within the computer code at CSC, their claims vendor. After Community Care researched this problem, it was found that the problem affected claims information during the previous 18 months. It did not affect timeliness during 2001, and only slightly altered timeliness in 2002.
    - Another processing error occurred at CSC for three months in 2002. The erroneous deletion of provider addresses by CSC staff prompted Community Care to suspend some of their check runs until the system was corrected. Because of this and the received date code change noted above, these three months were not in compliance with the contract.

Quarterly Trends of Paid Claims from January 2000 – December 2002

Quarter	Paid Claims (Millions)
Q1 2000	$22.01
Q2 2000	$20.06
Q3 2000	$24.98
Q4 2000	$23.13
Q1 2001	$24.40
Q2 2001	$26.44
Q3 2001	$22.24
Q4 2001	$25.29
Q1 2002	$21.45
Q2 2002	$28.71
Q3 2002	$25.55
Q4 2002	$28.89



Expenditure

B. Supplemental Services

Operational Definition:
Supplemental services are not included as capitated in-plan services and thus are not a requirement of the HealthChoices program. Rather, these are services that the managed care organization and the County deem clinically beneficial to consumers and are cost effective. Utilization indicates the volume of supplemental services provided based upon approved claims. Values can be expressed in units, dollars paid, and number of unduplicated recipients.

Rationale for Use:
Utilization of supplemental services indicates trends in fiscal allocation, resource consumption, demonstrates relative levels of access and treatment, and can be combined with other indicators to identify treatment needs.

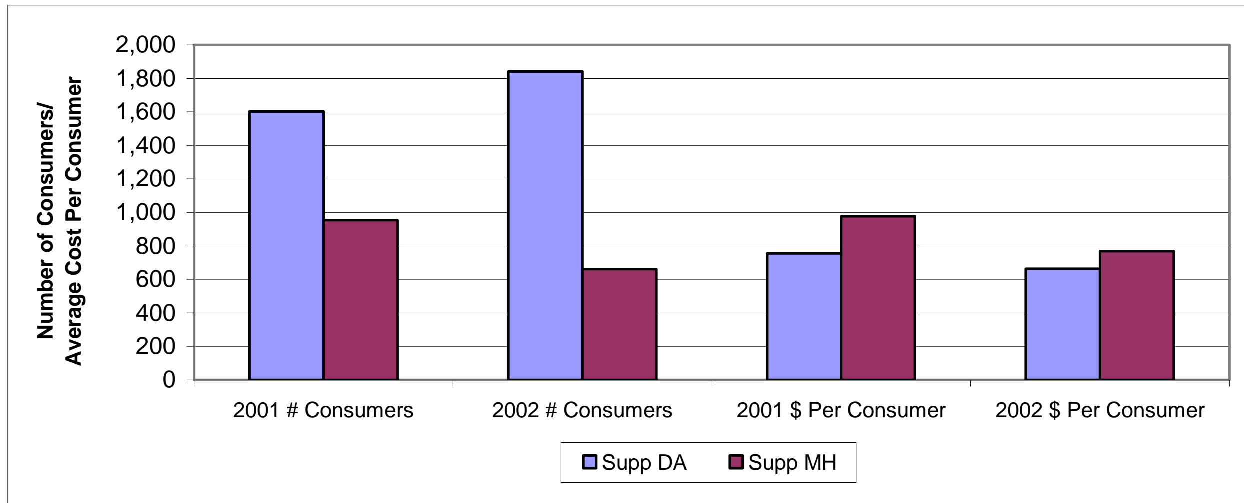
Operational Measures:
Utilization rate is calculated by dividing the number of unduplicated recipients who had at least one paid claim for behavioral health supplemental services by the number of persons enrolled in the HealthChoices program.

Discussion:

- Consistent with CY 2001, supplemental services represented 2% of the total paid claims and were used by 8% of the total consumers in CY 2002.
- A majority of consumers utilized the following supplemental services: drug and alcohol intensive outpatient services, community residential support, and mental health outpatient services.
  - The 31% decrease in the number of consumers who utilized supplemental mental health services is associated with the corresponding decrease in the number of consumers who utilized community residential support, from 623 consumers in CY 2001 to 282 consumers in CY 2002.
    - The decrease in the number of consumers who utilized the supplemental service of community residential support may correspond to the increase in the number of consumers who received CTT services in CY 2002. CTT services include assistance to obtain stable living arrangements.

Comparison of the Average Cost per Consumer and the Number of Consumers Who Utilized Supplemental Services in CY 2001 and 2002

Service Type	2001 Consumers	2002 Consumers	2001 Cost Per Consumer	2002 Cost Per Consumer
Supplemental Drug and Alcohol	1,602	1,841	$756	$664
Supplemental Mental Health	954	662	$978	$768



Service Utilization: Drug and Alcohol

A. Diagnoses

Operational Definition:
Diagnoses are based on the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The fourth edition of the manual published by the American Psychiatric Association established diagnostic criteria, descriptions, and other information to guide the classification and diagnosis of drug and alcohol disorders.

Rationale for Use:
Analysis of cost indicators and the number of consumers were completed to understand the utilization patterns of certain treatment modalities for persons with a given diagnosis. For example, treatment for a person with cocaine abuse/dependency represents a different set of services and costs than treatment provided for a consumer with cannabis abuse/dependency.

Operational Measures:
The average cost per consumer is calculated by dividing the total paid amount for a given diagnosis by the total number of unduplicated recipients who had an approved claim with the given diagnosis during the calendar year.

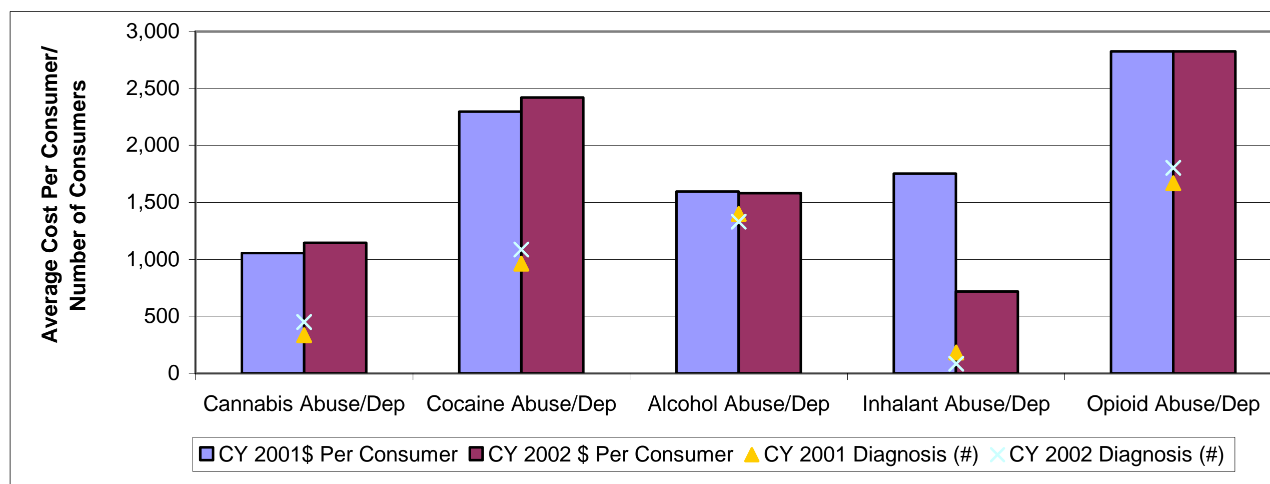
Because a consumer may access different levels of care concomitantly and more than one service during the study period, the consumer would be counted once (unduplicated) and each service would be counted as a unique episode.

Discussion:
- The number of consumers with a diagnosis of inhalant abuse/dependency decreased by more than half (184 to 85 consumers) from CY 2001 to 2002. Similarly, the average cost per consumer with this diagnosis decreased by 41% from CY 2001 to 2002. The median cost per consumer also decreased from $877 in CY 2001 to $274 in CY 2002.
  - The decrease in the average cost for consumers with a diagnosis of inhalant abuse/dependency is related to specific decreases in the average cost per consumer for halfway house and non-hospital rehabilitation treatment.
    - In CY 2001, 10 consumers 21-64 years old utilized halfway house services, with an average cost per consumer of $4,267. In CY 2002, consumers with a diagnosis of inhalant abuse/dependency did not utilize halfway house services.
    - In CY 2001, 103 consumers utilized 1,139 units of non-hospital rehabilitation services, with an average cost per consumer of $2,031. In CY 2002, only seven consumers with a diagnosis of inhalant abuse/dependency utilized 32 units of non-hospital rehabilitation services, with an average cost per consumer of $864. This implies a shorter average length of stay and thus, a lower cost.
  - Consumers with a diagnosis of inhalant abuse/dependency utilized 40 units of community treatment team (CTT) services during CY 2002.

- The average cost per consumer with a diagnosis of cocaine abuse/dependency increased by 5% from CY 2001 to 2002.
  - The number of units of case management services increased from 899 in CY 2001 to 6,808 in CY 2002. Likewise, the number of people using this level of care increased from 13 to 330 consumers.
  - Consumers with a diagnosis of cocaine abuse/dependency utilized 920 units of CTT services during CY 2002.
- Both the average cost per consumer and the number of consumers with a diagnosis of cannabis abuse/dependency increased from CY 2001 to 2002.
  - The number of consumers with a diagnosis of cannabis abuse/dependency increased from 336 to 450 people, with individual increases in the number of consumers who utilized case management services (10 to 136 people) and outpatient drug and alcohol services (200 to 336 people).

Comparison of the Average Cost per Consumer Based on Drug and Alcohol Diagnoses and the Number of Consumers by Diagnosis for CY 2001 and 2002

	CY 2001 Cost Per Consumer	CY 2002 Cost Per Consumer	CY 2001 Consumers	CY 2002 Consumers
Cannabis Abuse/Dependency	$1,056	$1,145	336	450
Cocaine Abuse/Dependency	$2,297	$2,421	962	1,085
Alcohol Abuse/Dependency	$1,597	$1,582	1,400	1,330
Inhalant Abuse/Dependency	$1,753	$718	184	85
Opioid Abuse/Dependency	$2,825	$2,825	1,668	1,803



Data Notes:

- The chart represents five substance abuse diagnoses with the largest average cost per person and/or largest number of consumers for the two report years.

Service Utilization: Drug and Alcohol

B. Cost per Consumer

Operational Definition:

The average cost per consumer is the amount of funds expended for each consumer who had at least one paid claim for drug and alcohol services during the calendar year.

Rationale for Use:

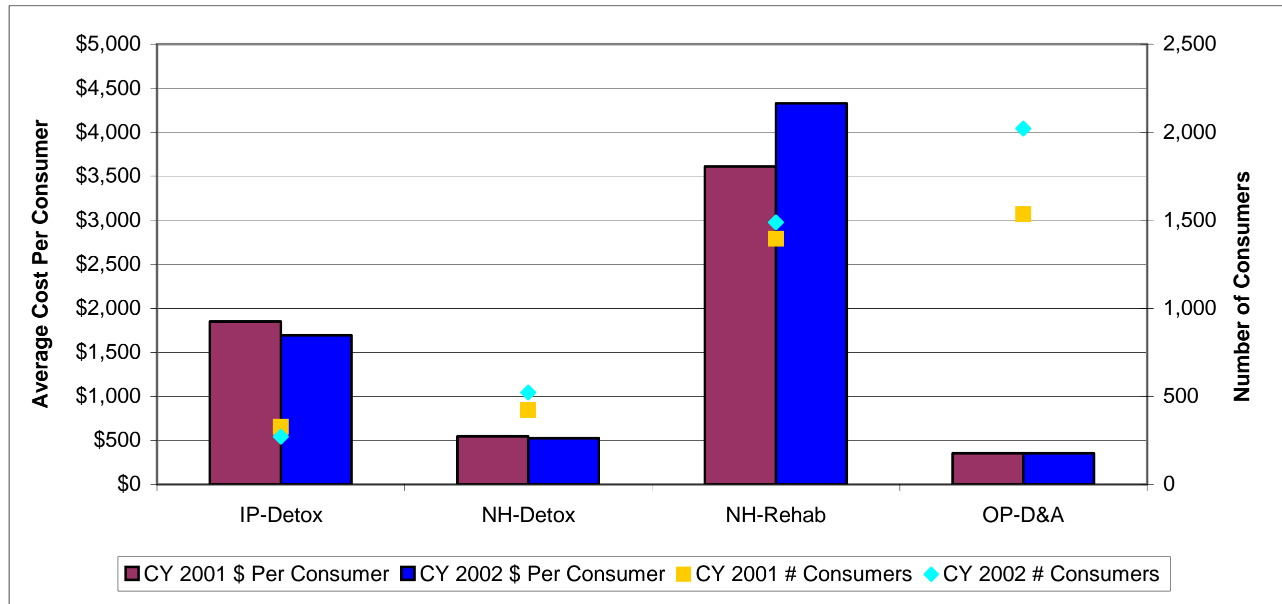
Cost indicators and the number of consumers were analyzed to report the changes in utilization patterns longitudinally.

Discussion:

- Approximately $3.1 million was paid during CY 2002 for services to treat people with a primary diagnosis of substance abuse. This represented 3% of total paid claims and 5% (1,322 people) of all consumers. These figures are consistent with CY 2001.
- The number of consumers who utilized non-hospital rehabilitation remained relatively stable while the average cost per consumer increased by 17% from CY 2001 to 2002.
    - The increase in the average cost per consumer is related to an increase in the average cost per unit of non-hospital rehabilitation services from $135 in CY 2001 to $150 in CY 2002.
- Conversely, the number of consumers who utilized outpatient drug and alcohol services increased by 24% while the average cost per consumer remained relatively stable from CY 2001 to 2002.
    - The overall increase in the number of consumers is due to increases in the number of individuals who received specific types of outpatient drug and alcohol services.
        - The number of consumers who had their first appointment/intake with a clinician increased from 342 in CY 2001 to 873 people in CY 2002. The number of consumers who received individual psychotherapy also increased from 1,092 in CY 2001 to 1,317 people in CY 2002.
    - Because the average number of units per consumer (18 units) of outpatient drug and alcohol services remained constant from CY 2001 to 2002, the average cost per consumer remained stable.

Comparison of the Number of Consumers and Average Cost per Consumer for Drug and Alcohol Services in CY 2001 and 2002

	CY 2001 Number Consumers	CY 2002 Number Consumers	CY 2001 Cost Per Consumer	CY 2002 Cost Per Consumer
IP-Detox	329	272	$1,850	$1,695
NH-Detox	422	522	$548	$525
NH-Rehab	1,395	1,487	$3,611	$4,328
OP-D&A	1,534	2,021	$354	$355



Data Notes:

- Drug and alcohol intensive outpatient services were not graphed because this level of care was re-categorized from an in-plan to a supplemental service in CY 2002.
- Inpatient rehabilitation was not graphed because of the low number of consumers who utilized these services (average of 34 consumers in CY 2001 and 40 consumers in CY 2002, with an average cost per consumer of $1,324 in CY 2001 and $2,403 in CY 2002).
- IP-Detox: Inpatient detoxification
- IP-Rehab: Inpatient rehabilitation
- NH-Detox: Non-hospital detoxification
- NH-Rehab: Non-hospital rehabilitation
- OP-DA: Outpatient drug and alcohol

Service Utilization: Drug and Alcohol

C. Admissions, Average Length of Stay, and Readmissions

Operational Definitions:

The admission rate is the number of inpatient detoxification/rehabilitation and non-hospital detoxification/rehabilitation stays per 1,000 members for each quarter of the study period.

The average length of stay (ALOS) is the average number of inpatient detoxification/rehabilitation and non-hospital detoxification/rehabilitation days consumers used per quarter.

The readmission rate is the number of times a consumer is readmitted to the same level of care (i.e. inpatient detoxification to inpatient detoxification) 1-30 days after discharge from the initial admission, calculated as a figure per 1,000 members for each quarter of the study period.

Rationale for Use:

Admission rates, ALOS, and readmission rates provide indicators regarding the amount of inpatient and residential (non-hospital) services being utilized. An important goal of treatment is to maximize the use of least-restrictive and appropriate levels of care.

Operational Measures:

The admission rate is calculated by multiplying the total number of admissions by 1,000 and dividing by the total MME (member month equivalents).

ALOS is calculated by dividing the number of days for each inpatient or non-hospital episode by the total number of stays (defined by discharges) within a given service category.

The readmission rate is calculated by multiplying the number of people readmitted within 30 days by 1,000 and dividing by the MME.

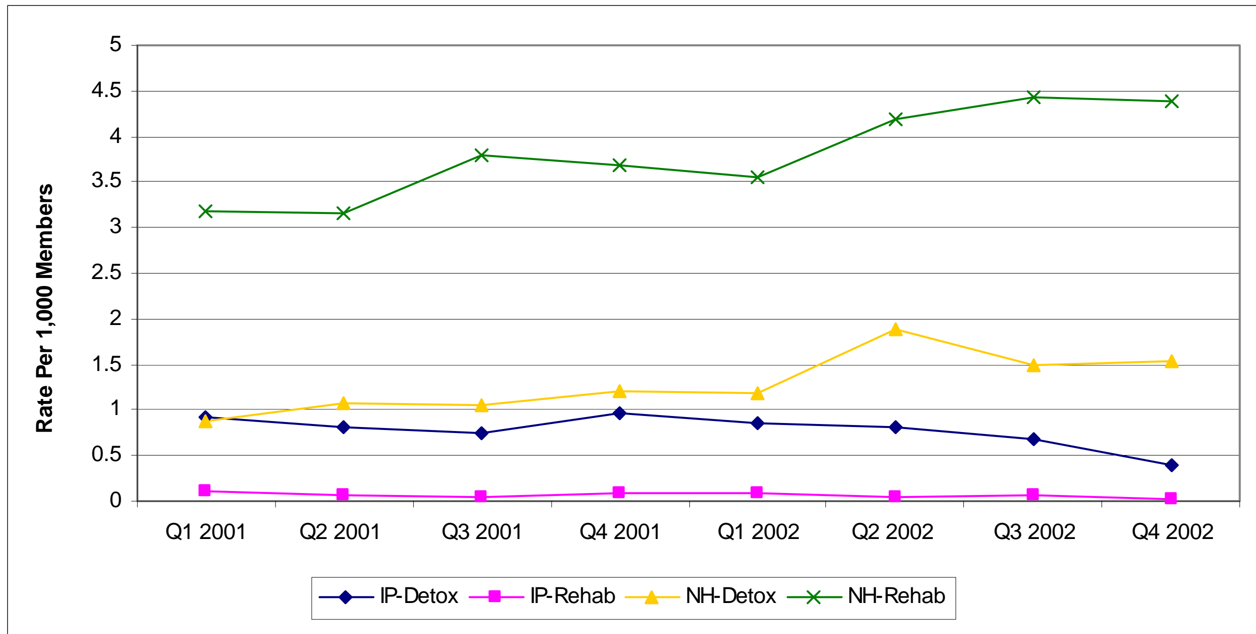
Discussion:

Admission Rates

- The admission rates for non-hospital rehabilitation increased from 3.18 per 1,000 members in the first quarter 2001 to 4.38 per 1,000 members in the fourth quarter 2002 and showed an upward trend in CY 2001 through 2002.
- The admission rates for non-hospital detoxification increased from 0.87 per 1,000 members in the first quarter 2001 to 1.54 per 1,000 members in the fourth quarter 2002 and showed an upward trend in CY 2001 through 2002.
- The admission rates for inpatient detoxification declined from 0.96 per 1,000 members in the fourth quarter 2001 to 0.39 per 1,000 members in the fourth quarter 2002.

Admission Rates for Drug and Alcohol Services in CY 2001 and 2002

	Q1 2001	Q2 2001	Q3 2001	Q4 2001	Q1 2002	Q2 2002	Q3 2002	Q4 2002
IP-Detox	0.93	0.82	0.75	0.96	0.85	0.82	0.68	0.39
IP-Rehab	0.11	0.07	0.04	0.08	0.09	0.05	0.07	0.03
NH-Detox	0.87	1.08	1.05	1.2	1.18	1.89	1.49	1.54
NH-Rehab	3.18	3.16	3.79	3.68	3.56	4.19	4.43	4.38



Average Length of Stay

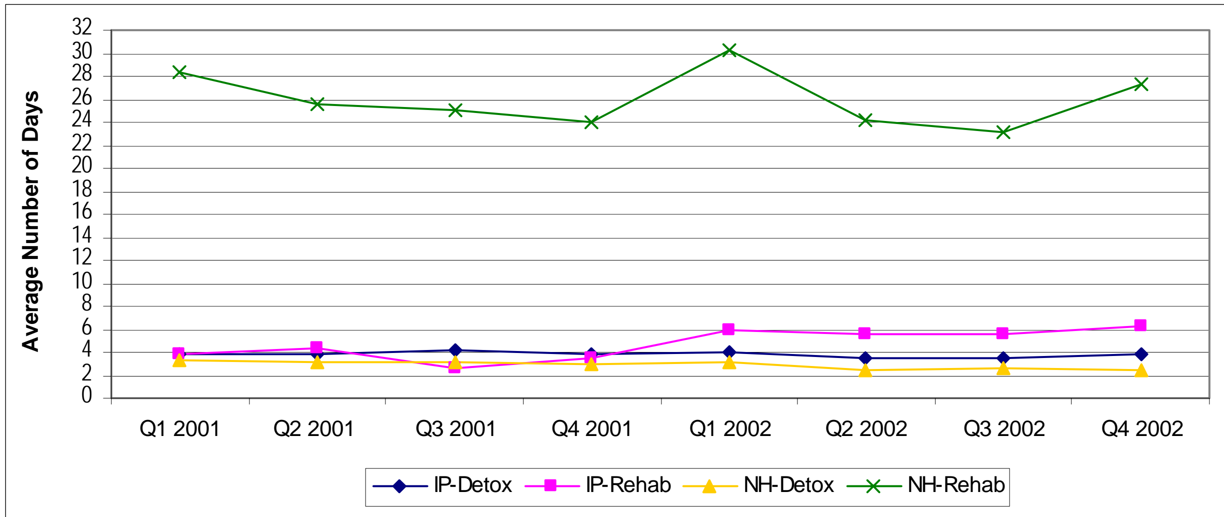
- The ALOS for non-hospital rehabilitation decreased during the four quarters of CY 2001 and fluctuated substantially during the four quarters of CY 2002.
    - Outliers of 30 to 231 days were associated with the increase in ALOS during the first quarter 2002. The median length of stay was 15 days.
- The ALOS for detoxification services remained relatively stable during CY 2001 and 2002.
    - The ALOS for inpatient detoxification was four days; and
    - The ALOS for non-hospital detoxification was three days.
- The ALOS for inpatient rehabilitation demonstrated a slight increase from five days in CY 2001 to six days in CY 2002.

Readmission Rates

- Both non-hospital detoxification and non-hospital rehabilitation readmission rates demonstrated an upward trend from CY 2001 through CY 2002, starting at 0.02 and ending at 0.14 per 1,000 members for non-hospital detoxification and starting at 0.29 and ending at 0.55 per 1,000 members for non-hospital rehabilitation.
    - Readmission rates may be affected by the decision of a consumer to end services prematurely, before the prescribed treatment is completed. During the same time period that the readmission rates increased, the completion rate for non-hospital rehabilitation services decreased from 87% to 81%, indicating that consumers did not finish services based on the prescribed timeframe.
- Readmission rates for inpatient detoxification continued to decline from CY 2001 through CY 2002, starting at 0.10 and ending at 0.03 per 1,000 members.

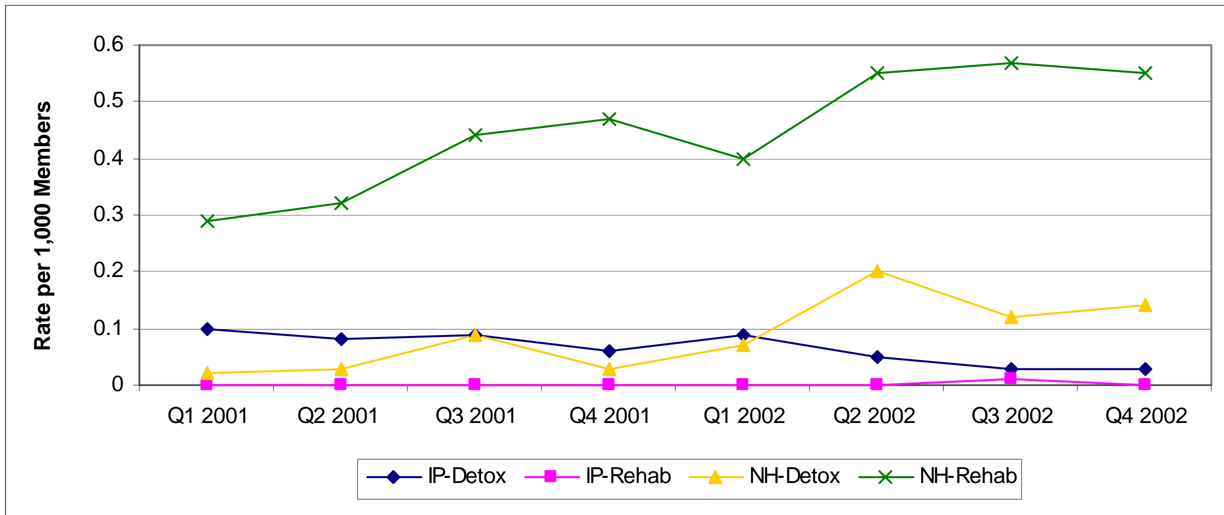
Average Length of Stay for Drug and Alcohol Services in CY 2001 and 2002

	Q1 2001	Q2 2001	Q3 2001	Q4 2001	Q1 2002	Q2 2002	Q3 2002	Q4 2002
IP-Detox	3.8	3.9	4.2	3.8	4.0	3.5	3.5	3.8
IP-Rehab	3.8	4.4	2.6	3.4	5.9	5.6	5.6	6.3
NH-Detox	3.3	3.1	3.2	3.0	3.1	2.4	2.6	2.5
NH-Rehab	28.4	25.5	25.0	24.0	30.2	24.1	23.2	27.3



Readmission Rates for Drug and Alcohol Services in CY 2001 and 2002

	Q1 2001	Q2 2001	Q3 2001	Q4 2001	Q1 2002	Q2 2002	Q3 2002	Q4 2002
IP-Detox	0.10	0.08	0.09	0.06	0.09	0.05	0.03	0.03
IP-Rehab	0	0	0	0	0	0	0.01	0
NH-Detox	0.02	0.03	0.09	0.03	0.07	0.20	0.12	0.14
NH-Rehab	0.29	0.32	0.44	0.47	0.40	0.55	0.57	0.55



Service Utilization: Mental Health

A. Diagnoses

Operational Definition:
Diagnoses are based on the criteria listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The fourth edition of the manual published by the American Psychiatric Association established diagnostic criteria, descriptions, and other information to guide the classification and diagnosis of mental health disorders.

Rationale for Use:
Analyses of cost indicators and the number of consumers were completed to understand the utilization patterns of certain treatment modalities for persons with a given diagnosis. For example, treatment for people with schizophrenia represents a different set of services and costs than treatment provided to people with conduct disorder.

Operational Measures:
The average cost per consumer is calculated by dividing the total amount paid for a given diagnosis by the total number of unduplicated recipients who had an approved claim with the given diagnosis during the calendar year.

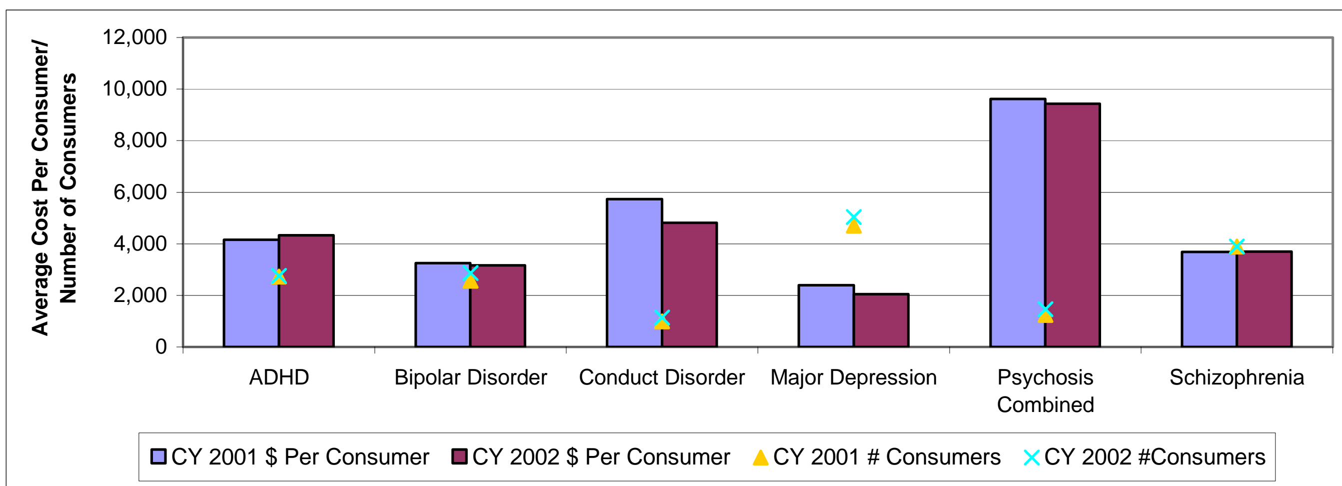
Because a consumer may access different levels of care concomitantly and more than one service during the study period, the consumer would be counted once (unduplicated) and each service would be counted as a unique episode.

Discussion:
- With the exception of the average cost per consumer for conduct disorder, the number of consumers and average cost per consumer remained relatively stable for the mental health diagnoses reported in CY 2002.
- While the number of consumers increased slightly, the average cost per consumer with a diagnosis of conduct disorder decreased by 16% from CY 2001 to 2002. The overall decrease in cost was affected by the following:
    - The average cost per consumer with a diagnosis of conduct disorder decreased by approximately $10,000 for utilization of residential treatment facility services from CY 2001 to 2002.
    - In CY 2001, 42 consumers with a diagnosis of conduct disorder utilized 6,353 units of residential treatment. In CY 2002, 35 consumers utilized 3,915 units of residential treatment. The decrease in the number of units by 38% indicates a shorter average length of stay and thus, a lower cost.

        - The number of units of family-based services utilized by consumers with a diagnosis of conduct disorder increased from 9,276 in CY 2001 to 16,207 units in CY 2002 (34 to 63 consumers, respectively).
        - The utilization of family-based services follows the best practices model of treatment in the least restrictive setting and functions to preserve the family unit.
        - The increase in the number of family-based units was substantial, but it is a less costly service than residential treatment, thus contributing to a decrease in the average cost per consumer.
    - Consumers with a diagnosis of conduct disorder utilized 1,170 units of community treatment team (CTT) services during CY 2002.

Comparison of the Average Cost Per Consumer Based on Mental Health Diagnosis and the Number of Consumers by Diagnosis for CY 2001 and 2002

	CY 2001 Cost Per Consumer	CY 2002 Cost Per Consumer	CY 2001 Consumers	CY 2002 Consumers
ADHD	$4,156	$4,331	2,733	2,758
Bipolar Disorder	$3,253	$3,168	2,564	2,871
Conduct Disorder	$5,735	$4,818	987	1,137
Major Depression	$2,390	$2,043	4,702	5,042
Psychosis Combined	$9,616	$9,436	1,243	1,461
Schizophrenia	$3,685	$3,692	3,895	3,893



Data Notes:

- The diagnoses analyzed in the chart represent the six highest average cost per person and/or largest number of consumers by mental health diagnosis. This is consistent with the cost to treat people with the same diagnoses during CY 2001.
- ADHD: Attention deficit hyperactivity disorder
- Psychosis combined: psychosis of childhood origin (autism) and unspecified psychosis (pervasive developmental disorder)

Service Utilization: Mental Health

B. Cost per Consumer

Operational Definition:
The average cost per consumer is the amount of funds expended for each consumer or who had at least one paid claim for mental health services during the calendar year.

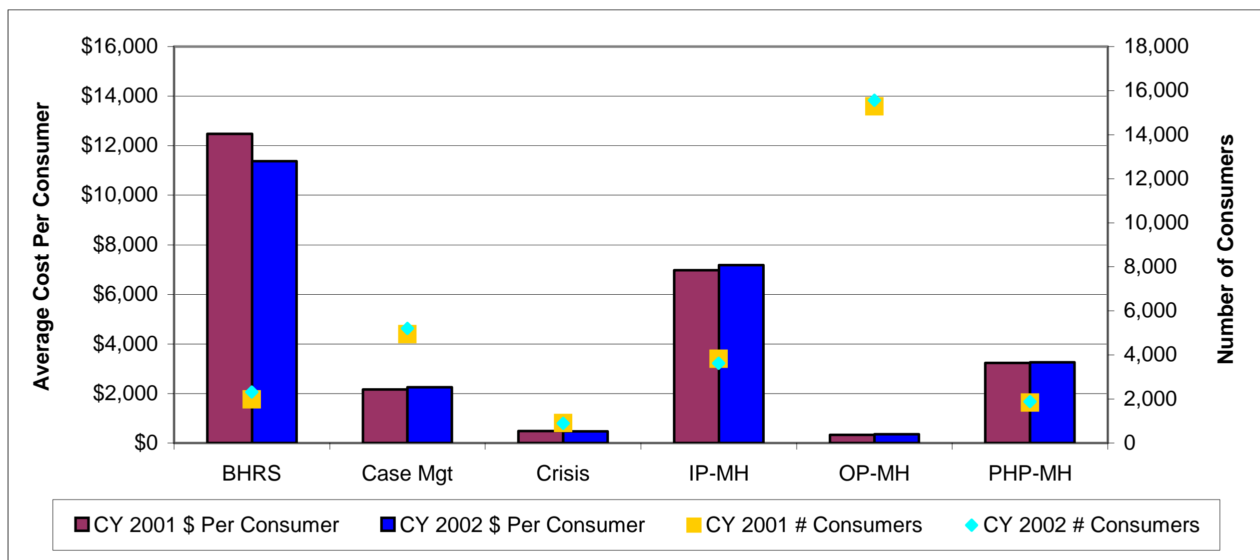
Rationale for Use:
Cost indicators and the number of consumers were analyzed to report the changes in utilization patterns longitudinally.

Discussion:

- Approximately $68.4 million was paid during CY 2002 for services to treat people with a primary mental health diagnosis. This represented 65% of total paid claims and 64% (16,046 people) of all consumers. In CY 2001, this represented 63% of total paid claims and 63% (14,728 people) of all consumers.
- With the exception of the average cost per consumer for behavioral health rehabilitation services, the number of consumers and average cost per consumer remained relatively stable for the mental health services analyzed in CY 2002.
- For behavioral health rehabilitation services, the number of consumers remained relatively stable while the average cost per consumer decreased by 9% from CY 2001 to 2002.
  - The decrease in the average cost per consumer is related to the decrease in the average number of units utilized per consumer. In CY 2001, 817 units per consumer were utilized for behavioral health rehabilitation services in CY 2001 and 741 units per consumer in CY 2002.
    - Specifically, the average number of units per consumer of behavioral specialist consultant services decreased from 402 in CY 2001 to 366 units in CY 2002.
    - Community Care's efforts to improve delivery of behavioral health rehabilitation treatment included modifications of prescriptions that correspond with best practice and medical necessity guidelines. Therefore, the amount of service authorized more closely matched the amount of service necessary to treat the child's symptoms.

Comparison of the Number of Consumers and Average Cost per Consumer for Mental Health Services in CY 2001 and 2002

	CY 2001 Number Consumers	CY 2002 Number Consumers	CY 2001 Cost Per Consumer	CY 2002 Cost Per Consumer
BHRS	1,986	2,324	$12,485	$11,366
Case Mgt	4,946	5,205	$2,168	$2,255
Crisis	908	894	$495	$478
IP-MH	3,831	3,623	$6,969	$7,183
OP-MH	15,288	15,561	$339	$366
PHP-MH	1,846	1,887	$3,233	$3,262



Data Notes:

- The analysis provided in the chart represents the six levels of care with the largest number of consumers and/or highest average cost per consumer. This is consistent with the levels of care identified for CY 2001.
- Respite services (not graphed) were processed through reinvestment funds from March to August 2002. For the remainder of CY 2002, 376 consumers utilized respite as an in-plan service at an average cost of $2,195 per consumer.
- BHRS: Behavioral health rehabilitation services
- IP-MH: Inpatient mental health
- OP-MH: Outpatient mental health
- PHP-MH: Partial hospitalization program, mental health

Service Utilization: Mental Health

C. Admissions, Average Length of Stay, and Readmissions

Operational Definitions:

The admission rate is the number of inpatient mental health stays per 1,000 members for each quarter of the study period.

The average length of stay (ALOS) is the number of inpatient mental health days consumers used per quarter.

The readmission rate is the number of times a consumer is readmitted to the inpatient mental health care within 1-7 days and/or 8-30 days after the discharge from the initial admission, calculated as a figure per 1,000 members for each quarter of the study period.

Rationale for Use:

Admission rate, ALOS, and readmission rate provide indicators regarding the amount of inpatient and residential (non-hospital) services being utilized. An important goal of treatment is to maximize the use of least-restrictive and appropriate levels of care.

Operational Measures:

The admission rate is calculated by multiplying the total number of admissions by 1,000 and dividing by the MME.

ALOS is calculated by dividing the number of days for each inpatient or non-hospital episode by the total number of stays (defined by discharges) within a given service category.

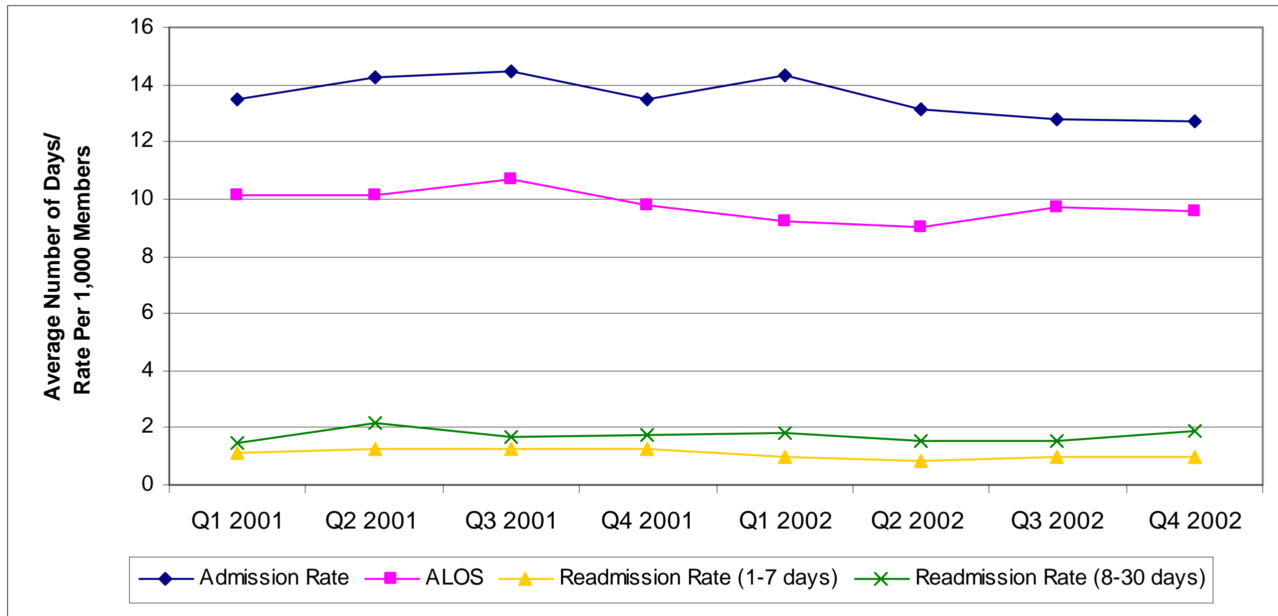
The readmission rate is calculated by multiplying the number of people readmitted within 1-7 or 8-30 days by 1,000 and dividing by the MME.

Discussion:

- There were a total of 6,419 admissions for inpatient mental health services in CY 2002, a slight decrease from 6,550 admissions in CY 2001.
- Inpatient mental health ALOS and readmission rates remained relatively stable, while admission rates declined slightly from CY 2001 to 2002 (14.45 per 1,000 members in the third quarter 2001 to 12.73 per 1,000 members in the fourth quarter 2002).
- Voluntary admissions (201) represented 81% of inpatient mental health admissions, followed by involuntary admissions at the 302 level (11%), 303 level (5%), and 304 level (3%) during CY 2002. These figures remained consistent with the percent of admissions by level in CY 2001.

Admission and Readmission Rates and ALOS for Inpatient Mental Health Services

	Q1 2001	Q2 2001	Q3 2001	Q4 2001	Q1 2002	Q2 2002	Q3 2002	Q4 2002
Admission Rate Per 1,000 Members	13.49	14.24	14.45	13.47	14.29	13.15	12.78	12.73
ALOS	10.10	10.10	10.70	9.80	9.20	9.00	9.70	9.60
Readmission Rate Per 1,000 Members (1-7 days)	1.10	1.24	1.28	1.23	1.00	0.85	0.97	1.01
Readmission Rate Per 1,000 Members (8-30 days)	1.50	2.17	1.69	1.74	1.80	1.57	1.57	1.87



Service Utilization: Dual Diagnosis

A. Cost Per Consumer

Operational Definition:
Average cost per consumer represents the average amount of funds expended for each consumer with a dual diagnosis of mental illness and substance abuse (MISA).

Rationale for Use:
Cost indicators and the number of consumers were analyzed to report changes in utilization patterns longitudinally.

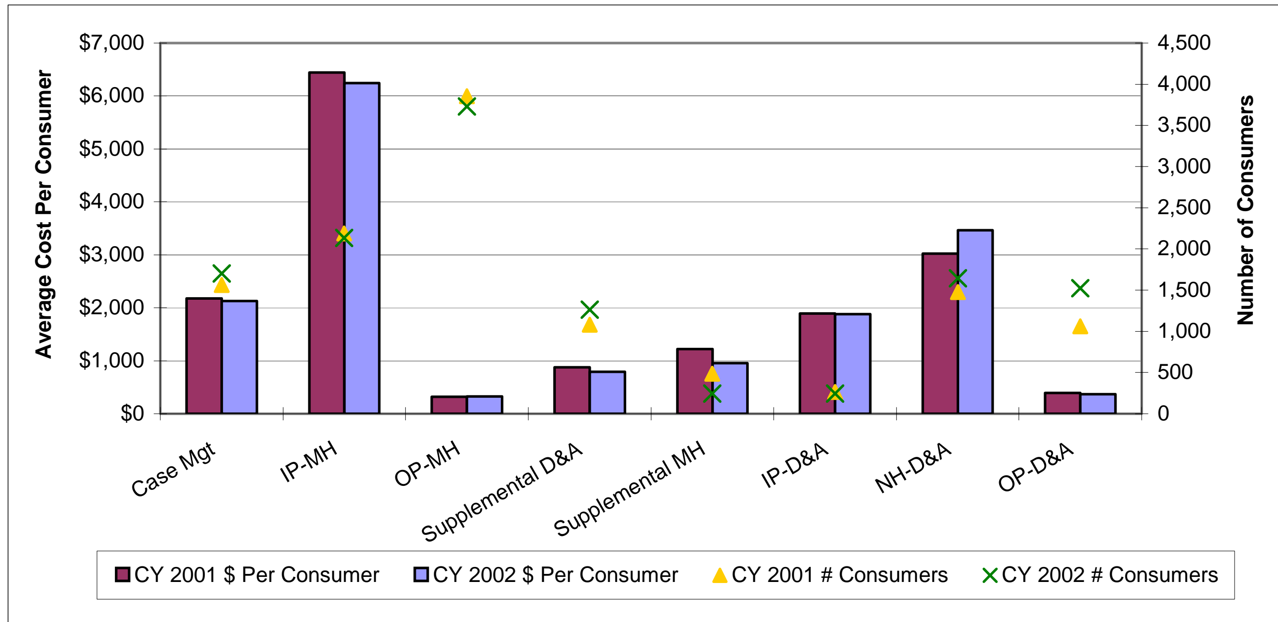
Operational Measures:
The average cost per consumer for people with a MISA diagnosis is calculated by dividing the total amount paid for a given service by the total number of unduplicated recipients who had a paid claim for the given service during the calendar year.

Because a consumer may access different levels of care concomitantly and more than one service during the study period, the consumer would be counted once (unduplicated) and each service would be counted as a unique episode.

Discussion:
- The number of consumers identified with a dual diagnosis increased by 17% from 5,710 consumers in CY 2001 to 6,854 consumers in CY 2002.
- The requirement for Community Care care managers to document the occurrence date of the MISA screening began July 1, 2002 for inpatient services and October 15, 2002 for outpatient services. AHCI verifies the administration of MISA screenings recorded in Community Care's electronic documentation system.
- A substantial increase of 30% was observed for the number of consumers who utilized outpatient drug and alcohol services (from 1,062 people in CY 2001 to 1,525 in CY 2002).
  - The overall increase in the number of consumers is due to increases in the number of individuals who received specific types of outpatient drug and alcohol services.
    - The number of consumers who had their first appointment/intake with a clinician increased from 238 in CY 2001 to 665 people in CY 2002. The number of consumers who received individual psychotherapy also increased from 809 in CY 2001 to 1,014 people in CY 2002.
- The relative stability in the average cost per consumer for outpatient drug and alcohol services is related to the utilization of units per consumer for CY 2001 and 2002. The average number of units utilized per consumer was 21 in CY 2001 and 17 in CY 2002.
- An increase of 10% was observed for the number of consumers who utilized non-hospital drug and alcohol services (from 1,475 people in CY 2001 to 1,642 in CY 2002). The average cost per consumer increased by 13%, from $3,025 in CY 2001 to $3,462 in CY 2002. As previously stated, the rise in cost was a result of a fee schedule increase.

Comparison of the Number of Consumers and Average Cost per Consumer (Dual Diagnosis) by Service for CY 2001 and 2002

	CY 2001 Cost Per Consumer	CY 2002 Cost Per Consumer	CY 2001 Consumers	CY 2002 Consumers
Case Management	$2,177	$2,130	1,561	1,703
IP-MH	$6,445	$6,243	2,187	2,132
OP-MH	$322	$327	3,854	3,729
Supplemental D&A	$875	$794	1,081	1,263
Supplemental MH	$1,223	$954	485	245
IP-D&A	$1,895	$1,878	265	245
NH-D&A	$3,025	$3,462	1,475	1,642
OP-D&A	$394	$369	1,062	1,525



Data Notes:

- IP-MH: Inpatient mental health
- OP-MH: Outpatient mental health
- IP-D&A: Inpatient drug and alcohol
- NH-D&A: Non-hospital drug and alcohol
- OP-D&A: Outpatient drug and alcohol

Complaints, Denials, and Grievances

Operational Definitions:
A complaint is an issue a member or provider presents to the managed care organization, either in written or oral form, which is subject to resolution by the managed care organization. If the member is not satisfied with the decision of a first level complaint, a second level complaint may be filed with the managed care organization, after which an external complaint or third level complaint may be filed. An external complaint review is a hearing conducted by the Department of Health or the Department of Insurance and the decision is binding on the managed care organization.

A denial of service is a determination made by a managed care organization in response to a provider's request for authorization to deliver HealthChoices services of a specific duration and amount which is:

- Denied completely based on medical necessity;
- Approved for a lesser amount or duration than originally requested by the provider; or
- Approved to deliver an alternative service(s) than originally requested by the provider.

A grievance is a request by a member or a health care provider, with written consent from the member to file a grievance, to have the managed care organization reconsider a denial concerning medical necessity and appropriateness of services.

Rationale for Use:
Complaints, denials, and grievances are monitored to ensure that Community Care maintains compliance with Act 68 guidelines for timely and accurate resolution of member issues.

Operational Measures:
The number of complaints, denials, and grievances is generated from information systems data from Community Care's electronic care management database.

Discussion:

Member Complaints

- Member/family members filed 223 first-level complaints with Community Care during CY 2002. This represents a 23% decrease from the number of complaints (290) filed in CY 2001.
- The two most common types of complaints were member/family being billed by the provider (68 or 31%) and consumer dissatisfaction with services (21 or 9%).
- In CY 2002, the majority of complaints were resolved during the first level process, with 20 (9%) continuing on to a second level review meeting.

Medical Necessity Denial and Member Grievances

- Community Care issued 133 medical necessity denials during CY 2002. This compares to 229 medical necessity denials issued in CY 2001 (a 42% decrease).
- Of the 133 denials in CY 2002, 42 (32%) were grieved at the first level and 26 (20%) were presented at a second level review meeting. Of the 229 denials in CY 2001, 97 (42%) were grieved at the first level and 25 (11%) were presented at a second level review meeting.

- As a result of the first and second level review meetings, a total of 54 denials were overturned in CY 2001 and 27 denials were overturned in CY 2002.

External Reviews and Fair Hearings

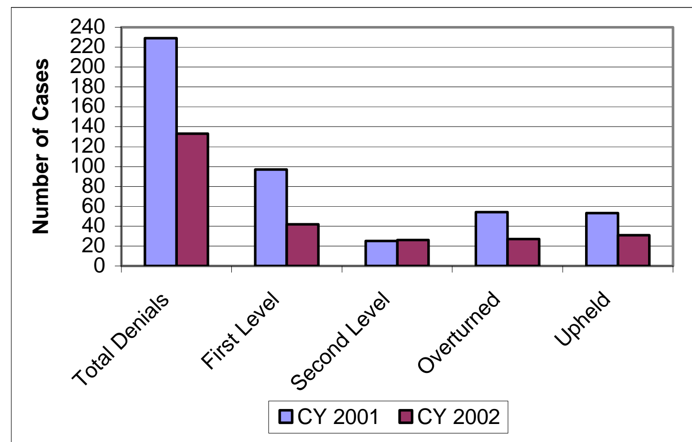
- Seven external review/fair hearings were filed during CY 2002. Of these, three were upheld, three were overturned, and one was pended. This is an increase from the two cases managed through the external review/fair hearing process in CY 2001.

Provider Complaints

- One hundred fifty-three (153) provider/facility complaints were received during the CY 2002. This compares to 58 (72 % increase) provider-initiated complaints for the CY 2001.
- Overall, the most frequent complaints regarded:
  - Claims processing – 56% (85);
  - Contracting/Provider Network – 27% (42); and
  - Authorization process – 17% (26).
- The most common issue associated with the claims processing was incorrect provider information (i.e. provider profiles) within Community Care's claims vendor system. This issue resulted in a significant increase in provider complaints for the third and fourth quarters of 2002. The expenditure section (A. Claims) of the report provides a summary of this issue.

The Number of Member Denials, Grievance Levels, and Decisions in CY 2001 and 2002

Denials	CY 2001	CY 2002
Total	229	133
First Level Grievances	97	42
Second Level Grievances	25	26
Overturned	54	27
Upheld	53	31



Critical Incidents

Operational Definitions:

Critical Incidents or Significant Member Incidents (SMIs) are identified as any member episode that may have an impact on outcome of care. These may include but are not limited to the following: member deaths, potentially lethal suicide attempts/self inflicted injury, apparent accidents, adverse effects of medications requiring medical intervention, injury to restraint/seclusion, injury at provider site, life threatening injury or illness while on provider site requiring hospitalization, sexual/physical abuse complaint by member against provider, and the arrest of a member active in treatment.

Rationale for Use:

Critical incidents or SMIs are monitored to ensure that care is delivered in a safe environment based upon clinically appropriate assessment and interventions and to identify delivery of care patterns and opportunities for improvement.

Operational Measures:

This section of the report focuses on three categories of critical incidents: member deaths, attempted suicides, and serious injuries. In the category of member deaths, AHCI has subdivided deaths into four categories: natural cause, unclear cause, apparent suicide, and apparent accident. Member deaths have a preliminary categorization by Community Care but the final designation is made based on Community Care's receipt of the Allegheny County Coroner's report, which can cause the number in any of the four categories to change slightly throughout the year.

The category identified as serious injuries, includes all of the events mentioned in the operational definition with the exception of member deaths, elopements/discharges categorized as AMAs (against medical advice), and readmissions.

Discussion:

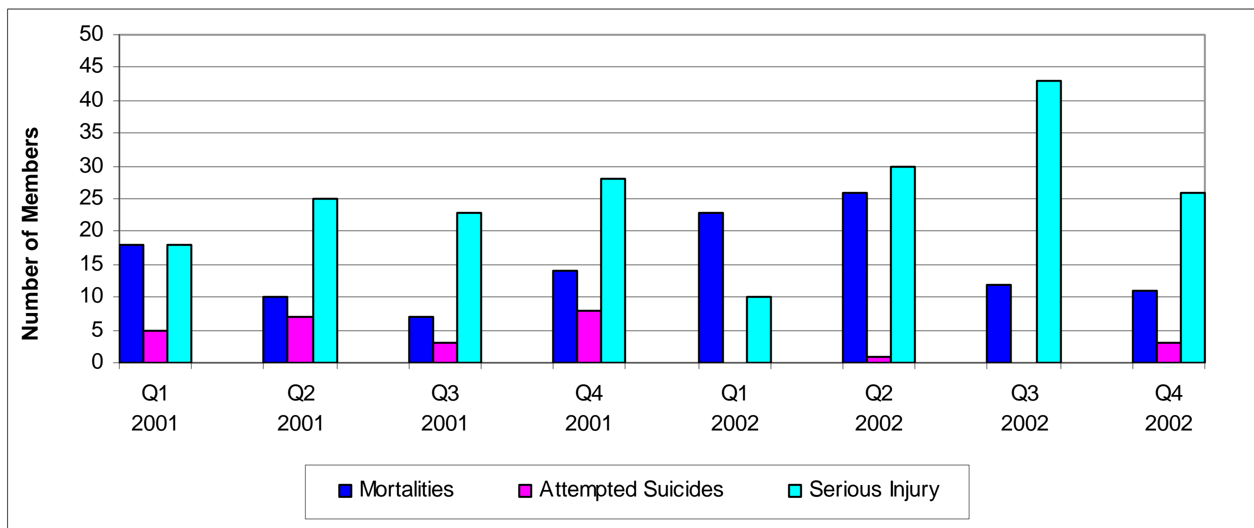
- During CY 2002, 188 incidents related to death and/or serious injury occurred including the following:
  - Death by natural cause……………………………………………….. 38
  - Death by apparent accident……………………………………………17
  - Death by apparent suicide………………………………………………1
  - Death with unclear cause.……………………………………………...16
  - Potentially lethal suicide attempts…………………………………….….. 6
  - Serious injury or illness requiring medical intervention……………...110
- During CY 2002, the largest category of critical incidents was serious injury. The number of incidents reported for the serious injury category fluctuated substantially throughout CY 2001 and 2002, ranging from 10 to 44 in any given quarter.
  - The largest percentage of people in this category continues to be male (57%), Caucasian (75%), and in the 13-17 year age group (53%).

- Residential treatment facilities continue to be the most prevalent level of care (74%) for consumers in this group for CY 2002. The number of critical incidents that occurred in residential treatment facilities increased from 47 in CY 2001 to 81 in CY 2002. This increase may be a result of improved reporting procedures implemented by residential treatment providers.

- Overall, the number of mortalities in each of the four categories remained low, with relative consistency over the past three years.
  - Natural cause continues to be the primary type of member death for CY 2001 and 2002.
  - The largest percent of people in this category are female, Caucasian, and in the 45-64 year age group. This represents the same pattern observed in CY 2001, with the exception of a higher percentage of male consumers in CY 2002.
  - All members within the four categories of member deaths received behavioral health services through Community Care.
- There was one reported suicide for CY 2002 and six attempted suicides.
  - In the category of attempted suicides, the largest percentage of people was evenly male/female, Caucasian, 22-44 years old, and who had utilized inpatient mental health services previously.

Critical Incidents Depicted by Quarter

Quarter	Mortalities	Attempted Suicides	Serious Injury
Q1 2001	18	5	18
Q2 2001	10	7	25
Q3 2001	7	3	23
Q4 2001	14	8	28
Q1 2002	23	0	10
Q2 2002	26	1	30
Q3 2002	12	0	44
Q4 2002	11	3	26



Education, Outreach, and Ombudsman Activity

Operational Definition:
Ombudsman services are services that assist HealthChoices members with access and treatment issues, complaints and grievances, and provide education regarding services and resources.

Rationale for Use:
AHCI promotes the principles and practices of recovery, best practices in both the provision and management of services, and core competencies for providers through education, training, outreach and health care rights advocacy. Ombudsman activities are analyzed to identify training and education opportunities, community outreach, and other member issues that are pertinent to access and service delivery.

Discussion:

Training and Education Efforts
During CY 2002, AHCI provided two trainings for recently implemented community treatment team (CTT) program managers and their staff. Sessions were conducted by national consultant Martha Hodge, and were directed at the incorporation of best practices and recovery principles. In addition, AHCI provided continued leadership and support to the Allegheny County Coalition for Recovery resulting in the following:

- Development and county-wide implementation of a recovery Tool Kit for educators and trainers;
- Establishment of a county-wide Speaker's Bureau to provide speaker resources on topics related to recovery from behavioral health disorders;
- Successful public awareness activities to celebrate the Coalition's declaration of the year 2002 as the "Year of Hope", including a Recovery Fair, a Recovery Picnic for consumers, and sponsorship of a dance event for the City of Pittsburgh First Night event; and
- Development of quality indicators for provider use, and collaboration with the County Department of Human Services which resulted in the incorporation of a statement of recovery principles in the County's contracts with behavioral health providers.

Community Outreach
AHCI continues its collaboration with Community Care in the provision of face to face, community based education and outreach for HealthChoices members, families, providers and other stakeholders. During CY 2002, AHCI's efforts continue to reflect a priority focus on the following areas:

- Educating consumers, family members, and providers about consumer rights in the HealthChoices program;
- Empowering consumers and family members to exercise their rights; and
- Promoting the principles and practices of recovery among all stakeholders and all levels of care throughout the Allegheny County behavioral health system.

Activities related to these efforts included updating and improving on AHCI Ombudsman resources. This includes the Ombudsman brochure; consumer rights training sessions for an increased number of child serving agency and advocate organizations; and AHCI participation in system improvement efforts of the Consumer Health Coalition on behalf of persons with disabilities.

Ombudsman Activities

Contacts with the Ombudsman have increased from an average of 47 per month in CY 2001 to 54 per month during CY 2002. Of total contacts, 46% occurred face-to-face. The majority of inquiries received involved dissemination of information, education, and/or assistance with complaints and grievances. Physical health issues accounted for approximately 6% of all inquiries. These trends are consistent with those seen in CY 2001.

Ombudsman Inquiries
Monthly Comparison 2000-2002