XV. Accountability

Availability of Data for Managed Care Decision Making

In both impact analyses, stakeholders in most states reported that inadequate management information systems (MIS) were viewed as a major impediment to building effective and useful accountability systems into managed care. Even where MIS systems were judged to be adequate, a number of problems were identified with respect to obtaining and using data, such as difficulty in obtaining encounter data from MCOs and the lack of human resources to analyze data in a timely manner for use in system monitoring and refinements.

The 2000 and 2003 State Surveys assessed the extent to which adequate data are available to guide decision making regarding behavioral health services in managed care systems. The availability of data for behavioral health-related decision making in managed care has increased from 59% of the systems reporting adequate data in 2000 to 70% in 2003 (**Table 110**). However, in 2003 about one-third of managed care systems (30%) still do not have adequate data to guide decision making. Given the late stage of managed care implementation in almost all states, it is troubling that so many systems reportedly do not have data available for system monitoring and improvement.

Table 110

Availability of Adequate Data to Guide Managed Care Decision Making Regarding Behavioral Health Services in Managed Care Systems

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Adequate data to guide decision making are available	59%	86%	47%	70%	11%
Adequate data to guide decision making are not available	41%	14%	53%	30%	-11%

Respondents specified the reasons for the lack of adequate data to guide decision making in those systems reporting inadequate data (**Table 111**). The most frequent reasons for lack of data availability are lack of encounter data and inadequate management information systems (each reported by 45% of systems with inadequate data), followed closely by lack of staff capacity to analyze data in a timely manner (36% of systems with inadequate data). It is possible that the severe budget cuts faced by many states have resulted in an inability to enhance the MIS infrastructure and capacity of state mental health and Medicaid agencies.

Table 111

Reasons for Lack of Adequate Data in Systems with Inadequate Data

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
Lack of encounter data	50%	0%	63%	45%	-5%
Lack of staff capacity to analyze	36%	67%	25%	36%	0%
Inadequate MIS System	57%	67%	38%	45%	-12%
Not tracking children's behavioral health services	21%	0%	0%	0%	-21%
Other	21%	67%	13%	27%	6%

Types of Performance Information Tracked

The previous state surveys found that the system performance information most likely to be tracked by managed care systems focused on access, service utilization, and cost. These findings were upheld in the 2003 State Survey. As shown on **Table 112**, the three types of performance measures tracked most frequently are:

- Child behavioral health service utilization (measured by 92% of systems)
- Access as gauged by child behavioral health penetration rates (71% of systems)
- Total cost of child behavioral health services (66% of systems)

Table 112

Percent of Managed Care Systems Tracking and Using Various Types of System Performance Information

	2000 Total	2003			Percent of Change 2000–2003	2003 Information is Used for System Planning
		Carve Out	Integrated	Total		
Child behavioral health penetration rates	85%	95%	38%	71%	-14%	26%
Child behavioral health service utilization	100%	100%	81%	92%	-8%	66%
Child behavioral health services utilization by culturally diverse groups	75%	73%	19%	50%	-25%	26%
Behavioral health service utilization by children in child welfare	74%	86%	31%	63%	-11%	42%
Behavioral health service utilization by children in juvenile justice	46%	55%	6%	34%	-12%	21%
Total aggregate cost of child behavioral health services	93%	73%	56%	66%	-27%	42%
Cost per child served with behavioral health services	79%	73%	38%	58%	-21%	34%
Cost shifting among child-serving systems	16%	14%	6%	11%	-5%	8%

Service utilization rates for children's behavioral health are measured by all carve outs (100%) and most integrated systems (81%). For penetration rates and total cost of child behavioral health services, however, the differences between carve outs and integrated systems are more dramatic. Nearly all carve outs (95%), but few integrated systems (38%) track access as measured by child behavioral health penetration rates. Total aggregate cost of child behavioral health services is measured by 73% of carve outs as compared with 56% of integrated systems. Carve outs also are far more likely to track children's behavioral health service utilization by culturally diverse groups, by children in the child welfare system, and by children in the juvenile justice system.

Consistent with the 2000 findings, the two types of performance information least likely to be tracked by managed care systems are service utilization by children in juvenile justice, measured by 34% of the systems, and cost shifting among child-serving systems, tracked by only 11% of the systems. As noted earlier, reports of cost shifting have decreased from two-thirds of the managed care systems in 2000, to half of managed care systems in 2003 (see **Table 55**), although this phenomenon rarely is systematically tracked.

Although managed care systems are tracking some system performance information relative to children's behavioral health, findings indicate that this information is not always actually used for system planning purposes. The type of system information used most frequently by managed care systems is service utilization, reportedly used by two-thirds of the systems (66%), followed by service utilization by children in child welfare and total cost of child behavioral health services (both types of information reportedly used by 42% of the systems). For the other types of performance information, even if it is collected, respondents generally reported that the data are used for system planning in only a third or less of the systems. These findings are consistent with reports from the impact analyses that few data were available for system planning purposes. Stakeholders indicated that data were not in usable form or had not been released, and that little progress had been made in producing data to inform system planning, monitoring, and refinements. The gap between data that are collected and data that are available for decision-making in managed care systems reported in the 2003 State Survey indicates that generating data that are relevant and timely continues to be a problem for managed care systems.

Matrix 5 displays the types of performance information measured by managed care systems by state.

Matrix 5: Types of Performance Information Measured by Managed Care Systems Related to Child and Adolescent Behavioral Health Services by State

States Alpha List		Child Behavioral Health Penetration Rates	Child Behavioral Health Service Utilization	Child Behavioral Health Service Utilization by Culturally Diverse Groups	Child Behavioral Health Service Utilization by Children in Child Welfare System	Behavioral Health Service Utilization by Children in Juvenile Justice System	Total Cost of Child Behavioral Health Services	Cost per Child Served with Behavioral Health Services	Cost Shifting among child-serving systems
Carve Out Design									
Arizona	AZ	●	●	●	●	●	●	●	
California	CA	●	●	●	●			●	
Colorado	CO	●	●	●			●	●	
Delaware	DE	●	●	●	●	●	●	●	●
Florida	FL	●	●		●	●			●
Georgia	GA	●	●	●	●		●	●	●
Hawaii	HI	●	●	●	●	●	●	●	
Indiana	IN	●	●	●	●	●		●	
Iowa	IA	●	●		●		●	●	
Maryland	MD	●	●				●	●	
Massachusetts	MA	●	●		●	●	●	●	
Michigan	MI	●	●	●	●	●	●	●	
Nebraska	NE		●		●				
New Jersey	NJ	●	●	●	●	●	●	●	
Oregon	OR	●	●	●	●	●	●		
Pennsylvania	PA	●	●	●	●	●	●	●	
Tennessee	TN	●	●	●	●		●		
Texas	TX	●	●	●		●	●	●	
Utah	UT	●	●						
Washington	WA	●	●	●	●	●			
West Virginia	WV	●	●		●		●	●	
Wisconsin 2	WI	●	●	●	●	●	●	●	
Integrated Design									
District of Columbia	DC						●		
Illionois	IL		●						
Minnesota	MN	●	●	●			●	●	●
Missouri	MO	●	●		●				
Nevada	NV	●	●	●	●		●	●	
New Mexico	NM	●	●		●				
New York	NY		●						
North Dakota 1	ND		●				●	●	
North Dakota 2	ND		●				●	●	
Oklahoma	OK		●						
Rhode Island	RI	●	●		●		●	●	
South Dakota	SD			●			●		
Vermont	VT	●	●		●	●	●	●	
Virginia	VA		●				●		
Wisconsin 1	WI		●						

Note: Connecticut and Ohio did not provide complete responses.

Quality Measurement

Previous state surveys found that the majority of managed care systems incorporated some child-specific quality measures, with carve outs more likely to do so than systems with integrated designs. Consistent with these findings, most managed care systems (82%) in 2003 include some child-specific indicators in their quality measurement systems (**Table 113**). Carve outs reportedly are more likely to have child-specific measures — 95% as compared with 65% of the integrated systems.

Table 113

Percent of Managed Care Systems Incorporating Quality Measures Specific to Child and Adolescent Behavioral Health Services

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Managed care system incorporates child-specific behavioral health quality measures	88%	71%	95%	65%	82%	-6%	11%
Managed care system does not incorporate child-specific behavioral health quality measures	12%	29%	5%	35%	18%	6%	-11%

The state surveys also have assessed the extent to which and ways in which families are involved in quality measurement activities in managed care systems. In 1997/98, 2000 and 2003, families reportedly were involved in quality measurement in some way in most systems (**Table 114**). As in the past, families are more likely to play a role in quality measurement processes in carve outs in 2003 (91% of systems) than in integrated systems (62% of systems). Overall, about one-fifth (21%) of the managed care systems reported no family involvement in quality measurement in 2003 (mostly integrated systems), representing a slight increase from previous findings.

Table 114

Percent of Managed Care Systems with Family Roles in Quality Measurement Processes

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Not involved	11%	13%	9%	38%	21%	10%	8%
Focus groups	44%	47%	68%	31%	53%	9%	6%
Surveys	77%	78%	82%	63%	74%	-3%	-4%
Design of quality measures and/or process	44%	44%	64%	6%	39%	-5%	-5%
Monitoring of quality measurement process	31%	44%	64%	6%	39%	8%	-5%
Other	11%	9%	32%	0%	18%	7%	9%

The 2003 State Survey investigated how families are involved in quality measurement activities, and found family roles reported in 2003 to be highly consistent with prior survey results. The most frequent way that families are involved in quality measurement is by responding to surveys; this was reported by three-fourths of the systems (74%). The next most frequently reported type of family role in quality measurement is participation in focus groups, indicated by 53% of the systems. Families are involved less frequently in designing quality measures or the measurement process and in monitoring the quality measurement process; 39% of the systems reported family involvement in these roles.

Carve outs are more likely than integrated systems to involve families in all capacities in the quality measurement process. For example, about two-thirds of the carve outs, as compared with only 6% of the integrated systems, reportedly include families in the design of quality measures and in monitoring of the quality measurement process.

Measurement of Clinical and Functional Outcomes

Since 1995 the state surveys have tracked the proportion of managed care systems measuring clinical and functional outcomes for children's behavioral health services. As indicated on **Table 115**, there reportedly has been a steady increase in the measurement of child clinical and functional outcomes, up from 51% in 1995 to 86% of the systems in 2003. In 2003, almost all carve outs (95%) and about three-fourths of the integrated systems (74%) reported that they measure child clinical and functional outcomes.

Table 115

Percent of Managed Care Systems Measuring Clinical and Functional Outcomes for Children's Behavioral Health Services

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Systems measuring clinical and functional outcomes	51%	63%	90%	95%	74%	86%	35%	23%	-4%
Systems not measuring clinical and functional outcomes	49%	37%	10%	5%	26%	14%	-35%	-23%	4%

Interviewees in both impact analyses reported that, even where outcome measurement systems existed, they were in early stages of development. Interestingly, despite the passage of time and the maturation of the managed care systems, the 2003 State Survey shows no change from 2000 in the reported stages of development of outcome measurement systems.

Table 116

Stage of Development of Measurement of Clinical and Functional Outcomes

	2000 Total	2003			Percent of Change 2000–2003
		Carve Out	Integrated	Total	
In early stage of developing measurement system	44%	38%	55%	44%	0%
Developed but not yet implemented measurement system	4%	14%	0%	9%	5%
Implementing measurement system but do not yet have results	26%	19%	36%	25%	-1%
Implementing measurement system and have results	26%	29%	9%	22%	-4%

As shown on **Table 116**, outcome measurement continues to be characterized as being in an early stage of development in 44% of the managed care systems. Also consistent with 2000 findings, one-quarter of the systems reportedly have implemented an outcome measurement system but do not yet have results. Slightly less than one-quarter of the systems (22%) reportedly do have results related to clinical and functional outcomes for children's behavioral health care. Carve outs are more likely than systems with integrated designs (29% versus 9%) to have results from their outcome measurement systems.

Measurement of Satisfaction

Consistent with the findings related to measurement of clinical and functional outcomes, increases were reported in the measurement of parent satisfaction over time. As shown on **Table 117**, 82% of the managed care systems reported measuring parent satisfaction in 2003, up 13% from 1995, although a small decline was reported from 2000 to 2003. Carve outs are more likely (91%) than systems with integrated designs (69%) to measure parent satisfaction with behavioral health services.

Table 117

Percent of Reforms Measuring Parent and Youth Satisfaction with Behavioral Health Services

	1995 Total	1997–98 Total	2000 Total	2003			Percent of Change 1995–2003	Percent of Change 1997/98–2003	Percent of Change 2000–2003
				Carve Out	Integrated	Total			
Managed care systems measure parent satisfaction	69%	80%	91%	91%	69%	82%	13%	2%	-9%
Managed care systems measure youth satisfaction	60%	63%	56%	73%	31%	55%	-5%	-8%	-1%

The measurement of youth satisfaction continues to receive less attention than parent satisfaction; only 55% of the systems reported assessing youth satisfaction in 2003. Little change has been found over time in the measurement of youth satisfaction; overall, there has been a slight decline (5%) since 1995 in the percent of systems that measure youth satisfaction. These findings are consistent with the results of the impact analyses, which suggested considerable attention to the measurement of parent satisfaction but less attention to assessing youth satisfaction with behavioral health services. The 2003 results reflect a dramatic difference between carve outs and integrated systems with respect to measurement of youth satisfaction in that about three-quarters (73%) of the carve outs but only 31% of the integrated systems measure youth satisfaction.

Child and Adolescent Focus in Formal Evaluations

A substantial increase was noted in the proportion of managed care systems reporting that their formal evaluations have a child and adolescent focus, 78% of the systems in 2003 as compared with 55% of the systems in 2000 and 47% in 1997/98 (**Table 118**). Evaluations with a child and adolescent focus are far more likely to occur in carve outs (94%) than in systems with integrated designs (43%).

Table 118

Percent of Managed Care Systems with Evaluations Have a Child and Adolescent Focus

	1997–98 Total	2000 Total	2003			Percent of Change 1997/98–2003	Percent of Change 2000–2003
			Carve Out	Integrated	Total		
Formal evaluation has child and adolescent focus	47%	55%	94%	43%	78%	31%	23%
Formal evaluation does not have child and adolescent focus	53%	45%	6%	57%	22%	-31%	-23%

Impact of Managed Care on System Performance

The 2000 and 2003 State Surveys explored the impact of managed care systems on various indicators:

- Child behavioral health penetration rates
- Overall child behavioral health utilization
- Total cost of child behavioral health services
- Overall clinical and functional outcomes
- Overall family satisfaction with services
- Incorporation of evidence-based practices

As indicated on **Table 119**, the most striking finding for both 2000 and 2003 is that for many systems, the impact of managed care on these indicators is not known. For example, in 2003 the impact of managed care on total cost of child behavioral health services and on overall clinical and functional outcomes remains unknown in 58% of the systems, and the impact on the overall quality of child behavioral health services is unknown to nearly half of the systems (47%). Given managed care's goals of improving quality, containing costs, and improving accountability, the lack of information on system performance in these areas is a concern.

Table 119
Impact of Managed Care Reforms on System Performance — 2000 and 2003

	2000				2003			
	Increased	Decreased	No Effect	Don't Know	Increased	Decreased	No Effect	Don't Know
Child BH penetration rates	41%	8%	10%	41%	42%	5%	13%	39%
Overall child BH service utilization	34%	12%	12%	42%	63%	5%	8%	24%
Total cost of child BH services	24%	19%	16%	41%	24%	5%	13%	58%
Overall quality of child BH services	38%	7%	10%	45%	39%	0%	13%	47%
Overall clinical and functional outcomes	24%	3%	10%	63%	37%	0%	5%	58%
Overall family satisfaction with services	31%	0%	23%	46%	58%	0%	3%	39%
Incorporation of evidence-based practices	NA	NA	NA	NA	51%	0%	5%	43%

Where the impact of managed care was known, however, the results for the following indicators were in a positive direction and reflected improvements over 2000 findings:

- 63% of the systems reported an increase in child behavioral health service utilization, as compared with 34% in 2000
- 58% reported an increase in overall family satisfaction with services, as compared to 31% in 2000
- 37% reported an increase in overall child clinical and functional outcomes, as compared to 24% in 2000
- 51% reported an increase in the use of evidence-based practices (not tracked in the 2000 State Survey)

Child behavioral health penetration rates and the overall quality of child behavioral health services, reportedly have increased about 40% of the managed care systems in both 2000 and 2003.

Although controlling costs is a major goal of managed care, increased total costs were reported by 24% of the systems in both 2000 and 2003, decreased aggregate costs were reported by only 5% of the systems in 2003, and no effect on costs was reported by 13% of the managed care systems. It should be noted that "controlling costs" may refer to both reducing expenditures for behavioral health care or controlling the rate of growth of such expenditures, an area that requires further exploration. Thus, increased costs should not necessarily be interpreted as a negative outcome since the rate of increase may have been slowed in some systems.

For most of the system performance indices, carve outs achieved more positive outcomes than integrated systems, with differences ranging from 7% more carve outs reporting increased child penetration rates to 36% more carve outs reporting increased overall quality of child behavioral health services and increased incorporation of evidence-based practices (**Table 120**).

Table 120
Impact of Managed Care Reforms on System Performance — 2003

	Increased			Decreased			No Effect			Don't Know		
	Carve Out	Integrated	Total	Carve Out	Integrated	Total	Carve Out	Integrated	Total	Carve Out	Integrated	Total
Child BH penetration rates	45%	38%	42%	5%	6%	5%	14%	13%	13%	36%	44%	39%
Overall child BH service utilization	68%	56%	63%	9%	0%	5%	0%	19%	8%	23%	25%	24%
Total cost of child BH services	23%	25%	24%	9%	0%	5%	18%	6%	13%	50%	69%	58%
Overall quality of child BH services	55%	19%	39%	0%	0%	0%	5%	25%	13%	41%	56%	47%
Overall clinical and functional outcomes	41%	31%	37%	0%	0%	0%	5%	6%	5%	55%	63%	58%
Overall family satisfaction with services	64%	50%	58%	0%	0%	0%	0%	6%	3%	36%	44%	39%
Incorporation of evidence-based practices	67%	31%	51%	0%	0%	0%	5%	6%	5%	29%	63%	43%