

**CHILDREN'S MENTAL HEALTH
BENCHMARKING PROJECT
SECOND YEAR REPORT**

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**The Annie E. Casey Foundation,
The Center for Health Care Strategies, Inc., and
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PREPARED BY:



Dougherty Management Associates, Inc.

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ADVISORY COMMITTEE

We also acknowledge with gratitude the helpful contributions made by the project's Advisory Committee, whose members are:

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EXECUTIVE SUMMARY

The goal of the Children's Mental Health Benchmarking Project is to disseminate administrative data from states and counties in order to enable policy makers to compare their own jurisdictions to others with regard to certain key indicators. Although billions of dollars are spent every year on providing mental health services for children, very little is known about how various systems allocate their resources, how they use state and federal funds, or what difference any of these variations makes. Dougherty Management Associates, Inc., (DMA) received support for this project from the Annie E. Casey Foundation, the Center for Health Care Strategies and The Robert Wood Johnson Foundation.

In 2001 information was requested from all 50 state mental health authorities, most state Medicaid agencies, and selected counties on a set of core indicators in four categories: access, utilization, expenditures and intersystem involvement. Thirty-one states, four counties and the District of Columbia submitted extensive data. Sixteen of these 36 jurisdictions submitted both Medicaid and MHA data. Some indicators display much consistency but have a few extreme outliers. In most of these instances, participating sites offered explanations for their outlier status. On other indicators there is a great deal of variability among jurisdictions. Overall, as this report demonstrates, the quantity of data submitted in the project's second year allows the beginning of meaningful comparisons of sites, and a step toward the development of benchmarks.

Among the key findings of this study are the following:

- *Access: Children: served per 1,000 population*
 - For 26 mental health authorities, the rates of children served per 1,000 population range from 3.8 to 53.5, with a mean of 19.3.
 - Medicaid rates of children served per 1,000 population for 25 jurisdictions range from 6.1 to 41.8 with a mean of 21.2.
- *Utilization: Readmission to inpatient care*
 - Five mental health authorities provided data on readmissions to state hospitals within 30 and 90 days following discharge. The 30-day readmission rates range from 2.9 percent to 12.7 percent with a mean of 6.2 percent; the 90-day rates range from 6.3 percent to 21.5 percent with a mean of 10.6 percent.
 - Five Medicaid agencies submitted data on readmissions for psychiatric hospitalization. The 30-day readmission rates range from 4.2 percent to 10.6 percent with an average of 8.4 percent. The 90-day readmission rates range from 8.6 percent to 15.5 percent, and average 13.4 percent.
- *Expenditures:*
 - For the ten jurisdictions that provided both mental health authority and Medicaid expenditure data, the combined expenditures per child range from \$55 to \$276 with a mean of \$118.

- For 16 mental health authorities, the proportion of all expenditures that was devoted to inpatient care ranged from one percent to 62 percent, with a mean of 22.1 percent.
- For 21 Medicaid agencies, the proportion of expenditures devoted to inpatient care ranges from three percent to 58 percent, with a mean of 24 percent.
- *Intersystem involvement:*
 - Nine mental health authorities reported on the percentage of children who received mental health services and were in foster care or other out-of-home placements at some time during the year. Rates ranged from 4.1 percent to 16.7 percent, with a mean of 10.5 percent.

The project has begun to play a valuable role both in the work of state and county policymakers and on the national scene. At the state and local levels, program analysts and decision makers can compare themselves to others, thereby enhancing their understanding of their own systems and their ability to seek ways of making positive changes in them. At the national level, while several initiatives have encouraged states to gather and report on common data elements, none has yet published data specific to children's mental health services. Nor has any other project systematically included both MHA and Medicaid data. This project is therefore augmenting the efforts of a variety of stakeholders.

An important element of Year Two of this project was the first Children's Mental Health Benchmarking Institute, which took place in Santa Fe, New Mexico, in November 2001. Each jurisdiction that provided data in 2001 was invited to send a representative to the Institute; the project paid all expenses for each participant. Twenty-four individuals, representing 21 jurisdictions, accepted the invitation. The assembled group, which totaled 35, also included four invited experts in the field, a representative of the Federation of Families for Children's Mental Health, representatives of the Annie E. Casey Foundation and The Robert Wood Johnson Foundation and DMA staff. The Institute served several purposes: first, it enabled a sizable group of project participants to compare data, discuss the challenges involved in gathering the data, hear the comments of experts on the project and offer insights to DMA staff. It also served to motivate individuals and their jurisdictions to provide data. Finally, the Institute gave staff from mental health and Medicaid agencies across the country an opportunity to think about how they might use data to influence the development of policy.

CHILDREN'S MENTAL HEALTH BENCHMARKING PROJECT SECOND YEAR REPORT

I. INTRODUCTION

Dougherty Management Associates, Inc. (DMA), a research and consulting firm, often advises states and counties that are restructuring aspects of their healthcare systems. Both DMA and our clients find that in such instances access to comparable data from other states can improve analysis and decision-making. Several years ago, while working with a number of states, DMA recognized that few if any sources of comparison data were available in the area of children's mental health. Beginning in 1999 with support from the Annie E. Casey Foundation, the firm sought to remedy that situation through the Children's Mental Health Benchmarking Project.

Now entering its third year, the project gathers administrative data directly from states and counties, develops the raw data into indicators that can be compared across sites, and, as in this report, disseminates the indicators in order to enable policy makers to compare their own jurisdictions to others with regard to certain key indicators.

During calendar year 2000 the mental health authorities (MHAs) of nine states, three counties and the District of Columbia submitted data to DMA. Following this exploratory phase of the project, and with continuing support from the Casey Foundation as well as additional funding from the Center for Health Care Strategies and The Robert Wood Johnson Foundation, the data collection instrument was revised and sent to all 50 state mental health authorities, most state Medicaid agencies, and selected counties. The current report offers the results of this second data collection effort.

In both years the project collected data on a set of core indicators in four categories: access, utilization, expenditures and intersystem involvement. In contrast to the first year, however, in calendar year 2001 31 states, four counties and the District of Columbia submitted extensive data. Sixteen of these 36 jurisdictions submitted both Medicaid and MHA data. As this report demonstrates, the quantity of data submitted in the project's second year enables us to begin to compare sites in a meaningful way and to develop benchmarks.

We are very grateful to those who contribute data to us, on whose efforts the project depends. We trust that this report will offer them adequate compensation for their work, by enabling them to compare themselves to others in a number of important domains. We look forward to a continuing collaboration with them to improve the quality of both the data and the analysis.

II. BRIEF REVIEW OF THE LITERATURE

DMA initiated the Children's Mental Health Benchmarking Project because, while we were conducting work for states and counties throughout the country, it became apparent that the field lacked standards that we or our clients could use to evaluate their mental health systems for children. There are others who are doing work that is peripherally related to this project, but none are providing data that child policymakers at the state or local level can use to help understand or guide their efforts. A review of the relevant literature will help to clarify this point.

INDICATOR STUDIES: THE FIVE-STATE AND SIXTEEN-STATE STUDIES

The National Association of State Mental Health Program Directors, with funding from the Center for Mental Health Services, coordinated an effort to develop and implement standardized performance and outcome measures for public mental health systems.¹ These projects, while they engaged states in an effort similar to that involved in the current project, focused almost entirely on adult indicators. The very few child indicators included in the studies have not been widely used or reported on. In addition, this project includes only mental health authorities, and therefore does not encompass Medicaid data.

STUDIES OF MEDICAID DATA

The most recent study of Medicaid mental health and substance abuse services, which draws on data from 1994, includes statistics on all states and on ten selected states, which were chosen in part due to their "limited penetration of Medicaid managed care."² Although this report does include data stratified by age, its sole focus on Medicaid limits its utility for planning and comparison purposes. Furthermore, given the extensive use of managed care systems in Medicaid programs across the country, different though the systems may be, this study's dearth of statistics from states with managed care programs reduces its utility for many stakeholders.

ESTIMATES OF UTILIZATION AND EXPENDITURES

A recent study has attempted to determine, at the national level, how many children and adolescents use mental health services, how utilization differs by insurance status, how much money is spent on mental health treatment for children and adolescents, and how those expenditures are distributed by type of service and insurance status.³ This study examines not just *public* expenditures (as most of the other work cited here does) but *all* expenditures. Because it focuses exclusively on children and adolescents, it does offer some relevant conclusions and useful comparative statistics. For example, the report includes data on services per 1,000 population and on total costs. One point of significance for the present work is that "a relatively large share of specialty mental health services is not paid for by private insurance, even among children who have such insurance."⁴ This conclusion would suggest that public mental health services cover a broader spectrum of children than one might expect.

¹ Ganju, V., and T. Lutterman, "The Five-State Feasibility Study: Implementing Performance Measures Across State Mental Health Systems," in Center for Mental Health Services. *Mental Health, United States, 1998*. R.W. Manderscheid and M.J. Henderson, eds., DHHS Pub No. (SMA) 99-3285. Washington, DC: Supt. Of Docs., U.S. Govt. Print. Off., 1998.

² Buck, J.A., Miller, K., and Bae, J. *Mental Health and Substance Abuse Services in Medicaid*, 1994. DHHS Pub. No. (SMA) 00-3284. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2000, p. 1.

³ Jeanne S. Ringel and Roland Sturm, "National Estimates of Mental Health Utilization and Expenditures for Children in 1998," *The Journal of Behavioral Health Services and Research*, 28:3, August 2001, pp. 319-333.

⁴ *Ibid.*, p. 330.

Another study of children is analyzing data from the 1997 Client/Patient Sample Survey conducted by the Center for Mental Health Services. That survey sampled more than 8,000 children in approximately 1,600 mental health care facilities⁵ and examines the characteristics of the children and of the services they receive. Because this work is still in progress, it does not yet offer many useful points of comparison for this study. Within the next year or so, however, it will probably begin to do so.

SERVICE USE ACROSS SECTORS

Another important approach is to “integrate information about mental health service needs and use across the various agencies that provide such services.”⁶ A North Carolina study from the early 1990s suggests that the education sector is actually by far the largest provider of mental health services to children, even to those with serious emotional disturbance. Children with severe problems tended to be involved in multiple sectors, while children with less severe problems were most likely to be seen in sectors other than specialty mental health. These findings, while they cannot necessarily be generalized to other states or counties, help to suggest a larger context in which to view the present study, as will be discussed below.

⁵ Kathleen J. Pottick, “Update: Latest Findings in Children’s Mental Health,” Rutgers University Institute for Health, Health Care Policy, and Aging Research.

⁶ Barbara J. Burns, E.J. Costello, A. Angold, D. Tweed, D. Stangl, E. Farmer and A. Erkanli, “Children’s Mental Health Service Use Across Service Sectors,” *Health Affairs*, 14:3, pp. 147-159.

III. COLLECTING THE DATA

METHOD AND SCOPE

For this study, Dougherty Management Associates (DMA) asked states and counties to submit data using a revised version of a data collection instrument that we had developed during the first year of the project. Once we had received the raw data, we used them to develop indicators that permit cross-site comparisons. The only source of data we used in developing indicators, other than what our respondents submitted, was the 2000 United States Census. The indicators included in this study are widely acknowledged to constitute important markers in the domains of access, utilization, expenditures and intersystem involvement.

DMA requested data from the MHAs of all 50 states and the majority of state Medicaid agencies. We asked that the two agencies within each state coordinate their efforts, and in a number of cases they did; in other cases, a single agency controls both sources of funds and/or manages information for both funding sources. In addition to the 50 states, we sought data from the same six counties we had included in the first year's survey, and from the District of Columbia. Ultimately, 31 states, four counties and the District of Columbia submitted data in the second year.

REVISING THE DATA COLLECTION INSTRUMENT

During the winter and early spring of 2001 DMA substantially revised the original data collection instrument⁷. The new instrument consists of two parts, one devoted exclusively to MHA data, and the other a "Medicaid Addendum." MHA respondents who lacked access to Medicaid data were asked to send the Medicaid Addendum to their counterparts in that agency, and vice versa.

In addition to creating two separate instruments, we clarified many of the questions and asked about community-based services in far greater detail than the Year One instrument had.

In order to maximize respondents' access to the instrument, we made it available on our Web site. (Refer to Appendix I for copies of the Data Collection Instruments.)

OUTREACH EFFORTS

In addition to revising the instrument, we conducted extensive outreach during the course of the winter and spring of 2001. We presented our first year results at three conferences between February and May, and used our attendance at the conferences, as well as our presentations, to encourage additional states to participate in the project's second year. We also wrote articles for two industry publications, *Mental Health Weekly* and *Behavioral Healthcare Tomorrow*, describing the project and our progress during its first year.

At the same time, we reached out to all the groups we learned of that are working on related issues, including:

- Children's Outcomes Roundtable;
- Georgetown's National Technical Assistance Center for Children's Mental Health;

⁷ We wish to acknowledge the assistance of John Pandiani, Ph.D., Janet Bramley, Ph.D., and Alice Maynard, all of the Vermont Department of Developmental and Mental Health Services, who offered invaluable advice on revising the data collection instrument.

- Carter Center Forum;
- Child Mental Health Foundations and Agencies Network (FAN);
- Federation of Families for Children's Mental Health;
- NASMHPD Research Institute;
- Center for Mental Health Services (SAMHSA); and
- American College of Mental Health Administration

During the second year DMA also established an Advisory Committee to offer comments and suggestions on the project's instrument, process and mailing list. The Advisory Committee included representatives of the project's funders and of the Federation of Families for Children's Mental Health as well as experts in the field.

Our efforts clearly influenced the quantity and quality of the responses we received. Separating out the requests for the two types of data enabled far more jurisdictions to respond, and our outreach and validation efforts apparently helped jurisdictions to recognize the potential value of participating in the project. The opportunity to travel to the Children's Mental Health Benchmarking Institute, which DMA sponsored in Santa Fe in early November (see below), also provided an incentive for many of the research and data staff to collect the data in a timely manner.

PROCESS AND TIME FRAME FOR DATA COLLECTION

DMA mailed the Data Collection Instrument to all 50 state MHAs, as well as to selected counties, in late June 2001. In those mailings we included the Medicaid Addendum, with the request that, if the MHA could not provide Medicaid data, they send the Addendum to the appropriate person at the state's Medicaid agency. About one month later, we mailed the Medicaid Addendum to 37 Medicaid directors. About one month after each of these mailings, we sent a reminder postcard to each potential respondent. The postcard highlighted the fact that submitting data would entitle the jurisdiction to an invitation to the Children's Mental Health Benchmarking Institute in November. We also sent messages via e-mail. The initial e-mail message served both as a reminder and as a means of assuring that the hard copy had been received. The original deadline for receipt of data was August 31, 2001, but shortly before that date we sent an e-mail message extending the deadline to September 30th, as we had anticipated doing. The fact that the Institute took place in early November undoubtedly motivated some respondents to submit their data in a more timely way than they otherwise might have. Although some data were submitted after the September 30th deadline, we received nearly all submissions before the time of the Institute. Thus the data collection period in Year Two extended for about three months.

COMPARABILITY OF SYSTEMS

Participants in this project, as well as other stakeholders who have reviewed its products, are finding the enterprise valuable. However, in addition to defining indicators as carefully as possible, there are further challenges involved in attempting to compare data from numerous states and counties, because each state has its own idiosyncratic system for providing and funding mental health services for children. One recent study of data from State mental health (MH), State substance abuse (SA) and Medicaid agencies in three states issued the following "note of warning about state comparison":

Comparisons of MH/SA utilization and expenditures between States should not be made because State programs for delivering MH/SA services differ in so many dimensions. Their history in such programs can differ, as can their program resources and financing, organization, benefits, arrangements for paying providers, incentives for treatment, available settings for care, extent of managed behavioral health care, and networks of providers . . . Also, the epidemiology of mental disorders being treated across regions or States can differ, as can the demographics of the populations. Furthermore, characteristics of Medicaid programs (their benefits, eligibility criteria, payment arrangements, levels of payment, and extent of managed care) also vary considerably from State to State These multi-dimensional differences make it impossible to ascribe any particular finding across the States to one underlying factor or another.⁸

In the effort to compare data from many more than the three states that study was examining, this project faces all those same issues, and we therefore echo the above warning. This report will attempt, and cautions the reader, not to make assumptions or jump to unwarranted conclusions about causation or correlation among indicators. Further, readers are advised not to interpret any of the state-to-state comparisons pejoratively. Given the limited ability to conduct any kind of “risk adjustment” among jurisdictions, there is at this point no basis for evaluating the relative quality or even the relative quantity of the services states and counties are providing. It is appropriate, however, to use all of the information available about the various states, their programs and demographics, to attempt to account for the differences among jurisdictions on the various indicators.

It is also important to note that in some cases the data submitted for this project represent not the entire child population of the jurisdiction reporting, but rather a subset for whom data are available. For example, the Massachusetts Division of Medical Assistance (the state’s Medicaid agency) provided data on children served through the behavioral health carve-out of the Primary Care Clinician (PCC) program. The PCC Plan is one of five managed care options for people in the Massachusetts Medicaid program, the other four being HMOs. Yet other individuals are served in the fee-for-service system.

Despite the above cautions, one of the virtues of a project like this is to raise awareness among state and county decision makers that their systems of structuring and funding care are not the only, or necessarily the best, possible ways of doing so. Being an extreme outlier on one or several of the indicators discussed in this report may mean that a state has found a “best practice,” or it may suggest that a state is adhering to practices that others no longer use, and that leads to longer lengths of stay or higher expenditures (or, of course, it may mean that the data submitted are, for some reason, not comparable).

INDICATORS AND BENCHMARKS

Technically, a benchmark is a standard, an external reference point. In order to establish benchmarks, appropriate indicators, and measures of those indicators, must be defined and performance of the systems compared. In addition, one must attempt to document the actual

⁸ R.M. Coffey, L. Graver, D. Schroeder, J. Busch, J. Dilonardo, M. Chalk and J. Buck, *Mental Health and Substance Abuse Treatment: Results from a Study Integrating Data from State Mental Health, Substance Abuse, and Medicaid Agencies*, SAMHSA Publication No. SMA-01-3528. Rockville, MD: Center for Substance Abuse Treatment, Center for Mental Health Services and Substance Abuse and Mental Health Services Administration, 2001, p. 12.

comparability of the systems. In the project's first year, we devoted considerable attention to selecting the most appropriate indicators and their measures. In that process, we reviewed the work of many organizations, including the American Managed Behavioral Healthcare Association, the Mental Health Statistics Improvement Program, the National Committee for Quality Assurance, the National Association of State Mental Health Program Directors, the National Association of County Behavioral Health Directors, the Institute for Behavioral Healthcare, the Center for Mental Health Services and the American College of Mental Health Administration. Ultimately, we determined that this project could contribute to the field most effectively by gathering data on a relatively small number of indicators based upon administrative measures in the areas of access, utilization, expenditures and intersystem involvement. Each indicator chosen had been recommended by one or more of the groups cited above. Specifically, we elected to try to answer four basic kinds of questions:

- How many children are served? (i.e., the access questions)
- In what settings? (i.e., the utilization questions)
- At what cost? (i.e., the financial questions)
- In what other systems of care are children who are receiving MHA and Medicaid funded mental health services simultaneously involved? (i.e., the intersystem involvement questions)

What is a Benchmark?

Webster's Dictionary defines a benchmark as "a standard or reference by which others can be measured or judged." While this project indeed seeks to develop such standards, it is important to make explicit the fact that the data presented here and the standards implicit in those data are describing the existing situation in states and counties across the country. As noted below, states' healthcare and mental health systems differ dramatically from one another, and many of those differences affect their data. For example, states differ significantly regarding the extent to which their education, child welfare and juvenile justice systems fund mental health services for children. Moreover, there are innumerable other characteristics of the states that may confound the data. Thus, it is not yet possible to determine from our data what would represent a desirable or "good" state of affairs. Nevertheless, stakeholders at the state and county level find it useful to be able to compare their own statistics to statistics for other jurisdictions, especially those with whose characteristics they are familiar.

Access

Medicaid and MHA penetration rates are the obvious measures of access to public mental health care for children. Since MHAs have no defined pool of "eligibles" other than the entire population of children, however, there can be no calculation of a meaningful MHA "penetration rate," as that term is commonly used in health plans. Therefore, in order to be able to compare access to Medicaid and MHA services, the number of children who received an MHA service, and the number who received a Medicaid funded mental health service, per 1,000 population under 18, were calculated. For Medicaid, penetration rate was also calculated in the standard way: the percentage of children enrolled in Medicaid who received at least one Medicaid funded mental health service. For population data (i.e., the denominator in our indicators), we used the United States *Census 2000* count of children under the age of 18 (as available on the Web site of the U.S. Census Bureau).

Utilization

Utilization indicators included inpatient services penetration rates, i.e., the percentage of children receiving any mental health service who were hospitalized, for both MHAs and Medicaid. Also reviewed were inpatient days per 1,000 served and per 1,000 population, as well as inpatient average lengths of stay and readmission rates. In addition, the utilization of other levels of care, such as non-hospital 24-hour care and outpatient services, was examined.

Cost

Cost indicators include expenditures per child served and expenditures per 1,000 population, as well as the proportion of expenditures devoted to the various service modalities.

Intersystem Involvement

There is general agreement among both researchers and clinicians that the quality of care children and families experience depends not only on the care they receive from mental health providers, but also on the level of integration of that care with the services of other agencies. For example, the efforts of child welfare agencies, juvenile justice agencies, substance abuse providers and schools can have a significant impact on the outcome of mental health services provided to children. Thus, measures of what we term intersystem involvement were included in our list of indicators. Both MHAs and Medicaid agencies were asked to provide data on how many of the children they serve are concurrently receiving child protective services, substance abuse services, or special education services. Data were also requested on the number of the children they serve who were placed outside the home in foster care or another child welfare placement and the number of children who had an encounter with the juvenile justice system.

IV. THE CHILDREN'S MENTAL HEALTH BENCHMARKING INSTITUTE

An important element of Year Two of this project was the first Children's Mental Health Benchmarking Institute, which took place in Santa Fe, New Mexico, in November 2001. We invited each jurisdiction that provided data in 2001 to send a representative to the Institute; the project paid all expenses for each participant. Twenty-four individuals, representing 21 jurisdictions, accepted the invitation; the number probably would have been somewhat larger had it not been for the impact of the September 11th attacks on some individuals' willingness to travel. The assembled group, which totaled 35, also included four invited experts in the field, a representative of the Federation of Families for Children's Mental Health, representatives of the Annie E. Casey Foundation and The Robert Wood Johnson Foundation and DMA staff. The Institute served several purposes: first, it enabled a sizable group of project participants to compare data, discuss the challenges involved in gathering the statistics, hear the comments of experts on the project and offer insights to DMA staff. It also served to motivate individuals and their jurisdictions to provide data. Finally, the Institute gave staff from mental health and Medicaid agencies across the country an opportunity to think about their work in a new light, and especially to think about how they might use data to influence the development of policy.

V. RESULTS

RESPONSE RATE

We received data from a total of 36 different jurisdictions: 31 states (out of the 50 from which we requested information), four counties (out of the six in our original sample) and the District of Columbia. Eighteen of those jurisdictions submitted both Medicaid and MHA data. This represents a significant improvement over the thirteen jurisdictions, nine states, three counties and the District of Columbia, which submitted data in the first year. (Six of those nine states and all three counties, as well as the District of Columbia, participated in year two.) Seven states that did not provide data sent letters explaining why they were unable to respond this year. In most cases they left the door open to future data requests from us and a few of these states suggested that they would be likely to be able to provide us with data in the near future.

REPORTING OF SPECIFIC DATA

Jurisdictions provided us with enough data points to permit reporting on numerous measures. States and counties submitted the largest amount of data for the number of children served: 26 MHAs and 25 Medicaid agencies reported these data. Most of these sites also submitted at least some expenditure data. Specifically, 20 MHAs and 22 Medicaid agencies reported expenditure data that allowed calculation of the total mental health expenditures per child served.

A total of 14 MHAs reported at least some intersystem data. The number of MHAs reporting on intersystem indicators ranges from six on involvement with child protective services to 13 on involvement with the juvenile justice system. In contrast, only five Medicaid agencies reported any intersystem data, and the data they reported were not sufficient for display or comparison.

WHAT IS NOT INCLUDED IN THIS STUDY

It is important to reiterate that this study reports only on data from public mental health authorities and Medicaid agencies. Other research, as mentioned in Section III, above, has shown that many, and in some states most, children who receive mental health services receive them through their schools, rather than through the formal mental health system.⁹ Moreover, in many states the child welfare and/or juvenile justice agencies provide extensive mental health services to their respective clientele. Thus, this study does not purport to describe the entire public mental health system for children, but only that portion of it funded by the mental health authority and the Medicaid agency. Finally, this study makes no effort to include use of private insurance to support access to mental health services.

SOME DIFFERENCES BETWEEN MENTAL HEALTH AUTHORITIES AND MEDICAID AGENCIES

In order to put this report in a meaningful context, it is vital that the reader understand the difference between the funding, function and goals of MHAs and Medicaid agencies. Although each state structures these two programs in its own way, there are certain basic differences that are constant. First, the state and Federal governments share Medicaid expenditures according to a standard formula that provides a match of 50 percent of eligible expenditures, with a more generous match to poorer states. Secondly, Medicaid is a program whose purpose is to pay for healthcare for certain specified populations, most of whom are poor. Children are funded by Medicaid because their families are poor or are confronted with catastrophic medical

⁹ Burns et al., *op. cit.*

expenditures, or children themselves may qualify by virtue of certain characteristics, such as a major disability. Many states have established managed care programs in order to control Medicaid costs and to expand the continuum of services available to recipients.

MHAs receive Federal Block Grant funding and also are responsible for setting the state's mental health policy, and spending state-only funds. Most states provide services directly through community mental health centers, while many also contract with private providers. Some states use state hospitals for children, while others do not. The MHA may or may not control any Medicaid funds (such as, for example, under the so-called rehabilitation option) and may or may not provide services to children in the child welfare and/or juvenile justice systems. MHAs often serve children who have exhausted the benefits available to them through private insurance.

VI. FINDINGS

INTRODUCTION

The project has clearly moved beyond the exploratory phase, and this report presents significantly more data than did our First Year Report. Nevertheless, as this section reveals, there are still indicators on which the data show extreme variation, and on which benchmarks cannot yet be suggested. For some indicators, where there are a large number of data points and a few extreme outliers, a median, rather than a mean, has been displayed, thus minimizing the effect of the outliers.

UTILIZATION AND PENETRATION RATES

A variety of research and advocacy groups recommend that public agencies and managed care organizations use penetration rates to measure access to care. For those who are unfamiliar with penetration indicators, it is important to recognize that the utilization data used in the numerator for these calculations (which were submitted in response to the question, "How many children received *any* mental health service from the public mental health system -- or paid for by Medicaid -- within the reporting year?") include both a child who received just one outpatient mental health service and a child who received numerous higher intensity services, such as inpatient psychiatric care and partial hospitalization.

Children served per 1,000 population was the indicator for which the largest number of states and counties, 25 MHAs and 25 Medicaid agencies, reported data.

Children Served per 1,000 Population

Children served per 1,000 population, that is, the proportion of the youth population in a state or county who received any mental health service through Medicaid or the MHA, represents one indicator of access to care. General population data provide the denominator for this rate because MHAs, unlike Medicaid agencies, do not usually have specifically identified, enrolled populations; rather, they are responsible to serve children with serious mental health needs (according to each jurisdiction's own definition) in their communities. Calculating children served per 1,000 population for both children receiving a MHA service and those receiving a mental health service paid for by Medicaid allows for comparisons in sites where both the MHA and the Medicaid agency reported these data. As shown in Figure 1, the rates per thousand children served for the MHAs range from 3.8 in Montana to 53.5 in Vermont¹⁰, with a mean of 19.3 per 1,000 and a standard deviation of 12.6. Figure 2 shows the Medicaid rates; they range from 6.1 in Virginia to 41.8 in Rhode Island, with a mean of 21.2 per 1,000 and a standard deviation of 9.1. It is important to note that many of the same children are being served by both agencies in many, if not most, states. That is, a child may receive, for example, outpatient therapy paid for by Medicaid and wraparound services paid for by the MHA, or a child might receive a Medicaid funded service during one part of the year and a MHA funded service during another part of the year.

¹⁰ In its 1998 Fact Book, the Vermont Department of Developmental and Mental Health Services reported on "people served per 1,000 population" in the state's children's services programs. The statewide average, very much in line with what was reported for this project for FY 2000, was 47.8 children (under 18) served per thousand child population. Within the state, however, there was substantial variation among service areas; rates per thousand ranged from 30.7 to 74.8. J. A. Pandiani, July 2000.

Figure 1 Mental Health Authority: Children served per 1,000 population

Number of children receiving a mental health service per 1,000 population under 18

(Source: Population Data: 2000 US Census)

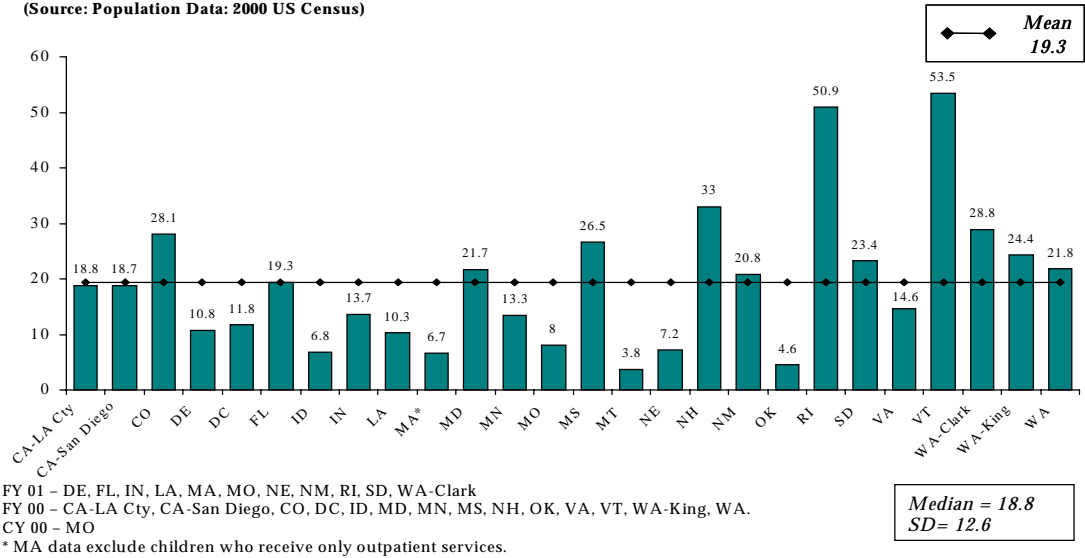
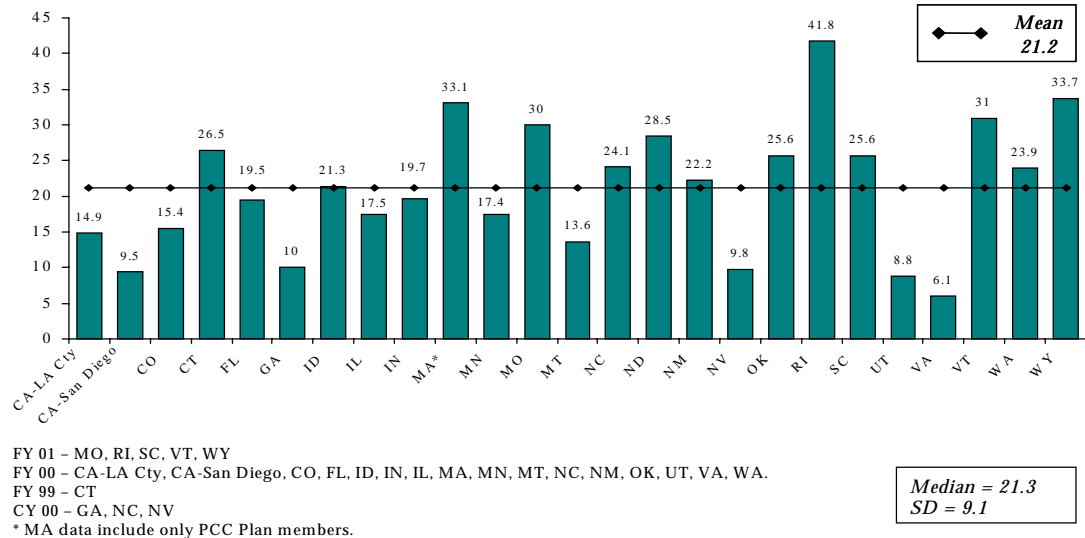


Figure 2 Medicaid: Children served per 1,000 population

Number of children receiving a mental health service(s) per 1,000 population under 18

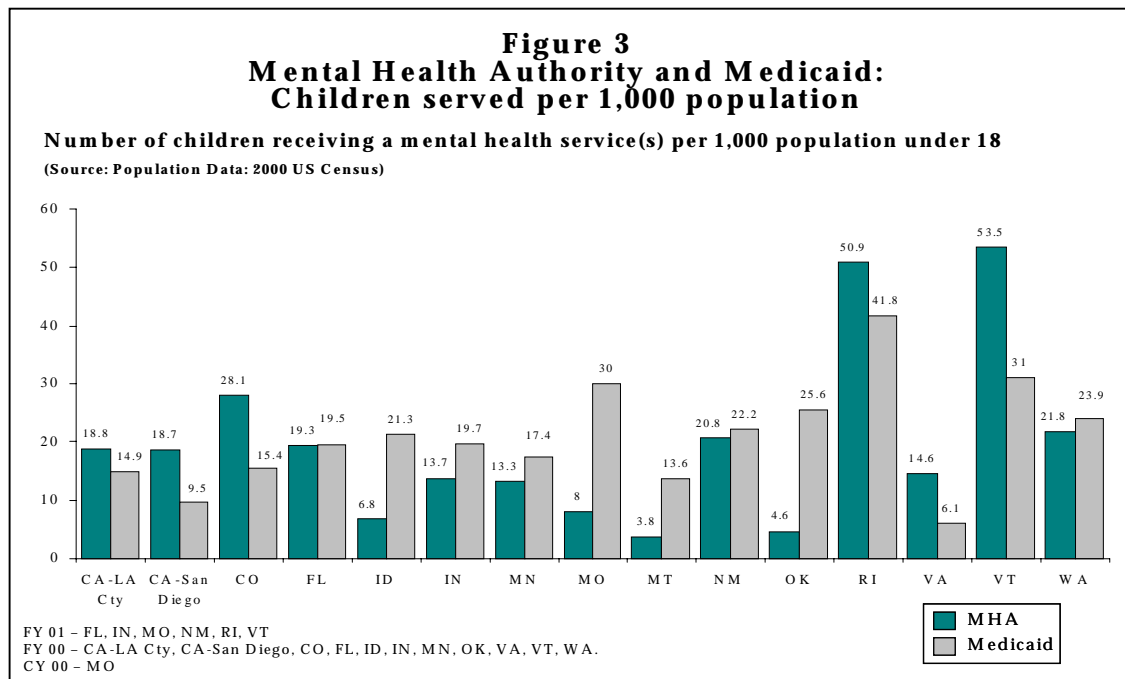
(Source: Population Data: 2000 US Census)



It is in fact interesting that the proportions of children receiving mental health services from the MHAs and the Medicaid agencies are so similar. Medicaid covers many children who receive only a relatively few outpatient services (in addition to children with serious illnesses), while MHAs often serve only children who have serious emotional disorders. We might expect the Medicaid rate to be somewhat higher than the rate for the MHA, for several reasons. Since

experts concur that “the prevalence rate [for serious emotional disturbance] is higher for youngsters living in low socioeconomic circumstances than for youngsters living in high socioeconomic circumstances,”¹¹ it would seem possible that Medicaid agencies would serve proportionately more children than MHAs do. Secondly, the Medicaid population generally includes a higher proportion of disabled and seriously ill children than does the general population, both because catastrophically high medical expenditures often qualify a family for Medicaid and because foster children and other special populations that are covered by Medicaid are prone to have greater than normal needs for mental health care.

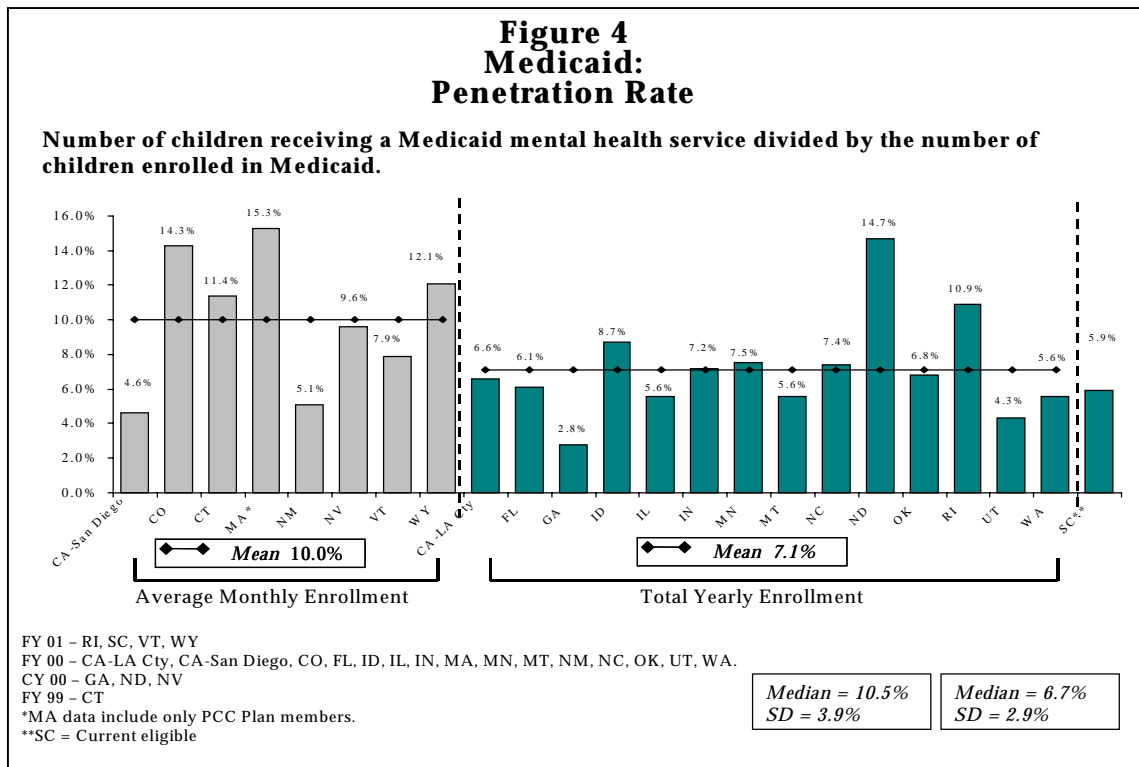
Figure 3 presents the data for MHAs and Medicaid agencies side by side for those jurisdictions for which we have both sets of data. These data provide evidence that states and counties structure their public mental health systems for children in very different ways. In some cases it seems likely that the two funding sources are serving many or even most of the same children, while in others there are dramatic differences between the two groups. In Oklahoma, for example, far more children receive services through Medicaid than through the MHA. In contrast, in Vermont and Rhode Island, more children receiving mental health services are served through the MHA than under Medicaid. Our understanding of the systems of care in Vermont and Rhode Island leads us to believe that those states’ high rates may result from the fact that they are including a larger proportion of their total service systems’ services and dollars in their data than are other states. It is also possible that they are double counting children served under Medicaid; that is those children are included both in the MHA statistics and in Medicaid statistics. The two states may not separate out children who receive services only through the mental health authority. The Medicaid data from Massachusetts include only children and adolescents enrolled in the state’s Primary Care Clinician program and the statewide behavioral healthcare carve-out. The Massachusetts Medicaid program supports services to children through two other mechanisms, a fee-for-service program, and four managed care organizations, but statistics are not available for those programs. It is therefore not known how the data would vary if all children supported by Massachusetts Medicaid were included.



¹¹ R. M. Friedman, J.W. Katz-Leavy, R. Manderscheid and D. Sondheimer, “Prevalence of Serious Emotional Disturbance: An Update,” in Center for Mental Health Services. Mental Health United States, 1998. Manderscheid, R.W., and Henderson, M.J., eds.

Medicaid Penetration Rate

As noted above, it is possible to calculate a traditional “penetration rate” for children on Medicaid, but not for children served by MHAs, because Medicaid covers a defined population. Thus, the Medicaid penetration rate is the proportion of all Medicaid enrolled children who received any mental health service paid for by Medicaid during the year. Figure 4 displays Medicaid penetration rates with jurisdictions divided into two groups, according to how they provided their enrollment data: one group of states and counties provided calculations based on Average Monthly Enrollment, while another group used Total Yearly Enrollment.



The distinction between these two is subtle: average monthly enrollment counts enrollment for each month independently, adds these numbers, then divides the resulting total by 12, while total unduplicated yearly enrollment counts every child who was covered by Medicaid at any point during the year. While the mean for the first group is 7.1%, the mean for the second group is 10%¹². Because the calculation based on average monthly enrollment uses a smaller denominator, it is not surprising that it results in a higher mean. Data gathered in the project’s first year yielded an average Medicaid penetration rate across seven sites of 9.0%; in that cycle, respondents were not asked how they had calculated enrollment.

DHHS Pub. No. (SMA)99-3285. Washington, D.C.: Supt. Of Docs., U.S. Govt. Print. Offl., 1998, p. 110.

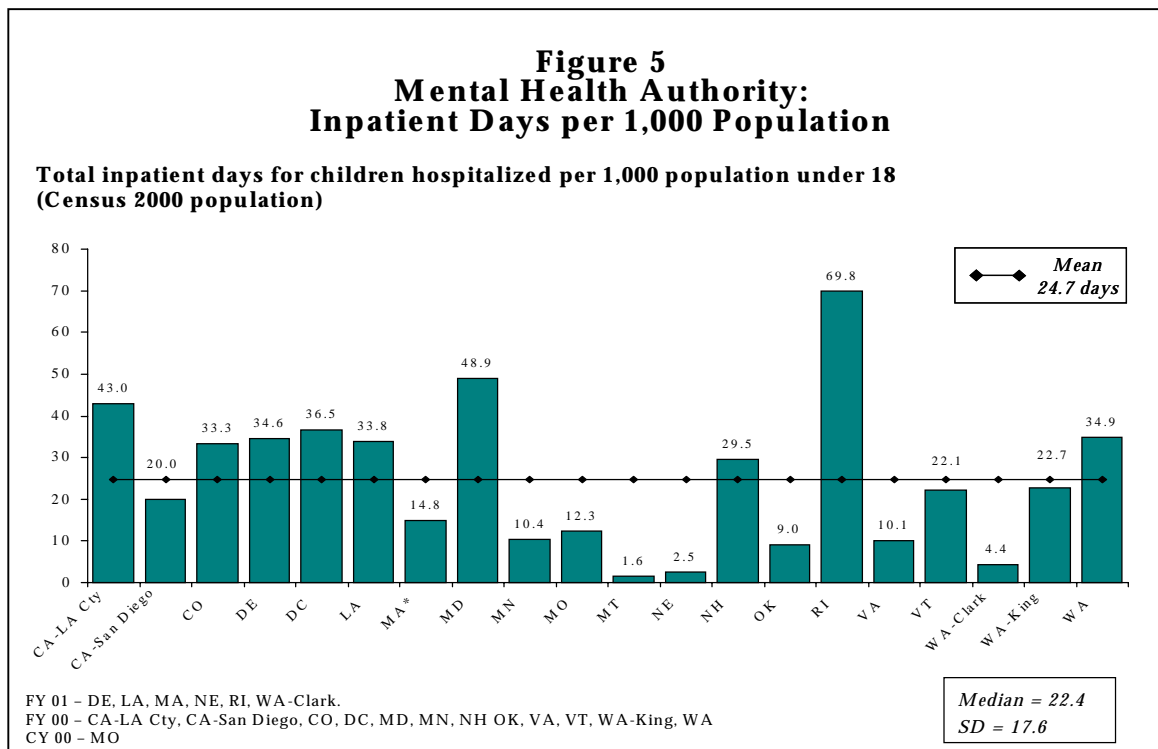
¹² Note that Figure 2 showed the number of children per thousand in the *general population* who received a Medicaid funded mental health service, and the median for all jurisdictions was 21.2 children *per thousand*.

INPATIENT CARE

The Surgeon General’s Report on Mental Health emphasizes that, “a great deal more research is needed on inpatient hospitalization, as it is by far the costliest and most restrictive form of care”¹³. Data on relative dependence on inpatient care can suggest important policy differences among jurisdictions. For example, one would expect rates of inpatient care to be relatively lower in jurisdictions that enroll most children in managed care programs and/or that have made significant efforts to develop community based wraparound services; one would expect relatively higher rates of inpatient usage in sites where there is little managed care penetration and where fewer resources and less effort have been devoted to developing community based systems of care.

Inpatient Days per 1,000 Population

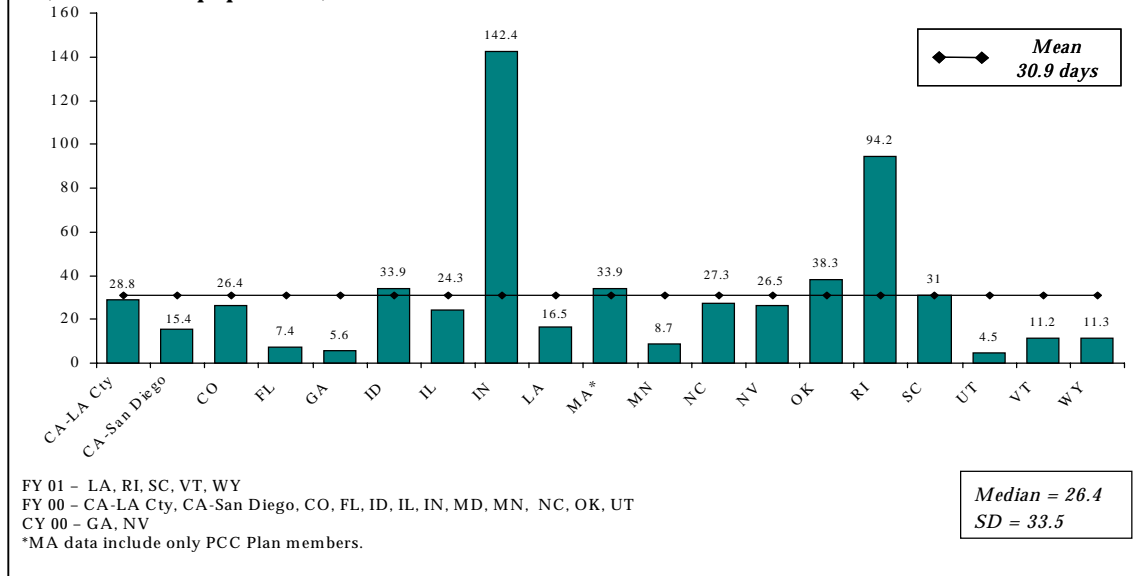
Figure 5 displays inpatient days per 1,000 population for 20 MHAs; the rates range from 1.6 in Montana to 69.8 in Rhode Island with a mean of 24.7 days. Figure 6 displays inpatient days per 1,000 population for 19 Medicaid agencies; those rates range from 4.5 in Utah to 142.4 in Indiana and have a mean of 30.9 days. Some of the variability may be attributed to the different types of inpatient psychiatric facilities included in the reported data. For example, some states’ data include only state hospitals, while others’ data include state hospitals, general hospitals with psychiatric units, and private psychiatric hospitals. (Appendix II lists the specific types of inpatient facilities reported.) It is also clear, however, that states have very different practice patterns with respect to the use of inpatient settings.



¹³ *Mental Health: A Report of the Surgeon General 1999*, U.S. Government Printing Office, Washington D.C., December 1999.

**Figure 6
Medicaid:
Inpatient Days per 1,000 Population**

**Total inpatient days for children hospitalized per 1,000 population under 18
(Census 2000 population)**



Average Length of Stay (ALOS)

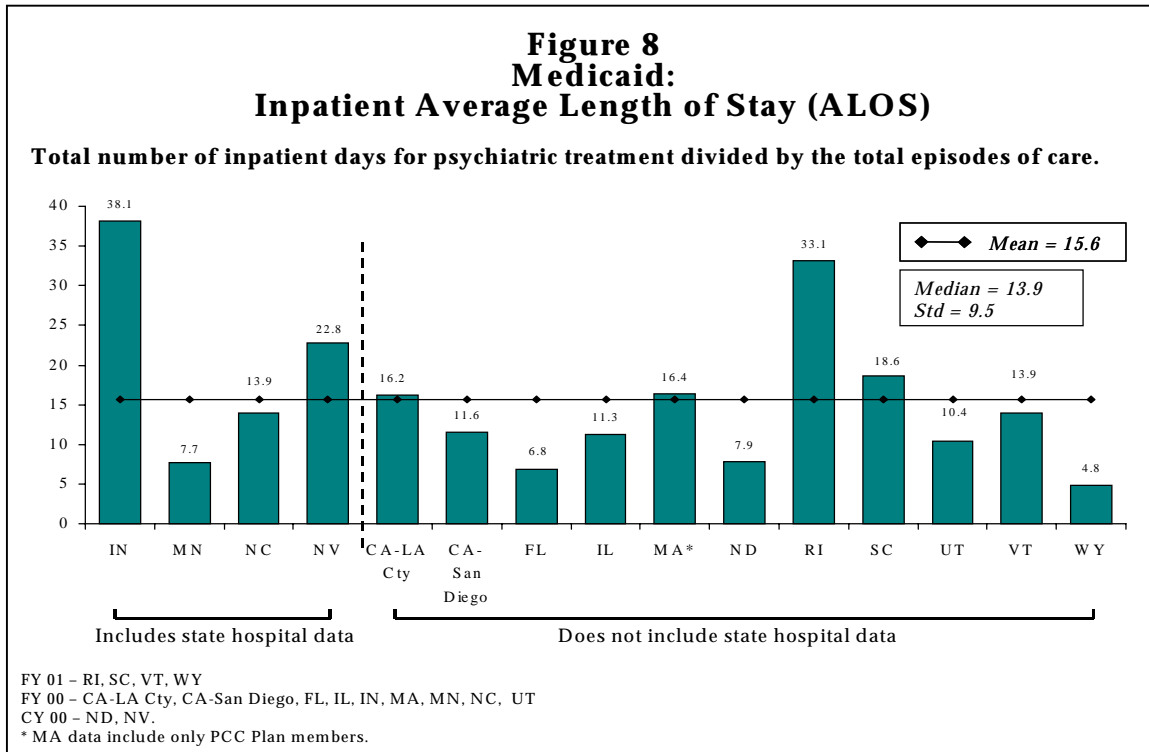
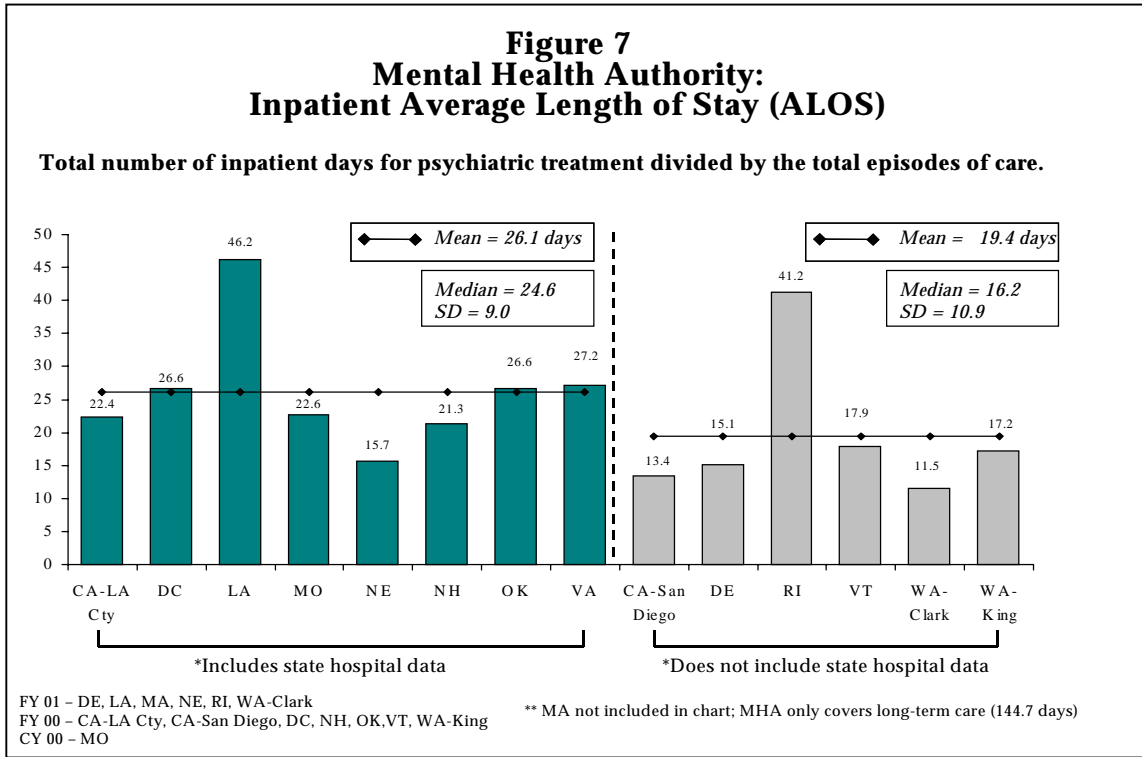
In Figure 7, MHA data on ALOS are separated into two groupings: one that includes state hospital data and another that does not. As expected, the mean for the former was higher than the mean for the latter. For the eight jurisdictions whose data include state hospitals, the average length of stay in an inpatient facility ranges from a low of 15.7 days in Nebraska to a high of 46.2 days in Louisiana, with a mean of 26.1 days and a standard deviation of 9. For the six jurisdictions whose data do not include state hospitals, the ALOS ranges from 11.5 days in Clark County, Washington, to 41.2 days in Rhode Island, with a mean of 19.4 and a standard deviation of 10.9 days.¹⁴

Although there is large variation between the jurisdictions with the lowest ALOS and those with the highest, most of the jurisdictions had explanations as to why their numbers fell where they did on the graph. For example, Louisiana, with a very high average, has indicated that its community-based system of care is relatively weak. The Rhode Island MHA’s high average length of stay may result in part from their inclusion in their data of children with developmental disabilities and children in the child welfare and juvenile justice systems.

Fifteen Medicaid agencies, as displayed in Figure 8, reported ALOS data ranging from a low of 4.8 days in Wyoming to a high of 38.1 days in Indiana, with a mean of 15.6 days and a standard deviation of 9.5. The more limited range and lower ALOS for Medicaid agencies probably reflects in part the fact that they may tend to be responsible for providing primarily or exclusively acute care to their enrollees; in contrast, many mental health authorities are

¹⁴ Because the MHA in Massachusetts covers only long term care, its ALOS (144.7 days) was so far outside the range of others’ numbers that the state has been omitted from the graph. The Massachusetts MHA serves a relatively small proportion of the population (compared to other states), and it is apparent that many of those it serves require extended stays in inpatient settings.

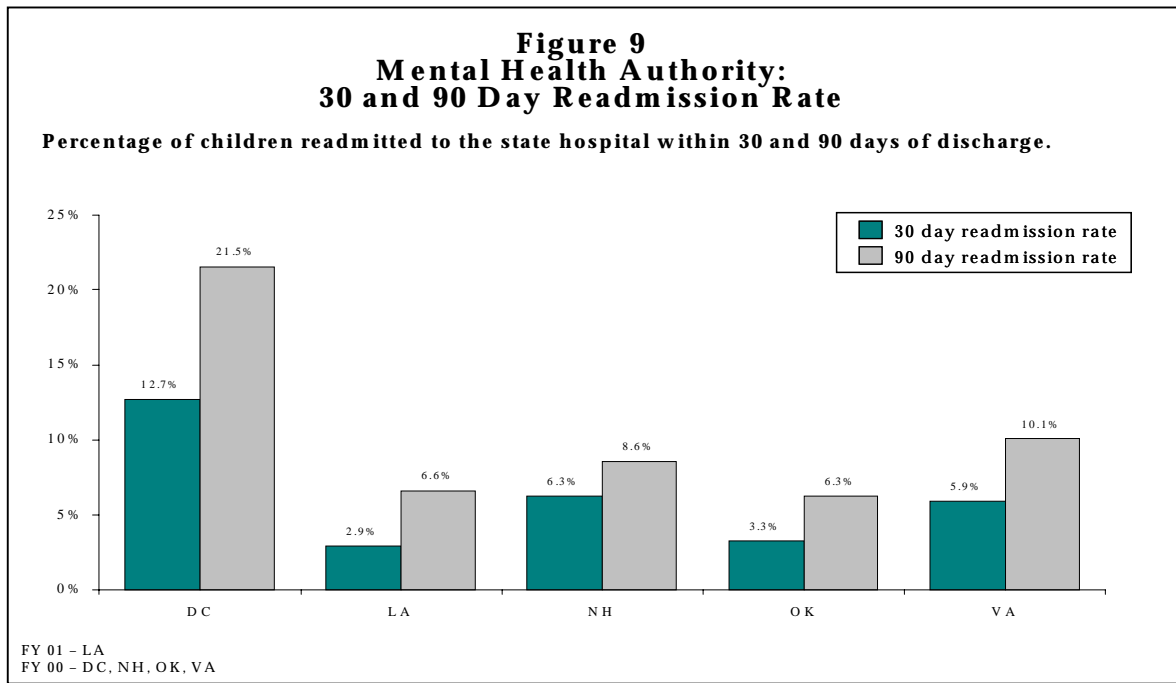
responsible for providing long term and chronic care. (Appendix II lists the specific types of inpatient facilities reported on by each jurisdiction.)



Readmission Rates: 30- and 90-Day

Readmission rate, the percentage of children readmitted to an inpatient facility within 30 or 90 days of discharge, is a measure frequently used to indicate the appropriateness of discharge and level of care decisions and, concomitantly, to suggest the availability or absence of community supports and community-based services. That is, consistently high readmission rates may indicate inappropriate discharge decisions (possibly due to reimbursement pressures) and/or the absence of appropriate community services.

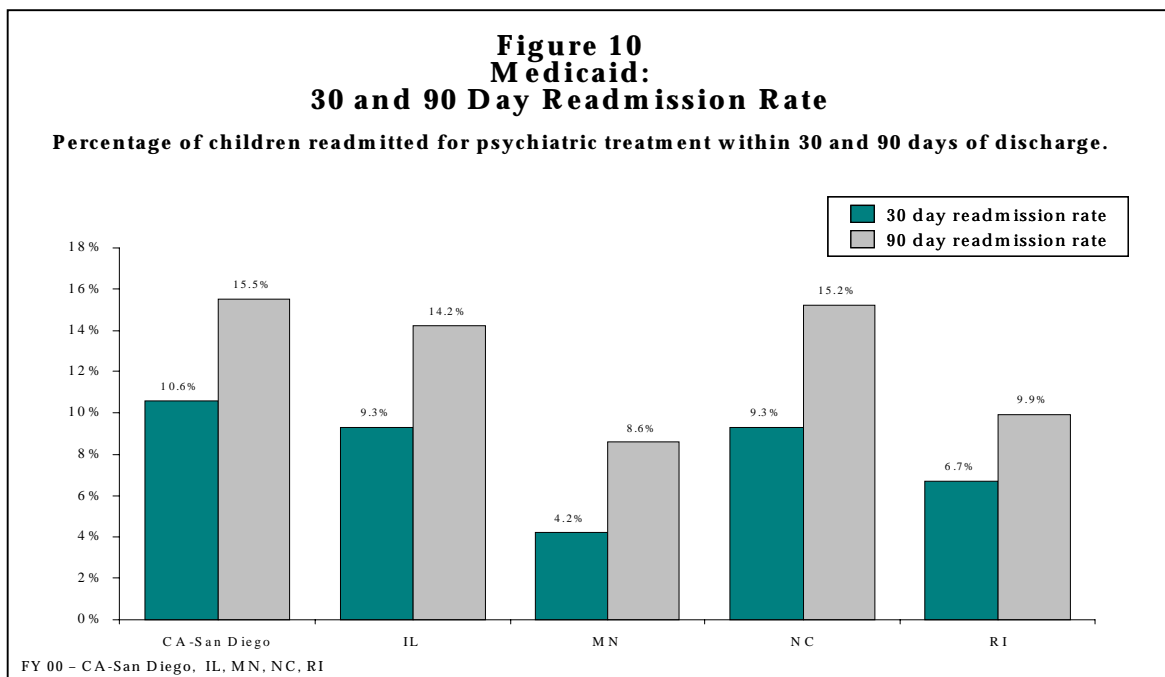
Figure 9 displays the 30- and 90-day state hospital readmission rates reported by MHAs. For the five sites reporting, the 30-day readmission rates ranged from 2.9% in Louisiana to 12.7% in the District of Columbia, with a mean of 6.2%. This is consistent with data from the Sixteen State Pilot Study on State Mental Health Agency Performance Measures, which reported an average 30-day state hospital readmission rate for individuals under 18 of 6%.¹⁵



The 90-day state hospital readmission rates ranged from 6.3% in Oklahoma to 21.5% in the District of Columbia. The mean for these five sites is 10.6%. The District of Columbia's high rates for both 30 and 90 day readmissions is probably explained at least in part by its system's acknowledged dearth of appropriate community services and placements for children.

Figure 10 displays the 30 and 90-day readmission rates for psychiatric hospitalizations paid for by Medicaid. The 30-day readmission rate ranged from 4.2% in Minnesota to 10.6% in San Diego County, California, with an average of 8.4%. The 90-day readmission rate ranged from 8.6% in Minnesota to 15.5% in San Diego County, California, with an average of 13.4%.

¹⁵Sixteen State Pilot Study, *State Mental Health Agency Performance Measures, Indicator Q11*, "Readmission to Any State Hospital Within 30/180 days" (www.mhsip.org).



Thus, for both MHAs and Medicaid agencies, the 90-day readmission rate tends to average about fifty percent higher than the 30-day rate. While it is likely that there is a significant relationship between average lengths of stay and readmission rates (that is, a jurisdiction with a relatively high ALOS would be more likely to have a relatively low readmission rate, and vice versa), there are not enough data points to enable calculation of such a correlation for this study.

EXPENDITURES

Since, as the Surgeon General’s Report on Mental Health notes, “state and local government has been the major payer for public mental health services historically and remains so today,”¹⁶ any discussion of public mental health data should include an analysis of public expenditures. As mentioned earlier, the vast majority of expenditures by each state’s mental health authority are funded by the state itself, with relatively small contributions from the Federal government through Block Grants or special programs. In contrast, Medicaid expenditures are shared between the state and Federal governments according to a standard formula that provides a match of 50 percent of eligible expenditures, or a more generous match to poorer states.

Although one might expect this to mean that the Federal government would establish one set of regulations covering provision of Medicaid-funded services, that situation holds only to a limited extent. States’ benefit packages must include a list of “mandatory” services, but are also free to cover many “optional” services (optional not to those individuals who need them, but to according to Medicaid law); many mental health services are included in the “optional” category, meaning that some states cover them but others do not. This situation is complicated further, however, by the existence of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under EPSDT children (under age 21) are required to receive regular screening for a

¹⁶ *Mental Health: A Report of the Surgeon General 1999, op. cit.*

wide variety of problems, and services to remediate those problems, thus minimizing the impact of the state's own Medicaid plan.

In addition, over the past decade, many states have applied for and received Medicaid waivers permitting them to develop managed care programs with widely varying rules about eligibility and benefits, and with significant differences in administration (for example, health maintenance organizations may be responsible for behavioral healthcare or not, there may be one statewide administrator or many county-based ones, and so on). Traditionally, both Medicaid and other insurance programs have paid only for inpatient and outpatient services, not for the entire potential continuum of care (e.g., day treatment, partial hospitalization, intensive outpatient services). The presence or absence of this service continuum in any locale, while likely determined by the availability of funding, in turn has an impact on the relative expenditures for inpatient and outpatient care. There is one common feature of the healthcare funding arena, however: while states may offer their own benefit packages, and have developed a wide variety of mechanisms for blending and coordinating funds from the different sources, as well as several different types of administrative systems, many if not most states make a conscious effort to shift expenditures to the Medicaid program whenever possible. The reader should bear these caveats in mind when reviewing the data on expenditures, below.

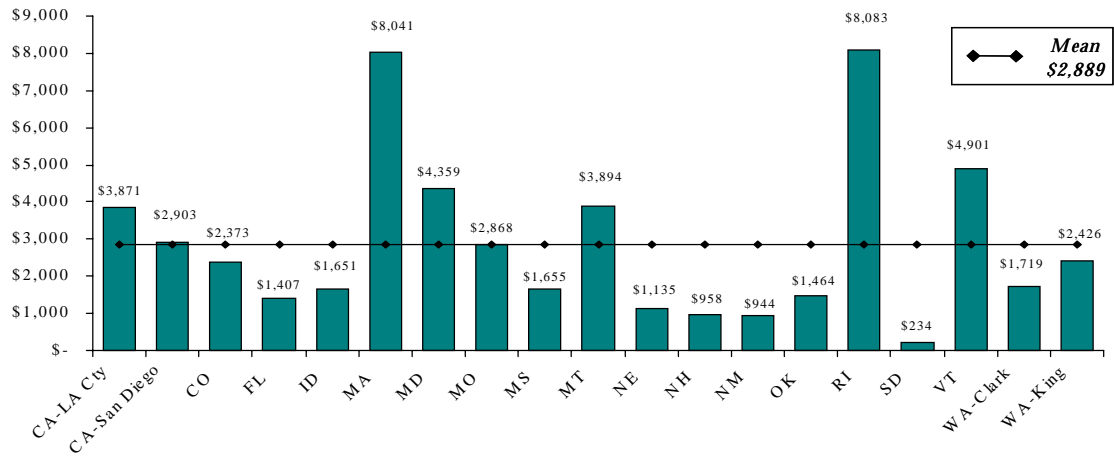
Expenditures per Child Served

The total amount of money spent on each child receiving service(s) obviously demonstrates the level of resources a system dedicates to children receiving treatment. As Figure 11 shows, the MHA expenditures per child served range greatly, from \$234 in South Dakota to \$8,083 in Rhode Island, with a median of \$2,373. Figure 12 displays the Medicaid agency mental health expenditures per child served, which range from \$444 in Vermont to \$8,013 in Rhode Island, with a median of \$2,468. Some differences among sites may be explained by varied financing structures and benefit packages and, especially in the case of MHAs, eligibility criteria. In addition, the various states include expenditures for different populations, and possibly different expenditures, in these data. For example some states, such as Rhode Island, include "all expenditures associated with the services provided, including room and board for residential treatment,"¹⁷ while many, if not most, other states exclude room and board expenditures from their data. Similarly, some states may be including data on services to children in foster care; because children in the foster care system tend to use mental health services at a relatively high rate, this difference may be important. Also, Massachusetts MHA serves only children with "high end," i.e., costly, needs. The third year of data collection will include an effort to learn more precisely what expenditures respondents are including in their data.

¹⁷ Personal communication from C. Lee Baker, of the Rhode Island Department of Children, Youth and Families.

Figure 11 Mental Health Authority: Expenditures per Child Served

Total mental health authority service expenditures divided by the number of children receiving a mental health service

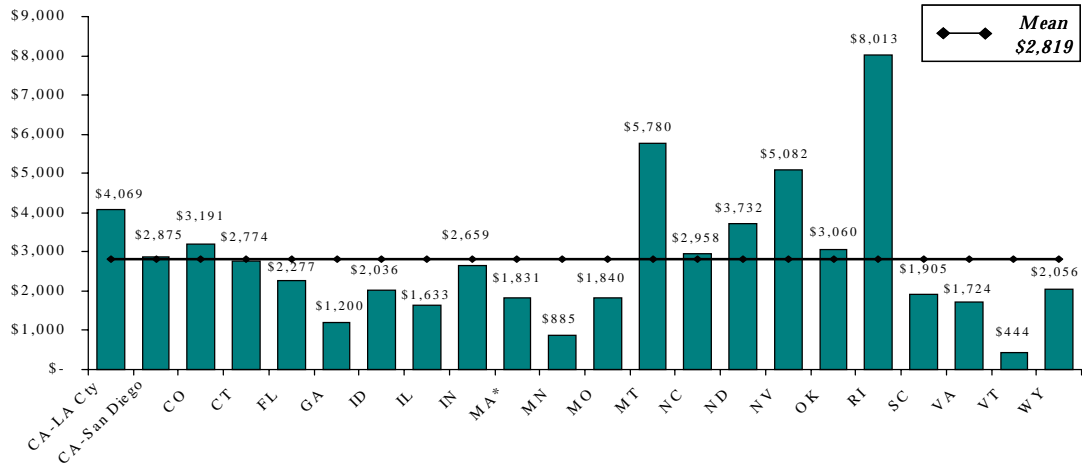


** DE not included in chart; MHA data includes all Medicaid funding and does not separate non-Medicaid (\$15,202 per child served).
FY 01 – DE, FL, MA, NE, NM, RI, SD, WA-Clark
FY 00 – CA-LA Cty, CA-San Diego, CO, ID, MD, MS, MT, NH, OK, VT, WA-King
CY 00 – MO

Mean = \$2,889
Median = \$2,373
SD = \$2,217

Figure 12 Medicaid: Expenditures per Child Served

Total Medicaid dollars paid for all mental health services divided by the number of children receiving a mental health service paid for by Medicaid



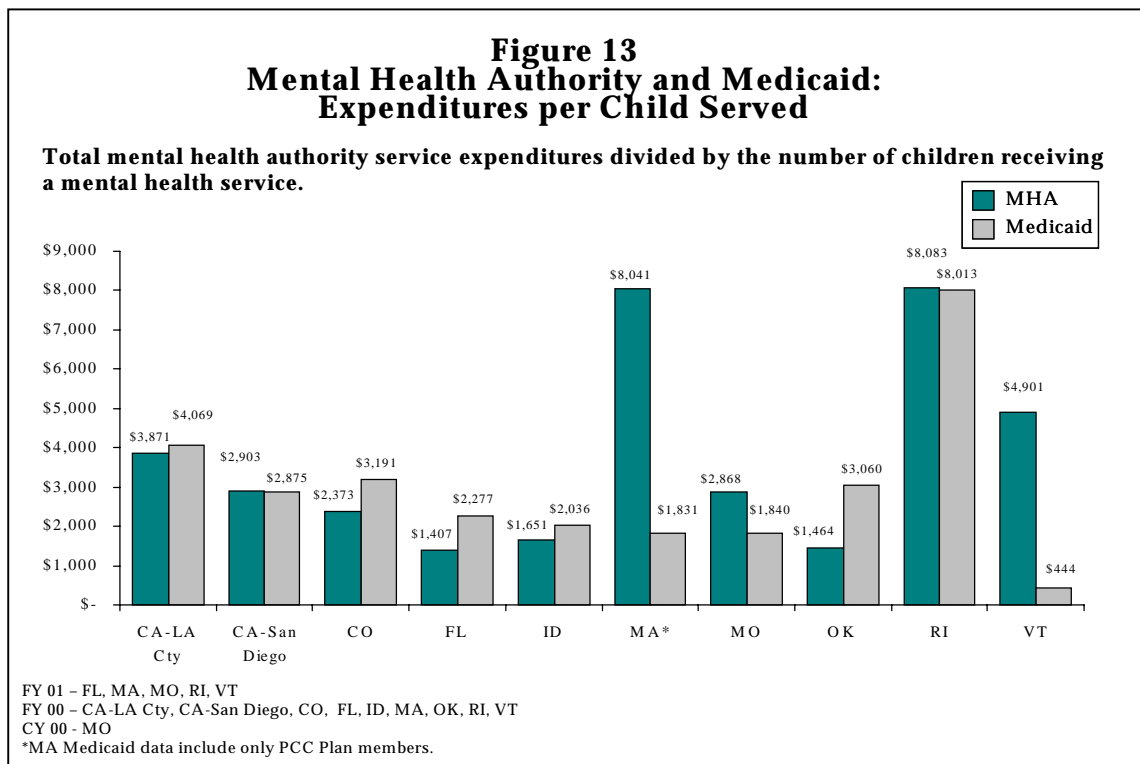
FY 01 – MO, RI, SC, VT, WY
FY 00 – CA-LA Cty, CA-San Diego, CO, FL, ID, IL, IN, MA, MN, MT, NC, OK, VA
CY 00 – GA, ND, NV
FY 99 – CT
*MA data include only PCC Plan members.

Mean = \$2,819
Median = \$2,468
SD = \$1,723

As discussed above, children enrolled in Medicaid receive both high and low intensity mental health services. In other words, Medicaid agencies fund services to children needing only one or two outpatient sessions as well as children requiring numerous high intensity services. In

contrast, MHAs generally serve only children who have serious needs and in many states only those who have a serious emotional disturbance.

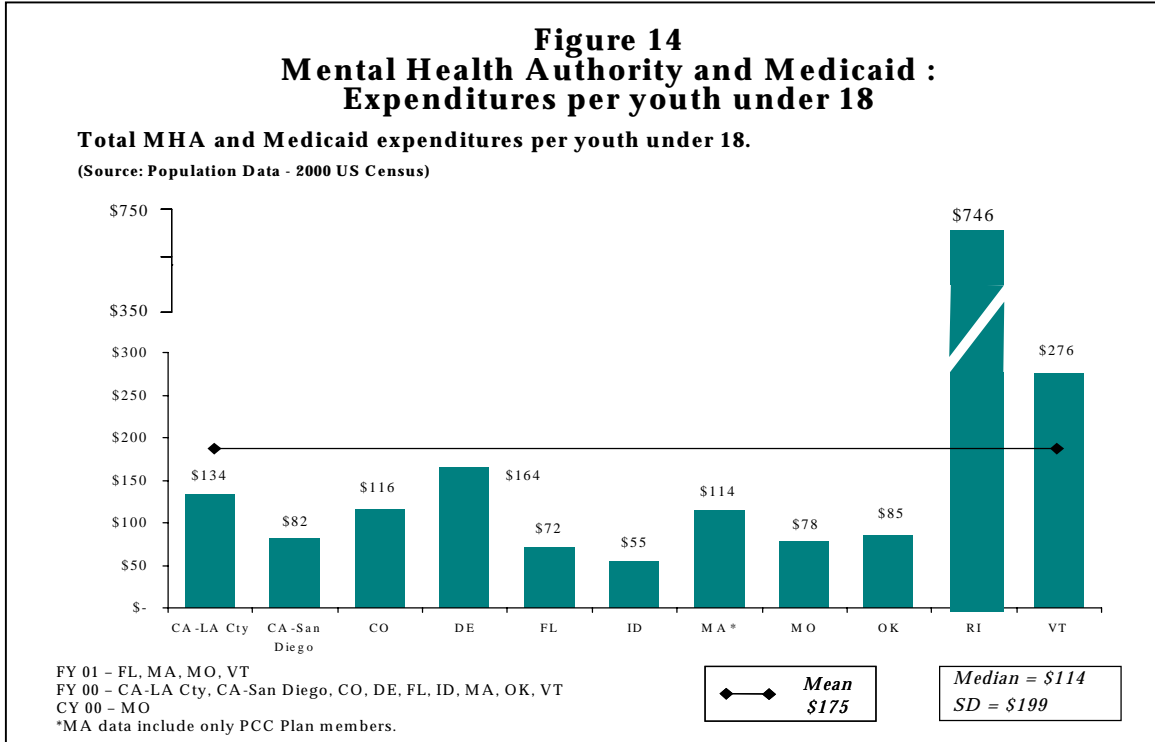
Figure 13 presents expenditures for the two agencies side by side for those jurisdictions that provided the relevant Medicaid and MHA data (two counties and eight states). While in most jurisdictions expenditures are comparable for the two agencies, Massachusetts, Oklahoma and Vermont stand out as exceptions. The Massachusetts MHA, as noted, serves only a relatively small number of very high need children (demonstrated by its well below average number of children served per thousand), thus accounting for their extremely high expenditure per child. Likewise, Oklahoma's Medicaid agency provides most of the state's public mental health services for children. In Vermont, since the MHA controls some Medicaid funds, a true picture of the expenditures per child requires inclusion of both agencies' expenditures. Rhode Island, as noted above, is including room and board expenditures in MHA data, which probably differentiates it from most other states.



Expenditures per General Population

For each jurisdiction from which both agencies submitted data, Figure 14 presents combined expenditures by the MHA and the Medicaid agency per child under 18 living in the jurisdiction. These numbers range from \$55 in Idaho to \$276 in Vermont and to \$746 in Rhode Island, with a median of \$114 and a mean of \$175. The standard deviation is 199. At \$746 per child under 18, Rhode Island's expenditures are far above those of any other state. As noted above, its number is especially high because the state includes in its expenditures for residential treatment many costs that other states exclude. Vermont's expenditures are also unusually high, because of the structure of the state's service system: it has an integrated system of care in which resources are shared across agencies. In addition, in many areas of this largely rural and socio-economically

integrated state, the public provider is the only option available. Thus, for example, when a Medicaid-eligible child in the child welfare system needs mental health services, the child is served by the public mental health system and the child welfare agency contributes the Medicaid match, which appears as an expenditure of the MHA.



Outpatient Expenditures per Child Receiving Outpatient Services

Figures 15 and 16 present, for MHAs and Medicaid agencies respectively, the average expenditure on outpatient services for each child who received those services. The total outpatient service expenditures include services provided in office, clinic, school, home, and other community settings. The MHA expenditures range from \$314 in Nebraska to \$3,077 in Los Angeles County, California, with a median of \$1,363, and the Medicaid expenditures range from \$221 in Vermont to \$2,520 in North Dakota, with a median of \$1,058. The higher median for the mental health authorities may reflect the fact that MHAs typically serve proportionally more children who require intensive services than do Medicaid agencies. In the category of outpatient services it is especially critical to note the importance of schools in the provision of care, and the exclusion of data on school-supported services from what was submitted for this project. Some local education agencies provide a full continuum of outpatient services, but none of those services would necessarily be included in reports from the MHA or the Medicaid agency.

Figure 15
Mental Health Authority:
Outpatient Expenditures per Child Receiving Outpatient Services

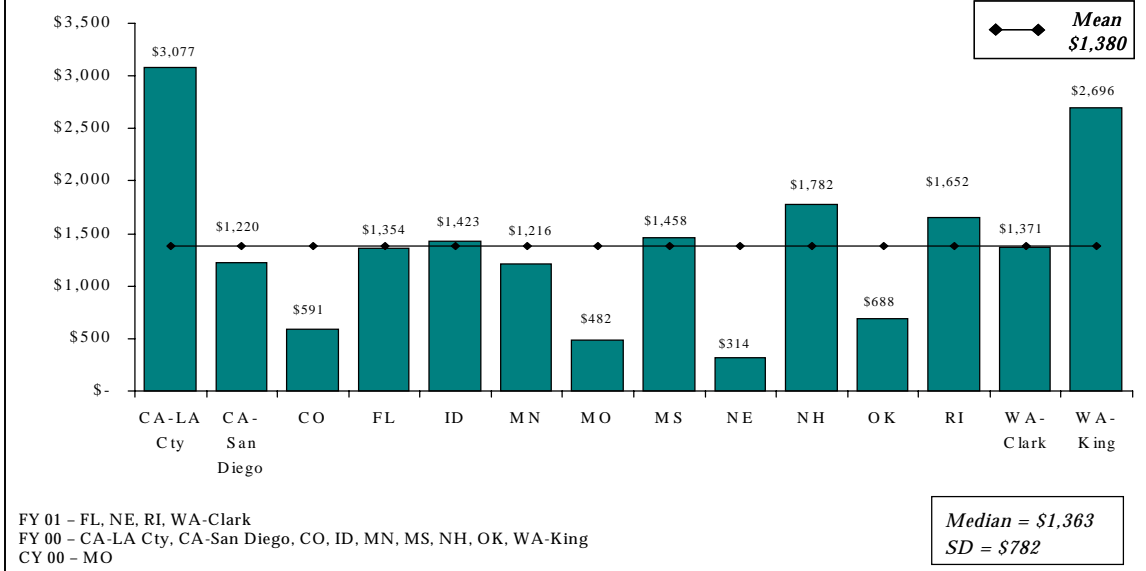
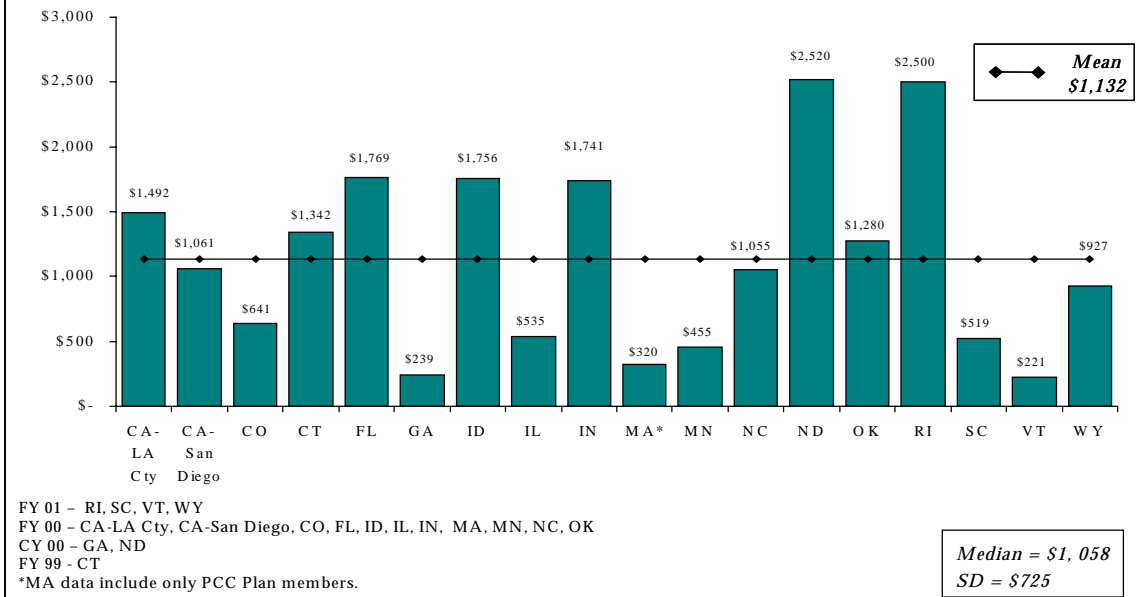


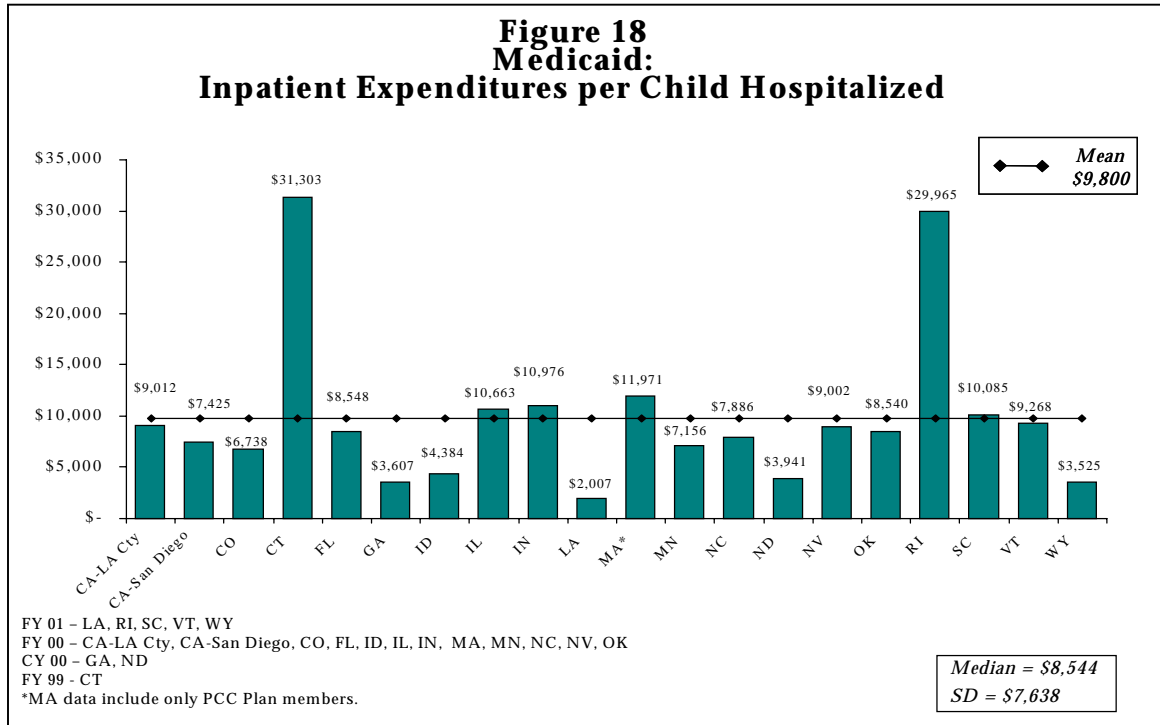
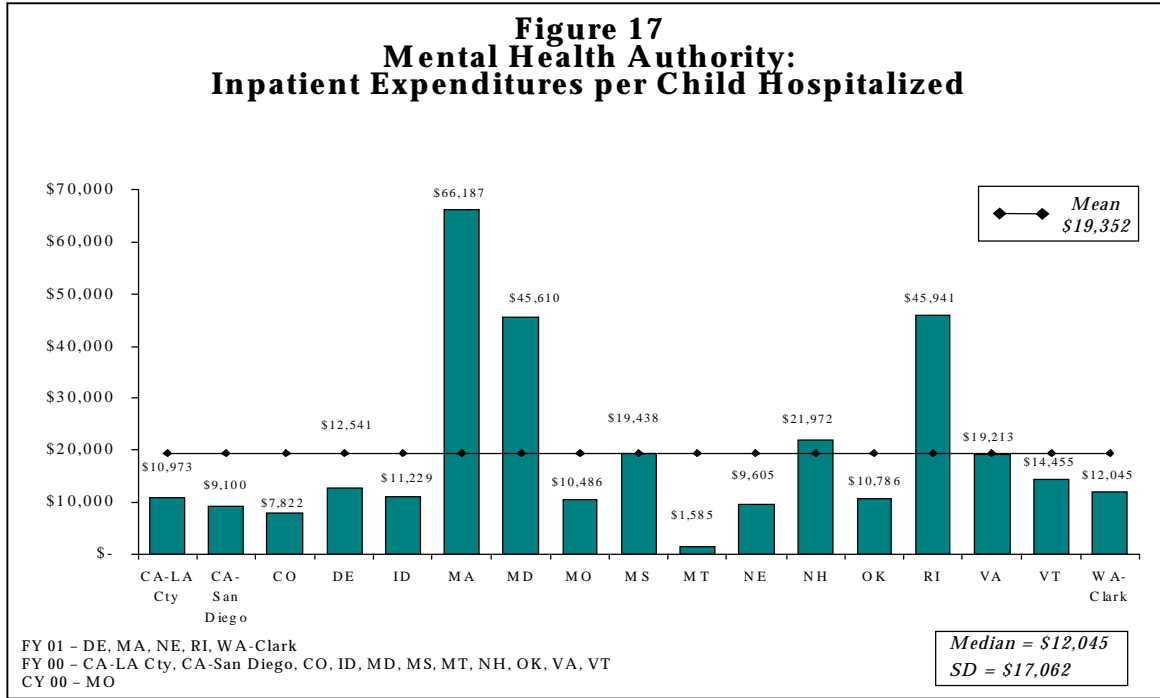
Figure 16
Medicaid:
Outpatient Expenditures per Child Receiving Outpatient Services



Inpatient Expenditures per Child Hospitalized

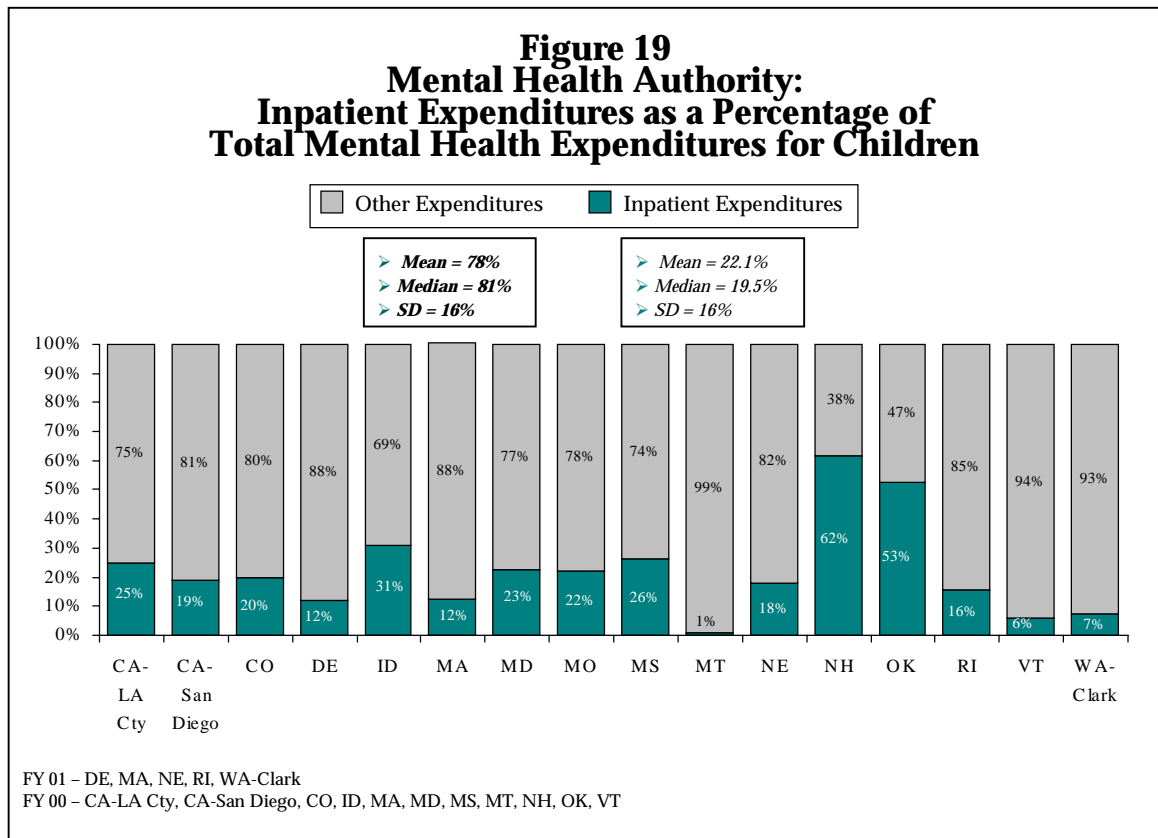
Figures 17 and 18 show the expenditures for inpatient psychiatric care per child hospitalized for MHAs and Medicaid agencies respectively. (Note that these numbers reflect not dollars spent per hospitalization, but dollars spent per child; if the same child is hospitalized three times during the year, the costs of all those inpatient stays will be totaled for this indicator.) These

charts display the enormous variation in expenditures per child served: the MHA numbers range from \$1,585 in Montana to \$66,187 in Massachusetts, with a median of \$12,045, and the Medicaid numbers range from \$2,007 in Louisiana to \$31,303 in Connecticut, with a median of \$8,544. While some variability may be attributable to the different types of inpatient facilities included in the data, to the uneven use of Medicaid funding to support inpatient services and to the use in some jurisdictions of managed care to control costs, the range exhibited in the data, particularly for the few outliers, is much greater than expected. (Refer to Appendix II for a listing of the specific types of inpatient facilities reported in each site's data.)

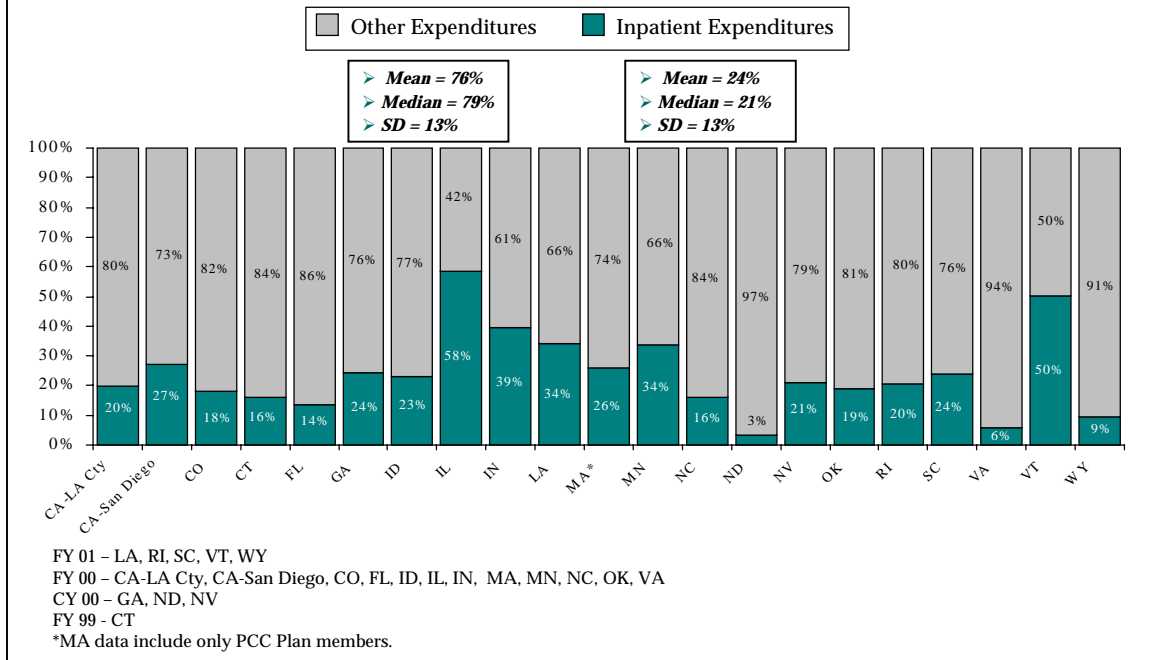


Inpatient Expenditures as a Percentage of Total Mental Health Expenditures

The proportion of all mental health expenditures for children represented by inpatient expenditures is shown, in Figures 19 and 20, for MHAs and Medicaid agencies respectively. For MHAs, the proportion of inpatient expenditures ranges from 1% in Montana to 62% in New Hampshire. These 16 MHAs devote an average of 22% of their mental health dollars to inpatient care. For 21 Medicaid agencies, the proportion of expenditures devoted to inpatient care ranges from 3% in North Dakota to 58% in Illinois, with an average of 24%. We can assume that proportions that vary significantly between the agencies of one state reflect issues of benefit or system structure. For example, Oklahoma's MHA spends 53% of its resources on inpatient care, while its Medicaid agency spends only 19% on inpatient services. And Montana, which uses residential treatment facilities for children, probably substitutes use of these for inpatient hospital services.



**Figure 20
Medicaid:
Inpatient Expenditures as a Percentage of
Total Mental Health Expenditures for Children**



OTHER SERVICE MODALITIES

Data were gathered on additional levels of care, including day treatment/partial hospitalization, case management and emergency services. Table 1 below displays the expenditures for each of these community-based services as a percentage of total mental health expenditures for children, and includes the range, sample size and median for each service type. Because of the very significant variation among jurisdictions, the table displays medians rather than means. Jurisdictions display so much variation in part because they categorize and define services differently.

Although jurisdictions also reported numbers of children served and units of service provided for each level of care, those data were not sufficiently comparable for analysis at this time. For example, in reporting on the number of outpatient services provided, respondents used many different units of measurement, limiting comparability of the data.

For year three, the request for community-based service data will be modified to enhance comparability. Ultimately, these data should be of considerable value to states and counties, because they will enable systems to describe themselves based on the proportion of expenditures they allocate to the different levels and types of community-based care.

Table 1
Community-Based Service Expenditures as a
Percentage of Total Expenditures

Service Type	Agency	Sample Size	Lowest %	Highest %	Median
Outpatient (office, clinic, school, home, and other)	MHA	N=15	.6%	88.1%	26.9%
	Medicaid	N=18	11.1%	77.1%	39.8%
Day Treatment and Partial Hospitalization	MHA	N=12	.4%	20.8%	7.2%
	Medicaid	N=15	.6%	21.0%	7.4%
Case Management	MHA	N=11	.9%	68.5%	14.4%
	Medicaid	N=14	.1%	33.4%	8.3%
Emergency	MHA	N=10	.1%	13.6%	2.2%
	Medicaid	N= 7	.1%	4.3%	1.0%
Other Services ¹⁸	MHA	N=11	1.7%	38.6%	7.9%
	Medicaid	N= 6	1.4%	13.6%	6.1%

DEMOGRAPHICS: RACE/ETHNICITY, AGE AND GENDER

Race/Ethnicity

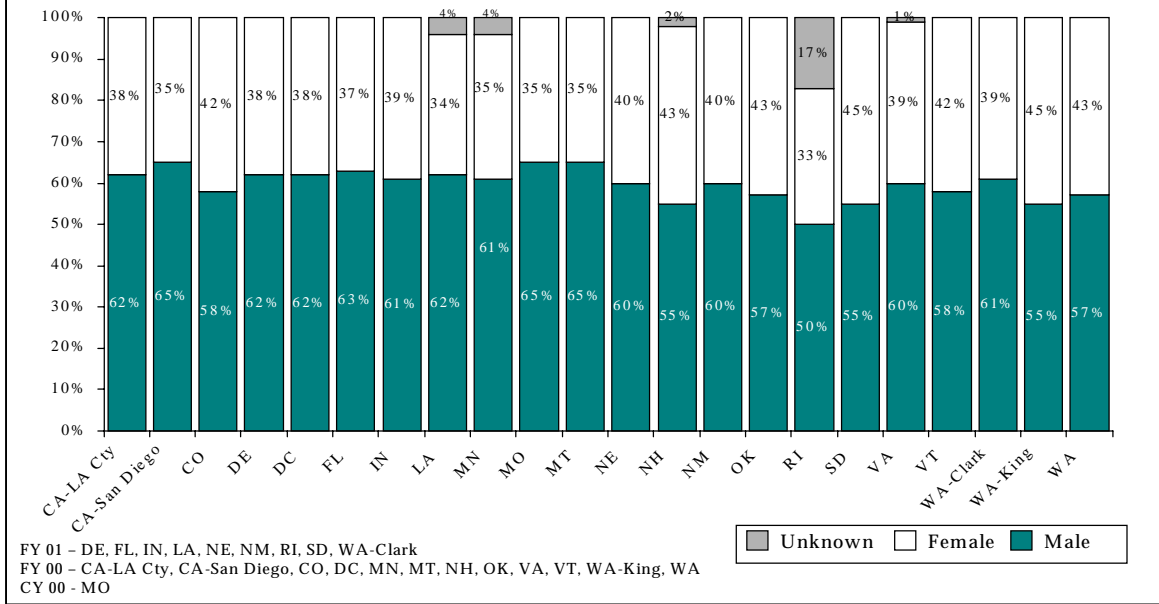
The second year Data Collection Instrument asked states and counties to report the racial and ethnic composition of their service recipients within the categories they themselves typically use. By asking the question this way, we not only maximized the ability of jurisdictions to report (20 MHAs and 16 Medicaid agencies did so), but simultaneously increased the difficulty involved in analyzing the data, because jurisdictions did not report the same categories. For the third year, we will request the categories that are used in the Center for Mental Health Services Uniform Reporting System, which are consistent with those used by the U.S. Census Bureau.

Gender

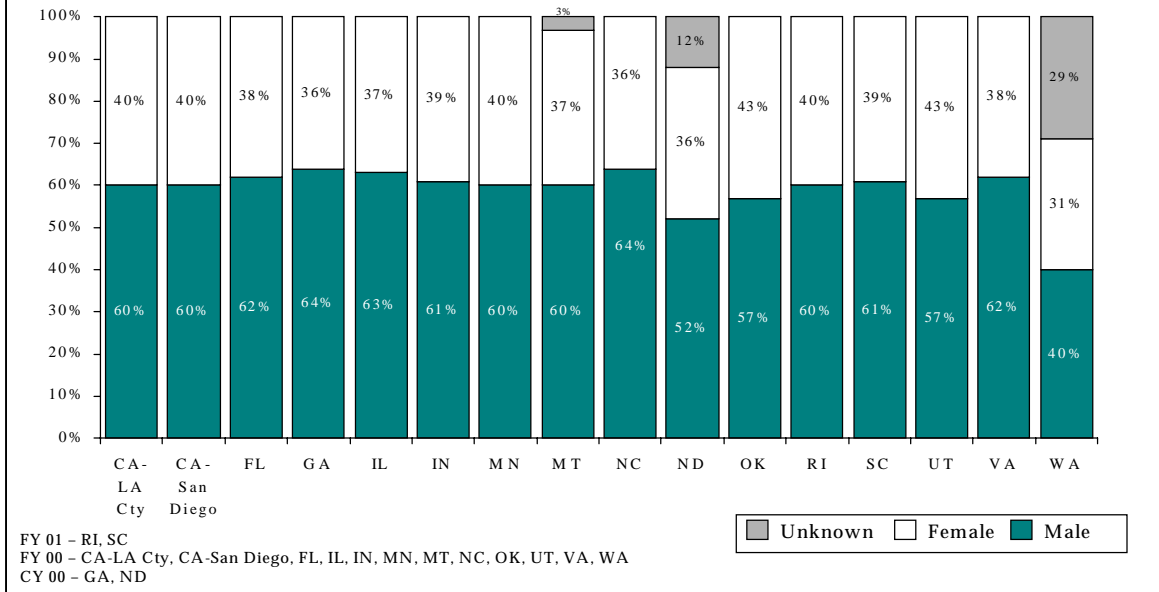
In all systems reporting complete data on gender, half or more of the youth receiving services are male. In fact, males represent 60% or more of the children receiving public mental health services from the Medicaid agency or mental health authority in the majority of systems represented in Figures 21 and 22.

¹⁸ Examples of 'other services' reported include respite care, vocational services, crisis support, mobile treatment, outreach, and evaluation/assessment.

**Figure 21
Mental Health Authority:
Gender of Youth Receiving Services**



**Figure 22
Medicaid:
Gender of Youth Receiving Services**

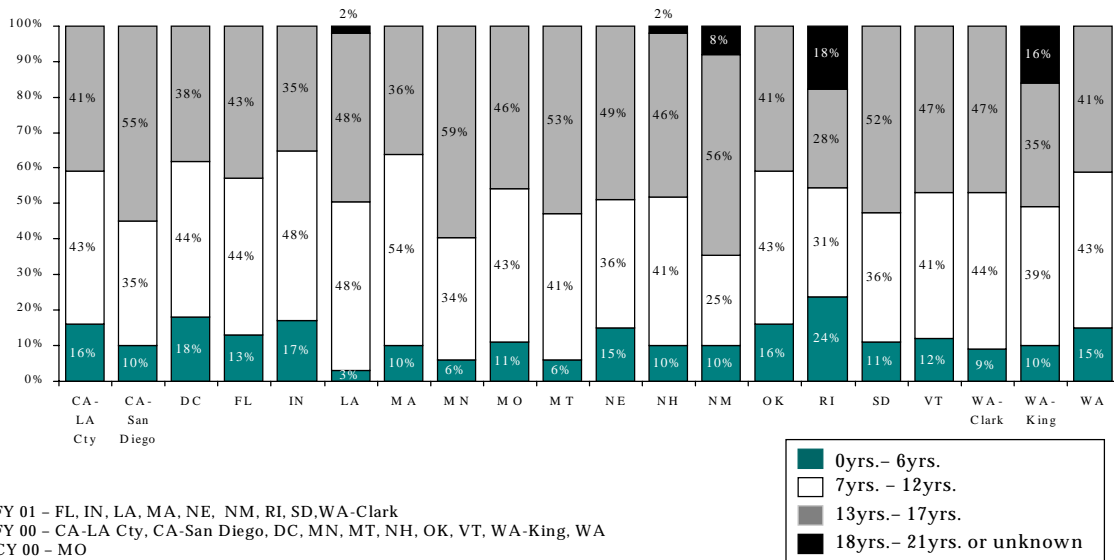


Age

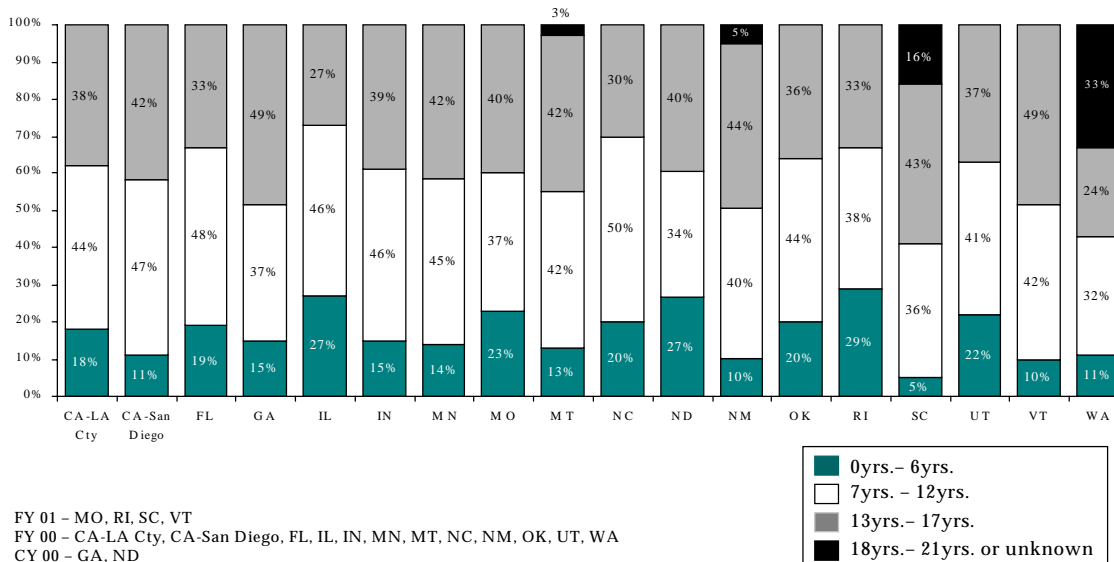
Figures 23 and 24 display the age ranges of children who received a mental health service. From the data reported, it appears that MHAs serve a higher proportion of youth age 13 to 17 than do Medicaid agencies. Conversely, Medicaid agencies serve a higher proportion of children age 0 to

age 6. The proportion of children who are 0-6 years old ranges from 3% to 24% for MHAs and from 5% to 29% for Medicaid agencies. The proportion of children who are 7-12 years old ranges from 25% to 54% for MHAs and from 32% to 50% for Medicaid agencies. The proportion of children who are 13-17 years old ranges from 28% to 56% for MHAs and from 24% to 49% for Medicaid agencies.

**Figure 23
Mental Health Authority:
Age Ranges of Youth Receiving Services**



**Figure 24
Medicaid:
Age Ranges of Youth Receiving Services**



INTERSYSTEM MEASURES

There is widespread agreement among experts in the field that children and adolescents with serious emotional disturbances and their families need a broad range of services from many sources, such as schools, community mental health centers, and social service organizations.¹⁹

As Pandiani, Banks and Schacht have suggested, “The vision of an integrated, coordinated ‘system of care’ has for years been central to discussions of meeting the needs of children and adolescents with severe emotional disturbances Interagency collaboration – the process of communication and coordination among child-serving organizations – is one of the core elements of the system of care philosophy.”²⁰ The measurement challenge is one of merging data from disparate systems. Pandiani *et al.* note that there are a variety of ways to measure what they call the “integration” of a service system, that is, the amount of overlap among the caseloads of child serving agencies. Among them are approaches focused on staff interaction, resources and services. Pandiani uses a “child-focused approach.” With a database that merges information from multiple sources, and employing the technique of probabilistic population estimation, he and his colleagues analyzed the variance in caseload segregation/integration among the mental health, child protection and special education sectors for Vermont’s ten community mental health service areas. They found that there was substantial variation among regions in the amount of caseload segregation/integration, as well as substantial consistency in the variable within regions over time. Caseload integration was strongly and positively related to the amount of money spent and the number of children served in the community mental health service sector. Caseload integration was negatively related to the number of children on the caseloads of the regional offices of the state’s child protection agency.

Most state agencies do not currently have the databases or the analytic capacity that Vermont has. The Children’s Mental Health Benchmarking Project has taken a small step toward understanding the relative levels of coordination among state agencies by asking how many children who are served by the MHA have also received services from other public agencies. This approach, which differs from those cited by Pandiani *et al.*, is recommended by the Mental Health Statistics Improvement Project, the Center for Mental Health Services Five State Feasibility Study and others. It is intuitively straightforward, and many states are able to provide relevant data. Knowing how their systems compare to others on these dimensions may also encourage state agencies to work together to improve their systems of care and to perform other, more intensive, types of analysis.

In the first year of the project, states and counties submitted very limited data on intersystem indicators. Therefore, in the second year we asked several new intersystem questions, in the hope that jurisdictions might submit more and better data; those hopes were largely realized. A total of 14 MHAs provided data on some or all of the intersystem variables this year. (Note: the data reported below reflect only information received from mental health authorities; while five Medicaid agencies provided such data, what they submitted was minimal.)

Substance Abuse Services

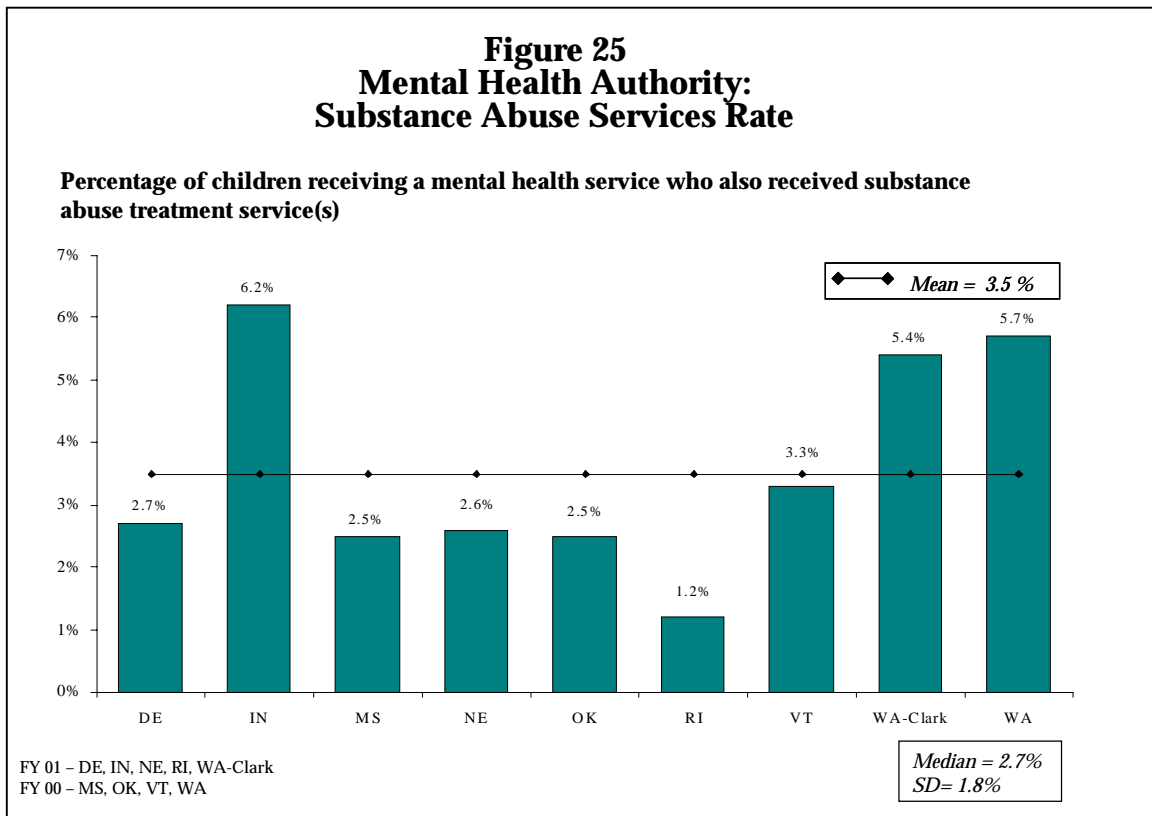
There is widespread consensus in the field that outcomes are dramatically improved if mental health and substance abuse problems are treated simultaneously rather than in isolation from one

¹⁹ See, for example, *Systems of Care*. The Center for Mental Health Services, Knowledge Exchange Network, December 1998, (www.mentalhealth.org/publications).

²⁰ John A. Pandiani, S.M. Banks and L.M. Schacht, “Caseload Segregation/Integration: A Measure of Shared Responsibility for Children and Adolescents,” *Journal of Emotional and Behavioral Disorders*, Summer 1999, Vol. 7, No. 2, pp. 66-71.

another. According to a report by the National Alliance for the Mentally Ill (NAMI), “The prevailing research confirms that integrated treatment for co-occurring [mental health and substance abuse] disorders is much more effective than treating these illnesses separately.”²¹ Therefore the year two Data Collection Instrument included a question about the number of children who had received any mental health service and also received any substance abuse treatment service during the year.

Ten jurisdictions submitted data on this indicator. The substance abuse treatment rates displayed in Figure 25 range from 1.2% in Rhode Island to 6.2% in Indiana, with a mean of 3.5% and a standard deviation of 1.8. These extremely low rates lead to the question of whether indeed extremely small numbers of children who receive mental health care are also receiving substance abuse services or whether there is another, more sensitive, measure that might be used. Perhaps, for example, age-specific data should be requested, because very few pre-adolescents are likely to receive substance abuse services. Another possibility is that in many jurisdictions young people who require substance abuse services receive them not through the publicly funded substance abuse system (presumably the system with which MHAs are comparing records) but under the auspices of other state or local agencies.



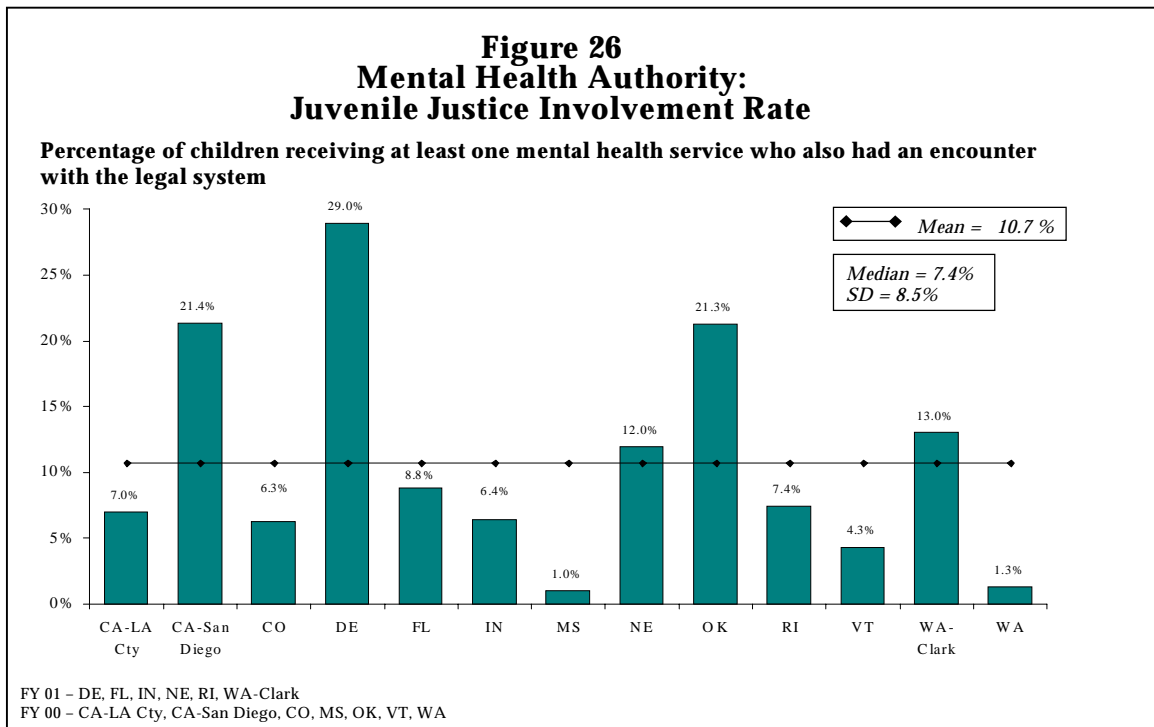
Juvenile Justice System Involvement

More MHAs provided data on juvenile justice system involvement than on any of the other intersystem indicators. This may reflect the strong relationship that exists between mental health and juvenile delinquency. For example, Ro and Shum note that, “in a 1994 study conducted by the Office of Juvenile Justice and Delinquency Prevention, 73% of juveniles reported having

²¹ NAMI Where We Stand Papers for 2001, “Integrated Treatment and Blended Funding for Co-Occurring Mental and Addictive Disorders,” National Alliance for the Mentally Ill (NAMI) (www.nami.org/update/unitedintegrate.html).

mental health problems and 57% reported having prior mental health treatment or hospitalization upon admission to juvenile facilities.” They suggest that this relationship illustrates the need for “better preventive interventions and the coordination of care between education, mental health and juvenile justice systems.”²²

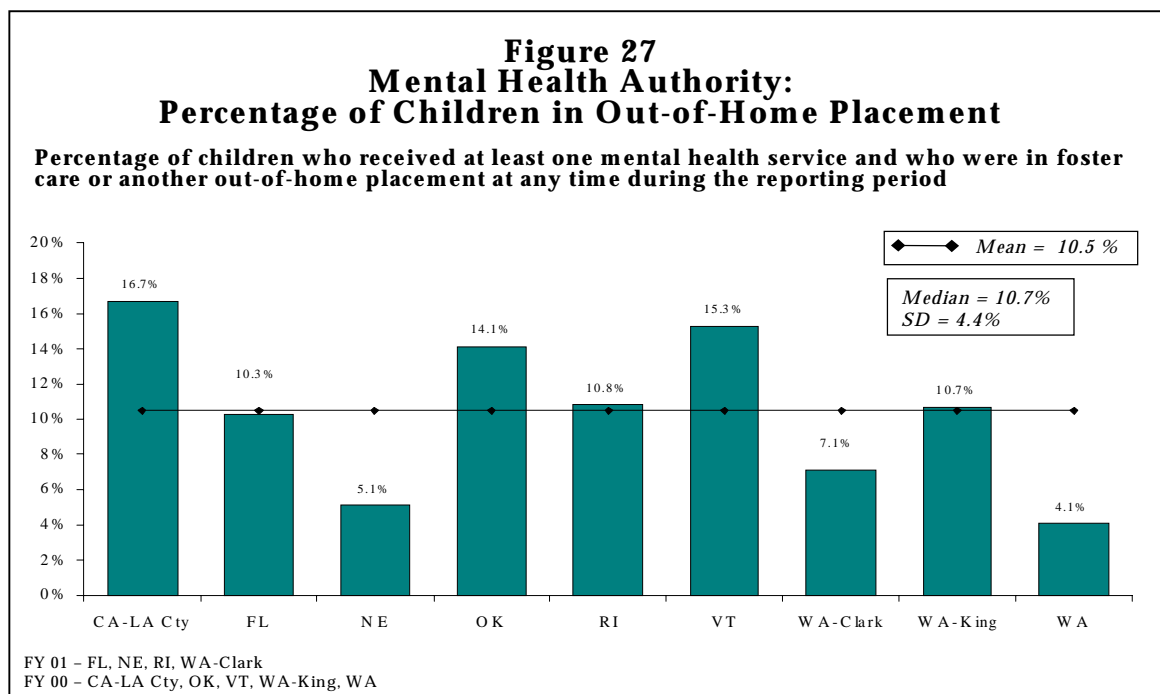
In the project’s first year, only four jurisdictions responded to the question on the percentage of children receiving any mental health service who also had an encounter with the juvenile justice system; they indicated rates ranging from 6.1% to 17.6%. This year the question was once again worded so as to elicit as much information as possible and thirteen MHAs reported data. The Data Collection Instrument asked for the “Number of children who received any mental health service and also had at least one encounter with the juvenile justice system at any time during the year.” Since the instrument also asked what types of juvenile justice system encounters were included in the numbers provided, respondents clarified that the kinds of juvenile justice encounters reported in the data did differ from site to site. The sites reported a combination of incarcerations, probation, parole, arrests, charges, convictions, and other court involvement. (Refer to Appendix II for a listing of the specific encounters each site reported.). The rates displayed in Figure 26 range from a low of 1% in Mississippi to a high of 29% in Delaware, with a mean of 10.7% and a standard deviation of 8.5%. Once again, Delaware’s high rate may reflect the structure of its system, in which a consolidated department serves as an organized gateway to care. For subsequent years of data collection, this indicator will be standardized. Data will be requested either separately by type of encounter or for only one specific type of encounter, such as incarceration.



²² Ro, M. and Shum, L., *Forgotten Policy: An Examination of Mental Health in the U.S.* Prepared for the W.K. Kellogg Foundation by Community Voices, May 2001, p.16.

Out-of-Home Placement

According to Ro and Shum, “Compared with other children, those in foster care suffer from higher rates of serious emotional and behavioral problems, developmental delays, and overall poor mental health”.²³ An MHA’s knowledge of the proportion of children served who resided outside their homes at some time during the year may be important to the integration of services in the system. Figure 27 displays the proportion of children who were in foster care or other out-of-home placements (under the purview of the child welfare agency), at any time during the year, among MHA service recipients in nine sites. The rates range from 4.1% in Washington State to 16.7% in Los Angeles County, California, with a mean of 10.5% and a standard deviation of 4.4%. That is, an average of 10.5% of children receiving any Mental Health Authority service were placed outside their homes at some point during the year. It would be of particular value to know the proportion of children in out-of-home child welfare placements who are receiving mental health services, but MHAs are unlikely to have that information.

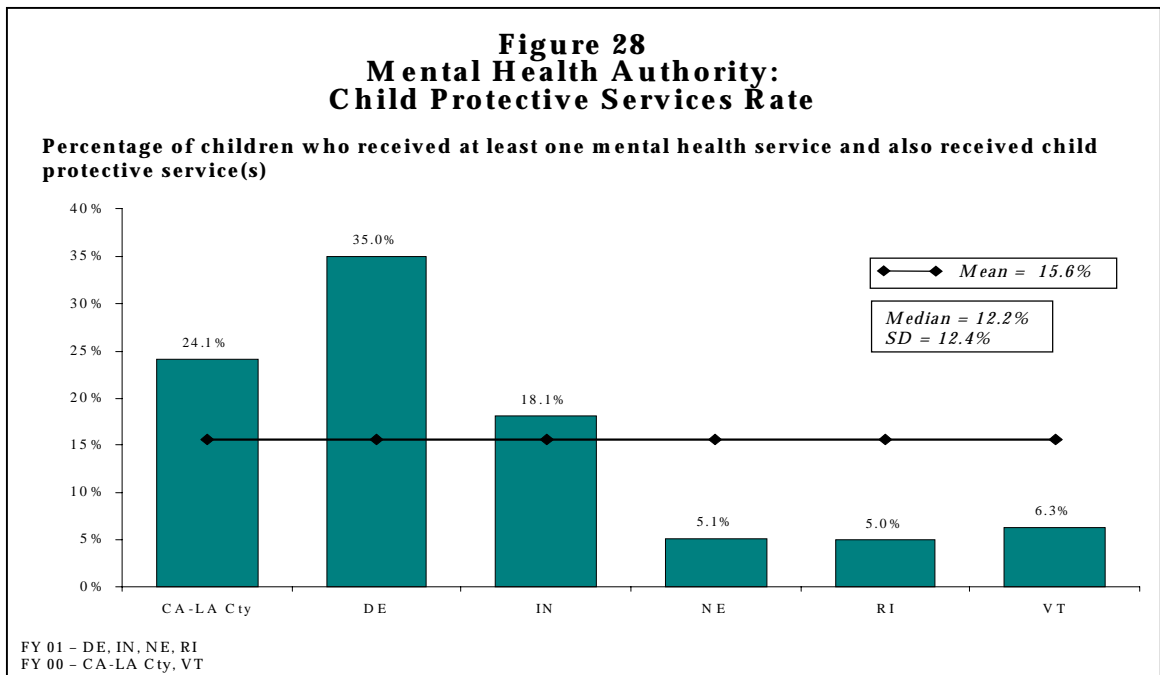


Child Protective Services

Only six sites reported data on the number of children who received any mental health service and in the same year received a child protective service. While this question was not asked in the first year, it is clearly an important intersystem variable. The child protective agency is by definition serving some of any state’s most at-risk and needy children, and strong linkages between it and the MHA are likely to be in the best interests of troubled children. It is also likely, however, that in some jurisdictions the child welfare agency uses its own resources to provide mental health services to children in its care; in such instances, the child might not appear in the mental health authority’s system at all.

²³ *Ibid.*, p.5.

As displayed in Figure 28, the rates range from 5% in Rhode Island to 35% in Delaware. Again, Delaware's high rate may reflect its consolidated system structure. The variability in rates for this indicator suggests that the question should probably be refined in year three. One possible approach may be to ask how many children received mental health services and were also dependents of the court, rather than asking how many children received child protective services. As with several of the other intersystem variables, it would be of even greater interest to know the proportion of children receiving protective services who are also receiving mental health services. A recent national study does provide insight into this question. Researchers at the Urban Institute examined data from their 1997 and 1999 National Survey of America's Families and found that "Twenty-seven percent of 6- to 17-year-olds involved with child welfare have high levels of emotional and behavioral problems,"²⁴ and 32 percent of those children have not received mental health services. Most significantly for this study, they found that 25 percent of children in the social welfare system received mental health services in the past year. In comparison: seven percent of all children in the care of parents and 13 percent of children in poor, single-parent families had high levels of behavioral and emotional problems; and six percent of children in the care of parents and nine percent of children in poor, single-parent families had received mental health services. However, 66 percent of each of the non-child welfare involved groups of children who had high levels of behavioral and emotional problems had received *no* mental health services. In other words while, as one would expect, children in the child welfare system had two to three times the need for mental health services as children who were not in the child welfare system, those who needed such services also were twice as likely to receive them.²⁵



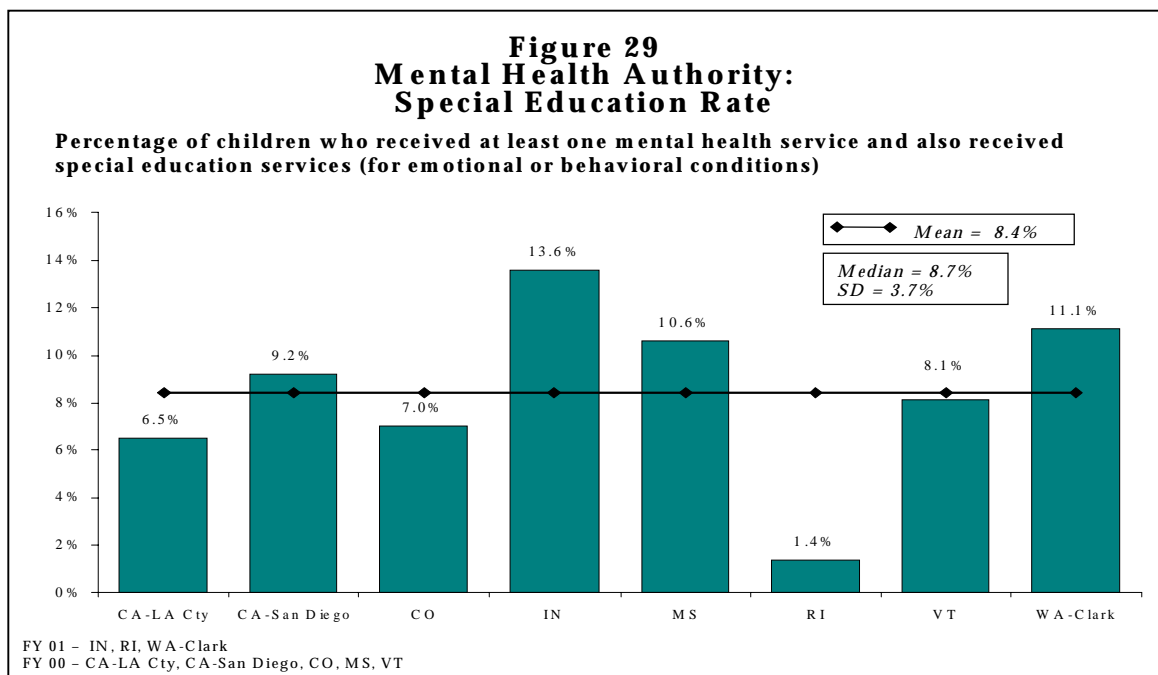
²⁴ Katherine Kortenkamp and Jennifer Ehrle, "The Well-Being of Children Involved with the Child Welfare System: A National Overview," The Urban Institute, Assessing the New Federalism, Series B, No. B-43, January 2002, p. 2.

²⁵ *Ibid.*

Special Education

As Figure 29 shows, eight mental health authorities reported data on the percentage of children receiving any mental health services who also received special education services for an emotional or behavioral condition. Their rates range from 1.4% in Rhode Island to 13.6% in Indiana, with an average of 8.4%.

Given the importance of school in children's lives, it is encouraging that so many MHAs could report on an intersystem variable related to education. The policy implications of the very low proportions of children receiving special education services are unclear, however. It seems likely that the low rates reflect a lack of information on the part of MHAs, rather than an actual absence of services received by children.



VII. DISCUSSION

IMPORTANCE OF THIS PROJECT

In the first year report on this project,²⁶ its significance and value were discussed in some detail. That report noted the importance of beginning to assist stakeholders in comparing one jurisdiction to another; the need for ways of developing within-system comparisons before and after major policy changes; and the fact that, although billions of dollars are spent every year on providing mental health services for children, very little is known about how different systems allocate their resources, how state and federal funds are used, or what difference any of these variations makes. Those reasons continue to hold true, and in fact have become increasingly important as many states are facing the need to reduce expenditures in this fiscal year. According to the Web site of the National Conference of State Legislatures, “Improving access to treatment and services for children with mental health needs has become a top priority for many states,”²⁷ suggesting that this study may have relevance for stakeholders beyond those in health and mental health agencies.

As DMA has gathered and explored the second round of data, interest in the project has continued to grow and its value has become increasingly evident to participants and other stakeholders in the system. The first year report noted the analogy to the *Kids Count Data Book*, a document that, over time, innumerable child advocates and policy makers have come to depend upon. The Children’s Mental Health Benchmarking Project has a similar potential as it continues, uniquely, to gather data related to children from both mental health authorities and Medicaid agencies. In just one year the number of jurisdictions reporting grew from 13 to 36, of which 18 contributed both Medicaid and MHA data. If the collection and reporting of these data become a normal part of operations for a sizable number of states and counties, these jurisdictions may come to count on being able to compare themselves to others along certain dimensions, just as stakeholders now routinely compare states using *Kids Count* data. It is only possible to have valid and usable benchmarks if those in the field begin to gather and analyze comparable data, as challenging as that process is. This project, which involves a collaborative effort between a research organization and public agency data analysts, is making real progress toward that goal.

EVALUATING SYSTEMS: MEASURING CLINICAL OUTCOMES

Development of benchmarks that will help decision makers and other stakeholders better understand their systems in comparison to others must begin by reporting on the *status quo*, as this report is doing. It is not yet possible to identify or define what is best. Advancing to that level will require more extensive analysis, over time, of service data in conjunction with data on clinical outcomes.

If states were using common measures of clinical outcomes (and, of course, assuming that those measures were reliable and valid), there would be another, perhaps more sophisticated, yardstick by which to evaluate the relative success of public policies. Therefore, in the year two survey, MHAs were asked whether they measure clinical outcomes, and if so what instruments or techniques they use. Of the 26 MHAs that provided data, 17 measure clinical outcomes of

²⁶ Children’s Mental Health Benchmarking Project, First Year Report. Dougherty Management Associates, Inc., September 28, 2000, (www.doughertymanagement.com), pp. 6-7.

²⁷ National Conference of State Legislatures Children’s Policy Initiative, Introduction to “Developing Mental Health Systems for Children: An NCSL Audioconference,” Thursday, February 28, 2002; <http://www.ncsl.org/programs/health/cmh-audio.htm>, April 18, 2002..

children's mental health services. Unfortunately, however, they use more than 13 different instruments, some of which are unique to one state. The Child & Adolescent Functional Assessment Scale (CAFAS)²⁸ was the only instrument used by more than two states. Four states used it, while two states used the Children's Functional Assessment Rating Scale; no other instrument was used by more than one jurisdiction. Therefore, given the current state of the art with regard to measurement of children's clinical outcomes, the next step cannot be taken toward understanding which state policies yield the best results. One day there may be an instrument that is widely used, and that will enable that step to be taken.

CHALLENGES TO ADDRESS

In this second year, the project has moved well beyond its exploratory stage. Aspects of the data collection instrument still need revision, however, and it will also be important to seek better ways to compare jurisdictions and to recruit additional participants. As these goals are achieved, the data collection effort will become institutionalized within many jurisdictions and the data will become increasingly meaningful.

Refining the Questions

While the second year instrument marks a major improvement over the first, certain questions should be further clarified. First, more information is needed about what categories of children are included in or excluded from the data being submitted. Some states, for example, include data on services to children in foster care in their submissions for this project, while others exclude these data. Also, some states include room and board costs within expenditures for residential treatment, while others do not.

In addition, more specific intersystem questions should be included in the third year. Because so few jurisdictions provided any intersystem data in the first year, very broad questions were asked in year two, aiming to maximize the number of responses. This strategy succeeded, and resulted in as many as 13 sites submitting data on, for example, involvement with the juvenile justice system. On that indicator in particular the instrument asked what kinds of encounters were being included, enabling us in year three to ask specifically about those which were most often reported, or which would be considered most important (e.g., incarcerations). Similarly, in year two data were requested on the number of children who received any mental health service and also received child protective services. For year three we might ask more specifically about children who received mental health services and were also dependents of the court.

While refinements will be added, as many questions will remain unchanged as possible, since only in that way will the data be comparable, both within and among jurisdictions, from one year to the next.

Improving Comparability of Data

Perhaps even more important than refining existing questions is the need to add new questions and develop techniques that will enhance the ability to make comparisons across jurisdictions. While it may never be possible to develop perfect methods for "risk adjusting" states and counties (i.e., using statistical techniques to make them comparable), it is important to find ways of comparing similar jurisdictions and of contrasting them with other, different, jurisdictions.

²⁸ The CAFAS is a rating scale that "assesses a youth's degree of impairment in day-to-day functioning due to emotional, behavioral, psychological, psychiatric, or substance use problems," according to <http://www.cafas.com/>, February 21, 2002.

One obvious means of doing this will be to request data from additional counties in California and Washington and from a number of counties in other large states as well. In addition, new questions should be added about managed care systems, use of inpatient facilities and enrollment in HMOs, among others, that will enable more meaningful sorting of states. Finally, an effort should be made to inquire further about system structure, because states with unified children's agencies (e.g., Delaware), may be accessing and aggregating data differently from other states.

Recruiting New Jurisdictions

The project continues to seek participation from additional states and counties for year three. One goal will be to recruit new counties, while another will be to encourage more MHAs to contribute data in jurisdictions where Medicaid data have been submitted and vice versa. The results of the project are also being shared with colleagues at relevant conferences (specifically, the National Association of State Mental Health Program Directors Research Institute conference, the University of South Florida's System of Care for Children's Mental Health conference and the Mental Health Statistics Improvement Program conference), to generate knowledge about and additional interest in the effort.

State Data System Improvements

Challenges related to state and county data systems include the need to enhance the ability to extract data and the need to coordinate a variety of data sets.

Enhancing the ability to extract data. While most jurisdictions provide many of the services covered in the data request, and while it is likely that most of them gather data on those services, their capacity to extract the relevant data differs significantly from one to another. For some it is, in the words of one participant, "expensive and burdensome," although not "impossible," to retrieve the requested data. For others it is relatively simple, once all terms are defined adequately. For some, retrieving data is easy for certain indicators (e.g., data on service utilization), but much harder for other indicators (e.g., financial data). A project like this one has the potential, as one of its funders suggests, to help promote the development and improvement of information systems.

Coordinating multiple data sets. This project, unlike most other indicator projects, has requested data on services funded by both mental health authorities and Medicaid agencies, which is one of its most important contributions to the field. In the real world, of course, the two funding sources are supporting services for many of the same children. Therefore, achieving an unduplicated count of children being served represents a significant challenge for many systems.

In addition, in some systems, certain statistics are reported and managed separately from the main body of data. For example, financial data and data on services may be handled by different units within a department, or state hospital data may be maintained in a completely separate database by different personnel. Also, some systems have a hard time separating out services and/or expenditures for children from those for adults. One participant at the Children's Mental Health Benchmarking Institute said with confidence that, "Most states know how much they spend" on specific services, and heard from several others that in fact they don't. Finally, grant-based and cost-reimbursement contracts, as well as deficit funding, may make it difficult for state MHAs to report on service utilization or cost by client.

Structural and Organizational Issues

In addition to the challenges that directly involve data systems, many jurisdictions face issues related to their structure and/or organization. These include the need for an internal demand for

data, the frequent lack of resources devoted to data gathering, the influence of departmental reorganizations and the impact of capitated payments.

Creating an internal demand, or “market,” for data. Organizations, whether public or private, differ dramatically in terms of the extent to which they use data to help determine and achieve management and quality improvement objectives. Organizations that use data will demand that systems be developed to produce accurate information on a regular basis, and will be more likely to devote sufficient resources to realize that goal. Both external and internal forces can move an organization to become a bigger and better consumer of data. Not all managers in the jurisdictions participating in this study are avid users of available data. However, this project, and the individuals who represent participating states, can become a force that helps to develop the demand for data in MHAs and Medicaid agencies. At the fall 2001 Benchmarking Institute, several participants indicated their appreciation for the fact that the project was improving their ability to present data to their colleagues and managers. Thus, both the project itself, and the state employees who have contributed data to it, may be playing roles in helping policymakers recognize the value of internal and comparative data.

Living with inadequate resources. Resources dedicated to collecting and processing data are often limited in public agencies. The available resources may be devoted primarily to addressing special initiatives determined by senior managers, to dealing with requests from state legislators or the governor or to meeting other competing demands, especially ones that have funding attached to them. This issue is likely to become more acute in the next year or so, as many states face significant budget shortfalls.

Departmental reorganizations. Several respondents mentioned that their departments were undergoing reorganization, which affected both resources and commitments. In other cases, the agency’s priorities changed because its leadership did. One respondent stated, in colorful terms, that his agency was in a state of “organizational meltdown.” These kinds of adjustments are, of course, an inevitable aspect of work within a public agency: as administrations and managers are replaced, and management priorities shift, there is an effect on the ability of jurisdictions to develop consistent and predictable responses to data requests. With 38 governorships up for reelection in 2002 more changes are probable, although of course their impact on this project cannot be anticipated.

Bundled or capitated payments. Seventeen states in this project enroll at least some of their children in health maintenance organizations (HMOs). In eight of those states, mental health services are carved into the HMO benefit; that is, the HMO’s capitated payment includes a portion intended for mental health services, and the HMO is therefore responsible for providing some or all of the range of those services. In most cases, HMOs are not required to report on services or expenditures for specific diagnoses or populations. The major exception tends to be the HEDIS²⁹ measures that relate to mental health, and these are not always reported separately for children. Not surprisingly, then, ten states were unable to provide data on children in HMOs. The significance of these missing data and the concomitant issue of selection bias vary according to the structure and incentives of the state’s system, and the proportion of children who are served through HMOs. Developing a better understanding of the utilization and costs of children served by HMOs, and whether high-risk children are being selected into or out of HMO systems, would help enable more meaningful comparisons among jurisdictions.

²⁹ Health Plan Employer Data and Information Set, measures required by the National Committee for Quality Assurance, the body that accredits health maintenance organizations.

VIII. CONCLUSIONS

This project is engaging an increasing number of states and counties in the effort to compare their data on mental health care for children. Using a series of administrative level indicators, the project gathers and reports information that can support policy makers' ability to better understand and manage their systems of care. Seeing their own data within the context of data from other jurisdictions helps administrators recognize that their procedures and policies are not the only possible ones, but rather that they have resulted from a series of choices made over the years. Seeing differences among jurisdictions often causes managers to ask questions that they would not otherwise ask. In some cases the answers to these questions are obvious, and in some cases the apparent differences are not real. At other times, however, the differences may spark actions that improve the lives of children receiving services and their families. In sum, by broadening stakeholders' perspectives, a project like this one can help them expand their understanding and use of data, and enhance the quality of the decisions they make.