MEDICAID MANAGED BEHAVIORAL HEALTH CARE BENCHMARKING PROJECT: FINAL REPORT

Produced for the
Substance Abuse and Mental Health Services Administration (SAMHSA)
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Eric Goplerud, recently with the SAMHSA OPPC, also contributed to this project, as did the managed care programs that participated in this project. The Annie E. Casey Foundation, the Robert Wood Johnson Foundation, and the Center for Health Care Strategies have supported Dougherty Management's work in benchmarking children's mental health, and have also directly and indirectly supported this project.

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EXECUTIVE SUMMARY

The purpose of the Medicaid Managed Behavioral Healthcare Benchmarking Project is to:

- Systematically review and compare data on Medicaid managed behavioral health system performance from multiple states and counties;
- Identify opportunities to improve consistency, comparability and quality of data;
- Build a database that can be maintained and augmented as programs are expanded and new initiatives begin; and
- Analyze trends in the ways that states and counties measure the performance of Medicaid managed behavioral health programs.

This SAMHSA-supported project is based upon and amplifies the important work done over the last several years by other state and national performance indicator initiatives. Seventeen states, five counties, and the District of Columbia agreed to participate in this project. All have a Medicaid managed care program that includes behavioral health services. The programs fall into the following three categories, recognizing important differences in the organization, financing and target populations of each waiver program.

- **Carve-ins**: Eight Medicaid managed care programs contract with HMOs to cover both medical and behavioral health care. They are generally offered statewide.
- **Medicaid only carve-outs**: Six programs with a variety of management entities manage a defined set of Medicaid behavioral health services in a state or a region.
- **Blended carve-outs that serve Medicaid and non-Medicaid eligibles**: Ten programs, most commonly operating on a county or regional basis, manage both Medicaid and non-Medicaid mental health services for people meeting income and clinical criteria for serious mental illness. One Medicaid-only carve-out, restricted to Medicaid eligibles with serious mental illness, is also included in this category because of its emphasis on serious mental illness.

Interviews with state and county staff responsible for overseeing Medicaid managed care programs provided a view of how they currently use information for management and accountability. These conversations indicated that states and counties have made great strides in using performance data to monitor, manage, and improve their Medicaid behavioral health systems of care, with carve-out programs having the most comprehensive reporting and performance requirements. Many states and counties regularly share measures of plan performance with advisory groups of public stakeholders; some actively disseminate such information to the public at large through websites and other methods. A few states and counties are tackling the challenge of collecting data on behavioral health outcomes by developing data systems to collect the needed measures (e.g. Washington and Colorado).

However, most measurement sets have been crafted to fit a specific managed care program and target population. This means that, despite the wealth of available data, the efforts of various national committees, and the expressed interest of program managers in using national data to help manage their own programs, it remains difficult to make cross-system comparisons. The following are some of the most significant measurement challenges identified in the course of this project that limit the usefulness of such comparisons.

- Program models are significantly different in covered services and in target populations, making it difficult to find relevant comparisons. Stratifying by age, eligibility categories, and race / ethnicity can help to control for some caseload mix and target population differences, but few states routinely stratify their measures by Medicaid eligibility category, and it has been difficult for them to collect accurate enrollment and utilization data by race.[1]
- No single, commonly accepted method currently exits for reporting on plan eligibles, affecting the ability to compare penetration and other measures that use total enrollment as the denominator.
- A number of programs have difficulty reporting using HEDIS inpatient, day / night, and outpatient service categories. In fact, these categories may not be sufficient to account for the expanded service menus of some programs that include rehabilitation services or Methadone treatment. However, no commonly agreed-upon alternative exists.
- Small programs find their sample size is insufficient to warrant the cost of collecting data for certain measures, particularly HEDIS.
- Certain measures, such as those requiring linkage of pharmacy and service data, or linkage of cost to encounters in systems that pay providers on a subcapitated or case rate basis, are difficult or impossible for certain systems.
- Outcome measures are not incorporated into existing data collection systems, which are primarily enrollment and claims driven sources. Outcome measures generally require the development of a new assessment and data collection system with timely feedback and a meaningful consequence for failure to submit data.

Nonetheless, this project was able to collect data points from more than half the participating programs for the following measures.

- ***Mental Health Penetration***
  - The penetration rate (percentage of members using mental health services) of ten Medicaid managed care plans ranged from 5% to 21%, with a program mean of 11%. All but one blended carve-out fell at or below the average penetration for programs, while Medicaid-only carve-outs were at or above the average.
  - Adults consistently had a higher mental health penetration than children, with a mean penetration of 15.3% compared to 9.5%. This may be partly due to the low incidence of mental disorders for infant and preschool children, the group with the most expansive eligibility for Medicaid coverage.
  - Differences in the methods of counting members complicate the interpretation of penetration measures.
- ***Psychiatric Inpatient Utilization***
  - Inpatient penetration for 13 Medicaid managed care programs ranged from 0.3% to 2.7%, with a mean of 1.0%. Children's inpatient penetration was lower than adults (average of .5% compared to 1.3%).
  - Twelve of thirteen Medicaid managed care plans had inpatient discharges per thousand that fell between 5 and 13. An outlier had 28 discharges per thousand.

[1] *This project did not attempt to collect data stratified by race or ethnicity.*

- Average length of stay had two clusters and an intermediate point; three programs fell between four and six days, and nine, mostly blended carve-outs, fell between 11 and 14 days. The average of all data points was 10.3 days.
- Thirty-day readmission rates varied widely, with a low of 4.2% and a high of 18%. The mean readmission rate was 11%. Ninety-day rates were much higher for most programs reporting.
- Follow-up outpatient care after discharge from an inpatient unit also varied. A low of 12% and a high of 79% of people discharged received follow-up care within 7 days. The high levels achieved by several programs demonstrate the ability of public sector programs to achieve high levels of performance on this indicator.
- One significant variation between measures is that some programs included state hospitals in the calculations of inpatient measures, while most did not.

- ***Day/Night Utilization***
  - Day / night penetration ranged from 0% to 2.0%; with a specialized program with an expanded residential care benefit constituting an outlier at 8.2%. The average penetration (excluding the outlier) was 0.6%.
  - Differences in the types of services included in this category and the units used to report them limit the usefulness of day / night utilization data.
- ***Outpatient Mental Health Utilization***
  - Outpatient penetration for 11 Medicaid managed care programs with 15 data points ranged from 4.5% to 18.9% with a mean of 10.9%. Adults consistently had higher penetration rates than children, with an average of 14.8% compared to 8.4%.
- ***Mental Health Expenditures***
  - Overall mental health expenditures ranged widely from $675 per service user to $4,556. The average expenditure was $2,616.
  - Inpatient expenditures per consumer served ranged from $1,936 to $13,721, with a mean of $7,874.
- ***Substance Abuse Measures***
  - Fewer Medicaid managed care programs cover substance abuse treatment than mental health treatment. Only 6 Medicaid managed care programs reported on substance abuse services.
  - Inpatient substance abuse treatment penetration ranged from 0.03% to 2.1% for the 5 plans reporting. Only Massachusetts reported residential (non-hospital) detoxification in this category, and that service accounted for most of the utilization for the plan with 2.1% penetration.
  - Outpatient penetration ranged from 0.3% to 4.2% with a mean of 1.2% for seven data points.
  - Massachusetts HMOs and carve-out had a much higher range in substance abuse discharges per thousand (30 to 51) than the other three programs, which fell between 1 and 6, likely due in part to Massachusetts' inclusion of residential detoxification utilization in this measure.
  - In contrast to the other inpatient substance abuse measures, average length of stay was remarkably consistent, ranging from 3 to 7 days, with a mean of 4 days.
- ***Measures of Treatment Process***
  - Relatively few programs submitted measures of treatment process, such as percentage of service users with dual (mental illness / substance abuse) diagnoses, the HEDIS depression treatment indicators, the MHSIP schizophrenia treatment measure, or on the percentage of their admissions that are involuntary. No states submitted data on use of restraint and seclusion, though many programs indicated that it is reported to a different authority, such as the licensing agency.

- ***Comparison to NCQA benchmarks***
  - The HEDIS measures collected for this project were compared to NCQA's available Quality Compass 2000 averages and its National Medicaid results. In general they showed higher penetration and utilization, but somewhat less desirable levels of preferred treatment process (e.g. Readmission and follow-up after discharge) than the NCQA's commercial population. In many cases, they fell in a similar range as NCQA's Medicaid results. It is notable that some programs exceeded commercial levels of preferred treatment process, demonstrating the potential for public programs to achieve high levels of performance. However, there is more to be understood about these comparisons.

These cross-system comparisons raise a number of important questions about the significance of methodological differences and the effects of differences between systems. Further investigation and discussion of these issues by program managers, consumers, and other stakeholders can assist the field in making the decisions needed to standardize methodology, refine measurement sets, and account for significant program parameters. This process will be challenging, but states and counties are likely to address these challenges if offered access to measures from other similar Medicaid managed care programs. Achieving this goal will require collection of the available data, development of a repository for such measures, mechanisms for discussing and reaching consensus on measures to be collected and the preferred methodologies for computing each, and dissemination of the results. Once methodologies have been defined and the data are more routinely collected, the field can begin the even more important work of engaging with researchers and consumers to understand the range of performance on these measures and identifying desirable levels of performance for each system of behavioral health services.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

MEDICAID MANAGED BEHAVIORAL HEALTH CARE BENCHMARKING PROJECT

I. INTRODUCTION

The purpose of the Medicaid Managed Behavioral Health Care Benchmarking Project is to:

- Systematically review and compare data on Medicaid managed behavioral health system performance from multiple states and counties;
- Identify opportunities to improve consistency, comparability and quality of data;
- Build a database that can be maintained and augmented as programs are expanded and new initiatives begin; and
- Analyze trends in the ways that states and counties measure the performance of Medicaid managed behavioral health programs.

This project is based upon and amplifies the important work done over the last several years by other state and national performance indicator initiatives. This includes the standard-setting efforts of the Substance Abuse and Mental Health Services Administration (SAMHSA), Mental Health Statistics Improvement Project (MHSIP), the National Committee on Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS), American Managed Behavioral Healthcare Association (AMBHA), the American College of Mental Health Administration (ACMHA), the Carter Center Forum, and other efforts to collect performance data, such as the National Association of State Mental Health Program Directors (NASMHPD) 16-State Study and the Children's Mental Health Benchmarking Project. Rather than duplicate these efforts, this project has built upon them by beginning the process of learning how data from different systems can be collected, compared, and benchmarks developed.

The growth of initiatives to define performance indicators has not resulted in a corresponding growth of performance data from publicly funded behavioral health plans nor has it resulted in a centralized location for the data. This is beginning to change. As the use of performance measures continue to grow, the benchmarking of performance data will become an increasingly important way for stakeholders to evaluate the success of Medicaid and other public behavioral health systems. The opportunity for states and counties to look at the performance of their Medicaid managed behavioral health systems in comparison to other similar and some different systems can raise important questions about priorities, methods, benefit structure, and system management. Exploring the questions raised by such comparisons can lead to productive discussions and the identification of opportunities for improvement.

While there remain many challenges and problems with the comparability of data that programs were able to provide for this report, this kind of project makes an essential contribution to resolving these same measurement issues. As with other national efforts like NCQA's HEDIS, the NASHMPD 16 state study and the Children's Mental Health Benchmarking Project, the iterative process of collecting, comparing and revising measures and the methods of reporting the data takes several years to successfully complete. As an initial effort, the comparisons that

follow can appropriately be used to raise questions for further investigation that will help identify relevant measurement differences, aspects of program design, and variations in the composition of target populations that need to be accounted for in order to fairly compare performance across systems. Absent such additional work, the comparisons cannot appropriately be used as definitive indications of relative performance.

II. METHODOLOGY

A. SELECTION OF PERFORMANCE MEASURES

As a foundation for this project, all the relevant proposed behavioral health performance measures were reviewed and cataloged and a subset of significant and readily available performance measures was selected for collection. Those reviewed include NCQA-HEDIS, the CMHS-NASMHPD 16 State Study, the Washington Circle Group, ACMHA, Decision Support 2000, and the Carter Center Forum, among others.[2] From this review, a set of performance measures was selected on the basis of their significance as indicators of the performance and effectiveness of behavioral health plans or systems of care. Significance was determined, in part, by inclusion in multiple measurement sets. The selected measures are listed in Table 1, below.

TABLE 1
SELECTED PERFORMANCE MEASURES FOR THE SAMHSA MEDICAID MANAGED BEHAVIORAL HEALTH BENCHMARKING PROJECT

Selected Performance Measure	Source
ENCOUNTER DATA BASED MEASURES	
Penetration	
Proportion of adult/child enrollees receiving any MH/SA services MH/SA ambulatory services MH/SA day/night services MH/SA inpatient services	HEDIS, NASMHPD 16 State, DS 2000, Summit 2001, AMBHA - PERMS
Utilization	
Units of MH/SA services provided per thousand enrollees: MH/SA ambulatory (visits) MH/SA day/night services (units) MH/SA inpatient services (days)	ACMHA; Summit 2001
Discharges from MH/SA inpatient services per 1000 enrollees	HEDIS, ABMHA-PERMS 2.0; Casey Benchmarking; IBH
Average length of MH/SA hospital stays in days	HEDIS, ABMHA-PERMS 2.0; Casey Benchmarking; IBH
Cost	
Medical loss ratio; Percentage of the plan's premium revenues paid out in claims (per definitions of NAIC)	Casey Benchmarking; DS 2000+; NASMHPD 16 State
Service spending per capita; Average cost of total MH and/or SA services per enrollee served MH/SA ambulatory services MH/SA day/night services MH/SA inpatient services	Casey Benchmarking, NASMHPD 16 State

[2] *Appendix A includes a complete list of the measurement sets reviewed for the selection of core measures.*

TABLE 1
SELECTED PERFORMANCE MEASURES FOR THE SAMHSA MEDICAID MANAGED BEHAVIORAL HEALTH BENCHMARKING PROJECT

Selected Performance Measure	Source
Other Encounter Measures	
Percentage of enrollees receiving MH/SA services who are diagnosed with a co-occurring SA/MH disorder	ACMHA
Percentage of enrollees with an index detoxification who initiated AOD plan services within 14 days following detoxification	Washington Circle Group
Percentage of enrollees with a schizophrenia diagnosis who have at least 4 visits in 12 months with a psychiatrist or DO for psychotherapy or medication management; patients 18 and over	HEDIS, ABMHA-PERMS 2.0
Follow-up service after hospitalization for ages 6 and older: Within 7 days Within 30 days	HEDIS, NASMHPD 16 state; ACMHA; AMBHA-PERMS 2.0; Summit 2001; DS 2000+
MH/SA Inpatient readmission rate: Within 30 days Within 90 days Within 180 days Within 365 days	SAMHSA EW System (authorizations); Casey Benchmarking; NASMHPD 16 State; NAPHS; AMBHA-PERMS 2.0
PHARMACEUTICALS	
Cost per enrollee served of psychotropic drugs by type of drug (for enrollees with any diagnosis)	AMBHA-PERMS 2.0
Number of enrollees prescribed atypical antipsychotics per 1000 enrollees	NASMHPD 16 State; APA
Antidepressant Medication Management (NCQA) Age 18 and older: >= 3 follow-ups within 12 weeks after initiation of antidepressant Taking antidepressant for at least 12 weeks Taking antidepressant for at least 6 months.	HEDIS, ABMHA-PERMS 2.0
ADMINISTRATIVE DATA BASED MEASURES	
Telephone Access to managed care organization - Calls answered in greater than 30 seconds	SAMHSA EW System; IBH
Rate of service denials by service type	SAMHSA EW System; IBH
Rate of involuntary commitment	ACMHA; AMBHA-PERMS 2.0; SAMHSA EW System
Consumer satisfaction with timeliness of access to outpatient care and outpatient services	IBH; DS 2000+; ACMHA; Summit 2001; CAHPS
Consumer complaints and rates of grievances	SAMHSA EW System; Casey benchmarking; IBH

TABLE 1
SELECTED PERFORMANCE MEASURES FOR THE SAMHSA MEDICAID MANAGED BEHAVIORAL HEALTH BENCHMARKING PROJECT

Selected Performance Measure	Source
CLIENT OUTCOME MEASURES	
Percentage of patients with improved, maintained and reduced levels of functioning	Outcomes Roundtable; NASMHPD 16 State; NAPHS; IBH; Summit 2001; DS 2000+
Change in living situation. Compare living situation (domiciled, homeless) at admission to MH/SA treatment and at a standard period post admission	DS 2000+; NASADAD; NASMHPD 16 State
Change in employment status. Compare status at admission to MH/SA treatment and at a standard period post-admission	ACMHA; NASADAD; DS 2000+
Criminal Justice involvement; Change in the number of arrests in a standard period before admission to a standard period post-admission	ACMHA; Outcomes Roundtable; NASMHPD 16 State
CLINICAL PROCESS MEASURES	
Use of seclusion and restraint:	NASMHPD 16 State; ACMHA; NAPHS
Percent of all patient hours of treatment spent in seclusion or under restraint.	
Clients with one or more episodes of restraint or seclusion as a percentage of all clients served during the reporting period	

B. SELECTION OF MANAGED CARE PROGRAMS

The focus of this project is on collecting data for adults and children in Medicaid managed care plans, rather than in state operated or state funded services that are not part of an approved Medicaid Managed Care initiative. States and counties with Medicaid managed care initiatives for behavioral health services were identified, and a subset was invited to participate. The proposed selection included:

- States that participated in the CMHS-NASMHPD 16 State study if they had a Medicaid managed care program that includes behavioral health services – either carve-in or carve-out;
- All Medicaid Managed Care behavioral health carve-out programs, e.g. Massachusetts, Iowa, TennCare Partners, etc.;
- A sample of integrated or carve-in behavioral health programs that represent a regional cross-section of states; and
- A cross-section of Medicaid behavioral health efforts that include other major plan characteristics. These could include: non-risk, administrative contracts with Managed Care Organizations (MCOs); states with single plans vs. a choice of plans; and states with perhaps different levels of inclusiveness of benefit structure, for example, including substance abuse services, limited to Temporary Assistance to Needy Families (TANF) Medicaid eligibles, etc.

Thirty-one Medicaid managed behavioral healthcare programs were initially selected. They provided a cross section of the different types of plan: carve-out, partial carve-out, integrated (Health Maintenance Organization, HMO) and non-risk (administrative services). Three were dropped because their programs were not truly managed care programs or had not yet been implemented (Idaho, Georgia, HMOs in the District of Columbia). Several relatively new programs did not yet feel confident that the data produced from their programs were ready to be shared, or did not yet have experience with measures for behavioral health (Texas STAR, Virginia). Three programs did not have sufficient time to participate (TennCare, Iowa, Nebraska). And one state (New York) felt that their data was not comparable and therefore did not participate. The Child and Adolescent SSI Program (CASSIP), the District of Columbia's specialty carve-in program for children on SSI, was added.

C. DATA COLLECTION

Three types of data were collected for this project:

1. Phone interviews with relevant state or county personnel to find how they use data and performance indicators for the management and oversight of behavioral health services covered in their Medicaid managed care program;
2. Reviews of the list of performance indicators to find which indicators are currently reported – or could be reported – for Medicaid behavioral health services; and
3. Collection of available data on those measures and indicators that participants already reported or could easily collect.

An interview protocol was created to collect consistent information from each of the contact people. The protocol included basic identifying information on the interviewee, the size and scope of the Medicaid plan, the nature of the behavioral health benefits, and a series of detailed questions about the plan's performance measures, health plan reporting requirements and quality improvement related efforts. This information is summarized in Section IV and common issues in producing and using performance data, and innovative and exemplary practices, are identified.

During the interviews[3], the selected performance measures were reviewed, identifying the ability of the managed care plan's MIS system to produce the measures, as well as requesting data on those measures that could be submitted in the time frame of this project. Two data collection tools, one for measures related to mental health treatment, and the other for measures related to substance abuse treatment were developed.[4]

[3] An overview of the interview topics appears in Appendix B. Interviews for this project were largely completed between late November and early January, with a few interviews conducted during February. Data included in the report were submitted between December 2001 and May 2002.
[4] These data collection tools contained more detailed specifications for the measures. They appear as Appendices C and D.

III. BENCHMARKING RESULTS

A. CHARACTERISTICS OF THE PROGRAMS

Table 2 lists the 23 programs participating in this project, indicating those participants that were interviewed, but did not submit data. A list of each participant and the primary contact for that participant appears in Appendix E. In this paper, the term 'program' refers to the Medicaid behavioral managed care programs administered by a state or county. Most states and all counties participating in this project have one managed care program, though multiple HMOs or MCOs may be contracted to provide services under that program. Massachusetts' program, however, has two components. The same behavioral health care services are managed with the same specifications by four participating HMOs, and a carve-out program. Because of the distinct organizational structures, the integrated services provided by HMOs have been reported separately from the carved-out services. Oregon also has two programs, an HMO program providing substance abuse services and a carve-out program providing mental health services.

TABLE 2
PROGRAMS PARTICIPATING IN THE SAMHSA
Medicaid Managed Behavioral Health Benchmarking Project

Medicaid-Only Carve-In	
District of Columbia – Child and Adolescent SSI Program (CASSIP) Massachusetts – HMOs New Hampshire Managed Care (interview only)	New Mexico – SALUD! Oregon Health Plan (for SA services) South Dakota (interview only) Rhode Island RIte Care Wisconsin HMOs (interview only)
Medicaid-Only Carve-Out	
Florida – Tampa Prepaid MH Plan Colorado Oregon – Oregon Health Plan (for MH services)	Pennsylvania – Health Choices BHS (interview only) Utah – Pre-Paid MH Plan West Virginia (interview only)
Blended Carve-Out: (blend Medicaid and Mental Health Authority funds and consumers)	
Arizona – AHCCS California – San Diego County California – Los Angeles County Maryland – Spec. MH System Massachusetts Carve-out	Texas – NorthSTAR (interview only) Washington State Washington – Clark County Washington – King County Washington – Spokane County
Partial Carve-Out	
Hawaii Quest – Child / SMI adults (interview only)	

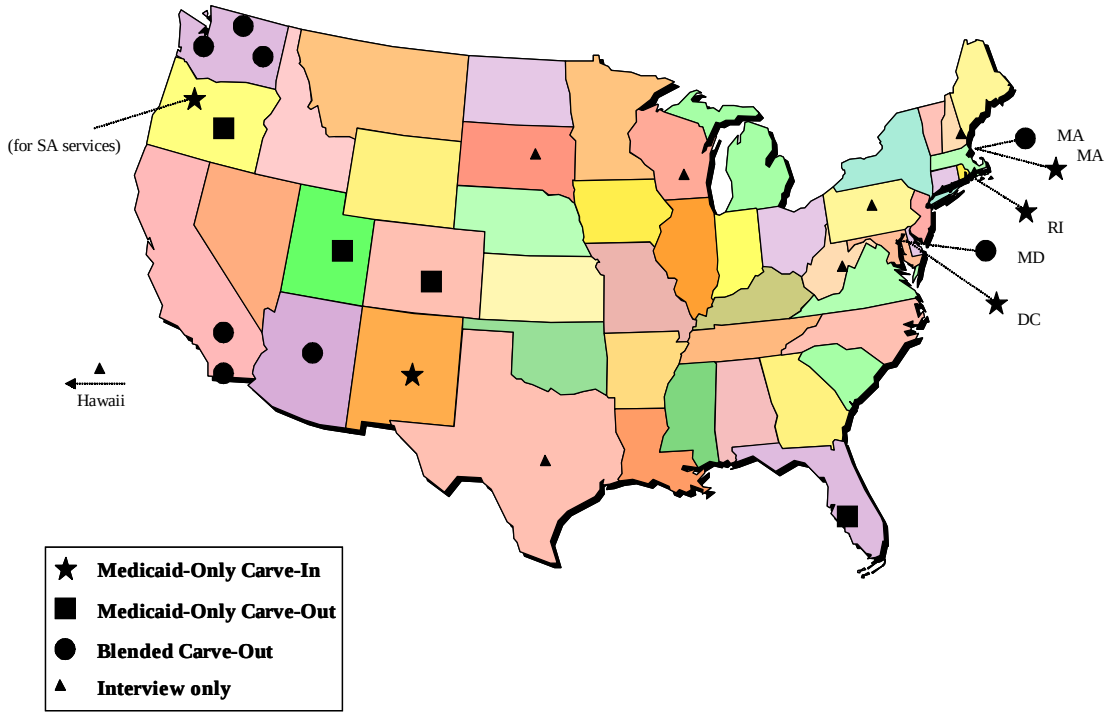
In order to recognize important differences in the organization, financing, and target populations of each waiver program, the programs were grouped into three categories.

- **Carve-ins**: Eight Medicaid managed care programs contract with HMOs to cover both medical and behavioral health care. They are generally offered statewide.

- **Medicaid only carve-outs**: Six programs contract with different types of management entities and manage a defined set of Medicaid behavioral health services in the state or a region;
- **Blended carve-outs that serve Medicaid and non-Medicaid eligibles**: Ten programs, most commonly operating on a county or regional basis, manage both Medicaid and non-Medicaid mental health services for Medicaid eligibles and for people meeting income and clinical criteria for serious mental illness. One partial Medicaid carve-out, restricted to Medicaid eligibles with serious mental illness is also analyzed in this category because of its emphasis on serious mental illness.

The map below shows that the participating programs are distributed throughout the country, with particularly strong representation by programs in Western states.

Project Participants



Appendix F provides further detail about the key parameters of these programs.[5] Program categories tend to differ in their target populations, as shown in Appendix G, which indicates the percentages of children and adults in each program, as well as the percentages of TANF, Supplemental Security Income (SSI), and Medicaid expansion recipients in each program. Appendix H provides information about the standards each state sets for Medicaid eligibility and indicates whether foster children are enrolled in the plan. Eligibility standards affect the composition of the target population of Medicaid managed care programs as well as the dynamics of the population, such as rate at which Medicaid eligibles gain and lose Medicaid coverage. Foster children have a higher incidence of mental health needs than income eligible children. Their inclusion or exclusion in a managed care plan will affect its case mix.

[5] *Programs are categorized by plan type as defined above and within category, from largest to smallest enrollment.*

Understanding the differences in the characteristics of enrolled populations may help to interpret differences in program performance.

Enrollment figures indicate that some county programs are larger than some state programs. As a result, state or county is not used as an analytic category. For example, Los Angeles County has enrollment levels that exceed many states. Massachusetts' statewide HMO program, on the other hand, enrolls a relatively small percentage of the total Medicaid population; the majority enroll in Massachusetts' joint Primary Care Case Management (PCCM)/behavioral health carve-out program.

1. Carve-Ins

Among the Medicaid carve-ins participating in the study, all but one, a specialized program only for children on SSI, serve the TANF population. Most serve the SSI as well as TANF populations, though several of the plans have restrictions on SSI enrollment (children only, or exclude the seriously mentally ill (SMI). This results in a target population with high TANF enrollment and a large percentage of children. For example, Massachusetts and New Hampshire HMOs serve a population composed of close to or over 80% TANF, and from 60% to 80% children, both less intensive utilizers of behavioral health services. There are two notable exceptions, the District of Columbia's CASSIP program, which specializes in children on SSI, and Oregon's HMOs, which serve a large expansion program which is primarily adults.

All but one program contracts with HMOs at full risk, but the HMOs may subcontract to a managed behavioral health organization (MBHO). South Dakota operates its own PCCM program without the assistance of an ASO or MCO. The programs range in size from 2,000 to almost 300,000 enrollees. The two smallest programs have voluntary managed care enrollment, while the remaining programs have mandatory enrollment. None of the carve-in programs have blended funding, e.g., serve individuals with serious mental illness who are not Medicaid eligible. One, South Dakota, exempts Medicaid recipients with serious mental illness from the referral requirements for mental health services and exempts the types of rehabilitation and case management services they need, from referral requirements. Most of these programs offer both mental health and substance abuse treatment services, though South Dakota exempts substance abuse from managed care. While the coverage of substance abuse services varies, all programs include outpatient treatment as well as detoxification. As a part of comprehensive coverage, the HMOs cover pharmacy.

2. Medicaid Only Carve-Outs

All the Medicaid-only carve-outs that participated in the project serve both TANF and SSI recipients, with no restrictions on SSI enrollment. It is difficult to generalize about the target populations of Medicaid carve-outs, because enrollment data was received from only a few plans. However, both Medicaid-only carve-outs that submitted TANF/SSI breakdowns had higher SSI enrollment than integrated programs. The age profiles of these programs, however, varied considerably.

States and Counties employ a variety of organizations to manage carved-out behavioral healthcare services. These include contracts with MBHOs, counties that have an option to subcontract, and Community Mental Health Centers. Most programs are at full risk; West Virginia, however, uses an ASO that is paid a flat fee. No very small programs (enrolling fewer than 10,000) are found in this category. Most of the programs cover a comprehensive set of mental health benefits. Two offer substance abuse services as well. However, one program, West Virginia's, focuses solely on rehabilitation and clinic services (both MH and

SA); inpatient services remain in the fee-for-service system. None of the Medicaid-only carve-out programs cover pharmacy.

3. Blended Carve-Outs

Blended carve-outs frequently, but not exclusively, involve Counties combining their role as mental health authority with responsibilities as Medicaid managed care entities. In turn, Counties may subcontract to an ASO. Most programs are fully capitated with Medicaid funds, though California pays its Counties a fixed annual allocation (global budget), Massachusetts shares risk with its MBHO, and Hawaii's very small program uses an ASO. All blended programs serve both TANF and SSI Medicaid recipients. Those who reported enrollment profiles had close to 20% SSI enrollment and served between 50% and 60% children. Hawaii serves only those Medicaid recipients who meet criteria designed to focus QUEST on people with serious emotional disturbance (SED) or SMI. Washington's county administered managed care program is also more focused on serving people with SED or SMI because Medicaid eligibles in Washington can also receive short-term outpatient benefits through Medicaid HMOs.

All blended programs also serve seriously mentally ill adults who meet the state's income criteria and receive additional state and/or county funds for that purpose. (Hawaii is the sole exception, being limited to SMI Medicaid.) Only one program, Hawaii's exceptionally small program, enrolled fewer than 10,000. Notably, Los Angeles County operates the largest program in the sample. With the exception of Hawaii, all carve-out programs offer comprehensive mental health benefits. However, only two include pharmacy in the blended carve-out benefit. Three blended carve-out programs, Massachusetts, Arizona, and Texas NorthSTAR, also provide substance abuse services. As with the carve-ins, all include outpatient substance abuse treatment as well as detoxification.

4. Unique Program Characteristics

Among carve-outs of both Medicaid-only and blended types, Florida is unusual in having the highest percentage of SSI, a full ten percent higher than the other programs that reported this figure, as well as serving the highest percentage of children. Oregon's carve-out, like its HMOs, is notable in serving more adults than children, the only two programs that reported doing so. Like Oregon, Massachusetts has an adult expansion population. Though not accounting for as great a share of managed care program enrollment as in Oregon, Massachusetts's long-term unemployed adults show high penetration in the use of behavioral health services.

B. DATA RECEIVED

Table 3 shows the number of programs that submitted each of the selected measures for this project.[6] Data were received from 17 managed care programs that reported on 22 separate entities. This includes multiple plans from two states.[7] The measures are listed beginning with the measures reported by the most programs to those reported by the fewest.

[6] *Appendix I contains an expanded version of this table showing which measures were submitted by program, the number of data points submitted, and, where relevant, whether stratifications for age or eligibility category have been provided.*
[7] *3 New Mexico and 4 Massachusetts HMOs.*

TABLE 3
INVENTORY OF MENTAL HEALTH DATA COLLECTED

Measures of Interest	Total Programs Providing Data	Measures of Interest	Total Programs Providing Data
Medicaid penetration rate	13	Consumer Satisfaction - Access	7
Inpatient Utilization – bed days per 1000	13	Percentage of discharges with f/u visit w/in 30 days	7
Inpatient penetration	13	Day/night cost per enrollee served	7
Percentage of discharges with f/u visit w/in 7 days	12	Outpatient cost per enrollee served	7
Outpatient Penetration	11	Involuntary Admissions	6
Inpatient discharges per 1000	11	Inpatient Readmission - 90 days	6
Inpatient ALOS	11	Dual diagnosis total	5
Total cost per enrollee served	10	Medical Loss Ratio	4
Day/night penetration	10	Telephone Access % calls answered > 30 sec	4
Inpatient Readmission - 30 days	10	Percentage with schizo. diag w/ 4 visits in 12 mos.	3
Outpatient utilization per thousand	9	Enrollees prescribed atypical antipsychotics per 1000	2
Inpatient cost per enrollee served	9	HEDIS Depression	1
Day/night utilization per thousand	9	Seclusion and Restraint	0
Consumer Satisfaction - Overall	8		

Table 4 provides the same information for measures of substance abuse treatment. Six managed care programs covered substance abuse services. As with MH services above, two states provided data from their individual HMOs.[8]

TABLE 4
INVENTORY OF SUBSTANCE ABUSE DATA COLLECTED

Measures of Interest	Total Programs Providing Data	Measures of Interest	Total Programs Providing Data
Inpatient discharges per 1000	5	Day/night penetration	2
Inpatient ALOS	5	Medicaid penetration rate	2
Inpatient Utilization - bed days per 1000	4	Inpatient Readmission - 30 days	2
Outpatient Penetration	4	Inpatient Readmission - 90 days	2
Inpatient penetration	4	Total cost per enrollee served	1
Inpatient cost per enrollee served	3	Day/night utilization per thousand (units)	1
Outpatient cost per enrollee served	3	Day/night cost per enrollee served	1
Outpatient utilization per thousand	2	Dual diagnosis total	1

Once data were received, they were checked for internal consistency and compared to data points from other programs. Any inconsistencies or outlier values were reported back to the submitting participants, and further investigated. Participants revised some values and confirmed others.

[8] *New Mexico reported on 3 HMOs and Massachusetts on 4, providing for a maximum of 13 data points.*

All participants reviewed the report in draft form and their questions and concerns were resolved.

C. COMPARISON OF PERFORMANCE MEASURES

This section discusses each core performance measure, presenting comparison data for those indicators for which there are sufficient data points. It focuses on:

- The significance of the measure and the reasons why it was included in our core measures;
- The ability of managed care programs to compute the measure and stratify it by relevant categories;
- Any issues related to the quality or comparability of the data points for this measure[9];
- The degree to which managed care programs use the measure and their reasons for using the measure or an alternative;
- A graphic or tabular presentation of the collected data; and
- What cross-system comparisons of the available data points suggest.

In presenting graphical data, data points are clustered by type of program: Carve-in, Medicaid-only Carve-out, and Blended Carve-out. Within each category, the programs are in order from largest enrollment to smallest enrollment. However, New Mexico HMOs are ordered by total program enrollment, not the enrollment of the individual plan.[10] In calculating means, medians and standard deviations when the state of Washington is present, individual Washington counties have been excluded since they are already counted within the state. Comparisons to NCQA summary statistics are provided for indicators included in HEDIS.

It is appropriate to emphasize that the following collection of cross-system comparisons is still in its early exploratory stages. For this reason, the methodological issues that have bearing on interpretation of these data and limit the conclusions that can be drawn are addressed. Nonetheless, this is a rich source of information that Medicaid managed care programs can use to identify areas of performance where they differ from others and initiate further investigation of possible reasons for those differences. Program and target population differences can cause different programs to have legitimately different levels of performance on the same measure. Comparisons that do not take program differences into account can be unfair to the programs that appear to have lower levels of performance. Two of the original participants withdrew their data from this project because of concerns about the limits of appropriate cross-system comparability. Readers are urged to use these data conservatively to ensure that programs that have contributed data are analyzed fairly. Further feedback is welcomed about how to best account for relevant programmatic and measurement differences as the field explores the implications of these data.

1. MH Penetration Rate

Penetration is a measure that shows the percentage of eligible plan members that actually have received services over a specified period of time.

Methodological Considerations:
While penetration is a well understood and widely used measure it may be calculated using different denominators. HEDIS uses total member years for the denominator (total member months divided by 12). However, only four states use total member months or years to count Medicaid enrollment, and one uses an enrollment snapshot. Most in the sample use an

[9] Appendix K lists participant's comments on specific data points they submitted related to its definition, completeness, or accuracy.
[10] Where possible, a weighted average was calculated for multi-HMO programs to show an overall rate for the managed care system.

unduplicated count of those enrolled in Medicaid during the year, resulting in higher enrollment counts that – all other things being equal – will result in lower penetration rates. Given the high rate of turnover in the Medicaid population, this difference in not inconsiderable. We found two programs for which we could compare the difference between the two types of enrollment counts; the unduplicated count was 23% higher than the average monthly enrollment for the all-SSI DC CASSIP program, and 33% higher for the TANF and children's expansion population in Wisconsin HMOs.

HEDIS calls for penetration to be stratified by gender and age. In addition, it looks at penetration for three categories of service, inpatient, day/night, and outpatient. The core measures for this project included the three service categories stratified by age (child/adult) and by eligibility category. For eligibility category, enrollment information for TANF eligibles, plus any expansion populations enrolled in Medicaid managed care were both requested. In most states, these are maternal and child populations, though Oregon and Massachusetts have adult expansion programs. SSI enrollment was also requested; these individuals are primarily eligible for Medicaid on the basis of a disability and, in general, have relatively intensive health care needs. Given the variation between programs in the composition of their target populations, stratifying for these characteristics helps to account for differences between programs.

About half the programs submitting penetration data stratified it by age category, with some differences in their definition of child (age 0 to 18 or age 0 to 21). Fewer stratified by TANF/SSI, but only two stratified for both age and eligibility category. Programs submitted at least 15 data points for overall, inpatient and outpatient penetration, but they did not necessarily represent the same programs. Somewhat fewer data points (12) were available for day/night penetration. The definition of day/night services is difficult to understand in HEDIS, and many of the programs interviewed were not familiar with the category. A number use reporting conventions that include day treatment as an outpatient service.

This project did not request data stratified by racial or ethnic categories, despite the fact that race has long been identified as a significant factor associated with differential access and utilization. States have noted a number of significant problems in collecting accurate and complete enrollment and service data on race. Fortunately, they are beginning to focus more attention on collecting these data and using it to stratify relevant measures. For example, Pennsylvania is monitoring service authorizations as a percentage of enrollees by race as an early warning indicator of potential access problems. Effectively addressing the challenges of reporting relevant access and utilization measures by racial/ethnic categories is one of the most important tasks facing the field.

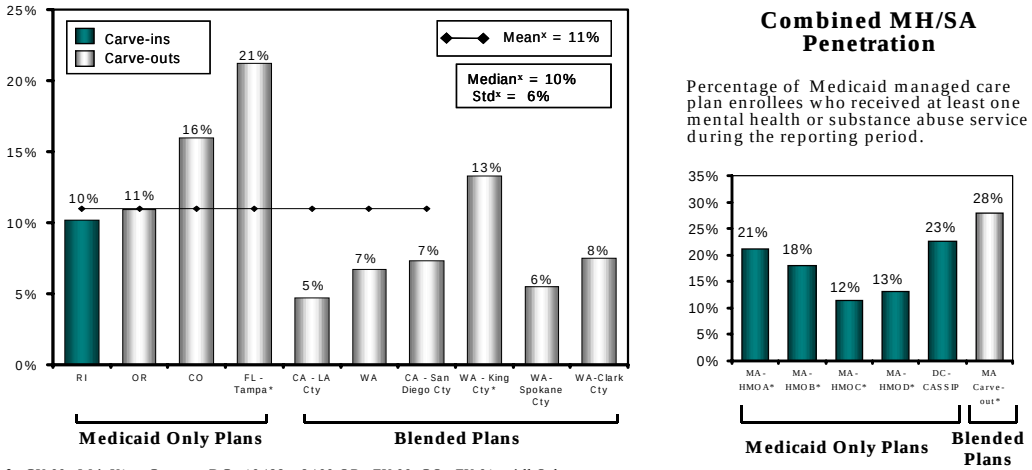
Penetration is an important summary level measure of provision of mental health care by managed care systems. The cross-system comparisons presented below show some areas of convergence as well as significant outliers that raise important questions. Better ability to stratify by such meaningful categories as age and especially eligibility group, use of a consistent method for counting the denominator, and better definition of service categories will make these comparisons and investigations more valuable.

1a. Overall Penetration

Chart 1 shows 10 data points for mental health penetration, and 6 data points from programs that submitted a combined penetration that counted individuals who had used a mental health or a substance abuse service. There is considerable variation in mental health penetration rates, which ranged from 5% to 21%. Medicaid-only carve-outs were at or above the mean, while the blended plans from California and Washington were close to or below it. Some of this variation is explained by the

methods that states use to calculate their Medicaid enrollment. The highest measures for Medicaid-only and blended carve-outs calculated penetration using average monthly enrollment as the denominator.

Chart 1
Medicaid Managed Care Plans: Penetration



- CY 00: WA King County, DC . 10/99 – 9/00 OR. FY 00: CO. FY 01 – All Others.
- Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.

x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.

Differences in the target populations of different programs may also affect penetration rates. Tampa's high proportion of SSI enrollees would be expected to have high penetration compared to programs serving a large percentage of TANF eligibles. Since Washington State makes outpatient mental health treatment available through their HMOs, some Medicaid recipients would not need to access the County managed Medicaid mental health services, and the penetration rates of these programs would therefore be somewhat lower than programs that are the only source of Medicaid mental health services.

Population differences are also reflected in the differences between penetration in these public programs and NCQA's Compass 2000 measures of a predominantly commercial population served in over 200 NCQA HMOs. The national average for those HMOs' overall mental health penetration using average monthly enrollment was 4.3%, much lower than most of the Medicaid penetration rates reported above. NCQA also reports summary statistics for plans with Medicaid Members. NCQA's National Medicaid results are only a little higher than that of their HMOs, with a mean of 5.6% for 39 data points.

The structure of covered benefits will also affect this measure. States with a wider variety of covered benefits, such as those that include both acute and rehabilitation services in their programs, meet a wider variety of needs and would be expected to show higher penetration. This explains, in part, why the plans that reported a

combined total of mental health and substance abuse treatment users for this measure had higher values than those for mental health services alone. However, target population differences also are a factor. The CASSIP program of the District of Columbia serves only children on SSI. It reports the majority of the behavioral health services it provides are mental health services. Therefore, its high penetration is more reflective of the high level of need of its disabled population.

Massachusetts, however, has significant adult enrollment, including those eligible through TANF or SSI, and those eligible for an expansion program for long-term unemployed. With an adult population likely to make significant use of substance abuse services, inclusion of substance abuse service users is likely to explain at least a part of its high levels of penetration. In addition, Massachusetts supplied us with a point in time enrollment count. As mentioned previously, this method results in lower figures than an unduplicated count, and could be lower than the average monthly enrollment method if the point-in-time count was during a low enrollment period. Despite these two explanatory factors for relatively high combined mental health / substance abuse penetration, Massachusetts' levels are high enough to suggest that the level of mental health penetration is also high.

Further stratification of penetration measures and an overall review of utilization patterns and program characteristics is necessary to better understand the nature and significance of the differences in penetration observed in these data.

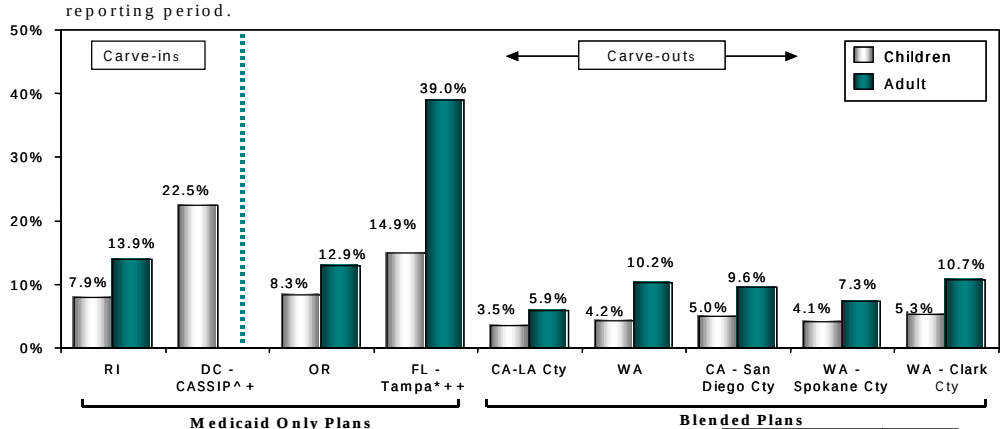
1b. Penetration by Age Category

Eight managed care programs provided age stratifications for overall penetration. Children's penetration was consistently less than adult penetration for mental health services. In some systems, adult penetration was more than twice that of children. This may be because the number of children eligible for Medicaid is much higher than the number of adults, and includes typically low utilizers in the TANF population. It may also be because many children are too young to exhibit the symptoms of mental illness. This question deserves further research.

Chart 2

Medicaid Managed Care Plans: Penetration by Age Category

Percentage of Medicaid enrollees who received at least one mental health service during the reporting period.



	Children	Adults
Mean[x]	9.5%	15.3%
Median[x]	7.9%	11.6%
Std[x]	6.9%	12.0%

• CY 00: DC. 10/99 – 9/00 OR.. FY 01 – All Others.
* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
^ Includes both mental health and substance abuse services.
+ Children: 0-21 years.++ Children under age 21.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

Children's penetration showed some clustering, especially for blended plans, whose rates fell in the range of 3% to 5%. Medicaid-only plans had higher rates, with Rhode Island and Oregon at about 8%. Tampa was somewhat higher and the District of Columbia's SSI-only plan was highest, consistent with their service of children on SSI, and their measurement of both mental health and substance abuse services in this penetration measure[11].

Adult penetration showed a similar pattern, with lower rates and less variation among blended plans, whose rates fell between 6% and 11%. Oregon and Rhode Island were only slightly higher. However, Tampa was an outlier having almost 40% penetration. This pattern is at least partly explained by Tampa's adult enrollment, of which SSI recipients account for over 60%.

1c. Penetration by Eligibility Category

As suggested above, a significant difference arises between TANF and SSI populations in the use of services. The data from the five managed care programs that stratify by eligibility category dramatically illustrate this phenomenon. Chart 3 presents mental health penetration for two programs and combined mental health and substance abuse penetration for three programs. There is considerable variation among the programs. In all cases, SSI penetration exceeds TANF/expansion penetration, often by three to four times, pointing to the value of stratifying for this variable to control for differences between programs. However, there is a considerable range in penetration for each eligibility type. Florida and Oregon's TANF and expansion populations show mental health penetration between 9% and 12%. Massachusetts' combined mental health/substance abuse penetration for TANF only enrollees showed a wider range, from 7% in an HMO to 20% in its blended carve-out. SSI population penetration for mental health services is considerably different, with 18% in Oregon and 47% in Tampa. Oregon's program includes statewide utilization in all HMOs, while Tampa's carve-out is just one enrollment option for Medicaid eligibles in its catchment area and, as a specialized carve-out, appears to disproportionately attract eligibles who use mental health services. Combined mental health/substance abuse penetration is 23% for DC CASSIP children on SSI, and double that for Massachusetts SSI enrollees, whose combined penetration ranges from 43% to 56%. The CASSIP rate is not unlike Oregon's mental health penetration rate of 19.6% for children on SSI, but not nearly as high as the 36.5% rate of Tampa's program. Massachusetts' penetration levels indicate that over half the enrolled population is using mental health or substance abuse services. Even if these rates are somewhat overstated by the use of a point-in-time enrollment count, they are very high. The degree of variation in this measure, suggests very high variability in access for disabled populations, and warrants further investigation.

It was also possible to measure penetration for Massachusetts' Basic program, an expansion program for long-term unemployed adults. The combined mental health/substance abuse penetration for this population ranged from 28% to 52%, appearing more like SSI penetration rates than those for TANF. While most expansion populations are low-income children and sometimes their parents, a population similar to TANF, this example makes it clear how important it is to account for the characteristics of the target population.

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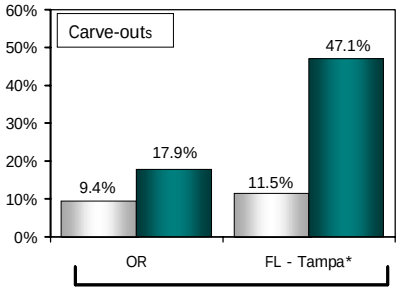
[11] DC CASSIP's combined mental health and substance abuse penetration is included in this chart because the program has stated, and it is reasonable to believe, that this measure primarily indicates use of mental health services. For this population of disabled children, there is a relatively low rate of substance abuse treatment. For the same reason, DC CASSIP's combined mental health and substance abuse utilization data are included in relevant mental health charts.

Chart 3

Medicaid Managed Care Plans: Penetration by Eligibility Category

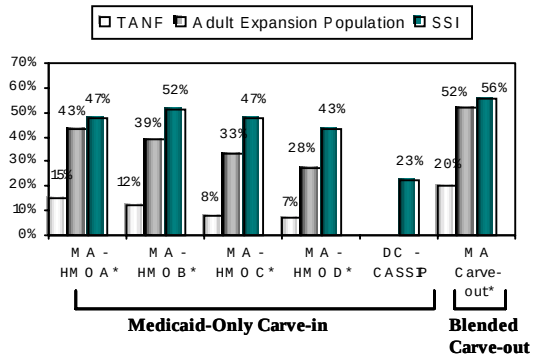
Mental Health Penetration

Percentage of Medicaid managed care plan enrollees who received at least one mental health service during the reporting period (TANF may include SCHIP enrollees).



Combined MH/SA Penetration

Percentage with at least one mental health or substance abuse service



- CY 00: DC. 10/99 – 9/00 OR. FY 01 – All Others.

* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.

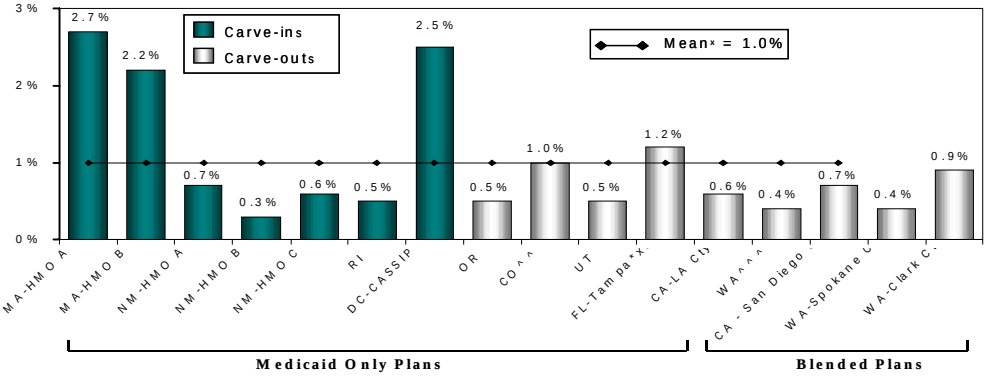
1d. Inpatient Penetration

Inpatient penetration i.e., the proportion of Medicaid enrollees, who received at least one inpatient MH service during the reporting period, shows a considerable range, from 0.3% in New Mexico HMO B to 2.7% in Massachusetts HMO A, with a mean rate of 1.0 and a median of 0.7%. However, most rates fall in a smaller range, between 0.3% and 1.2%. There is considerable clustering between 0.4% and 0.7%, with a mode value of 0.5%. This is higher than the NCQA Compass 2000 national HMO average of 0.23% inpatient mental health penetration but similar to NCQA's National Medicaid results, which have an average of 0.51%.

Chart 4

Medicaid Managed Care Plans: Inpatient Penetration

Percentage of Medicaid enrollees who received at least one inpatient mental health service during the reporting period.



- CY 00: NM, DC. 10/99 – 9/00 OR. FY 00: CO, UT. FY 01 – All Others.

* Average monthly enrollment or point in time. All others use Total Annual Enrollment used as denominator.

^ Includes both mental health and substance abuse services.

^^ Includes state hospitals. ^^^ Includes Evaluation and Treatment Centers.

xx Includes Crisis Stabilization Units.

x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

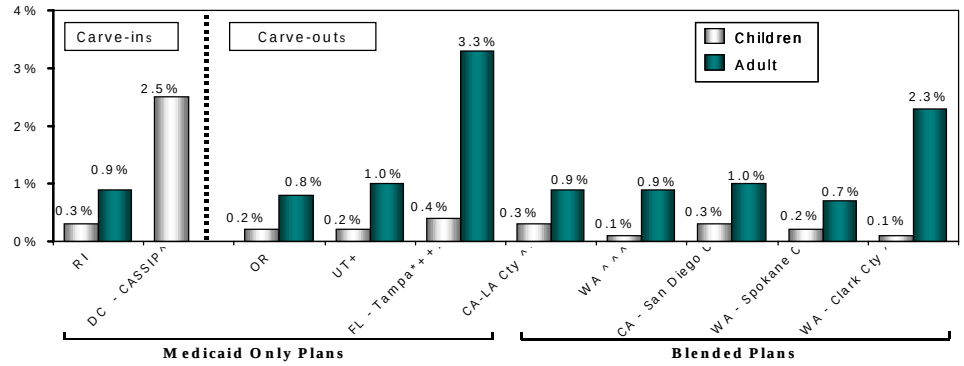
Three very high values occur between 2.2% and 2.7%. These high penetration programs include two Massachusetts HMOs and DC CASSIP. DC's high rate is explained by its enrollment only of SSI children. The reason for the high level in two of the four Massachusetts' HMOs is not immediately apparent. Remarkably, none of these outlier programs included state hospital admissions in its figures, though some of those with lower inpatient penetration levels did so.

1e. Inpatient Penetration by Age Category

Inpatient penetration data stratified by age category shows less variation than overall inpatient penetration, due in part to the lack of age stratifications for most of the high outliers from the previous chart. Children's inpatient penetration rates are consistently lower than adult rates, on average, slightly less than half of adult rates. Children's rates fall between 0.1% and 0.4%, with the exception of the District of Columbia's SSI-only program. Most adult rates fall between 0.7% and 1.0%, with the exception of Clark County whose rate reaches 2.3% and Tampa, whose adult rate – for a predominantly SSI population – reaches 3.3%

Chart 5
Inpatient Penetration by Age Category

Percentage of Medicaid enrollees who received at least one inpatient mental health service during the reporting period.



• CY 00: DC. FY 00: UT. 10/99 – 9/00 OR.. FY 01 – All Others.
* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
^ Includes both mental health and substance abuse. ^^ Includes state hospitals.
^^^ Includes Evaluation and Treatment Centers xx Includes Crisis Stabilization Units
+ Children: 0-21 years. ++ Children: under 21 years.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

	Children	Adults
Mean[x]	0.5%	1.3%
Median[x]	0.3%	0.9%
Std[x]	0.8%	0.9%

1f. Day/Night Penetration

Methodological Considerations:

Medicaid allows states to choose to cover a wide variety of non-hospital residential, day, and outpatient services, and managed care waivers provide even more flexibility to develop innovative rehabilitative and clinical services as long as overall spending limits are maintained. The variety of service models developed by different managed care programs presents the biggest challenge to meaningful benchmarking of non-hospital mental health services. HEDIS has attempted to address this by reporting three categories of mental health and substance abuse services, inpatient, day/night, and outpatient services. However, their distinction between day/night services and outpatient services is not easily understood, particularly given the variety of home and

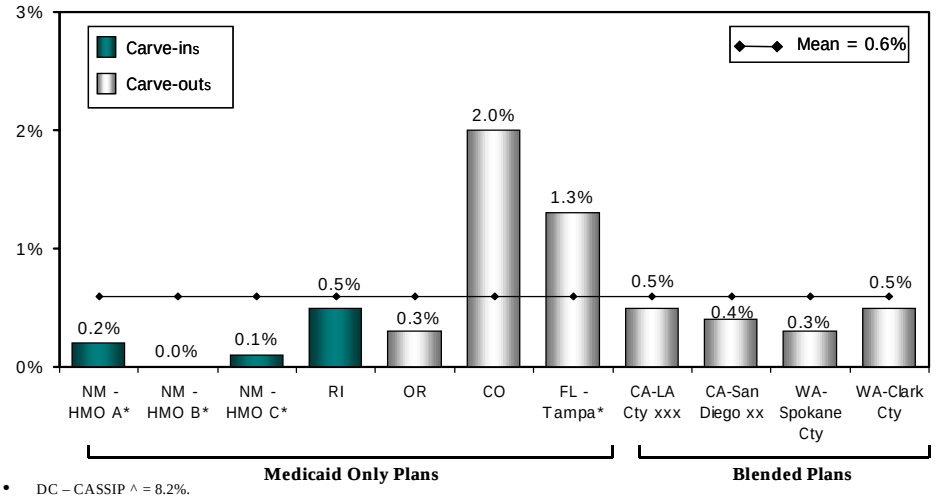
community based services offered by some public Medicaid programs. A number of the participating programs did not report using these definitions.

Eight of the ten programs reporting day/night penetration listed the services that they included in this category.[12] These definitions show the degree of variation captured in this measure. Six programs included residential treatment; five included day treatment, three included partial hospitalization and two included respite, school, after school or camp programs. IMDs, (institutions for mental disease), crisis residences, and emergency services were listed by one program each. Most programs offer two or three types of day/night services, but one program includes seven day/night services; two programs include only day services; and one includes only residential treatment. This variation may limit the comparability of day/night service utilization measures.

Chart 6

Medicaid Managed Care Plans: Day/Night Penetration

Percentage of Medicaid enrollees who received at least one day/night mental health service during the reporting period.



- DC – CASSIP ^ = 8.2%.
- CY 00: NM, DC. FY 00: CO. 10/99 – 9/00 OR. FY 01 – All Others.

* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
xxx Residential only. Excludes day treatment services.
xx Day Treatment only. Excludes residential.

Median = 0.4%
Std = 0.6%

Despite this degree of variation among programs, however, most day/night service penetration measures clustered between 0.1% and 0.5%. This compares to the NCQA Compass 2000 national HMO average of 0.17% day/night mental health penetration and NCQA National Medicaid results with a mean of 0.12%. Two systems, both Medicaid-only carve-outs that cover day and residential care, substantially exceeded that range. The District of Columbia's CASSIP program, not shown on this chart, was even higher, showing penetration of 8.2%. This program not only serves the high need SSI population, but also is unusual in covering residential treatment stays beyond 30 days, the point at which most Medicaid managed care programs would disenroll a residential client and financial responsibility for services would revert to fee-for-

[12] *Appendix L provides a matrix indicating the services reported in this category.*

service or another public agency. This unique program design was judged to be reason to exclude DC CASSIP from this and other charts and calculations affected by this element of its program design.

1g. Outpatient Services Penetration

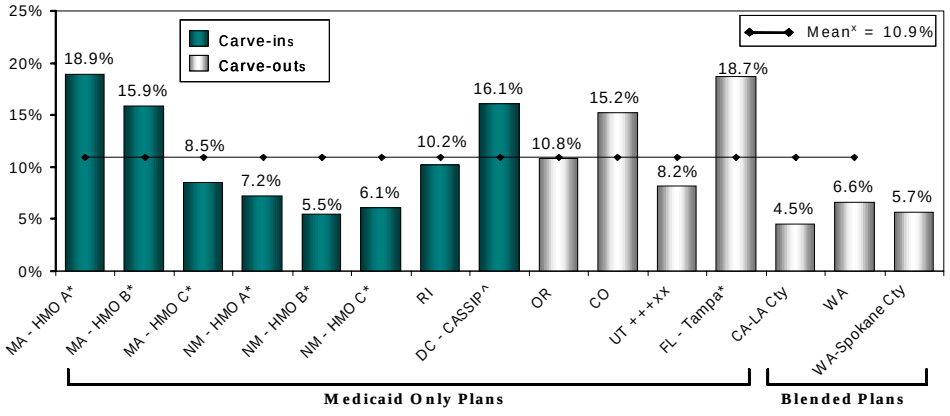
Ten of 12 programs submitting outpatient penetration rates listed the services included in this category.[16] Individual, family and group therapy and medication management are consistently included in this category. Six programs include case management services and two include crisis intervention. Colorado and Spokane County, Washington include a variety of rehabilitation and other programs. One program included day treatment, which is more commonly considered a day/night service, in its outpatient service counts.

Outpatient penetration corresponds generally to overall penetration but it has a smaller range (from 5% to 19%). The reported outpatient penetration rates do not show that more extensive coverage of outpatient services corresponds to higher rates of penetration. Spokane County, with the most extensive covered services, had among the lower rates. Blended plans showed generally lower levels than Medicaid-only plans, though the Massachusetts carve-out and King County that had high outlier levels in overall penetration did not report their outpatient penetration. Carve-in programs did not show a consistent pattern, since most tended to be somewhat lower than the mean, while others exceeded it substantially. These rates are higher, on average, than NCQA Compass 2000 HMO average of 4.2% outpatient mental health penetration, and its National Medicaid results of a 5.5% rate.

Chart 7

Medicaid Managed Care Plans: Outpatient Penetration

Percentage of Medicaid enrollees who received at least one outpatient mental health service during the reporting period.



Median^x = 9.4%
Std^x = 5.1%

• CY 00: NM, DC. FY 00: CO, UT. 10/99 – 9/00: OR. FY 01 – All Others.
* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
^ Includes both mental health and substance abuse services.
xx Includes day treatment. +++ Excludes foster children.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

[13] *No reference intended.*
[14] *No reference intended.*
[15] *No reference intended.*
[16] *Appendix M provides a matrix indicating the services reported in this category.*

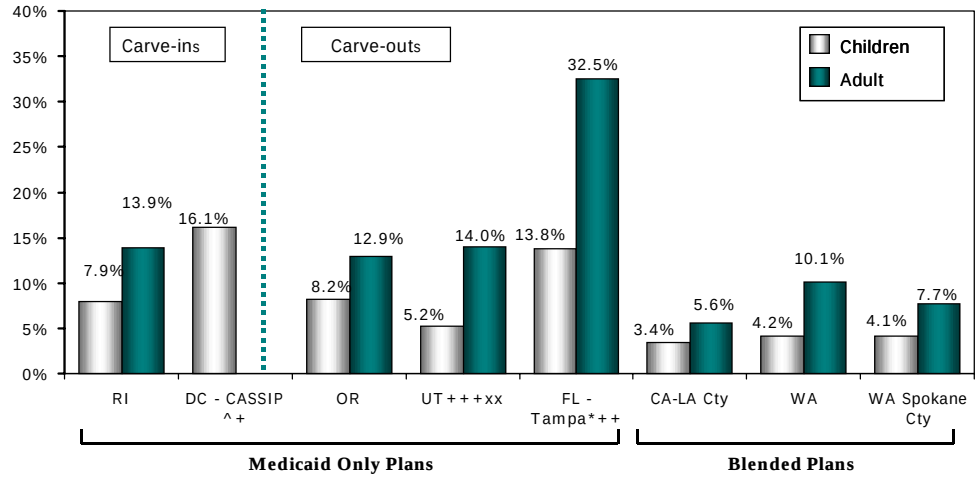
1h. Outpatient Penetration by Age Category

Outpatient penetration stratified by age shows that children's use of outpatient services is much lower than adults'. Most programs have children's outpatient penetration rates falling between 3% and 8%. Tampa and the District of Columbia are higher than the average, consistent with their high SSI enrollment. Adult outpatient penetration rates fall mostly between 6% and 14%, with Tampa a very high outlier at 33%.

Chart 8

Outpatient Penetration by Age Category

Medicaid enrollees by age group who received at least one outpatient mental health service during the reporting period.



• CY 00: DC. FY 00: UT. 10/99 – 9/00: OR. FY 01 – All Others.
* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
^ Includes both mental health and substance abuse services.
\+ Children: 0-21 years. ++ Children: Under 21 years.
+++ Children 0-21 years. Excludes foster children.
xx Includes day treatment.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

	Children	Adults
Mean[x]	8.4%	14.8%
Median[x]	7.9%	13.4%
Std[x]	4.9%	9.2%

2. *Psychiatric Inpatient Utilization*

Inpatient psychiatric service is the most intensive form of mental health care as well as a high cost service. Best practice and efficiency call for preventing inpatient admissions or providing short stays supported by a range of appropriate less intensive services. Access standards require having inpatient care available when less restrictive services are not appropriate or safe. The significance of this service to purchasers is reflected in a number of different measures, which together provide a comprehensive picture of how this service is used in a system of care.

Methodological Considerations:

Most states can calculate the number of inpatient episodes (admissions or discharges), and the days of inpatient care provided, which together allow for the calculation of average length of stay. Most can also calculate the rate of readmission for a defined period of time.

NCQA-HEDIS and other groups recommending outcome and performance measures for health plans have also focused on determining whether patients discharged from an inpatient stay receive outpatient follow-up services within a reasonable period of time, on the assumption that timely outpatient follow-up will prevent many readmissions. Therefore, most programs can calculate that measure as well.

Data were received from 12 to 14 programs on inpatient days and discharges, on readmissions within 30 days, and on post-discharge follow-up within seven days. Some programs include different types of facilities in their definitions of inpatient. State hospitals were included by three states and Washington included Evaluation and Treatment Centers, Arizona included residential treatment, and Tampa included crisis stabilization services. Since state hospitals frequently offer intermediate and long-term care to a population with serious mental illness, in contrast to acute care for a general population provided by community hospitals, their inclusion might affect many of the measures.

Measures such as readmission and follow-up after discharge for longer time periods can be affected by the methodology used to select those members to be included in the report. For example, it is important to exclude individuals who were not enrolled for the entire 90-day period following their hospital discharge when measuring the 90-day readmission rate. This level of detail was not requested, but is significant as consistency of data becomes more possible.

Another methodological difference between respondents is in the selection of the denominator used in calculating readmission rates. While most states calculated readmission rates by dividing readmissions by total discharges, some divided by unduplicated individuals served. The latter method results in higher rates since there are likely to be somewhat fewer unduplicated individuals than discharges.

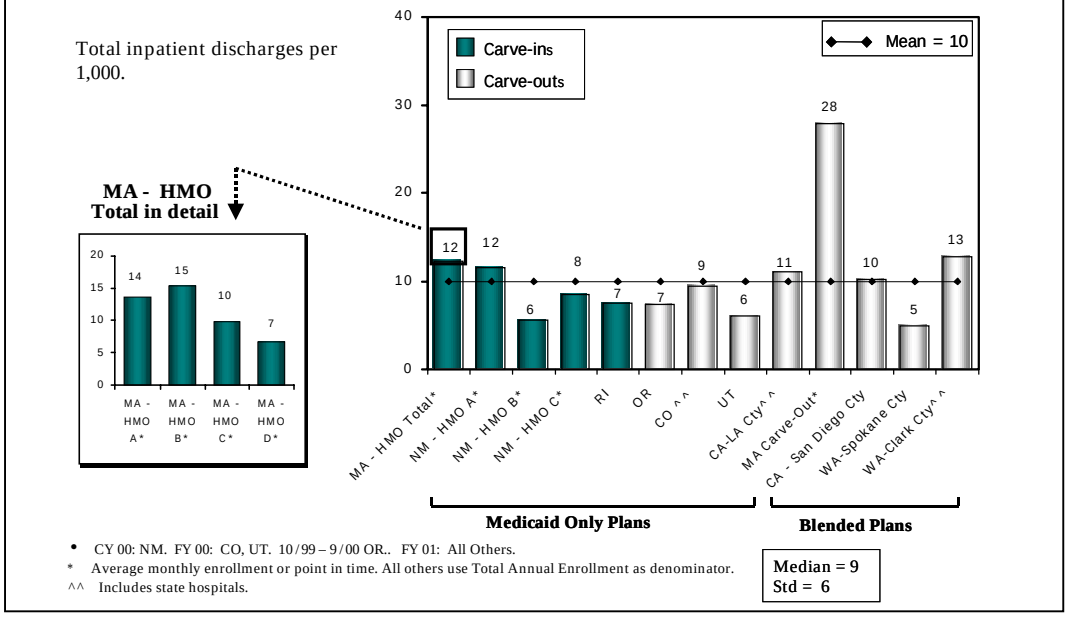
2a. Inpatient Discharges Per Thousand

Discharges per thousand provide an indication of the relative frequency of use of inpatient services in comparison to total enrollment. Most inpatient discharges per thousand range from 5 to 13, with a notable outlier, the Massachusetts Carve-out, that experiences 28 discharges per thousand. The high rate of the Massachusetts carve-out is consistent with its high rate of inpatient penetration. All data points exceed NCQA's Quality Compass national HMO average of 2.7 discharges per thousand for a predominantly commercial population. However, they fall into a similar range as NCQA's Medicaid results with average discharges per thousand of 8.6.[17]

[17] *Converted from discharges per thousand member months, the HEDIS reporting convention for Medicaid populations.*

Chart 9

Medicaid Managed Care Plans: Inpatient Discharges per 1,000 Enrollees



- CY 00: NM. FY 00: CO, UT. 10/99 – 9/00 OR.. FY 01: All Others.

* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.

^^ Includes state hospitals.

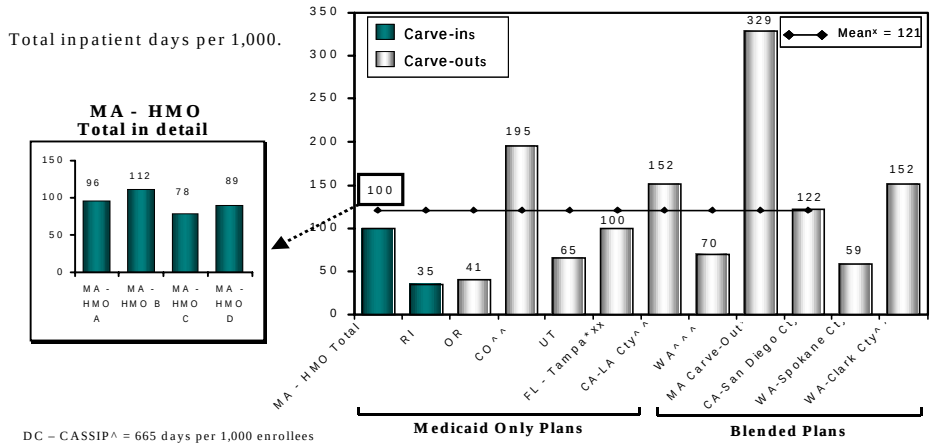
Median = 9
Std = 6

2b. Inpatient Days Per Thousand Enrollees

Days per thousand also provides information about the volume of hospital service provided in relation to total enrollment. There is a wide range in this measure, from 35 to 329 days per thousand (even disregarding DC CASSIP which was much higher at 665 days per thousand). This is reflected by a standard deviation that exceeds the median for this measure. There is little indication of clustering.

Chart 10

Medicaid Managed Care Plans: Inpatient Utilization (Days) per 1,000 Enrollees



- DC – CASSIP^ = 665 days per 1,000 enrollees
- CY 00: DC. FY 00: CO, UT. 10/99 – 9/00 OR. FY 01 – All Others.

* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.

xx Includes Crisis Stabilization Units.

^^ Includes state hospitals. ^^^ Includes Evaluation and Treatment Centers.

x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

Median^x = 100
Std^x = 88

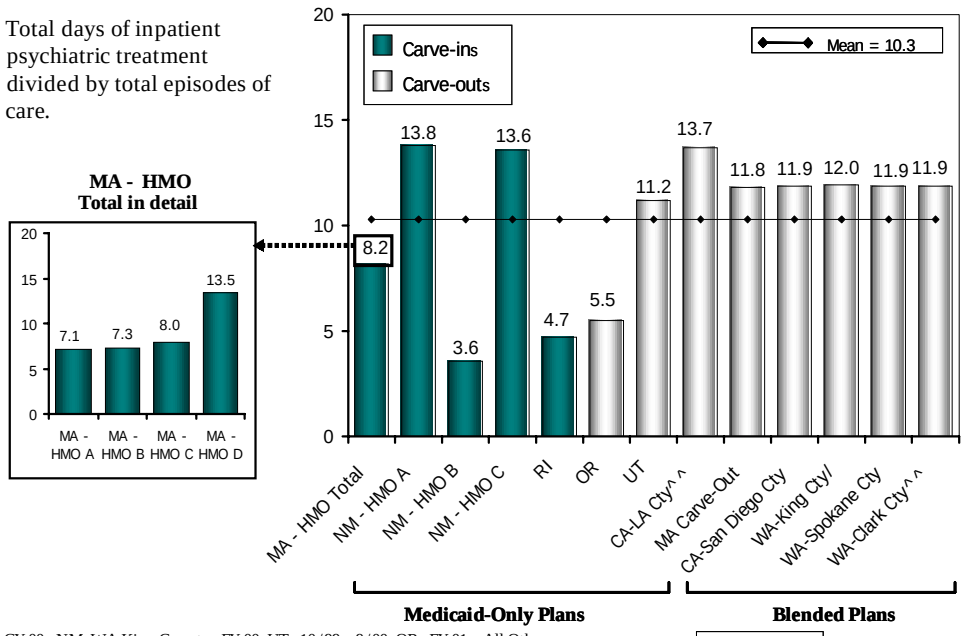
Administrators of CASSIP have several explanations for the program's high level of inpatient days per thousand. They indicate that CASSIP is responsible for extended inpatient stays while waiting for an appropriate out-of-state residential placement to be identified and the necessary Interstate compacts to be executed. Their program is also unusual in covering extended inpatient and residential stays; most Medicaid managed care programs disenroll people whose stays exceed 30 days.

The current data clearly point to the considerable difference in the extent to which different plans use inpatient treatment, both the number of people who use inpatient services as well as the average length of stay.

2c. Inpatient Average Length of Stay

Average length of stay, the average number of days that patients are treated in inpatient facilities, can be an indicator of the practice standards in the hospital facilities as well as the level of utilization management in the system. The distribution appeared to have two clusters, with three data points between three and six days, and nine between 11 and 14 days. Seven of the eight carve-out programs fell into this higher cluster. Three Massachusetts HMOs fell between these two ranges. This is one measure on which some public programs fell below the NCQA Compass 2000 HMO average of 6.3 days length of stay. NCQA's Medicaid results for this measure averaged 6.2 days length of stay, similar to its commercial plan average.

Chart 11
Medicaid Managed Care Plans:
Inpatient Average Length of Stay (ALOS)



- CY 00: NM, WA King County. FY 00: UT. 10/99 – 9/00: OR . FY 01 – All Others
^^ Includes state hospitals.
/ Includes Non-Medicaid utilizers.

2d. Inpatient Readmission Rates

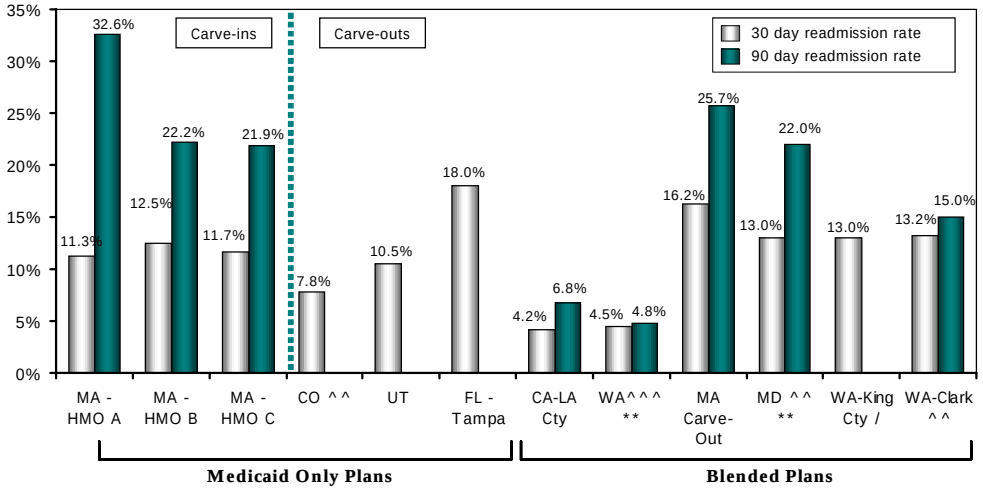
Readmission rates help managers evaluate how effectively an inpatient admission and its outpatient follow-up have met a patient's need. While readmission is considered to be clinically necessary for some patients, a high readmission rate is generally considered to be an indicator of ineffective inpatient and post-discharge mental health services. Most thirty-day readmission rates fell between 8% and 13%. Washington State and Los Angeles County were considerably lower, with approximately 4%. Both included state hospitals and had lengths of stay on the longer side, perhaps avoiding a higher readmission rate by treating patients for a longer period of time. Tampa at 18% and the Massachusetts carve-out at 16% were higher than all others.

Ninety-day readmission rates ranged from 5% to 33%, with Washington and LA County rates being considerably lower than the other states and health plans. Clark County was intermediate, experiencing 15% readmission at 90 days, and the remaining plans' rates were greater than 20%.

Chart 12

Medicaid Managed Care Plans: 30- and 90-Day Readmission Rate

Percentage of plan enrollees readmitted for inpatient psychiatric treatment within 30 and 90 days of discharge.



• CY 00: WA King County. FY 00: CO, UT. 4/00 – 3/01: MA HMO C. FY 01 – All Others.
^^ Includes State Hospitals. ^^^ Includes Evaluation and Treatment Centers.
** Readmission rates reported at an individual consumer level.
/ Voluntary Medicaid and non-Medicaid admissions.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

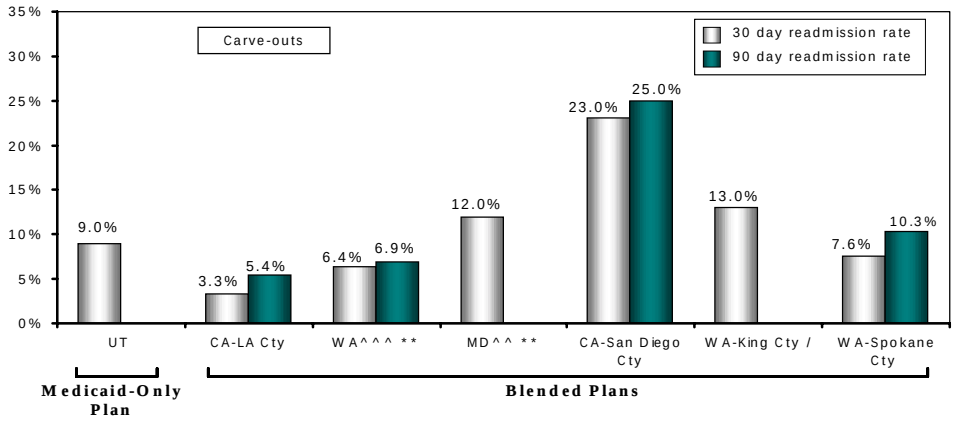
	30 Day	90 Day
Mean[x]	11.0%	15.1%
Median[x]	11.5%	21.9%
Std[x]	4.5%	12.2%

2e. Child and Adult Inpatient Readmission Rates

Readmission rates for children are lower than for adults for all programs reporting except Washington State and its King County. However, the differential is not as pronounced as it has been for other child / adult stratifications. Children's 30-day rates had an average of 10.7% and a range of 3% to 23%. Washington State and Los Angeles County, both including state hospitals, had the lowest readmission rates. San Diego County was a high outlier at 23%.

Chart 13
Medicaid Managed Care Plans:
Children's 30- and 90-Day Readmission Rate

Percentage of plan enrollees readmitted for inpatient psychiatric treatment within 30 and 90 days of discharge.



- CY 00: WA King County. FY 00: UT . FY 01 – All Others.

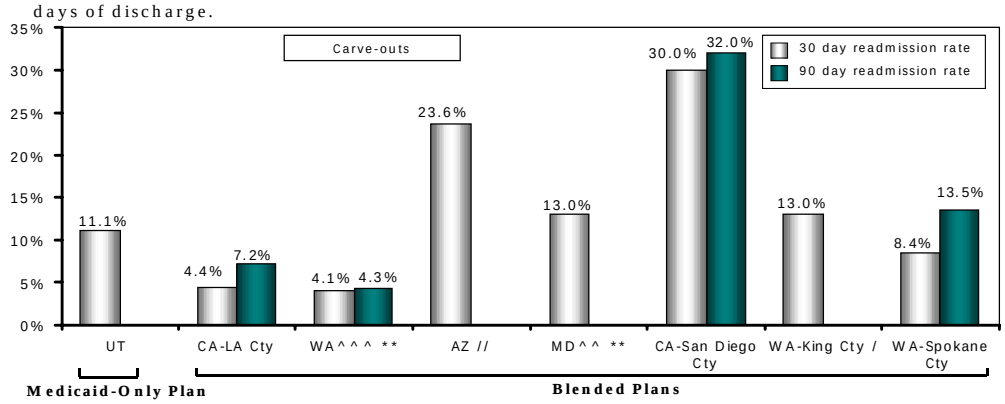
^^ Includes State Hospitals. ^^^ Includes Evaluation and Treatment Centers.
** Readmission rates reported at an individual consumer level.
/ Voluntary Medicaid and non-Medicaid admissions.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

	30 Day	90 Day
Mean[x]	10.7%	12.4%
Median[x]	9.0%	6.9%
Std[x]	7.6%	10.9%

Adult readmission rates showed a greater range than for children, with a total range of 4% to 30% for 30-day rates, and 4% to 32% for 90-day rates. Though the difference is small in most plans, adult rates were all higher than child rates. Arizona's rate of 24% is applicable only to its subset of inpatients identified as seriously mentally ill, a group more at risk for readmission. San Diego County's rates of 30% were high outliers. With relatively few observations, there is relatively little clustering apparent.

Chart 14
Medicaid Managed Care Plans:
Adults 30- and 90-Day Readmission Rate

Percentage of plan enrollees readmitted for inpatient psychiatric treatment within 30 and 90 days of discharge.



- CY 00: WA King County. FY 00: UT. Q1 & Q2, FY 01: AZ. FY 01 – All Others.

^^ Includes State Hospitals. ^^^ Includes Evaluation and Treatment Centers.
** Readmission rates reported at an individual consumer level.
/ Voluntary Medicaid and non-Medicaid admissions.
// Adults with serious mental illness only.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

	30 Day	90 Day
Mean[x]	14.4%	14.5%
Median[x]	12.1%	7.2%
Std[x]	10.5%	15.2%

2f. Follow-up after Inpatient Discharge

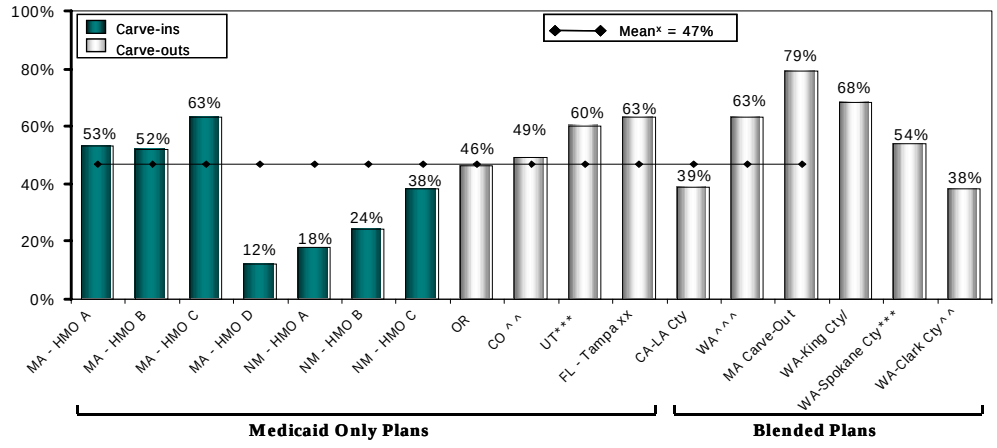
Follow-up after inpatient discharge indicates how well inpatient facilities and outpatient service providers collaborate to provide coordinated care for people being discharged from an episode of inpatient treatment. The data points received for follow-up within seven days show a very large range of performance, with 60% rates achieved by five programs and 79% by the Massachusetts' carve-out, and very low rates shown by all the New Mexico HMOs and one Massachusetts HMO[18]. In general, carve-out programs seem to perform a little better on this measure, though several HMO programs were above average.

In comparison to commercial managed care populations, nine of the eighteen data points exceeded the NCQA Compass 2000 HMO average of 49.7%. All but three exceeded NCQA's Medicaid results averaging 34%.

Chart 15

Medicaid Managed Care Plans:
Inpatient Discharges - Follow-up Visit within 7 Days

Percentage of inpatient discharges with a follow-up visit within 7 days (excludes children under 6).



- CY 00: NM, WA - King County. FY 00: CO. UT. 10/99 – 9/00 OR.
- MA HMO B. 4/00 – 3/01 MA HMO C, D, Carve-out. FY 01: All others.

Median^x = 51%
Std^x = 19%

*** Adults only.
xx Includes Crisis Stabilization Units.
^^ Includes state hospitals ^^^ State Hospitals and Evaluation and Treatment Centers included.
/ Follow-up visits within 5 days. Voluntary Medicaid and non-Medicaid discharges.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

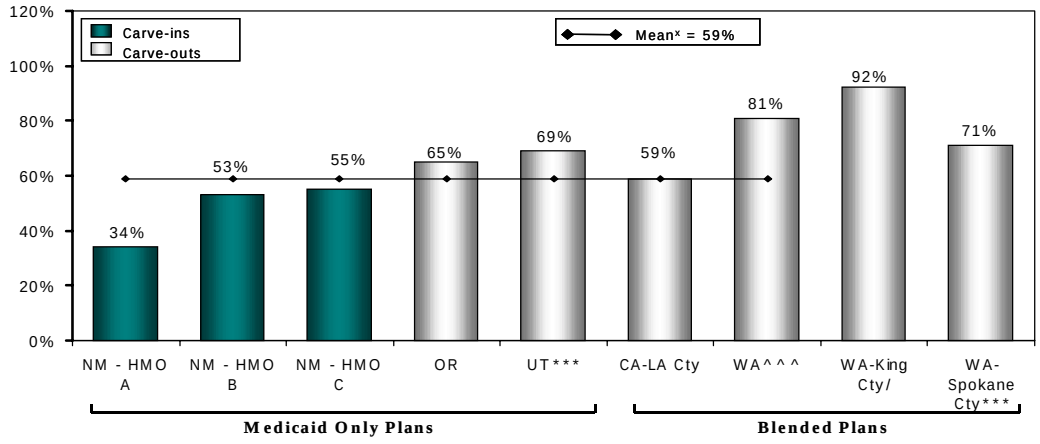
Fewer plans measured follow-up after 30 days. With an additional three weeks to provide follow-up, rates were higher, with three programs exceeding rates of 70% and one reaching a rate of 92%. King County's 92% rate did not include its discharges of those clients admitted involuntarily; the rate for involuntary admissions was also high however, at 87.6%. New Mexico's HMOs showed lower rates, ranging from 34% to 55%, than the carve-out programs shown. Overall, these public sector programs did not fare as well in comparison to HEDIS as they did on the seven-day measures. Two programs exceeded the Compass 2000 HMO average of 72.8% 30-day follow-up, though most equaled or exceeded NCQA's Medicaid results averaging 57% follow-up.

[18] *Due to the nature of the data, it is not possible to consolidate the Massachusetts HMO data as was done elsewhere.*

Given the populations served by the public sector populations, it is notable that some programs are able to come close to or exceed the commercial population rates. It is likely that states can generate improvements in provision of follow-up care in their managed care programs. For example, the successful Massachusetts carve-out was likely influenced by inclusion of performance specifications in its contract, calling for provision of clinically indicated services to be provided within three days of discharge.

Chart 16
Medicaid Managed Care Plans:
Inpatient Discharges - Follow-up Visit within 30 Days

Percentage of inpatient discharges with a follow-up visit within 30 days.



• CY 00: NM, WA - King County. FY 00: UT. 10/99 – 9/00: OR . FY 01: All others.
*** Adults only.
^^^ Includes State Hospital and Evaluation and Treatment Centers.
/ Voluntary Medicaid and non-Medicaid discharges
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

Median^x = 59%
Std^x = 15%

3. Outpatient and Day/Night Mental Health Utilization

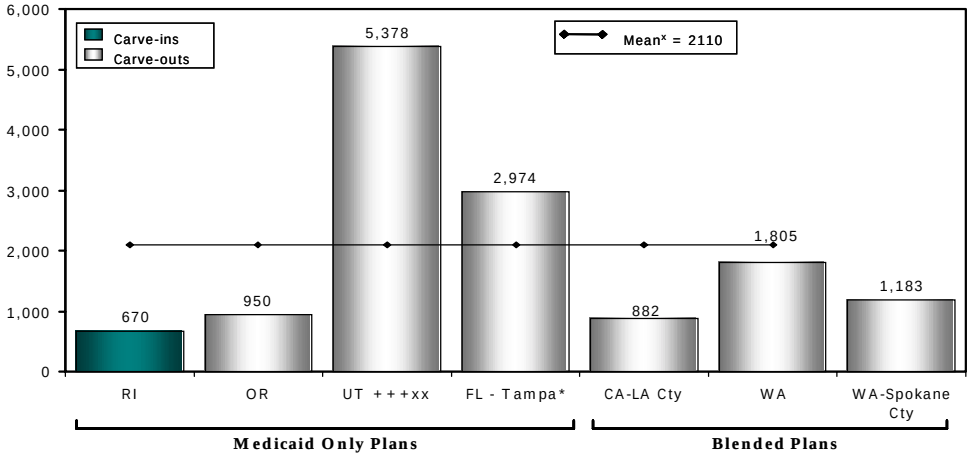
There is less consensus about the use of measures for non-hospital mental health services than there is for measures of inpatient utilization. In general, units of service per thousand are reported either service by service, or for total outpatient services. The biggest challenge in analyzing non-hospital service utilization results from differences in billing units. For day/night services, the unit is likely to be a "day", but the "day" may represent a 24-hour residential care day or a 6-hour day treatment program. Outpatient services may include 15-, 30- or 60-minute sessions, or visits of unspecified length. It is not unusual for a service, such as day treatment, to be billed using day units in one state, and 15-minute units in another.

Many programs indicated that they could produce reports on units of outpatient service; fewer could produce reports on day/night service units, often because they do not use the HEDIS definition. Data were received from 9 programs for outpatient utilization and from a different set of 9 programs for day/night utilization. Day/night utilization was not reported due to variation in unit definitions and in the types of services reported, which makes these data difficult to interpret.

Chart 17 shows outpatient hours per thousand enrollees for those programs whose units could be converted to hours. Additional data points, which counted units of different

lengths that could not easily be converted to hours, are shown in Table 6. Outpatient hours per thousand enrollees show considerable variation, with several high values, several low values, and only a few in between. This extreme range, from 670 to 5,378, makes it hard to interpret the data. Utah is an outlier value, almost twice as high as Tampa's program, which we know has an unusually high level of SSI enrollment. However, Utah's figures include day treatment hours, as do Washington State's.

Chart 17
Medicaid Managed Care Plans:
Outpatient Utilization (Hours) per 1,000 Enrollees



• FY 00: UT. 10/99 – 9/00: OR. FY 01 – All Others.
* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
+++ Excludes foster children. xx Includes day treatment.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

Similar issues arise in analyzing the table showing outpatient units per thousand. CASSIP is a high outlier, and we know that its SSI-only enrollment contributes to a high utilization rate. While population and reporting differences explain some of the variation in utilization of outpatient services, there is clearly more to be understood before programs can usefully be compared on their provision of outpatient services.

TABLE 6
OUTPATIENT MENTAL HEALTH UTILIZATION
UNITS PER THOUSAND

Program	Period	Units Per Thousand	Unit Length
DC CASSIP①	CY2000	6,826	From 5 min. to 1 ½ hrs
Colorado	FY2000	4,758	From 15 min to 1 ½ hrs

①*Includes both mental health and substance abuse services.*

4. Mental Health Expenditures

Expenditure measures indicate the resources used by a mental health service system, and are a critical measure for program managers and for accountability to the Centers for Medicare and Medicaid Services (CMS) and the public. Each CMS waiver is granted with the provision that the waivered program demonstrates cost neutrality. In addition, dollars can provide a common unit by which to compare different systems.

Methodological Considerations:
It is surprising that, while many programs can produce data on the overall cost of their services and on certain categories of service, some programs cannot tie their costs to service units. This is particularly true for programs that have subcapitated providers, such as community mental health centers that both provide services and purchase any services that they cannot provide directly. In these cases, the providers do not have claims data for the services they provide. While the system can total the costs of its subcapitation payments, it lacks an indication of the relative distribution of resources between different service types. Relatively few data points on cost were received, with inpatient cost being the most frequently provided measure. A few programs submitted cost estimates calculated by multiplying units provided times the average fee for service rate for the unit being counted.

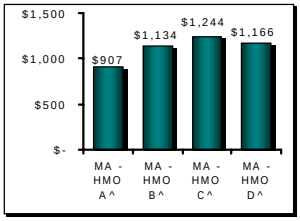
Service expenditures are a critical aspect of system performance and not as readily available as would be expected. It will be important to identify and address the barriers to collecting and analyzing cost data in those states that do not easily do so.

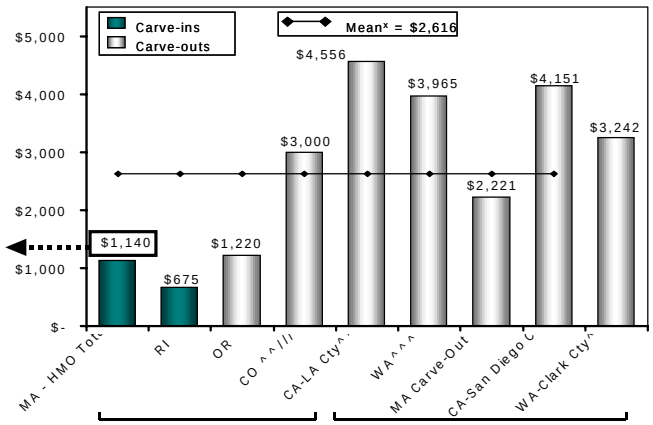
4a. Total Expenditures Per Enrollee

Expenditures per enrollee using services were assessed, and considerable variation among programs was found. Most fell between $1,100 and $4,600. Rhode Island was a low outlier at $675, consistent with its lower need TANF target population. The District of Columbia's CASSIP program not only serves high need SSI enrollees, but also covers costly long-term residential care in its benefit package, explaining its average cost of $9,243 and its status as a high cost outlier.

Chart 18
Medicaid Managed Care Plans:
Expenditures per Enrollee Using Services

Total dollars paid for covered mental health services divided by the number of Medicaid enrollees receiving a mental health service under the plan.





Median^x = $2,611
Std^x = $1,518

- DC – CASSIP^ = $9,243 per enrollee using services.
- CY 00: DC. FY 00: CO. 10/99 – 9/00 OR. FY 01: All others.

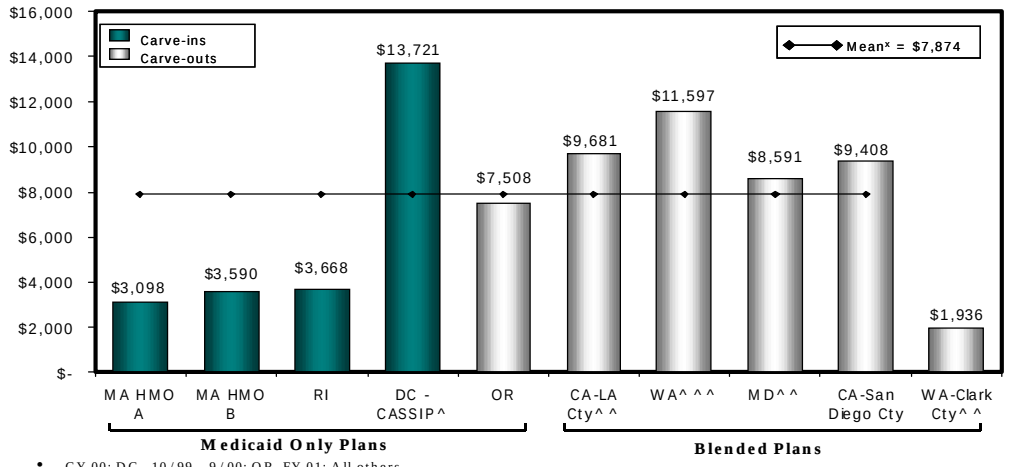
^ Includes both mental health and substance abuse services.
^^ Includes State Hospitals.
^^^ Costs exclude day treatment. Includes Evaluation and Treatment Centers.
/// Includes costs of MCO Administration.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

The variation between the other programs is considerable, and while there are reporting differences, they are not sufficient to explain the variation. However, the variation may be related to differences in inpatient utilization. Washington State, LA County and San Diego County all have high average lengths of stay. Average expenditures are not clearly related to the extensiveness of the service types covered in the benefit package. For example, Oregon with low average costs covers a wide variety of day / night and outpatient services. Other factors that will affect costs are the historical Medicaid pricing and current market price of mental health services in each state.

4b. Inpatient Expenditures

The three HMO data points for inpatient expenditures per enrollee hospitalized showed generally similar levels of expense from $3,100 to $3,600 per client. The CASSIP program, as discussed previously, would be expected to have higher average inpatient costs as a result of its higher need target population and lack of restrictions on long hospital stays. Three of the blended carve-outs clustered at about $9,000 to $10,000. Two of these programs, Maryland and LA County, include state hospital stays in their figures. Washington State, which includes the cost of evaluation and treatment centers in this figure, was slightly higher at $12,000, and Oregon was somewhat lower at $7,500. Clark County has a very low per user inpatient cost, even with state hospital stays included. The County reports having reduced hospital utilization considerably.

Chart 19
Medicaid Managed Care Plans:
Inpatient Expenditures per Enrollee Hospitalized



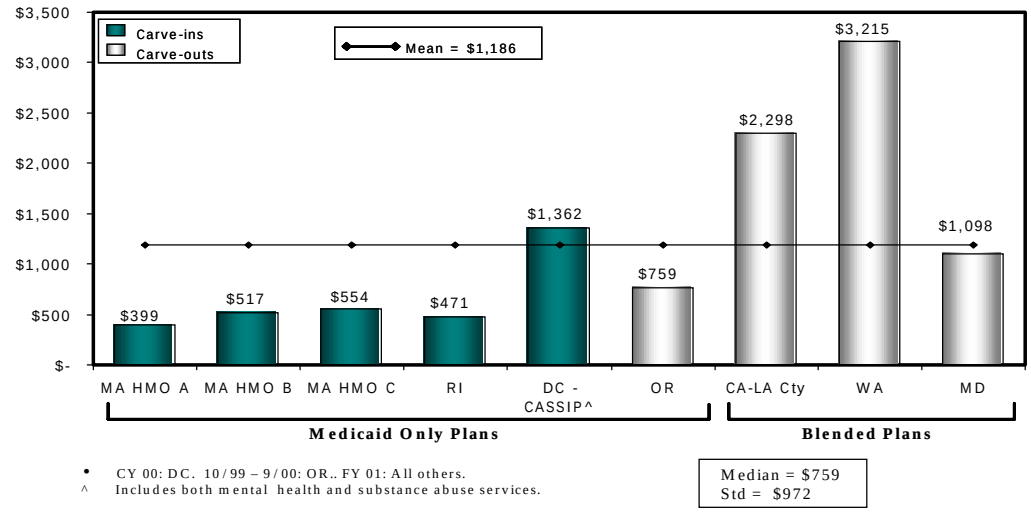
• CY 00: DC. 10/99 – 9/00: OR. FY 01: All others.
^ Includes both mental health and substance abuse services.
^^ Includes State Hospitals.
^^^ Includes Evaluation and Treatment Centers.
x Individual Washington counties are excluded from the calculation of summary statistics, since they are already counted within Washington State

4c. Outpatient Expenditures per Enrollee

Outpatient services also showed a pattern of much lower per utilizer costs for HMOs. HMO costs ranged from $400 to $550. A wider range of expenses was noted for blended carve-outs, which ranged from $1,100 to $3,200. The DC CASSIP program fell into this range. Oregon's Medicaid-only carve-out fell between the two groups. This variation suggests that blended carve-out programs are serving individuals with higher levels of need than those enrolled in HMOs. However, considerable variation

exists between the blended carve-out programs, suggesting that additional sources of variation are also likely.

Chart 20
Medicaid Managed Care Plans: Outpatient Expenditures per Enrollee Receiving Outpatient Services



5. *Substance Abuse Treatment Penetration*

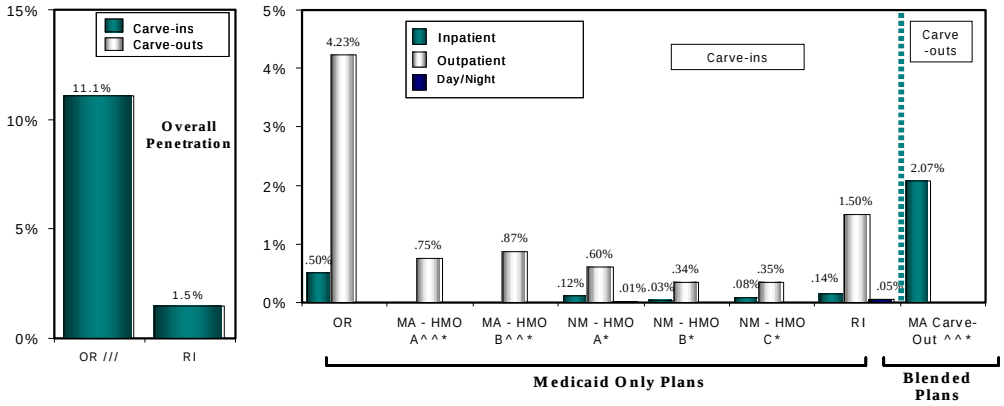
Penetration is just as important in the evaluation of access to substance abuse services as it is to mental health services. However, with fewer programs covering substance abuse services within managed care, it was not possible to report as many data points as desired. Substance abuse measures were received from only six managed care programs.

The two measures of overall penetration of substance abuse treatment, defined as Medicaid enrollees who received at least one substance abuse service during the reporting period, were considerably different, 1.5% and 11.1%. These rates all exceed both the 0.35% average chemical dependency penetration in national HMOs according to NCQA Compass 2000 and the National Medicaid results, averaging 0.9%. Oregon's 11.1% penetration includes members using inpatient and outpatient substance abuse services, as well as services counted in a third category, medical services. This third category includes physician services provided for a primary substance abuse diagnosis. When this rate is compared to Oregon's 4.2% outpatient substance abuse penetration rate, it is apparent that more members receive services related to substance abuse from primary care and other health care providers than in dedicated substance abuse treatment settings.

Most programs show 0.1% inpatient substance abuse penetration rates, similar to the NCQA Quality Compass national HMO average of 0.09%, but somewhat below NCQA's National Medicaid results, which averaged 0.18%. Oregon and the Massachusetts carve-out are outliers at 0.5% and 2.1% respectively. Massachusetts, as called for by HEDIS, categorizes treatment by Level III and IIIa detoxification facilities as inpatient care. Only Rhode Island also covers this level of care in its Medicaid managed care benefit. If Massachusetts counted only hospital level detoxification, inpatient penetration in the Massachusetts carve-out would be less than 0.01%.

Chart 21
Medicaid Managed Care Plans: Substance Abuse Penetration

Percentage of Medicaid enrollees who received at least one substance abuse service during the reporting period.



• CY 00: NM, OR.. FY 01: All Others.
* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
^^ Includes Level III (freestanding) detoxification facilities.
/ / / Overall penetration includes medical professional services. (These services are not included in inpatient or outpatient categories).

	Inpatient	Outpatient
Mean	0.48%	1.23%
Median	0.13%	0.75%
Std	0.79%	1.38%

Not unexpectedly, outpatient substance abuse penetration is considerably higher than inpatient for most programs. Outpatient penetration ranges from 0.3% to 4.2%. Rhode Island is high at 1.5% and Oregon considerably higher at 4.2%. All data points exceed the NCQA Compass 2000 national HMO average of 0.29% but most are not far from NCQA's National Medicaid results, averaging 0.75%.

The two day / night data points are 0.01% in a New Mexico HMO and 0.05% in Rhode Island HMOs. New Mexico's low rate is consistent with its very high percentage of children (about 80%), who are less likely to use substance abuse services. The NCQA Compass 2000 National HMO average for this measure is 0.03%. NCQA's National Medicaid results are higher than Rhode Island, at an average of 0.09%.

It is evident that substance abuse penetration has much lower ranges than mental health penetration. Only Oregon's overall substance abuse penetration level, which includes medical services, falls in the range of mental health penetration reported for this project.

In order to better understand overall substance abuse penetration, it will be important to better understand the types of services provided in medical settings, and to develop clear definitions of what should be included in measures of substance abuse penetration in integrated programs. In addition, more information about substance abuse benefits and the structure of Medicaid systems of substance abuse care could help us to better interpret the meaning of the high outlier values, and differential between substance abuse and mental health penetration. More data points may confirm the degree of clustering observed, or show more variation.

6. Substance Abuse Inpatient Utilization

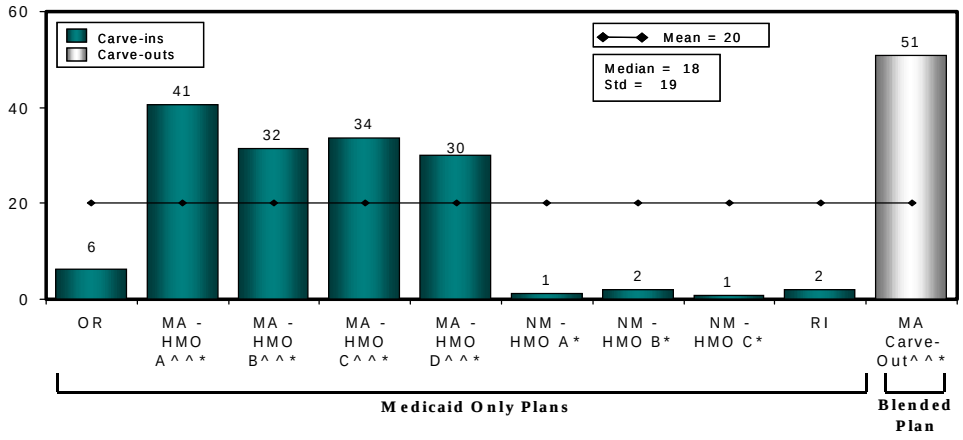
Utilization data for inpatient substance abuse treatment are presented in the following charts. As with mental health inpatient services, the inpatient data requested from states include discharges per 1,000, average length of stay, readmission rates and follow-up after discharge.

In general, significant differences were noted between Massachusetts and the other states on the use of inpatient care.

6a. Inpatient Discharges Per Thousand

Substance Abuse Inpatient Discharges per thousand fall into distinct high and low ranges, with states other than Massachusetts ranging between one and six. The low end of this range is similar to NCQA's Quality Compass national HMO average of 1.02 inpatient chemical dependency days per thousand. NCQA's National Medicaid results are somewhat higher, averaging 2.4 days per thousand. In distinct contrast, both Massachusetts' HMOs and its carve-out are many times higher than the highest rate among other plans, and are also higher than the highest rate for mental health discharges per thousand (28) in this report. Massachusetts has an expansion population of unemployed adults that likely has a higher incidence of chemical dependency than TANF adults. In addition, Massachusetts counts non-hospital detoxification in this category. Without the contrast of Massachusetts, Oregon's rate of six would seem to be an outlier, compared to New Mexico, Rhode Island, and both Medicaid and commercial HEDIS. Oregon's relatively high rate may also be due to its inclusion of adult expansion populations and relatively high proportion of adults generally in its managed care program.

Chart 22
Medicaid Managed Care Plans:
Substance Abuse Inpatient Discharges per 1,000



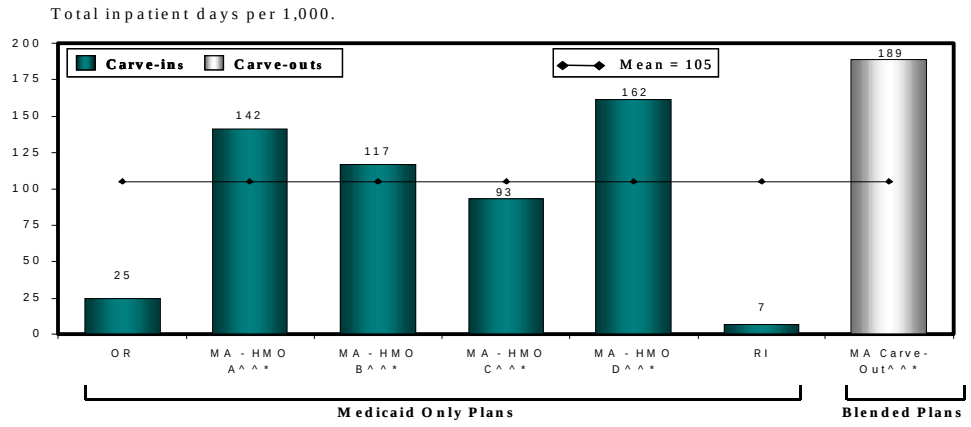
• CY 00: NM, OR. FY 01: All Others.
* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
^^ Includes Level III (freestanding) detoxification facilities or medically monitored residential detoxification.

6b. Inpatient Days per Thousand

Inpatient days per thousand shows the same significant difference between the Massachusetts inpatient substance abuse utilization and the levels of other states. Rhode Island reported seven days and Oregon 25 days (in itself a considerable range), while the Massachusetts programs ranged from 93 to 189 days per thousand. Massachusetts' substance abuse days per thousand fall into the mid-range of mental health days per thousand, while substance abuse days per thousand for all other reported programs fall well below the mental health days of the lowest state. As noted above, this dichotomy is likely due to the inclusion of non-hospital (Level III) detoxification in Massachusetts and their service of low-income adults. However, this

dramatic difference between Massachusetts and other service systems raises significant questions about the availability of detoxification services in other states, as well as what additional factors might be driving the relatively high utilization levels in Massachusetts.

Chart 23
Medicaid Managed Care Plans:
Substance Abuse Inpatient Days per 1,000



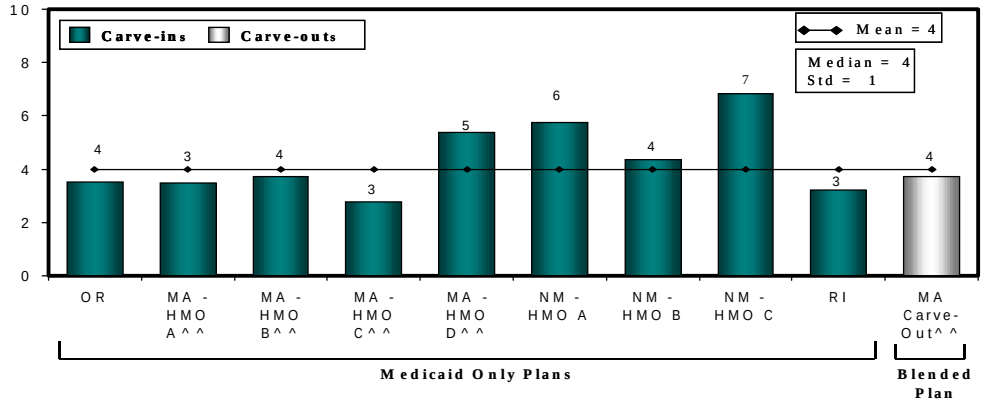
• CY 00: OR. FY 01: All Others.
* Average monthly enrollment or point in time. All others use Total Annual Enrollment as denominator.
^^ Includes Level III (freestanding) detoxification facilities or medically monitored residential detoxification.

Median = 117
Std = 68

6c. Inpatient Average Length of Stay

Average length of stay for inpatient detoxification shows a notable consistency compared to many of the measures we have collected. It clusters between three and four days for seven plans. Three HMOs have average lengths of stay that exceed four days. In this case, both the median and average for these Medicaid programs falls below the national HMO average length of stay for chemical dependency of 5.15 days as reported by NCQA Quality Compass 2000, but only slightly below NCQA's National Medicaid results, with an average length of stay of 4.6 days.

Chart 24
Medicaid Managed Care Plans: Substance Abuse Inpatient Average Length of Stay (ALOS)



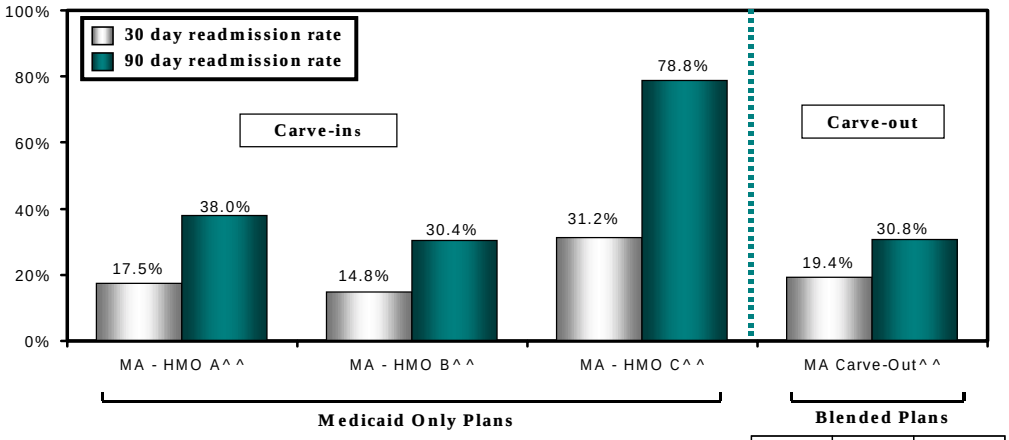
• CY 00: NM, OR. FY 01: All Others.
^^ Includes Level III (freestanding) detoxification facilities or medically monitored residential detoxification.

6d. Inpatient Readmission Rates

Only Massachusetts reported overall readmission rates for substance abuse inpatient facilities, which include Level III detoxification. There was considerable consistency in both 30- and 90-day rates for two HMOs and the carve-out. One HMO had higher rates, especially at 90 days. Readmission rates at both 30 and 90 days were somewhat higher than for psychiatric readmissions. Most 30-day psychiatric readmission rates fell below 13%, while 30-day substance abuse readmissions ranged from 14% to 19% with a 30% outlier. Ninety day psychiatric readmission rates ranged widely, from 4% to 33%. Ninety-day substance abuse readmission rates in Massachusetts fell between 30% and 38%, with an outlier of 79%.

Chart 25
Medicaid Managed Care Plans:
Substance Abuse 30 and 90 Day Readmission Rate

Percentage of plan enrollees readmitted for inpatient substance abuse treatment within 30 and 90 days of discharge.



	30 Day	90 Day
Mean	20.7%	44.5%
Median	18.5%	34.4%
Std	7.2%	23.1%

• 4/00 – 3/01: MA HMO C. FY 01 – All Others
^^ Includes Level III (freestanding) detoxification facilities.

6e. 14 Day Follow-up after Discharge from Detoxification

The Washington Circle Group has defined a series of process measures for desirable substance abuse treatment including the rate at which individuals discharged from residential detoxification enter substance abuse treatment within 14 days. Though this measure is methodologically equivalent to those used for 7- and 30-day follow-up after discharge from inpatient psychiatric treatment, a measure submitted by many programs, the substance abuse equivalent was not submitted by any of our participating programs. The Washington Circle Group is a relatively new effort, and there has not been sufficient time for states to adopt these measures. Given the established methodology for similar mental health measures, and the high level of substance abuse readmissions, states are encouraged to use the Washington Circle measures take a similar look at their substance abuse treatment systems.

7. Outpatient and Day/Night Substance Abuse Utilization

Only two programs provided data for outpatient and day/night service utilization, and the definitions of the categories were not necessarily consistent with HEDIS definitions. In addition, HEDIS does not explicitly address where to account for Methadone dosing, perhaps because Methadone maintenance is often explicitly excluded from commercial medical benefits. However, Methadone is often covered by Medicaid. Because it is a service needed daily on a long-term basis, provision of this service has the potential to significantly impact the utilization profile of outpatient substance abuse.

7a. Outpatient Substance Abuse Utilization per Thousand

Only two data points were provided for outpatient substance abuse utilization, and, as shown in Table 7, they differed considerably, ranging from 216 to 1,500 hours per thousand. Oregon covers Methadone dosing and includes those units in this category, likely contributing toward a high level of utilization.

TABLE 7
OUTPATIENT SUBSTANCE ABUSE UTILIZATION
UNITS PER THOUSAND

Program	Period	Units of Service Per Thousand	Unit Length
Oregon HMOs	CY2000	1,504	Hour
Rhode Island Rite Care	FY2001	216	Hour

8. Expenditures for Substance Abuse Treatment

Analyzing expenditures per service user provides additional information about use of services and the level of intensity of those services. Average inpatient expenditures had a wide range, from less than $2,000 to almost $3,000. The single data point for day/night expenditures was $731. The outpatient expenditures of Oregon and Rhode Island were quite similar, and a Massachusetts HMO was somewhat higher.

TABLE 8
OUTPATIENT SUBSTANCE ABUSE EXPENDITURES
PER SERVICE USER

Program	Period	Inpatient Expenditures	Day/Night Expenditures	Outpatient Expenditures	Total Expenditures
Oregon HMOs	CY2000	$2,905	n/a	$1,215	
Rhode Island Rite Care	FY2001	$2,076	$731	$1,160	$1,381
MA Carve-out	FY2001	$1,843			
MA HMO B	FY2001			$1,753	

More attention to development of reporting categories for substance abuse services, appropriate methods of accounting for Methadone treatment, and reporting on substance abuse treatment are needed to provide useful benchmarks for substance abuse treatment systems.

9. Mental Health/Substance Abuse Dual Diagnosis

In recent years, literature on mental health treatment has emphasized the high incidence of individuals with co-occurring mental health and substance abuse conditions. Identifying these individuals and then determining whether they have received appropriate treatment for both conditions is essential to the effective treatment of these individuals. The dual diagnosis measure used for this project was defined as the percentage of individuals receiving a mental health service who have a secondary diagnosis of substance abuse.

Methodological Considerations:
Many states were able to report this measure, though several states were concerned about underreporting because of incomplete data on secondary diagnoses. While a primary diagnosis is required for a claim to be complete, a secondary diagnosis is optional. A few states did not collect data on secondary diagnoses, at least in their most easily accessible data sets, and even among states that could compute the measure it was not routinely done.

Programs may choose to look at dual treatment rather than dual diagnosis. Texas NorthSTAR reported that it counts individuals that receive both mental health and substance abuse services within the year. This method focuses on the degree to which individuals are receiving treatment for both diagnoses and is most easily available to programs that cover both mental health and substance abuse benefits. Mental health-only programs will have to integrate their own encounter data with those from the system that covers substance abuse benefits to calculate this indicator. The indicator being presented measures the need for dual diagnosis treatment, but does not provide any indication of whether treatment has been provided for the secondary condition.

9a. Dual Diagnosis

Though more than ten states reported that they could compute this measure, only five data points were received. Three of the programs clustered between 6% and 8%, with higher levels (13% and 18%) reported at the two Washington State sites. These rates are significantly lower than the estimates in the literature.[19] Four of the five plans that reported this measure were blended carve-outs.

TABLE 9
DUAL DIAGNOSIS: SUBSTANCE ABUSE DIAGNOSIS AMONG USERS OF MENTAL HEALTH SERVICES

Program	Period	Secondary Substance Abuse Diagnosis		
		Child	Adult	Total
Los Angeles County	FY2001	4.1%	9.2%	7.3%
San Diego County	FY2001			6.9%
Oregon	10/99-9/00			5.7%
King County, WA	CY2000			18.3%
Spokane County, WA①	FY2001			12.6%

① *Combined incidence for Medicaid and non-Medicaid users.*

[19] *More than 50% of people with serious mental illness have been estimated to have a dual diagnosis of substance abuse and mental illness.*

Information about secondary mental health diagnoses was even less available for individuals receiving managed substance abuse services. Only one program, Oregon HMOs, reported these data. They showed that a very small percentage, only 0.9%, of individuals receiving substance abuse treatment carried a secondary diagnosis of mental illness.

Though the sample is small, the results confirm what many other researchers have found, that secondary diagnoses are significantly underreported. States may need to pursue other methods (review of a sample of charts, extract information from the clinical MIS) or make extra efforts to improve reporting of secondary diagnoses.

10. Treatment of Schizophrenia

The percentage of people diagnosed with schizophrenia who have four physician visits within 12 months of the first diagnosis in the reporting period is an AMBHA core measure and a HEDIS testing measure. More than ten programs indicated that they could compute this measure, but only three states reported the data. Two programs were able to reach this treatment standard for about half of the individuals diagnosed with this condition, and one met the standard for just over one-third. Several programs reported the percentage of service users with a diagnosis of schizophrenia, showing that this serious condition represents a significant percentage of service needs, at least in the carve-out programs.

TABLE 10
PERCENTAGE OF INDIVIDUALS OVER 18 WITH A SCHIZOPHRENIA DIAGNOSIS WHO RECEIVED 4 PHYSICIAN VISITS IN A 12-MONTH PERIOD

Program	Period	Percentage of enrollees diagnosed with schizophrenia	Percentage with 4 or more physician visits
Utah	FY2000		49.9%
Los Angeles County	FY2001	10.6%	35.1%
San Diego County	FY2001	16.5%	52.2%
Arizona①	FY2000	11.3%	
Spokane County, WA①	FY2001	12.7%	
Clark County, WA	FY2001	22.7%	
Oregon	10/99-9/00	14.9%	

① *Combined incidence for Medicaid and non-Medicaid users.*

Methodological Considerations:
States raised several concerns about the definition of this measure. One program does not get diagnoses from emergency room visits, or from inpatient stays that begin with a referral from an emergency room, meaning that it would exclude individuals whose earliest diagnosis began with an emergency admission. Another program uses prescribing RNs to provide medication management for people with schizophrenia. To provide an accurate count of those receiving appropriate care, the program would include visits to RNs in this measure, rather than just psychiatrists or D.O.s., as specified by AMBHA.

11. Depression Treatment

HEDIS defines a set of three measures for effective treatment of depression in adults: providing at least three physician visits in the 12 weeks post-diagnosis, keeping an individual on antidepressants for an initial 12 weeks; and maintaining an individual on antidepressants for a full six month period.

Methodological Considerations:
This is a complicated measure to report because it requires linkage between service claims and pharmacy claims for individuals with a specific diagnosis. More than ten programs reported that they could calculate this measure, but not all of these actually do calculate it. Two carve-out programs noted that they get incomplete results because they cannot account for people who get antidepressants from their PCPs. They have identified that approximately 70% of Medicaid recipients in their state who are prescribed antidepressants, get them from their PCPs.

11a. Depression Treatment

Only the three New Mexico HMOs submitted the set of three HEDIS measures for effective treatment of depression. They showed the best performance in getting individuals over age 18, who were diagnosed with depression, onto antidepressants for an initial period of 12 weeks, but did not do as well at maintaining consumers on antidepressants for a full six month period, and were much less successful in providing immediate follow-up care after diagnosis. This level of performance is similar to and sometimes slightly better than that of NCQA Medicaid results, except in providing follow-up care after diagnosis, where only one New Mexico HMO reached a similar level of performance.

TABLE 11
HEDIS DEPRESSION MEASURES
PERCENTAGE OF INDIVIDUALS WITH A DIAGNOSIS OF DEPRESSION WHO RECEIVED SPECIFIED TREATMENT INTERVENTIONS

Program	Period	Percentage w/3 follow-up visits within 12 weeks	Percentage w/12 weeks of scripts filled	Percentage w/ 180 days of medication treatment
NM HMO A	CY2000	6.01%	37.7%	25.14%
NM HMO B	CY2000	5.6%	33.3%	21.4%
NM HMO C	CY2000	22.1%	44.8%	32.4%
NCQA National Medicaid Results	2000 HEDIS	24.0%	37.7%	24.9%

11b. Number of Service Users Diagnosed with Depression

Five plans reported that adult service users with a depression diagnosis represent 10% to 35% of all enrollees, a significant subgroup in the treatment population.

TABLE 12

PERCENTAGE OF INDIVIDUALS 18 YEARS AND OLDER RECEIVING SERVICES WITH A DIAGNOSIS OF DEPRESSION

Program	Period	Percentage of adult enrollees diagnosed w/ depression
Rhode Island Rite Care	CY2000	20.4%
Arizona①	FY2000	10.5%
Oregon	10/99-9/00	17.5%
San Diego County, CA	FY2001	9.7%
Clark County, WA	FY2001	35.2%

① *Includes Medicaid and non-Medicaid enrollees.*

12. Medication Reporting

Medications are becoming increasingly important in the treatment of mental illness, as well as increasingly costly. For this reason programs were requested to report cost of psychotropic drugs per enrollee served by type of drug (for enrollees with any diagnosis).

Methodological Considerations:
Because no standard well-defined format or specification for this measure exists, programs were asked to submit the information in a format that they use. However, carve-out programs rarely cover medications within the benefits they administer, requiring coordination with a pharmaceutical database administered by another entity, and sometimes by another state agency. Some programs had done such intersystem reports or believed that they could, while others did not consider it to be possible.

12a. Cost and Utilization of Psychopharmacological Medications

Five programs indicated that they could prepare this report. Two, Oregon and Los Angeles County, actually submitted it. LA County shows total pharmacy costs, prescriptions, and unduplicated users in a report that show the same type of data for other major service categories. From these data, average costs ($769.88) and average prescriptions per service user are calculated. Oregon uses a more detailed reporting format, a portion of which is reproduced below in Table 13. Oregon has summarized medications into seven major pharmaceutical categories and includes the current year-to-date and the past year. The full table includes monthly data and year-to-date compared to the prior three full years, and shows percentage change between years.

TABLE 13
OREGON OFFICE OF MEDICAL ASSISTANCE PROGRAMS
COST OF PSYCHOPHARMACEUTICAL MEDICATIONS

Medication Category	1999 - 1 Yr. Summary		2000 YTD Summary (6 mos.)	
	Cost	Costs PMPM	Cost	Costs PMPM
Newer Antidepressants	$30,842,267	$6.93	$17,941,117	$8.18
Older Antidepressants	$2,702,360	$0.61	$1,512,426	$0.69
Lithium and Provigil	$588,258	$0.13	$341,323	$0.16
Newer Antipsychotics	$27,890,136	$6.27	$16,209,894	$7.39
Older Antipsychotics	$2,096,553	$0.47	$989,980	$0.45
Anxiolytics	$5,756,056	$1.29	$3,197,267	$1.46
MH Anticonvulsants	$4,486,840	$1.39	$3,090,161	$1.69

Texas NorthSTAR shared its reporting format, an Excel spreadsheet that classifies medications by the primary use descriptions listed below.

Alcohol Dependence	Potentiates Antidepressants
Alcohol Metabolism Blocker	Psychostimulant
Antianxiety	Sedative / Hypnotic
Antidepressant	Sedative / Hypnotic Antianxiety
Atypical Antipsychotic	Sedative / Hypnotic Antidepressant
Injectable Anti-Psychotics	Side Effect Control
Mood Stabilizer	SSRI Antidepressant
Not Psychotic	Traditional Antipsychotic
Opiate Dependence	Other

The number of service users, amount due (cost), and number of refills are stratified by seven Medicaid age / eligibility categories and Non-Medicaid child and adult. Figures are provided for three years and in a monthly format. This format allows for the calculation of average per client cost.

12b. Atypical Antipsychotics

Atypical antipsychotics are relatively new medications that have generally been more effective than older traditional medications for schizophrenia. However, they are expensive and some require close medical monitoring to control for side effects. NASHMPD and the American Psychiatric Association (APA) recommend monitoring access to these medications for diagnoses, such as schizophrenia for which they are most significant. APA looks only at access for adults, since these medications have limited use for those under 18. States were asked to submit a count of enrollees prescribed these medications. Some states have managed care carve-outs that do not cover pharmaceuticals and therefore do not have prescription data in their MIS. However, more than ten programs indicated that they could do this calculation. Several requested and were provided a list of the drug codes that identify atypical antipsychotics. However, only two states submitted this measure. Arizona reported that 18% of adult service users were prescribed antipsychotic medications and

Colorado reported that almost 12% of all their service users (child and adult) received these medications.

TABLE 14
PERCENTAGE OF SERVICE USERS PRESCRIBED ATYPICAL ANTI-PSYCHOTICS

Program	Period	Percentage of Adult Service Users	Percentage of all Service Users
Arizona①	FY2001	18.0%	
Colorado②	FY2000		11.9%

① *Includes Medicaid and non-Medicaid enrollees.*
② *Includes PCP prescriptions.*

Pharmaceuticals are increasingly more important as part of a comprehensive treatment plan and yet they also represent a significant system cost. This is an area in which programs can use assistance in defining relevant and useful reporting formats and in prioritizing the resources and intersystem collaboration where necessary, to calculate them.

13. Involuntary Admissions

AMBHA and other measurement initiatives include involuntary admissions as a percentage of all inpatient admissions. Involuntary commitment to an inpatient treatment setting is the most restrictive form of treatment, and system managers have an obligation to ensure that this option is used as minimally as possible.

Methodological Considerations:
Few programs indicated that they could produce this measure. Those programs most likely to have this measure were those where Mental Health Authorities had a role in administering the Medicaid managed care plan. Many states did not collect this measure for their Medicaid hospitalizations because the information is not included in authorization or claims data. Many of these same states indicated that they did collect it for their state hospitals. These figures may also vary depending on whether each state includes state hospital admissions in this count. Of course, states have different laws relating to involuntary commitment, which are also a source of considerable variation. Finally, Medicaid recipients lose Medicaid eligibility when they are admitted to state hospitals, making it necessary to track data between the two care systems.

TABLE 15
PERCENTAGE OF ADMISSIONS THAT ARE INVOLUNTARY

Program	Period	Involuntary Admissions
Los Angeles County, CA①	FY2001	22%
Oregon①	10/99-9/00	17%
San Diego County, CA	FY2001	67%
King County, WA②	CY2000	38%
Spokane County, WA①	FY2001	69%
Clark County, WA	FY2001	62%

① *Includes state hospitals.*
② *Includes Medicaid and non-Medicaid inpatient admissions.*

All the programs that reported their rates of involuntary admissions were blended carve-outs, and the rates reported covered a considerable range. Given the variation in the involuntary commitment statutes in each state and the inclusion of state hospitals and other residential programs, stratification of this measure for state hospitals and community hospitals may be a useful starting point in learning more about the incidence of this form of treatment on a national level. It is clear from the data that the admission practices in Oregon are quite different from those in San Diego County and Washington.

14. Seclusion and Restraint

States regulate the use of seclusion and restraint within inpatient settings by establishing requirements such as documentation of criteria that must be met, physician review and sign off, allowable methods, frequent monitoring of clients who have been secluded or restrained, and restrictions on the amount of time a client can be secluded or restrained. The mental health authority is generally responsible for monitoring compliance with these requirements.

In recent years, inpatient settings have focused on minimizing their use of seclusion and restraint, and NASHMPD and other measurement initiatives have adopted relevant measures of their use. Two measures of seclusion and restraint were requested. One measures the percentage of total treatment hours that were used for seclusion or restraint. The other measures clients who experienced seclusion or restraint as a percentage of all clients. These measures are collected most frequently for state hospitals, and sometimes also for private psychiatric hospitals. They may be collected at the facility level but never broken down by payer; Medicaid stays are not stratified from the total. None of our programs could report either measure. One state reported that it had discontinued collecting this measure, determining that it was not a managed care measure, but a facility measure for which the mental health authority had oversight responsibility as a part of licensing.

Medicaid managed care plans have significant influence over psychiatric inpatient facilities that serve their members, and thus it might seem reasonable to expect that these plans should be aware of the extent to which their members experience seclusion and restraint during treatment. However, given that separate reporting and oversight systems exist, states would do well to develop methods for communicating information to managed care plans, and collaborating to address problems that arise in facilities serving a significant number of Medicaid managed care plan members.

15. Medical Loss Ratio

States need to ensure that the management services they purchase from managed care entities are efficient and cost-effective, leaving sufficient resources for provision of direct care services. One common measure of efficiency is the medical loss ratio, which is defined as the ratio of service claims paid by a managed care organization to its capitation payments received for the same period. This measure is relevant and generally included in contract negotiations and terms for programs paid on a capitation basis. However, the principle of looking at direct service costs as a percentage of total system costs can be adapted for other program structures; for instance, the cost of an administrative-services-only entity can be considered as the administrative cost portion and combined with direct service costs to calculate the denominator for this measure.

Methodological Considerations:
There are several challenges involved in calculating this measure. While technically, this ratio can be calculated for an integrated carve-in program, the portion of administration to be allocated to behavioral health cannot be. In addition, managed care entities may provide some services, such as intensive case management, that are considered to be direct care.

Even in the same system of care, the organizational structure and accounting practices of different managed care entities may result in similar services being allocated between system administration and direct care in different ways, making it difficult to compare. The variation between different managed care systems can be even greater, with a different set of responsibilities delegated to the managed care entities. These measures can also be considered proprietary. Often contract language specifies that states that collect these measures may not make them public for comparison purposes.

We received medical loss data from four states, as shown in the table below. None of them were HMOs. Proprietary concerns were cited more frequently for integrated programs than carve-out programs and for integrated programs, the medical loss ratio for mental health is not reported separately from general health care costs. Two measures were as high as 93% and 95%, a high ratio, leaving only 5-7% of payments available to cover administration and profit (where applicable). Oregon's medical loss ratio was at 90%; meeting the industry rule of thumb that administration requires approximately 10%. Tampa's ratio is quite a bit lower, leaving almost 18% available for administration.

TABLE 16
MEDICAL LOSS RATIO

Program	Period	Medical Loss Ratio
Colorado	FY2000	95.0%
Florida – Tampa	FY2001	82.3%
Arizona	FY2001	93.4%
Oregon	10/99-9/00	89.9%

16. Telephone Access

Managed care plans often measure the timeliness of their ability to answer phones for consumers and/or providers as one indication of ease of access. This can be particularly important during program implementation when providers and consumers have frequent questions about new procedures and benefit changes. Because the technology is available for these data, states commonly require their managed care plans to report this measure. In integrated settings, however, the measure is not likely to be stratified for calls involving behavioral health matters.

Fewer than ten programs indicated that they had data on this measure: one state measured phone access during program implementation, but discontinued it when acceptable levels were being reached consistently. Another state regularly tests telephone access, but does not require reports.

Two programs reported on telephone access using measures that corresponded to our measure, the percentage of calls answered in less than 30 seconds. They achieved compliance rates of close to 100%. The four MA HMOs reported on calls answered in less than 20 seconds, Massachusetts' standard. While one reached almost 100% compliance, the others answered almost 90% of calls within this shorter time.

TABLE 17
PERCENTAGE ANSWERING PHONE IN LESS THAN 30 SECONDS

Program	Period	Answered in less than 30 seconds
MA HMO A①	FY2001	89%
MA HMO B①	FY2001	89%
MA HMO C①	FY2001	87%
MA HMO D①	FY2001	98%
Florida Tampa	FY2001	98%
San Diego County, CA	FY2001	96%

① *Reporting standard is 20 seconds.*

17. Complaints and Grievances

Medicaid requires states to institute formal mechanisms for complaints, grievances and appeals, and Fair Hearings, and to ensure that Medicaid managed care members are fully informed of their rights to use these mechanisms. Monitoring complaints can provide useful information about where problems exist.

Methodological Considerations:
A number of states have specific state statutes and Medicaid rules that define the types of complaints/grievances and outline the reporting process. These specifications governing complaints/grievances include state-level requirements for California's counties, Medicaid rules in Colorado and state statutes in Florida. Often a complaint is considered an informal or an oral expression while a grievance requires a more formal or written submission. Other systems define complaints/grievances in other ways; for example, PA HealthChoices states that a grievance results when a request is denied, reduced or altered in some way by the Behavioral Health Managed Care Organization.

Data were solicited on the number of complaints and grievances concerning mental health or substance abuse services and examples of complaint/grievance reports with the definitions of terms and reporting categories. Many states track complaints/grievances, but the variation in categorization, definitions and reporting for specific populations did not allow us to make useful comparisons across sites. Some programs indicated that the definitions of the reporting categories in their systems were sufficiently broad that they doubted the comparability within their own managed care system.

During interviews, some respondents described how they monitor complaint/grievance reporting to identify problem areas and trends. However, the review of the complaint/grievance reports submitted revealed that some of the reporting focuses more on the oversight of the process (i.e. the number of days to resolve a complaint) than summary reports to identify trends in reasons for complaint. Both dimensions are important.

Categorization of complaints/grievances also ranges across systems; some states focus more on categorizing by types of services (i.e. residential, emergency, etc.) while others focus on different areas of plan operations such as clinical care, benefit plan, and claims. Some integrated plans categorize complaints and grievances by type of service involved. However, this is not universally the case, and some integrated plans would have to examine individual

complaint records to identify whether mental health services were involved. A few states track and report data on appeals and fair hearings in addition to complaints/grievances. Some also track complaints/grievances at the provider level.

Tracking complaints/grievances within systems over time can be a useful monitoring tool. Those systems that track complaints tend to do so quarterly and calculate a rate per individual served or a rate per enrollee. For example, Pennsylvania HealthChoices tracks and compares the volume of complaints/grievances from year to year as part of an annual report. In addition, HealthChoices calculates a rate of complaints per enrollee, tracks these data quarterly and confirms the face validity of these data with various stakeholder organizations.

Standardizing reporting definitions used within a managed care program, ensuring that the content of grievances is monitored, not just the process, and looking at grievance data in the context of other client satisfaction indicators will strengthen the ability of states to monitor problem areas over time. However, this may be a less useful area for cross-system comparison; standardizing reporting definitions across systems of care may not be possible, can compromise the usefulness of a report within the managed care system, and may not offer much additional information to managers.

18. Service Denials

The rate of service denials by service type can provide information about the congruence between provider assessments of service need and those of the managed care entity, and indicate for which levels of care the greatest discrepancy exists. High rates of denial or significant changes in rates of denial can identify areas where purchasers need to further investigate the possibility of access problems. However, these data can be difficult to interpret. Only services that require prior authorization can be monitored since they are the only services for which an authorization can be denied. Most systems require prior authorization for inpatient care, but even within the same managed care systems, different plan administrators use different prior authorization procedures. Differences in what services require authorization, at what point authorization is required, and how frequently a service must be reauthorized will result in significantly different counts. Therefore, it is difficult to compare denial rates between different plans.

A simple denial rate provides limited information, because it does not indicate whether the individual denied service received another service, and whether that alternative was more or less appropriate than the service originally requested. Another potential weakness of this measure is the ability of managed care organizations to affect the way this measure is counted without affecting the underlying reality of how clients are authorized for service. For example, an MCO can modify its authorization procedures, change the definition of what it counts as a denial, and try to influence how providers make service requests without changing its authorization criteria.

Two states indicated that they measured rate of service denials by service type. Massachusetts requires its HMOs and its carve-out provider to report their inpatient diversion rates on a semi-annual basis, accounting for inpatient requests approved, modified, diverted, and denied or pended. Pennsylvania Health Choices measures service denial rate by service type on a quarterly basis as part of its Early Warning program. It also measures the number of approved authorizations by service. These measures are stratified by region and by managed care organization.

Service denial rates can provide a quickly available indicator of access to intensive services and of changes in authorization practices. Because of the variation in authorization procedures, this measure is likely to be most useful as trend data, in monitoring an organization over time rather than for comparing organizations or managed care systems. States that use this measure need to carefully define their reporting categories, require that they be informed about changes in authorization procedures, and be prepared to investigate any changes identified by reports in order to determine the impact of the change and its likely cause.

19. Consumer Satisfaction

As mental health systems work to become more consumer centered, similar to the trends in the overall health care system, formal surveys of consumer satisfaction have been developed and incorporated as an important aspect of system assessment. Two standardized satisfaction survey instruments are used by many managed care systems. The Consumer Assessment of Health Plan Survey (CAHPS) was designed for comprehensive managed care plans, and offers supplemental questions about satisfaction with mental health services that can be included for plans that include behavioral health services in their covered benefits. The Mental Health Statistics Improvement Project (MHSIP) has developed its own consumer satisfaction tool that focuses solely on mental health treatment. It is a much more comprehensive and in-depth instrument that also collects data on level of functioning and employment status from those who complete it. A new instrument, the Experience of Care and Health Outcomes (ECHO), has recently been developed, incorporating some of the strongest features of MHSIP and CAHPS, but was not yet in use by any of the participants.

Participants were asked to report consumer satisfaction data for two levels: satisfaction with *access* to mental health or substance abuse care and *overall satisfaction* with mental health or substance abuse care. If programs use either the MHSIP consumer survey or CAHPS, the results from specific questions on these instruments related to access and overall satisfaction were elicited. If programs use another consumer satisfaction tool, the measure was to be defined and the results reported.

Many states assess consumer satisfaction with behavioral health services. The MHSIP survey was the most frequently used survey, mentioned by 8 states that use the actual survey or a modified version. A few integrated plans used CAHPS or a similar tool that does not focus specifically on behavioral health. In addition, a few states also indicated that they collect and report data on provider satisfaction at regular intervals to assist them to monitor their service systems.

Despite the large number of sites using the MHSIP survey, due to differences in administration, variation in sample selection, and modifications made to the survey, the results on specific questions could not be directly compared across sites. Table 18 lists the data received from programs that reported on consumer satisfaction. It shows that sites vary considerable in the survey instrument used and the process of survey administration. Maryland performed a statewide telephone survey of a sample of consumers using an adapted version of the MHSIP survey, Arizona mailed the MHSIP survey to a statewide sample of clients, and Florida interviewed consumers in person using a different survey instrument administered by a trained interviewer. The timing intervals for survey administration also vary from state to state; Washington State alternates between the adult and child/caregiver survey each year while Utah administers its survey every 2 to 3 years.

However, Maryland, San Diego and Washington all assessed agreement with at least one similar access measure: "Services were available at times that were good for me". The

percentage of respondents agreeing or strongly agreeing ranged from 78% to 90%. Oregon and Washington asked the same question about overall service quality: "If I had other choices, I would still get services from this agency." Oregon reported 86% agreement and Washington 76% agreement with the statement. Maryland assessed satisfaction with inpatient and outpatient services, finding higher satisfaction with outpatient services (85.8%) than with inpatient (70.5%). Arizona measured several different dimensions of satisfaction; satisfaction levels were reported in the seventy percent range for access, quality / appropriateness, and overall, but only 56% satisfaction was reported with outcomes of treatment. Consumer assessment of progress may yield more information about opportunities for improvement than the relatively high scores for other dimensions of treatment.

Given these differences in survey instruments and methodology, ability to interpret differences in satisfaction ratings in limited. While it may not be necessary to settle on a single survey instrument or methodology, it would be valuable incorporate standardized questions whenever possible and develop consistent methods when using mail, telephone, or in-person administration.

TABLE 18
CONSUMER SATISFACTION WITH MENTAL HEALTH CARE

State	Domain and Survey Question	Results
MHSIP OR MODIFIED MHSIP		
Mail Administration		
Arizona	Access	71% with score of 2.5 or above out of 5
	Quality / Appropriateness	77% with score of 2.5 or above out of 5
	Outcome	56% with score of 2.5 or above out of 5
	Overall	78% with score of 2.5 or above out of 5
Oregon (Own survey includes MHSIP question)	Overall: "If I had other choices, I would still get services from this agency."	86.4% Agree or Strongly Agree
Telephone		
Maryland (modified MHSIP)	Access: "Services were available at times that were good for me."	87.8% Agree or Strongly Agree (outpatient services)
	Overall: "In general I am satisfied with the services I received here."	85.8% Agree or Strongly Agree (outpatient services) 70.5% Agree or Strongly Agree (inpatient services)
Unspecified Method of Administration		
San Diego, CA	Access: "Services were available at times that were good for me."	89.8% with score of 2.5 or above out of 5
	Access: " Staff returned my calls within 24 hours."	91.3% with score of 2.5 or above out of 5
	Access: "Staff were willing to see me as often as I felt was necessary."	88.6% with score of 2.5 or above out of 5

TABLE 18 (CONTINUED)
CONSUMER SATISFACTION WITH MENTAL HEALTH CARE

State	Domain and Survey Question	Results
Unspecified Method of Administration (continued)		
Washington	Access: "Services were available at times that were good for me."	78% scored this question 3 (Agree) or higher.
	Overall: "If I had other choices, I would still get services from this agency."	76% scored this question 3 (Agree) or higher.
CAHPS – Mail Administration		
Massachusetts	Mean Rating of Behavioral Health Treatment or Counseling	8.2 (Response scale is 0=Worst through 10=Best) for Adults
Florida Specific – In-person interviews by trained interviewer		
Florida	Access: "Are you able to get an appointment when you need one?"	87%
	Overall: "Overall how satisfied are you with the services you receive here?"	95%

20. Consumer Outcomes

Measurement of consumer outcomes is potentially the most significant form of accountability for any health care system in terms of both the lives of clients and the value to the public. NASMHPD, NASADAD, and other measurement initiatives seek to measure changes in functioning, living situation, employment and criminal activity before and after treatment. Committees working as a part of the 16-State Study are working to develop standard reporting conventions for these outcomes.

Methodological Considerations:
However, because outcome data - other than perhaps the Global Assessment of Functioning (GAF) - are not routinely reported with claims or encounters, they require the development of an additional data collection system. Programs perceive these data as difficult and expensive to collect reliably, and relatively few programs try to do so. Fewer than ten Medicaid managed care programs in our sample reported collecting data on functioning, living situation and employment. Fewer than five have information on their members' criminal activity. Because of the expense of collecting these data, some programs collect them only for a subset of the enrolled population, the seriously impaired and most vulnerable consumers. Those who use the MHSIP consumer survey get snapshots of consumer outcomes for a point in time, but are not able to analyze the progress of individual consumers through their treatment.

Data were requested on how systems are measuring consumer outcomes in four domains: level of functioning, living situation, employment, and criminal activity. Data on consumer change pre and post treatment were requested for all four domains. If respondents collected any of these data, they were asked to send their standard reports and indicate what instrument they used, the frequency of data collection, and the percentage of enrollees included in the data. Some of the programs that collect consumer outcomes data are still in the developmental stages of collecting data. They expressed concerns about the completeness and reliability of their outcomes data, and are not yet comfortable sharing them. Some of the data collection challenges they note are: incomplete reporting by

providers; the movement of clients in and out of treatment relationships so that they may not be available when a report is due; and the questionable accuracy of information reported to providers by clients.

On the other hand, two programs have been successful enough in collecting these data to use consumer outcomes measurement in their performance indicator or performance incentive program. One county ties the managed care entity incentive payments to specific consumer outcomes such as reductions in re-arrest rates and improvements in consumer level of functioning, and one state ties performance incentives to employment status data. A third county has established different outcomes expectations for different populations based upon diagnosis, level of functioning, and problem severity for adults and 'conditions and circumstances' for children; for some individuals improvement is a positive outcome while for others maintenance is positive. Several of these programs have developed information systems to assist and monitor the collection of complete data. They maintain electronic systems that track reporting dates for each client and notify providers for which clients reports are due. They also review completeness and consistency of provider reports and notify providers of missing or inconsistent data. Some further enforce complete data submission by showing providers how they are performing on data submission compared to their peers, or by sanctioning providers who are not meeting expectations for timely and complete reporting.

20a. Level of Functioning

Respondents use a number of different instruments to measure consumer changes in level of functioning. For children, these include the Child and Adolescent Functional Scale (CAFAS), the Children's Global Assessment Scale (CGAS), and the Achenbach. For adults they include the Global Assessment of Functioning (GAF), MHSIP's consumer perception of functioning, AFARS, CFAR, Arizona Level of Functioning (ALFA), and Multnomah. These last two instruments are Arizona and Oregon's state-specific instruments. The wide variety of instruments for children and adults also highlights the need for some common indicators.

The timing for administering an instrument is most commonly at initial assessment, every six months thereafter, and at discharge. States use level of functioning instruments both to assess consumer eligibility and to track changes in functioning over time while an individual is receiving mental health services. Los Angeles County stated that they find some level of functioning data to be useful on an individual level but difficult to use in the aggregate to monitor system-level outcomes.

20b. Living Situation, Employment and Criminal Activity

Living Situation. Five states tracked consumers' living situations in some manner. Measurements of change in living situation varied across systems and included the following three measures in this domain: the percentage of homeless clients who found housing vs. the percent who remained or became homeless; the number of clients that maintained or acquired independent housing; and the ratio of clients who acquired housing to those who lost housing. Washington State maintains data on outpatient clients' living situation, using 13 residential categories. These data are theoretically updated each time the client comes in for service. As with other consumer outcomes, sites are more likely to monitor the living arrangements for vulnerable populations such as clients who are homeless or living in a shelter.

Employment. Six respondents indicated their system monitors changes in client employment. These systems measure changes in employment by using the following

indicators: percent of consumers who maintain or gain employment and a ratio of those consumers who gained employment to those who lost employment. Colorado reported that they tie employment status to performance incentives and believe that the data have at least face validity when compared to statewide economic trends. In the first year, Colorado used the statewide median as the target for each local managed care entity since national benchmarks were unavailable; however, they ultimately would like to use national data to set performance targets. Maryland used the consumer responses from the MHSIP survey questions related to living situation and employment to monitor these outcomes. Washington State reports the employment status of outpatient clients. The methods used by Maryland and Washington State provide a snapshot of employment status, but cannot track individual changes over time.

Criminal Justice. Fewer respondents are able to report data on criminal justice involvement. A number of states indicated they were unable to do so because the data needed to come from the criminal justice system to which they did not have access. One county did report that they have reliable local data on criminal justice involvement because they are able to match their files weekly with the county jail records.

One respondent collects data on additional consumer outcomes, including whether individuals report a decrease or stabilization of symptoms while in treatment and whether individuals maintained or acquired age-appropriate activities while in treatment.

The following table shows available outcomes data that was well defined and presented at a high level of aggregation.

TABLE 19
CONSUMER MENTAL HEALTH OUTCOMES

Respondent	Measurement	Results
Level of Functioning		
Los Angeles, CA	Percentage of clients who change GAF levels of functioning between admission and discharge.	14% Improved 82% Maintained 4% Reduced (n= 65,771)
Arizona	Net change in ALFA scores from 1st to Last Assessment in Arizona Level of Functioning Assessment for clients who were disenrolled between January – March, 2001.	12% Improved 85% Maintained 3% Worsened (n=1500)
Living Situation		
Maryland	"I am satisfied with my housing situation."	65.2% agreed or strongly agreed (survey sample)
	Percentage of respondents living in a house or apartment alone, percentage living in a house or apartment with a friend or family member.	33% were living in a house or apt. alone 60% were living in a house or apt. with a friend or family member
Oregon	Percentage of consumers in an independent living situation.	71.9% of survey respondents

TABLE 19 (CONTINUED)
CONSUMER MENTAL HEALTH OUTCOMES

Respondent	Measurement	Results
King County, WA	Percentage of clients who became or stayed homeless and percentage that found housing.	2.1% of clients stayed homeless, 38.6% of clients who were homeless found housing, 3.2% clients became or stayed homeless
	Percentage of clients who maintained or acquired independent housing by the time their benefit ended.	76.3% of clients acquired or maintained independent housing
Employment		
Oregon	Percentage of members served with full-time, part-time or irregular paid employment.	10.7% (statewide subset)
Washington State	Percentage of outpatient service recipients in paid employment, unpaid employment or not employed.	12.6% of Medicaid and non-Medicaid outpatient clients were in paid employment 3.7% were in unpaid employment
King County, WA	Percentage of clients who maintained or acquired paid employment by the time their benefit ended.	14.5% of adult clients maintained or acquired employment, 5.9% gained employment
Criminal Activity		
King County, WA	Percentage of clients with decreased incarcerations	5.1% of adults had decreased incarcerations, 7.9% had the same or increased incarcerations, and 87% had no incarcerations

20c. Consumer Outcomes for Substance Abuse Treatment and Other Measures

Although programs that include both substance abuse and mental health care treatment in their managed care programs were asked to report outcomes data, the only data and sample reports received were from those programs that provide managed mental health care. As a result, our discussion of outcomes measurement above is limited to mental health specific data instruments and treatment outcomes.

D. CONCLUSION

1. Feasibility Issues

It is clear from this project that the differing structures of managed care programs impose limits on the types of data that are available for comparison purposes. Several factors contribute to these constraints: limits on the availability of data on services not paid on a fee-for-service basis; pharmacy benefit plan structure; integrated vs. carve-out reporting; co-occurring disorders; and outcomes.

1a. Subcapitated and Cost-Reimbursement Providers

Plans with subcapitated providers (other than HMOs) are less likely to have data on specific services or the cost of an individual's care. Subcapitated HMOs provide most or all services through provider networks that are reimbursed on encounter-based claims (fee for service), and are frequently required to both report and provide encounter data to state purchasers. However, when entities such as Community Mental Health Centers or counties are subcapitated, they may provide some or most services directly. While states are likely to require reporting of access and service utilization for eligible individuals, in these systems, there is not necessarily a determination of cost for specific services. A similar problem exists when providers are reimbursed using grants and cost-reimbursement contracts. In these cases it can be

very difficult to report costs for specific services and age groups within an overall budget.

1b. Pharmacy

The ability to analyze the use of pharmaceuticals in behavioral health treatment is also dependent in large part on the structure of the managed care plan. Most HMO programs include pharmacy as a covered benefit, allowing HMOs to analyze medications in the context of behavioral health service use or diagnosis. However, for carve-outs, pharmacy is often not covered by the managed care plan, but is accessed through fee for service, through physical health managed care providers or through a separate Pharmacy Benefit Management Contract. In addition, the management of carve-outs may be delegated to the Mental Health agency rather than the Medicaid agency, which has the responsibility for the majority of pharmacy benefits. Calculating the pharmacy and related measures we requested requires coordination between the Medicaid and Mental Health agencies, linking pharmacy data with enrollment data, and, for some measures, linking pharmacy data with utilization and diagnosis data. Some states have worked to link different data sets, and they identified these measures as feasible for their information systems to produce. Other states had not yet had the collaboration between sister agencies needed to do this sort of analysis. Some of the states interviewed did not think it was possible.

1c. Integrated Plans

Some managed care performance measures, such as medical loss ratio, consumer satisfaction, complaints and grievances, and telephone responsiveness cannot be separately reported for behavioral health services provided within an integrated program. This is partly a result of the inherent difficulties in allocating costs to services but also results from not having separate rating categories or contract reporting criteria. In addition, in plans not likely to include people with serious mental illness, such as those serving only TANF and expansion populations, utilization rates for mental health services may be low and may not offer a large enough sample size to provide for a robust measure of satisfaction among users of mental health services. Complaints and grievances can be categorized by type of service involved, and some plans do so. However, this is not universally the case, and some integrated plans would have to examine individual complaint records to identify whether they involve mental health services.

1d. Co-occurring Disorders

It is difficult to collect reliable data on co-occurring disorders, largely because claims require only one diagnosis. Some participants did not have two diagnoses in their datasets, while others felt that secondary diagnoses were not likely to be reported as consistently as primary diagnoses, leading to undercounts of the incidence of secondary conditions.

1e. Outcomes

Outcomes data, such as changes in functioning, employment, living situation and criminal involvement are not frequently gathered by integrated health plans. These types of data are most likely to be collected by blended programs that combine Medicaid and state mental health authority funding, and therefore provide services to the seriously mentally ill. Even when these data are required, they are perceived as difficult to collect and often incomplete and unreliable. However, one state, Colorado, enforces timely data collection by tying reimbursement to performance on some of these measures. NASMHPD's attention to the definition and collection of these

measures in the 16 State Study is likely to increase the collection of these important data.

1f. Use of Restrictive Treatment Options

Measurement of involuntary commitments and of the use seclusion and restraint are perceived as the responsibility of the licensing authority and/or mental health authority, and are unlikely to be collected by Medicaid managed care information systems.

2. Measures most likely to be used by state and county Medicaid managed care plans

There is widespread use of measures for penetration, inpatient utilization, and follow-up after inpatient. Not surprisingly, these are HEDIS measures and many were available from integrated programs. Cost, consumer satisfaction, complaints and grievances, and utilization by service type are also used for most Medicaid managed care programs we reviewed, although they are not always stratified for behavioral health.

Measures related to serious mental illness are not commonly calculated by Medicaid-only managed behavioral health plans – even when doing so is technically feasible. This is true for co-occurring disorders, the treatment of schizophrenia or use of psychopharmacological medications, for example. Even the treatment of depression is not evaluated as much as would be expected, perhaps because states are aware that more than half of those treated for depression are treated by PCPs, and PCP data are not easily available to carve-out programs.

3. Issues related to Benchmarking Comparisons

The interviews also identified some issues related to the comparability of certain measures across systems.

Most states can produce a set of measures based on encounter data even if it is not identical to the way they routinely report these data. The most feasible measures include penetration, inpatient patterns of care, and cost. Stratification of results by major eligibility categories, such as TANF and SSI, can help account for enrollment differences. It should be noted, however, that some plans cannot easily perform this level of stratification.

Some measures that are important in the treatment of people with serious mental illness are not very relevant for commercial HMOs that are serving predominantly TANF or expansion populations. The field may need to consider whether HEDIS measures adequately address the relevant concerns of people with mental health needs who are not seriously mentally ill, and if not, to develop consensus about what additional measures are important for this population. On the other hand, it will be important to consider how Medicaid programs should account for issues of special relevance for people with more serious behavioral health problems, such as involuntary admission and use of seclusion and restraint. The relative roles and responsibilities of the Medicaid and state mental health and licensing authorities need to be distinguished and accurately defined, and lines of communication and collaboration established. This needs to occur in each state; the federal challenge is how to best facilitate these state-by-state discussions.

Some administrative measures, such as service denials, complaints and grievances, and outcome measures, may never be comparable across systems. At this time, the definitions of what is being measured are specific to individual systems, and may not even be comparable within the system due to differences such as variation in which services require preauthorization. Similarly, plans chose from a wide variety of assessment tools to measure

functioning, and may find few other systems using the same tool. For administrative measures, it is likely to be useful to work toward standardizing reporting definitions used within a managed care program. However, cross system comparisons may be of less utility for these measures, as long as the system is compared to itself over time and the results are related to other measures, such as consumer satisfaction.

Despite the inherent challenges of collecting outcomes data and making cross-system comparisons, it is critical that mental health systems increase their efforts in this arena. States are early in the process of seriously collecting outcome data, with few having systems to enforce accuracy and completeness. But ultimately, such outcomes constitute the most significant measure of whether behavioral health systems are accomplishing their purposes, and provide public accountability for those aspects of recovery prioritized by consumers.

Finally, programs have realistic concerns about being compared to other systems in a public document. The direct visual comparison between measures is a powerful form of presentation; readers may easily overlook relevant programmatic and measurement differences that should be taken into account in interpreting such comparisons. Most of the programs participating in this project have extensive public reports that compare their program's performance over time or to a predecessor program serving the target population. However, as one program representative pointed out, participating in a public cross-system comparison requires program managers not only to understand one's own program and measurement methodology, but how other programs differ in programmatic parameters, target populations, and measurement methodologies. Along with the development of standardized measures and methodologies, attention is also needed to identifying and measuring relevant program parameters and target population profiles, and developing meaningful program categories so that program managers have the information they need to interpret the meaning of their program's level of performance in comparison to similar programs.

IV. SUMMARY OF INTERVIEWS

This section summarizes the interviews conducted with program managers about how they used the data they collected to manage their programs. Interviews were conducted over the phone using a standard list of topics. However, time for these interviews was sometimes limited, and it was not possible to fully address all topics in all interviews. See Section II.C for a description of the interviews, and Appendix C for a list of interview topics.

A. DATA QUALITY

Program managers reported varying levels of confidence in the quality of their behavioral managed care data. Most programs were comfortable with the quality of their encounter data, though two felt that it needed improvement, and one was not sure. A number of states that collect outcomes and level of functioning data mentioned that they were often not complete, and they had some concerns about the accuracy of what was reported. One state questioned the accuracy of eligibility categories reported by providers.

Some states used audits as part of their effort to ensure good quality data. Seven programs reported audit processes that involved their managed care plans, and an eighth has an audit scheduled for 2003. States also use a variety of other methods to maintain data quality. Several have electronic edits with tests for such items as procedure code, date of service, place of service, and client ID and enrollment status. When a problem is identified, an error report is sent to the submitting provider allowing a window during which a correction can be made. Other states use less formal methods, relying upon manual review of reports by staff with follow-up to investigate discrepancies and anomalies. Matching of data from one source to another – such as checks of medical records against encounter records, or comparing financial data to utilization data, are other methods used to test data validity.

From a best practice perspective, those systems that have well specified data reporting requirements, test data quality upon receipt and provide quick feedback to the data submitter about any errors, and have a deadline for final correction with a meaningful penalty for failure expressed the most confidence in their data quality. Though their systems are in different stages of development, Pennsylvania, Colorado, Arizona and Texas use a number of these elements.

B. DRAWING FROM BEHAVIORAL HEALTH MEASUREMENT INITIATIVES

Participants were asked whether they had drawn from any of the existing behavioral health measurement initiatives in developing their own performance measurement programs. HEDIS and MHSIP were the most commonly cited sources. Ten states had used HEDIS measures. In those states, that require NCQA accreditation of their managed care organization, the managed care organizations routinely produce HEDIS measures. All of the Medicaid carve-ins use HEDIS measures, as well as two of the five Medicaid-only carve-outs. Only one blended carve-in noted drawing from HEDIS. New Hampshire and Hawaii, however, found that HEDIS measures were not suitable for their small programs.

MHSIP was the second most frequently cited source of measures, with eight participants citing it, especially the customer satisfaction survey. One Medicaid-only carve-in program uses the MHSIP survey; all other MHSIP users were blended carve-outs. The state of California requires annual administration of MHSIP throughout the state.

Two states, Pennsylvania and New Mexico, explicitly cited Pennsylvania's Early Warning system. Texas NorthSTAR used principles of the Early Warning System in developing measures for the areas that they identified as most at risk during program implementation. Finally, two of the Medicaid-only carve-ins cited the waiver and the Quality Improvement System for Managed Care (QISMC) requirements of the CMS as the biggest influence in the development of their reporting systems.

Three states reported that broad stakeholder advisory groups were involved in selecting measures for evaluating managed care plans. Two states specifically mentioned searching for measures for which data would be available from other states, to allow them to compare their system to national benchmarks.

C. MONITORING

Most participants described monitoring multiple aspects of their managed care programs based upon encounter, or in some cases, authorization data. Managers looked at the relative use of different services, changes over time, and issues of treatment process that can be examined by analysis of encounter data, such as readmission rates, follow-up after discharge, etc. Two states use the HEDIS measures for this purpose.

Other monitoring priorities were not as consistently mentioned. A few states place emphasis on regularly tracking complaints and related forms of consumer feedback. Several states monitor such access measures as wait times, wait lists, and network capacity. Claims payment performance was an important focus for a few states. Only a few states mentioned case-focused monitoring; two use chart reviews, one also sought direct client feedback during site visits. Two Washington counties mentioned monitoring client outcomes in functioning, employment, etc., and one uses regular reporting to help identify high utilizing clients and check on their care.

D. MANAGEMENT STRUCTURES

States had a variety of management structures and staffing for the oversight of their behavioral managed care program. One program has just one major staff person assigned to oversee the program, while other projects involve a rich mix of staff. This in part reflects the widely varying size of the different programs in our sample, as well as the existing agency structure of each state.

Many states use multi-disciplinary staff to jointly review standard reports and determine follow-up. Some of these staff groups meet as frequently as weekly, while others have a monthly meeting schedule. Many states also describe formal meetings (more likely on a monthly or quarterly basis) with their managed care contractors for further discussion and follow-up on issues identified by review of data.

States or counties that serve as the management entities have slightly different processes that focus more on communication and reporting to network providers. They frequently utilize reports that show provider performance compared to overall system performance, and concentrate follow-up on providers whose performance is worse than average.

Florida described a much more hands-on approach than other programs. The Medicaid Contract Manager visited each CMHC subcontractor twice per year to review charts and speak with clients on-site. This review was done in the context of encounter data on penetration and utilization data. Now the Contract Manager has delegated this type of monitoring to the ASO and oversees its performance of this responsibility.

E. PERFORMANCE COMPARISONS

Most programs with multiple managed care entities report that they compare performance within their managed care systems, e.g., between regions, counties and/or providers. Only Florida reported difficulties making useful comparisons within its own system. Several programs reported that they find cross-county or cross-region comparisons somewhat challenging. For example, in San Diego County, regions are not totally distinct service areas; clients may receive some services in one region, and the rest in another. In Texas NorthSTAR, participating counties range from urban to almost frontier, and represent both extremes on the wealth/poverty spectrum as well. Utah also finds it needs to distinguish rural from urban counties for its benchmarking.

Carve-in programs are most likely to use HEDIS measures for comparing HMOs, though Wisconsin has modified some of those measures and Rhode Island supplements them. Wisconsin has been dissatisfied with the timeliness of HMO reporting, which currently corresponds to the HEDIS due dates, and therefore lags almost a year from the period being measured. They are developing a comprehensive data warehouse that will integrate data from all their HMOs, as well as data from the state's Department of Public Health; they will calculate the HEDIS measures themselves from this comprehensive database on a more timely basis. Massachusetts compares its HMOs to each other and to its risk-based carve-out, using a mixture of HEDIS and other measures. The carve-out initially had more extensive reporting and service requirements for behavioral health than the HMOs, but when HMO contracts were re-negotiated the reporting and service requirements were made essentially the same as those for the carve-out.

Medicaid-only carve-outs compare performance in diverse ways. Pennsylvania focuses on its Early Warning indicators which are produced for counties, regions and statewide. Colorado, in contrast, focuses more on access and outcome indicators such as penetration, MHSIP results, and client employment. Oregon looks at HEDIS access measures for its MCOs. West Virginia's ASO provides monthly reports to providers showing how their authorization processes and treatment planning are performing in comparison to the entire state.

Blended carve-outs also make comparisons in a variety of ways. Maryland shows how CSAs compare to the statewide average, but does not compare CSAs to each other. Arizona compares its RBHAs to each other as well as to the state as a whole. San Diego County reports on regions and providers; its managers emphasize drilling down in problem areas to identify providers with best practices and those with need for corrective action. Washington counties compare themselves to other Washington counties with similar characteristics saying, 'If we don't do it, someone else will.'

Only six states reported using external comparisons, with the most common measure compared being follow-up after inpatient discharge. One state mentioned MHSIP penetration measures and another, claims payment standards. Several more states had sought national comparisons, but found it difficult to locate data from systems that they felt were sufficiently comparable. The eagerness of states to use national benchmarks to evaluate the performance of their managed care systems and set goals for improvement highlights the significance of this first effort to gather such data.

F. TARGETS AND FINANCIAL INCENTIVES

A number of programs have set formal performance targets and goals for their managed care entities. Goals were set based on historical performance in their own programs (percentage improvement or reaching the median level of program performance), the goals or actual performance of other Medicaid managed care programs, and HEDIS commercial targets for the

measure of follow-up after inpatient discharge. Some mentioned goals for administrative performance factors, like claims payment and direct service claims, but goals relating to service quality, such as access, utilization, and quality of care, were more frequently mentioned.

Some states have tied financial penalties or incentives to these targets, while others respond to unacceptable performance using traditional management discipline, or by requiring a performance improvement project to address the matter requiring correction. Two states withhold a portion of the MCO's payment, which is released only when acceptable performance is achieved. Four states mentioned penalties; two assess them for uncorrected problems in data quality. Four also mentioned using or planning to implement incentive payments. In one program, the algorithm for auto enrollment of Medicaid enrollees who do not exercise their right to choose a managed care plan is weighted between managed care plans based on their relative levels of performance. This rewards higher performing plans with increased enrollment.

G. STAKEHOLDER REVIEW OF DATA

Medicaid managed care programs are generally required to establish Advisory Boards. The composition of these boards usually includes representatives of other state agencies, providers, trade associations, advocacy organizations, and consumers and families. These boards are a major method by which data on program performance is disseminated and reviewed, and priorities for further investigation and improvement are identified. Some states have multiple groups at different levels of the system. For example, New Mexico has a Medicaid Advisory Committee, with a subcommittee for Behavioral Health, and also requires each HMO to have its own Advisory Board whose meetings are attended by a representative of New Mexico's Medicaid agency. California requires that one-third of every State Planning Council Committee represent consumers; other states require that consumers constitute over 50% of board membership. Consumers may also be involved on Quality Improvement Committees established by MCOs, and several states have consumer-administered, consumer surveys. One has a consumer-administered provider survey.

Several states described their advisory and/or consumer groups as having significant influence on the development of their reports. In Massachusetts, the Managed Care Behavioral Advisory Council voted on a short list of indicators for regular review, in order to keep from being overwhelmed by the large amount of data available. For Pennsylvania, the Consumer Committee of the Medicaid Advisory Board has influenced the design of the reports to include the use of benchmarks and thresholds. They also monitor the state's action to follow-up on problematic results.

H. DISSEMINATION OF INFORMATION

States and counties have additional methods of disseminating information about their managed care programs to the public. Ten participants characterized data reports on their programs as widely available. Five maintain, or their MCO maintains, reports on websites. Other methods of dissemination include: bimonthly statistical publications focused on a specific topic, distribution of summary reports showing network providers their own statistics in comparison to the whole, quarterly and annual reports, regional forums to review managed care reports, and communication to legislatures or county commissioners.

V. CONCLUSION: CHALLENGES, OPPORTUNITIES, AND NEXT STEPS

In the relatively brief history of Medicaid managed behavioral healthcare, states and counties appear to have made great strides in using performance data to monitor, manage, and improve their systems of care. Much more remains to be done, however. In general, those responsible for overseeing managed care programs have developed measurement sets crafted to fit their own managed care programs and target populations. Generally, carve-out programs have the most comprehensive reporting and performance measurement requirements. Measures of plan performance are regularly shared with advisory groups composed of public stakeholders, and some states actively disseminate such information to the public at large through websites and other methods. A few states and counties are tackling the challenge of collecting data on behavioral health outcomes by developing systems to collect the needed measures.

However, despite the wealth of available data, the efforts of various national committees, and the expressed interest of program managers in using national data to help manage their own programs, it remains difficult to make cross-system comparisons. The following are some of the most significant measurement challenges identified in the course of this project that limit the usefulness of such comparisons.

- Program models are significantly different in terms of covered services and target populations, making it difficult to find relevant comparisons. Stratifying by age, eligibility categories and race/ethnicity can help to control for some caseload mix and target population differences, but few programs routinely stratify their measures by Medicaid eligibility category, and it has been difficult for them to collect accurate enrollment and utilization data by race.
- There is currently no single, commonly accepted method for reporting on enrollees, affecting the ability to compare penetration and other measures that use total enrollment as the denominator.
- A number of programs have difficulties reporting according to HEDIS service categories. In fact, these categories may not be sufficient to usefully account for the expanded service menus of some programs that include rehabilitation services or Methadone treatment. However, there is no commonly agreed upon alternative.
- Small programs find that their sample size is insufficient to warrant the cost of collecting data for certain measures, particularly HEDIS.
- Certain measures, such as those requiring linkage of pharmacy and service data, or linkage of cost to encounters for systems that pay providers on a subcapitated or case rate basis, are difficult or impossible for certain systems to report.
- Outcome measures are not incorporated into existing data collection systems, which are primarily enrollment and claims driven sources. Outcome measures generally require the development of a new assessment and data collection system with timely feedback and a meaningful consequence for failure to submit data.

Programs will address these challenges if they are offered access to measures from other similar Medicaid managed care programs. The effort and cost to compute measures conforming to a standard specification will be worthwhile when doing so makes it possible to compare one's own system of care to similar systems. Achieving this goal will require collection of the available data, development of a repository for such measures, mechanisms for discussing and reaching consensus on measures to be collected and the preferred methodologies for computing each, and dissemination of the results. Once methodologies have been defined and the data more routinely collected, the field can begin the even more important work of engaging with researchers and consumers to understand the variability on these measures and identifying desirable levels of performance for each system of behavioral health services.

MEDICAID MANAGED BEHAVIORAL HEALTH CARE BENCHMARKING PROJECT: FINAL REPORT

APPENDICES

APPENDICES

APPENDIX A

MEDICAID MANAGED CARE
BEHAVIORAL HEALTH OUTCOMES MEASURES

This table was developed by reviewing the many behavioral health performance and outcome measures proposed by various industry groups, and cataloging all the relevant proposed behavioral health performance measures in a table. These sources are listed below, and the table can be viewed on the website, www.doughertymanagement.com, "Review of Proposed and Current Performance Measures for Behavioral Health Care". It is available in a spreadsheet format so that the measures can be sorted using Excel to identify the range of proposed measures in different domains, from various sources of data and according to different Institute of Medicine domains.

List of Sources

1. Summit 2001: Reaching Consensus on Common Performance Measures in Behavioral Healthcare. Interim Report of the Summit Planning Workgroup, 11/1/2001.
2. "Fitting the Pieces Together: Building Accountability in Child Mental Health and Child Welfare Systems" SAMHSA Outcomes Roundtable for Children and Families. Undated.
3. "A Proposed Consensus Set of Indicators for Behavioral Health." American College of Mental Health Administration, (ACMHA) 2001 Interim Report.
4. "Sixteen State Pilot Study State Mental Health Agency Performance Measures: Draft Operational Measure Definitions". NASMHPD Research Institute, 2/27/01 (NASMHPD 16 State)
5. "CAHPS 2.5H Child Survey: Measure Work-Up Final Draft" NCQA Committee on Performance Measurement, September 2000.
6. Early Warning System. "Enhancing Oversight of Medicaid Managed Care with a Program of Quick Measures". Dichter, Howard. Funded by SAMHSA.
7. Health Plan Employer Data and Information Set: Behavioral Health HEDIS Measures. (HEDIS) - National Committee on Quality Assurance
8. AMBHA PERMS 2.0
9. MHSIP Consumer Survey
10. Decision Support 2000+. "Draft Requirements Analysis for Decision Support 2000+." Center for Mental Health Services and Abt Associates, Inc. – from www.MHSIP.org.
11. National Association of Psychiatric Health Systems (NAPHS) – White Paper: Lessons Learned from Pilot Testing of the NAPHS Benchmarking Indicators, 2001.
12. Institute for Behavioral Healthcare (IBH), National Leadership Council. "Performance Indicators in Behavioral Healthcare"
13. "Children's Mental Health Benchmarking Project: First Year Report" (Benchmarking) Funded by the Annie E. Casey Foundation. Dougherty Management Associates, Inc.
14. American Psychiatric Association (APA), Workbook of Quality Indicators
15. National Alliance for the Mentally Ill (NAMI), Stand and Deliver: Action Call to a Failing Industry. The NAMI Managed Care Report Card., September 1997.
16. Quality Outcomes Leadership Alliance, "10,000 Kids", presentation materials and information from www.qola.org.

APPENDIX B

TELEPHONE INTERVIEW TOPICS

1. Overview of Medicaid System

- Managed care model
- Population served
- Mandatory enrollment?
- Payment structure? Capitation rates available?

2. Performance Data

- Review listing of performance measures to determine whether the data are collected and can be reported for this project
- Are the data available for different subpopulations – stratified by age, eligibility group, MH/SA separately, etc?
- Are the data part of standard reports?
- Are there any other significant types of performance data not contained in our list that you regularly collect and use? If so, please describe.

3. Data Quality

- Do you have a process for validating the data?
- Do you have any concerns about the reliability of any of the performance measure data?

4. Use of Performance Measures

- How is your agency using these performance data to manage its managed care programs?
- How do you use the measures for performance monitoring? Target goals? As part of contractual arrangements? Attached to Financial incentives? As part of a Quality Improvement system?
- Are the data used for cross plan comparisons within the state, if applicable?
- Are the data made available to consumers? Other external stakeholders? If so, in what form—report cards, advisory group, etc.?

APPENDIX C

DOUGHERTY MANAGEMENT ASSOCIATES, INC.
SAMHSA MEDICAID BEHAVIORAL HEALTH CARE BENCHMARKING PROJECT
DATA COLLECTION INSTRUMENT FOR MENTAL HEALTH MEASURES
INSTRUCTIONS

Thank you, in advance, for participating in this project. If you need another copy of this instrument, you may call Susannah Dudley (781-863-8003) or send her an e-mail request at sdudley@doughertymanagement.com and she will e-mail you the document in a Word file.

Regarding financial data, in this addendum we are seeking all mental health expenditures under your waivered Medicaid managed care program (combined total of Federal and State contributions).

This form is provided to help clarify our data request and to provide a consistent format for reporting it to us. However, you may attach your own reports if it is more convenient than completing the form. When you have provided as much data as you can assemble by December 31, please fax the material to Dougherty Management Associates, Inc., at 781-863-1519, or mail it to *Dougherty Management Associates, 9 Meriam Street, Suite 4, Lexington, MA 02420.* If you have any questions, or if you are unable to submit your data by December 31st, please call Wendy Holt at 781-863-8003, or e-mail her at wendyh@doughertymanagement.com. Thank you.

Definitions: For your reference, we define below the terms we use in the data collection instrument whose exact meanings may not otherwise be clear.

1. **TANF**: Medicaid recipients eligible by meeting criteria for Temporary Assistance to Needy Families (TANF) – formerly AFDC. Also any additional eligibility categories based on income and enrolled in your managed care program.
2. **SSI**: Medicaid recipients eligible by qualifying for Supplemental Security Income (SSI) for the aged, blind or disabled. Also any additional eligibility categories based on disability or health status and enrolled in your managed care program.
3. **Expansion Populations**: Populations eligible for Medicaid services under expansions of Medicaid eligibility criteria. Includes State Children's Health Insurance Programs and programs that offer health benefits for adults under specified income limits that are greater than those for Medicaid TANF.
4. **Inpatient Services**: Acute, 24 hour, medically supervised services for a primary mental health diagnosis.
5. **Readmission**: Defined as returned to a hospital following a discharge; this would exclude those who were not discharged (such as those who were on leave with or without consent, and elopements).
6. **Day/Night Services**: Medicaid reimbursable services generally prescribed and billed by the half day (4 hours), day or bed day, excluding inpatient services. Includes partial hospitalization, day treatment, 23 hour observation stays, and non-hospital residential care
7. **Outpatient Visit**: Treatment delivered to a child or family in a mental health clinic, health care setting, or in a community setting (e.g. professional office, school, home, etc.). For the purpose of this project, an outpatient visit is one encounter for outpatient treatment. Please indicate the unit of measurement if other than one hour.
8. **Atypical Antipsychotics** clozapine, quetiapine, olanzapine, resperidone, other approved agents: NOT: chlorpromazapine, mesoridazine, trifluoperazine, fluphenazine, molindone, thioridazine, haloperidol, perphenazine, thiothixene, loxapine, pimozide

DOUGHERTY MANAGEMENT ASSOCIATES, INC.
SAMHSA MEDICAID BEHAVIORAL HEALTH CARE BENCHMARKING PROJECT
DATA COLLECTION INSTRUMENT

Respondent_____

Job Title _____ Agency Name _____

County or State _____

Medicaid Managed Care Program Name _____

Phone _____ Fax # _____ E-mail _____

Please provide as many data elements as are available concerning Medicaid mental health services provided through your waivered Medicaid managed care program. Be aware that we do not expect you to be able to provide data for all the questions. If you can only answer the most general question in a given section, but cannot respond to the more specific questions, your data will still be very helpful to us. Similarly, if one of your standard reports includes the requested or a substantially similar measure, you may submit the report. If so, please circle the relevant categories on the report and reference it to the items as numbered below.

Please provide data on children (from birth through age 17) and adults (18 and over). Please indicate here if you are reporting on a different age range _____. If the data are for a different age range for any individual indicator, please specify in your response. Please provide totals even if you can't separate children and adults.

Please provide data on SSI enrollees (and related eligibility categories) and TANF and Expansion enrollees. If these categories cannot be separated, please enter data on totals. Please list the Medicaid eligibility categories on which you are reporting.

TANF and Expansion Populations _____
SSI _____

For each indicator, provide data for the most recent year available. Please indicate here the Calendar Year (CY) or Fiscal Year (FY) for which you are reporting most or all data _____. If you are reporting data for a different year for any individual indicator, note that in the space provided.

Please provide unduplicated counts for each question or, if you are aware of minor duplications, you may use the *Comments* section at the end of this Instrument to let us know what causes them. If the numbers you are providing are estimates, please use the same *Comments* area to let us know what technique(s) you use to develop them.

1. ENROLLMENT/ELIGIBILITY

1.a. How many individuals were enrolled in your Medicaid managed care program (whether or not they received any mental health service) during the reporting year?

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

1.b. How is the Medicaid enrollment number provided above calculated? (please check one below)

Average Monthly Enrollment _____ Total number enrolled in Medicaid during the year _____

Other (describe)_____

2. TOTAL NUMBER OF ENROLLEES RECEIVING SERVICES

2.a. How many Medicaid managed care enrollees received any mental health service from your Medicaid managed care program within the reporting year?

Reporting Period	Children	Adults	Total
TANF and Expansion Populations			
SSI			
Total			

3. PSYCHIATRIC INPATIENT CARE

3.a. Unduplicated number of enrollees who experienced psychiatric hospitalizations from your Medicaid managed care program.

Reporting Period	Children	Adults	Total
TANF and Expansion Populations			
SSI			
Total			

3.b. Number of days of inpatient psychiatric care provided by your Medicaid managed care program.

Reporting Period	Children	Adults	Total
TANF and Expansion Populations			
SSI			
Total			

3.c. Number of episodes of inpatient psychiatric care provided by your Medicaid managed care plan. (total discharges)

Reporting Period	Children	Adults	Total
TANF and Expansion Populations			
SSI			
Total			

3.d. Total cost of inpatient psychiatric care provided by your Medicaid managed care plan.

Reporting Period	Children	Adults	Total
TANF and Expansion Populations			
SSI			
Total			

3.e. Percentage of Medicaid managed care program enrollees discharged from inpatient psychiatric care who are readmitted to any inpatient psychiatric facility within ***30*** days from discharge.

Reporting Period	Children	Adults	Total
TANF and Expansion Populations			
SSI			
Total			

3.f. Percentage of Medicaid managed care program enrollees discharged from inpatient psychiatric care who are readmitted to any psychiatric inpatient facility within ***90*** days from discharge.

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

3.g. Please specify the type(s) of inpatient care included in the numbers above:

State hospital Included_____

Private psychiatric hospital Included_____

General hospital with psychiatric unit Included_____

Other (specify) _____

4. DAY/NIGHT MENTAL HEALTH SERVICES

4.a. Unduplicated number of enrollees who used day/night mental health services from your Medicaid care program.

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

4.b. Number of units of day/night mental health services provided by your Medicaid managed care program.

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

4.c. Total cost of day/night mental health services provided by your Medicaid managed care program.

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

4.d. Please specify what types of day/night services are included in these numbers (i.e., types of facilities).

5. OUTPATIENT MENTAL HEALTH SERVICES (excludes day treatment and partial hospitalization)				
5.a. Unduplicated number of enrollees who used outpatient mental health services care in office, clinic, school, home and other community settings from your Medicaid care program.				
Reporting Period		**Children**	**Adults**	**Total**
TANF and Expansion Populations				
SSI				
Total				
5.b. Number of units of outpatient mental health services provided by your Medicaid managed care program. Indicate unit of measurement, if other than one hour. _____				
Reporting Period		**Children**	**Adults**	**Total**
TANF and Expansion Populations				
SSI				
Total				
5.c. Total cost of outpatient mental health services provided by your Medicaid managed care program.				
Reporting Period		**Children**	**Adults**	**Total**
TANF and Expansion Populations				
SSI				
Total				
5.d. Please specify what types of outpatient services are included in these numbers (i.e., types of facilities).				

6. MEDICAL LOSS RATIO	**$**	**Year**
6.a. Total service claims paid by your Medicaid managed care program contractors for the reporting year.		
6.b. Total capitation payments to Medicaid managed care program contractors for the reporting year.		

7. DUAL DIAGNOSIS	**#**	**Year**
7.a. Number of enrollees receiving mental health services from your Medicaid managed care program, who had a secondary diagnosis of substance abuse.		

8. SCHIZOPHRENIA TREATMENT	#	Year
8.a. Number of enrollees 18 years and older with a schizophrenia diagnosis.		
8.b. Number of enrollees 18 years and older with a schizophrenia diagnosis who had 4 or more visits with a physician or doctor of osteopathy in the 12 month reporting period.		

9. FOLLOW-UP AFTER INPATIENT DISCHARGE

9. a. Percentage of individuals discharged from a psychiatric inpatient setting who receive a day/night or outpatient mental health service within ***7*** days of discharge. Note. Exclude any children under age 6.

Reporting Period		Children 6 years and older	Adults	Total
TANF and Expansion Populations				
SSI				
Total				

9. b. Percentage of individuals discharged from a psychiatric inpatient setting who receive a day/night or outpatient mental health service within ***30*** days of discharge. Note. Exclude any children under age 6.

Reporting Period		Children 6 years and older	Adults	Total
TANF and Expansion Populations				
SSI				
Total				

10. PSYCHOTROPIC DRUGS BY TYPE

10.a. Total cost per enrollee served of psychotropic drugs by type.
Please use your own reporting format, stratifying by child/adult and or TANF/SSI if possible.

10.b. Does this measure include psychotropic drugs prescribed by primary care physicians? Yes_____ No_____

11. ATYPICAL ANTIPSYCHOTIC USAGE	#	Year
11.a. Number of adult enrollees (over 18) prescribed one or more atypical antipsychotic medications BID, TID, or QD		
11.b. Does this measure include atypical antipsychotics prescribed by primary care physicians? Yes_____ No_____		

12. TREATMENT OF MAJOR DEPRESSION	#	Year
12.a. Number of enrollees 18 years or older with a diagnosis of major depression (as defined by HEDIS)		
12.b. Does your definition of major depression differ from HEDIS? Yes_____ No_____ If yes, please attach the definition you used.		
12.c. Number of enrollees 18 years or older with a diagnosis of major depression, who were prescribed an antidepressant and who also received 3 or more follow-up visits within 12 weeks after initiation of antidepressant.		
12.d. Does your data include visits to primary care physicians? Yes_____ No_____		

	#	Year
12.e. Number of enrollees 18 and over with a diagnosis of major depression who filled a sufficient number of prescriptions to provide continuous treatment for a period of 12 weeks after initiation of antidepressant.		
12.f. Number of enrollees 18 years or older with a diagnosis of major depression who filled a sufficient number of prescriptions to provide continuous treatment for a period of 180 days after initiation of antidepressant.		

MEASURES FROM ADMINISTRATIVE DATA		
13. MEMBER PHONE CONTACTS	**#**	**Year**
13.a. Number of member calls answered in less than 30 seconds.		
13.b. Total number of member calls.		

14. SERVICE DENIAL REPORTS		
14.a. Total number of service denials by service type. Please attach your own service denial reports, with definitions of your terms and reporting categories.		

15. INVOLUNTARY ADMISSIONS	**%**	**Year**
15.a. Number of involuntary admissions of adults to inpatient settings divided by total adult inpatient admissions.		

16. CONSUMER SATISFACTION		
16.a. Consumer satisfaction with ***access*** to mental health care.	**%**	**Year**
i. If you use ***CAHPS***, please report: Number answering 3 to Adult Medicaid Behavioral Health question MH2 divided by those answering 1, 2 or 3.		
ii. If you use ***the*** MHSIP consumer survey, please report: Number with scale score of 2.5 or above out of 5 divided by total respondents. Scale consists of the average of each respondent's answers to the following questions: Staff were willing to see me as often as I felt was necessary. Staff returned my calls within 24 hours. Services were available at times that were good for me.		
iii. If you use another consumer satisfaction tool, please define your measure of access to mental health care and report it here.		

16.b. Consumer ***overall satisfaction*** with mental health care	%	Year
i. If you use CAHPS, please report: Number answering, 8, 9, or 10 to MH3 divided by those answering 0 through 10.		
ii. If you use the MHSIP consumer survey, please report: Number with scores of 4 (agree) or 5 (strongly agree) divided by total number of respondents answering question: If I had other choices, I would still get services from this agency.		
iii. If you use another consumer satisfaction tool, please define your measure of overall satisfaction with mental health care and report it here.		
16.c. Please briefly describe the sample for the survey you reported about, response rate, and how the survey was administered.		

17. COMPLAINTS AND GRIEVANCES

17.a. Number of consumer complaints and grievances concerning mental health services.

Please attach your own complaints and grievance reports, with definitions of your terms and reporting categories.

CONSUMER OUTCOMES

18. LEVEL OF FUNCTIONING

18.a. Consumers with improved, maintained and reduced levels of functioning pre and post treatment.

Please attach your own report on changes in consumer functioning with definitions of your terms and reporting categories.

18.b. What instrument do you use to measure functioning?

Adults _____ Children _____

18.c. Please indicate approximately what percentage of enrollees you have been able to collect measures of change in functioning. _____%

18.d. At what frequency are measures of functioning collected?

19. LIVING SITUATION

19.a. Consumer change in living situation pre and post treatment.

Please attach your own report on changes in consumer living situation with definitions of your terms and reporting categories.

19.b. Please indicate approximately what percentage of enrollees you have been able to collect measures of change in living situation. _____%

19.c. At what frequency are measures of functioning collected?

20. EMPLOYMENT

20.a. Consumer change in employment pre and post treatment.

Please attach your own report on changes in consumer employment with definitions of your terms and reporting categories.

20.b. Please indicate approximately what percentage of enrollees you have been able to collect measures of change in employment. _____%

20.c. At what frequency are measures of employment status collected?

21. CRIMINAL ACTIVITY

21.a. Consumer change in criminal involvement.

Please attach your own report on changes in consumer criminal involvement with definitions of your terms and reporting categories.

21.b. Please indicate approximately what percentage of enrollees you have been able to collect measures of change in criminal involvement. _____%

21.c. At what frequency are measures of criminal involvement collected?

21.d. What is the source of your information on criminal involvement?

Self-report _____

Court records _____

Other (specify) _____

CLINICAL PROCESS MEASURES

22. SECLUSION AND RESTRAINT	**%**	**Year**
22.a. Percent of all patient hours of treatment spent in seclusion or under restraint		
22.b. Clients with one or more episodes of restraint or seclusion as a percentage of all clients served during the reporting period		

22.c. For what types of facilities was this measure reported?

State hospital Included_____

Private psychiatric hospital Included_____

General hospital with psychiatric unit Included_____

Other (specify) _____

COMMENTS

THANK YOU AGAIN FOR PARTICIPATING IN THIS PROJECT.
PLEASE FAX THIS COMPLETED FORM TO :
781-863-1519

OR MAIL FORM AND ATTACHMENTS TO:
DOUGHERTY MANAGEMENT ASSOCIATES, INC.
9 MERIAM STREET, SUITE 4
LEXINGTON, MA 02420

APPENDIX D

DOUGHERTY MANAGEMENT ASSOCIATES, INC.
SAMHSA MEDICAID BEHAVIORAL HEALTH CARE BENCHMARKING PROJECT
DATA COLLECTION INSTRUMENT FOR SUBSTANCE ABUSE MEASURES
INSTRUCTIONS

Thank you, in advance, for participating in this project. If you need another copy of this instrument, you may call Susannah Dudley (781-863-8003) or send her an e-mail request at sdudley@doughertymanagement.com and she will e-mail you the document in a Word file.

Regarding financial data, in this addendum we are seeking all substance abuse expenditures under your waivered Medicaid managed care program (combined total of Federal and State contributions).

This form is provided to help clarify our data request and to provide a consistent format for reporting it to us. However, you may attach your own reports if it is more convenient than completing the form. When you have provided as much data as you can assemble by December 31, please fax the material to Dougherty Management Associates, Inc., at 781-863-1519, or mail it to *Dougherty Management Associates, 9 Meriam Street, Suite 4, Lexington, MA 02420.* If you have any questions, or if you are unable to submit your data by December 31st, please call Wendy Holt at 781-863-8003, or e-mail her at wendyh@doughertymanagement.com. Thank you.

Definitions: For your reference, we define below the terms we use in the data collection instrument whose exact meanings may not otherwise be clear.

1. **TANF**: Medicaid recipients eligible by meeting criteria for Temporary Assistance to Needy Families (TANF) – formerly AFDC. Also any additional eligibility categories based on income and enrolled in your managed care program.
2. **SSI**: Medicaid recipients eligible by qualifying for Supplemental Security Income (SSI) for the aged, blind or disabled. Also any additional eligibility categories based on disability or health status and enrolled in your managed care program.
3. **Expansion Populations**: Populations eligible for Medicaid services under expansions of Medicaid eligibility criteria. Includes State Children's Health Insurance Programs and programs that offer health benefits for adults under specified income limits that are greater than those for Medicaid TANF.
4. **Inpatient Services**: Inpatient care and residential treatment and rehabilitation with a primary diagnosis of chemical dependency, including detoxification.
5. **Readmission**: Defined as returned to a hospital or residential chemical dependency treatment facility following a discharge; this would exclude those who were not discharged (such as those who were on leave with or without consent, and elopements).
6. **Day/Night Services**: Medicaid reimbursable services generally prescribed and billed by the half day (4 hours), day or bed day, excluding inpatient services. Includes partial hospitalization, day treatment, and 23 hour observation stays.
7. **Outpatient Visit**: Treatment delivered to a child or family in a substance abuse clinic, health care setting, or in a community setting (e.g. professional office, school, home, etc.). For the purpose of this project, an outpatient visit is one encounter for outpatient treatment. Please indicate the unit of measurement if other than one hour.

DOUGHERTY MANAGEMENT ASSOCIATES, INC.
SAMHSA MEDICAID BEHAVIORAL HEALTH CARE BENCHMARKING PROJECT
DATA COLLECTION INSTRUMENT

Respondent_____

Job Title _____ Agency Name _____

County or State _____

Medicaid Managed Care Program Name _____

Phone _____ Fax # _____ E-mail _____

Please provide as many data elements as are available concerning Medicaid substance abuse services provided through your waivered Medicaid managed care program. Be aware that we do not expect you to be able to provide data for all the questions. If you can only answer the most general question in a given section, but cannot respond to the more specific questions, your data will still be very helpful to us. Similarly, if one of your standard reports includes the requested or a substantially similar measure, you may submit the report. If so, please circle the relevant categories on the report and reference it to the items as numbered below.

Please provide data on children (from birth through age 17) and adults (18 and over). Please indicate here if you are reporting on a different age range _____. If the data are for a different age range for any individual indicator, please specify in your response. Please provide totals even if you can't separate children and adults.

Please provide data on SSI enrollees (and related eligibility categories) and TANF and Expansion enrollees. If these categories cannot be separated, please enter data on totals. Please list the Medicaid eligibility categories on which you are reporting.

TANF and Expansion Populations _____
SSI _____

For each indicator, provide data for the most recent year available. Please indicate here the Calendar Year (CY) or Fiscal Year (FY) for which you are reporting most or all data _____. If you are reporting data for a different year for any individual indicator, note that in the space provided.

Please provide unduplicated counts for each question or, if you are aware of minor duplications, you may use the *Comments* section at the end of this Instrument to let us know what causes them. If the numbers you are providing are estimates, please use the same *Comments* area to let us know what technique(s) you use to develop them.

1. ENROLLMENT/ELIGIBILITY

1.a. How many individuals were enrolled in your Medicaid managed care program (whether or not they received any substance service) during the reporting year?

	Reporting Period	**Children**	**Adults**	**Total**
	TANF and Expansion Populations			
	SSI			
	Total			

1.b. How is the Medicaid enrollment number provided above calculated? (please check one below)

Average Monthly Enrollment _____ Total number enrolled in Medicaid during the year _____

Other (describe)_____

2. TOTAL NUMBER OF ENROLLEES RECEIVING SERVICES

2.a. How many Medicaid managed care enrollees received any substance abuse service from your Medicaid managed care program within the reporting year?

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

3. INPATIENT SUBSTANCE ABUSE CARE

3.a. Unduplicated number of enrollees who experienced substance abuse hospitalizations from your Medicaid managed care program.

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

3.b. Number of days of inpatient substance abuse care provided by your Medicaid managed care program.

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

3.c. Number of episodes of inpatient substance abuse care provided by your Medicaid managed care plan. (total discharges)

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

3. d. Total cost of inpatient substance abuse care provided by your Medicaid managed care plan.

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

3.e. Percentage of Medicaid managed care program enrollees discharged from inpatient substance abuse care who are readmitted to any inpatient substance abuse treatment facility within ***30*** days from discharge.

Reporting Period	**Children**	**Adults**	**Total**
TANF and Expansion Populations			
SSI			
Total			

3.f. Percentage of Medicaid managed care program enrollees discharged from inpatient substance abuse care who are readmitted to any inpatient substance abuse treatment facility within ***90*** days from discharge.

	Reporting Period		**Children**	**Adults**	**Total**
	TANF and Expansion Populations				
	SSI				
	Total				

3.g. Please specify the type(s) of inpatient care included in the numbers above:

Private psychiatric hospital Included_____

General hospital with psychiatric unit Included_____

Other (specify) _____

4. DAY/NIGHT SUBSTANCE ABUSE SERVICES

4.a. Unduplicated number of enrollees who used day/night substance abuse services from your Medicaid care program.

	Reporting Period		**Children**	**Adults**	**Total**
	TANF and Expansion Populations				
	SSI				
	Total				

4.b. Number of units of day/night substance abuse services provided by your Medicaid managed care program.

	Reporting Period		**Children**	**Adults**	**Total**
	TANF and Expansion Populations				
	SSI				
	Total				

4.c. Total cost of day/night substance abuse services provided by your Medicaid managed care program.

	Reporting Period		**Children**	**Adults**	**Total**
	TANF and Expansion Populations				
	SSI				
	Total				

4.d. Please specify what types of day/night services are included in these numbers (i.e., types of facilities).

5. OUTPATIENT SUBSTANCE ABUSE SERVICES (excludes day treatment and partial hospitalization)				
5.a. Unduplicated number of enrollees who used outpatient substance abuse services care in office, clinic, school, home and other community settings from your Medicaid care program.				
Reporting Period		**Children**	**Adults**	**Total**
TANF and Expansion Populations				
SSI				
Total				
5.b. Number of units of outpatient substance abuse services provided by your Medicaid managed care program. Indicate unit of measurement, if other than one hour. _____				
Reporting Period		**Children**	**Adults**	**Total**
TANF and Expansion Populations				
SSI				
Total				
5.c. Total cost of outpatient substance abuse services provided by your Medicaid managed care program.				
Reporting Period		**Children**	**Adults**	**Total**
TANF and Expansion Populations				
SSI				
Total				
5.d. Please specify what types of outpatient services are included in these numbers (i.e., types of facilities).				

6. MEDICAL LOSS RATIO	$	Year
6.a. Total service claims paid by your Medicaid managed care program contractors for the reporting year.		
6.b. Total capitation payments to Medicaid managed care program contractors for the reporting year.		

7. DUAL DIAGNOSIS	#	Year
7.a. Number of enrollees receiving substance abuse services from your Medicaid managed care program, who had a secondary diagnosis of mental illness.		

8. FOLLOW-UP AFTER DETOXIFICATION DISCHARGE				
8. a. Percentage of adults discharged from a detoxification setting (inpatient or residential facility) who receive a substance abuse treatment service (other than readmission to an inpatient or a residential facility) within 14 days of discharge.				
	Reporting Period		**Adults**	**Total**
	TANF and Expansion Populations			
	SSI			
	Total			

MEASURES FROM ADMINISTRATIVE DATA		
9. MEMBER PHONE CONTACTS	**#**	**Year**
9.a. Number of member calls answered in less than 30 seconds.		
9.b. Total number of member calls.		

10. SERVICE DENIAL REPORTS		
10.a. Total number of service denials by service type. Please attach your own service denial reports, with definitions of your terms and reporting categories.		

11. CONSUMER SATISFACTION		
11.a. Consumer satisfaction with access to substance abuse care.	**%**	**Year**
Please define your measure of access to substance abuse care and report the percentage of respondents rating their access to substance abuse care satisfactory here.		
11.b. Consumer overall satisfaction with substance abuse care	%	Year
Please define your measure of overall satisfaction with substance abuse care and report the percentage of respondents rating their substance abuse care satisfactory here.		
11.c. Please briefly describe the sample for the survey you reported about, response rate, and how the survey was administered.		

12. COMPLAINTS AND GRIEVANCES
12.a. Number of consumer complaints and grievances concerning substance abuse and/or substance abuse services. Please attach your own complaints and grievance reports, with definitions of your terms and reporting categories.

CONSUMER OUTCOMES

13. LEVEL OF FUNCTIONING

13.a. Consumers with improved, maintained and reduced levels of functioning pre and post treatment.

Please attach your own report on changes in consumer functioning with definitions of your terms and reporting categories.

13.b. What instrument do you use to measure functioning?

Adults _____ Children _____

13.c. Please indicate approximately what percentage of enrollees you have been able to collect measures of change in functioning. _____%

13.d. At what frequency are measures of functioning collected?

14. LIVING SITUATION

14.a. Consumer change in living situation pre and post treatment.

Please attach your own report on changes in consumer living situation with definitions of your terms and reporting categories.

14.b. Please indicate approximately what percentage of enrollees you have been able to collect measures of change in living situation. _____%

14.c. At what frequency are measures of functioning collected?

15. EMPLOYMENT

15.a. Consumer change in employment pre and post treatment.

Please attach your own report on changes in consumer employment with definitions of your terms and reporting categories.

15.b. Please indicate approximately what percentage of enrollees you have been able to collect measures of change in employment. _____%

15.c. At what frequency are measures of employment status collected?

16. CRIMINAL ACTIVITY

16.a. Consumer change in criminal involvement.

Please attach your own report on changes in consumer criminal involvement with definitions of your terms and reporting categories.

16.b. Please indicate approximately what percentage of enrollees you have been able to collect measures of change in criminal involvement. _____%

16.c. At what frequency are measures of criminal involvement collected?

16.d. What is the source of your information on criminal involvement?

Self-report _____

Court records _____

Other (specify) _____

COMMENTS

THANK YOU AGAIN FOR PARTICIPATING IN THIS PROJECT.
PLEASE FAX THIS COMPLETED FORM TO:
781-863-1519

OR MAIL FORM AND ATTACHMENTS TO:
DOUGHERTY MANAGEMENT ASSOCIATES, INC.
9 MERIAM STREET, SUITE 4
LEXINGTON, MA 02420

APPENDIX E

LIST OF RESPONDENTS: SITE AND AGENCY

State	Program Site	Contact Agency
Medicaid Carve-ins		
DC	CASSIP	Health Services for Children with Special Needs, Inc., responding for Medical Assistance Administration, District of Columbia
MA	MassHealth MCO Model	Division of Medical Assistance
NH	NH HMOs	Department of Health and Human Services, Medicaid Administration Bureau
NM	Salud! HMOs	Division of Health Care Financing and Policy
OR	Oregon Health Plan HMOs	Department of Human Services, Office of Mental Health and Addiction Services
RI	Rite Care HMOs	Department of Human Services
SD	Prime PCCP Plan	Department of Social Services, Medical Services
WI	WI Medicaid HMO Program	Department of Health and Family Services, Division of Health Care Financing
Medicaid-Only Carve-outs		
CO	CO Mental Health Capitation and Managed Care Program	Department of Human Services, Mental Health Services
FL	Tampa Prepaid Mental Health Plan	FL Agency for Healthcare Administration
PA	PA Health Choices, Behavioral Health Services	PA Office of Mental Health and Substance Abuse Services
UT	Utah Prepaid Health Plan	Department of Health
WV	New Directions in Medicaid Services Initiative	Department of Health and Human Resources, Bureau for Medical Services
Blended Carve-outs		
AZ	AHCCS	Division of Health Services, Division of Behavioral Health Services
CA	Los Angeles County	Los Angeles County Department of Mental Health
CA	San Diego County	San Diego County Department of Health, Mental Health Services
HI	Quest	Department of Human Services
MA	Mass Health Carve-out	Division of Medical Assistance
MD	Specialty Mental Health System	Department of Health and Mental Hygiene, Mental Hygiene Division
OR	Oregon Health Plan, Mental Health Services	OR Department of Human Services, Office of Mental Health and Addiction Services
TX	NorthSTAR	Health and Human Services Commission
WA	Clark County	Clark County, WA Community Services & Corrections, Behavioral Health
WA	Integrated Community Mental Health Program	Department of Social and Health Services, Mental Health Division
WA	King County	King County, WA Mental Health Division
WA	Spokane County	Spokane County, WA Community Services Department, Regional Support Network

APPENDIX F

SAMHSA MEDICAID BEHAVIORAL HEALTH BENCHMARKING PROJECT

PARTICIPATING MEDICAID MANAGED CARE PROGRAMS

Program	Managed Care Entity	TANF	SSI	Uninsured SED/ SMI	Program Enrollees [201]	MH Services	SA Services
MEDICAID CARVE-INS							
OR - County / Region SA	HMOs	Y	Y	N	323,936	See blended carve-outs	Y
New Mexico - SALUD!	HMOs (3) that subcontract with MBHOs or RCCs (local providers for uninsured adults)	Y	Y	N	205,387	Y	Y
MA – HMOs	HMOs, some with MBHO subcontractor	Y	Y	N	192,243	Y	Y
WI HMO Program	HMOs	Y	N	N	162,121	Y	Y
RI	HMO	Y excludes SMI / SED	N	N	137,767	Y	Y
SD	HMOs (3)	Y excludes SMI	Y excludes SMI	N	50,220	Y	N
NH Managed Care	HMO	Y	Y	N	5,812	Y	Y
DC HSCSN	MCO	N	Children only	N	2,651	Y	Y
MEDICAID ONLY CARVE-OUTS							
PA - Health Choices BHS	Counties (some subcontract to MBHOs)	Y	Y	N	713,154	Y	Y
OR - County / Region MH	HMOs, MBHOs, Local MH Authorities and consortia.	Y	Y	N	447,467	Y	See carve-ins
CO	CMHCs, CMHC / MBHO, HMO with ASO	Y	Y	N	288,466	Y	N
UT - PrePaid MH Plan	sole source with 9 CMHCs	Y	Y	N	185,122	Y	N
WV	ASO performs UM for clinic and rehab services and provider technical assistance.	Y	Y	N	63,644	Y	Y
FL - PrePaid MH Tampa	MBHO with CMHC partners	Y	Y	N	57,404	Y	N

APPENDIX F

SAMHSA MEDICAID BEHAVIORAL HEALTH BENCHMARKING PROJECT

PARTICIPATING MEDICAID MANAGED CARE PROGRAMS

Program	Managed Care Entity	TANF	SSI	Uninsured SED/ SMI	Program Enrollees [201]	MH Services	SA Services
BLENDED CARVE-OUTS							
CA – Los Angeles County	County	Y	Y	Y	2,323,897	Y	N
WA state – Integrated Community MH Health Program	Regional Service Networks	Y	Y	Y	1,019,889	Y	N
AZ – AHCCS	RBHAs Regional Behavioral Health Authorities	Y	Y	Y	434,911	Y	Y
MA	MBHO	Y	Y	For inpt & crisis	442,683	Y	Y
MD - Spec. MH System	MBHO as ASO. Core Service agencies (CMHCs)	Y	Y	Y	359,193	Y	N
CA - San Diego County	County subcontracted to ASO	Y	Y	Y	325,483	Y	N
TX - NorthSTAR	MBHO	Y	Y	Y	252,439	Y	Y
WA - King County	County with ASO (UBH)	Y- MH OP benefits also avail. through Medicaid HMOs	Y- MH OP benefits also avail. through Medicaid HMOs	Y	163,738	Y	N
WA – Spokane	County with ASO (UBH)	Y- MH OP benefits also avail. through Medicaid HMOs	Y- MH OP benefits also avail. through Medicaid HMOs	Y as resources allow	86,407	Y	N
WA – Clark	County as RSN	Y- MH OP benefits also avail. through Medicaid HMOs	Y- MH OP benefits also avail. through Medicaid HMOs	Y	62,641	Y	N
HI Quest - SMI adults	ASO	Y - SMI adults	Y- SMI adults	N	476	Y	N

① Enrollment is for period for which data was reported for this report. For programs that did not submit data, enrollment is for the period ending 6/30/00 as reported by The Lewin Group in SAMHSA Tracking System: 2000 State Profile on Public Sector Managed Behavioral Health Care, Feb 9, 2001.

APPENDIX G

MEDICAID MANAGED CARE PROGRAM ENROLLMENT PROFILES

Percentage of Medicaid Enrollees by Age		
Program	**Child**	**Adult**
D.C. CASSIP	100%	0%
New Mexico Salud! A	82%	18%
New Mexico Salud! B	83%	17%
New Mexico Salud! C	81%	19%
Oregon HMOs (SA)	32%	68%
Rhode Island Rite Care	61%	39%
Carve-in average	**73%**	**27%**
Utah Prepaid MH Plan	66%	34%
Florida Tampa Prepaid MHP	74%	26%
Oregon Health Plan (MH)	44%	56%
Medicaid-only carve-out average	**61%**	**39%**
CA-LA County	51%	49%
Arizona AHCCS+	37%	40%
CA-San Diego	50%	50%
WA-Spokane	57%	43%
WA-State	58%	42%
Blended carve-out average	**50%**	**45%**
Overall average	**63%**	**36%**

Percentage of Medicaid Enrollees by Eligibility Category			
Program	**TANF**	**SSI**	**Other**
D.C. CASSIP	0%	100%	0%
MA HMO A*	81%	10%	9%
MA HMO B*	82%	9%	8%
MA HMO C*	89%	3%	8%
MA HMO D*	83%	3%	14%
New Mexico Salud! A	81%	11%	0%
New Mexico Salud! B	81%	10%	0%
New Mexico Salud! C	78%	12%	0%
Oregon HMOs ** (SA)	32%	15%	53%
Carve-in Average	**67%**	**19%**	**10%**
Florida Tampa Prepaid MHP ***	43%	32%	25%
Oregon Health Plan (MH)**	83%	17%	0%
Medicaid-only carve-out average	**63%**	**25%**	**13%**
Arizona AHCCS+	59%	18%	23%
Massachusetts Carve-out*	73%	19%	8%
Blended carve-out average	**66%**	**19%**	**16%**
Overall average	**66%**	**20%**	**11%**

***** Other enrollment is an expansion program for unemployed adults.
****** Other enrollment is for two expansion programs, a CHIP program for children and a larger program for adults. These enrollees are included in the TANF counts for the Oregon Health Plan MH carve-out.
*** Other enrollment is a children's expansion program.
+ Other enrollment are Medicaid recipients (could be TANF, SOBRA, or SSI) not identified in the mental health system.

APPENDIX H

MEDICAID INCOME ELIGIBILITY STANDARDS BY STATE
(INCOME STANDARD EXPRESSED AS PERCENT OF POVERTY)

	AZ	CA	CO	DC CASSIP	FL	MD	MA	NM	OR	PA	RI	UT	WA
Reporting Year	FY01	FY01	FY00	2000	FY01	FY01	FY01	2000	10/99 - 12/00	2000	FY01	FY00	FY01
Foster Kids enrolled in mgd care? …included in submitted data?	Y	Y	Y	y/y	y/y	Y	Y	Y	MH y/y SA y/n	Y	Y	Inpat. y/y Outpt n/n	y/y
Pregnant women	140%	200%	185%	n/a	185%		185%	185%		185%	350%	133%	200%
Infants	140%	200%	133%	n/a	185%		185%	185%		185%	350%	133%	200%
Ages 1-5	133%	133%	133%	n/a	133%			185%		133%	250%	133%	
Ages 6-14	100%	100%	100%	n/a	100%			185%		100%	250%	100%	
Ages 15-19	100%	100%	39%	n/a	100%			185%		40%	250%	100%	
TANF based eligibility													
Family	100%	Above national average *	39%	n/a				36%		40%		~ 45%	Above national average
Separate CHIP		Healthy Families	CHP+									n/a	
Ages 1-5		200%	185%	n/a	200%			235%		235%		Not enrolled in Utah PPHP	
Ages 6-14		200%	185%	n/a	200%			235%		185%			
Ages 15-19		200%	185%	n/a	200%			235%		185%			
Medically Needy													
	40%	86%	N	N	28%		Y	N		43%		45% to 50%	Y

APPENDIX I

Measures	Total Programs Providing Data	Total Data Points	NM Salud! HMOs	MA HMOs	RI Rite Care	DC CASSIP
Medicaid penetration rate	**13**	**16**		**4**	**1**	**1**
TANF/SSI	5	8		4		SSI
Child/Adult	9	9			1	child
Inpatient penetration	**13**	**16**	**3**	**2**	**1**	**1**
TANF/SSI	3	3				SSI
Child/Adult	10	10			1	child
Day/night penetration	**10**	**12**	**3**		**1**	**1**
TANF/SSI	3	3				SSI
Child/Adult	8	8			1	child
Outpatient Penetration	**11**	**15**	**3**	**3**	**1**	**1**
TANF/SSI	3	3				SSI
Child/Adult	8	8			1	child
Inpatient Utilization - bed days per 1000	**13**	**16**		**4**	**1**	**1**
TANF/SSI	2	2				SSI
Child/Adult	9	9			1	child
Inpatient discharges per 1000	**11**	**16**	**3**	**4**	**1**	
TANF/SSI	1	1				
Child/Adult	5	5			1	
Inpatient ALOS	**11**	**16**	**3**	**4**	**1**	
TANF/SSI	1	1				
Child/Adult	8	8			1	
Inpatient Readmission - 30 days	**10**	**12**		**3**		
TANF/SSI	0	0				
Child/Adult	7	7				
Inpatient Readmission - 90 days	**6**	**8**		**3**		
TANF/SSI	0	0				
Child/Adult	4	4				
Day/night utilization per thousand (units)	**9**	**9**			**1**	**1**
TANF/SSI	2	2				SSI
Child/Adult	6	6			1	child
Outpatient utilization per thousand	**9**	**9**			**1**	**1**
TANF/SSI	2	2				SSI
Child/Adult	7	7			1	child
Total cost per enrollee served	**10**	**13**		**4**	**1**	**1**
TANF/SSI	3	3		TANF		SSI
Child/Adult	6	7		2	1	child
Inpatient cost per enrollee served	**9**	**10**		**2**	**1**	**1**
TANF/SSI	2	2				SSI
Child/Adult	7	8		2	1	child
Day/night cost per enrollee served	**7**	**7**			**1**	**1**
TANF/SSI	2	2				SSI
Child/Adult	4	4			1	child
Outpatient cost per enrollee served	**7**	**9**		**3**	**1**	**1**
TANF/SSI	2	2				SSI
Child/Adult	6	7		2	1	child
Medical Loss Ratio	**4**	**4**				
Dual diagnosis total	**5**	**5**				
Dual diagnosis kids	1	1				
Dual diagnosis adults	1	1				
Telephone Access % calls answered > 30 sec	**4**	**7**		**4**		**1**
Consumer Satisfaction - Access	**7**	**10**		**4**		
CAHPS Access	2	5		4		
MHSIP Access	4	4				
Other Access	1	1				
Consumer Satisfaction - Overall	**8**	**11**		**4**		
CAHPS Overall Satisfaction	2	5		4		
MHSIP Overall Satisfaction	4	4				
Other Overall Satisfaction	2	2				
Percentage with schizo. Diag w/ 4 visits in 12 mos.	**3**	**3**				
Percentage of discharges with fu visit w/in 7 days	**12**	**17**	**3**	**4**		
Percentage of discharges with fu visit w/in 30 days	**7**	**9**	**3**			
Enrollees prescribed atypical antipsychotics per 100	**2**	**2**				
HEDIS Depression	**1**	**3**	**3**			
Depression w/ 2 fu visits in 12 weeks	1	3	3			
Depression w/12 weeks of scrips	1	3	3			
Depression w/ 180 days of medication treatment	1	3	3			
Involuntary Admissions	**6**	**6**				
Seclusion and Restraint	**0**	**0**				
TOTAL MAJOR DATA POINTS (unbolded items)	**17**		**24**	**52**	**13**	**12**

Inventory of MH Measures for Medicaid-only Carve-outs

Measures	OR Health Plan-MH	CO	UT Prepaid MH Plan	FL Tampa Prepaid HP
Medicaid penetration rate	**1**	**1**		**1**
TANF/SSI	1			1
Child/Adult	1			1
Inpatient penetration	**1**	**1**	**1**	**1**
TANF/SSI	1			1
Child/Adult	1		1	1
Day/night penetration	**1**	**1**		**1**
TANF/SSI	1			1
Child/Adult	1			1
Outpatient Penetration	**1**	**1**	**1**	**1**
TANF/SSI	1			1
Child/Adult	1		1	1
Inpatient Utilization - bed days per 1000	**1**	**1**	**1**	**1**
TANF/SSI	1			
Child/Adult	1		1	
Inpatient discharges per 1000	**1**	**1**	**1**	
TANF/SSI	1			
Child/Adult	1		1	
Inpatient ALOS	**1**		**1**	
TANF/SSI	1			
Child/Adult	1		1	
Inpatient Readmission - 30 days		**1**	**1**	**1**
TANF/SSI				
Child/Adult			1	
Inpatient Readmission - 90 days				
TANF/SSI				
Child/Adult				
Day/night utilization per thousand (units)	**1**	**1**		**1**
TANF/SSI	1			
Child/Adult	1			
Outpatient utilization per thousand	**1**	**1**	**1**	**1**
TANF/SSI	1			
Child/Adult	1		1	
Total cost per enrollee served	**1**	**1**		
TANF/SSI	1			
Child/Adult	1			
Inpatient cost per enrollee served	**1**			
TANF/SSI	1			
Child/Adult	1			
Day/night cost per enrollee served	**1**			
TANF/SSI	1			
Child/Adult	1			
Outpatient cost per enrollee served	**1**			
TANF/SSI	1			
Child/Adult	1			
Medical Loss Ratio	**1**	**1**		**1**
Dual diagnosis total	**1**			
Dual diagnosis kids				
Dual diagnosis adults				
Telephone Access % calls answered > 30 sec				**1**
Consumer Satisfaction - Access		**1**		**1**
CAHPS Access				
MHSIP Access		1		
Other Access				1
Consumer Satisfaction - Overall	**1**			**1**
CAHPS Overall Satisfaction				
MHSIP Overall Satisfaction	1			
Other Overall Satisfaction				1
Percentage with schizo. Diag w/ 4 visits in 12 mos.			**1**	
Percentage of discharges with fu visit w/in 7 days	**Child/Adult**	**1**	**Child/Adult**	**1**
Percentage of discharges with fu visit w/in 30 days	**Child/Adult**		**Child/Adult**	
Enrollees prescribed atypical antipsychotics per 100		**1**		
HEDIS Depression				
Depression w/ 2 fu visits in 12 weeks				
Depression w/12 weeks of scrips				
Depression w/ 180 days of medication treatment				
Involuntary Admissions	**1**			
Seclusion and Restraint				
TOTAL MAJOR DATA POINTS (unbolded items)	**19**	**14**	**10**	**13**

Inventory of MH Measures for Blended Carve-outs

	CA-LA County	WA-State	MA Carve	AZ AHCC	MD	CA-San Diego	WA-King County	WA-Spokane	WA-Clark

			out	S					County
Medicaid penetration rate	**1**	**1**	**1**			**1**	**1**	**1**	**1**
TANF/SSI			1						
Child/Adult	1	1				1		1	1
Inpatient penetration	**1**	**1**				**1**		**1**	**1**
TANF/SSI									
Child/Adult	1	1				1		1	1
Day/night penetration	**1**					**1**		**1**	**1**
TANF/SSI									
Child/Adult	1					1		1	1
Outpatient Penetration	**1**	**1**						**1**	
TANF/SSI									
Child/Adult	1	1						1	
Inpatient Utilization - bed days per 1000	**1**	**1**	**1**			**1**		**1**	**1**
TANF/SSI									
Child/Adult	1	1				1		1	1
Inpatient discharges per 1000	**1**		**1**			**1**		**1**	**1**
TANF/SSI									
Child/Adult	1					1			
Inpatient ALOS	**1**		**1**			**1**	**1**	**1**	**1**
TANF/SSI									
Child/Adult	1					1	1	1	1
Inpatient Readmission - 30 days	**1**	**1**	**1**		**1**		**1**		**1**
TANF/SSI									
Child/Adult	1	1		SMI Adults	1	1	1	1	
Inpatient Readmission - 90 days	**1**	**1**	**1**		**1**				**1**
TANF/SSI									
Child/Adult	1	1				1		1	
Day/night utilization per thousand (units)	**1**					**1**		**1**	**1**
TANF/SSI									
Child/Adult	1							1	1
Outpatient utilization per thousand	**1**	**1**						**1**	
TANF/SSI									
Child/Adult	1	1						1	
Total cost per enrollee served	**1**	**1**	**1**			**1**			**1**
TANF/SSI									
Child/Adult	1	1							
Inpatient cost per enrollee served	**1**	**1**			**1**	**1**			**1**
TANF/SSI									
Child/Adult	1	1				1			
Day/night cost per enrollee served	**1**				**1**	**1**			**1**
TANF/SSI									
Child/Adult	1								
Outpatient cost per enrollee served	**1**	**1**			**1**				
TANF/SSI									
Child/Adult	1	1							
Medical Loss Ratio				**1**					
Dual diagnosis total	**1**					**1**	**1**	**1**	
Dual diagnosis kids	1								
Dual diagnosis adults	1								
Telephone Access % calls answered > 30 sec						**1**			
Consumer Satisfaction - Access		**1**	**1**	**1**		**1**			
CAHPS Access			1						
MHSIP Access		1		1		1			
Other Access									
Consumer Satisfaction - Overall		**1**	**1**	**1**		**1**			**1**
CAHPS Overall Satisfaction			1						
MHSIP Overall Satisfaction		1		1		1			
Other Overall Satisfaction									1
Percentage with schizo. Diag w/ 4 visits in 12 mos.	**1**					**1**			
Percentage of discharges with fu visit w/in 7 days	**1**	**1**	**1**				**5 days**	**Child/ Adult**	**1**
Percentage of discharges with fu visit w/in 30 days	**1**	**1**					**1**	**Child/ Adult**	
Enrollees prescribed atypical antipsychotics per 100				**1**					
HEDIS Depression									
Depression w/ 2 fu visits in 12 weeks									
Depression w/12 weeks of scrips									
Depression w/ 180 days of medication treatment									
Involuntary Admissions	**1**					**1**	**1**	**1**	**1**
Seclusion and Restraint									
TOTAL MAJOR DATA POINTS (unbolded items)	**20**	**14**	**10**	**4**	**5**	**16**	**7**	**13**	**15**

Inventory of SA Measures

Measures	Total Programs Providing Data	Total Data Points	Medicaid-only Carve-ins				Blended Carve-outs	
			OR HMOs	NM Salud! HMOs	MA HMOs	RI Rite Care	MA Carve-out	AZ AHCCS
Medicaid penetration rate	**2**	**2**	**1**			**1**	**1**	

TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Inpatient penetration	**4**	**6**	**1**	**3**		**1**	**1**	
TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Day/night penetration	**2**	**4**		**3**		**1**		
TANF/SSI	0	0						
Child/Adult	1	1				1		
Outpatient Penetration	**4**	**7**	**1**	**3**	**2**	**1**		
TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Inpatient Utilization - bed days per 1000	**4**	**7**	**1**		**4**	**1**	**1**	
TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Inpatient discharges per 1000	**5**	**10**	**1**	**3**	**4**	**1**	**1**	
TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Inpatient ALOS	**5**	**10**	**1**	**3**	**4**	**1**	**1**	
TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Inpatient Readmission - 30 days	**2**	**4**			**3**		**1**	
TANF/SSI	0	0						
Child/Adult	1	1						Adults
Inpatient Readmission - 90 days	**2**	**4**			**3**		**1**	
TANF/SSI	0	0						
Child/Adult	0	0						
Day/night utilization per thousand (units)	**1**	**1**				**1**		
TANF/SSI	0	0						
Child/Adult	1	1				1		
Outpatient utilization per thousand	**2**	**2**	**1**			**1**		
TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Total cost per enrollee served	**1**	**1**				**1**		
TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Inpatient cost per enrollee served	**3**	**3**	**1**			**1**	**1**	
TANF/SSI	1	1	1					
Child/Adult	2	2	1			1		
Day/night cost per enrollee served	**1**	**1**				**1**		
TANF/SSI	0	0						
Child/Adult	1	1				1		
Outpatient cost per enrollee served	**3**	**4**	**1**		**2**	**1**		
TANF/SSI	1	1	1					
Child/Adult	3	4	1		2	1		
Medical Loss Ratio	**0**	**0**						
Dual diagnosis total	**1**	**1**	**1**					
Dual diagnosis kids	1	1	1					
Dual diagnosis adults	1	1	1					
Telephone Access % calls answered > 30 sec	**0**	**0**						
Consumer Satisfaction - Access	**0**	**0**						
CAHPS Access	0	0						
MHSIP Access	0	0						
Other Access	0	0						
Consumer Satisfaction - Overall	**0**	**0**						
CAHPS Overall Satisfaction	0	0						
MHSIP Overall Satisfaction	0	0						
Other Overall Satisfaction	0	0						
14 day detox follow-up rate	**0**	**0**						
TOTAL MAJOR DATA POINTS (unbolded items)			**11**	**15**	**22**	**13**	**8**	**1**

APPENDIX J

FEASIBILITY OF PRODUCING MEASURES AND INVENTORY OF DATA POINTS

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

FEASIBILITY OF PRODUCING MEASURES AND INVENTORY OF DATA POINTS

Core Performance Measure	Source	Percentage of programs interviewed who can produce measures	Percentage of all participating programs than submitted measures	Comment
Medical loss ratio; Percentage of the plan's premium revenues paid out in claims (per definitions of NAIC)	Casey Benchmarking; DS 2000+; NASMHPD 16 State	< 25%	4 (24%)	States mentioned audits and cost reports as methods for overseeing financial performance. Some states were unsure whether they had this information. If so, it would be reported to their financial management counterparts. Some, who have this information, do not make it public, citing proprietary concerns and lack of comparability due to different definitions of service costs. This measure is not easily available for many programs, either because they are not at risk (though costs of an ASO could be a proxy for the administrative costs) or because they are integrated and premiums cover more than behavioral health.
Service spending per capita; Average cost of total MH and/or SA services per enrollee served	Casey Benchmarking, NASMHPD 16 State	50%- 75%	10 (59%)	Several programs who do not have cost data have subcapitated service providers (like CMHCs) that do not generate claims for services that they provide themselves. It is notable that any program lacks this type of cost data.
MH/SA ambulatory services		50%- 75%	7 (41%)	
MH/SA day/night services		25% - 50%	7 (41%)	
MH/SA inpatient services		50%- 75%	9 (53%)	
Other Encounter Measures				
Percentage of enrollees receiving MH/SA services who are diagnosed with a co-occurring SA/MH disorder	ACMHA	50%- 75%	5 (29%)	Several states were concerned that this would be underreported because of data completeness. Several others did not collect the relevant data. A number of states that could compute this measure do not do so routinely.
Percentage of enrollees with an index detoxification who initiated AOD plan services within 14 days following detoxification	Washington Circle Group	< 25%	0	A few states thought that they could compute this measure, though it was not relevant to more than half of them, since they did not provide SA services.
Percentage of enrollees with a schizophrenia diagnosis who have at least 4 visits in 12 months with a psychiatrist or DO for psychotherapy or medication management; patients 18 and over	HEDIS, ABMHA-PERMS 2.0	50%- 75%	3 (18%)	Few states compute this measure, though several monitor services for people with schizophrenia in other ways. Several identified aspects of their information systems that would make this measure incomplete.

FEASIBILITY OF PRODUCING MEASURES AND INVENTORY OF DATA POINTS

Core Performance Measure	Source	Percentage of programs interviewed who can produce measures	Percentage of all participating programs than submitted measures	Comment
Follow-up service after hospitalization for ages 6 and over:	HEDIS, NASMHPD 16 state; ACMHA; AMBHA-PERMS 2.0; Summit 2001; DS 2000+			
Within 7 days		> 75%	12 (71%)	Some states report 5 days or 14 days, rather than 7
Within 30 days		> 75%	7 (41%)	Fewer states routinely report follow-up after 30 days than report for a shorter period
MH/SA Inpatient readmission rate:	SAMHSA EW System (authorizations); Casey Benchmarking; NASMHPD 16 State; NAPHS; AMBHA-PERMS 2.0			Most states and counties can and do produce one or more of these measures.
Within 30 days		> 75%	10 (59%)	This was the most frequent measurement period. A few also measure at 7 days.
Within 90 days		> 75%	6 (35%)	Several states measure at 90 days
Within 180 days		> 75%	n/a	Several states measure at 180 days.
Within 365 days		> 75%	n/a	Few states routinely calculate for 365 days.
PHARMACEUTICALS				
Cost per enrollee served of psychotropic drugs by type of drug (for enrollees with any diagnosis)	AMBHA-PERMS 2.0	25% - 50%	2 (12%)	Quite a few programs do not cover medications within the benefits they administer, requiring coordination with a pharmaceutical database administered by another agency. Some programs believed that coordination could be done. Others did not consider it possible. One noted that this report would cost real money.
Number of enrollees prescribed atypical antipsychotics per 1000 enrollees	NASMHPD 16 State; APA	50%- 75%	2 (12%)	A number of states that can calculate this measure needed specifications defining the codes for atypical antipsychotics.
Antidepressant Medication Management (NCQA) Age 18 and older:	HEDIS, ABMHA-PERMS 2.0			This is a complicated report, and not all those who can, calculate it. Two states noted that they get incomplete results because they cannot account for people who get antidepressants from their PCPs. They have identified that approximately 70% of Medicaid recipients in their state, who are prescribed antidepressants, get them from their PCPs.
>= 3 follow-ups within 12 weeks after initiation of antidepressant		25% - 50%	1 (6%)	
Taking antidepressant for at least 12 weeks		50%- 75%	1 (6%)	

FEASIBILITY OF PRODUCING MEASURES AND INVENTORY OF DATA POINTS

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

FEASIBILITY OF PRODUCING MEASURES AND INVENTORY OF DATA POINTS

Core Performance Measure	Source	Percentage of programs interviewed who can produce measures	Percentage of all participating programs than submitted measures	Comment
CLIENT OUTCOME MEASURES				
Percentage of patients with improved, maintained and reduced levels of functioning	Outcomes Roundtable; NASMHPD 16 State; NAPHS; IBH; Summit 2001; DS 2000+	25% - 50%	2 (12%)	Two more states are implementing or requiring functional outcomes measurement. Those states that do collect outcomes measurement frequently prioritize higher need subpopulations. Several identified problems with the reliability and completeness of data collected. Some states only have point in time data rather than change over time. Instruments used included GAF, MHSIP, AFARS, CFAR, Alpha, CGAS, CGI, SF-12, and Multnomah. Timing is most commonly at admission, every 6 months, and at discharge.
Change in living situation Compare living situation (domiciled, homeless) at admission to MH/SA treatment and at a standard period post admission	DS 2000+; NASADAD; NASMHPD 16 State	25% - 50%	5 (29%)	As with functioning, these data are sometimes collected for a more vulnerable subset of service users. There are similar problems with data reliability and completeness.
Change in employment status. Compare status at admission to MH/SA treatment and at a standard period post-admission	ACMHA; NASADAD; DS 2000+	25% - 50%	6 (35%)	Similar issues of data quality and completeness as those expressed above. However, one state is sufficiently confident in its data to tie a performance incentive to employment outcomes.
Criminal Justice involvement; Change in the number of arrests in a standard period before admission to a standard period post-admission	ACMHA; Outcomes Roundtable; NASMHPD 16 State	< 25%	1 (6%)	A number of states indicated that they did not have this measure because it needed to come from the Criminal Justice System. One County, however, indicated that it had good data which was matched weekly with County jail records.
CLINICAL PROCESS MEASURES				
Use of seclusion and restraint:	NASMHPD 16 State; ACMHA; NAPHS			These measures are most frequently collected for state hospitals, and sometimes also for psychiatric hospitals. When Medicaid stays are included, they are not always stratified from the total. One state discontinued this measure,
Percent of all patient hours of treatment spent in seclusion or under restraint.		< 25%	0	

FEASIBILITY OF PRODUCING MEASURES AND INVENTORY OF DATA POINTS

Core Performance Measure	Source	Percentage of programs interviewed who can produce measures	Percentage of all participating programs than submitted measures	Comment
Clients with one or more episodes of restraint or seclusion as a percentage of all clients served during the reporting period		< 25%	0	determining that it was not a managed care measure, but a facility measure for which the mental health authority had oversight responsibility.

APPENDIX K

Data Comments

Medicaid Carve-In Programs
MA: Phone answering timeframe is 20 seconds, not 30 seconds
Rhode Island Rite Care: enrollees counted who were enrolled in Medicaid at least one day in period.
DC HSCSN: All figures are for program's full age range, 0 to 22. Day / night includes residential treatment without time limitation plus placement in step-down local group homes. The program thinks that it is likely it has adverse selection for children who need this type of care.
Medicaid-Only Carve-outs
Utah: Age range 0-20 and 21+, Foster care kids enrolled only for inpatient services. Therefore they are not included in outpatient service user and utilization counts. Inpatient episodes are admissions not discharges.
FL Tampa PMHP: The PMHP also provides, to qualifying members as a downward substitution, several additional services not reimburseable by traditional Medicaid programs. These services currently include: crisis stabilization, drop-in / self-help centers, preventive services, residential care for adults, respite care, sheltered and supported employment, supported housing and partial hospitalization.
CO: Denominator for antipsychotics per thousand is total enrollment, not just adults.
Blended Carve-outs
OR: **Day treatment is excluded from day/night services, because it is billed with a 15 minute unit.** Involuntary admissions include those to state psychiatric facility as well as to acute care facilities. It is an estimate combining two separate data systems.
Maryland: Readmission rates reported at an individual consumer level not calculated using actual # of readmissions.
AZ: Adults are from age 18.
Washington State: Service use calculated for Medicaid eligibles for entire reporting year, even for services received when not eligible for Medicaid. Costs are estimated by multiplying average cost per inpatient day and average cost per outpatient unit by units of each.
King County: Inpatient services not included in prepaid health plan payments. Overall penetration is Medicaid only. Other service #s includes non-Medicaid eligibles receiving srvcs. Inpatient data combines voluntary / involuntary admissions unless otherwise specified. Units for day / night and outpt. are 'service hours'. 30 day readmission rate is for voluntary admissions only.
Spokane County: Total enrollees are for children 0-17. Service counts are for children 0-18. Data excludes urgent care program mandated to serve everyone, regardless of financial calls. Involuntary admissions include those to state hospital plus community hospitals. State hospitals otherwise excluded. Follow-up visits after discharge exclude visits to medical physicians, a community medical clinic, or the VA.

APPENDIX L

Covered Services Reported* in Day/Night Measures by Program

Program	IMDs	Residential Treatment Centers	Respite Care	Crisis residence	Emergency Services	Partial Hospitalization	Day treatment	School/ camp programs
CA-LA County							y	
CA-San Diego	y	y		y				
Colorado		y, incl. ATU					y	
D.C. CASSIP		y - including stays beyond 30 days					Children only	Therapeutic Afterschool/ Summer Camps
Florida Tampa Prepaid Mental HP		y			y	y	y	
New Mexico Salud!								
Oregon		Sub-Acute Psychiatric Care; ITS (Intensive Treatment Services);ITS Residential Assessment & Evaluation; Children and Adolescent Treatment Services at the Oregon State Hospital	Y			y		School-Based Integrated Treatment Services
Rhode Island Rite Care								
WA-Spokane						for children	for certain children	
WA-Clark		Y and hospital alternative programs	Crisis respite					

* Please note, some programs provide services included in the categories covered by this chart, but did not report them in the day/night category.

APPENDIX M

Covered Services Reported* in Mental Health Outpatient Measures by Program

Programs	Individual/ family	Group	Medication Mgmt.	Case Mgmt.	Crisis Intervention	Day Treatment	Rehab.	Vocational	Other
CA-San Diego	Office and home based		Y						
Colorado	Y	Y	Y	Y				Y	Respite, psych. Testing.
D.C. CASSIP	Office and home		Y		Emergency rooms				
Florida Tampa Prepaid Mental HP	Y	Y	Y	Y					In-home therapy and Home and Com. Based services
MA HMO	Y	Y	Y						
New Mexico Salud!									
Oregon	Y	Y	Y	Y					
Rhode Island Rite Care									
Utah Prepaid MH Plan	Y, including crisis intervention	Y	Y	Y		Y			Creative interventions including wraparounds, respite,etc.
WA-Spokane	Y	Y	Y	Y				Y	Club House
WA-State	Y	Y	Y	Y	Y				

* Please note, some programs provide services included in the categories covered by this chart, but did not report them in the outpatient category.