2015 Year in Review

The Allegheny County HealthChoices Program

Medicaid is the primary publicly financed health care program in the United States, covering approximately 80 million individuals with low-incomes and/or a disability.[1] Pennsylvania's mandatory managed care program for Medicaid recipients, HealthChoices, provides services to address physical and behavioral (mental health and substance use disorders) health needs. The three goals of the HealthChoices program are to assure greater access to care and improved quality while managing costs.[2]

This annual report is part of Allegheny HealthChoices, Inc's (AHCI) oversight and monitoring of the HealthChoices program and highlights enrollment, service utilization and cost information from claims data. Since Medicaid expansion became effective in Pennsylvania on January 1, 2015, this report also indicates changes observed within Allegheny County's behavioral health system as a result of its implementation.

The HealthChoices Behavioral Health program makes mental health and substance use disorder services available to over two million Pennsylvanians[2]

Medicaid Expansion and Access to Behavioral Health Care

Coverage for the Uninsured

In early 2015, Pennsylvania joined 27 states and the District of Columbia in the implementation of Medicaid expansion.[1] Under Medicaid expansion, health care coverage is extended to all adults with incomes up to 138 percent of the federal poverty level.[1, 3] As of July 2015, 439,000 people were enrolled in Pennsylvania's expanded Medicaid program.[4] In Allegheny County, enrollment in Medicaid expansion from January to December 2015 included 53,630 people.

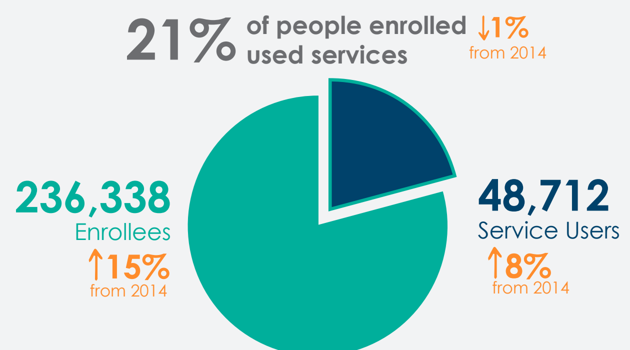
Cost Benefits of Medicaid Expansion

States that have implemented Medicaid expansion have been able to save on behavioral health and uncompensated care costs for people who were previously uninsured.[1,5] Thirteen states have reported behavioral health savings due to people who previously relied on state funds to cover behavioral health services who now receive those services under Medicaid.[5-6] In an analysis conducted by AHCI, Allegheny County[i] behavioral health costs have decreased by $2.09 million from 2014 to 2015, as a result of Medicaid expansion.

Enrollees and Service Users in Allegheny County

As anticipated with Medicaid expansion, the number of enrollees and people that access services increased by 15% and 8%, respectively (see Figure 1). Despite this, there was a 1% decline in the percentage of people who accessed services from 2014. This decline indicates that Medicaid expansion has provided access to behavioral health services for a significant number of adults but behavioral health service use has not increased at the same rate to date. The penetration rate may increase in the future as more newly eligible adults become aware of and begin using behavioral health services.

Figure 1. Enrollees[ii] and Service Users, 2015



In FY 2015, across all 50 states and the District of Columbia, Medicaid enrollment increased on average by 13.8%, with an average of 18% for the states that implemented expansion.[5] Enrollment increased by 15% in Allegheny County.

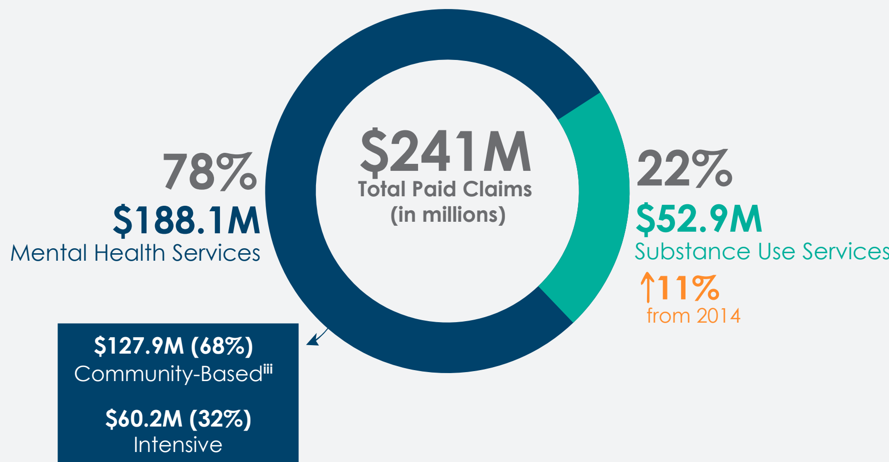
[i] In Allegheny County Base funds are used to provide support to people who are not eligible for HealthChoices, and to deliver services and supports not covered under Medical Assistance.

[ii] The number of enrollees in this report are based on the distinct number of people who were eligible for services as reported by the Behavioral Health Managed Care Organization (Community Care Behavioral Health) in Allegheny County. Previous annual reports reported the number of enrollees based on the amount of time someone was enrolled in Medicaid, which results in a lower number of people enrolled. As a result, service penetration is lower in this report, however, this rate is a more accurate representation of the data.

Cost of Behavioral Health Care

Figure 2. Total Behavioral Health Paid Claims, 2015

A. Everyone (All ages)



B. Medicaid expansion cohort (Adults only)

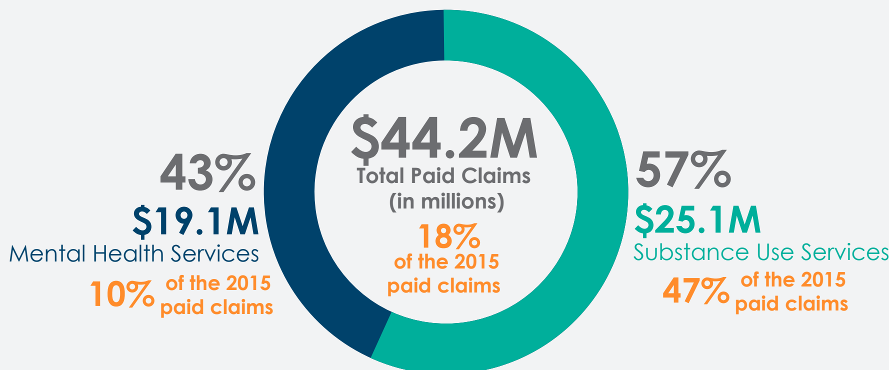


Figure 2 presents behavioral health paid claims for all HealthChoices members in Allegheny County (A), as well as for adults in the Medicaid expansion cohort (B). Table 1 presents the top ten behavioral health services[iv] by cost.

Overall paid claims for mental health services were similar to 2014, however, there were some notable changes in 2015.

- An increase in paid claims of 10% (+$2.0M) for outpatient mental health, 49% (+$1.97M) for crisis services, 4% (+$1.42M) for inpatient mental health, and 7% (+$769.7K) for residential treatment facilities for youth.
- A decrease in paid claims of 14% (-$4.6M) for behavioral health rehabilitation services (BHRS), 22% (-$1.5M) for partial hospitalization - specifically school based services, 44% (-$885.3K) for residential treatment facilities for adults, and 8% (-$652.7K) for extended acute care services.

Table 1. Top Ten Behavioral Health Services by Cost for All Age Groups, 2015[iv]

#	Service	Cost
1	Inpatient Mental Health	$35,622,559
2	Behavioral Health Rehabilitation Services (BHRS)	$29,283,845
3	Non-Hospital Rehabilitation	$25,872,412
4	Outpatient Mental Health	$25,575,923
5	Service Coordination	$19,154,986
6	Community Treatment Team (CTT)	$15,860,224
7	Residential Treament Facility (RTF)	$11,923,490
8	Family-Based	$9,552,236
9	Medication Checks	$8,336,494
10	Methadone Maintenance	$7,990,074

Notable changes from 2014 in paid claims for substance use disorder (SUD) services include:

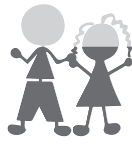
- An increase in paid claims of 11% (+$5.4M) for substance use services. Non-hospital rehabilitation (+$2.4M; 10%), methadone maintenance (+$702.1K; 10%), and intensive outpatient SUD services (+$559.8K; 22%) were the cost drivers.
- Much of the increase for SUD claims is attributable to adults in the Medicaid expansion population, as their SUD paid claims accounted for 47% of the total SUD paid claims in 2015.

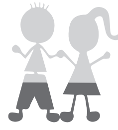
[iii] Community-based services are services provided within the community and/or home setting to meet the needs of the person (i.e. behavioral health rehabilitations services, community treatment teams, crisis services, outpatient mental health, etc.). Intensive services provide care in an inpatient or more restrictive setting (i.e. extended acute care, residential treatment facilities, and inpatient hospitalizations).

[iv] For a complete list and description of all services available in 2015 please visit http://www.ahci.org/wordpress/wp-content/uploads/2016/07/2015_HCAL_YearInReview_ServiceDescriptions.pdf.

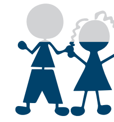
Behavioral Health Care Service Use for Youth (0 - 17) and Adults (18+)

48,712
People used mental health and/or substance use disorder services in 2015[v]


68% Adults

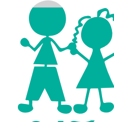

32% Youth

44,357
People used mental health services in 2015


66% Adults

34% Youth

10,727
People used substance use disorder services in 2015


94% Adults

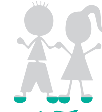

6% Youth

Table 2. Top Ten Behavioral Health Services (and top diagnoses)* by Number of People, 2015[v,vi]

Rank	Service (and top diagnoses)
1	**Outpatient Mental Health - 31,019** Depressive Disorder, Major Depression, Adjustment Disorder, Anxiety Disorder, ADHD, Bipolar Disorder
2	**Medication Check - 22,809** Major Depression, ADHD, Depressive Disorder, Bipolar Disorder, Anxiety Disorder, Schizophrenia
3	**Outpatient SUD - 7,764** Opioid, Alcohol, Cannabis
4	**Service Coordination - 6,230** Depressive Disorder, Major Depression, Schizophrenia, Bipolar Disorder, ADHD
5	**Crisis - 5,517** Diagnosis Deferred, Depressive Disorder
6	**Behavioral Health Rehabilitation Services (BHRS) - 5,292** Autism Spectrum Disorder, ADHD, Conduct Disorder, Adjustment Disorder, Oppositional Defiant Disorder
7	**Inpatient Mental Health - 3,839** Major Depression, Depressive Disorder, Bipolar Disorder, Schizophrenia
8	**Non-Hospital Rehabilitation - 3,046** Opioid, Alcohol
9	**Methadone Maintenance - 2,576** Opioid
10	**Intensive Outpatient SUD - 2,068** Opioid, Alcohol, Cannabis

Diagnoses are listed in this table if 10% or more of the people that used the service received the diagnosis.

Notable changes from 2014 for service use and diagnoses include:

- A decrease in the number of people that used BHRS (-423; 7%) and partial hospitalization mental health (-259; 17%).
- An increase in the number of people that used outpatient mental health (+2,207; 8%), medication checks (+957; 4%), outpatient SUD (+946; 14%), crisis services (+766; 15%), and inpatient mental health (+427; 13%).
- An increase in the number of people that received a diagnosis of depressive disorder (+5,399; 107%), opioid related use (+1,287; 24%), anxiety disorder (+1,168; 20%), bipolar disorder (+801; 14%), and alcohol related use (+428; 21%).
- A decrease in the number of people with a diagnosis related to poly-substance use (-645; 34%).

Of note is that with the introduction of the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) in 2015, the criteria set of symptoms was expanded for some diagnoses, which may have contributed to the increases observed in the data.[7] Additionally, poly-substance use is no longer classified as a diagnosis, which is the reason for the observed decrease.

9,943 people in the Medicaid expansion cohort used behavioral health services. For this group:

- **Non-hospital rehabilitation was among the top five services used.**
- **The top diagnoses were related to opioid use, followed by depressive disorder and major depression.**

[v] People could use more than one service and/or have more than one diagnosis.
[vi] For a complete list and description of all services available in 2015 please visit http://www.ahci.org/wordpress/wp-content/uploads/2016/07/2015_HCAL_YearInReview_ServiceDescriptions.pdf.

Drug and Alcohol Case Management: “Theresa’s Story”

The Drug and Alcohol Case Management (DACM) program, an independent, mobile, intensive case management program, was developed to serve 100 Medicaid eligible adults between the ages of 18-65 with a primary diagnosis of substance use disorder or co-occurring substance use disorder and mental illness. DACM offers four to six months of support for individuals with a history of readmission to detoxification or residential rehabilitation, who have not historically remained engaged in follow-up substance use treatment for at least 90 days.

Acting as a single point of contact, staff in this program use a Brief Critical Time Intervention (BCTI) approach to deliver individualized, person/family-centered support. Services also include 24 hours a day/7 days a week crisis intervention support, service planning, care coordination, advocacy, self-advocacy skill development, and assistance with accessing other relevant recovery-oriented services.

This program was initially developed using reinvestment funds but became a HealthChoices-eligible service in October 2015. Under the HealthChoices program, Theresa was one of the 115 people served in 2015.

Theresa is a lifetime resident of Allegheny County, works part-time, and enjoys spending time with her two daughters and her five grandchildren - soon to be six. Theresa also shares that she has been fighting alcohol addiction for a long time, going in and out of drug and alcohol treatment, and that she is currently approaching her ninth month of sobriety.

When asked about what has made a difference this time around Theresa says, “Probably me. I was more willing and open for suggestions. I did everything different this time. I got the [drug and alcohol] case manager, I was willing to do a step down (from a three quarter house) program, and I’m willing to do whatever it takes to stay sober. [It also] seems like every place I’ve been to this time around, everybody has been so supportive of me.” She also says her family has been very supportive, “They showed up at the Alcoholics Anonymous picnic and I was in tears.”

After trying many different programs, Theresa learned about the Drug and Alcohol Case Management program from previous program participants. Her case manager has helped her transition from treatment to the step-down program, ensures she has her medications, checks in with her regularly to make sure she’s doing well, assists with setting up therapy appointments, and referred her to the peer specialist program that starts in September. Theresa says they also plan to work on housing, “I don’t want to be here [step-down residence] forever . . . I [would] like to have a key to my own place.”

When speaking about her case worker, Theresa says, “She’s really good. She helps me. She’s very kind [and] caring. [She] makes you feel good. She’s always here for me. . . She keeps things running smoothly . . . I have a psychiatrist now, thanks to her telling me about that because I didn’t know how to go about doing that. . . . Also going to school [to be a peer specialist], that’s a big deal . . . I’m excited about that. . . I wouldn’t give her up for the world.”

When thinking about the future, five years from now Theresa wants to be stable, in her own apartment, still attending meetings, and working as a peer specialist. “[I] just want to live the rest of my days happy and serene.” Her advice to others, “. . . be more open minded and give things a chance. Don’t [think] we can do it all on our own . . . We have to take suggestions in order to get another day clean and to feel good. You need a [drug and alcohol] case worker. You need one on one therapy. You need the therapy because without that you’re never going to get to what the core of your disease is because it’s an ongoing thing, it goes on for a lifetime.”

Summary

In 2015, a majority of the changes noted were a result of Medicaid expansion. However, enrollment and growth are expected to slow over the next few years as most people eligible for Medicaid expansion join the program. AHCI will continue to monitor utilization and costs for the HealthChoices program quarterly and annually, as well as changes as it relates to Medicaid expansion.

Works Cited

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AHCI's mission is to assure equitable access to quality, cost-effective behavioral health care that promotes positive clinical outcomes, recovery, and resiliency.

AHCI is a contract agency for Allegheny County Department of Human Services's Office of Behavioral Health.