

Allegheny County HealthChoices Program

Consumers with Serious & Persistent Mental Illness

presented by



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

HealthChoices Behavioral Health Program Focus Quality Review:

Consumers with Serious & Persistent Mental Illness (SPMI)

Introduction

Many stakeholders have asked the question “Has HealthChoices made a difference in Medicaid recipients’ lives?” The answer to this question is not a simple one, and it can be approached in a variety of ways. One way AHCI has elected to look at this issue, is by analyzing the services that a sample of Medicaid consumers received both prior to and after mandatory enrollment in the HealthChoices program to determine if there has been any change in service delivery patterns. This is the topic of the October 2000 focus quality review.

For the purposes of this report, please note the following explanation of terms:

- Enrollees – Eligible Medicaid recipients who were enrolled in the HealthChoices program during the report period. This information is based on member month equivalents reported in capitation data.
- Community Care Consumers – HealthChoices enrollees on whose behalf a claim has been adjudicated for behavioral health services received through Community Care during the report period.
- Paid Claims – Paid Claims are used for calculation of numerous reports, including service utilization. Paid claims are based on all claims that have been adjudicated for behavioral health services received by enrollees through Community Care during the report period. Please note that these include some claims for services that were provided prior to the actual report period.

Defining the Data

Defining the Population

The sample population selected for this report was those consumers identified as seriously and persistently mentally ill (SMPI), since this group is the most likely to be involved in ongoing services. This includes HealthChoices consumers who are:

- 1) Designated as either Tier I or Tier II in Community Care’s PsychConsult care management data system; **and**
- 2) Designated in Allegheny County Department of Human Services (DHS) database as priority population P03 or P04; **and**

- 3) Have a base-funded service indicated in the DHS database. (Base-funded services are services that are not in-plan services for the HealthChoices program and are paid for by the County.)

According to Community Care's Tier system, Tier I cases are the highest priority and include consumers who have had three or more inpatient episodes of care, are in a level of care other than outpatient, and have a diagnosis consistent with the DPW standards for SPMI. Factors such as recidivism, severity and chronicity of illness and history of treatment non-compliance are all considered when making a recommendation for inclusion in Tier 1.

Tier II cases are those where a consumer has a diagnosis of SPMI, one inpatient episode, and belongs to either the Social Security Income or Federally Assisted Medical Assistance for General Assistance Recipients (FGA) categories of aid; or is a child/adolescent with authorizations for behavioral health rehabilitation or residential treatment facility services.

P03 cases are the "Adult Priority Group" defined in the *Mental Health Bulletin OMH-94-04*. In order to be included in this priority group a consumer must:

- Meet the federal definition of serious mental illness;
- Be age 18+ years (or 22+ years if in Special Education);
- Have a diagnosis of schizophrenia, major mood disorder, psychotic disorder NOS (not otherwise specified) or borderline personality disorder; and
- Meet at least one of the following criteria: treatment history; functioning level; and coexisting condition or circumstance. (The criteria for treatment history, functioning level, and coexisting condition or circumstance are included as *Attachment A* to this report.)

P04 cases are defined as consumers age 18+ years (or 22+ years if in Special Education) who meet the federal definition of serious and persistent mental illness as defined in the *Mental Health Bulletin OMH-94-04*, but do not meet all of the criteria for the adult target population as defined above (P03).

There was a total of 2,252 consumers with the Tier I or Tier2 and P03 or P04 designations as of September 18, 2000. Eighty three percent (or 1,877) of these consumers also had an identified base-funded service. This is the SPMI population considered in this report.

Defining the Timeframe

There were two timeframes used in this report to analyze service utilization. The first included January 1, 1999 (the beginning of the HealthChoices enrollment and implementation) to June 30, 2000 for the HealthChoices data. This timeframe allowed for an analysis of the data from the voluntary enrollment period as well as the first full year of mandatory enrollment for the HealthChoices program.

The second timeframe included July 1, 1998 to June 30, 2000 for the base-funded services data. This timeframe allowed for an analysis of the two fiscal years of base-funded services prior to HealthChoices implementation.

Report Limitations

While AHCI was able to match 83% of Community Care consumers with base-funded services, there was a difference of 375 HealthChoices consumers between these two samples. This includes consumers who had no identifiable base-funded service (199) and consumers who had a base-funded service, but not during the timeframe used for this report (176).

Although AHCI was not able to identify base-funded services for the 375 consumers, they may have indeed received such services, but the extent to which this occurs cannot be determined. This is due to difficulties matching consumers in the Department of Human Services (DHS) database, which can be attributed to:

- The differences in identification of consumers. The DHS database does not always have a social security number for a consumer, or the social security number is unknown and designated as 999-99-9999.
- Incomplete data entry due to resource constraints at DHS and/or reporting errors made by providers.

Despite the issues listed above, this information is the most reliable data available at this time for comparing service utilization prior to after HealthChoices implementation.

Demographics

Overall, the largest percentages of consumers in the SPMI population were Caucasian, female, and between the ages of 22 to 44 years. Additionally, most of these consumers were in Social Security Income (SSI) category of aid and had a diagnosis of schizophrenia. This information is based on paid claims for the 1,877 SPMI consumers in the sample.

Age*¹

Looking at the SPMI population by age, there were 1,211 consumers in the age group of 22 to 44 years, or 64% of population, followed by the 45-64 year age group, comprised of 605 (32%) consumers. Those consumers in the 18-21 year age group (69) represented 4% of the population, and the 31 consumers in the 65 and over age group represented 2% of the population. You would not expect to see consumers less than 18 years in the sample population, since SPMI is a category for adults.

¹ It should be noted that for age, eligibility category and diagnosis a consumer may be counted more than once, as it is possible for a consumer to have switched age groups, eligibility categories and diagnostic category during the 18 months that are included in this report. Only gender and race are categories can not change, and therefore, each consumer is counted only once in each of these categories.

Gender

There were 1072 (57%) female consumers in the SPMI category and 805 (43%) males. These numbers are similar to the distribution of consumers by gender in the general HealthChoices consumer population.

Race

The largest percentage of SPMI consumers were Caucasian (1,157 out of 1877 or 61%), followed by consumers identified as African American (692 or 37%), and those identified as 'Other' (28 or 2%). These numbers are almost identical to the distribution of consumers by race in the general HealthChoices consumer population, but disproportionately low when compared to the number of African American consumers in the HealthChoices enrollee population.

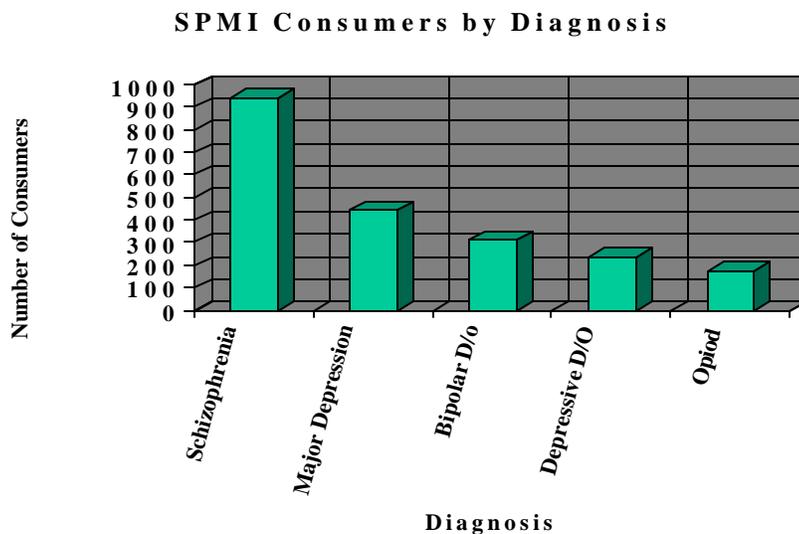
Category of Aid

Social Security Income (SSI) and Social Security Income with Medicare (SSIM) categories of aid accounted for the majority of the consumers in this group. SSI ranked first with 1,051 consumers or 56% of the SPMI population. SSIM was second with 465 consumers or 25% of the population. This was followed by Temporary Assistance for Needy Families (TANF) with 191 consumers (10%) and Federally Assisted General Assistance (FGA) with 187 consumers (10%).

Diagnosis

Looking at diagnosis, 940 of the 1,877 consumers in SPMI population (50%) were identified as having a diagnosis of schizophrenia. The following chart illustrates the five diagnoses with the largest percentage of consumers in the SPMI population.

Chart 1.0



The large number of SPMI consumers with a diagnosis of schizophrenia, major depression, bipolar disorder, and depressive disorder are not unexpected, since these diagnoses tend to be chronic in nature, often requiring various intensities of service over an extended period of time. Of interest is the diagnosis of opiod abuse/addiction as the diagnosis with the fifth largest number/percentage of SPMI consumers (176 consumers or 9% of the population). AHCI staff believes this is an indication of the issue of co-occurring disorders with HealthChoices consumers, includes those with SPMI. It is also likely that a large percentage of the remaining consumers have significant alcohol and drug problems that may not be reflected in the diagnostic data.

Service Utilization

Base-Funded Service Utilization

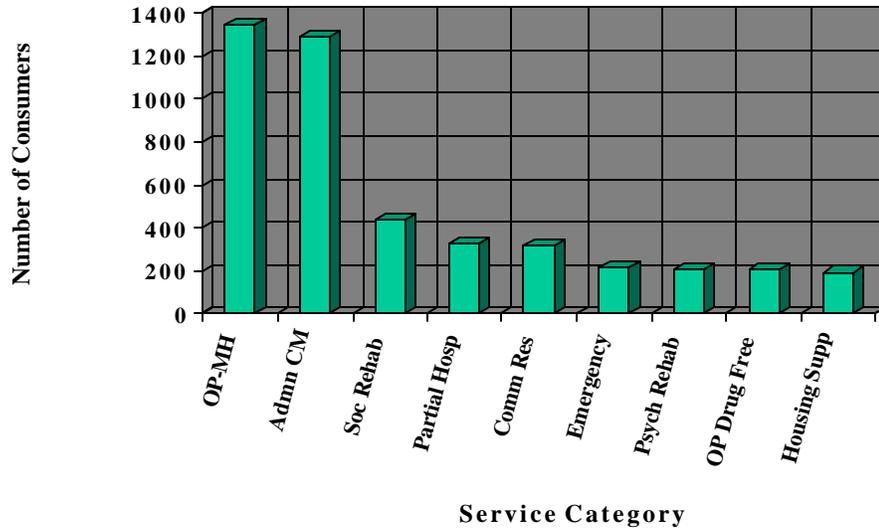
The data presented in this section represents two fiscal years of base side data, from July 1, 1998 to June 30, 2000, and shows the SPMI population who became HealthChoices members and utilized at least one base-funded service during this time period (pre-HealthChoices). While the total number of consumers is an unduplicated number (1,877), when looking at service utilization a consumer can be counted more than once, as a consumer can access more than one service type in a given timeframe.

Outpatient mental health services were the most frequently utilized base-funded service, with 1,346 out of 1877 (72%) of the SPMI population utilizing this service. Administrative case management was second with 1,288 consumers (69%) using this service.

The chart on the following page illustrates the nine most utilized base-funded services for the SPMI population from July 1, 1998 to June 30, 2000.

Chart 1.1

SPMI Population Utilization of Base-Funded Services



OP-MH: Outpatient mental health
Admin CM: Administrative case management
Soc Rehab: Social rehabilitation
Partial Hosp: Partial hospitalization
Comm Res: Community residential

Emergency: Emergency services
Psych Rehab: Psychiatric rehabilitation
OP Drug Free: Outpatient drug free
Housing Supp: Housing support services

With the exception of outpatient drug free services, the utilization of drug and alcohol base-funded services was lower than the utilization of mental health services for SPMI consumers. This is a historical trend that continues with the HealthChoices program.

While not the most utilized services, there were SPMI consumers who did use drug and alcohol services, again raising the issue of co-occurring disorders. The following includes a list of the base-funded drug and alcohol services most utilized by SPMI consumers prior to the implementation of the HealthChoices program:

- Inpatient non-hospital residential treatment & rehabilitation (95 consumers or 5%);
- Outpatient methadone maintenance (70 consumers or 4%);
- Drug and alcohol partial hospitalization (66 consumers or 4%);
- Inpatient non-hospital detoxification (29 consumers or 2%); and
- Inpatient non-hospital halfway house (20 consumers or 1%).

Overview of HealthChoices Service Utilization for the SPMI Population

From January 1999 through June 2000, Community Care paid nearly \$9 million in claims for the SPMI population. The average HealthChoices claims dollars spent per consumer was \$4,491. In terms of dollars paid by service categories, inpatient mental health services had the most paid claim dollars in each of the six quarters analyzed for this report. As AHCI has discussed before in previous reports, inpatient mental health services are the most intensive and costly of the HealthChoices in-plan services. It is anticipated that this service category would have the highest claims dollars associated with it.

When analyzing the SPMI population by age group, the 22 to 44 age group consistently has the highest number of dollars spent, the largest percentage of total expenditures, and the highest number of SPMI consumers utilizing these services. The 45 to 64 age group is second highest in these categories. This outcome is what one would expect, given that this report is looking at the adult population; that many of the consumers receiving mental health treatment are diagnosed as being mentally ill somewhere in their twenties; and that by the time a consumer reaches age 45, they generally are more stable having been in treatment for a number of years and require more maintenance type treatment rather than acute/stabilization treatment. Also, one must keep in mind that those over 65 are Medicare primary consumers with the bulk of the treatment they receive most likely to be paid by Medicare monies. Therefore, their HealthChoices utilization of services is heavily skewed by the fact that HealthChoices is the payer of last resort.

Looking at service utilization by race, consumers identified as Caucasian have the highest dollars spent, the largest percentage of expenditures and the highest number of consumers, with two exceptions. These include utilization by race in halfway house and non-hospital rehabilitation services, where African American consumers have the highest dollars spent, the largest percentage of expenditures, and the largest percentage of consumers utilizing this service. This is consistent with general HealthChoices service utilization patterns analyzed to date, where African American consumers (males especially) are more likely to use non-hospital (and longer term) drug and alcohol services, while Caucasian consumers are more likely to use other categories of service.

HealthChoices Service Utilization – By Quarter

There are two issues that need to be considered when analyzing HealthChoices service utilization by quarter. First, it is important to keep in mind that while the HealthChoices program began in January 1999, mandatory enrollment did not take place until July of that year. During the voluntary enrollment period, Medicaid recipients were actively encouraged to enroll early by entities such as Benova (the Independent Enrollment Assistance Program) and DPW caseworkers. It is believed, however, that the more chronically ill consumers were more likely to have waited until mandatory enrollment and were automatically enrolled in the program, much like the Southeast HealthChoices program experienced. It is likely that the SPMI population did not enroll in HealthChoices until July 1999. Therefore, one would expect to see a substantial increase in service utilization beginning with the third quarter of 1999.

Second, the data regarding service utilization is based on authorizations, not paid claims. This means that while the services have been approved, they may or may not have been utilized. (Lack of utilization is more likely to occur with less intensive services, such as outpatient, than with more intensive services, such as inpatient.) While this may effect the total number of consumers utilizing services in any given quarter, the differences should not significantly change the results.

When looking at service utilization patterns, medication management services consistently has the largest number of consumers utilizing these services across the six quarters reviewed. This is followed by outpatient mental health services, intensive case management, inpatient mental health services, and resource coordination.

Also of interest are two distinct changes that occur between the third and fourth quarters of 1999. The first is the large increase in volume of consumers. As noted earlier, the third quarter marks the beginning of mandatory enrollment, the point at which many of the SPMI consumers joined the HealthChoices program. In the third quarter there were 373 SPMI consumers receiving HealthChoices services. This number jumped to 1,490 in the fourth quarter.

Even with this large addition of consumers in the sample population, the practice patterns or mix of services these consumers used remained fairly consistent from quarter to quarter. That is, medication management and outpatient mental health services continued to be the categories of service utilized by the largest number of consumers across the six quarters.

As to whether or not this lack of change in practice patterns is positive or negative for consumers is not clear. It was an expectation with the implementation of the HealthChoices program/managed care that practice patterns would change to better manage and coordinate care. For the SPMI consumers, there have not been significant changes in practice patterns, but additional data collection and analysis are needed to determine the consequences of this.

Conclusions

The question remains “Has HealthChoices really made a difference in Medicaid recipients’ lives?” The data suggests that there may not have been any significant changes in practice patterns with the implementation of the HealthChoices program. The consequences of this lack of change is unclear.

Assuming that the goal of HealthChoices is to make positive changes in consumers’ lives, AHCI staff recommends further refining the way in which these differences are defined. Indicators could include:

1. Decrease in inpatient hospitalizations and other acute and intensive levels of care.

2. Increase in the utilization of treatment in the community, such as partial hospital, outpatient, intensive case management, resource coordination, and medication management.
3. Increase in the time between inpatient hospitalizations/Decrease in recidivism.
4. Increase in consumer satisfaction with treatment, treatment planning, and their involvement in treatment.

This issue will continue to be analyzed to see how utilization patterns evolve over time. With the addition of more HealthChoices data over time, it is hoped that analysis will show a positive change in the lives of the consumers as a result of the HealthChoices program.

ATTACHMENT A

Adult Priority Group Criteria for Treatment History, Functioning Level, and Coexisting Condition or Circumstance

- A. The criteria for treatment history are as follows:
- 1) Current residence or discharge from a state mental hospital within the past two years; **or**
 - 2) Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20+ days within the past two years; **or**
 - 3) Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years; **or**
 - 4) History of sporadic course of treatment as evidenced by at least three missed appointments within the past 6 months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services; **or**
 - 5) One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician (e.g. Area Agency on Aging) within the past two years.
- B. The criteria for functioning level are Global Assessment of Functioning (GAF) Scale (found in the DSM IV) rating of 50 or below.
- C. The criteria for coexisting condition or circumstance are:
- 1.) Coexisting diagnosis:
 - Psychoactive Substance Use disorder; **or**
 - Mental Retardation; **or**
 - HIV/AIDS; **or**
 - Sensory/Developmental and/or Physical disability; **or**
 - 2.) Homelessness (consumers sleeping in shelters or in places not meant for human habitation such as cars, parks, sidewalks, etc.); **or**
 - 3.) Release from criminal detention (jail diversion; expiration of sentence or parole; probation or Accelerated Rehabilitation Decision [ARD]).