The Allegheny County HealthChoices Program: *2011 Year in Review*

Allegheny HealthChoices, Inc.

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Executive Summary

HealthChoices is Pennsylvania's managed care program for Medical Assistance (Medicaid). This program provides physical and behavioral health care for children and adults. The Year in Review report presents data on the behavioral health portion of the HealthChoices program in Allegheny County. It describes changes in enrollment and service use in comparison to 2010, and details information on cost management, satisfaction, and quality benchmarking. This information addresses the goals of the HealthChoices program, which include improving access to services; improving the quality and continuity of care; and providing effective distribution of limited Medicaid resources.

The enrollment population continues to grow in 2011 while service penetration rates remain comparable to 2010.

- **171,601 people were enrolled, on average, each month in 2011.** This was a 3% increase from 2010. Even though overall enrollment increased, there was a decrease in enrollment from September 2011 to December 2011. This is due, in part, to a new enrollment calculation used by the Department of Public Welfare.

- **44,737 of the people enrolled (26%) accessed mental health and/or drug and alcohol services.** Service utilization is evenly split between men and women. However, disproportionate gaps exist in utilization between age and race. More adults used services compared to children while more whites use services compared to blacks and other minority groups. Continued efforts are needed to understand how different people access or use services in the community, especially minority populations.

Community-based services continue to serve an important role in Allegheny County for adults and children.

- **$231.8 million was spent on paid claims for treatment and services in 2011.** Services for adults made up 53% of paid claims while services for children and adolescents made up 47% of paid claims. The proportion of paid claims and number of people using community-based services is substantially larger than paid claims and the number of people receiving services in a more restrictive setting, such as an inpatient or residential treatment facility. This is similar to 2010 results.

- **Behavioral health rehabilitation services (BHRS) paid claims increased in 2011.** The Pennsylvania Autism Insurance Act, more commonly known as Act 62, requires private health insurance companies to cover the costs of assessments and certain services for autism spectrum disorders up to $36,000 per year. Costs for services not covered by Act 62 and for services above $36,000 are covered by the HealthChoices program. This helped drive the decrease in paid claims seen in 2010. In 2011, more children used these services than in 2010 and there were rate increases for several BHRS services. As a result, the total costs increased from 2010 by 11%.

- **While more people continue to access crisis services, paid claims for crisis services decreased for children and adults in 2011.** Even though the number of people accessing these services increased, the average amounts of crisis services used per person decreased. This decrease is seen in all crisis services, especially walk-in services available through Allegheny County's re:solve Crisis Network facility.

- **Some current services are seeing a shift in funding streams.** In the first quarter of 2011, three community treatment teams moved from reinvestment funding to HealthChoices funding. Reinvestment funds are funds remaining after medical claims and other obligations are paid, and are available for expanding services and supports based on the local population's need. Reinvestment funds, as in this case, are often used to fund the start-up of evidence based practices in the County.

Positive changes in service utilization are being seen in RTF, EAC and RTFA levels of care.

- **Decreases in average lengths of stay for some levels of care are showing promising trends.** Children and adolescents had a 25% decrease in average length of stay in residential treatment facilities. Adults also had noticeable decreases in extended acute care settings, inpatient mental health facilities and in residential treatment facilities for adults. There was a two day decrease in inpatient days and an 18 day decrease in RTFA for average length of stay for adults in 2011 compared to 2010. The goal is to treat people in the least restrictive level of care that is clinically appropriate and to keep children and youth in their home community whenever possible.

- **A new clinical service unit opened in 2011.** To assure the local system has sufficient capacity for longer term, intensive treatment, a new extended acute unit opened at Western Psychiatric Institute & Clinic. This is a ten-bed unit that focuses on rehabilitation, recovery and reintegration into the community.

Collaborative efforts continue to support the Allegheny County HealthChoices program in working to meet state benchmarks and measuring people's satisfaction with their services.

- **Allegheny County had higher follow up service rates from individuals with psychiatric hospital discharges and non-hospital rehabilitation services in 2011 compared to 2010.** Also, Allegheny County continues to have better outcomes on readmission rates and follow-up service indicators compared to Philadelphia County**.** These measures play an important role with the quality of care received by consumers. Community Care, the managed care organization, continues to establish internal quality indicators to help monitor and reduce the amount of hospital readmissions and provide initiatives to help people obtain follow-up appointments once discharged from a restrictive setting.

- **Based on the 2011 Consumer Action Response Team Annual Report, consumers are generally satisfied with the services received and notice an improvement in their quality of life.** Also, youth and adult consumers were also given the opportunity to provide input into their treatment plan.

Based on the data reported, this report has identified several areas where additional utilization and quality analysis are recommended for 2012:

- ***Enrollment and service utilization rates*** should continue to be monitored to determine if the enrollment decrease seen in late 2011 continues throughout 2012 and the impact that may have on service penetration.

- ***Act 62's impact on HealthChoices funds*** received for BHRS warrants monitoring paid claims over the next few years to determine if they will continue to increase or stabilize.

- ***Evaluation on people accessing crisis services*** is needed to help determine whether or not they are having fewer encounters with the crisis system or if individual encounters are shorter and what implications these results may have.

In addition to these recommendations, AHCI will use this report to help define special topic reports and projects based on the needs of the community.

Introduction

Medicaid, a publicly-funded health insurance program for people with low-income and/or a disability, is the largest public funding source for behavioral health care in the United States and plays a critical role in the public safety net today. In Pennsylvania, the Department of Public Welfare instituted a managed care program that "carved out," or separated, the administration and Medicaid funding of all mental health and substance use services from physical health services into the HealthChoices behavioral health program.

In 1999, Allegheny County took a novel approach to implementing the behavioral health carve-out locally by developing private-public partnerships where program responsibilities are divided among the Allegheny County Office of Behavioral Health; Community Care Behavioral Health (Community Care), a non-profit managed care organization; and Allegheny HealthChoices, Inc. (AHCI), an independent non-profit oversight and monitoring agency.

This report details the analysis completed to monitor the HealthChoices program against the program's goals. The goals include improving access to services, providing quality and continuity of care, and effectively coordinating and distributing limited Medicaid resources. The report contains information on the people served, access to care, service utilization and cost, quality and continuity of care, and consumer satisfaction in the Allegheny County HealthChoices behavioral health program for 2011.

In addition to providing an overview of the HealthChoices program in 2011, this report gives the entire service system an opportunity to identify areas where additional utilization and quality analysis are needed. AHCI will use this report to help define special topic reports and projects for 2012 and 2013.

A Story of Hope and Recovery

Listening to people talk about their recovery is the best way to really understand how services help people. Below is one person's story of how services have helped him on his recovery journey.

After being in Mayview State Hospital for many years, Wayne currently resides in a community group home, where he values the privacy of his own room. "I like having my own room . . . it's like having my own apartment," reports Wayne.

Since his discharge from Mayview, Wayne receives services from one of the community treatment teams (CTTs) in Allegheny County. CTTs provide intensive, team-delivered services in the community to people with serious mental illness and often co-occurring substance abuse. CTTs are expected to follow the Assertive Community Treatment (ACT) model, an evidence-based practice, and provide most of the community-based services a person needs.*

How important are these services to Wayne? "Very important!"

Overtime, through collaboration with the team during therapy sessions, he was able to work on coping and relaxation skills to deal with his anxiety. The team psychiatrist also helps him manage his medication.

One of Wayne's biggest successes has been obtaining a job at a local grocery store bagging groceries one to two days a week. The vocational specialist on the team helps him work on problem solving at his job, as well as how to deal with symptoms of his mental illness.

Wayne likes working with his fellow co-workers and assisting customers. He looks forward to going to work and appreciates having some extra money. Since becoming employed, Wayne uses some of his extra cash to go shopping at the local Thrift Store.

In addition to the CTT services, Wayne also relies on natural supports, especially his family. He regularly attends church services, enjoys taking walks in the community with friends, and loves playing the harmonica in his spare time.

In the future, Wayne hopes to learn more about computers and hopes to one day purchase a digital camera. Wayne's compassionate and heartfelt message to others is, "If I can do it, you can do it!"

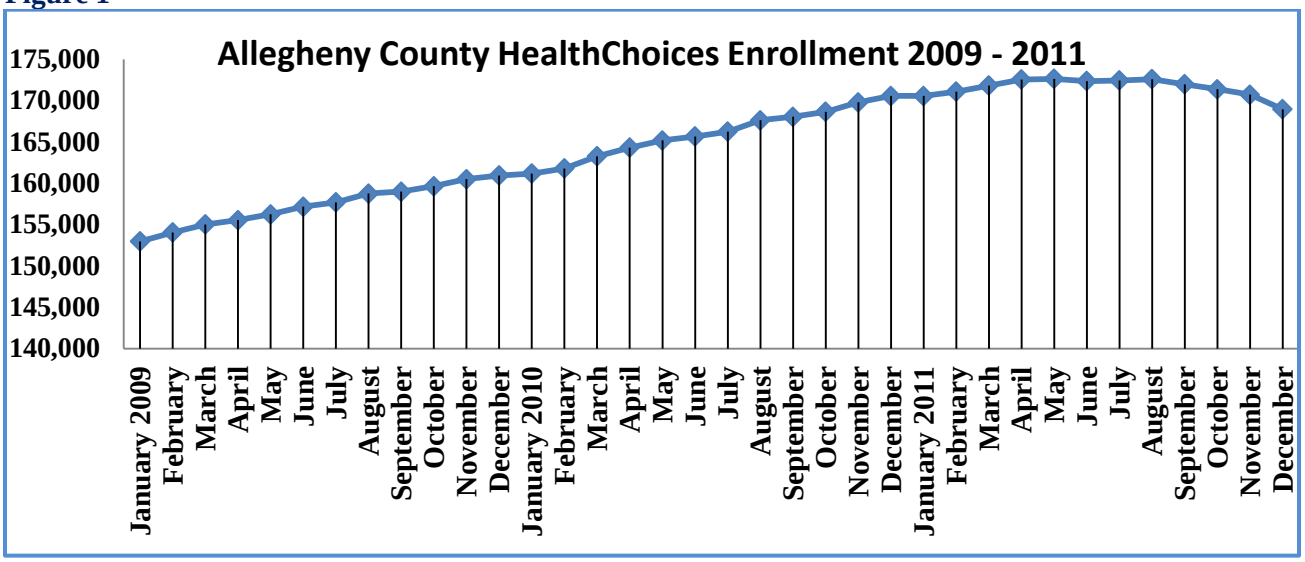
**For more information on the quality and outcomes related to CTT services in Allegheny County, visit www.ahci.org/reports.php*

People Served by the HealthChoices Behavioral Health Program

While looking at costs and service utilization by level of care is important, the behavioral health needs of people in the HealthChoices program are at the center of all monitoring and oversight activities. Given that assumption, AHCI analyzes who is enrolled in the program, and of those enrolled, who actually uses services. This provides a means for identifying and tracking trends by age group, race, and gender.

From 2010 to 2011, enrollment in the Allegheny HealthChoices behavioral health program increased about 3% to 171,601 people. This rate of growth is similar to changes seen in previous years. Figure 1 displays changes in program enrollment from January 2009 to April 2012.

Figure 1



Enrollment steadily increased from January 2011 to August 2011, then decreased from September 2011 to December 2011. A potential reason for this decrease is that beginning in July 2011, the Department of Public Welfare (DPW) invested additional resources to catch up on a backlog of eligibility reviews, in which some people were ultimately determined to be ineligible. Additionally, DPW began more diligently enforcing the timeframes in which a person had to present for redetermination of eligibility or otherwise be terminated. Also, in November 2011, DPW established a new method for calculating enrollment to assure that recipients are only included once, even if they are eligible for benefits through multiple programs. Many people who were found ineligible by this new method were ultimately reinstated after further review and found eligible for Medical Assistance, preventing enrollment from dropping even further. These were the administration's efforts to achieve cost savings and administrative efficiencies.

Of the 171,601 people enrolled in the HealthChoices behavioral health program, 44,737 people, or 26%, used at least one mental health or substance use service during 2011. This proportion is similar to 2010. There is not an expectation that all of the people enrolled will need behavioral health services since enrollment can be based on either income level or disability, but the HealthChoices program wants to ensure that everyone who is eligible and needs services

received them. (See *Access to Care*, page 9.) Other issues can also affect utilization, such as the stigma often associated with behavioral health diagnoses.

The following table delineates the similarities and differences between the enrollment and service use populations.

Table 1

Allegheny County HealthChoices Program 2011
Demographic Characteristics of Enrollees and Service Users

	Enrollees	Service Users
Age	Enrollees are almost evenly split between the 0-20 year (54%) and 21+ year old group (46%)	Service Users include more adults (62%) than youth (38%)
Race	Enrollees are almost evenly split between white (53%) and black (41%)	Service Users include more people who are white (62%) than are black (34%)
Gender	Enrollees are almost evenly split between men (44%) and women (56%)	Service Users are evenly split between men and women (both at 50%)

Note: These figures are similar to 2010.

The enrollment and service use populations are fairly similar in several areas but do have some differences, specifically with regard to age and race. In terms of age, the difference may be related to eligibility. Enrollees are eligible for the HealthChoices program because of their income level and/or disability. Service users only utilize HealthChoices program services if they have a behavioral health issue, which may not develop or be diagnosed until they are older, possibly lowering the number of youth (i.e., the very young) in this category.

There is also a difference by race, with a higher proportion of white enrollees accessing services than black enrollees. While the prevalence of some behavioral health disorders varies by age and gender, research has shown few differences between these two racial groups in terms of the overall prevalence of mental illness, thus we would expect to see some similarity between the proportion of enrollees and service users by race. Differences in the number of people accessing services by race suggest that continued efforts are necessary to improve access to behavioral health services for minorities. Cultural differences, a heightened sense of stigma, and use of non-traditional supports also need to be taken into consideration when trying to provide services and supports for these individuals.

Access to Care

Improving access to care is a key goal of the HealthChoices program. Timely access to health services can improve health outcomes, quality of life and prevent unnecessary hospitalizations.[1] AHCI monitors access by measuring penetration rates and ensuring that the managed care company, Community Care, meets DPW access standards.

[1] More information on the importance of access to care can be retrieved at http://www.healthypeople.gov/ 2020/ topicsobjectives2020/overview.aspx?topicid=1.

Service Penetration and Utilization

Annual penetration rates measure how many people accessed one or more behavioral health service in a given year. Table 2 details the penetration rates by age and race for the HealthChoices program in 2011.

Table 2

Allegheny County HealthChoices Penetration Rates by Age and Race, 2011 (percent of enrollees who used at least one service)		
	Number of Members	**Percent Accessing at Least One Service**
Children/Adolescents (0-20 years old)	**16,936**	**18%**
Black	*6,357*	*16%*
White	*9,629*	*21%*
Other	*950*	*15%*
Adults (21+ years old)	**28,077**	**36%**
Black	*8,829*	*30%*
White	*18,499*	*41%*
Other	*749*	*21%*
Total Penetration	**44,737**	**26%**

Note: These percentages will not equal 100%. Each percent represents each group's utilization of services, not the utilization of the total population.

About 26% of Allegheny County's total enrolled population utilized behavioral health services in 2011. By comparison, previous data has indicated between 7% and 13% of the United States' Medicaid population receives some form of behavioral health service each year.[2] It appears that a high proportion of those expected to need behavioral health services have access to them through the HealthChoices program.

When breaking down people who used services by race, as with the enrollee population, there is a higher proportion of whites accessing services than blacks. This is similar to what was seen in 2010. It speaks to the need for additional attention to how different populations access services.

DPW's Access Standards

Monitoring access also involves assessing the provider network to assure a sufficient number of providers are available within specific geographical parameters set by DPW's Office of Mental Health and Substance Abuse Services (OMHSAS). Community Care met these access standards on about twenty in-plan[3] levels of care, in all areas of Allegheny County, except for the following substance use services:

1. Inpatient detoxification services for children and adolescents
2. Inpatient rehabilitation services for adults

[2] This information was found in a journal article published in *Psychiatric Services* in 2010 and can be accessed at http://ajp.psychiatryonline.org/data/Journals/PSS/3915/10ps871.pdf.

[3] In-plan services are services that DPW requires Community Care to provide to enrollees in the HealthChoices program. The list of services required by the HealthChoices program can be found in DPW's publication *Program Standards and Requirements (PSR) - Primary Contractor* on pages 18 and 19 at http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s_002381.pdf.

3. Inpatient rehabilitation services for children and adolescents

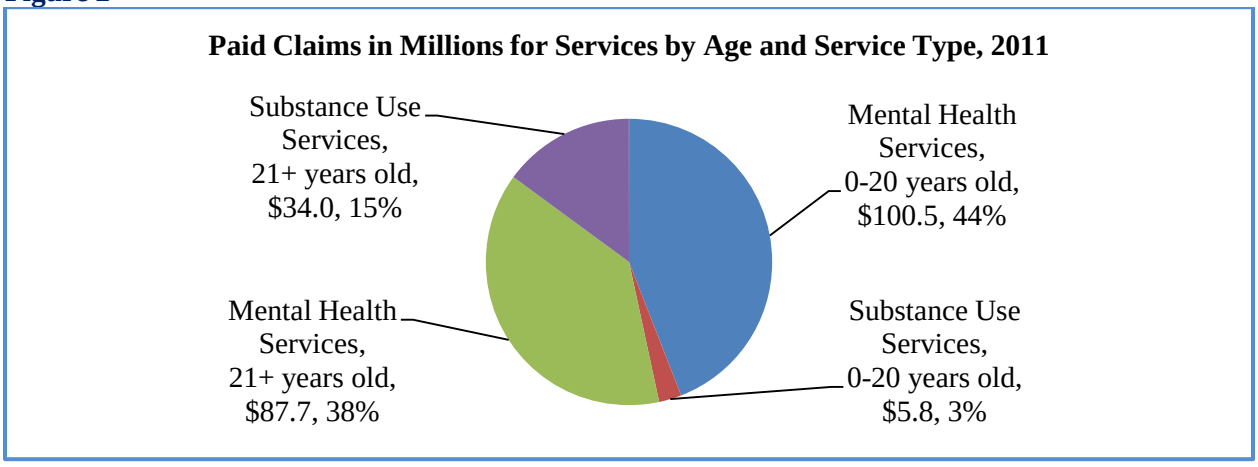
Allegheny County and Community Care requested exceptions to the access standards for these three levels of care from OMHSAS. All three exceptions were granted by OMHSAS for the time period of January 1, 2012 to December 31, 2012. In order to receive these exceptions, Community Care must monitor requests for these levels of care and complaints related to accessing them. There were 25 requests for inpatient rehabilitation services for adults in 2011, and these requests were handled by existing providers in the network. There were no requests for services for the other levels of care listed above, nor were there any complaints related to access to any of these levels of care.

Service Use and Cost Summary

A primary goal of the HealthChoices program is to assure that finite financial resources are allocated responsibly and that the growth of spending is controlled. Monitoring the proportion of funds spent on inpatient and other restrictive levels of care, and utilization changes in specific services, can help identify trends that may require further investigation or intervention or suggest the need to develop new types of services.

Figure 2, below, summarizes claims paid in 2011 by age and service type -- mental health and substance use services. About 47% of claims were for mental health and substance use services for children and adolescents (0-20 years), while 53% of claims were for services for adults 21 years and older.

Figure 2



Service Utilization & Cost: Children and Adolescents

Youth receive HealthChoices behavioral health treatment for a variety of diagnoses, including:

- 33% of service users had paid claims for the treatment of ADHD
- 25% had paid claims for treatment of adjustment disorders
- 21% had paid claims for the treatment of major depression or other depressive disorders
- 20% had paid claims for conduct disorder or oppositional/defiant disorder

- 17% had paid claims for the treatment of autism spectrum disorders
- 9% had paid claims for anxiety disorders[4]

Because of the intensive community services many children with autism spectrum disorders need, the average annual cost for service users with these diagnoses is $9,659. Average annual costs for other common diagnoses range from $2,300 for adjustment disorder to $5,200 for major depression.[5] Approximately 7% of youth received services for the treatment of a substance use diagnosis; Common substance use diagnoses seen in HealthChoices-eligbible youth include cannabis (64%), dependence on multiple substances (16%), and opiates, e.g. heroin and oxycontin (14%).

Monitoring service utilization and costs involves analyzing how costs are allocated across service groups as well as changes in specific levels of care. Because inpatient services cost more per person, decreasing overall inpatient utilization allows financial resources to shift to community-based services that are able to serve more people (improving access) and are better suited to promote long-term recovery (improving quality and outcomes). For children and adolescents, averting the need for psychiatric hospitalizations and for placement outside the home in residential treatment facilities (RTF) are both important goals. While these restrictive and intensive services are important within the continuum of care, providing services in a community setting whenever possible not only conserves resources but helps foster recovery.

Table 3 summarizes the 2011 costs and service use across five service groups: community-based mental health services, crisis services, residential treatment facilities, psychiatric inpatient (and related intensive services), and substance use services. The highest proportion of paid claims in 2011 was paid for community-based mental health services (73%, $78.7 million) and 95% of children and adolescents who used services accessed a community-based service at least once during the year. While used by a small number of youth, psychiatric inpatient and residential treatment facilities combined accounted for 21% of costs. Crisis services and substance use treatment services make up the smallest proportion of costs. The allocation of costs across these five service groups was very similar from 2010 to 2011, although the share of RTF services decreased from 14% to 11%.

[4] Because many youth may have different primary diagnoses reported on claims within the same year, individuals may be counted in more than one percentage (and the total of the percentages exceeds 100%).
[5] Note the costs covered by the HealthChoices program do not reflect prescription costs, which are covered by the physical health portion of the HealthChoices program.

Table 3

Service Costs, Number of Service Users, and Average Costs for Community Based and Intensive Services, 2011: Children and Adolescents						
	2011 Paid Claims (millions)	% Change in Claims from 2010	% of 2011 Claims	Number of Service Users	% of 2011 service users	Average cost per service user, 2011
Community-based MH Services	$78.71	5.2%	73%	16,105	95%	$4,887
Behavioral Health Rehabilitation Services	$44.37	11.0%	41%	5,651	33%	$7,852
Crisis Services	$1.00	-18.2%	1%	1,558	9%	$641
Residential Treatment Facilities	$12.09	-14.7%	11%	326	2%	$37,098
Psychiatric Inpatient and Related Intensive Services	$10.35	8.5%	10%	817	5%	$12,077
Substance Use Services	$5.94	25.1%	5%	1,285	8%	$4,622
Total	**$108.10**	**3.5%**	**100%**	**16,942***	**100%**	**$6,381**

*Since most people use more than one service, this column will total to more than the unduplicated number of service users, which is 16,942.

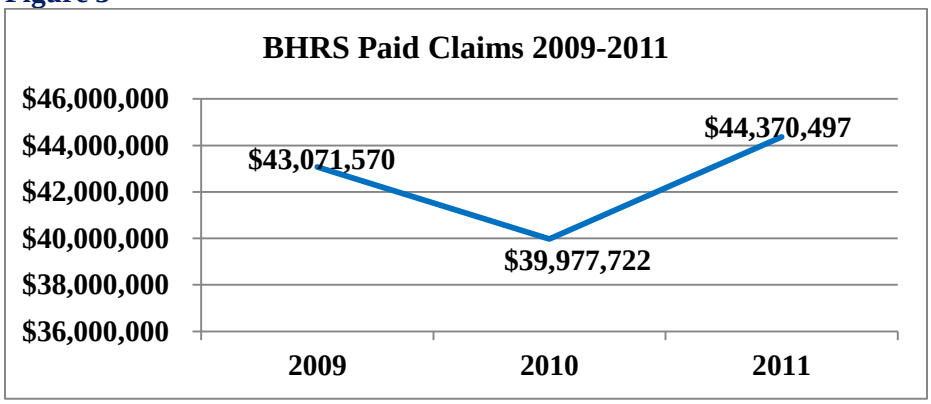
Community-based mental health services

- **Service group description:** This service group includes behavioral health rehabilitation services (BHRS), clinic based outpatient therapy and medication management, partial hospitalization services, family-based services, and service coordination, and other smaller specialized services.

  BHRS accounted for 56% of claims in this service group and is a cost driver for the HealthChoices program. Outpatient mental health, partial hospital, family-based, and service coordination account for another 36% of services in this category (in similar proportions).

- **Changes from 2010:** Paid claims for BHRS increased 11% from 2010 due to an increased number of children and adolescents receiving these services, and as the result of rate increases for mobile therapists and behavioral specialist consultants. See Figure 3 on the following page.

Figure 3



In 2010, Act 62, the Autism Insurance Act, went into effect, requiring private insurers to cover some costs for BHRS.[6] As a result, 2010 BHRS paid claims were 7% lower than 2009. In 2011, the combination of increased penetration and rate increases for services resulted in costs comparable to 2009.

Other community-based mental health services did not change significantly from 2010.

Crisis services

- **Service group description:** Crisis services are a critical part of an effective mental health system. Beginning in 2008, a spectrum of crisis services were consolidated in the re:solve Crisis Network, operated by Western Psychiatric Institute and Clinic (WPIC). These services include telephone crisis, mobile crisis teams, walk-in crisis, and residential crisis services; re:solve services account for about 90% of claims in this service group. Evaluations at the Diagnostic, Evaluation Center (DEC) at WPIC's psychiatric hospital in Oakland account for the rest of the costs.

- **Changes from 2010:** Although paid claims for crisis services decreased in 2011, the number of children and adolescents accessing crisis services increased 10%; on average, children and adolescents used smaller amounts of each type of crisis service provided by re:solve in 2011. Improved access is a positive change, and the decreases in the amount of services used will be investigated further to determine if youth are having fewer encounters with the crisis system or if individual encounters are shorter.

Residential Treatment Facilities (RTF)

- **Service group description:** RTFs provide intensive treatment in a residential setting for youth who have severe emotional and/or behavioral problems, and is recommended when other community-based services have not been successful. Family involvement is very

[6] The Pennsylvania Autism Insurance Act (Act 62) requires private health insurance companies to cover the costs of assessments and treatments for autism spectrum disorders up to $36,000 per year per person. All allowable costs above $36,000 are covered by the HealthChoices program. For some children, this went into effect January 1, 2009 while January 1, 2010 was the effective date for most children. Act 62 has the potential to help the HealthChoices program experience cost savings. Additional administrative costs for providers in managing billing are not reflected in claims data.

important in this service. Because supporting youth in their home communities rather than out-of-home placements is an important goal, admissions and lengths of stay are important quality indicators (summarized on page 21).

- **Changes from 2010:** Costs for RTF services decreased 14.7% from 2010, as a result of fewer youth being admitted and those who are have shorter average lengths of stay. Also, twelve RTF provider sites closed within Allegheny County's network. The closing of these sites was due to low utilization at these sites. This suggests that more youth are receiving services in the community.

Psychiatric Inpatient and Related Intensive Services

- **Service group description:** This service group primarily includes short-term psychiatric hospitalizations, accounting for 95% of the claims paid in this service group. The remaining 5% of claims ($547,239) are associated with 16 older adolescents using extended acute services and the residential treatment facility for adults (RTF-A), services providing longer periods of inpatient stabilization in a recovery-oriented environment for people who would have previously used state hospital services.

- **Changes from 2010:** Paid claims for psychiatric hospitalizations increased 4.5% from 2010. While the admission rates in 2010 and 2011 were very similar (about 9 admissions per 1,000 enrollees), the average length of stay increased from 12.5 days to 14.2 days. AHCI has been monitoring this through its quarterly service utilization analysis and reports. The average length of stay in the first quarter of 2011 was 15.1 days and decreased throughout the year. The high first quarter average length of stay pushed up the overall average. In the fourth quarter of 2011, the average length of stay was 13.1 days. AHCI will continue to analyze the average length of stay over time.

Substance Use Services

- **Service group description:** This service group includes outpatient, intensive outpatient, and partial hospital services, as well as inpatient and residential detoxification and rehabilitation services. Non-hospital rehabilitation is the primary cost driver in this service group, accounting for 74% of paid claims. Outpatient services account for 11% of claims, and other services have relatively low utilization.

- **Changes from 2010:** The substantial increase in claims for this service category is the result of the 39% increase in costs for non-hospital rehabilitation. This results primarily from the increase in the average length of stay from 43 days in 2010 to 60 days in 2011. This may be an indication of improved retention in treatment, or changes in referral patterns, with more youth being referred to long-term vs. short-term rehabilitation treatment programs.

Summary

Overall, the allocation of costs in 2011 between community-based services, RTF, inpatient, crisis, and drug and alcohol services was similar to 2010, with a substantially larger proportion of costs supporting community-based services in both years. RTF use continued to decrease, a positive trend suggesting that youth are being supported through community based services. A

number of changes require further monitoring: the increased average length of stay for psychiatric inpatient services, the increased costs for non-hospital rehabilitation, and the changes in crisis service use.

Service Utilization & Costs: Adults

Adults receive HealthChoices behavioral health treatment for a variety of diagnoses, including:

- 44% had paid claims for the treatment of major depression or other depressive disorders
- 18% had paid claims for the treatment of bipolar disorder
- 16% of service users had paid claims for the treatment of schizophrenia
- 12% had paid claims for anxiety related disorders
- 32% had claims for the treatment of a substance use disorder[7]

These 2011 diagnosis patterns were very similar to 2010. Adults with schizophrenia had the highest average annual costs, over $8,000 per service user. Average annual costs for the treatment for other common diagnoses ranged between $900 (anxiety disorders) and $2,400 (bipolar disorder).

For adults with a substance use disorder, over 50% received treatment for opioid disorders (including heroin and prescription drugs like oxycontin); the number of service users receiving treatment for opioid disorders increased 10% in 2011. Also, 26% received treatment for alcohol related disorders, 24% received treatment for dependency on multiple substances, and 15% received treatment for cocaine abuse or dependence. Many adults have co-occurring mental health and substance use diagnoses; of adults using services in 2011, 54% have received a mental health and substance use diagnosis at some point in the HealthChoices program.

Monitoring service utilization and costs involves analyzing how costs are allocated across service groups and changes in specific levels of care. For adults, preventing unnecessary hospitalizations and averting the need for psychiatric hospitalizations and extended acute care, while promoting community tenure, are important goals. While these restrictive and intensive services are important within the continuum of care, providing services in a community setting when possible not only conserves resources but helps foster recovery.

Table 4 summarizes the costs and service use in 2011 across four service groups: community-based mental health services, crisis, respite, and diversion/acute stabilization services, psychiatric inpatient and other intensive services, and drug and alcohol services. Despite some utilization changes in the cost drivers (discussed below), the proportion of financial resources distributed to each of these four service groups did not change from 2010.

[7] Because many adults may have different primary diagnoses reported on claims within the same year, individuals may be counted in more than one percentage (and the total of the percentages exceeds 100%).

Table 4

Adult Service Costs, Number of Service Users, and Average Costs by Service Group & Cost Driver, 2011						
	Claims (millions)	% Change from 2010	% of Claims	# of Service Users	% of Service Users	Average Cost/User
Community-based MH Services	**$46.40**	**6.2%**	**37%**	**24,141**	**86%**	**$1,922**
Community treatment teams	*$13.95*	*13.4%*	*11%*	*693*	2%	*$20,128*
Outpatient MH & med checks	*$14.65*	*6.5%*	*12%*	*22,495*	80%	*$651*
Service coordination	*$11.47*	*-3.4%*	*9%*	*3,860*	14%	*$2,970*
Crisis, Respite, & Diversion/Acute Stabilization (DAS) Services	**$6.55**	**-6.2%**	**5%**	**3,412**	**13%**	**$1,919**
Crisis services	*$3.53*	*-15.5%*	*3%*	*3,185*	*11%*	*$1,109*
Respite/DAS	*$3.01*	*7.7%*	*2%*	*472*	*2%*	*$6,382*
Psychiatric Inpatient and Related Intensive Services	**$35.32**	**8.7%**	**29%**	**3,001**	**11%**	**$11,768**
Psychiatric Inpatient	*$25.91*	*-2.5%*	*21%*	*2,931*	*10%*	*$8,840*
Inpatient extended acute	*$5.16*	*23.1%*	*4%*	*88*	*0%*	*$58,629*
Community extended acute and long-term structured residential	*$2.51*	*N/A*	*2%*	*76*	*0%*	*$33,092*
Residential Treatment Facility - Adults	*$1.73*	*-0.8%*	*1%*	*68*	*0%*	*$25,484*
Substance Use Services	**$35.47**	**3.1%**	**29%**	**8,550**	**30%**	**$3,991**
Non-hospital rehab	*$12.94*	*6.1%*	*10%*	*2,460*	*9%*	*$5,259*
Methadone maintenance	*$7.09*	*5.2%*	*6%*	*2,263*	*8%*	*$3,131*
Outpatient substance use	*$5.13*	*0.0%*	*4%*	*6,310*	*22%*	*$814*
Total	**$123.73**	**5.2%**	**100%**	**28,083***	**100%**	**$0**

*Since most people use more than one service, the numbers in this column total more than the unduplicated number of service users, which is 28,083.

Community-based Mental Health Services

- **Service group description:** Most adults (86%) who used services during 2011 used some community-based mental health services. The majority of paid claims for this category are for community treatment teams (CTTs)[8] (11%), outpatient mental health and medication checks (12%), and service coordination (9%). Other less utilized services in this category include partial hospitalization, enhanced clinical service coordination, mobile medications, and psychiatric rehabilitation.

- **Changes from 2010:** As shown in Table 4, community-based services grew 6.2%, primarily the result of an increased number of people using CTT services and a small increase in the reimbursement rate for medication check services. CTTs are an evidence-based practice following the Assertive Community Treatment model, providing comprehensive, intensive services to people with serious mental illness.[9] Increased

[8] CTTs are an almost all-inclusive service, fully responsible for a variety of services, including case management, psychiatric services, medication management, counseling, housing support, substance abuse treatment, peer support, crisis and diversion services, employment and rehabilitation services, assistance in management of personal finances, and hospital and criminal justice liaison services

[9] For more information on the quality and outcomes related to CTT services in Allegheny County, visit www.ahci.org/reports.php.

access to this service is a positive trend, as CTT is considered more effective and less costly than hospital alternatives.

- Three CTTs moved from reinvestment funding to HealthChoices funding in the first quarter of 2011. During 2011, the majority of individuals receiving CTT services were not hospitalized or incarcerated. Also, the proportion of individuals receiving CTT services moving into independent living increased. Other services in the community-based service group did not change substantially from 2010.

Crisis, Respite, & Diversion/Acute Stabilization (DAS) Services

- **Service group description:** This service group includes telephone, walk-in, mobile, and residential crisis services provided by the re:solve Crisis Network (WPIC), as well as respite and DAS services, which are short term, community-based residential programs intended to divert consumers who would otherwise be admitted to the hospital (and may also serve as a step-down after hospitalization). This service group also includes a small amount of paid claims (3% of the total) for evaluations at the Diagnostic, Evaluation Center (DEC) at WPIC's psychiatric hospital in Oakland.

- **Changes from 2010:** A decrease in paid claims for walk-in crisis services at re:solve accounts for the decrease in total costs for crisis services. While 14% more adults used walk-in crisis services in 2011, the average amount of services used per person decreased 31%. Improved access is a positive change, and the decreases in the amount of services used will be investigated further to determine if adults are having fewer walk-in crisis visits or if individual encounters are shorter. Use of other crisis, respite and DAS services in 2011 were similar to 2010.

Psychiatric Inpatient and Related Intensive Services

- **Service group description:** This service group includes psychiatric hospitalizations (73% of claims in this group), as well as extended acute services and the residential treatment facility for adults, both services providing longer periods of stabilization in a recovery-oriented environment for people who would have previously used state hospitalization services. Treatment costs associated with a few long-term structured residences (LTSRs) are also included. These programs were developed to help people leaving Mayview State Hospital as part of the closure to reintegrate back into the community.

- **Changes from 2010:** Inpatient mental health claims decreased 4% from 2010, although the number of service users with paid claims for these services increased 2%. The average length of stay decreased from 14.2 to 12.5 days between 2010 and 2011, resulting in the overall decrease in paid claims. Readmissions and follow up services after hospital discharge, two important quality indicators, are summarized on page 19.

- Paid claims for inpatient extended acute care increased 23% from 2010 to 2011, and adult service users increased 17%. The increases seen in paid claims are primarily due to the opening of the Comprehensive Recovery Unit (CRU) in the second quarter of 2011. CRU is an additional 10-bed inpatient extended acute unit at WPIC, which focuses on

community reintegration and can act as a step down from inpatient services. However, the length of stay for inpatient extended acute care services decreased from 164 days in 2010 to 133 days in 2011; this is also related to the opening of CRU and greater availability of services. At the same time, the length of stay for the community-based extend acute facility increased from 114 days in 2010 to 128 in 2011.

- Treatment costs associated with several LTSRs were initially funded through reinvestment monies program in 2010 and became HealthChoices funded in 2011.

- The increase in costs for the intensive service group is the result of expanded availability and coverage of these services by the Allegheny County HealthChoices program.

- Lastly, while costs for the RTF-A program were very similar to 2010, the program demonstrated an 11% decrease in average length of stay (from 74 days to 66 days in 2011). While still above the targeted 45 day length of stay, this decrease is a positive trend.

Substance Use Services

- **Service group description:** This service group includes outpatient, intensive outpatient, and partial hospitalization services, as well as inpatient and residential detoxification and rehabilitation services and halfway houses. Non-hospital rehabilitation is the primary cost driver in this service group, accounting for 38% of paid claims, followed by methadone maintenance (21% of claims) and outpatient substance use services (15% of claims). Annual costs for other substance use services ranged from $1.0 million for non-hospital detoxification to $2.9 million for halfway houses; each of these services accounted for less than 10% of costs in the service group.

- **Changes from 2010:** Adult use of substance use services in 2011 was very similar to 2010. A 10% increase in the number of service users for outpatient substance use services is a positive indication of increased penetration. Paid claims for non-hospital detoxification services increased 12%, the result of a small increase in both service users and provider rate increases received in 2011.

Summary

Overall, the allocation of costs in 2011 between community-based mental health services, crisis services, psychiatric hospitalizations and related services, and substance services for adults was similar to 2010, with a substantially larger proportion of costs supporting community-based services in both years. Positive increases in CTT use, coupled with a small decrease in inpatient use and the increased availability and funding of longer term intensive services suggests adequate capacity for both community services and intensive services. Monitoring the use of CTT and longer term hospital level services, and investigating the decreased average costs for walk-in crisis services will be important in 2012 and 2013.

Quality and Continuity of Care

Measuring quality of care requires a collaborative effort. OMHSAS, consumers and families members worked together to devise and create guiding principles that promote efforts in achieving and maintaining the highest quality and satisfaction with care. These principles guided the development of approaches and measures used to help ensure high standards are met in the HealthChoices program.

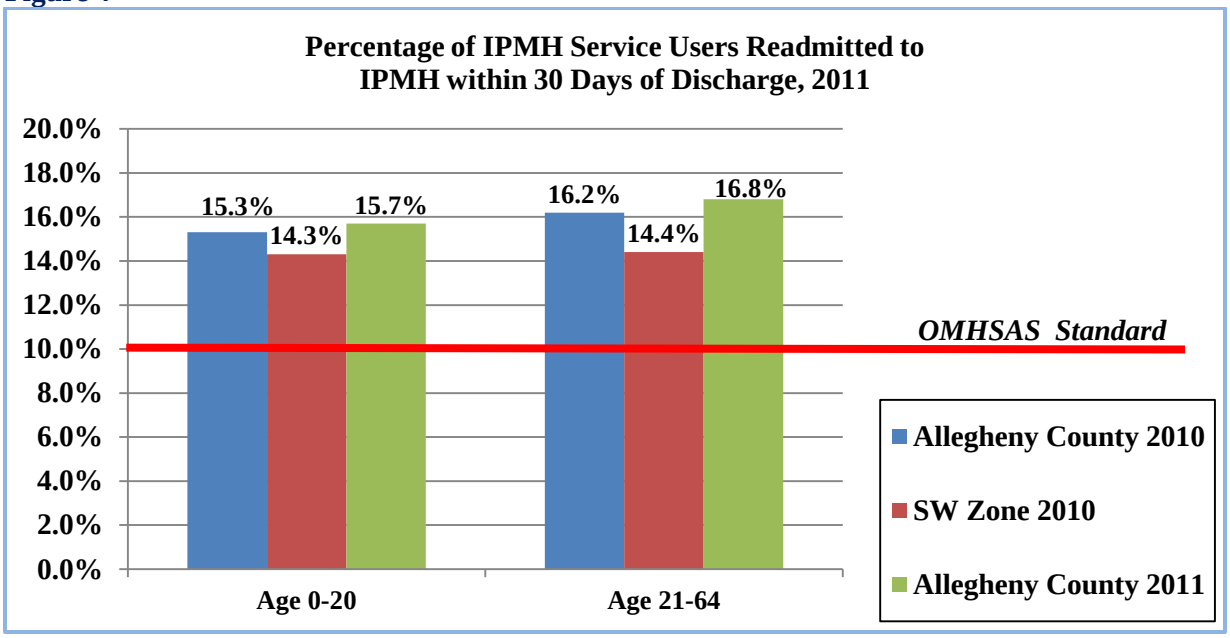
State Quality Benchmarks[10]

Psychiatric Hospitalization Readmission Rates

OMHSAS has several benchmarks that are used to help monitor quality and access to services. These benchmarks measure how the Allegheny County HealthChoices program is performing in comparison to other HealthChoices programs in Pennsylvania and identify areas for quality improvement.

Figure 4 displays the percentage of HealthChoices members who had readmissions to inpatient mental health services within 30 days of discharge from this level of care. It includes the 2010 Allegheny County HealthChoices program rate and the 2010 Southwest zone[11] rate as points for comparison.

Figure 4



Note: The PBC did not report data for ages 65 and older for 2010. Data from this age group is usually hard to analyze because it is small and most people in this age group have both Medicaid and Medicare for insurance. When someone is dual eligible, Medicare is the primary payer.

[10] All referenced benchmarks (i.e. gold standards, national norms) and state data is provided from the *HealthChoices Behavioral Health Performance-Based Contracting Report – 2011* (PBC). No reference point data from the state is available for 2011. The most recent year of data reported for most benchmarks is 2010.

[11] The HealthChoices Southwest Zone is made up of Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington and Westmoreland counties.

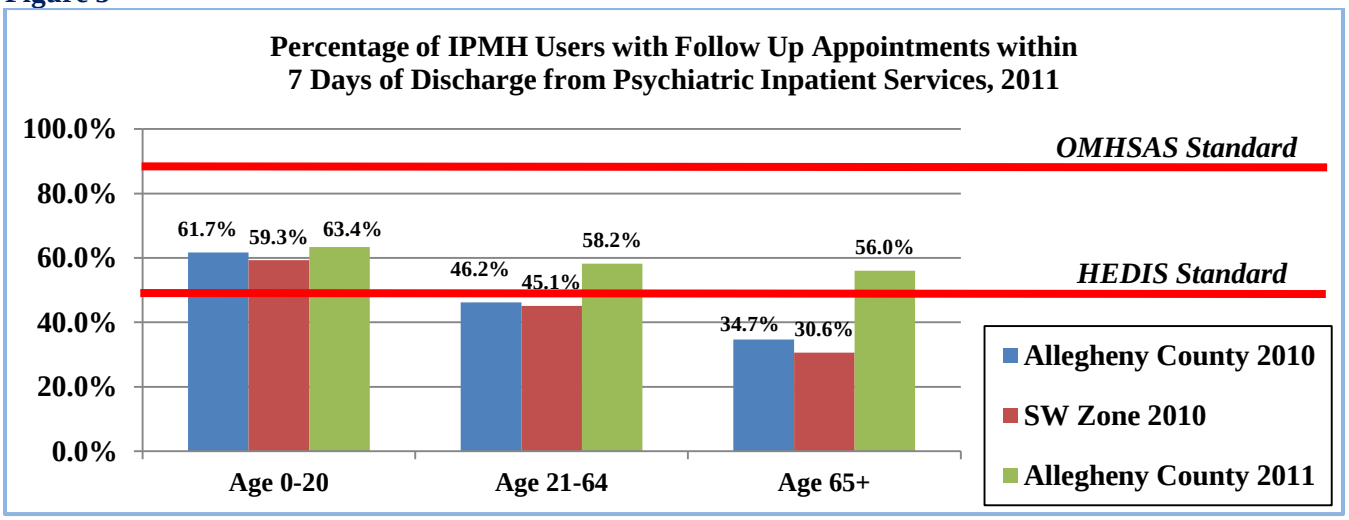
Previous research has found that effective discharge planning and after-care services help reduce unnecessary readmissions to inpatient facilities. Based on health care trends, OMHSAS established a standard benchmark of a 10% readmission rate to this level of care for all age groups. In 2011, the Allegheny County HealthChoices program did not meet this benchmark for any age group, and rates increased slightly from 2010. However, it had lower readmissions than Philadelphia County, the other urban county in the state. The Allegheny County HealthChoices program's rates were 3% lower for ages 0-20 and 9% lower for ages 21-64 than Philadelphia's in 2010.

This is an ongoing issue in Allegheny County HealthChoices program and throughout the state. To improve the readmission rates, Community Care established a set of quality indicators related to the inpatient discharge process. Providers that did not meet these benchmarks were required to complete quality improvement plans, which are reviewed and monitored by Community Care. OMHSAS initiatives are reinforced through Community Care Provider Alerts and their website as appropriate. Additionally, Community Care's contract with Allegheny County has established performance standards, of which a 12% readmission rate to psychiatric inpatient is a goal.

Follow-up Services after Psychiatric Hospital Discharge

Follow up with community-based services within seven days post discharge from an inpatient facility is crucial for continuity of care and preventing readmissions. Figure 5 displays the percentage of Allegheny County HealthChoices members who had follow up appointments within seven days of discharge from an inpatient mental health facility.

Figure 5



OMHSAS established a gold standard benchmark at 90% for this standard. OMHSAS also uses the Healthcare Effectiveness Data and Information Set (HEDIS)[12] Medicaid rates as a national benchmark for this standard. The HEDIS benchmark is 44.56%.

[12] HEDIS performance measures are often used in managed care organizations across the United States.

In 2011, the Allegheny County HealthChoices program did not meet the OMHSAS benchmark of 90% for any age group, but met and exceeded the HEDIS standard by at least 10% for all age groups.

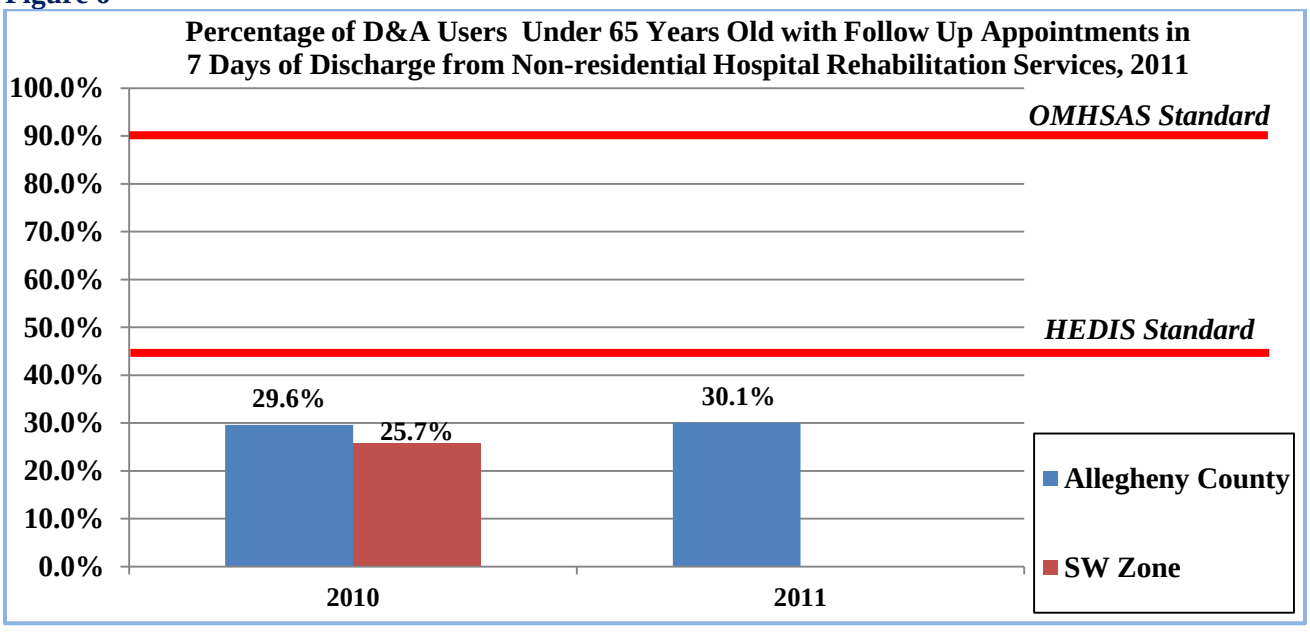
All age groups had higher follow up service rates in 2011 in comparison to 2010. Moreover, all age groups also had higher follow up service rates than the average for the Southwest Zone in 2010. Also, the Allegheny County HealthChoices program had follow up service rates 10% higher than Philadelphia for all age groups in 2010.

Community Care established internal quality indicators related to the people who are recently discharged from an inpatient facility to ensure that a follow up appointment is scheduled within seven days. They require providers not meeting that benchmark to submit quality improvement plans, which are reviewed and monitored by Community Care.

Follow-up Services after Non-hospital Rehabilitation Services

Similar to the previous benchmark, follow up services received post-discharge from non-hospital rehabilitation services are critical for continuity of care and positive health outcomes. Figure 6 displays the percentage of HealthChoices members under 65 years old who had follow up appointments within seven days of discharge from non-residential hospital rehabilitation services. This includes non-hospital residential detoxification, residential rehabilitation and halfway house services.

Figure 6



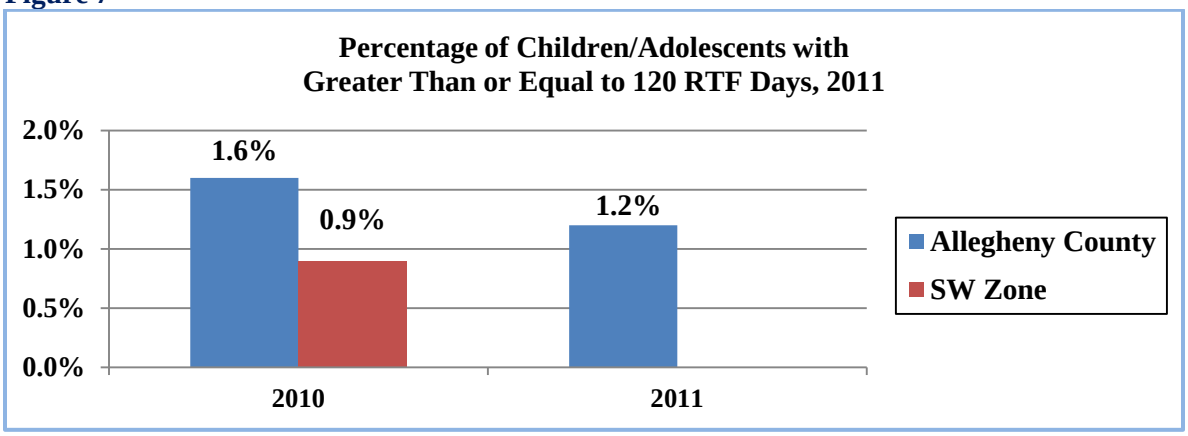
While there are no national benchmarks related to non-hospital rehabilitation services, OMHSAS expects that the same results related to the previous HEDIS standard of 44.56% for follow up services after a psychiatric inpatient stay should be achieved. OMHSAS also established a gold standard benchmark at 90%.

In 2011, the Allegheny County HealthChoices program did not meet the HEDIS or OMHSAS standard for this age group. However, people in Allegheny County did receive slightly more services in 2011 compared to 2010. Also, Allegheny County is performing better in this measure than the average of the Southwest Zone (25.7%) and Philadelphia County (26.5%) in 2010. As with inpatient discharges, Community Care established an internal quality indicators to monitor people who are recently discharged from a non-residential hospital rehabilitation service to ensure that a follow up appointment is scheduled within seven days. The organization also requires providers not meeting that benchmark to submit quality improvement plans, which are reviewed and monitored by Community Care.

Length of stay in Residential Treatment Facilities for Youth

Figure 7 displays the percentage of children and adolescents from the Allegheny County HealthChoices population who had 120 or more days in a residential treatment facility.

Figure 7



There are no established benchmarks for this measure but it is of interest for OMHSAS because the goal is to keep children in their homes and their home communities whenever possible. Although the Allegheny County HealthChoices program is higher than the Southwest Zone in 2010, the Southwest Zone is the lowest among all of the other HealthChoices regions in Pennsylvania. The Allegheny County program's 1.2% in 2011 is lower than Philadelphia County (2.4%) and all other HealthChoices regions reported in 2010, except for the North/Central County region. Allegheny County historically has a very low RTF utilization rate in comparison to other counties across the state. To ensure Allegheny County maintains its current status, Community Care holds monthly RTF provider meetings on various topics, including any areas where quality improvement initiatives are necessary.

Satisfaction

Evidence of quality services in the Allegheny County HealthChoices behavioral health program extends beyond service utilization and cost trends. Looking at the satisfaction of children, youth, adults, and parents/guardians of children who use behavioral health services also provides some insight into program quality.

In Allegheny County, the Consumer Action and Response Team (CART) regularly conducts surveys to measure service users' satisfaction with various levels of care[13]. After surveying, CART analyzes the responses and provides quarterly and annual satisfaction reports to Allegheny County, Community Care, AHCI and OMHSAS. Reports are also sent to the providers of the specific levels of care and, when trends dictate, request information on how providers will use the information to improve their programs. These reports provide context on the areas where the HealthChoices program is doing well and help identify areas for improvement.

In 2011, CART surveyed 1,123 people who were enrolled in the HealthChoices program. Of that number, 55% were adults, 42% were parents/guardians of children involved with services, 2% were family members of adults surveyed, and 1% were adolescents. The following table reflects these individuals' responses to several specific survey questions.

Table 5

Allegheny County HealthChoices Program 2011 Satisfaction Survey Responses

Survey Questions	Adult (21 and over)	Children and Youth (20 and under)
In the last 12 months were you able to get the help you needed?	72% reported getting the help needed	76% reported getting the help needed
Were you given the chance to make treatment decisions?	79% responded "Yes, Always"	96% responded "Yes, Always"
What effect has the treatment you received had on the quality of your life?	77% responded "Much or a Little Better"	88% responded "Much or a Little Better

While there is still room for improvement, more than half of respondents were able to get the help they needed and were given a chance to make treatment decisions. Additionally, respondents also report seeing a positive effect related to the quality of their life from the treatment they received.

[13] Community Care also conducts an annual satisfaction survey; however the 2011 results were not available during the development of this report.

Recommendations and Outlook for 2012

The Allegheny County HealthChoices program continues to be successful in meeting the goals of improving access to services, providing quality and continuity of care, and effectively coordinating and distributing limited Medicaid resources. Allegheny County was generally consistent in growth in enrollment, service utilization, and access to care in 2011 compared to 2010.

This report identifies several areas which AHCI's routine monitoring will address:

- ***Enrollment and Service Utilization.*** The decreasing enrollment seen towards the end of 2011 continues to be seen in 2012. This trend will be monitored closely to see if this continues throughout the rest of 2012 to ensure that people who are eligible can enroll in HealthChoices and thereby access any needed services.

- ***Act 62 and BHRS.*** Analysis will continue to be done on Act 62 and its impact on behavioral health rehabilitation services. Due to the rate increases in 2011, it is hard to predict if paid claims will continue to increase in 2012 or stabilize.

There are also some areas where additional monitoring and analyses will be needed:

- ***Crisis Services.*** In 2010, paid claims increased dramatically but decreased in 2011 (even though utilization continues to increase) for both children and adults. There is a need to determine if people are having fewer encounters with the crisis system or if individual encounters are shorter and what implications these results may have. In addition to data analysis, this will be addressed on a quarterly basis with crisis service staff to address any additional quality improvement initiatives. Currently, trainings are being done on using crisis/recovery plans with providers. These tools provide the opportunity for these service users to have a better understanding of their individual triggers and warning signs to help in an effort to divert future crises and utilization of crisis services.

- ***State Quality Benchmarks.*** The OMHSAS gold standard benchmarks continue to be a challenge for HealthChoices regions across the state. AHCI will work collaboratively with Community Care, Allegheny County, providers and other entities as needed on what actions and interventions are needed to improve performance against benchmarks. As barriers are addressed and interventions are designed, different methodologies and measures will be created and added within Community Care's internal benchmarking system. These benchmarks will be reviewed on a quarterly basis.

The behavioral health environment also continues to face many changes and challenges as we look towards the future. System planning needs to take into account the following:

- ***The Affordable Care Act (ACA) and Integration of Care.*** The expansion of Medicaid enrollment has the potential to create a higher demand for services. Also, there is a greater emphasis placed on health systems to create unified approaches in the coordination and integration of behavioral health and physical health services. The Allegheny County behavioral health system and the HealthChoices carve-out both need to be able to demonstrate an understanding of the ACA and continue working to better integrate behavioral and physical health services.

- ***Economic and Funding Issues.*** Collaborative efforts between OMHSAS, Allegheny County Office of Behavioral Health, Community Care, AHCI and other system stakeholders work to build a strong behavioral health system that is accessible, provides quality services, and is accountable. Given the current fiscal climate, it is more important than ever to be able to measure outcomes and show how services are meeting program and system goals.

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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 of the Allegheny County Department of Human Services' Office of Behavioral Health.