CHANGES IN DATA NEEDS AND REQUIREMENTS FOR COST-EFFECTIVE MENTAL HEALTH SERVICES IN A MANAGED CARE ENVIRONMENT

Prepared for

Marilyn Henderson
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, Maryland

Prepared by

Cecil R. Wurster
Consultant
NASMHPD Research Institute, Inc.
Alexandria, Virginia

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Managed Care -- a system of financing and organizing health care delivery that influences utilization and cost of services and measures provider performance. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

Managed Health Care Plan -- one or more products which integrate financing and management with the delivery of health care services to an enrolled population; employ or contract with an organized provider network which delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and use an information system capable of monitoring and evaluating patterns of covered persons' use of medical services and the cost of those services.

(Definitions adapted from "The Managed Care Resource: A Language of Managed Health Care and Organized Health Care Systems"(1).)

Never in the history of behavioral health services, or health services in general, has there been greater and more rapid change than in recent years with the implementation of managed care and the emergence of managed care organizations (MCOs) which are contracted to carry out managed care plans. With this change has come a growing and essential need for more statistical data to provide information on which to make informed decisions about the persons in need of behavioral health services, the types and amounts of services they need and receive, the costs of these services, and the quality of the care provided. Each of the stakeholder groups, in this new behavioral health managed care environment, brings its own unique perspective to decision making and its own requirements for data and information. Consumers need report card information and outcome data to choose among behavior health care plans and service providers; providers need measures of clinical outcomes achieved, volumes of clinical encounters, and information on financial claims; payers require information on costs, quality of care, and efficiency of services; and management services entities, such as managed care organizations, need to understand how well capitation systems are working, through "shadow" encounter and cost information.

Underlying all of these data and information requirements is the need to develop and implement statistical data systems which provide quality and timely data that meet a minimum degree of uniformity and comparability, based on data standards, to facilitate statistical aggregation and analysis across systems of services and service providers.

Recognizing the changing needs for statistical data and information in the growing managed behavioral health care environment, the Center for Mental Health Services convened a technical

and policy expert panel, representative of the wide range of stakeholders, to address statistical data needs and the degree to which current mental health data standards are adequate to meet data needs and information requirements. This report provides a summary of the nature of the panel's discussions and the issues and recommendations resulting from their two-day meeting.

Background

The mental health field has a long history of developing and advocating for data standards, starting with the 1880 census of population and continuing, almost uninterrupted, with the Mental Health Statistics Improvement Program (MHSIP) under the leadership of the Federal Government (currently the Center for Mental Health Services (CMHS)) and the State Governments. (For a complete discussion of the early history of mental health data standards, see "Speaking with a Common Language: the Past, Present and Future of Data Standards for Managed Behavioral Healthcare", by Ronald W. Manderscheid, Ph.D. and Marilyn J. Henderson of the Center for Mental Health Services.) Currently, the MHSIP is the only recognized national resource for developing and recommending data standards for the mental health field. In its early beginnings in 1976, the MHSIP focused on data standards for mental health service organizations to facilitate the collection of data from provider organizations to meet data needs of the Federal and State governments. These standards heavily influenced the Center for Mental Health Services' (formerly the National Institute of Mental Health) Inventory of Mental Health Organizations (IMHO) and its National Reporting Program (NRP). By the mid-1980's, it became apparent that these early data standards were not sufficient to meet the needs of the mental health field; a new and vastly expanded recommended data set and data standards was developed and adopted by the MHSIP, the Center for Mental Health Services, and, ultimately, all State mental health agencies. The current MHSIP data standards were published in 1989 (2) and accompanied a major CMHS program of grants to states to enhance their statistical systems and implement the MHSIP data standards where appropriate. All of these efforts to produce and implement mental health data standards were undertaken on a voluntary and collaborative basis--a key element in the successful history of the MHSIP.

Now, eight years later, major changes in the mental health service system through the implementation of managed care approaches have generated an urgent need to review statistical data needs and assess the gaps in the national mental health data standards that are central to the MHSIP. In the new managed care environment, consumers of services, families of persons with mental illness, public and private service providers, service payers, and management service entities (Managed Care Organizations) are all vitally concerned with and affected by the appropriateness, coverage, and quality of the data standards that are employed in management information systems and statistical data systems. Recognizing the need for revised data standards for the behavioral health care industry and the urgency of addressing these needs, the Center for Mental Health Services contracted for selecting and convening an Expert Panel to consider data needs and data gaps in the MHSIP recommended data standards as a first step in the development of revised (or new) data standards for the behavioral health field in a managed care environment. The contract was awarded to Abt Associates, Inc. of Cambridge, Massachusetts which in turn subcontracted with the National Association for State Mental Health Program Directors (NASMHPD) Research Institute, Inc. for recommending Technical/Policy Expert Panel members, convening and facilitating a meeting of the Panel, and reporting on Panel

discussions and outcomes. This activity was part of a larger CMHS contract to Abt Associates which included a number of focus group meetings that addressed mental health concerns under managed care and the preparation of several policy papers for informing the behavioral health field regarding managed care policy issues.

Expert Panel and Meeting

The Technical/Policy Expert Panel met August 15 and 16, 1996, in Bethesda, Maryland. Expert Panel membership was recommended by the NASMHPD Research Institute, Inc., Abt Associates, and CMHS staff, and the final selection of Panel members was the responsibility of the CMHS. The purpose of the meeting was to assess the changing needs for mental health data as managed care is being implemented in the financing of mental health care and to determine the gaps in the data standards developed through the Mental Health Statistics Improvement Program. The emergence of managed care in the provision of services for persons with mental illness has placed new and expanded demands for data and information to support decision making by consumers, clinicians, funders, and managers of mental health services. Since the national data standards developed by MHSIP (2) pre-date managed care, the standards are not totally responsive to some of these new data needs; therefore, it is critical that consideration be given to identifying and filling gaps in data content and definitions to bring data standards into the era of managed care. The Technical/Policy Expert Panel meeting was seen as the beginning of a process to revise national data standards for mental health data and information systems.

The Technical/Policy Expert Panel members were selected to represent a wide range of perspectives and stakeholder groups. The 17 member Panel included: Marshall Beckman, Ulster County Mental Health Department, New York; Vijay Ganju, Ph.D., Texas Department of Mental Health and Mental Retardation; Ronald E. L. Gibson, Pennsylvania Department of Mental Health; John Hornik, Ph.D., New York Department of Mental Health; J. Rock Johnson, Esq., Lincoln, Nebraska; Caroline Kaufmann, Ph.D., Duquesne University, Pittsburgh; Karla Kornmeyer, M.D., Human Affairs International, Salt Lake City, Utah; Teresa Kramer, Ph.D., University Psychiatric Services, Cincinnati, Ohio; Candice Nardini, Iowa Division of Medical Services; Scott Philpo, AdvoCare of Tennessee; Dorothy Webman, Ph.D., Webman Associates, Cambridge, Massachusetts; Marilyn Henderson, CMHS; Ronald Manderschied, Ph.D., CMHS; Olinda Gonzales, Ph.D., CMHS; Ted Lutterman, NASMHPD Research Institute, Inc.; and Cecil R. Wurster, NASMHPD Research Institute, Inc. A list of Panel members and their addresses is attached (Attachment A).

The Panel meeting agenda (Attachment B) was structured to provide participants an opportunity to (1) discuss their data needs and their perceived gaps in MHSIP data standards and definitions; (2) to review of current efforts to establish data standards, including the work of the National Committee on Quality Assurance (NCQA), the Department of Health and Human Services (DHSS) National Committee on Vital and Health Statistics, Work Group for the Computerization of Behavioral Health and Human Services Records, and MHSIP; (3) consider the role of MHSIP regarding data standards; (4) review existing MHSIP standards; and (5) recommend next steps for enhancing MHSIP data standards or other approaches to meeting needs for mental health data standards. The meeting discussions were facilitated by Dr. Noel A. Mazade of the NASMHPD Research Institute, Inc.

Nature of the Discussions

As might be expected with the wide range of perspectives represented by the Panel members, the discussions were broad-based and went beyond the intended purpose of the meeting and the focus of the agenda. Early in the discussions, it became quite clear that data needs, and gaps in data standards, must be reviewed and understood in relation to a host of policy, organizational, and economic concerns. More importantly, all of these concerns and data needs must be considered in relation to a shared value regarding the experiences and needs of mental health consumers, their perceptions of the mental health service system in the past and in the present, and their concerns and fears about the rapidly changing mental health services system in a managed care environment.

Data needs and related issues and concerns that emerged during the Panel discussions can be organized into two major themes: (1) Managing Managed Care and Outcomes; and (2) Standardization and Best Practice. To a degree, this organization of the discussion into two themes is arbitrary since, necessarily, many issues relate to and fit into both themes. Prime among these is the importance and value of consumer involvement in every aspect of behavioral health care, especially in relation to policy making, planning, implementing, and managing managed care. The experience and expertise of consumers of behavioral health services is unique and vital to the development and delivery of health care in the new managed care environment; and consumer involvement and leadership was put forth in the Panel discussions as the underpinning of effective, responsive behavioral health care systems. It was further suggested that consumer leadership be incorporated by reference into all Panel recommendations.

The Managing Managed Care and Outcomes theme includes (1) the process of contracting with managed care entities to ensure that the behavioral health care needs of a population are met, (2) information systems which provide the data needed to assess the operation and impact of managed care, and (3) measures of client and systems outcomes to judge the success of managed care in meeting stated goals and objectives. Standardization and Best Practice includes (1) data standards to provide comparable data among the various provider organizations, across systems of care, and over time to document and study changes in client care and service delivery, (2) data on the managed care industry and the managed care organizations that comprise the industry to understand changes in the industry over time, its impact on behavioral health care services, and best practice, and (3) data that reflect the extent to which services are integrated across systems of health care and other human services supports for persons with mental illness. The relevance of each of these issues in relation to data needs and data gaps is discussed below.

A host of recommendations for meeting data needs was suggested by the Panel members; however, because of the limited time available in the two-day meeting, no attempt was made to reach consensus on the issues or the recommendations. The recommendations have been reported separately in this report, since many of the recommendations could be associated with more than one issue.

Issues and Concerns

Managing Managed Care and Outcomes

Contracting with Managed Care Entities The process of contracting for managed care services is one of the most critical aspects of ensuring that the behavioral health care needs of a population are met and services are maintained in a cost-effective manner resulting in high quality care where and when it is needed. It is important that the views of all stakeholders---consumers, payers, providers, and managed care entities---be considered in the development of managed care policies, plans, and contracts. The contracting process provides many opportunities to use data for developing the managed care plan. In addition, it is important that the contracting process include language about data requirements to ensure that all levels of data needs are met and that data are made available and accessible through the managed care entities.

Information Systems Information systems provide the major mechanism and resource for managing managed care. These systems must include, and make available, data that support decision making at all levels, including the consumers' selection among behavioral health care plans and providers; payers' assessments of costs, quality of care provided, and efficiency of services; providers' assessment of clinical outcomes achieved, volumes of clinical encounters, and information on financial claims; and managed care entities understanding of how well the capitation systems are working. Considerable costs are associated with the development, implementation, and operation of effective and efficient information systems; however, cost-savings can be achieved through the use of shared technologies and standardized content and reporting procedures which minimize the reporting burden on providers involved with multiple managed care entities.

Outcome Measurement Managing the financing of behavioral health care is the driving force behind the implementation of managed care. With the rapidly rising costs of health care over recent years, payers for health care are increasingly looking for mechanisms to reduce cost and at the same time maintain quality care as defined by consumers, clinicians, and managers. The Federal Medicaid program has led the way in this effort by providing States the option, through voluntary waivers, of implementing of managed care. The key element in monitoring the success of the managed care movement is the development and implementation of outcome measures, including clinical outcomes, consumer satisfaction, cost containment, and impact on systems of care.

Standardization and Best Practice

Data Standards New issues and data needs have accompanied the growth of managed care in the behavioral health care area. As a result, the existing data standards, developed and implemented prior to managed care, are not adequate to provide the wider range of information required for decision making by consumers, payers, providers, and managed care entities. This concern is specifically true of the current MHSIP-recommended data standards. Data content areas, where new or enhanced data standards are needed, include: outcome measures; enrollment and encounter data; report card data; data on consumer concerns; and data on the managed care industry.

Managed Care Industry Systematically compiled data about managed care organizations are

not currently available. To fully understand the role of the managed care industry in the changes that are occurring in the behavioral health care system, bench marking data are needed on average length of stay of persons treated, pre-hospitalization care, shifts in care, availability of a continuum of care, and emergency contacts. In addition, information is needed on hiring and staffing practices for individuals who make decisions about consumer's access to care and the services they receive.

Integration of Services Across Systems   Managed behavioral health care puts at risk the integration of the many support services needed by consumers of behavioral health services and most often made available through psychosocial programs. Among these other health and psychosocial services are general medical care, welfare, housing, rehabilitation, employment, etc. Data are needed across systems to monitor the impact of managed care on the comprehensive support services (wrap around services) that consumers need but that fall outside the scope of managed behavioral health care.

Recommendations

Data Needs and Data Gaps

The following Panel recommendations relate specifically to the purpose of the meeting of the Technical/Policy Expert Panel which was to identify statistical data needs and the degree to which the current data standards recommended by the MHSIP are adequate to meet these needs.

1. There is a continuing need for standardization of data content and definitions in the behavioral health field to ensure uniformity in data acquisition and comparability of data across the field to support decision making at all levels, including consumers, payers, providers, and managed care entities.

2. Because of the rapid changes that are occurring in behavioral health care, existing data standards recommended by the Mental Health Statistics Improvement Program (MHSIP) are necessary, but not sufficient, to meet the new and emerging needs for data and information.

3. The MHSIP has functioned effectively in setting data content and data standards and should be continued as the venue through which new or revised data content and data standards are developed and promulgated for the behavioral health care field, including the managed behavioral health care industry and its role in the delivery of services to persons with mental illness.

4. The MHSIP Consumer-Oriented Report Card (3), the MHSIP data standards in FN-10 (2), the recommended children data standard (4) developed by MHSIP and two papers addressing the importance of person-centered decision support systems (5) (6) should provide the foundation for developing new or revised data content and data standards to meet current and future data needs.

5. The primary areas of data needs and data standards that are not fully met by the existing MHSIP standards include: (1) enrollment and encounter data; (2) outcome measures; (3)

fully developed and tested indicators and measures for the Consumer-Oriented Report Card; (4) data that reflect concerns that are important to consumers; and (5) data on the managed care industry and managed care organizations.

6. The development of data content and data standards should involve all stakeholder groups within the behavioral health field and should be coordinated across other systems of services effecting the lives of persons receiving behavioral health care services, such as welfare, housing, rehabilitation, and justice and should address the information requirements of special population groups, including elderly, children, incarcerated, minorities, etc.

Consumer Involvement

As reported earlier, the need for consumer involvement and leadership surfaced as a major, overarching concern in relation to the behavioral health care system, the implementation of managed care, and changes that are occurring in the system as a function of managed care. Participants identified many areas where consumers should be in positions of leadership in policy making, planning for managed care, contracting with managed care entities, monitoring changes resulting from managed care, clinical record keeping, and information systems content, standards, and design. The following recommendations were suggested by participants in the group.

1. There is a need for consumer-run research relative to the definition, development, and operationalization of concepts and related data content, to ensure that consumers can read, understand, and interpret information, using native language where necessary. The development of a Center for Consumer Studies was suggested as a mechanism for research on policy and services issues.

2. The managed care contracting process should provide a mechanism for consumer involvement, where consumers, including minorities, participate in the Request for Proposal (RFP), Request for Application (RFA), and Request for Information (RFI) processes to ensure consumer issues are addressed in areas of confidentiality, clinical records, and managed care policies and processes.

3. Training opportunities should be provided for consumers to help them assume positions of leadership in the behavioral health care field.

Managing Managed Care

In discussions of managing managed care, the Panel focused on (1) managed care contracting, (2) monitoring the impact of managed care on recipient services and outcomes, and (3) information systems. Suggested recommendations include the following:

1. Outcome measures need to be developed as a basis for monitoring the managed care process, and the categories of outcome elements should include clinical outcomes, self-defined outcomes by consumers, and administration of the managed care plan with data to support the contracting process and to determine the effects of plan changes and their impact on the system and on recipients.

2. “Guardian ad litem” (a person appointed by a court of law as guardian of a person to act on an individual’s or class of individuals’ behalf) in the private mental health service system contracting process to represent the public interest, and with freedom of information principles included in the contract.

3. Data should be standardized across contracts with managed care entities and data requirements should be written into these contracts.

4. Data policies concerning data content, access, owner, etc. should be imposed on managed care entities and should be enforced by the contracting authorities.

5. Issues of data ownership, retention, and access and consumers rights to privacy should be included in managed care contracting.

6. Additive systems development should be avoided to eliminate layering of reporting requirements, to reduce multiplicity of reporting requirements on providers.

7. Information systems should be publicly accessible to the public.

Conclusions

The Technical/Policy Panel members were in unanimous agreement that the availability of uniform, reliable, and timely data is essential for orderly change to occur in the system of behavioral health care to meet the goals of managed care---giving people access to quality, cost-effective health care. Because of the speed with which change is occurring, there is a sense of urgency for the development of data standards, both content and definitions, to ensure that information systems are designed, implemented, and maintained to meet these data needs. Data are needed at all levels of the system including consumers, payers, providers, and managed care entities.

The Panel also agreed that with the Federal Government’s role of leadership in the development of data standards over more than 100 years, the Government should provide the leadership necessary to take the behavioral health field to the new levels of data production and use required as a result of the implementation of managed care. It is important to build upon the previous work started by the National Institute of Mental Health (NIMH) and continued by the Center for Mental Health Services and the Mental Health Statistics Improvement Program which provides a sound foundation and philosophy of inclusion for developing the new or revised data content and definitions needed to provide cost effective behavioral health services in a managed care environment.

It is, therefore, the Panel’s recommendation that the Center for Mental Health Services give early attention and support to a revision of the data standards recommended by MHSIP, the development of outcome data that are uniform for systems of services, and the creation and testing of measures of performance included within the MHSIP client-oriented report card.

References

1. ***The Managed Care Resource: A Language of Managed Care and Organized Health Care Systems,*** United HealthCare Corporation, 1994.

2. Leginski, et al. ***Data Standards for Mental Health Decision Support Systems***. FN-10, DHHS Pub.No. (ADM)89-1589. Washington, D. C.: Supt. Of Docs., U.S. Govt. Print. Off.

3. ***The MHSIP Consumer-Oriented Mental Health Report Card***. The Final Report of the Mental Health Statistics Improvement Program Task Force on a Consumer-Oriented Mental Health Report Card, April 1996.

4. ***Enhancing MHSIP to Meet the Needs of Children***, Task Force on Enhancing MHSIP to Meet the Needs of Children, October 1992.

5. ***Humanizing Decision Support Systems***, Jean Campbell, Ph.D. and Elizabeth Doore Frey. An unpublished report to the MHSIP.

6. ***Moving MHSIP Toward a Person-Centered Paradigm***, Susan M Buckley. An unpublished report to the MHSIP.