Allegheny County

HealthChoices Program

Year End Report 2000

presented by

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April 2, 2001

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

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Executive Summary

The HealthChoices program is Pennsylvania's managed care program for adults and children who receive Medical Assistance. The program includes both physical and behavioral health care. This report reviews the second year of implementation of the behavioral health component of the HealthChoices program in Allegheny County, Pennsylvania. Allegheny County holds the contract for management and implementation of the program; the County in turn contracts for managed care services with Community Care Behavioral Health Organization (Community Care) and for oversight and other services with Allegheny HealthChoices, Inc. (AHCI).

Calendar Year (CY) 2000 represents the second year of implementation of HealthChoices but the first year of full enrollment. In that respect, 2000 will likely be the baseline year against which future performance can be evaluated.

The customary start-up issues experienced by the HealthChoices program in 1999 generally were not experienced in 2000. Community Care substantially met contractual performance standards in all areas, with the exception of claims payment. During the first and second quarters of 2000, Community Care did not meet claims performance standards due to a change in their claims vendor's payment system. Once the vendor corrected its system problems, these standards were met.

Enrollment remained steady through the year at about 120,000 persons, of which approximately 23,000 individuals used behavioral health services. Patterns of utilization observed in the second half of 1999 continued in 2000, with African American consumers accessing services at an apparent disproportionately low level compared to enrollment. Utilization of services between men and women was about equal. The greatest percentage of users was in the 22-44 year age group. Children under 18 years of age represented 34% of users.

The year 2000 saw a substantial increase in community education and outreach activities on the part of both AHCI and Community Care. Several community forums were held; the Ombudsman initiated regularly scheduled visits to drop-in centers, community fairs and other sites. AHCI and Community Care each also developed education and outreach plans focusing on minority communities and other underserved populations.

Allegheny County views 2000 as a successful year for the HealthChoices program as evidenced by the following:

- Achievement of substantial costs savings for reinvestment into new and expanded services;
- Development of several in-depth quality focus studies that provided useful information for program initiatives and reinvestment planning;
- Provision of training and technical assistance to many providers in the HealthChoices network; and

- Implementation a quality review program for Behavioral Health Rehabilitation Services for Children and Adolescents and the institution of a provider profiling system.

The third year (2001) of HealthChoices will provide an opportunity for greater improvement in the range and quality of services for Allegheny County residents. The system will focus on:

- Implementation of a comprehensive community education and outreach plan with strong collaboration between AHCI and Community Care;
- Increased integration between Community Care and the physical health managed care organizations to improve the coordination of medical and behavioral health services; and
- Implementation of services funded through reinvestment dollars.

I. Introduction

A. Overview of the HealthChoices Program

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

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

B. Allegheny County Model for HealthChoices

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

Allegheny County, in turn, contracts with AHCI to carry out the County's oversight and monitoring responsibilities required under the HealthChoices Program. This includes overseeing the HealthChoices administrative and programmatic operations of the County's subcontractor for the program, and providing training for and operating the Ombudsman Program.

The County also contracts with Community Care Behavioral Health Organization (Community Care) to manage behavioral health services for the HealthChoices program. This includes provider network development, utilization management, quality management, claims management, information systems, reporting, member services, and prevention and outreach.

C. The Face of HealthChoices

The HealthChoices program began operations on January 1, 1999. MA recipients were able to voluntarily enroll in the program through July 1, 1999, when full mandatory enrollment was implemented. At that point, any MA recipient who had not chosen an HMO plan was automatically assigned one by the State. This mandatory phase boosted enrollment to almost 121,000 people. Throughout the remainder of 1999 enrollment remained between 120,000 and 122,000 people. Enrollment began to decline slightly through 2000, ranging from 121,000 down to 119,000 by year-end.

It should be noted that whenever a person enrolls in one of the HealthChoices physical health managed care organizations (PH-MCO), s/he is automatically enrolled with Community Care, regardless of whether s/he has used or currently uses behavioral health services.

For the purposes of this report, the term "**members**" refers to people who have enrolled in the HealthChoices program. The term "**users**" refers to people who have enrolled in HealthChoices and who have accessed services sometime during the year.

After two years of operation, eligibility and claims data provide a snapshot of the people enrolled in HealthChoices and the services they have used. An average of 120,349 members were enrolled per month (member month equivalents) in the HealthChoices program for the year. The total number of unduplicated members enrolled in Health Choices CY 2000 was 119,253. Of the total members, 23,074 people (or 19% of those enrolled) actively used behavioral health services in CY 2000. Fifty two percent of these people were women and 48% were men. The breakdown by age of the HealthChoices users is illustrated in the following table:

Table 1.0

HealthChoices Users by Age Group

Age Group	Number of Users	Percentage of Total User Population
0–5 years	889	4%
6-12 years	4,363	18%
13-17 years	3,058	12%
18-21 years	1,101	4%
22-44 years	9,299	38%
45-64 years	5,068	21%
65+ years	615	3%
Total Number of Members Using Services: 23,074*		

**NOTE*: *Members may appear in more than one age group if one claim was filed on their behalf before their birthday and another claim was filed after their birthday, thus moving them into a different age category.*

As Table 1.0 shows, users 22-44 years old represented the largest age group. The next largest age group was people 45-64 years of age, followed closely by those ages six-twelve years old. Very little has changed from 1999; all age groups represent nearly the same proportion of the total enrolled population.

In terms of race, the HealthChoices user population reflects neither the HealthChoices program membership nor the overall Allegheny County population. Unchanged from 1999, the majority of people who accessed HealthChoices services in CY 2000 were identified as Caucasian (61%). The second largest group was identified as African American (38%). This represents a higher percentage of African American people than is found in the County population at large. However, it is a lower percentage than found in the HealthChoices membership. This implies that while more African American people are eligible for HealthChoices services, fewer utilize them. The disparity in service utilization is addressed further in one of the focus reports summarized later in this report.

Other ways to look at the HealthChoices population is by category of aid, diagnostic category, and service utilization.

1. Category of Aid

There are seven different eligible groups or aid categories to which HealthChoices members can belong. These include the following: (Category abbreviations are bolded and included in parenthesis. Please note that two categories of members are represented in the "State Only" description below.)

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

Category of aid is important because it determines the amount of capitation funds the managed care organization receives for each member, whether the person receives behavioral health services or not. Different aid categories receive different capitation rates. Projecting the number of members and users in each category is crucial in the managed care budgeting and administrative management processes.

Throughout CY 2000, enrollment activity among the different categories of aid shifted. For example, the TANF category of aid, which covers many recipients receiving welfare benefits, decreased by 2,700 members through the year. Conversely, the SSI category of aid increased by 2,300 members throughout the year, and may indicate that individuals formerly covered by TANF have transitioned to SSI. Charts 1.0 and 1.1 depict these changes.

Chart 1.0
2000 TANF Enrollment by Month

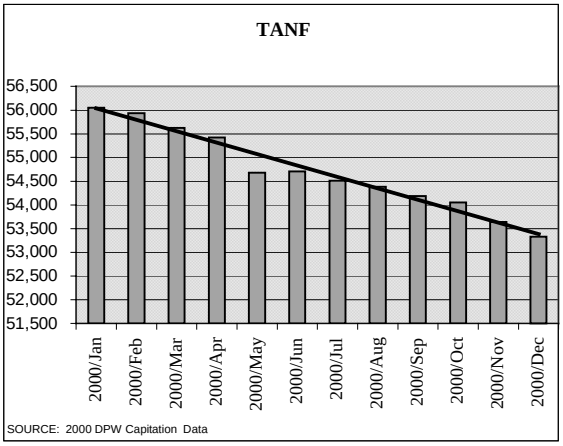
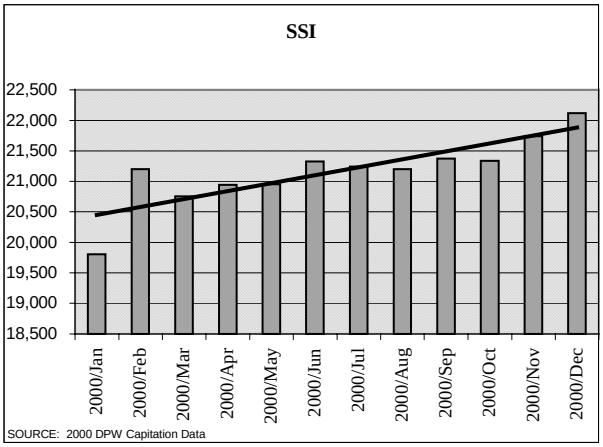


Chart 1.1
2000 SSI Enrollment by Month



One impact these shifts had on the program was that the amounts paid for each member vary between categories. In addition, a member's needs are different among categories of aid. Typically, members who qualify for SSI experience more chronic, severe problems. Further discussion of shifts between categories of aid occurs in the financial performance section of this report.

Other categories of aid shifted slightly, including Healthy Beginnings, which increased by over 1,000 members, and was most likely due to the state's increase in the age limit for eligibility.

2. Diagnostic Category

The top mental health and substance abuse diagnoses are presented separately in this section. This presents a comprehensive picture of the diagnoses associated with behavioral health services utilized during CY 2000. It is important to remember that a user may carry more than one diagnosis. When this was the case, more than one diagnosis was associated with the care a user received. Therefore, a user could be included in more than one diagnostic category.

Mental Health Diagnostic Categories

Table 1.1 illustrates the mental health diagnostic categories that had the highest expenditure and number of users during CY 2000.

Table 1.1

Diagnosis by Expenditure and Number of Users

Diagnostic Category	Number of Users	Expenditure	Cost Per User
Major depression	4,537	$9,073,533	$2,000
Schizophrenia	3,778	$13,275,365	$3,513
Depressive disorder	2,859	$6,776,381	$2,370
Attention deficit/hyperactivity disorder	2,713	$12,480,993	$4,600

Substance Abuse Diagnostic Categories

Table 1.2 illustrates the substance abuse diagnostic categories with the highest expenditure and number of users for CY 2000.

Table 1.2

Substance Abuse Diagnostic Categories by Expenditure and Number of Users

Diagnostic Category	Number of Users	Expenditure	Cost Per User
Opioid dependence/abuse	1,570	$4,539,587	$2,891
Alcohol dependence/abuse	1,268	$1,688,247	$1,331
Cocaine dependence/abuse	912	$1,919,639	$2,105

The substance abuse diagnostic categories with the highest number of users and expenditure were different for adults and children/adolescents. The top diagnostic categories for adult users were opioid disorders, alcohol dependence/abuse, and other substance dependence/abuse. The top categories for children/adolescents were cannabis disorders, alcohol dependence/abuse, opioid disorders, and other substance dependence/abuse.

Substantially different numbers of total users and expenditure were seen between mental health diagnoses and substance abuse diagnoses. Capacity issues, historically low funding, and difficulty in engaging clients have influenced the underutilization of substance abuse services.

3. Service Utilization

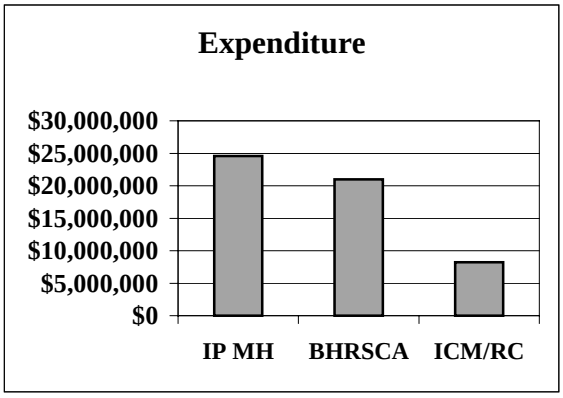
During CY 2000, 23,074 users in Allegheny County accessed services under the behavioral health component of the HealthChoices program. The total expenditure for these services was $90,602,289, or an average of $3,927 per user.

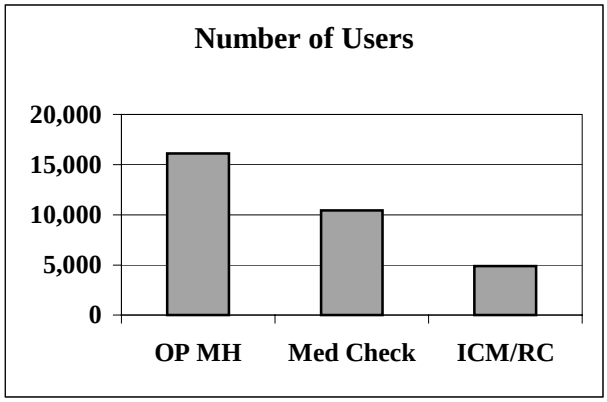
Mental Health Services

The highest average cost per user for the year was $31,557 for residential treatment facility services. Charts 1.2 and 1.3 reflect the services with the highest total number of users and expenditure.

Charts 1.2 and 1.3

Mental Health Services By Expenditure and Number of Users





Key:

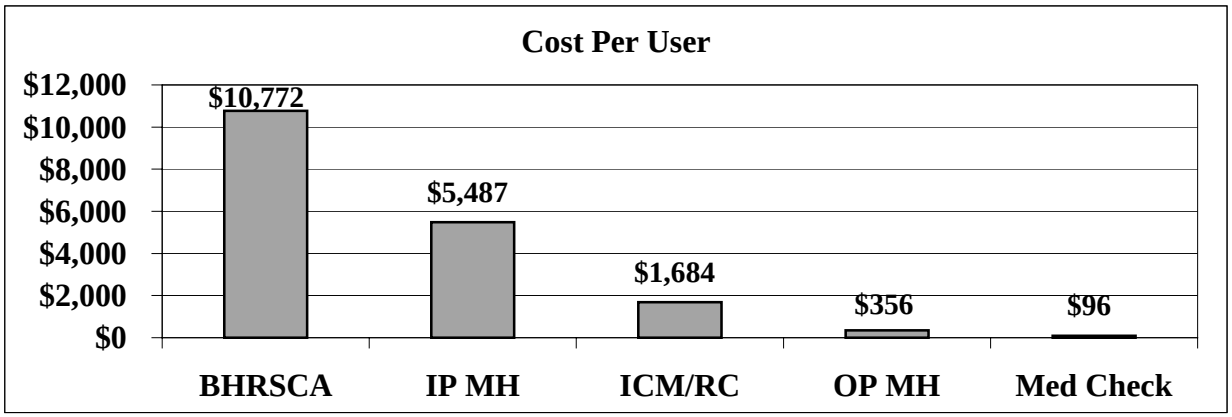
IP MH	Inpatient mental health services
OP MH	Outpatient mental health services
BHRSCA	Behavioral health rehabilitation services for children and adolescents
Med Check	Medication check
ICM/RC	Intensive case management/resource coordination

Given the nature of the service, only a few persons (18% of total users or 22% of adults and 11% of children/adolescents) utilize inpatient mental health services, yet it represents 27% of the total expenditure. Likewise, behavioral health residential services represented 26% of the total children/adolescents served at 46% of the total costs to treat children/adolescents. This is expected because facility-based services tend to be more costly. The comparison of the number of users served (13%) and costs (9%) was closer for intensive case management services.

Chart 1.4 reflects the average cost per user for mental health services with the highest expenditure and highest utilization by users.

Chart 1.4

Average Cost Per User for Mental Health Services by the Highest Number of Users and Expenditure



Key:

BHRSCA	Behavioral health rehabilitative services for children and adolescents
IP MH	Inpatient mental health
ICM/RC	Intensive case management/resource coordination
OP MH	Outpatient mental counseling
Med Check	Medication check

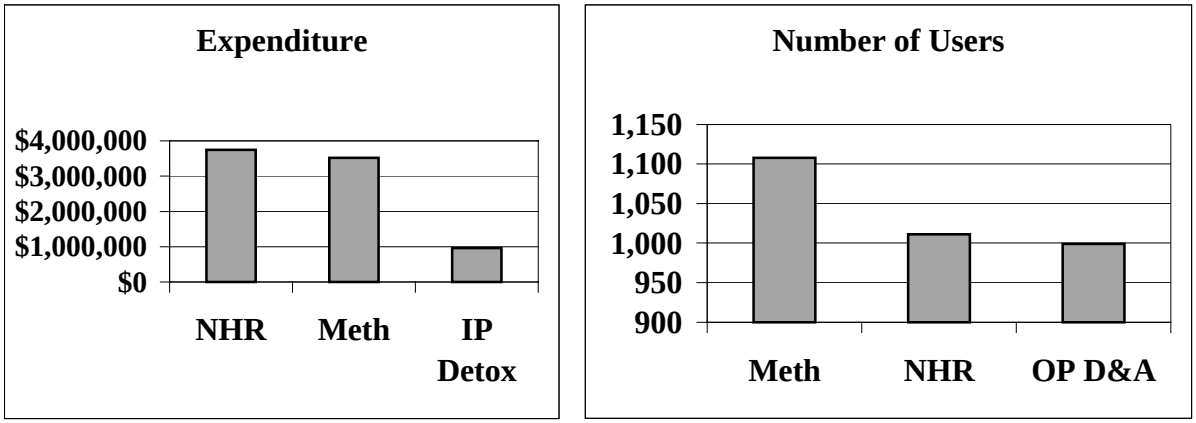
The same relationship was observed in the average costs per user as seen with total costs and number of users. Fewer people utilized high-intensity, costly services as compared to maintenance services such as medication checks, which were accessed by 45% of the total population for a fraction of the total costs.

Substance Abuse Services

Charts 1.5 and 1.6 on the following page reflect the substance abuse services accessed by the highest number of users and expenditure for CY 2000.

Charts 1.5 and 1.6

Substance Abuse Services by the Highest Number of Users and Expenditure



Key:

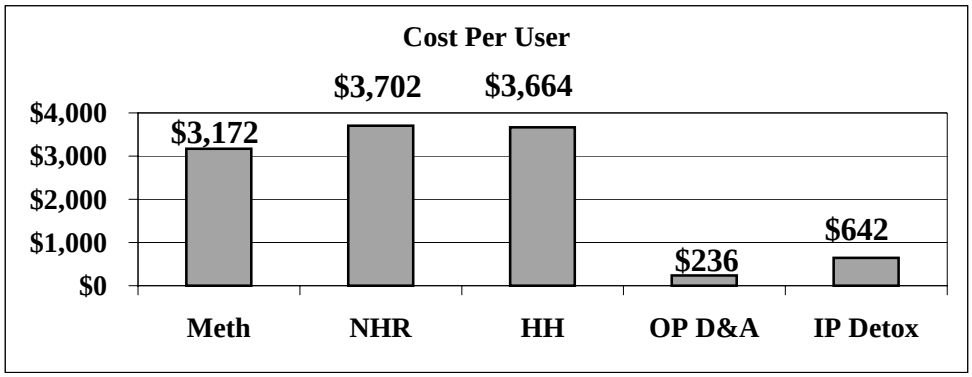
NHR	Non-hospital rehabilitation
Meth	Methadone maintenance
IP Detox	Inpatient detoxification
OP D&A	Outpatient drug and alcohol counseling

Methadone maintenance appeared at or near the top of the list for the number of users and highest costs because of the nature of the service. Individuals may be managed on methadone for prolonged periods of time, thus the collective number of individuals and the dollars consumed are higher than other services that are used periodically. Non-hospital rehabilitation services represented 4% of the total population and the total costs.

Chart 1.7 on the following page reflects the average cost per user for substance abuse services with the highest utilization by users and the highest expenditure.

Chart 1.7

Average Cost Per User for Substance Abuse Services With the Highest Number of Users and Expenditure



Key:

Meth	Methadone maintenance
NHR	Non-hospital rehabilitation
HH	Halfway house
OP D&A	Outpatient drug and alcohol therapy
IP Detox	Inpatient detoxification

Four of the five services in Chart 1.7 were represented in Charts 1.5 and 1.6 as the highest total cost and highest total number of users. The fifth service, halfway house, represented only two percent of the total adult population and two percent of the total dollars spent on adult services. The high cost per person is due to the nature of the service; the program is intense and lengthy.

4. Supplemental Services

During CY 2000, Community Care funded $1,673,763 worth of supplemental services. This represents 2% of the total expenditure. Adult used $1,630,115 or 97% of the total supplemental services.

Of the supplemental services purchased, the greatest number of users accessed drug and alcohol services. The services that were purchased as supplemental services during 2000 were as follows:

- Community residential support;
- Drug free drug and alcohol partial program;
- Drug and alcohol partial hospital program;
- Mental health outpatient practitioner; and
- Targeted case management.

The highest expenditure was for community residential support services (both mental health and mental illness/substance abuse). For CY 2000, $875,177 was paid for 316 users. This is an average of $2,770 per user. This service was the third highest for the total number of users.

Drug and alcohol partial hospitalization program was the service with the second highest expenditure with $486,066 or $937 paid per user. This service represents the second highest number of users accessing this service (519).

The third highest service for expenditure during CY 2000 was drug free drug and alcohol partial hospitalization program, with $298,487 in expenditure, or $455 per user. The highest number of users accessed this service.

Mental health outpatient practitioner services accounted for $13,828 in expenditure by 56 users. This represents an average of $247 spent per user. The least utilized supplemental service during CY 2000 was targeted case management, accessed by two users for a total of $204, or $102 per member.

In addition to supplemental services utilization patterns, the percent of utilization was low for services such as: mobile crisis, family-based services, intensive case management, and an array of drug and alcohol services. Increased utilization of these services could favorably impact the quality of care users received. Additionally, increased use of underutilized services could potentially decrease expenditure for higher cost services such and inpatient levels of care. Reducing higher cost services could result in additional monies available for a wider range of services to serve more people.

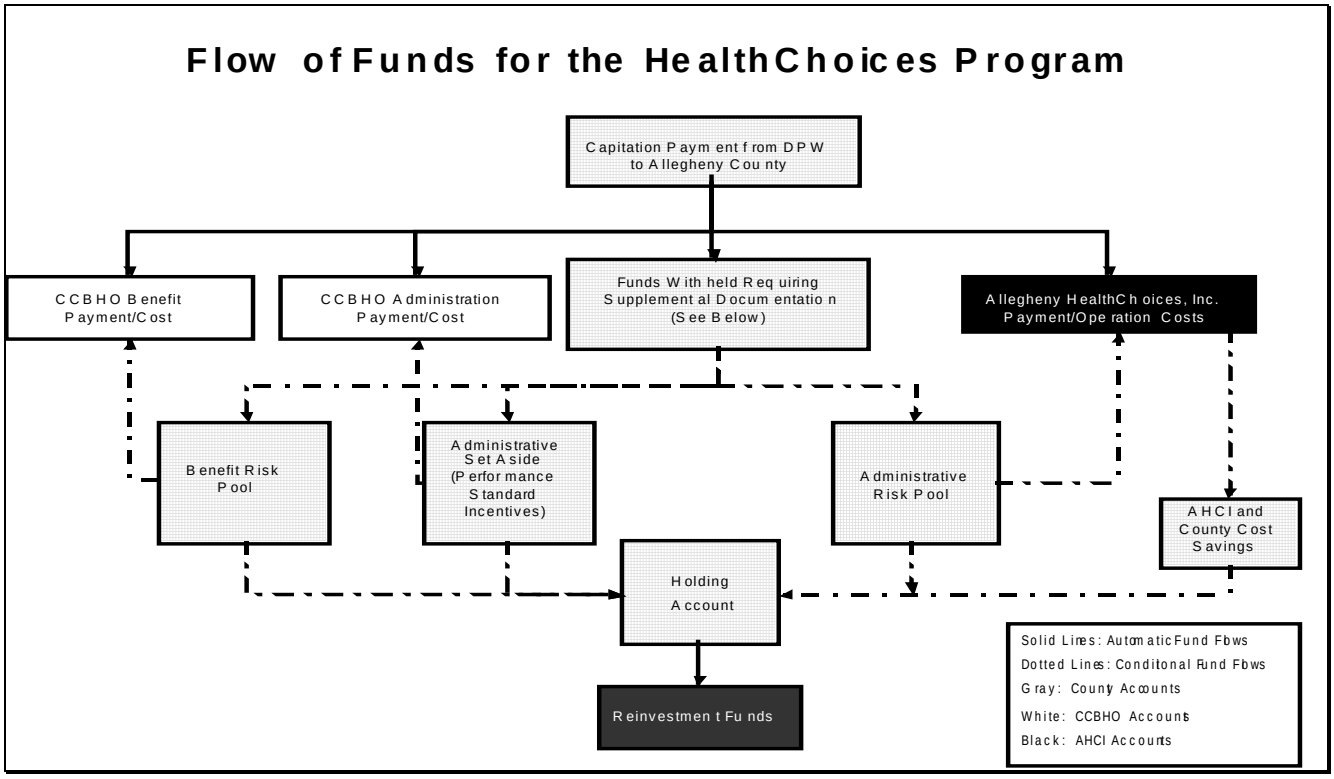
II. Performance Assessment

A. HealthChoices Financial Model

The model for the distribution of HealthChoices funds is complex. While the majority of these funds are automatically disbursed each month, the release of the balance of the money is based on the contractual agreements between the Pennsylvania Department of Public Welfare (DPW), Allegheny County, AHCI, and Community Care. Their release and distribution is contingent upon performance. Chart 1.8 displays the flow of funds within the HealthChoices program.

Chart 1.8

Flow of HealthChoices Funds for the HealthChoices Program



During the second year of the HealthChoices program, both revenue and expenses increased. One hundred three million dollars was paid to Allegheny County in CY 2000. Revenue increased by $26 million. The increase is due to the fact that full enrollment was effective only in mid-1999, and enrollment/capitation payments did not reach the current levels until that point. Since mandatory enrollment began, revenue levels have remained fairly constant.

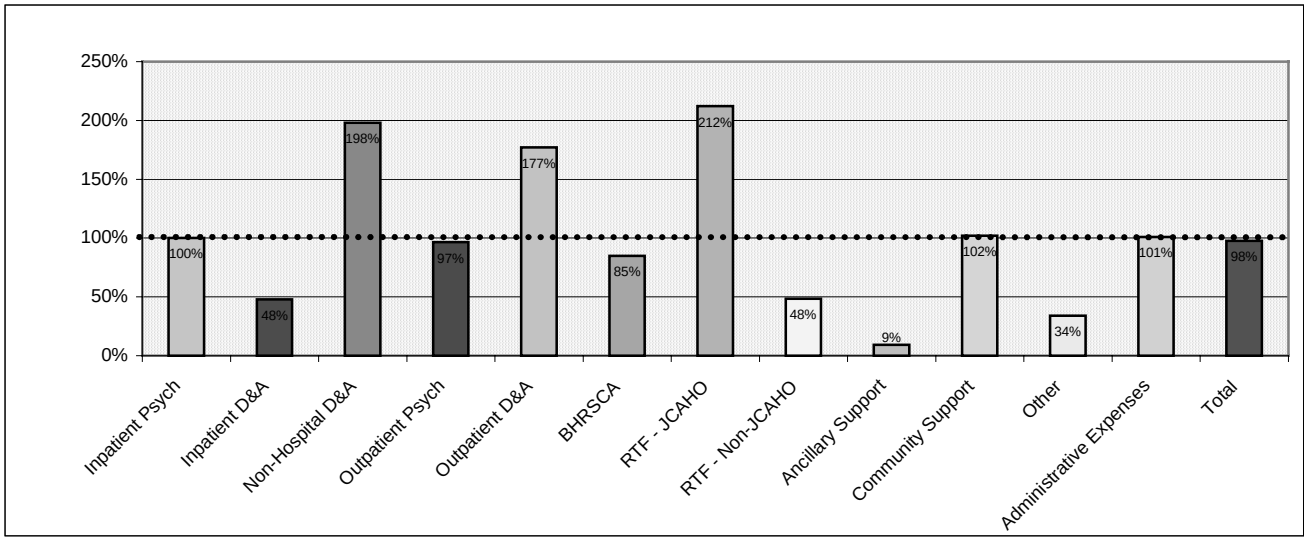
Of the $103 million received in CY 2000, $88.2 million, or 86% of the total revenue received, was spent or was earmarked for spending on medical claims.

Administrative expenses amounted to almost $12.5 million or 11.8% of capitation revenue for the year. It should be noted that $2.4 million of the administrative expenses was actually classified as "medical management expenses," which is attributable to the medical portion of Community Care's contract. Medical management expenses include the following: clinical staff salaries, consulting physician services, medical director services, quality improvement and management programs, training for certification and licensing purposes (clinical staff), 24-hour phone accessibility for crisis issues, and utilization management and review.

Based on the capitation rates and enrollment by category of aid, a budget was created to monitor Community Care's expenditure by category of service and category of aid. The following charts display the expenses reported by Community Care for each service group compared to the budget.

Chart 1.9

Comparison of Reported Expenses to Variable Operating Budget by Category of Service for Year Ending December 31, 2000



Key:

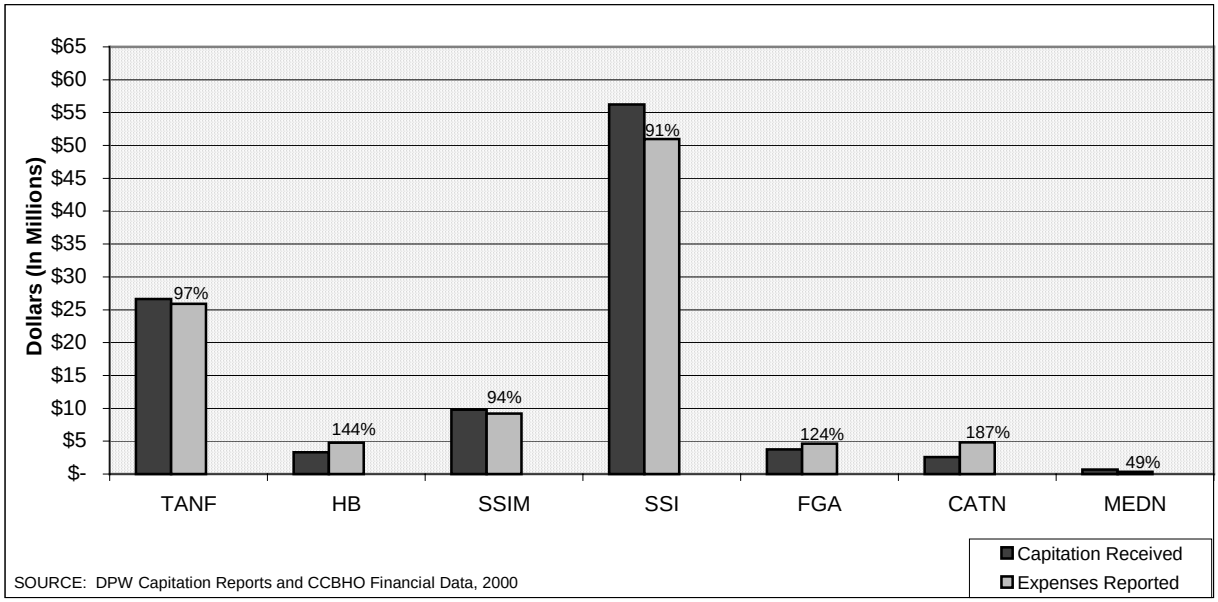
Inpatient Psych	Inpatient psychiatric services
Inpatient D&A	Inpatient drug and alcohol services
Non-Hospital D&A	Non-hospital drug and alcohol services
Outpatient Psych	Outpatient psychiatric services
Outpatient D&A	Outpatient drug and alcohol services
BHRSCA	Behavioral health rehabilitative services for children and adolescents
RTF-JCAHO	Residential treatment facilities with Joint Commission on Accreditation of Healthcare Organizations accreditation
RTF-Non-JCAHO	Residential treatment facilities without Joint Commission on Accreditation of Healthcare Organizations accreditation
Ancillary Support	Ancillary services
Community Support	Community-based services
Other	Other services
Administrative	Administrative-related expenses

Chart 1.9 shows expenses reported by Community Care as a percentage of the variable operating budget for the 12 service categories defined by the state. The variable operating budget was based on capitation payments and an actuarial model to determine the level of spending expected for each service category based on actual payments. This graph shows that inpatient psychiatric treatments are reported at 100% of budget. While outpatient drug and alcohol services and non-hospital drug and alcohol services were utilized at a higher rate than budgeted, these services represent a small portion of the total budget. JCAHO-approved residential treatment facilities (RTFs) and community support services (including intensive case management, family-based therapy, and resource coordination) were utilized at a greater rate than budgeted.

Chart 2.0 on the following page compares expenses reported by Community Care to the capitation payments received from DPW for the seven categories of aid. Currently, three categories of aid are exceeding the budget. These categories include Healthy Beginnings, General Assistance, and Categorically Needy. An interesting aspect of this finding is that while these categories were all significantly over budget, the dollar amounts related to the overages were each less than 2% of the total budget. One possible explanation for the increased expenses for the Healthy Beginnings category may be that children rolling off of TANF become eligible for this program. A theory regarding the overages in the Categorically Needy Only category is along the same lines. Once federal welfare eligibility expires, members may become eligible for assistance at the state level. Often, this population is in need of more intensive services than the cohort of users typically enrolled. This leads to overages in this category. Items such as these are discussed and considered when bidding for new capitation payment rates each year.

Chart 2.0

Comparison of Capitation Payments to Reported Expenses by Category of Aid for Year Ending December 31, 2000



Key:

TANF	Temporary Assistance to Needy Families
HB	Healthy Beginnings
SSIM	Social Security Insurance with Medicare
SSI	Social Security Insurance
FGA	Federal General Assistance
CATN	State Assistance – Categorically Needy Only
MEDN	State Assistance – Medically Needy Only

As Table 1.3 illustrates, most HealthChoices users were included in two categories of aid: Social Security Income (SSI) and Temporary Assistance for Needy Families (TANF).

Table 1.3

2000 HealthChoices Users by Category of Aid

Category of Aid	Number of Users in Category *
CATN	2,032
FGA	1,989
HB	1,645
MEDN	227
SSI	8,909
SSIM	3,229
TANF	7,820

* NOTE: Users can be included in more than one category of aid in any given month due to changes in income status.

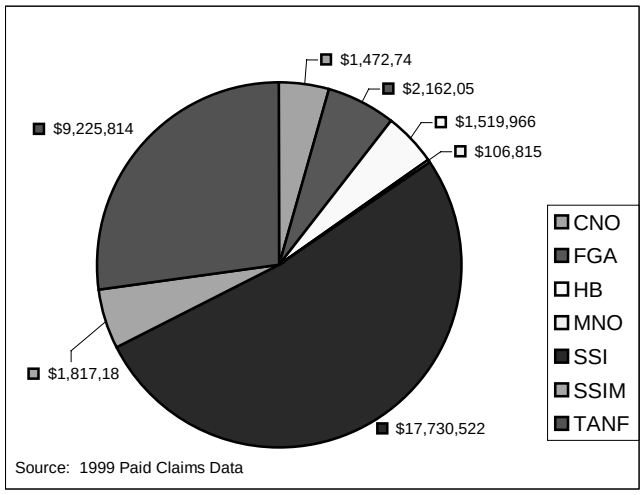
Key:

CATN State Assistance – Categorically Needy Only
FGA Federal General Assistance
HB Healthy Beginnings
MEDN State Assistance – Medically Needy Only
SSI Social Security Insurance
SSIM Social Security Insurance with Medicare
TANF Temporary Assistance to Needy Families

In terms of dollars spent by category of aid, the number of users in a category generally reflected the amount of funds spent on services by that group. For example, services provided to persons enrolled in the SSI and TANF categories (73% of all users) comprised 79% of the behavioral health spending in CY 2000.

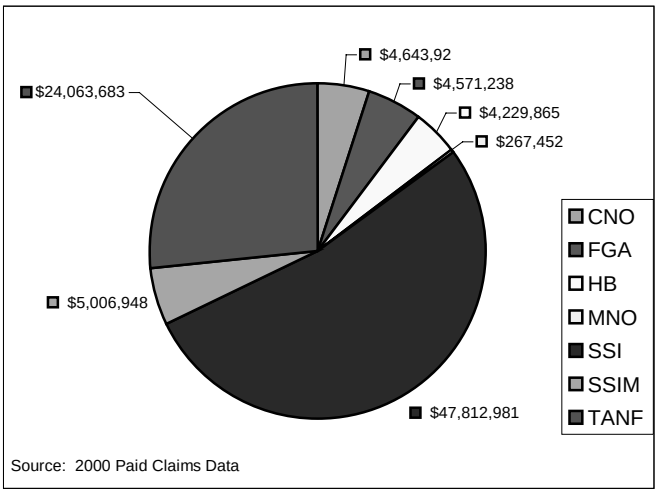
On the following page, Charts 2.1 and 2.2 depict the breakout of paid claims by category of aid during CY 1999 and CY 2000. Paid claims increased from approximately $34 million in CY 1999 to an estimated $91 million in CY 2000. This increase is explained by a full year of mandatory enrollment as compared to start up activities during CY 1999, when the program was voluntary for the first half of the year. In spite of the dollar differences, it is noteworthy that the distribution of paid claims by category of aid remained constant between the two years.

Chart 2.1
1999 Claims Paid by Category of Aid



Source: 1999 Paid Claims Data

Chart 2.2
2000 Paid Claims by Category of Aid



Source: 2000 Paid Claims Data

Key:

CNO	State Assistance – Categorically Needy Only
FGA	Federal General Assistance
HB	Healthy Beginnings
MNO	State Assistance – Medically Needy Only
SSI	Social Security Insurance
SSIM	Social Security Insurance with Medicare
TANF	Temporary Assistance to Needy Families

B. Reinvestment

The transition to managed care is expected to effectively manage the use of existing funds and service utilization. Each county is responsible for using the funds that remain at the end of each contract year to target needs, expand capacity, and find innovative ways to improve service delivery. These initiatives are accomplished through approved reinvestment plans. Cost savings were apparent in the first year and are projected for the second year of the program, although not at the same level as CY1999.

The approved 1999 reinvestment plan is being implemented at this time. This plan includes a number of different programs, including continuous treatment teams targeting adults and adolescents and young adults (ages 16 – 24 years); residential respite services for children and adolescents with serious emotional disturbance; and outreach programs focusing on African American children and persons who are homeless. The development of non-traditional supports to parents in recovery through Family Support Centers and peer support program development will be included as well. Because reinvestment funds are not guaranteed each year, all providers interested in receiving reinvestment dollars for new programs are required to document how the program will be sustained without these funds.

C. Contractual Compliance

1. Overview of Performance

In general, Community Care met its contractual obligations as they relate to performance standards. One exception to this was compliance with performance standards pertaining to claims adjudication and timeliness (standards one, two, and three). These standards were mostly unmet for the first and second quarter. Community Care stated that the problems were due to changes made by the vendor and the lack of adequately testing new automated features of the claims adjudication process prior to implementation. The issues were addressed and rectified during the second half of the year.

2. Contract Performance Standards

The following is a summary of the performance standards that Community Care met throughout CY 2000:

Standard One	90% of clean claims are adjudicated within 30 days of receipt.
Standard Two	100% of clean claims are adjudicated within 45 days of receipt.
Standard Three	100% of claims are adjudicated within 90 days of receipt.
Standard Four	95% of claims are accurately adjudicated.
Standard Five	95% of calls to Member Services are answered within 20 seconds. The abandonment rate is less than or equal to five percent.
Standard Six and Seven	Members will have access to in-plan services within the identified DPW treatment access standards for emergency, urgent, and routine care.
Standard Eight	Community Care will comply with the DPW and Act 68 requirements for response to and resolution of complaints and grievances.
Standard Nine	95% of all DPW-required reports must be submitted to AHCI within five business days before the DPW deadline.
Standard Ten	95% of all reports contractually required of Community Care are received by AHCI on or before the due date.
Standard Eleven	Outreach will be initiated for 95% of underserved members in priority populations.
Standard Twelve	Community Care will authorize drug and alcohol and other supplemental services, consistent with the DPW criteria of care.
Standard Thirteen	Members, users, and their families will be satisfied with the services provided through the HealthChoices program.
Standard Fourteen	Providers participating in the HealthChoices program will be responsive to issues raised by members, users, and families.
Standard Fifteen	Providers who are treating members with primary drug and alcohol diagnoses will assess the well being of the family.
Standard Sixteen	Electronic claims submission and electronic fund transfer/payment will be available for network providers.

3. Performance Standards Recommendations

As HealthChoices implementation in Allegheny County approaches its third year, it is time for a reexamination of the performance standards as reflected in the current contract between the County and Community Care. The standards as currently written have served their purpose in ensuring the development of a strong operational program at Community Care. The original intent, however, behind the development of performance standards was to use those standards as a way to foster system change and focus on clinical and financial outcomes. Therefore, AHCI will be recommending several changes in the performance standards based both on the experiences of the last two to three years and the needs of the program moving forward.

During CY 2001, AHCI will be working closely with the County and Community Care to include the following categories and types of performance standards and penalties in the County's contract with Community Care:

1. Many of the current performance standards are directly tied to sanctionable components of the County's contract with DPW. These include standards related to timeliness and accuracy of claims payment, timely telephone response, and timely reporting. Following what will be three years of operation, it seems reasonable these areas should be considered as baseline for acceptable performance and not subject to performance rewards. AHCI recommends that these types of standards be eliminated but that Community Care be held accountable for its performance in these areas by tying financial penalties for failure to comply.

2. The performance standards are reviewed and awarded on a quarterly basis. Several standards, however, represent single occurring events or events that are more appropriately measured on an annual basis. For example, the standard requiring availability of electronic claims submission should not be a reoccurring performance standard. Once it is met, it will continue to be met. Another example is that the standard related to consumer satisfaction is based on an annual survey. AHCI recommends these types of standards either be eliminated or restructured to more accurately reflect intent and measurement techniques.

3. The next set of AHCI recommendations address certain standards that are not currently being clearly measured, particularly as they relate to outcomes. These include standards around access to services and outreach to at-risk, high priority populations. AHCI will work with Community Care to transition measurement of those standards away from process measures to actual outcome measurements.

4. The last set of recommendations is that new performance standards be developed or currents standards be revised to focus more on the care management process and specific service utilization patterns and clinical or program outcome indicators. For example, AHCI will recommend standards that begin to require a decrease in the use of more restrictive forms of care, particularly inpatient mental health services. We will also be looking, with Community Care, at issues in the area of recidivism, services to minorities, use of crisis services, and the use of case management.

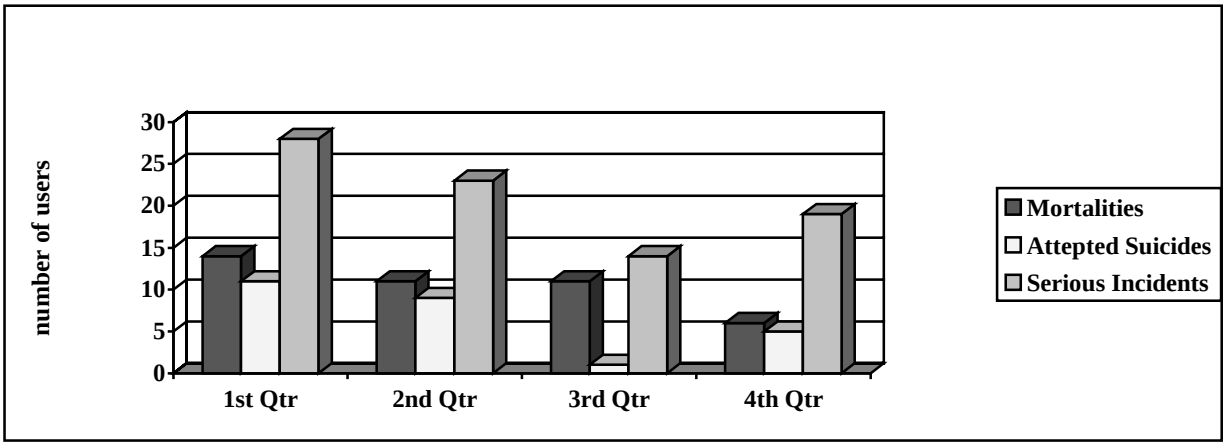
III. Quality Monitoring and Enhancement

A. Critical Incidents

During CY 2000, a total of 153 critical incidents identified as priorities were reported. There was a significant reduction of critical incidents for the third and fourth quarters of 2000. Chart 2.3 illustrates this decrease. Community Care reviewed the data, and due to the small numbers, found no trends with gender, level of care, or provider. Community Care continues to monitor individual incidents as well as track aggregate data for these areas to ascertain any trends that require more analysis.

Chart 2.3

Critical Incidents in 2000



The category of critical incidents classified as mortalities is subdivided into four types. During CY 2000 there were 43 member deaths in Allegheny County. These deaths are broken down as follows:

- Natural causes – 25 events;
- Apparent accidents – 2;
- Apparent suicides – 4; and
- Unclear cause – 12.

Natural cause was the primary type of member deaths. Of this category, the largest percentages of people were female, Caucasian, and 45-64 years old.

B. Complaints and Grievances

1. Member Complaints

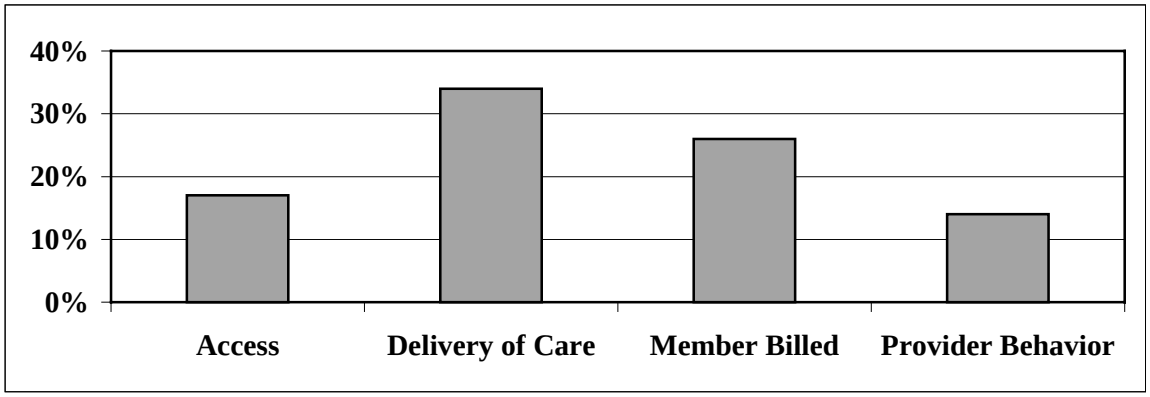
There were 263 member/family complaints filed with Community Care during CY 2000. This represents 88 more complaints than were filed during CY 1999. Quarterly complaint totals showed normal variances and ranged from 60 to 74 complaints per quarter. This increase in complaints may reflect an increased awareness of the complaint process and increased understanding of how to use

the process. This positive trend can be attributed to an increase in member/family educational efforts by a variety of entities, such as Community Care, Allegheny County, and AHCI.

Chart 2.4 reflects the complaint issues most often cited by members/families when filing a complaint with Community Care during CY 2000.

Chart 2.4

Four Highest Complaint Issues for 2000



Access issues included difficulty receiving a timely appointment, difficulty finding a provider with specific characteristics, and cancellation of appointment by provider. Delivery of care issues included a member/family not being included in treatment planning, lack of understanding of treatment plan, and treatment not meeting expectations of the member/family. Member billed issues included users receiving a bill for service. (Community Care believes that this issue represents members confusing notification of coordination of benefits with bills for service.)

During CY 2000, 98% of member/family complaints were resolved at level one with the remaining two percent being resolved at level two of the complaint process. In comparison, 96% of member/family complaints were resolved at level one during CY 1999, with the remaining four percent being resolved at level two.

2. Provider Complaints

There were 36 provider complaints identified for CY 2000, involving 29 providers. Authorizations, authorization reports, and claims issues represented 77% of all provider complaints logged by Community Care during CY 2000.

The issues seen in CY 1999 were consistent with a program that is undergoing start up and full implementation. The issues centered around difficulties with processes that were new, such as authorizations, claims and coordination of insurance benefits. The issues seen during CY 2000 were consistent with a continuing program. The providers' concerns focused on ongoing operations rather than unfamiliarity with contracting, rates and procedures for claims, care management, and coordination of insurance.

3. Denials and Grievances

A total of 121 medical necessity denials were issued by Community Care's physician advisors during CY 2000, representing 86 less than the total for CY 1999 (207). This decrease is attributable to improved knowledge and application of medical necessity criteria by Community Care staff.

During CY 2000, 53% of the denials issued were not grieved, 8% were grieved and upheld, and 39% were ultimately overturned.

Table 1.4 illustrates the services that were denied based on medical necessity during CY 2000. The number of denials did not correlate with the service utilization patterns. However, there was a relationship of denials and the level of intensity/request frequency of the service. Higher intensity/frequently requested services such as inpatient services and behavioral health rehabilitative services for children and adolescents (wrap around) are more likely to be denied than less intensive/less often requested services such as residential treatment facility and psychological testing. This finding is expected because higher intensity services are usually more closely managed.

Table 1.4

Service Types For Denials Issued in 2000

Service Type	Number of Denials	Percent of Denials
Inpatient mental health	84	69%
Behavioral health rehabilitation services	14	12%
Non-hospital rehabilitation	7	6%
Inpatient detoxification	5	4%
Residential treatment facility	3	2%
Independent residential treatment	2	1.7%
Psychological testing	2	1.7%

During CY 2000, 57% (52) of the denials issued were appealed (grievance). This is the same percentage as seen in CY 1999.

In late CY 1999, a significant increase was seen in the number of denials issued based on lack of clinical information. In response to this, Community Care worked with the provider utilization staff and physicians to provide education about the pre-certification and continued stay review processes. There was a strong relationship between the increase in the number of denials based on lack of information and the increase in the overturn rate. AHCI will continue to track this issue closely and request action plans as needed.

Table 1.5 provides some details of grievances overturned in CY 2000 in comparison to CY 1999.

Table 1.5

Grievances Overturned in 2000

Grievance Type	Total Number		Number Overturned		Overturn Percent	
	2000	1999	2000	1999	2000	1999
Level One	52	118	39	64	75%	54%
Level Two	6	18	1	9	17%	50%
External Review	1	2	1	1	100%	50%

During CY 2000, there were more level two grievances filed than actually were heard at second level review. Community Care's receipt of the clinical information prior to the second level review enabled Community Care to administratively overturn the denial. The denials that were overturned prior to an actual level two review were cancelled with the permission of the member and therefore not counted in the number of level two reviews.

A critical difference was seen in the grieved-upheld percentages. During CY 1999, 24% of the denials grieved were upheld, while in CY 2000, the percent upheld fell to 8%. This reflects the issues surrounding unavailability of clinical information prior to making an authorization decision based on medical necessity.

C. Consumer Action and Response Team (CART) Satisfaction Report

In CY 2000, CART interviewed approximately 650 family members and HealthChoices users in Allegheny County. CART conducted interviews and identified barriers to service with 88 people who were homeless and not receiving behavioral health care services. Quarterly reports identified trends by level of care supported by quantitative and qualitative data. The quantitative section of the reports contained summarized responses to the survey questions based on Appendix L criteria[1]. The qualitative section presented themes identified from the open-ended survey questions. In CY 2000, CART also developed a simplified reporting format for providers and a more rigorous system for quantifying user responses to the open-ended survey questions.

System issues that CART identified during CY 2000 include:

- Satisfaction rates for questions related to Appendix L domains exceeded 90%;
- Over one-third of the parents of children with serious emotional disturbance receiving crisis services were dissatisfied with the service;
- Approximately one-half of users interviewed were not aware of their user rights; and
- More than one-half of users did not know whom to call with a complaint or grievance.

[1] Contractors are required to measure user satisfaction of behavioral health services. This is accomplished by an internal satisfaction survey conducted by CART. The guidelines are contained in Appendix L, pages 1-4 of the Department of Public Welfare Request for Proposals for HealthChoices Behavioral Health Services RFP NO. 11-97.

The formal CART report containing these concerns was distributed after the close of 2000. CART will address the issues in 2001 in the following ways:

- CART will produce reports for providers that describe the satisfactions and dissatisfactions of specific user populations.
- Twelve community focus groups will be conducted to further define consumer issues in special needs populations.
- CART will explore issues for HealthChoices members around behavioral health service access.
- CART will print a quarterly newsletter to promote attendance at focus groups, community forums, inform the public about data trends, and include writings by CART staff.

D. Quality Improvement Focus Studies

In addition to the quarterly monitoring reports, AHCI conducted analysis and produced reports for three targeted studies. The degree of interest and concern of the stakeholders determined the topics. The focus studies for CY 2000 included: Behavioral Health Rehabilitation Services, Users with Serious and Persistent Mental Illness, and High Cost Users of Services Report. The following is a brief summary of the findings and implications of each focus area. The full text of these reports is available on AHCI's web page at www.ahci.org.

1. Behavioral Health Rehabilitation Services for Children and Adolescents

The total expenditure for behavioral health residential services for children and adolescents (BHRSCA) in CY 2000 was $14 million or 32% of the total expenditure for HealthChoices users, representing 1,489 children and adolescents. The most remarkable comparison between BHRSCA and all behavioral health services was the average cost per user. The average difference in cost was $6,992, with BHRSCA users averaging $9,402 per user annually.

The utilization findings revealed that 8% of persons using BHRSCA services had an inpatient mental health admission, representing 8% of expenditure. Readmissions within seven days and thirty days of discharge were 8% and 10% respectively. This is significant in that the intensity of BHRSCA services was designed to deter inpatient admissions. Other services were used by a larger percent of the population (outpatient mental health 35%, medication checks 30%, ICM/RC 27%, and partial hospitalization 12%), but represent less than 1%-6% of expenditure.

The implications of the financial and utilization findings are two-fold:

- The process of wraparound services does not appear to be ensuring a continuum of care that enables the child/adolescent to be maintained in a less restrictive, less costly environment. Factors that influence this include:
  - Medical necessity criteria;
  - Cohesive relationships with the user, family, case manager, and providers of all services (academic, social, and behavioral health); and
  - Capacity of services and providers.

- The identification process of children and adolescents with coexisting drug and alcohol conditions needs to be improved. This is accomplished by:
  - Educating at all levels – families, communities, providers, and systems (juvenile justice, school, etc.);
  - Adopting and applying standardized tools to identify coexisting conditions; and
  - Engaging users/families in substance abuse services that are specific to the individual's need.

2. Consumers with Serious and Persistent Mental Illness

An 18-month study period allowed for analysis and comparison of the six-month voluntary enrollment period to the 12-month mandatory enrollment period for the HealthChoices program. Services were provided to 2,252 persons who were in Tier Level One or Tier Two[2] and Priority Populations Three or Four[3]. Of these users, 1,877 (83%) concomitantly received base-funded services (services that are not in-plan for the HealthChoices program and are paid for by the county). The remaining 17% did not have a corresponding match to a base-funded service during the study period.

The financial analysis confirmed that nearly $9 million was paid for services provided to persons with serious and persistent mental illness, or an average of $4,491 per user. The two most frequently utilized services by persons receiving base-funded services were outpatient mental health (72%) and case management (69%). The percent of utilization declines dramatically after these most frequently used services. Other services accessed by users of base-funded services include: social rehabilitation, partial hospitalization, community residential, emergency services, psychiatric rehabilitation, outpatient drug and alcohol, and housing support services. Utilization of these services ranges from 20% to 10%. Comparing service utilization patterns of the voluntary period to the mandatory period, the utilization patterns remained essentially unchanged.

Persons with serious and persistent mental illness can greatly benefit from behavioral health services; however, the analysis does not indicate a change in practice patterns with the implementation of managed care. The implications of these finding are significant and provide the following opportunities for improvement:

- Increased education of members/families/providers may influence practice patterns.
- Improved identification of the persons with serious and persistent mental illness and communication of their individual needs with the provider and case manager may assist in identifying additional services.
- Increased use of supplemental services to complement the continuity of care.
- Increase the number of non-traditional settings and providers to meet the needs of this high-risk population.

[2] Designed by Community Care, the tier system categorizes users into four levels of intensity based on the diagnosis, clinical risk factors, utilization rates, and their Medical Assistance eligibility category.

[3] Allegheny County Department of Human Services designates the highest adult Priority Populations as P03 or P04. The criteria for both categories include: a diagnosis of schizophrenia, major mood disorder, psychotic disorder NOS, or borderline personality disorder. Additional criteria include: treatment history, low functional level, and a coexisting condition or circumstance (as defined in the *Mental Health Bulletin OMH-94-04*).

3. High Cost Users of Services

AHCI defined the highest cost HealthChoices users as any member with aggregate paid claims in excess of $25,000 per person. A total of 499 persons met this criterion and were included in the focus study. High cost users represented 2.5% of total users and consumed $19.5 million or 28% of the total expenditure.

Services that were used the most by these persons included: behavioral health residential services for children and adolescents, mental health inpatient, and outpatient mental health services. Readmissions for inpatient mental health services primarily occurred within seven days of discharge.

Several implications can be drawn from this study:

- Multiple use of inpatient services may indicate ineffective coordination of services and difficulty in engaging the user in appropriate and acceptable outpatient services.
- Outcomes can be improved for some members who utilize non-traditional and culturally sensitive providers.
- Programs that provide childcare options may enable the user to remain in the program until the goals are met.
- Programs that provide an intensive level of follow up and coordination, such as mobile crisis, partial hospitalization, family-based services, and targeted case management help to engage the user and lessen the need for more restrictive services.

4. Focus Study Implications of the Reinvestment Plan

The Allegheny County Department of Human Services, Community Care, and stakeholders collaboratively developed a reinvestment plan. The plan recognizes that at-risk individuals require non-traditional methods of engagement and do not inherently seek treatment or understand access to care. The services and target populations were selected as a result of identifying problems and barriers as found in current research literature and other analysis.

The plan includes a myriad of programs and service delivery vehicles that are not found in a traditional model. Services are customized to meet each individual's needs. Without the flexibility and resources of the reinvestment plan, many of the users may be required to function in a structured environment that is not as responsive to their individualized needs.

IV. Training, Outreach and Ombudsman Activities

A. Training Efforts

AHCI conducted three types of training programs during CY 2000. The goal of these efforts was to build both provider and system capacity.

The first training effort was a comprehensive Training Institute developed for performance and outcomes measurement. The purpose of the six-session Training Institute was to help providers learn processes and mechanisms to better monitor their daily operations and systematically improve their clients' outcomes.

The second educational outreach program was one-on-one meetings with network providers. AHCI met with providers to find out how their organization and the service system were functioning under managed care and to discuss AHCI's mission and role in the HealthChoices program.

The third program was targeted at local agencies that expressed the need for Continuous Quality Improvement (CQI) training. AHCI provided one-on-one assistance and practical application specific to each organization.

B. Outreach Activities

Through quality improvement activities as well as stakeholder feedback, AHCI and Community Care identified a need for improved education and outreach to the community. As a result, goals for 2000 included:

- Increase community awareness of the rights and responsibilities of HealthChoices members and the role of the AHCI Ombudsman in assisting members in exercising that right.
- Establish a community education and outreach plan as collaboration between AHCI and Community Care to provide focused outreach to members of the HealthChoices program who are unserved, underserved, and/or have special service needs.

During CY 2000, AHCI and Community Care conducted several activities toward these goals.

- AHCI developed and widely disseminated Ombudsman educational materials to behavioral health providers, advocacy organizations, County Human Service programs and other human service institutions.
- AHCI expanded Ombudsman presence in the community through regular ongoing site visits to drop-in centers, community fairs, and other program sites.
- AHCI completed a first draft of a comprehensive plan for Community Education and Outreach.
- Community Care implemented a focus outreach program for families of children in BHRSCA and other intensive levels of care.
- Community Care developed a minority outreach plan for members identified as African American.
- AHCI conducted presentations and provided information regarding user rights and the role of the AHCI Ombudsman to 13 advocacy groups and community organizations during CY 2000.

- AHCI served as an active participant of 13 Advisory Committees and Workgroups that are involved in addressing a myriad of community stakeholder issues including user and family health care advocacy, healthcare for homeless, wraparound services for children and adolescents, and persons with dual mental health and substance abuse treatment needs.

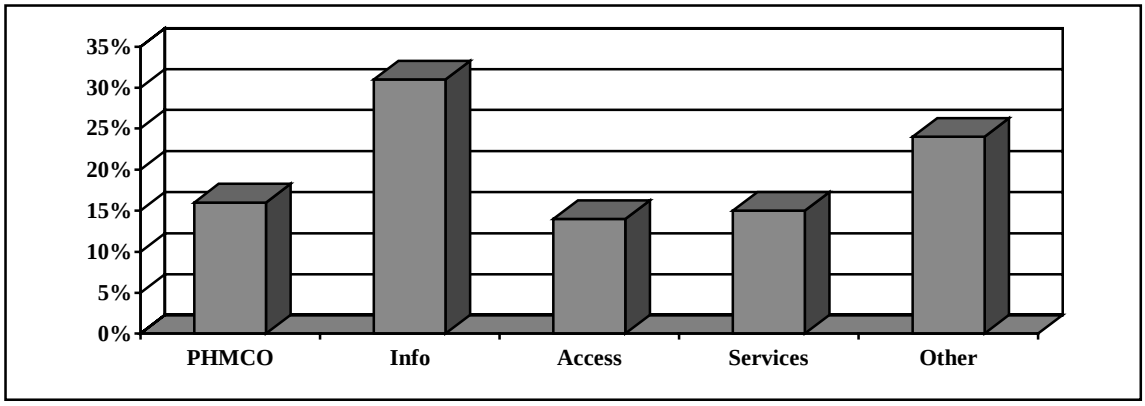
C. Summary of Ombudsman Activity

During CY 2000, there were a total of 191 contacts with the Ombudsman for an average of 16 contacts per month. Ombudsman activity was highest during the first quarter of the year in response to a countywide mailing of educational materials completed in January.

Approximately 87% percent of the total Ombudsman contacts involved more than one issue or concern. Of the total issues and concerns that were addressed by the Ombudsman, the majority or 31% percent involved requests for information. The following chart depicts issues and concerns by major category type and number.

Chart 2.5

Issues and Concerns Reported to the Ombudsman for 2000



Key:

PHMCO	Issues involving physical health managed care organizations
Information	Requests for information/education
Access	Issues involving access to service
Service	Issues involving service quality, denials, involvement in treatment planning, continuity of care, etc.
Other	Issues that do not meet definitions of above: includes claims problems

V. Accomplishments

A. Lessons Learned

The year 2000 saw much progress toward the successful implementation of the Allegheny County HealthChoices program. The kinds of operational/start-up problems experienced during 1999 were minimal in 2000, allowing time for greater emphasis on issues such as access to services, consumer satisfaction, studies focusing on quality of care issues, and developing ways to use data to inform decision-making throughout the County behavioral health system.

The primary accomplishments for this past year included:

- Considerable cost savings were achieved allowing the development of a reinvestment plan that addresses specific issues identified in quality improvement and quality monitoring activities. The specific service areas addressed included the following:
    - Alternative support models for family support services;
    - Psychiatric rehabilitation;
    - Peer support services and networking;
    - Respite housing;
    - Outreach to African American children and persons who are homeless; and
    - Community Treatment Teams for target populations.

- Community Care substantially met its contractual performance standards for the year. In areas in which performance began to become problematic, Community Care responded quickly in remedying the situation;
- There was a substantial increase in community education and outreach activities;
- Several in-depth quality focus studies were conducted providing useful information to improve the behavioral health system for HealthChoices and non-HealthChoices clients;
- Community Care implemented a BHRSCA quality review program and began its provider profiling system;
- AHCI reorganized its staff to better reflect its responsibilities in the system and to more efficiently use its resources; and
- Training and technical assistance were provided to many members of the HealthChoices network.

B. Plans for 2001

The third year of HealthChoices in this region, CY 2001, will provide even greater opportunity to improve the range and quality of services available to HealthChoices members. Specific areas of activity targeted for the year include:

- Continued activity in conducting focused quality reports, including following up on reports prepared in CY 2000;
- Implementation of a comprehensive community education and outreach plan with strong collaboration between Community Care and AHCI;

- Developing a process to work with the PH-MCO's allowing Community Care and AHCI to receive data on medication usage and prescribing practices for members receiving services through Community Care;
- Implementation of the services being funded through the reinvestment plan;
- Examining the feasibility of more closely integrating management of HealthChoices services and base-funded services; and
- Development of contractual performance standards that provide a greater focus on clinical and fiscal outcomes for the program.

Allegheny County continues to see the HealthChoices program as a vital component to overall efforts to improve the quality of care and expand the range of services for Allegheny residents who are members of the program. However, it is also clear that there is a need for better integration and coordination of services irrespective of their funding stream. For the next year, much of the efforts of the County, Community Care, and AHCI will be directed toward gathering the information necessary to achieve that goal.