

# **Perspectives on Using a Rapid Monitoring System**

*A Report from the Effective Managed Behavioral Healthcare Program  
Monitoring Summit*

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## EXECUTIVE SUMMARY

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Medicaid is a major funder of behavioral health services in the United States. As a result, it has a significant impact on how behavioral health care is delivered in this country and the quality of that care. In addition, states that rely heavily on managed care for delivering services—including mental health and substance abuse services—to Medicaid beneficiaries, are concerned that enrollees get the services they need, that these services are of sufficient quality, and that costs are contained.

In order to achieve these goals, states have established various monitoring systems to identify and correct potential problems in their managed care behavioral health systems. Some of these states have grown concerned that their monitoring systems do not provide information as rapidly or effectively as possible. Some have developed systems designed to identify and correct issues of concern rapidly, before they develop into larger problems.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and The Centers for Medicare & Medicaid Services (CMS) have worked with program administrators and other stakeholders in Pennsylvania, Vermont, and Oklahoma to pilot Early Warning Systems (EWS). These systems use a limited set of measures and administrative processes to oversee the managed care behavioral health system and provide real-time, performance-based information to state, federal, and local governments; consumers; families; providers; advocates; and other key stakeholders. The EWS is designed to rapidly identify weaknesses in clinical care and to facilitate quality improvement efforts, leading to enhanced patient health outcomes. The program combines the use of current performance measures with a system of public accountability that increases stakeholder involvement in performance monitoring.

Each state's EWS is unique. It is developed, with stakeholder input, to reflect the behavioral health delivery system and the concerns with care within each state. States collect EWS measures on at least a quarterly basis. Any problems identified are usually addressed within weeks or months. Stakeholders receive data, help prioritize trends that need additional attention, assist in developing strategies to remedy problems, and help monitor corrective actions.

To support states in their efforts to develop and refine EWS-type systems, SAMHSA and CMS also asked the National Academy for State Health Policy to convene a small group of state policymakers and other experts to discuss their experience in operating an EWS or a similar system. The summit, organized by NASHP in May 2002, revealed eight key findings.

1. It is important that monitoring efforts can both (a) rapidly identify and address potential problems and (b) assess achievement of long term health and societal outcomes, outcomes that may not be measurable for several years.
2. Most of the tools needed to develop a system to rapidly identify and address potential problems already exist.

3. Stakeholders are likely to identify three issues as being particularly important for early warning systems to focus on: (1) enrollee access to care, (2) the timeliness of provider payments, and (3) the cost of providing care. The relative importance of these three issues will change as a program is implemented and becomes established.
4. A need exists for standard reporting among states to provide comparative data, but states will also always need the flexibility to address local concerns.
5. An effective system to identify potential concerns must be able to identify unanticipated problems.
6. States have to balance the need to rapidly identify problems with the need to ensure that the data they use to make decisions accurately reflect contractor and program performance.
7. States must also balance the need for consistent reporting with the need to keep up with an evolving program and focus on issues that are currently important.
8. Routinely sharing performance data creates a starting point for working with consumers and advocates.

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## INTRODUCTION

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Medicaid is a significant funder of behavioral health services in the United States. In 1997, the United States spent \$47.9 billion in public funding (federal, state, and local) on mental health and substance abuse services; \$16.7 billion of that amount was Medicaid funding.<sup>1</sup> As a result, Medicaid can have a major impact on how behavioral health care is delivered and the quality of that care.

Over the past decade, states have come to rely heavily on managed care for delivering services—including mental health and substance abuse services—to beneficiaries. As of July 1, 2000, 48 states and the District of Columbia had some form of Medicaid managed care program through which more than half of all Medicaid beneficiaries received some or all services. Thirty-five Medicaid agencies provided at least some behavioral health services through risk-based managed care.<sup>2</sup>

States that rely on managed care to deliver behavioral health services are concerned that enrollees get the services they need, that these services are of sufficient quality, and that costs are contained. All states with Medicaid managed care collect information that they can use to monitor their contractors' delivery of behavioral health services and assess whether they are meeting goals for access, quality, and cost. A National Academy for State Health Policy (NASHP) survey found that as of June 30, 2000, 33 or more of the 35 states that provide behavioral health through either an MCO<sup>3</sup> or PAHP/PIHP collected four types of data: utilization data (35 states), performance measures (35 states), enrollee surveys (34 states), and grievances/complaints (33 states).<sup>4</sup>

Few question the idea that scientifically validated, statistically valid, performance measures provide the most accurate assessment of managed care contractor performance. However,

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<sup>1</sup> Rosanna M. Coffey et al., *National Estimates of Expenditures for Mental Health and Substance Abuse Treatment, 1997*, (Rockville, MD: US Department of Health and Human Services, 2000), Table D.2(a).

<http://www.mentalhealth.org/publications/allpubs/SMA01-3492/SMA01-3492.pdf>

<sup>2</sup>Risk-based managed care includes services delivered by (1) managed care organizations (MCOs) that deliver a comprehensive range of services, including behavioral health services; (2) Prepaid Ambulatory Health Plans (PAHPs) that deliver only a limited set of outpatient services, such as mental health services; and (3) Prepaid Inpatient Health Plans (PIHPs) that delivery only a limited set of services but do include in-patient services for that type of care, such as in-patient and out-patient mental health services.

<sup>3</sup>Throughout the remainder of this paper, the term MCO includes PAHPs and PIHPs.

<sup>4</sup>Neva Kaye, *Medicaid Managed Care: A Guide for States, 5<sup>th</sup> edition*, (Portland, ME: National Academy for State Health Policy, 2001).

- validated measures may not always exist that measure the areas of concern to stakeholders;
- validating the data submitted by contractors, as well as analyzing the resulting measures and producing reports, can be a lengthy process; and
- some conditions may occur so infrequently that it may take a long time to accumulate enough data to judge performance

Due to these issues—and the need to be accountable to many stakeholders—states have grown concerned that their monitoring systems might not be able to identify and correct potential problems quickly enough. Some of these states have moved to develop systems that would rapidly identify issues that could develop into problems. These systems may use sources of data that are more quickly available, if not as complete as other sources. For example, using data about the services enrollees are authorized to receive instead of utilization data about the services they actually do receive allows states to more rapidly assess enrollee access to care. Also, input from stakeholders through complaints, focus groups, or regular meetings can both identify potential problems and build stakeholder support for the managed care program.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS) have made efforts to help states more quickly address their concerns about access, quality, and cost. The organizations began those efforts by working with two states to pilot an Early Warning System (EWS).

1. SAMHSA; HCFA Region Office III in Philadelphia; and the Commonwealth of Pennsylvania's Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS) piloted an early warning monitoring performance project for public behavioral health care. Implemented in January 1, 1999, the behavioral health program was piloted in Pennsylvania's HealthChoices program which covers 10 Southwestern counties, serving 320,000 recipients. The pilot has proved so successful that it has now been expanded throughout the 25 counties, serving 900,000 beneficiaries under the HealthChoices program.
2. Vermont uses its EWS to monitor the specialized Medicaid program it operates for a small number of persons with serious mental illness. This program pays regional community programs a case-rate that is risk adjusted for enrollee health status. Vermont's EWS uses specialized performance measures to monitor the unique issues related to using a case rate that relates payment to client status.



In these states, the EWS<sup>5</sup> uses a limited set of measures and administrative processes to oversee the managed care behavioral health system and provides real-time, performance-based information to state, federal, and local governments; consumers; families; providers; advocates; and other key stakeholders. The EWS is designed to rapidly identify weaknesses in clinical care and facilitate quality improvement efforts, leading to enhanced patient health outcomes. The programs combine the use of a limited set of current performance measures with a system of public accountability that actively involves stakeholders in performance monitoring. Each state's EWS is unique. It is developed, with stakeholder input, to reflect the behavioral health delivery system and the concerns with care within each state. These two states collect EWS measures on at least a quarterly basis. Any problems they identify are usually addressed within weeks or months. Stakeholders receive data, help prioritize trends that need additional attention, assist in developing strategies to remedy problems, and help monitor corrective actions.<sup>6</sup>

Based on the success of the system in these states and the knowledge that other states (e.g., Arizona, New Mexico, Texas) have been developing their own strategies to rapidly identify potential problems in managed behavioral health care, SAMHSA and CMS decided to hold a one-day summit to gather more information about state strategies for rapid identification and to facilitate information sharing among states with similar concerns.

The National Academy for State Health Policy convened the “Effective Managed Behavioral Healthcare Program Monitoring Summit” on May 2, 2002, in Alexandria, VA. The Summit brought together 33 state policymakers and other experts to discuss effective means to monitor behavioral healthcare programs. The meeting focused on systems such as the EWS piloted by the District, Pennsylvania, and Vermont that aim to identify and address potential problems in the delivery of behavioral health services before they become major problems. Collectively these systems are referred to as Rapid Monitoring Systems (RMS).<sup>7</sup> The state policymakers at the meeting represented Medicaid, substance abuse, and/or mental health agencies from 14 jurisdictions: Arizona, California, Colorado, District of Columbia, Iowa, Massachusetts, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Texas, Vermont, and Wisconsin (A table displaying pertinent policies for each of these states is included as Appendix B, a participant list for the summit is Appendix C, and the summit agenda is Appendix D.)

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<sup>5</sup>This description of an EWS is drawn from Howard Dichter, *Monitoring Medicaid Managed Care via an Early Warning Program*, (Princeton: The Center for Health Care Strategies, 2002). <http://www.chcs.org/publications/pdf/ips/earlywarning.pdf>.

<sup>6</sup>Please refer to Appendix A for more information about the EWS and how states have used them.

<sup>7</sup>The term Rapid Monitoring System (RMS) includes both (1) those EWS systems piloted by the District, Pennsylvania, and Vermont); and (2) those systems independently designed by states, such as New Mexico and Texas, for a similar purpose—rapid problem identification and resolution.

## SUMMIT FINDINGS

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This remainder of this report summarizes the discussion at the Summit. The summary is organized around the seven major themes that emerged from the discussion. These themes are:

1. It is important that monitoring efforts can both (a) rapidly identify and address potential problems and (b) assess achievement of long term health and societal outcomes, outcomes that may not be measurable for several years.
2. Most of the tools needed to develop a system to rapidly identify and address potential problems already exist. States, however, need to apply these tools by selecting and producing lead indicators that can be used to rapidly identify and address potential problems
3. Stakeholders are likely to identify three issues as being particularly important for rapid monitoring systems to focus on: (1) enrollee access to care, (2) the timeliness of provider payments, and (3) the cost of providing care. The relative importance of these three issues will change as a program is implemented and becomes established.
4. A need exists for standard reporting among states to provide comparative data, but states will also always need the flexibility to address local concerns.
5. An effective system to identify potential concerns must be able to identify unanticipated problems.
6. States have to balance the need to rapidly identify problems with the need to ensure that the data they use to make decisions accurately reflect contractor and program performance.
7. States must also balance the need for consistent reporting with the need to keep up with an evolving program and focus on issues that are currently important.
8. Routinely sharing performance data creates a starting point for working with consumers and advocates.

## The Importance of Rapid Problem Identification and Correction

Summit participants clearly saw a need to rapidly identify and correct problems in the delivery of behavioral health services. They identified the following reasons for operating an RMS:

- States are accountable to many stakeholders and an RMS enables states to meet their responsibilities in this area. As one participant stated, “The value of the program is to let stakeholders know you’re paying attention. It needs to be timely and act as a trigger for further analysis and action.”
- Rapidly identifying and correcting problems enables a state to avoid a crisis. It provides an important tool enabling the state to be first in identifying a problem.
- An RMS can provide a base on which to build stakeholder (especially consumer) relationships. When the state devotes the resources necessary to rapidly identify and correct potential problems—particularly when stakeholders are involved in the process—it becomes clear that the state places importance on delivering quality care to beneficiaries.
- The data provided by an RMS can move the discussion of a problem from anecdote to data and can enable a state to respond convincingly to criticism of the program.
- Using data to make program decisions, as an RMS requires, ultimately improves the quality of data reported and care provided as MCOs realize they will be held accountable for their performance as it appears in the data.

**“The value of the program is to let stakeholders know you’re paying attention. It needs to be timely and act as a trigger for further analysis and action.”**

Summit participants also strongly emphasized that the purpose of an RMS must be to identify potential problems, not to serve as the final word on MCO performance. In other words, the purpose of an RMS is to raise questions, not make judgements. Further exploration is usually required to evaluate performance data. A related point is that an RMS is necessary but insufficient for monitoring MCO performance. In addition to the rapid problem identification, states need to be able to assess long-term health and societal outcomes and to undertake more in-depth examinations of service delivery.

Finally, participants agreed that a single report from the RMS system within each state, one that could meet state, MCO, provider, and consumer needs would be ideal—but unrealistic—given the current state of the art in performance measurement and RMS development. They felt that everyone would be interested in the same issues, but that the different needs and perspectives of the various groups would

make achieving the ideal impossible. Still, most felt that striving for that ideal would produce the best RMS and benefit all stakeholders.

## **Most of the Tools States Need for a Rapid Monitoring System Already Exist**

Summit participants agreed that a number of measures, data sets, and sources of information that could be used for rapid monitoring exist.<sup>8</sup> States interested in developing an RMS, however, need to engage in a process to design an RMS that meets their needs. As one participant summarized the discussion, “States already have a tremendous amount of data; they need to use it better.”

### **Considerations in Developing an RMS**

Participants suggested that states should consider the following issues when developing an RMS. (Those of greatest concern are discussed in more detail later in this document.)

- Involve other stakeholders (consumers, MCOs, advocates, providers) from the start, and involve them in deciding which aspects of the program need rapid monitoring.
- To minimize any additional burden created by an RMS, an ideal RMS would not require MCOs and providers to collect any information beyond what they are already collecting to manage their own operations.
- An RMS will change over time as the program evolves. In particular, stakeholder concerns about an established program will be different from those they have about a new program, one that may not yet be operating.
- States need to consider how they will evaluate MCO performance. Will they compare an MCO’s performance on a specific measure to a pre-established benchmark? To the performance of other MCOs? To national performance levels? To the MCO’s performance over time? It is also important to measure system performance “pre-managed care” to establish a baseline to help assess MCO performance.

**“States already have a tremendous amount of data; they need to use it better.”**

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<sup>8</sup> Please see Appendix E for information related to the range of behavioral health measures states can produce.

- States need to consider where they will obtain the resources needed to operate an RMS. These resources will include:
  - S People and information-processing capabilities to collect data, analyze performance, and prepare reports that help state staff and other stakeholders make their own assessments of MCO performance;
  - S Resources to disseminate the information produced from an RMS;
  - S Contract language that provides a platform for monitoring and improving MCO performance; and
  - S People to monitor the MCOs efforts to investigate and correct potential problems.
- Behavioral health involves multiple state and local agencies. The agency that administers the program needs to make sure that its sister agencies are also involved in RMS development. In the best of circumstances, the RMS will help these agencies meet their goals. Several participants also pointed out that problems are most likely to appear at the boundaries between delivery systems; so it is important to have all agencies at the table when developing an RMS to improve the ability of the individual agencies to mesh their monitoring efforts.
- An RMS needs to examine issues of importance to the general public as well as those that are important to the behavioral health community. Participants specifically suggested making sure that an RMS addresses issues related to public safety.
- Support from upper-level state management is key to developing an effective RMS. The support must include a willingness to expend resources on the project.

## Categories of Measures

Based on experiences in their own states, summit participants identified access, payment, and cost as key issues that any RMS will need to examine. One participant summarized this discussion best, “We need to ask: Are people getting in and are providers getting paid?” Participants suggested that certain items should be included in a system, among them: changes in daily hospital census; waiting time to see psychiatrist; percentage of rejected claims; timely provider payment; percentage of funding going from MCO to providers; percent of enrollees receiving services; and the volume of services provided.

**“We need to ask: Are people getting in and are providers getting paid?”**

Cost measures could address: (1) Are providers getting paid for the services they deliver? (2) Is enough of the money in the system going to the clinicians or staff who provide direct services?

Although participants felt strongly that the first cost issue should be examined, they differed as to whether or not the second concern should be (or could be) examined. Some felt that it was important to know how much funding was going to administration and how much to service costs, and some states do collect information on that topic. But others pointed out that one of the expectations of managed care was to increase the cost effectiveness of the system. As a result, the real focus of state monitoring should be “did those who needed services get enough of the right services?” rather than “did the contractor spend what the state and other stakeholders think is enough money on services?”

Participants strongly believed that an RMS needs to be able to identify problems that nobody thought of when designing the system. They consistently identified consumer complaints and informal relationships with consumers as the best source of this type of information. They also identified some issues around using complaint information that are discussed later in this paper.

Participants also strongly believed that consumers and other stakeholders need to be involved in deciding which program areas need assessment. In particular, participants felt that community input was key to making sure that the RMS adequately addressed local “hot button” issues. MCOs and states agreed that the community would likely have a valuable sense of the weaknesses of a current system and of the issues that might arise in a new program. As one participant put it: “If it’s important to the community, it WILL be important to the MCO.”

Finally, some felt that focusing on the care delivered to special needs groups might provide valuable information in an RMS. These participants believed that if the program served the most difficult cases well, that it would also serve others well. They also pointed out that the specific populations considered to be special needs would vary by state. For example, a program that serves only those who qualify for Medicaid because they belong to low-income families would identify different groups as special needs than would a program that also serves those who qualify for Medicaid because they have a disability.

**“If it’s important to the community,  
it WILL be important to the MCO.”**

## **Data Sources and Measures**

Table 1 (which was provided to all summit participants) summarizes the specific measures and sources of data used by the agencies that participated in the pilot of the formal EWS. The discussion at the summit confirmed that these major types of data (utilization, authorization, consumer complaints, administrative, and stakeholder feedback) are potential sources of data for RMS measures. Participants also emphasized that although it is important to have a “data-driven” system, it is also important to include descriptive measures in an RMS to help understand the more quantitative

measures. Finally, they confirmed that RMS measures should lead<sup>9</sup> (not lag) indicators and that there should be redundancy among measures.

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<sup>9</sup>Lead indicators are obtained quickly, are sensitive to change in the health care system, and are likely to reflect underlying problems.

**Table 1 Early Warning System Measures<sup>10</sup>**

Measure	PA	VT	DC	Data Source
<b>Encounters</b>				
Psychiatric Service—Inpatient and outpatient services		✓		MCO
Children’s residential treatment	✓			Counties
Clients not receiving any core services		✓		Providers
Average client service hours		✓		Providers
<b>Occurrences</b>				
Children’s admission for asthma			✓	MCO
In-patient psychiatric rehospitalization	✓	✓		MCO
Involuntary commitment	✓	✓		MCO
Homelessness among adult SMI	✓			Counties
<b>Authorization</b>				
Physical health, home health care, and speech therapy			✓	MCO
Behavioral health services	✓			MCO
Services to minorities (behavioral health services)	✓			MCO
<b>Denials of Service Authorization</b>	✓		✓	MCO
<b>Consumer Complaints</b>	✓		✓	MCO
<b>Provider Payments</b>				
Claims paid by 30 days	✓			MCO
Case rate provider payments		✓		State
<b>Provider Opinion Surveys</b>	✓			Providers
<b>Changes in MCO Policy, Operations, and Key Staff</b>	✓		✓	MCO
<b>Telephone Access to MCO</b>	✓			MCO
<b>Stakeholder Feedback</b>	✓			Stakeholders
<b>Telephone Proxy Calls</b>			✓	State

## Resources

<sup>10</sup>See Note 5 for table source. Also, please note that Oklahoma is now developing an EWS and is considering including measures that directly address quality and case management, such as “crisis follow-up within 14 days for children.”



Summit participants considered the issue of how many measures are too many. Including more measures in an RMS enables agencies and stakeholders to examine more issues—if there are enough resources to examine and follow-up on all the measures. Obviously there are limits to the time and resources that state and MCO personnel can devote to developing and operating an RMS. But it is also important to remember that many other stakeholders have limited time and limited resources to devote to analysis and follow-up. For example, a consumer representative at the meeting reported: “Information needs to get to consumers but it needs to be simple. A bulleted summary of no more than two pages would be best.” So, even if an RMS includes many measures, states need to consider how they will consolidate that extensive information into something that is useful to stakeholders.

Table 1 also gives an indication of how many measures those states that operate formal EWS use. It is clear that these states have opted to collect different types and numbers of measures. They have made the decisions about which and how many measures to collect in consultation with other stakeholders and based on the specifics of their program, the behavioral health delivery system in their state, and the level of resources they planned to devote to the RMS.

Summit participants suggested that resources could be minimized by using, as much as practical, the data that contractors and providers already collect and use to manage their business. For example, claims, authorization, and enrollment data are all maintained by MCOs because they need that information to manage their business. Measures produced from that data require fewer resources from the MCO than measures that cannot be produced without collecting additional data. In addition, the MCO is likely to be concerned about many of the same issues as other stakeholders and already collecting the data needed to assess performance in those areas.

The following is a summary of the annual resources Pennsylvania devoted to the development and operation of the EWP for 10 counties. The "Consultation Service Contract" funded a psychiatrist to provide consultation to the project by trending data and writing reports.<sup>11</sup>

**Office of Mental Health and Substance Abuse**

Director of Quality Management	0.20 FTE
Director of Western Operations	0.15 FTE
Director of Information Systems	0.10 FTE
Information Systems Staff	0.20 FTE
Provider Satisfaction Calls	0.25 FTE
<b>Consultation Service Contract</b>	<b>\$120,000/year</b>

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<sup>11</sup>The quarterly reports that Pennsylvania produced with these resources as part of the Early Warning–Care Monitoring Project are available at <http://www.dpw.state.pa.us/general/guides.asp#omh>.

Of course other resources, such as data processing, are needed to produce these reports, and the amount of resources will vary among states. For example, some states may want to develop the reports in-house instead of contracting that function out. This information is provided simply to help those interested in developing an RMS start to gauge the amount and type of resources they will need for the project.

## **Standardization versus Flexibility**

Two types of standardization were discussed at the summit.

1. Standardized reporting: all states report the same measures (but may define them differently or use different reporting periods); and
2. Standardized measures: states collectively define specific measures and how they will be implemented.

Although Summit participants felt that states needed to have the flexibility to examine the issues of importance within their states they also felt that some standardization of reporting and measures would occur naturally and be beneficial. All strongly emphasized, however, that no two states are alike and that programs and concerns change over time. Therefore, any requirements for standardized reporting by states should be kept to a minimum, and states need to retain the ability to include measures that assess performance on “hot button” issues specific to each state. Most participants agreed that a two-part RMS had promise, one part with a core set of standardized measures and another that would examine issues specific to the state (or even region).

States felt that there were some items, such as the percent of people getting services, that most states would include in any RMS they developed. Participants suggested that a comparison of the currently existing systems would reveal those items that might be most promising for standardization. In other words, if all or almost all, states with such systems measured an item it is likely that it is one that all states will want to measure. Including those measures in a standardized report would most likely result in a report that examined issues of national interest and be least intrusive to states.

Standardization has several advantages, but most importantly it provides the basis for comparison among states, among contractors, and over time. It is difficult to compare measures that are defined differently because they are not measuring the same thing, even if they are measuring the same item of concern. Summit participants were particularly eager to compare MCO performance among states. Since many states use a single contractor to deliver behavioral health care they cannot compare “their” MCO’s performance with another’s unless they look to another state.

An example related by one participant illustrates the need for a cross-state or national comparison. Two states each measured the penetration rate (i.e. what percent of enrollees received services) achieved by their behavioral health contractors. One state was very pleased with the penetration rate

in their state until they got comparative data from a second state and found the second state's rate to be much higher. The second state had been concerned that their penetration rate was too low until they saw the data from the first state. Without that comparative data neither state was able to assess what its measurement's results meant about its MCO's performance.

Standardization also allows for the development of national information or benchmarks about plan performance. Such information would ultimately be very useful for creating objective performance benchmarks.

Despite the clear desire for standardization—at least in areas of common concern—participants felt that standardization would be difficult. They noted that it was difficult to achieve within states, harder still across states. Similarly one participant from an MCO reported that developing a consistent data set could be difficult to do even within a company. Participants were particularly emphatic that it was not enough to standardize the definition of the measure because administrative methods could still change results. If two states administer the same consumer survey but one uses a mail-in response and the other calls enrollees, their surveys are likely to produce different results. Similarly if two states measure penetration but one uses utilization data from claims and another gathers data through chart reviews, the two states are likely to produce different results even if the penetration rate is the same in both states.

Participants were also concerned that the use of different procedure coding and units of service among contractors and states would make standardization difficult but felt that the uniform coding required under the Health Insurance Portability and Accountability Act (HIPAA) would address many of those concerns. Finally, states pointed out that not all states enroll the same groups of Medicaid beneficiaries into managed care programs so that program performance will continue to vary even if measures are standardized.

Despite these concerns about standardization, participants felt that cross-state comparison as part of an RMS would be very useful. One participant pointed out that even if the measures aren't quite the same, any observed differences in performance would raise questions, the purpose of measurement done as part of an RMS.

## **Identifying Unanticipated Problems**

Many participants reported that it is often the problem they didn't think of that causes a crisis, not the ones they track in their reports. As a result, an effective RMS needs to have a method for identifying issues that no one thought of when designing the RMS, the so-called "fuzzy-measures" that pick up a variety of issues. As one participant put it: "We need to design a report that looks at where consumer risk is going to be, not necessarily where current concerns are."

Consumer, advocate, and provider input were identified as the most promising sources for this type of information. Complaints were the most frequently mentioned source. As one participant noted, trending complaint data means that, “instead of solving the same issue many times we can solve the system.” Pennsylvania, for example, used complaint data to identify a problem with ambulance services that would not have been identified from the formal measures. Participants identified several issues that need to be worked out to make complaints valuable, among them: collecting consistent data, identifying the root cause of a complaint, and reaching those who do not complain.

The use of consistent data is important when comparing performance. For example, an MCO that defines complaints to include only written concerns will report fewer complaints than those who include oral complaints from calls to customer service. To address this, participants recommended establishing clear definitions of complaints when developing the MCO contract.

**“We need to design a report that looks at where consumer risk is going to be, not necessarily where current concerns are.”**

Arizona and New Mexico assign state staff to work with individual enrollees to resolve problems. Both states collect and trend information from the resolution process to help them identify issues that require a systems change instead of an individual correction.

- Arizona uses a computerized “Problem Resolution Tracking System” that allows them to analyze problems by a number of factors (MCO, problem type, facility, date of service, enrollee demographics, etc.).
- New Mexico uses reports from the state’s Ombudsman.

These states explain that getting complaint data from someone other than the MCO enables them to make sure that a “complaint” is defined consistently, and assigned to consistent complaint categories. This approach also helps them make sure that they do not mistake the apparent cause of a complaint for its real cause. Ensuring that the root cause of complaints is examined is very important. For example, the District of Columbia received a number of complaints that managed care enrollees were unable to fill their prescriptions, but analysis of these complaints identified that the problem was not caused by managed care. Instead there was a problem with timely receipt of MCO membership cards in combination with difficulties verifying enrollee eligibility. As a result, pharmacists were unable to confirm enrollee eligibility and fill prescriptions. This problem would not have been identified quickly without complaint information. But if the complaint data had not included information about the true cause of the problem, the District might have spent resources attempting to correct the wrong problem.

Consumer complaints were considered a rich source of information, but states were also interested in developing ongoing communications with consumer and provider stakeholder groups. All agreed that,

as one participant said, “relationships and informal communication are key to identifying real risk.” As another put it, “States need to make consumers and families a ‘trusted relationship’ to get information about program performance.” It

**“Something about consumer experience cuts to the heart of the matter...”**

was felt that this was a promising route to resolve the problem of finding out how the system could better serve “those who get discouraged and just go away.” Summit

participants felt that simply establishing an effective RMS would be helpful in gaining these stakeholder’s trust. Once they saw that their concerns were considered and states were working to address them, they would be more likely to provide information about their experiences in managed care. (This issue is discussed in more detail later in this paper.) Summit participants also felt that involving those who consumers already trusted (advocate groups, for instance) was important to gaining consumer trust. State participants had used several strategies to as one said “use consumers as a data collection arm.”

- Ohio and Pennsylvania both fund teams of consumers that gather information for the state about how well the behavioral health system is (or is not) functioning. Both states saw this approach as a good one. As one state put it, “the information from them is right on target.” Both also noted, however, that the effectiveness of these teams varied: “Some are good and some are still learning.”
- Some managed care plans have contracts with advocate groups to perform consumer surveys. They have found that the advocates are better able to reach out to both those who do and do not use services (the non-complainers) to find out how the system functions. They also noted that plans “need staff from ranks of consumers, but not in an advocate role, as management.”
- New Mexico and Iowa also hold meetings with consumers and advocates to discuss the program. They both felt this was a good way to gather information, especially as consumers could give specific examples that make the issues more concrete. As one participant noted: “Something about consumer experience cuts to the heart of the matter. They can say, ‘I brought Sally in and this is what happened to her.’”
- Most states represented at the summit survey consumers to find out about their experience in behavioral health managed care. Most of these states use the CAHPS<sup>12</sup> survey to examine consumer experiences. Although states find these surveys useful for gathering consumer input they expressed concern that varied administration methods can affect survey results.

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<sup>12</sup>More information about the CAHPS survey, including information about using the survey to assess consumer experiences in managed mental health care is available on-line at <http://www.ahrq.gov/qual/cahps/cahpques.htm>.

- Most states represented at the summit attend meetings of existing community groups to get informal feedback on proposed policies or program operations.

## Balancing Data Validation and Rapid Identification

The validity of data is also an issue. One participant reported: “We need to go through a report/correct/feedback cycle to get MCO buy-in to what was reported. Plans are resistant to discussing delivery issues when they haven’t had an opportunity to correct the data.” The time needed to conduct that cycle can be so lengthy that the data is too old for use in an RMS by the time it is considered correct.

**“Plans are resistant to discussing delivery issues when they haven’t had an opportunity to correct the data.”**

A participant from Pennsylvania noted: “When we initiated our EWS we grappled with the question of data validity and decided that the data was a marker to bring up a set of questions so it was OK to use data without spending a lot of time on correction or to use alternate sources of data.”<sup>13</sup>

As a result, Pennsylvania decided to use data about the number of services authorized by the MCO, instead of the number of services delivered, to gauge access.<sup>14</sup> Although an authorization is not always guaranteed to result in a service, it can serve as a proxy for the number of services that will be delivered and is available much more quickly than utilization data.

**One state decided that since the data was used primarily to identify questions that needed exploration, it was OK to use it without spending a lot of time on correction.**

Summit participants agreed that concerns over the validity of the data could be lessened by emphasizing that the purpose of an RMS is to raise questions—that can then be examined through other means (such as chart reviews)—and not to serve as the sole determinant of MCO performance. They also pointed out that using the data was a good way to improve it. When MCOs see that data is being used and distributed to stakeholders, ensuring that the data is correct becomes more of a priority.

Summit participants suggested four other strategies for moving the discussion from data quality to quality of care. They were:

1. Using redundant measures for the same issue so that they can validate each other;

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<sup>13</sup>Note: Pennsylvania routinely gives MCOs two weeks to review the data and trends they plan to report. During this time, MCOs can identify/correct errors and comment on findings. This approach has resulted in enhanced cooperation with the MCOs.

<sup>14</sup>**Authorized** services are services that the MCO has approved (agreed to pay) for delivery to an individual enrollee.

2. Looking at trends over time;
3. Comparing measures among similar populations, such as among counties or MCOs; and
4. Comparing performance against an objective, data-driven, benchmark.

## Balancing Consistent Reporting and Program Development

As discussed in the previous section, consistent reporting and follow-up is important for a number of reasons. However, summit participants also noted that programs evolve over time and issues that are important during program start-up may not be important once the program has operated for a few years. As one participant stated: “This type of system is a response to the need to be accountable. The system is always changing—new services, new populations, new concerns, new contractors.” Another noted: “What you need to look at will change over time. You will need to concentrate on different things at different times, probably access first.”

**“This type of system is a response to the need to be accountable. The system is always changing—new services, new populations, new concerns, new contractors.”**

Summit participants felt that in balancing these two concerns, states should keep four things in mind.

1. That the act of measuring and monitoring performance in an area draws more attention and resources to the area;
2. That you cannot assume that because there have been no problems in any one area for some time that there will be no problems in the future;
3. That producing and using each measure requires resources; states cannot simply continue adding new measures as programs evolve without taking away measures that examine issues that are no longer of concern to an RMS; and
4. That an RMS is one of several monitoring systems and needs to remain focused on rapidly identifying questions about performance, especially those related to issues of critical concern, while leaving other issues to systems that focus more on overall quality and outcomes.

One participant noted that when operating an RMS-type program, states need to stay focused on “what do we need to manage on a daily basis?”.



## Sharing Performance Information

States reported that sharing performance information with consumers and advocates helps build trust and facilitate efforts to improve the delivery of behavioral health services. On the other hand, some participants expressed concern that in their experience: “Some stakeholders who get information litigate with it. So some may obfuscate data for fear of suits.”

Despite these misgivings there was a general consensus among summit participants that sharing information on program performance with consumers and involving them in program monitoring was good practice. One state explained the situation in this way: “In the past we didn’t present information. This created mistrust, and we are now paying. We need to build trust with consumers.” As another said:

**“Data calms consumers. They see that the program is working well in many areas, and they see that where there is an issue it has been identified, and activity is underway to correct it.”**

“States should expect an initial bad reaction, but if advocates and consumers see consistent attempts to address issues and include them in decision-making, their attitude will change over time.” Ultimately, as one other person put it: “Data calms consumers. They see that the program is working well in many areas, and they see that where there is an issue it has been identified, and activity is underway to correct it.”

As previously discussed, summit participants felt that consumer input was a key source of information about MCO performance. They also recognized that in order to get that input, they needed to provide information to consumers and involve them in program monitoring. They further recognized that, “Repetition and consistency is important. When an initiative [such as an RMS] starts no one believes it at first. We need to stick with what we start to develop credibility [with consumers].” Participants also noted that repetition and consistency allow consumers and other stakeholders to become familiar with the reports used to identify problems and learn how to analyze the information. As one participant observed: “Teaching is involved in making [the input from] consumers more effective. You need consistency and to tailor data to what you’re trying to achieve. It is not a short-term commitment.”

In particular those states that piloted the EWS reported that stakeholders are active partners in the monitoring process and that their involvement was critical to success. One consumer representative confirmed this: “Consumers not only sit at the table but gather information and make decisions. This is an active partnership.” She further emphasized: “We need action. Nice reports don’t do it. We can report and plan our way to paralysis.”

**“We need action. Nice reports don’t do it. We can report and plan our way to paralysis.”**

Finally, most summit participants felt that managed care program managers needed detailed information about performance but that other stakeholders needed a more summarized version. The consumer representative explained: “Information needs to get to consumers, and it needs to be simple, a bulleted summary of no more than two pages.” A plan representative confirmed this, noting: “Bear in mind there are lots of measures, but don’t ‘dull-down’ people by reporting on everything every month.” One state participant suggested reporting on different measures at different frequencies.

**“Giving people information educates them on its use.”**

Finally, participants noted the need to educate consumers and advocates on how to read and interpret the data that is provided to them. One participant characterized that need in this way: “A big issue in sharing data is that most want simple best/worst information, but we need to move beyond that—and they will. Giving people information educates them on its use.” Another participant pointed out that presentation can help people interpret data. If graphics are used, explain the meaning of the graphic in the title. For example, use a title such as *Most plans provide adequate access to care* rather than *Plan performance on access measures*.

## Technical Assistance Needs

During the summit many participants offered ideas about the types of assistance they would find helpful in developing and implementing an RMS. In addition to the previously discussed assistance in standardizing reports and measures, they suggested the following specific items.

- Checklists of no more than two pages to help states think through how to build an RMS—and possibly why they should do so.
- A more detailed technical assistance paper that recognizes that states already have the tools they need to build an RMS and helps them think through how they can pull these tools together and use them as part of an RMS.
- A meta-analysis of the RMS-type reports already being produced by states to find out which measures/measurement areas they have in common and how much variation exists among the states, which issues, for example, are specific to individual states.
- Actions to put the concept of an RMS into the marketplace. Perhaps convene software vendors and let them know of state and federal interest in RMS programs.

- A support network for states developing and operating an RMS. Even a list of states (and individuals within those states) who would be willing to be a resource to others would be helpful.

## SUMMARY

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Summit participants strongly believed that they need to be able to rapidly identify and address potential problems in managed behavioral health care, but

- these efforts must be part of a monitoring system that also examines long-term outcomes; and
- states need the flexibility to examine the issues that are of concern in their own state; each state's RMS will need to be unique, although comparable information about performance from other states would be helpful where common concerns exist.

Participants also confirmed that:

- stakeholders need to be a vital part of RMS design and operation; and
- most of the tools states need to develop a system to rapidly identify and address potential problems already exist.

One participant's comment may best summarize the group's sentiments. "This system is an opportunity for states to enhance or reinforce performance and relationships with stakeholders. You already have data; it's how you use it."

**"This system is an opportunity for states to enhance or reinforce performance and relationships with stakeholders. You already have data; it's how you use it."**

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## Appendix A

### **Early Warning Systems and How States Have Used Them**

## Appendix A

### EARLY WARNING SYSTEMS AND HOW STATES HAVE USED THEM<sup>15</sup>

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An Early Warning System (EWS) monitors clinical and administrative indicators as well as provider and stakeholder concerns and opinions regarding key aspects of managed care performance. This program, which is currently operating in three jurisdictions (The District of Columbia, Pennsylvania, and Vermont) also fosters resolution of problems. In these three jurisdictions, the EWS uses a limited set of measures and administrative processes to oversee the managed care behavioral health system and provide real-time, performance-based information to state, federal, and local governments; consumers; families; providers; advocates; and other key stakeholders. The EWS is designed to rapidly identify weaknesses in clinical care and to facilitate quality improvement efforts, leading to enhanced patient health outcomes. The program combines the use of current performance measures with a system of public accountability that increases stakeholder involvement in performance monitoring.

Each state's EWS is unique. It is developed, with stakeholder input, to reflect the behavioral health delivery system and the concerns with care within each state. States collect EWS measures on at least a quarterly basis. Any problems identified are usually addressed within weeks or months. Stakeholders receive data, help prioritize trends that need additional attention, assist in developing strategies to remedy problems, and help monitor corrective actions.

#### How States Have Used EWSs

States have used EWSs to provide state, federal and local oversight agencies with real-time, reliable data about MCOs during startup and ongoing operations. EWSs have been used to demonstrate overall program effectiveness, as well as to identify and address specific performance issues. This in turn results not only in improved performance but also in increased consumer and provider support for the program. Specific examples of how states have used EWSs are identified below.

##### 1. Increase Provider Support

Using the EWS timeliness of claims payment measure, Pennsylvania identified problems with one MCO's payment to providers. The provider opinion surveys that the state routinely conducts confirmed the problem. In response, the state required the MCO to prepare a plan of correction under which it agreed to advance funds to providers with cash flow problems, hire additional staff, develop

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<sup>15</sup> The information in this appendix is extracted from: Howard Dichter, *Monitoring Medicaid Managed Care via an Early Warning Program*, (Princeton: The Center for Health Care Strategies, 2002). <http://www.chcs.org/publications/pdf/ips/earlywarning.pdf>.

educational forums to assist providers, and modify policies for dealing with third party benefits. Subsequently the MCO was able to meet the standard for timeliness of payment (30 days). This improvement increased provider confidence in managed care.

## **2. Increase Consumer Support**

In Vermont the number of adult clients with serious mental illness receiving in-patient hospital services declined 43 percent during the first year of the EWS implementation. This was viewed as a positive trend and suggested that acute exacerbations of mental illnesses requiring in-patient care declined. As a result, consumer confidence in MCO services increased.

EWS data showed that after the implementation of behavioral health managed care in Pennsylvania, the rate of denials remained low despite financial pressures. Less than one out of six hundred authorized members were denied out-patient services during the first three quarters of 2001. The number of denials for in-patient psychiatric hospitalization, the service with the highest rate of denials, declined after Pennsylvania began using the EWS. Consumers received quarterly information on service denials so they could track current program performance. This information and, perhaps more importantly, the ongoing consumer involvement in program monitoring it enabled, increased consumer confidence in managed care.

## **3. Correct Weaknesses in Provider Networks**

In Pennsylvania, the EWS revealed low use of out-patient mental health services in one rural county (which was a contractor in the behavioral health program). To correct the situation, the county doubled the number of out-patient service sites, resulting in 44 percent more members seeking services.

In a second Pennsylvania county, most arrests were alcohol related, yet the EWS showed low utilization of drug and alcohol services. In response, the MCO increased access to drug and alcohol services by expanding the provider network into a neighboring state and co-locating substance abuse services with physical medical services in Federally Qualified Health Centers.

## **4. Correct Inappropriate Expenditures**

Pennsylvania used their EWS to identify inefficient expenditure of funds. Using authorization data, a county contractor identified a provider who rendered an unusually high level of in-patient care for children. After further investigation, it was discovered that this provider was self-referring patients and the state took corrective action.

## **5. Assure Beneficiaries Access to an Appropriate Level of Care**



Vermont's data on core services indicated that one agency had higher rates of clients not receiving core services when compared to the other agencies. Core services include case management, individual and group treatment, day treatment, vocational services, and chemotherapy contacts. Vermont evaluated the cause of the variation and found that this agency assigned patients to out-patient therapists who did not make aggressive efforts to bring clients into treatment. The agency reviewed the clients who were assigned to these therapists and who were not receiving services. Clients who needed intensive services were transferred to programs that engaged in assertive outreach. Other clients, who did not need intensive services, were reassigned to less intensive programs.

## **6. Improve MCO Responsiveness to Consumers**

In Pennsylvania, immediately after the managed care program's implementation, the state found that members were having difficulty reaching one of the MCOs with their questions and problems. The state requested that the MCO improve telephone access to meet the MCO's internal standard: reaching a person to speak to within 30 seconds for more than 95 percent of member calls. As a result of adjustments in staffing, the MCO was able to meet its standard on a continuing basis.

Appendix B

**Participating State Background Information**

## APPENDIX B: PARTICIPATING STATE BACKGROUND INFORMATION

State	Program Type		PIHP/PAHP contractor type (if use the model)		Populations enrolled			Who manages?			Organization
	Comp. MCO	Specialty PIHP/PAHP	Public	Private	Families	SSI	Elderly	Medicaid	MH agency	SA agency	
AZ		✓		✓	✓	✓	✓		✓		<ul style="list-style-type: none"> <li>MH and SA are within same department (Health)—Substance Abuse Bureau is within Division of Behavioral Health Services; Medicaid program is in a separate agency (AHCCCS).</li> <li>Contracts w/5 regional organizations that are local partnerships</li> </ul>
CA	✓ (Ltd) <sup>16</sup>	✓ (MH only)	✓		✓	✓	✓	✓ (Comp)	✓ (Spec.)		<ul style="list-style-type: none"> <li>Delivery system varies widely by county</li> <li>Medicaid, MH, and SA are all located within the Health and Human Services Agency; MH and SA are both Departments within the agency; Medicaid is within Dept. of Health Services.</li> </ul>
CO		✓ (MH and detox)	✓	✓ (one is a non-profit HMO)	✓	✓	✓		✓		<ul style="list-style-type: none"> <li>MH and SA are both Divisions within the Office of Behavioral Health and Housing in the Dept of Human Services</li> <li>Medicaid is an Office within the Dept of Health Care Policy and Financing</li> </ul>

<sup>16</sup> Ltd means that the MCO is not responsible for providing all behavioural health services, but that some remain on fee-for-service or are the responsibility of another contractor.

State	Program Type		PIHP/PAHP contractor type (if use the model)		Populations enrolled			Who manages?			Organization
	Comp. MCO	Specialty PIHP/PAHP	Public	Private	Families	SSI	Elderly	Medicaid	MH agency	SA agency	
DC	✓ (specialty program for CSHCN w/few enrollees)					✓		✓			<ul style="list-style-type: none"> <li>SA and Medicaid are both located within the Dept of Health</li> <li>MH is a separate Dept.</li> </ul>
IA		✓		✓	✓	✓		✓			<ul style="list-style-type: none"> <li>SA is a Division within the Dept. of Public Health</li> <li>MH and Medicaid are Divisions within the Dept. of Human Services</li> </ul>
MA	✓	✓		✓	✓	✓		✓	✓		<ul style="list-style-type: none"> <li>SA is a Bureau within Dept. of Health—within the Executive Office of Health and Human Services</li> <li>MH is a Dept. and Medicaid is a Division within the Executive Office of Health and Human Services</li> </ul>
NM	✓				✓			✓			<ul style="list-style-type: none"> <li>MH and SA are both within the Behavioral Health Services Division within the Department of Health</li> <li>Medicaid is a Division within the Human Services Dept.</li> </ul>
NY	✓ (Ltd)				✓	✓		✓			<ul style="list-style-type: none"> <li>SA and MH are both Offices</li> <li>Medicaid is an Office within the Dept of Health</li> </ul>
OH	✓ (Ltd)				✓			✓			<ul style="list-style-type: none"> <li>MH and SA are both Departments</li> <li>Medicaid is within the Dept of Jobs and Family Services</li> </ul>

State	Program Type		PIHP/PAHP contractor type (if use the model)		Populations enrolled			Who manages?			Organization
	Comp. MCO	Specialty PIHP/PAHP	Public	Private	Families	SSI	Elderly	Medicaid	MH agency	SA agency	
OK	✓				✓	✓	✓	✓			<ul style="list-style-type: none"> <li>MH and SA are both within the Oklahoma Dept of Mental Health and Substance Abuse Services.</li> <li>Medicaid is in a separate agency—the Oklahoma Health Care Authority</li> </ul>
PA	✓ (voluntary MC)	✓ (Health choices)	✓		✓	✓	✓	✓	✓		<ul style="list-style-type: none"> <li>MH and SA are a combined office within the Dept of Public Welfare</li> <li>Medicaid is a separate office within the same Dept</li> </ul>
TX	✓ (ltd)	✓		✓	✓	✓	✓	✓	✓	✓	MH and SA agencies jointly manage specialty program, but program staff are located in MH dept.
VT											<ul style="list-style-type: none"> <li>MH is a Dept within the Human Services Agency</li> <li>SA is an Office within the Dept of Health, also within the Human Services Agency</li> <li>Medicaid is an Office within the Dept of Prevention, Assistance, Transition and Health Access, also within the Human Services Agency</li> </ul>
WI	✓	✓		✓	✓	✓	✓	✓	✓		<ul style="list-style-type: none"> <li>MH and SA are both Bureaus within the Division of Supportive Living in the Dept. of Health and Family Services</li> <li>Medicaid is a Division within the same Dept.</li> </ul>

## Rapid Monitoring System Activity Among Participating States

- Arizona has a flexible system of analysis that can produce both targeted reports based on real-time information and standardized quarterly reports
- Iowa attaches financial incentives to meeting performance standards
- Massachusetts manages their behavioral health program by establishing performance standards and financial incentives for meeting standards. Measures are annual.
- New Mexico has a state-developed EWS incorporated into other management activities. Reports are available at: [http://www.state.nm.us/hsd/mad/pdf\\_files/salud\\_rfp/EWS1stquartfinalreport.pdf](http://www.state.nm.us/hsd/mad/pdf_files/salud_rfp/EWS1stquartfinalreport.pdf)
- Pennsylvania is an EWS Pilot State. Reports are available at: <http://www.dpw.state.pa.us/general/guides.asp#omh>
- Texas publishes quarterly and other information. Reports are available at <http://www.mhmr.state.tx.us/CentralOffice/NorthSTAR/northstardatabase.html>
- Vermont is an EWS, pilot state; the EWS is modified for a case-rate payment system
- Wisconsin has an annual HMO comparison report with information on behavioral health services. The most recent covers 1998/1999 and is available at: <http://www.dhfs.state.wi.us/medicaid4/hmo98-99/index.htm>

Appendix C

**Summit Participant List**

## APPENDIX C: SUMMIT PARTICIPANT LIST

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Appendix D

**Summit Agenda**

## APPENDIX D

### SUMMIT AGENDA

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#### Effective Managed Behavioral Healthcare Program Monitoring Summit

Facilitator: Trish Riley, Executive Director, National Academy for State Health Policy

9:00 am	<b>Continental Breakfast Available</b>
9:30-10:00 am	<p><b>Welcome, Introduction, and Purpose</b></p> <p>Eric Goplerud, Associate Administrator for Managed Care, SAMHSA          Theresa Pratt, Director, Disabled and Elderly Health Programs Group, CMS/CMSO          Trish Riley, National Academy for State Health Policy</p>
10:00-10:30 am	<p><b>What is the state of the art in behavioral health performance measurement among the states?</b></p> <ol style="list-style-type: none"> <li>1. How do you think most states are measuring behavioral health contractor performance? Do you see any trends or patterns?</li> <li>2. Do current monitoring systems give states enough early warning to avoid problems?</li> </ol> <p><i>Discussants:</i>          Terry Cline, Commissioner, OK Department of Mental Health and Substance Abuse Services</p>
10:30-11:30 am	<p><b>Is an Early Warning Program (EWS) useful to states? How?</b></p> <p>An EWS combines rapidly obtained measures which tell you about current system performance with a system of public accountability that disseminates information to stakeholders (consumers, advocates, government, MCOs, and providers) and actively involves them in program and contractor monitoring.</p> <ol style="list-style-type: none"> <li>1. How have states used EWS-type programs? How would they like to use them?</li> <li>2. What made them useful? What would make them more useful?</li> <li>3. What is an effective EWS?</li> <li>4. How does a state decide what to track in an EWS and how to track it? Are there different measures for different purposes? Are different measures important for different managed care delivery models (carve-in, carve-out, case rate, etc.)?</li> <li>5. How many measures are “too many” in an EWS-type system?</li> <li>6. How can states make sure their EWS evolves as their program and stakeholder concerns change?</li> </ol> <p><i>Discussants:</i>          Mary Jeanne Serafin, Director, Quality Management Program, PA Department of Public Welfare          Beth Tanzman, Director, Adult Community Mental Health Programs, VT Department of Developmental and Mental Health Programs</p>

11:30-12:45 pm	<p><b>Who needs “early warning” in the states and what do they need?</b></p> <ol style="list-style-type: none"> <li>1. What do high-level administrators need?</li> <li>2. What do program management staff need?</li> </ol> <p><i>Discussants:</i>  Michael Hogan, Director, OH Department of Mental Health  Robert Maruca, Director, Medical Assistance Division, NM Department of Human Services  David Wanser, Executive Director, Texas Commission on Alcohol &amp; Drug Abuse</p>
12:45-1:30 pm	<p><b>Lunch</b> (Discussion continues)</p>
1:30-3:00 pm	<p><b>Is an “early warning” useful to other stakeholders? How?</b></p> <ol style="list-style-type: none"> <li>1. How is “early warning” useful to consumers, their families, and advocates? What do they need to make it useful?</li> <li>2. How is “early warning” useful to MCOs and providers? What do they need to make it useful?</li> </ol> <p><i>Discussants:</i>  Mary Kohut, CSTAP  Candice Nardini, Vice President, Public Sector Development, ValueOptions</p>
3:00-4:00 pm	<p><b>What do stakeholders (states and others) need to help them develop and operate a system that enables them to quickly identify and address problems in behavioral health managed care?</b></p> <ol style="list-style-type: none"> <li>1. What resources do states need? How can the need for resources be minimized?</li> <li>2. What resources do MCOs and providers need? How can their level of need be minimized?</li> <li>3. What do consumers need?</li> </ol> <p><i>Discussants:</i>  Jane Gaskill, Managed Health Care Program Manager, Iowa Department of Human Services  Danna Mauch, Magellan Behavioral Health</p>
4:00-4:15 pm	<p><b>Concluding Remarks and Next Steps</b></p>



Appendix E

**Behavioral Health Measures**

## APPENDIX E

### BEHAVIORAL HEALTH MEASURES<sup>17</sup>

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The table on the following pages summarizes the data collected as part of the SAMHSA Medicaid Managed Behavioral Health Benchmarking Project. It offers a snapshot of the performance measures states are producing (or could produce) regarding behavioral health care.

1. *Column 1* lists the measures selected for collection and benchmarking in this project. Most are included in one or more mental health system measurement initiatives;
2. *Column 2* indicates the initiatives in which each measure has been included;
3. *Column 3* summarizes information about the ability of participating programs to produce the core measures. This information was collected during interviews with 21 of the 23 participating programs. The column shows the approximate percentage of the 21 programs that can produce each measure. Since programs were asked to submit only those measures that they either had currently available or could produce with a minimum of effort, the number of data points we received does not necessarily correspond to the percentage of programs that could produce the measure.
4. *Column 4* shows the number and percentage of data points received for each of the core measures for this project. As of July 2002, 17 states had submitted data.
5. *Column 5* provides comments that summarize interviewees' comments regarding the feasibility of producing a measure or issues involved in benchmarking it.

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<sup>17</sup>The information in this appendix is extracted from: Richard Dougherty. *Medicaid Managed Behavioral Health Care Benchmarking Project Final Report, June 30, 2002*. (SAMHSA, forthcoming).

**SAMHSA MEDICAID BEHAVIORAL HEALTH BENCHMARKING PROJECT  
FEASIBILITY OF PRODUCING CORE MEASURES  
AND  
INVENTORY OF DATA POINTS**

1. Core Performance Measure	2. Source of Measure	3. Percent of programs interviewed who can produce measures	4. Percentage of all participating programs that submitted measures	5. Comment
<b>ENCOUNTER DATA BASED MEASURES</b>				
<b>Penetration</b>				
Proportion of adult/child enrollees receiving any MH/SA services	HEDIS, NASMHPD 16 State, DS 2000, Summit 2001, AMBHA - PERMS	100%	13 (76%)	One state does not use this measure any more. They found that it was not helpful for their very small population.
MH/SA ambulatory services		> 75%	11 (65%)	A few states do not collect data on users by service categories.
MH/SA day/night services		50%- 75%	10 (59%)	Some states do not categorize their MH services using HEDIS definitions (e.g. Day/night)
MH/SA inpatient services		> 75%	13 (76%)	A few states do not collect data on users by service categories.
<b>Utilization</b>				
Units of MH/SA services provided per thousand enrollees:	ACMHA; Summit 2001	50%- 75%		Many states can produce units by type of service. Not all categorize them as HEDIS does.
MH/SA ambulatory (visits)		50%- 75%	9 (53%)	Several states use minutes, hours, or encounters, rather than units
MH/SA day/night services (units)		25% - 50%	9 (53%)	Several states use only the categories of in-patient and out-patient
MH/SA inpatient services (days)		> 75%	13 (76%)	Most states can report in-patient days. Some include certain residential or state hospital services in their counts.
Discharges from MH/SA in-patient services per 1000 enrollees	HEDIS, ABMHA-PERMS 2.0; Casey Benchmarking; IBH	> 75%	11 (65%)	Some count only certain types of hospital. One counts admissions rather than discharges
Average length of MH/SA hospital stays in days		> 75%	11 (65%)	One state compiles this only for a subset of high utilizers. It is difficult for another state to get these data.

**SAMHSA MEDICAID BEHAVIORAL HEALTH BENCHMARKING PROJECT  
FEASIBILITY OF PRODUCING CORE MEASURES  
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1. Core Performance Measure	2. Source of Measure	3. Percent of programs interviewed who can produce measures	4. Percentage of all participating programs that submitted measures	5. Comment
<b>Cost</b>				
Medical loss ratio; Percentage of the plan's premium revenues paid out in claims (per definitions of NAIC)	Casey Benchmarking; DS 2000+; NASMHPD 16 State	< 25%	4 (24%)	States mentioned audits and cost reports as methods for overseeing financial performance. Some states were unsure whether they had this information. If so, it would be reported to their financial management counterparts. Some, who have this information, do not make it public, citing proprietary concerns and lack of comparability due to different definitions of service costs.  This measure is not easily available for many programs, either because they are not at risk (though costs of an ASO could be a proxy for the administrative costs) or because they are integrated and premiums cover more than behavioral health.
Service spending per capita; Average cost of total MH and/or SA services per enrollee served	Casey Benchmarking, NASMHPD 16 State	50%- 75%	10 (59%)	Several programs that do not have cost data have subcapitated service providers (like CMHCs) that do not generate claims for services that they provide themselves.
MH/SA ambulatory services		50%- 75%	7 (41%)	
MH/SA day/night services		25% - 50%	7 (41%)	
MH/SA in-patient services		50%- 75%	9 (53%)	
<b>Other Encounter Measures</b>				
Percentage of enrollees receiving MH/SA services who are diagnosed with a co-occurring SA/MH disorder	ACMHA	50%- 75%	5 (29%)	Several states were concerned that this would be under-reported because of data completeness. Several others did not collect the relevant data. A number of states that could compute this measure do not do so routinely.
Percentage of enrollees with an index detoxification who initiated AOD plan services within 14 days following detoxification	Washington Circle Group	< 25%	0	A few states thought that they could compute this measure, though it was not relevant to more than half of them, since they did not provide SA services.

**SAMHSA MEDICAID BEHAVIORAL HEALTH BENCHMARKING PROJECT  
FEASIBILITY OF PRODUCING CORE MEASURES  
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1. Core Performance Measure	2. Source of Measure	3. Percent of programs interviewed who can produce measures	4. Percentage of all participating programs that submitted measures	5. Comment
Percentage of enrollees with a schizophrenia diagnosis who have at least 4 visits in 12 months with a psychiatrist or DO for psychotherapy or medication management; patients 18 and over	HEDIS, ABMHA-PERMS 2.0	50%- 75%	3 (18%)	Few states compute this measure, though several monitor services for people with schizophrenia in other ways. Several identified aspects of their information systems that would make this measure incomplete.
Follow-up service after hospitalization for ages 6 and over:	HEDIS, NASMHPD 16 state; ACMHA; AMBHA-PERMS 2.0; Summit 2001; DS 2000+			
Within 7 days		> 75%	12 (71%)	Some states report 5 days or 14 days, rather than 7.
Within 30 days		> 75%	7 (41%)	Fewer states routinely report follow-up after 30 days than report for a shorter period.
MH/SA in-patient readmission rate:	SAMHSA EW System (authorizations) Casey Benchmarking; NASMHPD 16 State; NAPHS; AMBHA-PERMS 2.0			Most states and counties can and do produce one or more of these measures.
Within 30 days		> 75%	10 (59%)	This was the most frequent measurement period. A few also measure at 7 days.
Within 90 days		> 75%	6 (35%)	Several states measure at 90 days.
Within 180 days		> 75%	n/a	Several states measure at 180 days.
Within 365 days		> 75%	n/a	Few states routinely calculate for 365 days.
<b>Pharmaceuticals</b>				
Cost per enrollee served of psychotropic drugs by type of drug (for enrollees with any diagnosis)	AMBHA-PERMS 2.0	25% - 50%	2 (12%)	Quite a few programs do not cover medications within the benefits they administer, requiring coordination with a pharmaceutical database administered by another agency. Some programs believed this could be done. Others did not consider it possible. One noted that this report would cost real money.
Number of enrollees prescribed atypical antipsychotics per 1000 enrollees	NASMHPD 16 State; APA	50%- 75%	2 (12%)	A number of states that can calculate this measure needed specifications defining the codes for atypical antipsychotics.

**SAMHSA MEDICAID BEHAVIORAL HEALTH BENCHMARKING PROJECT  
FEASIBILITY OF PRODUCING CORE MEASURES  
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INVENTORY OF DATA POINTS**

1. Core Performance Measure	2. Source of Measure	3. Percent of programs interviewed who can produce measures	4. Percentage of all participating programs that submitted measures	5. Comment
Antidepressant Medication Management (NCQA) Age 18 and older:	HEDIS, ABMHA-PERMS 2.0			This is a complicated report, and not all those who can, calculate it. Two states noted that they get incomplete results because they cannot account for people who get antidepressants from their PCPs. They have identified that approximately 70% of Medicaid recipients in their state, who are prescribed antidepressants, get them from their PCPs.
>= 3 follow-ups within 12 weeks after initiation of antidepressant		25% - 50%	1 (6%)	
Taking antidepressant for at least 12 weeks		50%- 75%	1 (6%)	
Taking antidepressant for at least 6 months.		50%- 75%	1 (6%)	

**SAMHSA MEDICAID BEHAVIORAL HEALTH BENCHMARKING PROJECT  
FEASIBILITY OF PRODUCING CORE MEASURES  
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INVENTORY OF DATA POINTS**

1. Core Performance Measure	2. Source of Measure	3. Percent of programs interviewed who can produce measures	4. Percentage of all participating programs that submitted measures	5. Comment
<b>ADMINISTRATIVE DATA BASED MEASURES</b>				
Telephone access to managed care organization – Calls answered in greater than 30 seconds	SAMHSA EW System; IBH	25% - 50%	4 (24%)	States frequently require this measure, but in integrated settings, the measure is not likely to stratify for behavioral health calls. One state measured this during program implementation, but no longer does so. Another state tests telephone access, but does not require reports.
Rate of service denials by service type	SAMHSA EW System; IBH	< 25%	3 (18%)	This is a difficult measure for cross-system benchmarking due to differences between benefits and managed care prior authorization practices. Even within a single state, comparisons between different HMOs can be affected by their prior authorization requirements and procedures.  This is not a relevant measure for some systems, such as those where PCPs authorize, or where there are minimal prior authorization requirements.  Some states look at all service requests that get modified; some only at service denials resulting in a complaint or appeal.
Rate of involuntary commitment	ACMHA; AMBHA-PERMS 2.0; SAMHSA EW System	< 25%	6 (35%)	States most likely to have this measure were those where Mental Health authorities had a role in administering the Medicaid managed care plan. States that did not collect this measure for their managed care hospitalizations frequently indicated that they did collect it for their state hospitals
Consumer satisfaction with timeliness of access to out-patient care and out-patient services	IBH; DS 2000+; ACMHA; Summit 2001; CAHPS	50%- 75%	8 (47%)	A few integrated plans used CAHPS or a similar tool and did not focus on behavioral health specifically. MHSIP was the most frequently used instrument, used by 8 states. However, there is considerable variation in the tools used and the methodology for administering them.

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FEASIBILITY OF PRODUCING CORE MEASURES  
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1. Core Performance Measure	2. Source of Measure	3. Percent of programs interviewed who can produce measures	4. Percentage of all participating programs that submitted measures	5. Comment
Consumer complaints and rates of grievances	SAMHSA EW System; Casey benchmarking; IBH	50%- 75%	6 (35%)	Many states have some form of monitoring for complaints and grievances, but there are considerable limitations in making cross-system comparisons due to differences in definitions and categorization of complaints and – in integrated systems–lack of identification of MH/SA related complaints. In this area, reporting is often in the form of complaint logs that focus more on oversight of the complaint process than summary reports for identification of patterns and trends.



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FEASIBILITY OF PRODUCING CORE MEASURES  
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1. Core Performance Measure	2. Source of Measure	3. Percent of programs interviewed who can produce measures	4. Percentage of all participating programs that submitted measures	5. Comment
<b>CLIENT OUTCOME MEASURES</b>				
Percentage of patients with improved, maintained, and reduced levels of functioning	Outcomes Roundtable; NASMHPD 16 State; NAPHS; IBH; Summit 2001; DS 2000+	25% - 50%	2 (12%)	Two more states are implementing or requiring functional outcomes measurement. Those states that do collect outcomes measurement frequently prioritize higher need subpopulations. Several identified problems with the reliability and completeness of data collected. Some states only have point in time data rather than change over time.  Instruments used included GAF, MHSIP, AFARS, CFAR, Alpha, CGAS, CGI, SF-12, and Multnomah.  Timing is most commonly at admission, every 6 months, and at discharge.
Change in living situation. Compare living situation (domiciled, homeless) at admission to MH/SA treatment and at a standard period post-admission	DS 2000+; NASADAD; NASMHPD 16 State	25% - 50%	5 (29%)	As with functioning, these data are sometimes collected for a more vulnerable subset of service users. There are similar problems with data reliability and completeness.
Change in employment status. Compare status at admission to MH/SA treatment and at a standard period post-admission	ACMHA; NASADAD; DS 2000+	25% - 50%	6 (35%)	Similar issues of data quality and completeness as those expressed above. However, one state is sufficiently confident in its data to tie a performance incentive to employment outcomes.
Criminal justice involvement. Change in the number of arrests in a standard period before admission to a standard period post-admission	ACMHA; Outcomes Roundtable; NASMHPD 16 State	< 25%	1 (6%)	A number of states indicated that they did not have this measure because it needed to come from the Criminal Justice System. One County, however, indicated that it had good data which was matched weekly with County jail records.
<b>CLINICAL PROCESS MEASURES</b>				
Use of seclusion and restraint	NASMHPD 16 State; ACMHA; NAPHS			

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FEASIBILITY OF PRODUCING CORE MEASURES  
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1. Core Performance Measure	2. Source of Measure	3. Percent of programs interviewed who can produce measures	4. Percentage of all participating programs that submitted measures	5. Comment
Percent of all patient hours of treatment spent in seclusion or under restraint		< 25%	0	These measures are most frequently collected for state hospitals, and sometimes also for psychiatric hospitals. When Medicaid stays are included, they are not always stratified from the total.  One state discontinued this measure, determining that it was not a managed care measure but a facility measure for which the mental health authority had oversight responsibility
Clients with one or more episodes of restraint or seclusion as a percentage of all clients served during the reporting period		< 25%	0	