

# V. Requirements for Financial Data

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## Summary

At the top of the public's agenda in mental health are questions about the impact of consumers' financial access to services and payment incentives for health care providers. Moreover, day-to-day management of both the clinical and business aspects of the delivery system requires well-organized financial information. Finally, consumers need access to information on copayments and provider incentives to make informed choices. In this context, the term incentives refers primarily to elements of the provider payment system that explicitly or implicitly reward specific clinical choices or treatment patterns. For example, many reimbursement contracts included a withhold arrangement where a portion of the clinician's fees are set aside and may be used to cover excess (above a target) hospital charges incurred by the clinician's patients.

Looking more closely at the different uses of financial data, it is apparent that a few basic elements recur in most of the specific measures required by various users. Because it is not possible to list or foresee all the possible measures that will be needed by the mental health care system, a more sound strategy is to identify the essential data elements that users need and from which total spending, profit, risk, and financial incentives can be constructed. For example, rather than require organizations to report average spending per episode of treatment, we should gather the elements of total payments<sup>1</sup> for each encounter (clinician payment, pharmacy payment, etc.). Then, total payments per episode could be constructed and analyzed in an infinite number of ways—not only the average payments but also the variance of payments (which measures risk to the paying organization) could be computed with episodes as the level of aggregation. Furthermore, by linking financial data to other data (e.g., encounter and organizational), a wide range of analyses are possible at different levels of aggregation.

The most critical financial data revolve around payment for services and financial incentives for providers and consumers. For these data, the primary unit of observation is the encounter. Payment data for encounters can be bundled into total payments for episodes and case rates. A second type of data records financial transactions and incentives that are not associated with a single encounter, such as capitation payments and performance bonuses. These data could be, and in some cases are, integrated into existing billing systems, with the financial transaction as the unit of analysis.

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<sup>1</sup> Throughout this section we focus on the flow of funds and financial status of organizations. To avoid confusion, we generally refer to payments rather than costs associated with delivering services. In practice, however, providers and organizations account for costs and payments separately. For example, if a provider group receives a case rate payment for one year of outpatient treatment for a consumer, they will want to compare this payment to the cost of services actually provided to the consumer. These costs may include part of the salary of a case manager and fees paid to a therapist. Costs here are the accounting value of inputs required to produce a service. Note that costs are defined in reference to a particular stakeholder. A provider group's costs are also the payments made to individual clinicians. Similarly, the insurers costs are the payments made to providers.

Encounter payment data could also be used to construct capitation rates, by adjusting the denominator (i.e., to total enrolled population) for the analysis. Finally, organizational financial status information is desired by some users. Periodic income statements and balance sheets could be incorporated into the data system with the provider organization or agency as the unit of observation.

There are numerous barriers to collecting these types of data in a consistent way, including:

- a lack of standard definitions for financial incentives and some of the accounting measures;
- the number of managed care organizations that are reluctant to reveal payment and incentive information and may not be obligated to do so; and
- the increasingly hierarchical nature of the health system that makes the problem of tracking payment and incentives especially complex.

A glossary of financial and accounting terms is provided at the end of this section.

## V. Requirements for Financial Data

### What Is the Intended Purpose or Function of the Financial Component?

The purpose of the financial component of the information system is the specification of domains of economic and accounting data that can be used alone or with other components for planning, managing, and evaluating mental health services. The financial component should be constructed to meet the different needs of a wide variety of stakeholders, including consumers; advocates; providers; managed care entities; Federal, state, local and private funding and regulatory entities; and researchers. While stakeholders share some types of financial concerns, each group also has specific information needs of its own.

Researchers and policy analysts use high-level financial data, e.g., data aggregated at a national level, to evaluate state and national mental health funding policies (Frank and McGuire, 1994). In addition, individual-level claims and eligibility data provide the basis for understanding the effects of payment innovations in Medicaid and elsewhere (Lave and Frank, 1990; Ellis and McGuire, 1996). In the private sector, managed care entities devote significant resources to developing financial data management systems, but the proprietary nature of these systems has prevented dissemination of design and content information. Vendors who want to sell their information system products to provider organizations, however, share general, if not specific, descriptions of their systems with the public (National Community Mental Health Council, 1996).

Although consumers and advocates have been involved in developing measures of satisfaction with services, little has been done to determine the kinds of mental health financial data that would be useful to support their decision-making in regard to either health care or advocacy. The questions for consumers and advocates to answer with financial data include:

- How does spending on mental health services compare to spending on general medical services?
- How much did Medicaid spend on mental health last year?
- What is the average total payment for a hospitalization for a person with schizophrenia?
- How much do people enrolled in a particular plan spend in out-of-pocket payments?
- To what extent do coinsurance and deductibles prevent people from accessing necessary services?

Of special interest to providers is the issue of risk sharing. How much risk do providers bear for treatment costs? How much risk is involved in a case-rate contract for a particular population? What is the association between risk sharing and treatment patterns or outcomes? Finally, given concerns about the ability of both public and private providers to manage under a fixed budget, are providers spending too much on administrative overhead? Do providers have sufficient reserves to insulate them against risk? Are providers losing money on a particular contract or type of service?

Managed care organizations and mental health agencies are concerned about the financial stability of the provider organizations they contract with for the care of enrollees. They also need a wide range of

detailed financial data to manage effectively their business and service operations and to make decisions about current and future matters with financial implications.

## **What Information is Required and Produced to Accomplish this Purpose?**

Considerable work has been done in some areas to specify financial data requirements and to provide financial data guidelines for mental health service providers and managed care organizations. For example, the Federal government has published recommendations for data system design that include financial elements to be collected by service providers and oversight agencies (Fishman, 1981; Sorensen et al., 1983; Leginski et al., 1989). Service system researchers and information system specialists have also recommended financial data elements for service provider data systems (Newman and Sorensen, 1985; Smith, 1996; Yennie, 1998).

Because of their many potential uses and the needs of different stakeholders, financial data in the information system must be complex and varied. For managed care entities, the financial data component should include deductibles and co-pays, capitation rates and fee-for-service schedules for various plans, as well as claims payment and related information (Yennie, undated). For mental health administrators, it should permit accounting of assets, liabilities, revenue, and expenses (Smith, 1996) and financial measures built from those data elements that are indicators of the agency's solvency (Leginski et al., 1989). For consumers and advocates, the financial data component must include information on premium and co-pay amounts and be able to generate performance indicators that combine cost data with consumer outcomes (such as cost-effectiveness data) and ratios that show expenditures for a particular program as a percentage of the total budget at various provider agencies (MHSIP, 1996).

In addition, the information system must allow financial data to be used at both the person-level and the organization-level. The same data item entered into the financial component—for example, an amount of money— will be used differently by different users: for the consumer's purposes it will be recorded and analyzed as a payment, whereas for the MCO's purposes, it will be recorded and analyzed as a revenue. Similarly, from the consumer's perspective, the financial data would be analyzed to show the sum of payments an average consumer might make in a year, whereas the MCO would want to analyze the data to show its total revenues from all consumers of a certain type.

Working backward from the uses for financial data, we can identify the unique common elements needed to construct the information sought by different users. Three types of “fundamental” data can be aggregated and combined in different ways to serve all the purposes described above: (1) transaction data (2) financial incentive data, and (3) general accounting data.

### **Transaction Data**

The most important transaction data are the financial information that accompany each patient encounter or discharge from an institution and include items such as the amount (if any) a provider received for delivering a service and the amount of the consumer's co-payment (including spending towards a deductible). These data could be aggregated in an infinite number of ways. For example they could be aggregated into regional or national mental health spending, used to compute the cost per episode of treatment for a particular disorder, or used to estimate the amount of financial risk a

capitated provider faces. Transaction data could also track the amount and timing of financial transactions that occur outside of an encounter, such as the payment of a capitation check or a lump-sum subsidy to a community mental health program. If these transactions were recorded, then funds could be followed from insurer or agency down through provider organizations to the treating clinician. From these data, system wide expense ratios could be computed that would allow us to evaluate the efficiency of different types of systems.

### **Financial Incentive Data**

The second critical domain of information relates to consumer and provider incentives to access and provide care. Financial incentive information should describe the coinsurance rate, deductible, and coverage limits that an individual consumer faces. These could be linked to an individual enrollee or contained in a “product” file that could be linked to all enrollees who are covered by this product (e.g., a particular HMO’s standard benefit with \$10 visit co-payment and \$5 drug co-payment). On the provider side, there should be information attached to each encounter to describe the method of compensation of the clinician providing the service. Because clinicians may be compensated differently for different consumers (and because a single payer may compensate providers in multiple ways) this information should be recorded as a property of an encounter, rather than as a property of a clinician or insurance product. Ideally we would also obtain the method of compensation of provider organizations or hospitals and clinics as part of the flow-of-funds type transactions mentioned above (e.g., the payment of a capitation from an HMO to a provider-sponsored network.).

### **General Accounting Data**

General accounting data are the types of income statement and balance sheet information that document the financial flows and stocks of business entities. The unit of analysis for general accounting data is the organization, rather than an encounter or other transaction. These data are commonly reported on a quarterly basis by publicly-traded companies, but in practice could be semiannual or annual. One problem with these data is that accounting standards differ across different segments of the industry (e.g., by tax status, for-profit vs. not-for-profit). In addition, comparisons of accounting data across systems with different ownership structures and levels of vertical and horizontal integration may be misleading (Robinson, 1997.) Because these standardization issues are well beyond the scope of this effort to resolve, the limitations of this component of the information system should simply be recognized. In principle, however, there are numerous valid uses for accounting data such as oversight activity by a hospital regulator.

## **How are the Financial Data Linked to Other Data?**

Financial data would be organized primarily around encounters. The elements that would be measured at the encounter level include both payments and financial incentives. More aggregate transactions (such as lump-sum transfers or capitation payments) would enter the information system as records within a billing/general ledger system. In other words: (1) every patient encounter with the mental health system (including ancillary, pharmacy, and hospital use), will be accompanied by information on the flow of dollars associated with the encounter as well as the method of payment (which conveys financial incentives) and (2) each purely financial transaction within the mental health system will generate a record. Finally, the periodic income statement and balance sheet components of the data could be stand-alone or attached to individual records for health care organizations and agencies.

## What Future Efforts Are Required for Inclusion in an Integrated Information System?

For the purposes of an integrated mental health information system, answers are needed to the following specific questions:

- What existing financial data systems or designs in the public or private sectors meet the needs of a wide range of identified users? And how can these best be shared and implemented broadly?
- How can issues of disclosure of financial data be addressed to meet the concerns of providers and payers while fulfilling the needs of consumers and policy makers to understand incentives and financial performance?
- Are there data elements not being collected (broadly, routinely, consistently) that need to be collected to answer important questions?
- What guidelines exist for presenting financial data in an understandable way to users with varying decision support needs and varied levels of technical ability?
- How will the Federal Health Insurance Portability and Accountability Act (HIPAA) affect financial data reporting requirements, availability, accuracy, and accessibility for behavioral health services?

Although most types of data described in the previous section are collected in some way by most MCOs, they may not all be electronically stored and are unlikely to be linked in the ways that would be most useful. This is especially true of financial incentive information, which is not uniformly attached to encounter data. Agencies and other public payers are likely to have much less of the data needed for this component. Medicaid, for example, does not uniformly have good encounter data for its fee-for-service delivery systems, let alone for managed care.

The example of Medicaid managed care raises another difficulty. When a payer (or MCO) delegates risk and clinical management to an MCO or provider-sponsored organization, there is no presumption that it will monitor the method and flow of payments between this “vendor” and the individual clinicians who actually treat consumers. Thus, encounter-based financial data must find their way up from the point of service through the vendor and back to the payer. Moreover, if the financial flow information associated with an encounter are to be complete, each level will need to contribute to the record.

A third potential problem is that disclosure of financial information and financial incentives is not to be taken for granted. Publicly-traded and government entities are required to disclose basic financial statements, but private entities including medical groups and independent practice associations are not. Mandatory disclosure of financial incentives is also uneven. Organizations that serve the Medicaid and Medicare populations are required to reveal financial incentives (with some loopholes), but for the privately-insured population access to this information is only guaranteed by a few states.

Finally, the problem of tracking financial flows raises a more general question about conceiving of a *mental health* information system. Will mental health services that are integrated into a global capitation be accounted for and how? How will pharmacy and other carve-outs be handled when they overlap with mental health services?

In spite of these difficulties, progress can be made towards unifying the financial data that are collected and made available by health care payers and their intermediaries. The first steps include identification of a minimum set of financial measures to be included with each encounter record. Some of these have already been discussed in the encounter data section, but will be repeated here for completeness. Table 1 summarizes the data elements for the financial data set.

We propose the following such elements:

- copayment
- consumer payment towards deductible
- third party payment
- method of third party payment (if any)
- compensation method (this is different from above if the clinician does not contract directly with the third party – e.g., is in a group practice)

Because capitation, case rates and global budgets are not based directly on encounters these financial transactions will have to be accounted for separately. However, it should be possible to link capitation or case-rate payments to a particular consumer at a point in time (specifically, the time at which the amount is paid on his/her behalf). The data elements for these more aggregated financial transactions would include:

- payer identifier
- payee identifier
- amount of payment
- method of payment (capitation, case rate, global budget, administrative fee, flat subsidy)
- individual or population covered by payment
- date of payment
- time period covered by payment (e.g., capitation payments often cover one month)

Finally, we adopt the following items from Leginski, et al. (1989) as a preliminary list of financial status elements to be collected for provider and managed care organizations on an annual basis. Precise definitions of these variables are available in the source document (Leginski, et al., 1989).

- organization identifier
- current assets
- non-current assets
- total assets
- current liabilities
- non-current liabilities
- total liabilities
- operating revenue and support: first and third-party revenue by program element

- operating revenue and support: all other sources
- non-operating revenue
- total revenue and support
- in-kind contributions and volunteers
- operating expenses by program element
- non-operating expenses
- total expenses

**Table 1****Data Elements for the Financial Data Set**

<b>Domain</b>	<b>Data Elements</b>	<b>Definition</b>	<b>Ready for Prototype</b>
Unique Identifiers	Payer or sponsor identifier	Unique identification number for the entity who is funding (providing payment for) the coverage. This could include a private employer, government (Medicare, Medicaid), self-pay, union, etc.	No
	Payee identifier	Unique identification number for the entity who receives payment for the service delivered.	No
	Organization identifier(s)	Unique identification numbers for all entities involved in the financial transactions	No
	Individual covered by payment identifier	Unique identification number for the consumer.	Yes
Person-level data elements	Consumer copayment	An out-of-pocket payment made by or charged to the consumer at the time of visit or discharge.	Yes*
	Consumer payment towards deductible	Total copayments made that are counted toward a deductible. Once a deductible amount is met, copayments generally decline or are zero.	Yes*
	Third party payment	Payment made by an insurer or other payer (e.g., Medicaid).	Yes*
	Method of third party payment (if any)	Describes the financial incentives: fee-for-service, salary, capitation, case rate, DRG, per diem are the principal examples.	No
	Compensation method	This is different from method of third party payment if the clinician does not contract directly with the third party – e.g., is in a group practice.	Yes
	Date of payment	Date on which claim or prospective payment is made.	Yes

\*dollar amount

**Table 1****Data Elements for the Financial Data Set**

<b>Domain</b>	<b>Data Elements</b>	<b>Definition</b>	<b>Ready for Prototype</b>
Person-level data elements, continued	Time period covered by payment (e.g., capitation payments often cover one month)	Dates over which payment is intended to cover average costs (if fee-for-service, then point in time).	Yes
Organization-level Data Elements	Current assets	<ul style="list-style-type: none"> <li>• Cash—funds on hand and in the organization’s bank account</li> <li>• Marketable securities—holdings of short-term notes, stocks, and bonds held for their return and which can be readily sold</li> <li>• Accounts receivable—amounts owed to the organization</li> <li>• Allowance for doubtful accounts (bad debts—an estimate of the amount of accounts receivables that will not be collected)</li> <li>• Other current assets—current assets other than cash and accounts receivable that are to be converted into cash within a year, e.g., inventories and prepaid items such as rent and insurance</li> </ul>	No
	Non-current assets	<p>Unlike current assets, non-current assets are not expected to be converted into cash within a year.</p> <ul style="list-style-type: none"> <li>• Furniture and equipment—tangible assets other than buildings and land owned by the organization and used in the course of business, depreciated over time</li> <li>• Buildings—those being purchased or already owned by the organization and used in the course of business, depreciated over time</li> <li>• Land—land such as building sites, used in the course of business and which is being purchased or owned by the organization, not depreciated</li> <li>• Other non-current assets—all non-current assets other than land, buildings, furniture, and equipment used in the course of business, such as long-term investments, franchises, and other intangible assets</li> </ul>	No
	Total assets	The total of all current and non-current assets as a dollar value.	No

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**Table 1****Data Elements for the Financial Data Set**

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<b>Domain</b>	<b>Data Elements</b>	<b>Definition</b>	<b>Ready for Prototype</b>
Organization -level Data Elements, Continued	Current liabilities	A dollar value for the debts that require payment within a year (wages payable, accounts payable, interest payable, etc.)	No
	Non-current liabilities	A dollar value for the long-term obligations to be paid beyond a year (mortgages, bonds payable, notes payable, etc.)	No
	Total liabilities	The total of current and non-current liabilities as a dollar value.	No
	Operating revenue and support: first and third-party revenue by program element	A dollar figure for each category should be provided for each program element operated by the organization. <ul style="list-style-type: none"><li>• Consumer revenue (revenue earned from the delivery of services paid by the consumer or a responsible party other than third party payers)</li><li>• Insurance revenue, including CHAMPUS (revenue paid by an insurance carrier for services delivered)</li><li>• Medicare revenue</li><li>• Medicaid revenue (Federal and State)</li><li>• Total first- and third-party revenue by program element</li></ul>	No
	Operating revenue and support: all other sources	A dollar figure for all categories should be provided for each program element operated by the organization. <ul style="list-style-type: none"><li>• State mental health agency support</li><li>• Other State agency support</li><li>• Federal Block Grant support</li><li>• Other Federal support</li><li>• Municipality, county, and other local support</li><li>• Other operating revenue and support</li></ul>	No
	Non-operating revenue	A dollar amount for the income the organization receives that is not related to the delivery of mental health services (investments such as interest, business income, capital gains, gifts and contributions of cash or liquid assets, bequests and charitable contributions, and research support).	No

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**Table 1****Data Elements for the Financial Data Set**

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<b>Domain</b>	<b>Data Elements</b>	<b>Definition</b>	<b>Ready for Prototype</b>
Organization -level Data Elements Continued	Total revenue and support	The sum of operating and non-operating revenue and support as a dollar value.	No
	In-kind contributions and volunteers	The estimated dollar value of benefits received by an organization where no funds are exchanged (examples include the fair market value minus actual rent for a building or value of staff assigned to the organization by other entities who are on the payroll of those entities).	No
	Operating expenses by program element	Expenses related to the delivery of mental health services broken out by program element. Operating expenses include rent, salaries, supplies, insurance, and utilities.	No
	Non-operating expenses	A dollar amount for the expenses of the organization that is not related to the delivery of mental health services (e.g. interest on loans).	No
	Total expenses	The sum of operating and non-operating expenses as a dollar value.	No

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## Glossary

*Administrative fee:* An administrative fee is a sum of money paid to an organization for administrative services, such as claims processing or network management. The fee may be fixed or based on the number of enrollees but is not related to use of services or payments for services.

*Balance sheet:* Balance sheet is an accounting term for a record of assets and liabilities of an organization at a point in time. A balance sheet records financial stocks (balances). For example, a principal balance of a mortgage at a given date is a liability to be noted on a balance sheet.

*Capitation rate/capitation payment:* A *capitation rate* is an amount of money allocated or computed per person for a set period of time (e.g., month, year) for a defined scope of services. A capitation rate can be computed under any reimbursement system by dividing total payments by the number of enrollees. A *capitation payment* is an amount that is paid in advance to a managed care organization or provider to cover some or all services required by an enrollee for a period of time.

*Case rate/case rate payment:* A case rate is an amount of money allocated or computed for an episode of treatment. In comparison to a capitation rate, the denominator for a case rate is the total number of cases or episodes of treatment. As with a capitation rate, we may compute case rates as the total payments made over a period of time divided by the number of cases. A *case rate payment* is an amount that is paid in advance to a managed care organization or provider to cover some (e.g., outpatient visits only) or all services required by a consumer who has begun an episode of treatment until the episode concludes or a predetermined amount of time has passed (e.g., a year.)

*Charges/incurred charges:* charges are the reported value of services rendered by any part of the delivery system. We contrast charges with payments, which are actual financial flows and may be more or less than incurred charges.

*Encounter/claims data:* Encounter and claims data both provide a record of utilization of services. Under a fee-for-service reimbursement system, claims are filed by providers with the insurer to request payment for services rendered. Under prospective reimbursement (e.g., case rate or capitation payment), provider payments are independent of the level of utilization, so that claims are no longer filed. Most insurers, however, recognize the need to track utilization for quality management and other purposes. Thus, they require that providers file encounter records (also called "shadow claims") that are analogous to claims except that they are not associated with payment.

*Episode:* An episode is a defined series of treatments that are bundled according to some clinical or temporal criterion. For example, an episode of outpatient mental health treatment is often defined as a series of visits in which no sequential visits are separated by more than 8 weeks. An episode of inpatient care may be defined as all treatment that occurred between admission and discharge from an inpatient facility.

*Global budget:* A fixed sum of money intended to cover all expenses for a program for a given period of time. In contrast to capitation payments, global budgets do not increase with enrollment. For example, community mental health centers may be given a global budget to accomplish their mission that is independent of their changing needs.

*Income statement:* Income statement is an accounting term for a record of the revenues and expenses of an organization over a period of time. An income statement records financial flows. For example, monthly mortgage or rental payments are financial flows that are accumulated on an income statement.

*Subsidy/flat subsidy:* A subsidy is a financial transfer intended to offset a share of the expenses of operating a program. A *flat* subsidy is one that is not a function of the number of people enrolled in a program (a per capita subsidy) or the quantity of services provided (a per unit subsidy).

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