II. Types of System Performance Information Collected and Tracked

The findings of the *2000 State Survey* are consistent with previous survey findings with regard to the types of performance indicators most likely to be tracked by public managed care systems. These indicators are: (1) service utilization, (2) access (measured by child behavioral health penetration rates), and (3) total cost of child behavioral health services. Carve outs are similar to integrated systems in the rate at which they track service utilization and penetration. However, there is a dramatic difference in the rate at which they track the cost of children's behavioral health services. As shown in **Table 3**, nearly all carve outs (96%), but very few integrated systems (21%), track the total cost of children's behavioral health services. Also, carve outs are more likely to track the service utilization of children involved in the child welfare system.

Table 3

Percent of Reforms Tracking and Using Various Types of System Performance Information

System Information	2000			
	Not Tracked	Carve Out	Integrated	Total
Child behavioral health penetration rates	15%	86%	83%	85%
Child behavioral health service utilization	0%	100%	100%	100%
Child behavioral health service utilization by culturally diverse group	25%	79%	60%	75%
Behavioral health services utilization by children in child welfare	26%	78%	50%	74%
Behavioral health services utilization by children in juvenile justice	54%	45%	50%	46%
Total aggregate cost of children served with behavioral health services	7%	96%	21%	93%
Cost per child served with behavioral health services	21%	87%	50%	79%
Cost shifting among child-serving systems	84%	13%	25%	16%

The two system-level performance indicators least likely to be tracked by managed care systems reportedly are service utilization by children in the juvenile justice system, tracked by fewer than half of the reforms (46%), and cost shifting among child serving systems, tracked by only 16% of the reforms. Despite the low rate of systematic tracking of cost shifting, allegations of cost shifting resulting from managed care reforms have been widespread and were made by stakeholders in both the 1997 and 1999 impact analyses as well as being reported in the *2000 State Survey*.

Although the few systems that reportedly collect information on cost shifting use the information for system planning, data collected for most of the other performance indicators is used for system planning in only about one-third to one-half of the reforms. The *1999 Impact Analysis* also found that few data were available in states in the sample, despite reports that performance information was being collected. Furthermore, the *2000 State Survey* indicates a gap between information that is tracked and information that is used for system planning, and a continuing problem in the capacity of managed care systems to generate data in a format and time period that is helpful for planning and decision-making.

Promising Approaches in Tracking System Performance Information

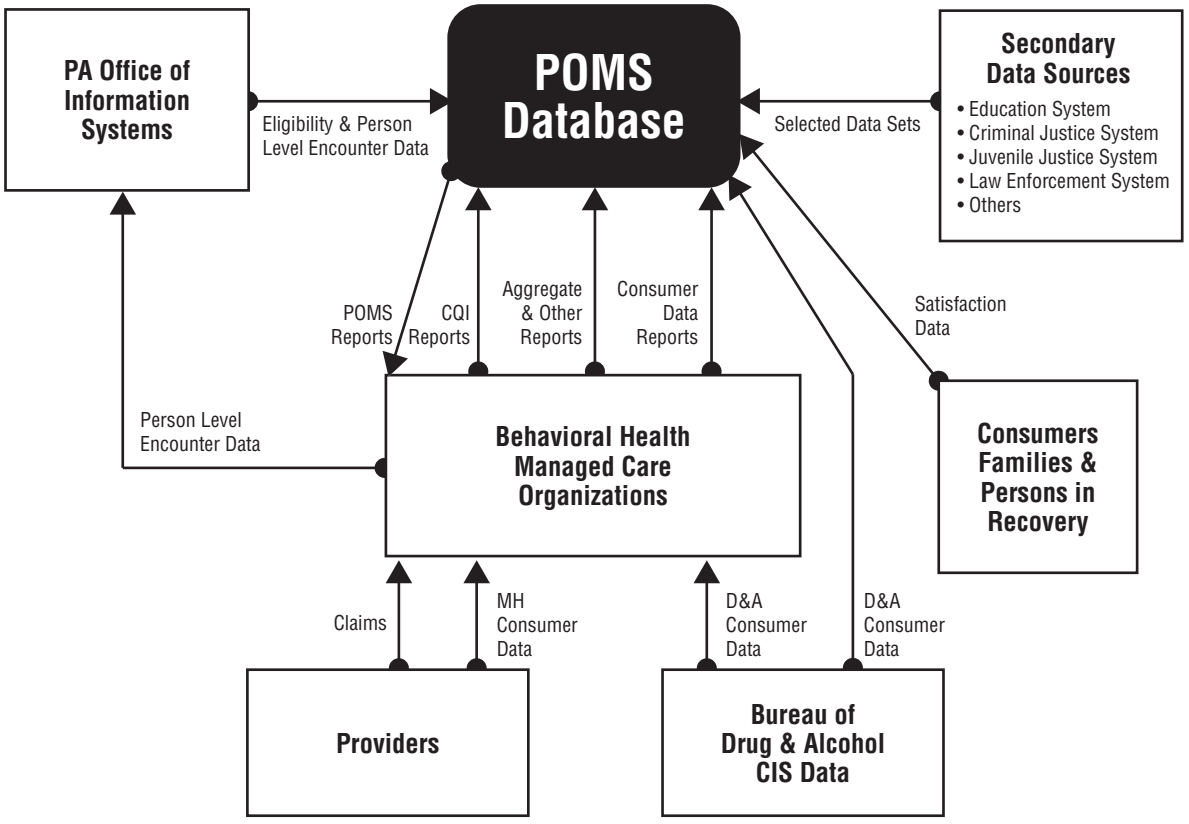
• Pennsylvania's Performance/Outcomes Management System (POMS)

HealthChoices is Pennsylvania's statewide Medicaid managed care program that is being implemented in stages across the state. The goals of HealthChoices are to improve access to care, quality of care, continuity of care, and management of scarce Medicaid resources. Behavioral health services are administered and financed separately from physical health through a behavioral health carve out. Counties have the right of first opportunity to act as their own managed care entity through a contractual arrangement with the state **Office of Mental Health and Substance Abuse Services**. Counties may choose to subcontract managed care functions to nonprofit or commercial organizations.

The state Office of Mental Health and Substance Abuse Services has created a performance monitoring system, tied to a **Continuous Quality Improvement** (**CQI**) process. The **Performance/Outcomes Management System** (**POMS**) consists of a database that is updated on a periodic basis through batch data file extracts that are obtained from a variety of data sources, including encounter data, enrollee eligibility and demographic data, consumer/family satisfaction reports, behavioral health organizations' quarterly status files, and performance indicator reports. Work has begun to obtain secondary data through data exchange agreements with other state agencies, as feasible, such as the education system and the juvenile justice system (see **Figure 1**).

Figure 1

Performance/Outcome Management System (POMS) for Behavioral Health Managed Care Organizations



Commonwealth of Pennsylvania
HealthChoices–Lehigh-Capital BH RFP

The POMS serves three primary functions:

- Provides accountability for public funds expended through the State's capitation payments to the behavioral health organizations (BHOs)
- Provides a fair and objective evaluation of the BHOs that can be used for outcome-oriented incentives and sanctions
- Supports the Department and the BHOs in the implementation of a collaborative continuous quality improvement process

The integrated database provides the basis for producing quantitative performance indicators related to the following system-level outcomes:

- Increase community tenure and less restrictive services
- Increase vocational and educational status
- Reduce criminal/delinquent activity
- Improve health care

- Increase penetration rates
- Increase consumer/family satisfaction
- Implement continuous quality improvement actions
- Increase the range of services and improve utilization patterns

Each outcome is measured by a set of performance indicators. For example, the outcome regarding increasing vocational and educational status is measured by the following indicators: (1) increasing school attendance, (2) increasing school retention, (3) increasing school performance, and (4) improving school behavior.

The POMS is used for a number of purposes, including production of an **Early Warning** monitoring system. The Early Warning system is a quarterly report that compares all HealthChoices counties with one another on a number of quality indicators and reports on quarterly trends on a statewide basis. The indicators include:

- Rates of authorization by service categories
- Percent of members with a service denial
- Grievances
- 30-day inpatient readmissions
- Service authorizations for racial minorities
- Feedback from stakeholders (consumers, family members, providers, organizations)

• HealthChoices in Allegheny County, Pennsylvania

The Department of Human Services in Allegheny County subcontracts with two entities, **Allegheny HealthChoices** and **Community Care Behavioral Health**, for the administration and operation of behavioral health managed care. The County is responsible for governance, financial risk, and administrative oversight of program operations. Community Care provides the managed care functions for the County, with an emphasis on management of high risk and priority populations. Community Care also assumes financial risk on behalf of the County. The role of Allegheny HealthChoices is to monitor the performance and outcomes of the managed care functions performed by Community Care.

Allegheny HealthChoices and Community Care share responsibility for the tracking and monitoring of system performance indicators. Allegheny HealthChoices tracks and analyzes program trends in the areas of: health outcomes; consumer and family satisfaction; quality of service; provider performance; financial management and outcomes; and coordination of care. Data sources include: claims data; complaints and grievances; ombudsman activities; consumer/family satisfaction data; clinical/fiscal chart audits; and focus studies of special topics. Quality measures for children include: access standards (different requirements for various children's services); average length of stay in intensive services; utilization family-based services as an in-plan alternative; and the quality of treatment and discharge planning.

Community Care has developed a **Children's Team**, which oversees the entire spectrum of services for children and adolescents. The team's mission includes communication and collaboration with child serving systems, maintaining children in the least restrictive and least intrusive environment, and securing the safety and needs of all children. Its decision-making process is based upon Pennsylvania's medical necessity

criteria and the application of the system of care principles of child-centered, family-focused, community-based, multi-system, culturally competent, and least-restrictive environment. Managed care strategies used by the Children's Team of Community Care include care management, a physician advisor review process, team approval of new programs and services, the development of performance standards for levels of care, provider meetings and training, utilization management, and quality reviews. For example, the monitoring plan for children's behavioral health rehabilitation services includes the use of outcomes data through the Columbia Impairment Scale, review of monthly reports of service utilization, and quality reviews.

• Iowa's Monitoring Plan for Performance Indicators

In 1999 Iowa's Medicaid agency and the Department of Public Health integrated two separate carve outs for mental health and substance abuse services into one statewide behavioral health care program, the **Iowa Plan for Behavioral Health**. The two state agencies contract with one for-profit managed care organization on a prepaid capitation basis to provide comprehensive mental health and substance abuse services statewide.

The Iowa Plan for Behavioral Health contract for fiscal year 2003 includes a set of performance indicators that are divided into three broad categories: (1) indicators with monitoring only, (2) indicators carrying financial incentives, and (3) indicators with financial penalties. The performance indicators that are "monitored only" (i.e., without fiscal incentives or penalties) fall within the domains of: (1) consumer involvement and quality of life, (2) network management, (3) access and array, (4) quality and appropriateness, (5) integration and interface, (6) quality of care, and (7) administrative accountability. Examples of performance indicators with monitoring only are:

- Consumer satisfaction surveys shall be conducted at least two times per contract period.
- 98% of all enrollees who request any Iowa Plan service will be offered a service.
- The number of Iowa Plan enrollees, reported overall and separately for children and adults, for whom wraparound and rehabilitation and support services were provided during the month.

For each of the nine performance indicators carrying financial incentives, the contract specifies the annual dollar amount the contractor shall be paid if the indicator is attained ($110,000 to $120,000). Examples of performance indicators with financial incentives are:

- The percent of involuntary admissions for mental health treatment to 24 hour inpatient settings shall not exceed 20% of all children admissions and 15% of all adult admissions.
- Based on claims during the contract period, the contractor shall provide services to at least 13.5% of Iowa Plan enrollees.
- At least 4.5% of mental health service expenditures will be used in the provision of integrated services and supports, including natural supports, consumer run programs, and services delivered in the home of the enrollee.

For the 10 performance indicators with financial penalties, the state assesses damages if the contractor fails to comply with the minimum performance expectations for any two quarters in a contract period. The first occurrence of non-compliance for a performance

indicator is assessed a penalty of $5,000, the second occurrence penalty ranges from $10,000 to $25,000, and the penalty for a third occurrence is either $15,000 or $50,000. Performance indicators with financial penalties include:

- The percentage of enrollees under the age of 18 discharged from a mental health inpatient setting to a homeless or emergency shelter shall not exceed 3% of all mental health inpatient discharges of children under the age of 18.
- The contractor shall arrange or participate in at least 20 Joint Treatment Planning conferences per month.
- Medicaid claims shall be paid or denied within the following time periods:
  - 85% within 12 calendar days
  - 90% within 30 calendar days
  - 100% within 90 calendar days

The perception of the Iowa Plan administrators is that the use of financial incentives and penalties tied to performance indicators in the managed care contract has a number of advantages. First, the performance indicators provide an opportunity for the managed care organization to influence provider behaviors. Second, the indicators direct attention of the managed care organization and the provider network to client outcomes. Third, spending levels can be monitored because the percentage of services offered that are authorized is reported on a monthly basis. Finally, the data that are collected regarding the performance indicators are useful in refuting myths about both process and outcomes.

Advice to other states and communities regarding tracking system performance information:

- Know what performance outcomes and indicators you want to collect before the system is implemented.
- Make sure that the performance indicators include what is needed for waivers and other administrative requirements.
- Re-organize at the state level one year before implementation so that the infrastructure (e.g., Management Information System) is in place.
- Engage all stakeholders (advocates, county government, legislators, consumers/families, and providers) early in the development process.
- Recognize that performance outcomes systems can be burdensome and time-intensive for providers.
- Develop a strategy for providing feedback to MCOs, providers, and parents.
- Commitment to quality improvement entails resources for increased personnel and different skill sets.
- Be cautious about making changes post-implementation in system level performance outcomes.
- Define each indicator with the managed care organizations, including data elements (numerator and denominator) and the data source.
- Recognize and address the challenge of balancing quality and cost.