Evaluation of Florida's Mental Health and Substance Abuse System Redesign Strategies: Year 1 Report

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June 2002

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Submitted to the Mental Health Program Office, Florida Department of Children & Families as a deliverable under contract #LH043.

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I. Introduction

Under contract with the Department of Children and Families (DCF) and in accordance with the requirements of Senate Bill (SB)1258, the Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida, is conducting an ongoing formative evaluation of the financing strategies authorized to be implemented by the legislation. The demonstration sites that were selected were DCF District 1, including Escambia, Okaloosa, Santa Rosa and Walton Counties and DCF District 8, including Charlotte, Collier, Glades, Hendry and Lee Counties. FMHI's role is to help identify the most effective methods and techniques used to manage, integrate, and deliver behavioral health services as specified in the legislation. This report describes the progress achieved during fiscal year (FY) 2001-2002.

II. Methods

One component of the evaluation is defined as the implementation analysis. The goals of this aspect of the study are (1) to describe how the behavioral health care management and financing strategy is being implemented, (2) to assess the extent to which a strategy is being implemented as envisioned by the legislation, and (3) to provide contextual information and interpretation of all available and relevant data, including administrative data. The implementation analysis will assist in monitoring program development and, more importantly, serve to identify challenges or barriers that could impede the successful execution of the strategies.

The second component of the evaluation uses administrative data to provide county-level background data on the mental health/substance abuse (MH/SA) markets in Districts 1 and 8. The analysis primarily employs FY 2000-2001 data from the Integrated Data System (IDS) to describe users of the public MH/SA system and the types of services used. The IDS contains service event data for all behavioral health services provided by providers who have contracted with DCF's Alcohol, Drug Abuse, and Mental Health Program (ADM). The IDS contains services paid for with general revenue and Medicaid funds. Types of MH and SA services were classified into broad categories that are similar to the categories used by ADM to report service utilization. Service utilization is reported by county of residence rather than county of service. Data from the 2000 Census and the Florida Research & Economic Database are used to describe population and demographic data for the two districts. Data on the number of public mental health and substance abuse providers came from the Substance Abuse and Mental Health Provider search engine at **www.myflorida.com**. Medicaid enrollment data came from the Agency for Health Care Administration's database.

III. Findings

District 1

Demographics

District 1 is comprised of the four counties in the western end of Florida's Panhandle: Escambia, Okaloosa, Santa Rosa, and Walton. Bordered by the Gulf of Mexico to the south and Alabama to the north and west, District 1 covers an area of 4,369 square miles.

Table 1. Population and Area by County

County	2000 Population	Total Land Area (in Square Miles)	Population per Square Mile of Land Area
Escambia	294,410	662	444
Okaloosa	170,498	936	182
Santa Rosa	117,743	1,017	116
Walton	40,601	1,058	38
District Total	623,252	3,673	170

Source: 2000 Census

The counties are fairly different in terms of population and area. As shown in Table 1, Escambia County has the largest population by far (294,410), but the smallest total land area. Okaloosa and Santa Rosa Counties have about the same combined population as Escambia County, but are more rural. Walton County is the most rural, with a population density of only 38 persons per square mile.

Table 2. Age Statistics by County

County	Population Under Age 18	Population Age 65 and Older	Median Age
Escambia	24 %	13 %	35
Okaloosa	25 %	12 %	36
Santa Rosa	27 %	11 %	37
Walton	22 %	16 %	41

Source: 2000 Census

There are modest differences in age distribution, racial makeup, and income among the four counties. Walton County has a slightly older population than the other three counties in District 1, as shown in Table 2. Table 3 shows that Escambia County is the most racially diverse county in the district, with more than one-fifth of the county population reporting their race as Black or African-American. The other three counties have much smaller minority populations, ranging from 4 % Black or African-American in Santa Rosa to 9 % Black or African-American in Okaloosa. The number of individuals reporting their ethnicity as Hispanic or Latino was similar in all four counties and ranged from 2% to 4%.

Table 3. Race and Ethnicity by County

County	White	Black or African-American	Hispanic or Latino
Escambia	72 %	21 %	3 %
Okaloosa	83 %	9 %	4 %
Santa Rosa	91 %	4 %	3 %
Walton	88 %	7 %	2 %

Source: 2000 Census

In addition to having an older population and being the most rural county in the district, Walton County also has the lowest per capita income, as shown in Table 4. Okaloosa County has the highest per capita income in the district, while Escambia and Santa Rosa Counties have similar per capita incomes that are only about 10% lower than in Okaloosa County.

Table 4. Per Capita Income by County

County	Per-capita Income
Escambia	$ 22,389
Okaloosa	24,720
Santa Rosa	22,680
Walton	17,159

Source: Florida Research & Economic Database (1999 Data)

Service Users

District 1's counties have similar proportions of their populations using the public mental health/substance abuse system, as reported in IDS. As shown in Table 5, Walton County has the largest proportion of its population using the system (3%), while Escambia, Okaloosa, and Santa Rosa Counties all had 2% of their populations using the public mental health/substance abuse system. Because there is no "enrolled" population in the ADM system, we are unable to report penetration rates in the traditional way (i.e., dividing the number of service users by the total number of people enrolled in a program).

Table 5. MH/SA Users by County

County	MH/SA Users	Percent of 2000 County Population
Escambia	5,762	2 %
Okaloosa	3,929	2 %
Santa Rosa	1,982	2 %
Walton	1,257	3 %
District Total	12,930	2 %

Source: Integrated Data System, FY 2000-01 data; data reflect number of unique users

Children under age 18 are disproportionately high users of MH/SA services in District 1 when compared to the number of children in the district's overall population. As shown in Table 6, children represent 27% of the service users in Walton county and 34% of users in Escambia County while the proportion of children in District 1's counties ranged from 22% to 27% (as shown in Table 2). In contrast, elderly people are underrepresented among service users. They comprise only 2-3% of the user population but comprise 11-16% of the district's overall population.

Table 6. Age Statistics by County for MH/SA Users

County	Population Under Age 18	Population Age 65 and Older	Median Age
Escambia	34 %	3 %	31
Okaloosa	28 %	2 %	28
Santa Rosa	32 %	2 %	29
Walton	27 %	3 %	32

Source: Integrated Data System, FY 2000-01 data

There are a few differences in the racial/ethnic makeup of users compared with the general population in District 1. In all four counties, Black and African-American people comprise a larger proportion of the user population as compared to their representation in the counties' populations, as shown in Table 7. This difference is especially large in Escambia County, where Black and African-Americans represent 39% of MH/SA users but only 21% of the general population. The proportion of Hispanic/Latino users in each county is slightly lower than their presence in the general population.

Table 7. Race and Ethnicity by County for MH/SA Users

County	White	Black or African-American	Hispanic or Latino
Escambia	59 %	39 %	1 %
Okaloosa	84 %	13 %	3 %
Santa Rosa	92 %	6 %	1 %
Walton	87 %	10 %	1 %

Source: Integrated Data System, FY 2000-01 data; sum of columns may exceed 100 % because respondents can report more than one race or ethnicity

The types of behavioral health services used varied by county, as shown in Table 8. Use of residential treatment services ranged from an average of 47 days per user in Walton County to an average of 79 days per user in Santa Rosa County; the district-wide average was 55 days per user. (See Appendix 1 for a list of the services that make up each of the seven service categories.) Santa Rosa also had the highest average usage of residential crisis services (16 days), while Walton County had the lowest average usage of residential crisis services (5 days). The use of rehabilitative services in Walton County (40 hours per user) was much lower than in the district's other counties, where the average use for the year was 269 hours per user. Conversely, the average Walton County service user used more case management (29 hours) and treatment services (34 hours) than the average user in the rest of the district. Although Walton County's average methadone maintenance usage was the highest in the district, only one Walton County resident received methadone maintenance from the public MH/SA system, as shown in Appendix 2. The average number of hours of non-residential crisis services (e.g., mobile crisis) was small (2 hours per user district-wide) and similar across counties.

Table 8. Average Behavioral Health Services Usage by Users of Public MH/SA System by County (FY 2000-01)

	Average Units per Service User				
Service Category (units)	Escambia	Okaloosa	Santa Rosa	Walton	District-wide
Case Management (hours)	17.91	23.97	14.54	28.98	19.32
Treatment (hours)	8.61	8.06	10.79	33.57	11.40
Rehab Services (hours)	285.21	253.90	369.46	39.80	268.61
Methadone Maintenance (units)	276.18	342.20	275.00	380.00	285.23
Residential Crisis (days)	9.97	9.17	15.95	5.08	9.56
Non-Residential Crisis Services (hours)	2.47	1.81	1.91	1.33	2.06
Residential Treatment (days)	53.15	50.82	79.24	46.53	55.08

Source: Integrated Data System, FY 2000-01 data

There are two important limitations to the service utilization data. One limitation to comparing usage is that providers may not use the same codes for the same services. A more significant limitation is that some of the usage data appears to be lower than what we would expect to see in real-life clinical practice. From glancing at some of the raw data, it appears that some of the service units were reported using the wrong scale (e.g., therapy usage was reported in quarter-hours rather than minutes). In subsequent data analysis, we will investigate whether viable methods exist to reconcile these sorts of reporting problems.

Medicaid Enrollees/Users

Medicaid is an important financing source for public MH/SA services. In evaluating the impact of SB 1258, it will be important to consider MediPass enrollees because the managing entity that is being contracted to manage and provide ADM services (Lakeview Center) is also responsible for managing mental health care for Medicaid MediPass enrollees in the Prepaid Mental Health Plan implemented in District 1 on November 1, 2001. It is important to note that substance abuse is not included in the Medicaid Prepaid Mental Health Plan and continues to be reimbursed on a fee-for-service basis. Of the 79,225 Medicaid enrollees in District 1, 44% (or 34,858) are in the MediPass plan. In FY 2000-01, 9,512 Medicaid enrollees used MH/SA services, which is a 12% penetration rate.

Table 9. Proportion of Medicaid Enrollees in MediPass by County

County	Medicaid Enrollees	% in MediPass
Escambia	45,629	37%
Okaloosa	15,837	58
Santa Rosa	11,947	44
Walton	5,812	60
District 1 Total	79,225	44

Source: Medicaid Public Enrollment Chart, May 2002

Service Providers

Table 10 shows the number of public mental health and substance abuse providers by county in District 1. Escambia, the most populous county in District 1, has the highest number of public mental health and substance providers in the district. Lakeview Center is Escambia County's largest service provider. Bridgeway Center is Okaloosa County's largest public provider and only source for adult mental health services; Gulf Coast Treatment Center provides Medicaid-funded mental health services to children in the county. Lakeview Center and the West Florida Community Care Center (WFCCC) are the sole public providers of mental health services in Santa Rosa County; WFCCC is a receiving facility and specialty hospital that provides treatment to a district-wide catchment area. The COPE Center is the only public mental health services provider in Walton County.

Table 10. Number of Public Mental Health and Substance Abuse Providers By County

	Number of Public Providers		
County	Adult Mental Health	Children's Mental Health	Substance Abuse
Escambia	3	4	13
Okaloosa	1	2	5
Santa Rosa	2	2	5
Walton	1	1	3

Source: http://www5.myflorida.com/cf_web/myflorida2/healthhuman/substanceabusementalhealth/provsearch.html

Implementation Analysis

Methods

ADM's new financing demonstration began in District 1 on July 1, 2001, with the first fiscal year (FY 01-02) as a transition year. The new method of contracting, along with other features of the demonstration will be implemented more fully on July 1, 2002. During this transition year, FMHI staff has observed workgroup meetings, including the Adult Systems of Care, Monitoring, Data, and Contract Workgroups. We also have conducted informal, unstructured interviews about the development and progress of the system changes with the District 1 ADM Program Supervisor, Dr. Paul Rollings, and other key staff in that office. In addition, Institute staff attended the comprehensive briefing that was conducted for DCF's Mental Health and Substance Abuse programs on March 1, 2002. On May 31, 2002, a focus group consisting of key district stakeholders was conducted to solicit their views on the demonstration's progress and what information they would like to obtain from the evaluation.

Documents that have been reviewed thus far include the enabling legislation, the original concept papers outlining the overall strategy and goals for the demonstration, and documents prepared for workgroup meetings. These include an outline of the contracting guide and a data workbook that will serve to direct the contracting processes and the data systems to be implemented on July 1, 2002.

Demonstration Design

District 1 began its initial planning for the implementation of the new management and financing strategies well in advance of July 1, 2002, the full implementation date. A steering committee was established and has met twice. Other workgroups, including Contract, Finance, and Payment; Adult Systems of Care; Child Systems of Care; Data and Outcome Integration; and System Monitoring have been meeting regularly to

address the details of program implementation. According to workgroup chairs, there has been good representation and participation from all the key system components.

Beginning with the July 1, 2002 contract period, District 1's ADM Program Office will contract with a managing entity, Lakeview Center, for all core mental health and substance abuse services. There are some exceptions for which ADM will continue to contract directly with the provider (e.g., Community Drug & Alcohol Council for substance abuse prevention services). Lakeview Center will, in turn, contract with the behavioral health treatment providers who are responsible for core ADM services for their respective counties. The comprehensive providers include: Lakeview Center (Escambia and Santa Rosa Counties), Bridgeway Center (Okaloosa County), and COPE Center (Walton County).

The district will no longer contract with providers on a unit of service basis, but will contract with the managing entity based upon a prepaid, aggregate, fixed sum payment methodology determined by experience and history of service provision in the district. The contract will provide fixed sums of money in four broad categories (adult mental health, children's mental health, adult substance abuse, and children's substance abuse services) to the managing entity based upon a projected number of individuals to be served during the contract year and a projected cost per individual. The contract's program description details the range of services that may be provided, rather than stipulating a specific number or type of service that must be provided, giving the provider more flexibility in service delivery.

A new data system is being implemented and is expected to support the new contract mechanisms as well as provide data necessary to the State Mental Health and Substance Abuse Programs for their reporting requirements. Although a few reporting requirements will not be addressed by the new system, the data system will eliminate the need to maintain dual systems of data collection and processing.

Ultimately, the stated goal of these systems is to be able to track individuals who have received services, identify the services they have received, and determine the outcomes that have been achieved through service provision. At the same time, the district also intends for service delivery systems to become more consumer focused, where the needs of the individual will determine the services that are to be provided rather than allowing financial reimbursement mechanisms to drive service delivery.

Early Observations on Progress to Date

Considerable progress has been made within the transition year. The work that has been accomplished on the development of the new contracting methodology and district data systems has been most impressive. The redesigned, web-based data system, Pilot Integrated Data System (PIDS), will make agency-specific data available to provider agencies for their own use almost immediately upon submission. It can also be used to report required information to the state. According to the district, it will provide information that is more useful and timelier than what current systems provide. It will also help to account for services that are being provided but not captured by the systems currently in place. District staff is also confident that PIDS will give them the

information needed to assure accountability in these new financing structures. If the data system operates as designed, DCF is likely to consider implementing this system statewide.

The level of cooperation and shared effort in the system redesign on the part of key system participants has also been impressive. From observations of workgroup meetings it was apparent that information was willingly shared among providers, the district office and other stakeholders. This was evidenced, for example, by the open sharing of agency-specific data in workgroups. The longstanding relationships among the key players within the district and the inclusiveness of the planning efforts appear to have eased tensions that, inevitably, have been part of these major changes.

Consumers and their families have had a limited role in the planning and development of the system redesign. There are family members of primary consumers in the adult and children workgroups and a primary consumer in the children's workgroup. As system changes are considered, greater opportunities must be provided to consumers and their families to incorporate their perspectives if the goal of making the service delivery system more consumer-directed is to be achieved. It is noteworthy, however, that the district has committed resources to provide for a Client Advocate Program to be operated by the mental health associations, and also is promoting the use of mental health advanced directives and consumer and family education through the NAMI Family to Family curricula.

Preliminary Conclusions for District 1

Implementation of the new financing strategies in District 1 has been clearly enhanced by the longstanding relationships among the service system components, stable district leadership, the selection of a competent managing entity, and significant time and resource commitments by key participants in the system redesign process.

It is apparent that considerable energy and time have been devoted to the planning and development of these new processes in order to accommodate the demonstration goals and timeframes. It is rare to see such major system developments accomplished within a relatively short time. Although the investment of time and energy has led to important accomplishments, it has also raised concern about the burden on staff time and resources to attend and prepare for so many meetings, planning sessions, etc. This can be particularly difficult for smaller agencies. Hopefully, as systems are implemented there will be some relief from these demands.

While there is an advantage to having a smaller network of providers that have worked together for a long time, its important that there be opportunity for new providers to become part of the network or for alternative services to be developed. This is especially relevant if consumer choice is one of the important considerations in re-directing the service delivery system to becoming more consumer-focused.

There is evidence that the model being implemented in District 1, where the managing entity is also a provider, is causing concern. Specifically, questions have been raised about whether or not the managing entity can be truly objective and even-handed when

dealing with providers in the network. This issue is exacerbated by the fact that Lakeview Center is such a large, well-financed organization and is also the managing entity for the Medicaid Prepaid Mental Health Plan (PMHP), the Community Based Care (CBC) provider, and has the contracts for the Statewide Inpatient Psychiatric Program (SIPP) and Florida Assertive Community Treatment (FACT) projects. While there appears to be sensitivity to this issue on the part of Lakeview Center and a commitment to demonstrate that such an arrangement can work equitably for all involved, this is an area of potential conflict in the system.

Because the district is implementing multiple initiatives at the same time (the Medicaid PMHP, CBC, and the SB 1258 service delivery strategy) it presents a rare opportunity to bring divergent systems of care together in order to meet the service needs of an individual. However, it will also make it more difficult to discern which initiative or aspect of any one initiative is having an impact (either positive or negative). Implementing multiple initiatives simultaneously will complicate the ability to segregate the effects of any one intervention in order to determine its potential for further expansion in the state. For example, how do the access standards for the Medicaid PMHP affect access to services for non-Medicaid eligible individuals? While the district intends that the same access standards shall apply for both Medicaid-eligible and other indigent individuals, can smaller or more rural providers realistically meet these expectations given limited staffing and resources? Will this result in non-Medicaid eligible individuals having to wait for services?

Because substance abuse is not a part of the Medicaid managed care demonstration that is currently being implemented in AHCA Area 1, the Lakeview Center has no way to manage the fee-for-service substance abuse billings to Medicaid. Yet, Lakeview is responsible for "managing" substance abuse general revenue services under SB 1258. This is one area where there appears to be a gap in the managing entity's ability to integrate the overall systems of service.

These new contracting strategies represent a significant shift in the way the state has operated its general revenue supported services. Instead of executing contracts directly with providers, District 1 will begin contracting with a managing entity that will contract with the provider network. There are also new data systems and contract methodologies being implemented. The new relationships and organizational structures create new roles for the managing entity as well as the district. It will be important for DCF, at both the district and central office levels, to promote the success of these strategies by permitting flexibility. Rather than adhering to traditional ways of doing business and maintaining its former role with providers, DCF should rely upon the managing entity to manage the network. Further, wherever possible, the Department should continue to require only those processes essential for maintaining accountability and should minimize any dual reporting and monitoring requirements. Understandably, it may take time for the necessary level of confidence in these new structures to be achieved.

District 8

Demographics

District 8 is made up of five counties in the southwestern corner of Florida. Charlotte, Collier, Glades, Hendry, and Lee Counties cover 6,552 square miles.

Table 11. Population and Area by County

County	2000 Population	Total Land Area (in Square Miles)	Population per Square Mile of Land Area
Charlotte	141,627	694	204
Collier	251,377	2,025	124
Glades	10,576	774	14
Hendry	36,210	1,153	31
Lee	440,888	804	549
District Total	880,678	5,450	162

Source: 2000 Census

Lee County is the district's dominant county in terms of population, with 50% of the district's residents and a very high population density, as shown in Table 11. With the largest landmass in the district, Collier County has 29% of the district's population. Glades and Hendry Counties are extremely small and quite rural.

Table 12. Age Statistics by County

County	Population Under Age 18	Population Age 65 and Older	Median Age
Charlotte	16 %	35 %	54
Collier	20 %	25 %	44
Glades	22 %	19 %	40
Hendry	30 %	10 %	30
Lee	20 %	25 %	45

Source: 2000 Census

As shown in Table 12, there are some important age differences in District 8. Hendry County has a significantly younger population than the rest of the district, with only 10% of its population 65 years or older; children make up nearly one-third of Hendry County's population. Charlotte County is District 8's oldest county, with a median age of 54. Collier and Lee Counties have identical age profiles, and Glades County has a slightly younger age profile.

Table 13. Race and Ethnicity by County

County	White	Black or African-American	Hispanic or Latino
Charlotte	93 %	4 %	3 %
Collier	86 %	5 %	20 %
Glades	77 %	11 %	15 %
Hendry	66 %	15 %	40 %
Lee	88 %	7 %	10 %

Source: 2000 Census; sum of columns may exceed 100 % because respondents can report more than one race or ethnicity.

District 8's racial and ethnic makeup varies by county, too, as shown in Table 13. Hendry County has, by far, the most Hispanic/Latino residents in the district, with 40% of the county's population identifying themselves as Hispanic or Latino. Hendry County also has the highest proportion of Black or African-American residents (15%). Collier and Lee Counties have similar proportions of White and Black/African-American residents, but the proportion of Hispanic/Latino residents in Collier County (20%) is twice the proportion of Hispanic/Latino residents in Lee County (10%). Charlotte County has the smallest proportion of minority residents in District 8.

Table 14. Per-capita Income by County

County	Per-capita Income
Charlotte	$ 24,356
Collier	44,862
Glades	18,905
Hendry	24,858
Lee	27,861

Source: Florida Research & Economic Database (1999 Data)

There are significant disparities in per-capita income across the district, as shown in Table 14. Collier County's per capita income of $44,862 is more than 60% higher than the per capita income for Lee County ($27,861), District 8's second wealthiest county. Glades County has the lowest per capita income ($18,905) in the district, and this amount is less than half that of Collier County. Charlotte and Hendry Counties have similar per capita incomes.

Service Users

District 8's counties have similar proportions of their populations using the public mental health/substance abuse system. As shown in Table 15, Charlotte and Hendry Counties

had the highest per capita service penetration (2%), while Collier, Glades, and Lee Counties all had 1% of their populations using the public MH/SA system.

Table 15. Population and Area by County, MH/SA Users

County	MH/SA Users	Percent of 2000 County Population
Charlotte	2,141	2 %
Collier	3,752	1 %
Glades	104	1 %
Hendry	614	2 %
Lee	6,213	1 %
District Total	12,824	1%

Source: Integrated Data System, FY 2000-01 data

The number of elderly MH/SA users in District 8 is disproportionately small compared with the proportion of elderly people in the general population. As shown in Table 16, people 65 and older make up only 1-4% of all MH/SA service users despite representing 10-35% of the general population. The median age of public MH/SA system users in Collier County is 16, which is less than half of 44, the median age in the county's general population. Similarly, Charlotte County's median user is 29 years old, compared with a median age of 54 in the general population.

Table 16. Age Statistics by County for MH/SA Users

County	Population Under Age 18	Population Age 65 and Older	Median Age
Charlotte	35 %	3 %	29
Collier	54 %	1 %	16
Glades	28 %	4 %	30
Hendry	25 %	4 %	31
Lee	27 %	3 %	32

Source: Integrated Data System, FY 2000-01 data

Black and African-American users comprise a larger proportion of users than their presence in the general population, as shown in Table 17. This difference is especially large in Collier County, where Black and African-American represent 27% of MH/SA users but just 5% of the general population. Collier County also has a much higher proportion of Hispanic/Latino users (34%) than their presence in the general population (20%). Conversely, the proportion of Hendry County MH/SA system users who are Hispanic/Latino (21%) is much lower than their presence in the general population (40%).

Table 17. Race and Ethnicity by County for MH/SA Users

County	White	Black or African-American	Hispanic or Latino
Charlotte	89 %	8 %	3 %
Collier	65 %	27 %	34 %
Glades	71 %	17 %	11 %
Hendry	63 %	20 %	21 %
Lee	74 %	13 %	8 %

Source: Integrated Data System, FY 2000-01 data; sum of columns may exceed 100 % because respondents can report more than one race or ethnicity

Table 18 shows large, county-level differences in the types of behavioral health services received in District 8 during FY00-01. Charlotte County had more than triple the district average of residential treatment days (157 days per user versus 47 days per user). Average use of rehabilitative services was also much higher in Charlotte County (414 hours per user) than district-wide (177 hours per user). For all types of services, Glades and Hendry Counties had the fewest users and the lowest average usage in the district. The same limitations discussed above for the District 1 data apply to the District 8 data.

Table 18. Average Behavioral Health Services Usage by Users of Public MH/SA System by County (FY 2000-01)

	Average Units per Service User					
Service Category (units)	Charlotte	Collier	Glades	Hendry	Lee	District-wide
Case Management (hours)	23.94	9.16	6.64	3.71	16.42	12.11
Treatment (hours)	14.38	17.30	6.38	7.96	9.43	12.67
Rehab Services (hours)	413.79	182.37	108.00	99.40	118.00	177.35
Methadone Maintenance (units)	281.00	202.50	0.00	99.00	221.53	224.50
Residential Crisis (days)	6.04	6.23	4.00	4.55	7.29	6.78
Non-Residential Crisis Services (hours)	2.78	3.42	2.00	1.78	2.42	2.58
Residential Treatment (days)	156.57	26.80	26.86	16.78	35.16	46.54

Source: Integrated Data System, FY 2000-01 data

Medicaid Enrollees/Users

In District 8 there are 79,094 Medicaid enrollees. In evaluating the impact of SB 1258, it will be important to consider the number of MediPass enrollees because the managing entity being established to manage and provide ADM services may, at some point in the future, manage care for those in MediPass. As shown in Table 19, 38% (or 30,055 people) of District 8's 79,094 Medicaid enrollees are in the MediPass plan. In FY 2000-01 4,949 Medicaid enrollees used MH/SA services, which is a 6% penetration rate.

Table 19. Proportion of Medicaid Enrollees in MediPass by County

County	Medicaid Enrollees	% in MediPass
Charlotte	10,070	49%
Collier	19,396	57
Glades	129	45
Hendry	6,848	54
Lee	42,651	24
District 8 Total	79,094	38

Source: Medicaid Public Enrollment Chart, May 2002

Service Providers

Table 20 shows the number of public mental health and substance abuse providers by county in District 8. The Ruth Cooper Center is the largest public provider in Lee County. The David Lawrence Center is the largest public provider in Collier County and the only provider of adult mental health services. Charlotte Community Mental Health Services is the sole provider of adult and children's mental health services in Charlotte County. The Hendry-Glades Mental Health Clinic is the primary public provider for both Hendry and Glades Counties.

Table 20. Number of Public Mental Health and Substance Abuse Providers by County

	Number of Public Providers		
County	Adult Mental Health	Children's Mental Health	Substance Abuse
Charlotte	1	1	6
Collier	1	2	12
Glades	1	1	2
Hendry	2	1	2
Lee	4	8	17

Source:
http://www5.myflorida.com/cf_web/myflorida2/healthhuman/substanceabusementalhealth/provsearch.html

Implementation Analysis

Methods

FMHI staff observed workgroup meetings in January and June 2002, had informal, unstructured interviews with the District 8 ADM supervisor and central office staff, and conducted a focus group with District 8 ADM staff and providers on June 4, 2002 in Fort Myers to solicit their views on the demonstration's progress and what information they would like to obtain from the evaluation. Documents that have been reviewed thus far include Senate Bill 1258, the original concept papers, and documents distributed at the workgroup meetings.

Demonstration Design

Unlike Area 1, AHCA has not implemented a PMHP in Area 8 under the state's current 1915b waiver because the historical fee-for-service (FFS) billings in Area 8 are too low, and capitating a vendor at 92% of historical FFS costs would not provide a sufficient capitation rate. ADM's original plan for District 8 was to competitively procure an administrative services organization (ASO) that would perform managed care functions for ADM-funded services. Because DCF anticipated major revenue shortfalls and budget reductions for FY 01-02 several months into the fiscal year, they felt that a transfer of general revenue from services to fund an ASO during FY 01-02 would not be approved by the Legislative Budget Commission. One alternate plan may be to develop a provider service organization (PSO) in District 8 that could function as a managing entity. However, the law requires that this be competitively procured.

ADM and the provider agencies agreed that there needs to be consensus on several areas of management before a PSO can be functional: a single point of access, network management (credentialing, contracting), level of care criteria, clinical treatment guidelines, utilization management, quality assurance mechanisms, performance indicators, information system management, and consumer complaints and choice. In addition, there needs to be consensus on the type of provider network model (e.g., lead agency, partnership) and how the network will be funded.

Early Observations on Progress to Date

In light of budget shortfalls prohibiting a contract with an ASO, ADM staff identified two tasks that would help accelerate the project: exploring provider readiness, and hiring consultants to assist with network formation.

Several consultants have presented to and worked with District 8 ADM staff and providers over the past year, but providers indicated a lack of follow-up or feedback resulting from this work. A meeting was held in Tampa at FMHI on January 3 and 4, 2002 to discuss "How Can Florida Support Best Practices in its Community Mental

Health System?" The 1 ½ day meeting was well attended by DCF/ADM district and central office administrators, AHCA administrators, District 8 providers, the CEO of the Florida Council on Community Mental Health (FCCMH), FMHI staff, Florida State University (FSU) Professional Development Center staff, consumer advocates, and consultants. The discussion focused on best practices, determining which activities are Medicaid reimbursable, supported housing, supported employment, drop-in centers, the clubhouse model, and acute care alternatives. Tentative agreements were reached with AHCA at this meeting on changes to the Medicaid manual, but these changes do not appear to have been implemented yet. In fact, some of the recent changes made by Medicaid may be contrary to these previous discussions.

ADM Central Office staff met with District 8 ADM staff, providers, and AHCA Area 8 staff to discuss potential strategies for meeting the legislative goals of Senate Bill 1258 on June 18 and 19, 2002 in Fort Myers. Celeste Putnam, ADM Program Director, led a discussion about the possibility of applying for an additional Medicaid waiver for District 8 (e.g., 1915c, 1115; AHCA already has a 1915b waiver for the PMHPs, and the Florida Legislature approved expansion into Area 8) and recommendations that might be made to AHCA. They discussed different organizational structures for the managing entity (e.g., ASO, PSO). A work plan, including immediate action steps, was developed at the meeting. The plan included priorities and timeframes for clinical and systems issues. A conceptual document and additional timeline information will be presented at the next workgroup meeting on July 30. Two key stakeholders were not in attendance at the June meeting: (1) a representative from the AHCA Central Office, and (2) the CEO from one of the district's largest providers, who is an opinion leader among District 8 providers. It was also noted that District 8 hospitals and consumers were important stakeholders that should be invited to subsequent workgroup meetings.

Overall, the Department and AHCA have completed the initial steps towards implementing a new financing strategy for public MH/SA services. There have been several obstacles: Sarasota and DeSoto counties were taken out of the DCF District 8 catchment area; the state hospital in their district closed; district and provider staff were preoccupied with implementing new and expanded services with the additional money appropriated because of the hospital closing; and, in general, there are serious inadequacies in the range of available services (lack of inpatient and other crisis service options, inadequate funding for medications, lack of children's services, and great difficulty recruiting psychiatrists, nurses, and licensed clinicians).

District 8 providers reported having formed a corporation in response to legislation allowing AHCA to expand the PMHP demonstration to Area 8 (in addition to Areas 1 and 5, and Alachua County). Reportedly, their corporation was functional for a time with each agency contributing 10% of their revenues. The knowledge and experience of creating that corporation remains and will be very helpful as they move forward under SB 1258. However, District 8 providers are very concerned about how to respond to the call for a collaborative effort and at the same time maintain their local identity with their community. Providers are also concerned about increased regulatory oversight with the addition of a managing entity on top of what they feel is already excessive monitoring by multiple state agencies and other funders. Finally, providers are wary of adding another

data system and more reporting requirements for the managing entity, in addition to the multiple existing systems needed to be responsive to their current funding sources.

District 8 providers have been working to increase their Medicaid billings over the past year, which may make Medicaid capitation a possibility at some point. However, with the implementation of prior authorization for three Medicaid community mental health services on April 1, 2002, Medicaid billings in District 8 may decrease again. Providers feel positive about having "grown the system" over the past year, which has resulted in more crisis services, more focus on employment, the addition of FACT, and more children's CSUs.

Preliminary Conclusions for District 8

A summary of all the input from the consultants over the past year may facilitate the necessary discussions with District 8 providers about the gaps in the current ADM system of mental health and substance abuse care, the goals of the providers for the new system, and how to structure a managing entity so it meets those goals.

Strong leadership by ADM with clear timeframes and assistance will be key to implementing a managing entity in District 8.

The assistance of consultants, who have expertise in designing or reforming systems of care and specific expertise in developing provider networks, to accomplish the concrete tasks of this process may be necessary.

District 8 providers may not be aware of the specifics associated with the progress in District 1 and may benefit from a formal presentation by Dr. Paul Rollings and his colleagues involved in the implementation of SB 1258 reforms in that area.

Even if a managing entity is implemented in District 8, this will not fulfill SB 1258's goal of having a "single well-integrated behavioral health system" until AHCA can contract with the same managing entity for mental health and substance abuse services on a prepaid basis.

Conclusions

ADM has made tremendous progress in District 1 during FY 2001-02 in planning and implementing their new contracting, financing, and data systems in response to SB 1258. Beginning July 1, 2002, the managing entity for DCF District 1 is Lakeview Center, which is also the managing entity/PMHP for Medicaid Area 1 MediPass enrollees. The District 1 ADM supervisor has collaborated some with Area 1 AHCA staff and the PMHP contract manager on local operational issues regarding the two initiatives. This common managing entity between AHCA and DCF/ADM accomplishes a large part of SB1258's mandate. District 1 and ADM Central Office staff are to be commended for their heroic efforts to implement this groundbreaking demonstration project.

ADM's progress in District 8 during FY 2001-02 was much more modest. The absence of a Medicaid managing entity in Area 8 means that AHCA and ADM face a significant barrier to overcome in order to meet the legislative goals of SB 1258. The first workgroup meeting in January 2002 was successful in that ADM and AHCA Central Office staff were present, and there was important discussion about coordinating benefit packages. The second workgroup meeting in June 2002 was successful in terms of continuing the discussion about options for meeting the legislative goals and establishing next steps, but AHCA Central Office was not represented at this meeting. The past year's accomplishments set a good foundation for the coming year.

The administrative data suggests that there are important differences both within and across the two districts participating in the SB 1258 demonstration that should be considered. While the District 1 service area is fairly homogeneous across counties with respect to age and race, the district has one very small rural county (Walton) and one larger urban county with a fairly large proportion of Black/African-Americans who are disproportionately high users of the public MH/SA system. District 8's service area is more heterogeneous. Collier County is very wealthy, while Hendry and Glades Counties are very small rural areas with very few system users (710 in the two counties combined in FY 2000-01).

These differences in service areas are even more significant with regard to average service use. In District 1, average service utilization was highest in Santa Rosa County or Walton County for all service categories except non-residential crisis services. In District 8, Charlotte County had the highest average usage of rehabilitative services, residential treatment, case management, and methadone maintenance. System users in Hendry and Glades Counties had lower average usage for all service categories compared with system users in the rest of the district.

There are also important similarities between the districts. Even though District 8's general population is larger by about 260,000 people, IDS reports almost exactly the same number of MH/SA users in Districts 1 and 8 (12,775 and 12,677, respectively). In addition, Districts 1 and 8 have almost the same number of Medicaid enrollees (79,225 and 79,094, respectively) and similar numbers of MediPass enrollees (34,858 and 30,055, respectively) who are included in the SB 1258 demonstrations. However, the Medicaid penetration rates in the two districts are very different (6% in District 8 and 12% in District 1). It is clear that the lower Medicaid billings in District 8 are not the result of having fewer Medicaid enrollees, but at least in part due to fewer Medicaid enrollees accessing MH/SA services. It may also be that once in services, Medicaid enrollees receive a lower volume of services in District 8. This lower service volume may reflect the district's limited service capacity, particularly for inpatient services.

Solving the problem of low, historical, fee-for-service Medicaid billings in District 8 is an important part of being able to capitate Medicaid mental health care and fulfilling the promise of SB1258. In addition, AHCA's prepaid demonstration does not include substance abuse services, which makes it difficult for the managing entity in either district to fully integrate mental health and substance abuse services for both the ADM and Medicaid populations. An important note to these analyses of MH/SA users

calculated using IDS and Medicaid datasets is that there is overlap between the two systems. With the exception of inpatient hospitals, all ADM-contracted providers are expected to report their Medicaid MH/SA billings in IDS, but not all do. It is very important that ADM and Medicaid resolve these data issues for the new behavioral health care system, and such resolution will enable FMHI to do a high quality evaluation using accurate and unduplicated data.

The main goal of Senate Bill 1258 is to have the DCF and AHCA collaborate to have a single, well-integrated, behavioral health system. The bill lists several methods that may facilitate the accomplishment of that goal, including:

- DCF and AHCA may align and integrate procedure codes, standards, or other requirements;
- The managing entities must submit data to the DCF and AHCA on the use of services and the outcomes for all enrolled clients;
- The managing entities must meet performance standards developed by AHCA and the DCF.

In Area 1 thus far, it appears that AHCA and ADM are conducting initiatives somewhat separately even though they are contracting with the same managing entity. The managing entity has prepaid amounts from both public funding sources, and still answers to two "masters". In both districts, it appears that AHCA and ADM Central Office staffs have not collaborated equally on the system changes needed to accomplish the goals set out by SB 1258. It is noteworthy, however, that some consideration has been given to interagency collaboration at the local level, as the Medicaid PMHP contract manager and the Area 1 ADM Supervisor have conducted joint monitoring visits to Lakeview Center. We encourage the ADM and Medicaid Central Offices to engage in joint planning for benefit packages, procedure codes, performance standards, and data reporting. It may be necessary to blend funding and functions at some administrative level (e.g., one contract and contract manager for ADM and Medicaid behavioral health services). It is noteworthy that this evaluation is funded through a contract with ADM because the evaluation of Senate Bill 1258 could be jointly contracted and funded by both agencies in the future, which might help model the demonstration.

Joint policymaking is an important role for the ADM and AHCA Central Offices in this process. The AHCA and ADM policymakers will have to collaborate at the central office level to achieve the well-integrated behavioral health system called for by SB 1258. The collaboration needs to include both the Medicaid PMHP and the HMOs, as they are both integral parts of the Medicaid prepaid mental health demonstration. If this level of joint policymaking is not accomplished, the service delivery system is likely to remain fragmented, with more duplicative accountability measures resulting in excessive burden on the managing entities. The potential benefit from these financing strategies is a seamless system of care for ADM and Medicaid-funded behavioral health service users.

Appendices

Appendix 1: Services Associated with Service Categories Used in Tables 8 and 18

Case Management:

- *Case management*
- *Intensive case management*
- *Intervention services (e.g., individual assessments, short-term counseling)*
- *Treatment Alternatives to Street Crime (TASC)*

Treatment Events:

- *Assessment*
- *In-home and on-site services*
- *Medical services*
- *Outpatient-individual and group*
- *Aftercare/follow-up*

Rehabilitative Services:

- *Day/night services*
- *Supported employment*
- *Supported housing/living*

Methadone Maintenance

Residential Crisis Events:

- *Crisis stabilization*
- *Inpatient*

Non-Residential Crisis Services:

- *Crisis support/emergency services (e.g., mobile crisis, emergency walk-in)*

Residential Treatment:

- *Residential – Levels 1, 2, 3, & 4*
- *Room & board with supervision – Levels 1, 2, & 3*
- *Substance abuse detoxification*

Appendix 2: Service Events, Users, and Events Per User by Type of Service

District 1

District-wide (12,930 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	123,594	6,396	19.32
2 = Treatment Events (hours)	119,615	10,492	11.40
3 = Rehab Services (hours)	293,324	1,092	268.61
4 = Methadone Maintenance (units)	13,406	47	285.23
5 = Residential Crisis Events (days)	5,141	538	9.56
6 = Non-Residential Crisis Se rvices (hours)	3,065	1,486	2.06
7 = Residential Treatment (days)	88,685	1,610	55.08

Escambia (5,762 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	69,382	3,874	17.91
2 = Treatment Events (hours)	39,524	4,593	8.61
3 = Rehab Services (hours)	188,239	660	285.21
4 = Methadone Maintenance (units)	9,390	34	276.18
5 = Residential Crisis Events (days)	1,925	193	9.97
6 = Non-Residential Crisis Services (hours)	1,633	660	2.47
7 = Residential Treatment (days)	42,520	800	53.15

Okaloosa (3,929 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	31,522	1,315	23.97
2 = Treatment Events (hours)	25,134	3,117	8.06
3 = Rehab Services (hours)	64,745	255	253.90
4 = Methadone Maintenance (units)	1,711	5	342.20
5 = Residential Crisis Events (days)	2,356	257	9.17
6 = Non-Residential Crisis Services (hours)	1,108	613	1.81
7 = Residential Treatment (days)	26,425	520	50.82

Santa Rosa (1,982 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	12,373	851	14.54
2 = Treatment Events (hours)	18,195	1,687	10.79
3 = Rehab Services (hours)	37,315	101	369.46
4 = Methadone Maintenance (units)	1,925	7	275.00
5 = Residential Crisis Events (days)	606	38	15.95
6 = Non-Residential Crisis Services (hours)	134	70	1.91
7 = Residential Treatment (days)	15,134	191	79.24

Walton (1,257 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	10,317	356	28.98
2 = Treatment Events (hours)	36,762	1,095	33.57
3 = Rehab Services (hours)	3,025	76	39.80
4 = Methadone Maintenance (units)	380	1	380.00
5 = Residential Crisis Events (days)	254	50	5.08
6 = Non-Residential Crisis Services (hours)	190	143	1.33
7 = Residential Treatment (days)	4,606	99	46.53

District 8

District-wide (12,824 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	31,818	2,628	12.11
2 = Treatment Events (hours)	112,469	8,878	12.67
3 = Rehab Services (hours)	128,937	727	177.35
4 = Methadone Maintenance (units)	5,837	26	224.50
5 = Residential Crisis Events (days)	13,803	2,037	6.78
6 = Non-Residential Crisis Services (hours)	4,284	1,663	2.58
7 = Residential Treatment (days)	70,502	1,515	46.54

Charlotte (2,141 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	5,506	230	23.94
2 = Treatment Events (hours)	25,151	1,749	14.38
3 = Rehab Services (hours)	44,276	107	413.79
4 = Methadone Maintenance (units)	1,124	4	281.00
5 = Residential Crisis Events (days)	2,464	408	6.04
6 = Non-Residential Crisis Services (hours)	45	16	2.78
7 = Residential Treatment (days)	25,365	162	156.57

Collier (3,752 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	11,742	1,282	9.16
2 = Treatment Events (hours)	45,843	2,650	17.30
3 = Rehab Services (hours)	32,827	180	182.37
4 = Methadone Maintenance (units)	405	2	202.50
5 = Residential Crisis Events (days)	1,844	296	6.23
6 = Non-Residential Crisis Services (hours)	1,006	294	3.42
7 = Residential Treatment (days)	6,272	234	26.80

Glades (104 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	212	32	6.64
2 = Treatment Events (hours)	383	60	6.38
3 = Rehab Services (hours)	108	1	108.00
4 = Methadone Maintenance (units)	0	0	0.00
5 = Residential Crisis Events (days)	44	11	4.00
6 = Non-Residential Crisis Services (hours)	14	7	2.00
7 = Residential Treatment (days)	188	7	26.86

Hendry (614 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	1,007	271	3.71
2 = Treatment Events (hours)	3,145	395	7.96
3 = Rehab Services (hours)	398	4	99.40
4 = Methadone Maintenance (units)	99	1	99.00
5 = Residential Crisis Events (days)	305	67	4.55
6 = Non-Residential Crisis Services (hours)	110	62	1.78
7 = Residential Treatment (days)	386	23	16.78

Lee (6,213 users)

	Units	Users	Units Per User
1 = Case Management Events (hours)	13,351	813	16.42
2 = Treatment Events (hours)	37,947	4,024	9.43
3 = Rehab Services (hours)	51,328	435	118.00
4 = Methadone Maintenance (units)	4,209	19	221.53
5 = Residential Crisis Events (days)	9,146	1,255	7.29
6 = Non-Residential Crisis Services (hours)	3,109	1,284	2.42
7 = Residential Treatment (days)	38,291	1,089	35.16