



THE LOUIS DE LA PARTE FLORIDA MENTAL HEALTH INSTITUTE



Evaluation of Florida's Medicaid Managed Mental Health Plans: Year 9 Report

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The Louis de la Parte Florida Mental Health Institute at the University of South Florida has a mission to strengthen mental health services throughout the state. The Institute provides research, training, education, technical assistance, and support services to mental health professionals and agencies as well as consumers, consumer organizations, and behavioral health advocates statewide. At the state level, the Institute works closely with the Departments of Children and Families (DCF), Corrections (DOC), Elder Affairs (DOEA), Education (DOE), and the Agency for Health Care Administration (AHCA), as well as with members and staff of the State Legislature and providers of mental health services throughout Florida.

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**Evaluation of Florida Medicaid
Managed Mental Health Plans:
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Evaluation of Florida Medicaid Managed Mental Health Plans: Year 9 Report

Executive Summary

Overview of Evaluation

The Agency for Healthcare Administration (AHCA), the agency that oversees Florida's Medicaid program, began managed care for general health services in 1984 and in 1996, established prepaid mental health programs (PMHPs) for community mental health care. On behalf of the AHCA, we, at the Louis de la Parte Florida Mental Health Institute, have been conducting a series of integrated, multi-method evaluation projects to examine the effects of managed care on access, cost, quality, and outcomes of mental health services since the establishment of the PMHPs. This is the 9th report in a series of yearly reports that document the implementation of prepaid mental health programs and the expansion of community mental health benefits being managed by Medicaid Health Maintenance Organizations (HMOs). However, this report reflects an important transition in the development of managed care programs in Florida; it is the first that tracks the statewide implementation of these initiatives.

In this year's analysis, we focus on the development of new prepaid programs in AHCA Areas 5 and 7, as well as the expansion of comprehensive mental health benefits in HMOs in other AHCA areas. In addition to an implementation analysis, we are including summary findings from a children's quality of care study conducted in Area 5 and a mail survey of Medicaid enrollees conducted in Areas 5 and 7, just prior to the expansion of mental health managed care in those areas. Finally, we present a series of analyses of previously obtained administrative data for the period of January 2001 to June 2004 from the Area 1 implementation of managed mental health care in which we examine new approaches for evaluating service penetration and outcomes.

Medicaid Managed Mental Health Care in Florida

Two approaches are employed to manage mental health services in Florida. The first is a behavioral health care "carve-out" plan in which a specialty behavioral health managed care organization provides or arranges for a specified range of mental health services for plan participants, including community mental health, targeted case management, and psychiatric inpatient services. In this pre-paid arrangement, the managed care organization is paid by AHCA a fixed monthly fee per enrollee rate which is based on prior utilization. This is the Prepaid Mental Health Plan or PMHP.

In the second managed care approach, HMOs receive a risk-adjusted premium that includes general health, pharmacy, and a range of community mental health services identical to those in the pre-paid plan. Since HMOs receive an

integrated premium for all three components of the benefit, these arrangements are characterized as a “carve-in” purchasing arrangement. HMOs arrange health, mental health, and pharmacy services for their enrollees through sub-contractual agreements with providers or behavioral health managed care organizations. Both the PMHPs and HMOs are at financial risk for the mental health service utilization of their enrollees for the services that are specified in their contractual arrangements, which we refer to as the carve-out services.

Implementation

Although we have several years of experience in implementing these programs, we found some common concerns emerging regarding the new start-ups.

First, the implementation of managed care is associated with disruptions in care. Both the providers and the caregivers in the children’s study report that the implementation of the mental health managed care programs was associated with changing procedures for the authorization of care or changes in the availability of certain types of services, such as case management. It is not always clear that the disruptions were related to new benefit structure, utilization management procedures or changes in the resource base. However, it is clear from the reports of caregivers and clinicians that the availability of services was perceived to have changed negatively following the implementation of managed mental health care.

Second, establishing new relationships between HMOs/BHOs and the traditional community mental health providers in the expansion sites is also characterized by confusion and disruption in service payments. As was the case in Area 6, CMHC administrators complain about difficult and confusing procedures for service authorization and billing. Representatives of the HMOs/BHOs offer training in their procedures and also expressed frustration at the pace at which these new provider agencies adapt to their authorization and claiming processes. These disruptions have caused revenue problems for the CMHCs as their receivable account balances grow. Uncompensated care may become an increasing problem if these administrative procedures are not streamlined and mastered.

Third, the integration of the mental health and general health premium of the HMOs has not resulted in the integration of service networks. The ‘carved in’ mental health premium is generally carved out and the financial risk for care is passed from the HMO to a BHO, which is either a subsidiary of the parent company or a separately incorporated, for profit entity. HMO/BHOs are purchasing services on a fee-for-service basis from the providers, which has resulted in some of the authorization and billing difficulties discussed earlier.

Fourth, the implementation of HMO comprehensive community mental health benefit has been accompanied by increased administrative costs reported both by the MCOs and the provider agencies. Both report having to add staff in order to accommodate the implementation of the program.

While many of these problems also characterized the start-up phase in Area 6, some implementation issues seem to have improved in the most recent efforts. For example, consumer and family involvement has improved over time. The

PMHP has formally incorporated consumers into their management processes. The HMOs/BHOs seem to be increasingly aware of the importance of consumer involvement in care and some have begun processes to better engage them in the oversight of the program

The BHO market may have stabilized relative to the early years of the Area 6 implementation when multiple BHOs competed for HMO business. While it is too early to conclude that the market will remain stable, such stability will likely be of great help in overcoming the confusion that characterized this current start-up period.

The HMO/BHOs were successful in negotiating service relationships with the traditional community mental health providers. While providers reported that some clients were lost in the transition to the HMO comprehensive benefits, the disruption was likely not as substantial as was experienced in Area 1 where a new panel of mental health providers had to be created.

Children's Quality of Care

The in-depth case study in AHCA Area 5 of children with SED and their families did not find large differences between the quality of care or consumer outcomes financed by the HMOs and the PMHP. Consistent with the findings of the implementation study, families reported disruptions in care related to the transition, but the transition problems were not unique to either of the financing conditions. The apparent confusion with other changes in the Medicaid program related to pharmacy caused further disruptions and was reported to be associated with adverse consequences for children and their families. Similarly, provider agency policies regarding scheduled appointments and cancellations also frustrated access to services. While these are not uniquely associated with either financing condition, they may be areas for service improvement.

Pre-Implementation Mail Survey

In an analysis of administrative data, we observed some differences between HMO and PMHP enrollees. Most notably, PMHP enrollees are much more likely to be SSI beneficiaries than HMO enrollees and to meet diagnostic criteria for severe mental illness. Some initial differences were also detected in the population mail survey of enrollees conducted in AHCA Areas 5 and 7 just prior to the full implementation of managed care. Results from that survey indicated that children enrolled in the HMO had greater levels of unmet need for mental health services and lower satisfaction with both mental health and medical services than their counterparts in the PMHP. Interestingly, none of these differences were detected for adults. These pre-existing differences can not relate to the financing of the carve-out mental health services, but are more likely associated with at-risk general health and pharmacy services. To the degree to which the new 'carved-in' premium may provide an incentive to better integrate general and mental health care and to broker more comprehensive community mental health services, these differences for children may be ameliorated.

Measure Development

Finally, the new approaches to the analysis of encounter data that we tested with Area 1 data indicated both the value of the approach and some potential concerns regarding effects of differing service networks on types of services delivered and consumer outcomes. Specifically, the data indicated that when the HMO established a service network that was independent of the traditional community mental health providers, profound differences in service patterns occurred. Penetration rates for psychiatric office visits increased significantly while penetration rates for community mental health services dropped dramatically. Additionally, these changes were associated with increases in involuntary evaluations – particularly for adult males with severe mental illnesses (SMI). In contrast, arrest rates declined for HMO adults, particularly females, following the implementation of the comprehensive HMO benefits and the establishment of the new services networks. It is important to note that, although the rates declined, they ultimately equaled those of the PMHP enrollees. It would be helpful to look behind the aggregate statistics in order to determine if the changing service networks and the resulting change in access to community mental health services mediates these outcome differences. These new evaluation approaches, however, appear to more sensitive than those used in the Year 8 evaluation and will continue to be pursued next year.

Recommendations

Most of the recommendations from this year's evaluation parallel those from earlier years. They relate to careful monitoring of the implementation of the program, its performance and the outcomes experienced by enrollees. Clearly, the transition from the fee-for-service to the prepaid system was accompanied by confusion and disruption in services. Since multiple AHCA areas are anticipating implementation in the coming year, we recommend that:

- AHCA continue careful monitoring of the payment and service authorization process in Areas 5 and 7 as well as active oversight of any new implementation areas. Any procedures that can reduce the error in these processes and increase timely authorization and payment will increase service access and system efficiency. Facilitated discussions and training sessions among the providers and purchasers may be explored in a process to support the transition.
- Since at least some of the disruption associated with the transition resulted from misunderstandings between providers, purchasers, and AHCA, and, since these misunderstandings resulted in service disruptions and negative outcomes for children and their families, AHCA should explore new methods for educating providers, including line clinical staff, regarding the implications of overall changes in the Medicaid system. Better knowledge regarding the implications of system changes (like the pharmacy benefit) will not only assure more effective implementation of these changes, but also reductions in inappropriate service disruptions resulting from the misunderstandings. Additionally, AHCA will profit by direct interaction with service providers regarding the clinical implications of its policies.

- AHCA should continue to monitor service penetration rates with the minimal goal of maintaining pre-implementation levels of service. Constantine (2006) makes specific suggestions regarding the corridors within which penetration for specific types of services should be maintained and further suggests that we provide data on penetration on a timelier basis than we have in years past. Establishing concrete targets for penetration will help to assure access at, or above, that experienced prior to the implementation of prospective payment.
- AHCA should continue efforts to obtain and improve the quality of encounter data from the managed care organizations so that such real time monitoring can occur. Health, as well as mental health data, should be collected in order to better understand the integration of care and the provision of mental health services in the general health sector.

Given the suggestive relationships between the provision of specialized community mental health services and adverse outcomes for adults with SMI, we further recommend that AHCA work with FMHI to

- Actively monitor the nature of the service networks that are formed and the types of services that are provided. To the degree to which providers that have not traditionally treated populations with severe illnesses or disabilities related to mental illnesses join panels, AHCA should assure their ability to deliver the treatment, supportive, and rehabilitative services needed by these individuals.
- With the assistance of FMHI, AHCA should actively monitor administrative outcome indicators for vulnerable populations. To the degree to which these indicators change, as they did in Area 1, AHCA should work collaboratively with the MCOs to complete case studies that examine the linkage between patterns of service provision and outcomes. Based on these studies, intervention strategies should be tailored to reduce the likelihood of adverse events.
- Relatedly, AHCA should examine strategies for collecting enrollee specific data on clinical status and functioning that would help in the interpretation of the administrative indicators and provide a direct indicator of client outcomes.

AHCA should continue to pursue recommendations from earlier evaluation studies as well as those consistent with emerging standards of competent mental health care.

- AHCA should encourage the active involvement of consumers and families in program oversight and direction to help assure accessible and effective services. The educational strategies that we suggested for providers and insurers would also benefit consumers.
- While it is too early to determine if the flexibility inherent in prospective payments results in flexible services that are outside of the conventional procedure-bound Medicaid system, AHCA should continue to encourage service strategies that respond to consumer needs. More flexible, recovery oriented services were ultimately developed in Area 6, although they were not originally part of their service continuum. To the degree to which these prove helpful in Area 6, their more rapid adoption in the other areas of Florida is sensible.

- In the mail survey, unmet need for mental health services occurred at twice the rate for unmet need for physical health services. This persistent finding underscores the importance of improving access to mental health services. Problems with transportation, service hours, missed appointment policies, should all be investigated to improve access.

Following the release of the President's New Freedom Commission report on mental health, Florida and other states began efforts to transform their mental health systems. Medicaid financing strategies are central to the transformation efforts. Mental health managed care programs should embrace the vision of system transformation, the promotion of resilience for those without disabilities and recovery for persons who have experienced disability related to mental illnesses. In a resource constrained environment that only promises to become more constrained, it is essential that Medicaid managed care strategies be optimally used to promote efficiency and the delivery of effective services to foster population well-being.

Introduction

The National Context

Several important themes continue to dominate Medicaid policy discussions. First, is the effect of Medicaid on state budgets. The National Association of State Budget Officers (2004) noted that in 2003 Medicaid budgets became the largest component of many state budgets and in both 2002 and 2003 they were the fastest growing single component of state budgets. Containing costs and appropriately managing the Medicaid budget, therefore, is a paramount concern for states.

Second, at the same time that Medicaid costs have grown to dominate state budget discussions, mental health services have come to increasingly rely on Medicaid funding. While state mental health authorities have traditionally used state general fund resources to finance public mental health services, during the last two decades these funds have been used to match federal funds and expand the overall budget available for mental health services to Medicaid enrollees (Frank, Goldman and Hogan, 2003). Nationally, Medicaid expenditures for ambulatory mental health services exceed state general fund expenditures by at least 10% (Lutterman, Hollen & Shaw, 2004). One unintended consequence of this fund shift to Medicaid may be the ‘squeeze out’ of individuals who are not enrolled in Medicaid, but who can not afford to purchase mental health services or who do not have insurance that will reimburse for these services. Public mental health services have become increasingly reliant on Medicaid, making cost containment strategies important for both enrollees and the uninsured.

Third, concerns with the quality of care and the health status of populations further complicate the discussion. While the United States spends more on health care per capita than any other industrialized nation, our outcomes continue to be mediocre at best (Anderson and Poullier, 1999). Disparities between per capita expenditures and population health status relate both to access and quality of care. Insurance availability and benefit design can both impact access to care. Clearly, the uninsured are losing access to care through the Medicaid squeeze out. Unmanaged utilization, to the degree it creates inappropriate over-utilization, and Medicaid pricing policy can also dampen access – particularly when budget caps are enforced and prices are at or below the cost of delivering care.

In 2005, the Institute of Medicine documented ongoing problems with the quality of care and suggested differing strategies for addressing the quality and efficiency gap in contemporary health care. Methods to improve care that increase the efficiency of our system and return on our health care investment are also prominent features of the policy discussion.

A dominant strategy for addressing these concerns in mental health during the last decade has involved the development and implementation of mental health managed care programs (Frank, et al, 2003). These programs seek to contain cost through prospective payment systems which typically are capped slightly below fee-for-service-billings. Additionally, they provide incentives for providers to

appropriately manage the volume of care so as to increase efficiency and perhaps increase overall access by reducing over-utilization. Reductions in treatment variability and improvement in quality were also thought to be characteristic of managed care strategies as was preventatively oriented care to avoid expensive acute and crisis care services. While the cost containment objectives have generally been met through managed care approaches (Frank et al, 2003; Mechanic & McAlpine, 1999), their impact on quality and outcomes are less well established (Mowbray, Grazier and Holter, 2002; Shern et al 2004).

Florida Context

The Agency for Healthcare Administration (AHCA) oversees Florida's Medicaid program. It began managed care efforts in 1984 for general health services and expanded to prepaid mental health programs (PMHPs) in specialty mental health care in 1996. Following the evaluation of the demonstrations in the Tampa Bay and Panhandle regions of Florida (Shern, et al; 2004, 2005), the Florida legislature authorized AHCA to establish prepaid mental health programs throughout the state.

This is the 9th in a series of yearly reports that documents the implementation of these specialty managed mental health programs. In this year's analysis, we focus on the development of prepaid programs in AHCA Areas 5 and 7, presenting information about the start up phases in these areas as well as information about the inclusion of comprehensive mental health benefits that are being managed by Health Maintenance Organizations (HMOs) throughout Florida. In addition to an implementation analysis, we are including summary findings from a children's quality of care study conducted in Area 5 and a mail survey of Medicaid enrollees conducted in Areas 5 and 7 just prior to the implementation of mental health managed care. Finally, we present a series of analyses of previously obtained administrative data for the period of January 2001 to June 2004 from the Area 1 implementation of managed care in which we examine new approaches for evaluating service penetration and outcomes.

Medicaid Managed Mental Health Services in Florida

Two approaches are employed to manage mental health services in Florida. The first is a behavioral health care "carve-out" plan in which a specialty behavioral health managed care organization provides or arranges for a specified range of mental health services for plan participants, including community mental health, targeted case management, and psychiatric inpatient services. In this pre-paid arrangement, the managed care organization is paid by AHCA a fixed monthly fee per enrollee rate based on prior utilization. This is the Prepaid Mental Health Plan or PMHP.

In the second managed care approach, HMOs receive a risk-adjusted premium that includes general health, pharmacy, and a range of community mental health services identical to those in the pre-paid plan. Since HMOs receive an integrated premium for all three components of the benefit, these arrangements are characterized as a "carve-in" purchasing arrangement. HMOs arrange health, mental health, and pharmacy services for their enrollees through sub-contractual

agreements with providers or behavioral health managed care organizations. Both the PMHPs and HMOs in the demonstration sites are at financial risk for the mental health service utilization of their enrollees for the services that are specified in their contractual arrangements, which we refer to as the carve-out services.

Services excluded from managed care include Florida Assertive Community Treatment (FACT), behavioral health overlay services, comprehensive assessments for children, the Statewide Inpatient Psychiatric Program (SIPP), Therapeutic Group Care Services (TGCS) substance abuse services, and specialized therapeutic foster care. Outside of Areas 1 and 6, children in the child welfare system also are currently excluded from these managed care arrangements.

Table 1 summarizes the differential risk arrangements that characterize the two managed care financing conditions that are contrasted in the evaluation. The financing conditions differ in their financial risk arrangements for health, mental health care, and pharmacy. The HMOs are fully at risk for all three categories of services, while the PMHPs are not at risk for medical or pharmacy benefits which continue to be reimbursed on a fee-for-service basis.

Table 1
Financial Risk Arrangements

Financing Condition	Health	Mental Health	Pharmacy
Areas 5 & 7 MediPass/PMHP	No Risk	At Risk	No Risk
Areas 5 & 7 Other AHCA Areas of the State HMOs	At Risk	At Risk	At Risk

Outside of the areas in which PMHPs have been implemented, comprehensive mental health services for Medicaid enrollees are either reimbursed through a fee-for-service mechanism in which the state is at risk for mental health service utilization or as part of an HMO administered benefit where the HMO bears the risk. In addition, prior authorizations for inpatient admissions and intervention strategies for intensive service users are managed statewide by First Health, a utilization management firm. These services began in 1997. Medicaid requires prior authorization for three additional services—day treatment, intensive therapeutic onsite services, and rehabilitation day treatment on a targeted basis for some providers.

Implementation Analysis

This implementation analysis describes the organizational structures, financing arrangements, and program features of the PMHP and the various HMO plans that added expanded mental health benefits as of December 31, 2005. During 2005-2006, AHCA expanded prepaid mental health plans in two new areas of the state, Area 7, comprised of Orange, Seminole, Brevard, and Osceola Counties, and Area 5, which includes Pinellas and Pasco Counties. The PMHPs in both areas became operational in August 2005.

In addition to the prepaid plans, Medicaid HMOs have expanded their mental health benefits to include community mental health services in AHCA Areas throughout Florida, once they demonstrated readiness and were granted approval by AHCA to proceed. While no new managed care organizations providing comprehensive mental health services entered the market in 2005, every AHCA Area now has at least one HMO providing expanded mental health care benefits. Further expansion of Medicaid HMOs is anticipated during 2006-2007 and additional prepaid plans are also expected to be established in AHCA Areas 2, 3, 4, 8, 9, and 11. Table 2 shows the PMHP and the HMOs/BHOs operating in Areas 5 and 7 and when they began implementation.

Table 2
Implementation of Managed Mental Health Care

Counties	Managed Care Organizations					
	Ameri-group	HealthEase (Harmony)	Staywell (Harmony)	Citrus Healthcare (CompCare)	United HealthCare (United Behavioral Health)	PMHP FHP/ Value Options
Pinellas	4/1/05	5/1/05	5/1/05	9/1/05	9/1/05	8/1/05
Pasco	4/1/05	5/1/05	5/1/05	9/1/05	9/1/05	8/1/05
Orange	3/1/05	4/1/05	4/1/05	n/a	9/1/05	8/1/05
Seminole	3/1/05	4/1/05	4/1/05	n/a	9/1/05	8/1/05
Brevard	7/1/05	9/1/05	9/1/05	n/a	9/1/05	8/1/05
Osceola	3/1/05	4/1/05	4/1/05	n/a	9/1/05	8/1/05

Source: Agency for Health Care Administration, April 17, 2006, personal communication.

Methods

In order to document the implementation of these managed care plans throughout Florida, we conducted semi-structured, in-person interviews with key administrative staff from the PMHPs and HMOs/BHOs as well as provider organizations in their networks. A total of 24 interviews was conducted, four with managed care organizations and 20 with providers. Information was also obtained from observing Advisory Committee Meetings in Areas 5 & 7.

Each managed care plan was asked to provide a list of their current service networks and to identify the high volume providers within their networks. We then identified high volume providers who were providing services for more than one managed care plan (e.g., two HMOs or an HMO and the PMHP). Providers

that served more than one managed care plan were interviewed in each of the expansion areas. Face-to-face interviews were conducted onsite at each agency. Of the 20 interviews with providers, six were conducted within Area 7 and four were conducted in Area 5. Three additional in-person interviews were conducted with agencies in the HMO service networks that were providing the expanded mental health benefits, two in Area 8 and one in Area 11.

Due to the large number of sites across the state where HMOs expanded their mental health benefits, we conducted telephone interviews with randomly selected providers from each of their networks, focusing on those areas without PMHPs. After extensive attempts to contact and follow up with providers, some of who were in solo or small group practices while others were in larger agencies, we successfully completed 7 interviews. Table 3 below indicates the AHCA Areas and MCO networks that were represented in our phone interview sample.

Table 3
Supplemental Phone Interviews with HMO Network Providers

Provider Interviews	MCO Networks Represented	AHCA Area/County
Interview #1	Amerigroup, Harmony/HE	Area 4 Volusia County
Interview #2	Amerigroup, Harmony/SW & HE, United, PMHP	Area 7 Orange County
Interview #3	Amerigroup, Harmony/SW & HE, United	Area 3 Lake County Sumter County
Interview #4	Amerigroup, United	Area 5 Pinellas
Interview #5	Amerigroup, Harmony/ SE & HE, United	Area 10 Broward County
Interview #6	Amerigroup, Harmony/SW & HE	Area 8 Lee County
Interview #7	Amerigroup, United, Harmony/SW & HE	Area 9 Palm Beach County

Three different interview protocols were developed: the MCO survey, the provider face-to-face survey and the provider telephone survey. The MCO survey measured MCO organizational structures; financial arrangements with their providers; clinical management strategies, including utilization management processes and clinical guidelines; management information systems; consumer and family involvement; and implementation issues that they experienced during 2005-2006. For the larger provider organizations, such as the community mental health centers, we conducted in-person interviews in which we collected information regarding their organizational structures, their relationships with the managed care organizations, their services and clinical management processes, management information systems, consumer and family involvement, as well as concerns regarding managed care implementation. A shortened version of the provider interview protocol was used for the phone interviews. In all instances, the survey protocols were provided in advance of the interviews. A few agencies/ individuals elected to complete them prior to the visit or to send them by mail rather than complete a telephone interview.

Individuals who participated in either the telephone or in-person interviews were asked to sign an informed consent form. Interviews were audio taped and transcribed. Interviewer notes and the transcriptions were used in the data analysis. Each interviewer conducted content analyses of the interviews they

completed to identify common themes. The results were then shared among the interviewers to identify consistent themes across interviews.

Administrative data from AHCA enrollment files were used to describe the characteristics of the enrolled populations in the expansion sites with respect to gender, age, eligibility status, race, ethnicity, and diagnoses. Data from the administrative files were obtained for the 12-month period prior to the specific implementation dates in the expansion sites for each of the managed care plans.

While we report differences between the PMHP and the HMOs/BHOs as if the HMOs/BHOs were a single group, we recognize that not all HMOs/BHOs operate in the same way. In fact, in our interviews with providers, it was not uncommon for them to refer to a specific HMO/BHO in their remarks. However, the concerns identified in this summary reflect the views of providers across all the AHCA areas included in this study.

Also, we successfully conducted interviews with only a small sample of providers in the HMO networks outside the areas in which the PMHPs are currently operating. Consequently, we would caution against overgeneralization of those findings. Additionally, most of our interviews were conducted with administrative staff, as opposed to direct service or program staff; consequently, we have only limited information regarding how direct service staff or services have been affected by these managed care strategies. We also did not interview any consumers or families about their experiences in this transition, but plan to do so in the coming year.

Background

Area 5. AHCA Area 5 is comprised of Pasco and Pinellas counties in the Tampa Bay region. Of the two counties included in the demonstration, Pinellas County has the larger population (921,482) and a land area with a population density of 3,292 per square mile. Pasco County has a more rural population than Pinellas County, with a population density of 463 persons per square mile and a total population of 344,765 (U.S. Census Bureau, 2000).

There are differences in age, race/ethnicity, and income between the two counties. Pinellas County has a lower median age (43) as compared to Pasco County (45) and is more racially diverse. Approximately 9% of the Pinellas population reports their race as Black or African-American; fewer than 5% are of Latin or Hispanic origin; 2% are Asian American and another 3% report as another race or identify as bi-racial. Pasco County has much smaller minority populations (2% Black or African American; under 6% are of Latin or Hispanic origin; fewer than 5% report being of another race or identify as bi-racial) Pinellas County has a higher per capita income (\$23,497) compared with Pasco County (\$18,439) (U.S. Census Bureau, 2000). There are approximately 142,000 Medicaid recipients in Area 5 (AHCA Enrollment Report, March 2006).

Area 7. Of the four counties included in AHCA Area 7, Orange County has the largest population (896,344). Brevard and Seminole Counties have population sizes of 476,230 and 365,196, respectively, but differ significantly in

land area and population density. Seminole County is the smallest geographically (slightly more than 300 square miles) and is the most densely populated of all four counties (1,185 persons per square mile). Osceola County is the least densely populated with only 130 persons per square mile and a total population of 172,493 (U.S. Census Bureau, 2000).

There are differences in age distribution among the four counties, with Orange having the lowest median age (33) and Brevard having the highest (42). Osceola has the lowest per capita income (\$17,022) and Seminole has the highest (\$24,591). Orange County has the most culturally diverse population of the four counties with 18% of its population reporting their race as African American or Black and 19% reporting their ethnicity as Hispanic. The other three counties have smaller African-American populations (between 7%-9%). Osceola County has the highest percentage of its population reporting their ethnicity as Hispanic (29%) with Seminole reporting 11% and Brevard reporting only 5% (U.S. Census Bureau, 2000). There are almost 250,000 Medicaid recipients in Area 7 (AHCA Enrollment Report, March 2006).

Public Behavioral Healthcare Provider Market

Area 5. In Pinellas County there are 3 community mental health centers that provide comprehensive mental health services. Directions for Mental Health primarily serves the Clearwater, Largo and Tarpon Springs areas in Pinellas County, the Suncoast Center for Community Mental Health serves the St. Petersburg area, PEMHS (Personal Enrichment through Mental Health Services) serves the entire county as the public receiving facility for Pinellas County and offers emergency, short term residential and inpatient services with a strong focus on children and families. Boley Center, Camelot Community Care and Gulfcoast Jewish Family Services are other providers in the Pinellas area that provide specialized services, such as psychosocial rehabilitation services, supported housing, services to elders and residential and therapeutic services for children, especially those in the child welfare system. The Harbor (Baycare) is the comprehensive community mental health center that serves Pasco County.

Area 7. There are four major comprehensive mental health providers in Area 7, each serving one of the four counties that comprise the area. Lakeside Alternatives primarily serves Orange County, Circles of Care serves Brevard County, Seminole Community Mental Health Center serves Seminole County, and Park Place serves Osceola County. Each agency offers a comprehensive array of services, including emergency/acute care, outpatient services, substance abuse services, and residential care. There are other providers in each of the counties that provide specialized services, such as children's residential services and a number of independent practices and small clinical groups that provide services to Medicaid enrollees in the various plans.

Health Maintenance Organizations

There are five Medicaid HMOs/BHOs in Area 5 and four in Area 7 providing the full array of community mental health services through their provider networks.

HealthEase and Staywell (sister HMOs within the Wellcare organization), Amerigroup, and United Health Care are operating in all six counties in Areas 5 and 7. At this time, Citrus Health Care provides comprehensive community mental health services in Pinellas and Pasco Counties only.

HMOs have created large networks that include comprehensive community mental health centers as well as individual and small group practices. Two HMOs report having more than a hundred providers listed in their networks within Areas 5 and 7.

Enrollment Characteristics

According to AHCA's March 2006 Enrollment Reports, in both Areas 5 and 7, the largest percentage of Medicaid enrollees are enrolled in HMOs (63%, [58,822] and 73% [134,116] respectively). A relatively greater proportion of enrollees in Area 5 are enrolled in MediPass/PMHP condition, approximately 37% (34,965), as contrasted with 27% (50,159) in Area 7. For individuals who fail to choose a plan (either MediPass or a Medicaid HMO) it is still Medicaid's policy to assign 50% of all eligible Medicaid enrollees to an HMO.

Not everyone enrolled in MediPass is eligible to participate in the PMHP. For example, individuals who are dually enrolled in Medicaid and Medicare, individuals enrolled in the Medically Needy programs, and individuals receiving hospice services, are excluded. In addition, there are certain Medicaid enrollees who, while they are receiving services in other special programs, are disenrolled from the managed care plans (e.g., children in residential treatment, children and adolescents being served in the Statewide Inpatient Psychiatric Program, people who receive Assertive Community Treatment Services, or children receiving behavioral health overlay services in residential programs). This year, because of the impending implementation of a special statewide PMHP for children in Home SafeNet (child welfare), children engaged in child welfare are also exempt from being enrolled in either the PMHP or the HMOs (except in Areas 1 and 6, where they were already included). The following table reflects the numbers of individuals enrolled in the various plans in Areas 5 and 7.

Table 4
Managed Care Enrollments April 2006

Counties	Amerigroup	Citrus Health Care (CompCare)	HealthEase (Harmony)	Staywell (Harmony)	United (United Behavioral Health)	PMHP FHP/ Value Options
Pinellas	18,843	3,045	5,246	7,839	3,582	19,080
Pasco	7,502	1,790	4,462	5,012	1,501	10,216
Total Area 5	26,343	4,835	9,708	12,851	5,083	29,296
Orange	21,986	n/a	13,204	27,311	9,760	23,660
Seminole	4,061	n/a	2,902	5,032	4,279	4,592
Brevard	1,495	n/a	8,605	10,467	1,999	9,342
Osceola	5,089	n/a	5,679	8,777	3,470	5,144
Total Area 7	32,631	n/a	30,390	51,587	19,508	42,738

*Source: Agency for Health Care Administration, Bureau of Managed Care, April 3, 2006, personal communication.

We examined demographic differences of the enrolled populations in the two financing conditions in Areas 5 and 7 prior to implementation of managed mental health care. These findings are presented below in Tables 5 and 6. We found few differences in the demographic characteristics of the HMO and PMHP enrollees. There are differences, however, in the percent of individuals with disabilities in the respective plans. In Areas 5 and 7, SSI recipients comprise 26% and 29%, respectively, of the MediPass enrollees while they represent between 8% -13% of the HMO population. Consistent with these differences in disability rates, the MediPass conditions are also more likely to have persons with the serious mental health diagnoses of schizophrenia, bipolar disorder, major depression, attention deficit hyperactivity disorder (ADHD) or oppositional defiant disorder. There were also more individuals ages 55-64 enrolled in MediPass than the HMOs prior to implementation.

Table 5
Area 5 Medicaid Enrollee Characteristics

Enrollee Characteristics	Managed Care Organizations					
	PMHP	Ameri group	HealthEase (Harmony)	Staywell (Harmony)	United	Citrus (CompCare)
Females	53%	56%	56%	56%	58%	57%
Age <21	73%	75%	71%	74%	74%	71%
Age 55-64	5%	2%	2%	2%	2%	2%
Hispanic	7%	7%	8%	6%	7%	7%
African American	21%	32%	23%	31%	25%	27%
SSI	26%	12%	13%	13%	9%	8%
Serious MH Diagnoses	13%	6%	6%	6%	3%	4%

Table 6
Area 7 Medicaid Enrollee Characteristics

Enrollee Characteristics	Managed Care Organizations				
	PMHP	Amerigroup	HealthEase (Harmony)	Staywell (Harmony)	United
Females	52%	56%	55%	55%	56%
Age <21	77%	78%	77%	79%	73%
Age 55-64	4%	2%	1%	1%	2%
Hispanic	23%	26%	28%	22%	25%
African American	26%	38%	29%	36%	26%
SSI	29%	12%	11%	11%	9%
Serious MH Diagnoses	11%	5%	5%	5%	3%

Findings

Organizational Structures and Relationships

Florida Health Partners (FHP) was awarded the contract for the PMHP in AHCA Areas 5 and 7. FHP is a partnership of Florida Behavioral Health, Inc. (FBH), a not-for-profit provider sponsored network, and Value Options, Inc, a private, for-profit corporation. FBH and ValueOptions are each 50% owners of FHP which means they have equal voice in determining how the PMHP will operate.

FBH is comprised of the traditional community mental health centers and large mental health provider agencies in Areas 5, 6 and 7. In Area 5, the providers (Boley Centers, Suncoast Center, Personal Enrichment through Mental Health Services, Directions for Mental Health, Gulfcoast Jewish Family Services, and the Harbor) formed a network called P3G and in Area 7 the four major centers (Lakeside Alternatives, Circles of Care, Seminole Community Mental Health Center, and Park Place) formed a network called Florida Cares. Both P3G and Florida Cares are members of the board of FBH.

FHP contracts with their member agencies as their provider network. FHP also contracts with associate providers for their network, but they are not members of the FHP. In order to contract with FHP, niche providers that had previously offered only specialty services, such as targeted case management, were required to provide a core set of services (i.e., assessments, outpatient services, medication management and case management). As a result, some specialty providers like Devereux, have chosen not to join the network. Figure 1 illustrates the organizational structure of FHP.

Figure 1
Organizational Structure of Florida Health Partners, Inc.



*Source: Florida Health Partners, February 2006, personal communication.

FHP has established Regional Councils in each of the new sites. These Councils involve FHP member providers and focus on local issues and problem solving. Consumers and families are also invited to attend their meetings.

Figures 2 and 3 graphically represent the relationships that comprise the managed mental health care plans in Areas 5 and 7, respectively. The HMOs differ in the ways in which they structure their behavioral health business. Amerigroup, for example, contracts directly with their network of providers, whereas Staywell and HealthEase are represented by Harmony Behavioral Health, a behavioral health subsidiary of Wellcare that manages the behavioral health benefits for both HMOs. The behavioral health services of United Health Care are managed by United Behavioral Health, a BHO subsidiary of United Health Care. Citrus Health Care (in Area 5) subcontracts with a BHO, CompCare, to manage their mental health benefits. All of the HMOs/BHOs are currently contracting with their provider networks on a fee-for-service basis.

Figure 2
Area 5 Funding Streams as of April 2006

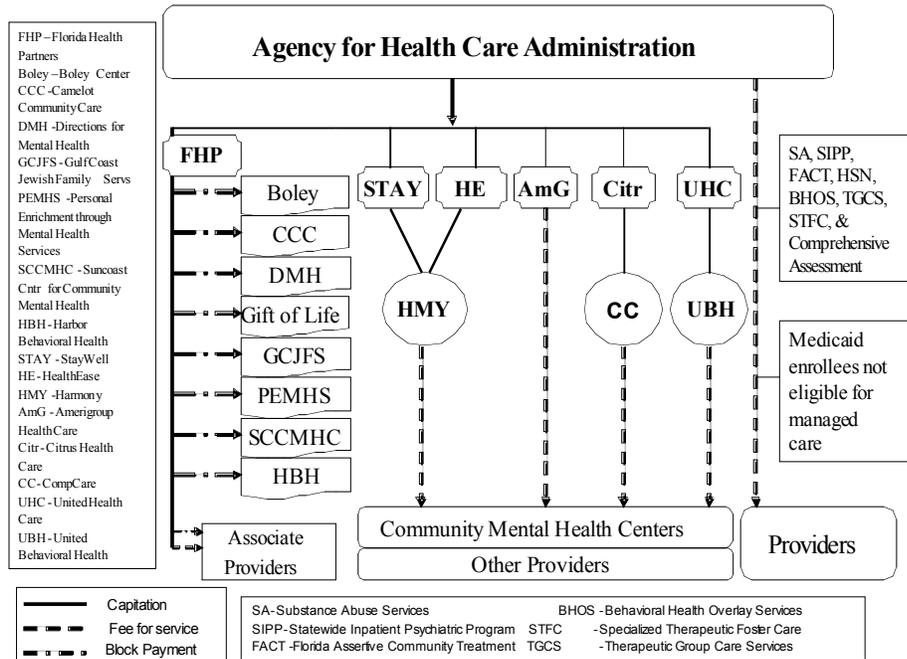
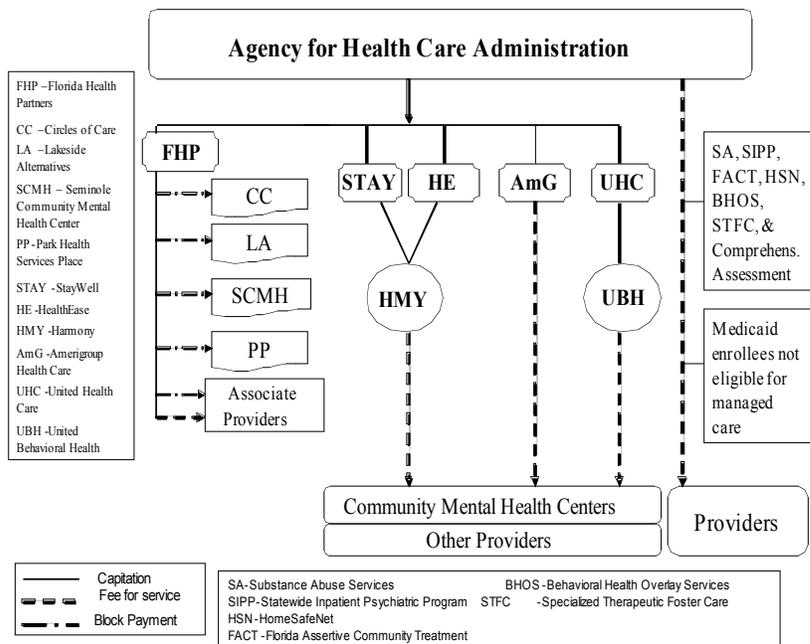


Figure 3
Area 7 Funding Streams as of April 2006



In terms of organizational changes that have occurred with the implementation of the managed mental health care benefits, MCOs and providers alike reported having added staff to meet the demands associated with the expansion of managed care. HMOs/BHOs added staff to accommodate their expansion to new areas of the state. Providers added administrative staff (in some cases as many as 12 to 14 new people) to manage prior authorizations for services and billing for the various HMOs/BHOs with which they contract.

Financial Arrangements

The PMHP subcontracts with their providers in Areas 5 and 7 using a non risk-adjusted, prospective payment methodology for community mental health services. Unlike the method used by FHP in Area 6 of assigning enrollees and their associated capitation payment to providers based upon their zip code, in Areas 5 and 7 enrollees are not assigned to specific providers. Therefore, FHP member provider payments are not linked to specific enrollees, but are based upon the providers' historical rates of service provision (i.e., numbers served, units provided and dollars spent). We refer to this payment methodology as a prospective block payment. FHP also offers a block payment to some of the other non-member providers in their network, again based upon historical billings. FHP expects to review the block payment rates annually to adjust for changes in service delivery volume to the enrolled population.

Value Options receives a fixed administrative fee (reported to be less than 15%) from the payment received from AHCA. FHP also has created a re-insurance risk pool, wherein 2% of the overall payment received from AHCA is set aside to help agencies absorb extraordinary costs incurred by a particular individual or to manage adverse selection. All providers who receive a block payment in the network can access the risk pools.

FHP maintains a pool of resources to pay for inpatient services as well as for services provided by specialty providers on a negotiated fee-for-service basis. During the initial implementation phase, FHP also created a fee-for-service pool to provide for limited transition services as individuals were changing from non-network to network providers. When these various pools are unspent, the resources are allocated to the member providers of FHP. Contractually, all PMHP providers are required to spend 90% of their payment on services.

HMOs/BHOs pay their network providers for mental health services on a fee-for-service basis. With the exception of negotiated inpatient rates, rates in the fee-for-service arrangements are typically the AHCA Medicaid fee-for-service rates. Currently, there are no capitation payment arrangements in place between the HMO/BHO plans in Areas 5 or 7 and their network providers. At least one BHO indicated that they may consider a capitated, risk-sharing arrangement in the future once they have more experience with the providers in their networks.

Management of Information Systems

FHP reports that they have made considerable changes to their MIS to accommodate the expansion to the new sites and their new role in assuring

continuity of care for their enrollees. Since enrollees are no longer assigned to particular providers, FHP has assumed much of the responsibility for assuring that there is improved communication and continuity of care among different providers who may be providing services to the same individual. This has necessitated the generation of new management reports that are shared with their providers.

HMOs/BHOs also report that they have had to make few changes to their MIS to accommodate the expansion to the new sites. Some HMOs/BHOs have added electronic systems for service authorizations, billings, and data reporting. Provider agencies in Areas 5 and 7, however, have reported that they have had to make considerable changes to their systems, including the addition of staff, to accommodate the various HMO/BHOs' fee-for-service billing procedures, since they differ for each HMO/BHO. Providers have reported that these changes have been time consuming, labor intensive and costly.

Utilization Management Procedures

FHP has contracted with providers on a block payment basis as discussed earlier, with the exception of a few services, such as inpatient care and where they purchase "capacity" such as family emergency treatment services and/or niche services such as support for child abuse victims. Consequently, authorizations for services by FHP, other than inpatient care, are not required. In order to assist providers to manage within their block payment, FHP routinely provides them information regarding their utilization rates and expenditures. Inpatient services still require authorization by FHP because they pay for those services centrally. For those agencies that maintain a Crisis Stabilization Unit (CSU) or have an inpatient unit, the first four days of services do not require authorization, but on the fifth day, FHP must be contacted for consultation regarding ongoing services.

In contrast, HMOs/BHOs are contracting with providers in both areas on a fee-for-service basis. They require prior authorization for certain services such as therapeutic behavioral health onsite services (TBOS) and psychosocial rehabilitation services primarily because of their concerns about the quality, standardization, and volume of services provided. Also, inpatient care generally still requires prior authorization. HMOs/BHOs report that they do not require prior authorization for more routine services such as outpatient visits. Providers report that one BHO provides blanket approvals "up front" for minimal amounts of services and that authorization for continued services requires that complete treatment plans be submitted.

The HMO/BHO utilization management and billing procedures have proven to be difficult for many providers in this early phase of implementation. Many of the same problems that occurred during the first year of implementation in Area 6 are being repeated in Areas 5 and 7. Providers report significant delays in reimbursements that are resulting in their accrual of large receivables from the HMOs/BHOs (some of which are reported to be over \$100,000), causing some providers to re-assess their contractual relationships with at least one of the HMOs. Some providers reported that the HMOs/BHOs have offered minimal to no training on the new authorization and billing procedures.

HMOs/BHOs, however, report that despite considerable efforts on their part to train and assist providers with billing procedures, there are multiple problems associated with providers failing to submit accurate billings and to get proper authorizations for services that cause delays in reimbursement or denial of payments.

Service Provision

Access

Both the PMHP and HMOs are contractually required to meet the AHCA access standards that prescribe the timeframes within which enrollees must be able to access care. These same requirements are passed on to providers in the networks who will be monitored for compliance. People enrolled in either the PMHP or the HMOs can access services without having to obtain a referral from their plan. However, providers report that they are providing fewer services now to individuals than before the implementation of managed care, especially for HMO enrollees. Some providers indicated that they believed that a number of individuals were lost in the transition period when they were being transferred from non-network providers to network providers.

Guideline Use and Quality of Care

FHP contractually requires providers to use a set of clinical criteria provided by ValueOptions (VO) for all levels of care determinations. In addition, recommended diagnosis-based treatment guidelines are given to providers during implementation of the PMHP. In the new sites, additional guidelines were added to accommodate AHCA's requirement that there be criteria and guidelines used for every Medicaid service. Reportedly, however, FHP is moving to the use of APA guidelines. The HMOs/BHOs also use level of care guidelines, generally the McKeesson Interqual Level of Care Guidelines. In some cases, HMOs/BHOs have made clinical guidelines available to providers in their networks, but they are not required to use them.

The scope of the quality improvement program for the PMHP includes conducting quality improvement activities, analyzing and reporting of functional and clinical outcomes for service recipients through the use of the Functional Assessment Rating Scale (FARS) and the Children's Functional Assessment Rating Scale (CFARS) instruments, clinical treatment record evaluations, practitioner quality performance reviews and member satisfaction surveys. The PMHP routinely shares information with its providers on a variety of issues, such as their status in meeting the 90% service provision requirement, inpatient utilization, readmissions, member satisfaction and outcomes.

The HMOs cite mechanisms such as random file and chart audits, outlier reviews of providers, consumer and stakeholder satisfaction surveys and quality improvement initiatives to help assess the quality of care. AHCA also requires HMOs to collect functional outcome data using the FARS and CFARS instruments, and to report that information to AHCA in their encounter data submissions. However, the degree to which these data are being collected by the HMOs was not determined. However, at least one of the BHOs is seeking to use

functional outcome measures to improve services to children and adults. Providers report that they get little, to no feedback from the HMOs with which they contract, in contrast to the types of information that they receive from FHP.

Continuity/Coordination of Care

The network providers for the PMHP and the HMOs/BHOs in Areas 5 and 7 offer a full array of community mental health and substance abuse services. They also have longstanding relationships with other service agencies in their communities. If an enrollee needs a service they do not provide, they can make arrangements with other providers to either be paid fee-for-service by the plan or, for Medicaid services not covered by the plans, paid by AHCA. Medicaid enrollees in both the PMHP and HMOs/BHOs may also receive services, such as residential care, supported employment, that are funded through the DCF.

There were mixed responses to the question about coordination of mental health care with a person's physical health care. However, most agencies reported making some efforts to contact individuals' primary care physicians, especially in those instances where the enrollee has more complex medical conditions. One HMO noted that they are making efforts to better integrate their behavioral health services with other medical care that their enrollees may receive through their plan.

Consumer/Family Involvement

The PMHP reports that the clinical criteria that their providers have adopted require the involvement of consumers and families in treatment. Their involvement is monitored in treatment record audits. The PMHP has also created two consumer affairs coordinator positions that help to enhance consumer and family participation. Consumers and families are also invited to attend the FHP Member Advisory Committee meetings as well as the Regional Councils.

One of the BHOs has a consumer advocate working at the local corporate level and is reaching out to consumer and family organizations as they have expanded their services in other areas of the state. Others have reported minimal involvement of consumers and families in their organizations, although they have expressed interest in greater involvement.

Consumer and family involvement at the provider level varies in the expansion sites. Some providers have advisory committees in which consumers participate. Others report that there are consumers and/or family members on their boards of directors. Some providers have employed consumers in their programs. The MCOs do have expectations that consumers and families will be involved in their treatment, but do not appear to have explicit expectations regarding their involvement at the provider organizational level at this time.

Cultural Competency

MCOs report that their materials (member handbooks, satisfaction forms, etc.) are printed in English and Spanish. They also try to ensure that their providers have bi-lingual staff. (Some MCOs are collecting information from providers regarding their staff on a regular basis.) They have access to interpreters

that can accommodate individuals who speak languages other than English, and can provide for individuals with hearing impairments and blindness. Providers also report having bilingual staff, but some have indicated that they are having difficulty recruiting staff of different racial and ethnic backgrounds.

HMO Expansion in Non-PMHP AHCA Areas

HMOs have expanded their mental health benefits in several additional areas of the state where there has yet to be a PMHP implemented. The chart below shows those AHCA Areas and counties in which HMOs began to offer additional mental health benefits in 2005. In all but one of the AHCA Areas (Area 10), there are counties in which there are currently no HMOs providing the full array of mental health benefits. Table 7 identifies those AHCA Areas where HMOs have expanded to include the community mental health benefits.

Table 7
HMO Sites Offering Expanded Mental Health Benefits

HMOs

New AHCA Areas/ Counties	Amerigroup	Staywell	HealthEase	United
Area 2				
Calhoun			6/1/05	
Gadsden			6/1/05	
Jefferson			6/1/05	
Leon			6/1/05	
Liberty			6/1/05	
Madison			6/1/05	
Wakulla			6/1/05	
Area 3				
Citrus			5/1/05	
Lake			5/1/05	
Putnam			5/1/05	
Marion			5/1/05	
Hernando		5/1/05		9/1/05
Area 4				
Duval			6/1/05	
Volusia				
Area 8				
Lee	5/1/05	6/1/05		
Sarasota	5/1/05	6/1/05	6/1/05	
Area 9				
Palm Beach	6/1/05			
Area 10				
Broward	6/1/05			
Area 11				
Dade	6/1/05	9/1/05	9/1/05	

Source: Agency for Health Care Administration, April 17, 2006, personal communication

Phone interviews with randomly selected providers from the HMO/BHO networks serving these areas, as well as the areas in which the PMHP is operational, revealed many of the same concerns expressed by the agencies that were interviewed in Areas 5 and 7. The providers who participated in the phone interviews work in a variety of settings from smaller group practices to larger organizations. The majority of them reported that the requirement for prior authorizations for certain services (especially TBOS) has proven to be the most difficult and time consuming aspect of the transition to managed mental health care. The prior authorization process reportedly is also lengthening the intake process resulting in delays in service delivery.

Others reported having problems with meeting the medical necessity criteria that seem to differ with each HMO. Some providers indicated that they offer less frequent and less intensive levels of services to their HMO clients, which raises their concerns about being able to provide adequate treatment. The larger agencies have experienced significant delays (up to six months) in reimbursements and have had to hire additional administrative personnel to manage the prior authorizations and billing procedures. These unanticipated, additional administrative costs reportedly have come out of service budgets.

Enrollees in the HMOs generally access services through self-referral or through other social services; however, respondents from phone interviews report that their “no show” rates for office visits have been a problem, as high as 40% in some cases. Some providers reported that they prefer TBOS in-home services for children and families for this reason, among others, because it increases the likelihood that individuals will participate in treatment. However, given the expense of home visits and that HMOs/BHOs now reject some or all of their TBOS claims, agencies are now reconsidering these services.

Summary

It is early in the development of Medicaid managed mental health care in these new AHCA areas. The PMHPs are not yet one year old and the HMOs have just passed their one year mark in some of their expansion sites. As we saw in the early phases of implementation of managed mental health care in other AHCA areas, the transition from traditional fee-for-service to managed care has been difficult for both MCOs and providers. In this latest round of expansion, in almost all instances, MCOs and providers alike have had to add administrative staff to accommodate the demands of adding new sites, establishing new relationships, new providers (some of which have had little experience with managed care arrangements prior to the implementation of Medicaid managed mental health care in their areas), and additional expectations with respect to prior authorizations for services and complex billing procedures. MCOs have had to learn about the complexities of each new community as well as to understand the varying capabilities of the providers in their networks. Providers have had to quickly develop capacities to respond to the unique requirements and procedures of the various MCOs with which they contract and in some instances, have had to continue providing services to individuals without clear assurances that they

would be paid. There is mixed optimism among the providers that these issues will be resolved quickly. Some providers have begun to question whether or not they will continue to contract with at least some of the HMOs to provide mental health services to their Medicaid enrollees.

MCOs and providers have had to add administrative staff to accommodate the expansion of Medicaid managed mental health care, while having to adjust to reductions in the overall Medicaid revenues for mental health that are allocated to each AHCA area. Agencies also reported that they have had to lay off direct service staff (e.g., case managers) in order to avoid incurring deficits. They attribute these staff reductions to restricted authorizations for services and lack of payment. This has particularly affected children's services in Area 7, where a major children's services provider was unable to negotiate a successful arrangement with the PMHP. This failure to negotiate a contract caused other providers in the PMHP network to "rebuild" their children's services that for some had been discontinued or scaled back due to earlier changes made by the Department of Children and Families in the way funds for children's mental health services were administered. Reportedly, there were several hundred children and families who needed to be transferred to other providers. It was unclear that those transitions occurred successfully.

Providers in Area 7 have also raised specific concerns about being reimbursed for services to children who are in the child welfare system and are excluded from participating in the PMHP or the HMOs operating in that area. The time involved in identifying the correct source to bill for their services has caused some providers to experience significant delays in payments or loss of reimbursement. The problem has been raised both with AHCA and DCF, and there are efforts to address the problems on a case-by-case basis. However, until the Child Welfare PMHP is established and there is one payer identified for their services, it is not likely that the underlying problems will be resolved soon.

Providers report that their relationship with the PMHP is going well. They appreciate the flexibility made possible by block financing arrangements and the feedback they receive from the PMHP related to their performance. Many providers indicated that they would welcome similar feedback from the HMOs/BHOs regarding such things as their levels of service delivery compared to other providers and even with other states in which the HMOs operate. Unfortunately, to this point, most of the communication with the HMOs/BHOs has focused on administrative problems associated with prior authorizations and billing procedures. Providers indicated a need for more consistent information from the HMOs/BHOs related to these administrative processes, preferably in writing, especially in these early months of the transition to managed mental health care.

HMOs/BHOs have reported that the rapid rate of expansion in the diverse areas of the state has made it difficult for them to address many of the issues that emerged in the process, especially as they included providers in their networks with little experience with managed care and who may vary widely in the way they provide services. They indicated that many agencies have had difficulty in submitting 'clean' claims even after their many attempts to provide assistance to their billing staff.

In conclusion, it is clear that issues related to prior authorization and billing procedures associated with some of the fee-for-service financing arrangements have dominated the implementation of managed mental health in the expansion sites. These issues generated many of the same concerns among providers that were experienced initially in Area 6. Providers' cash flow has been interrupted and reportedly, the rate of uncompensated care has grown. Some provider agencies have indicated that they may have to begin denying services to HMO enrollees if they do not have assurances that their care is authorized. The effects of this transition to managed care on the viability of the specialty mental health providers that have traditionally provided mental health services for people with serious mental illnesses are unclear. We will continue to address these concerns in our evaluation of the expansion of managed mental health care.

Given the complexities of these managed care arrangements and the loss of revenues among providers in a system that is already leanly funded, it is not surprising that this first year has been challenging for MCOs and providers alike. Frequent and open communication between the MCOs and their providers will be important in successfully addressing these challenges.

Children's Quality of Care Study

Background and Methods

As we have done previously in Areas 1 and 6, a special study was conducted evaluating the effects of financing conditions on children with SED and their families. This year, the child quality of care study was conducted in AHCA Area 5 and included the following managed care organizations: ValueOptions, Harmony-Healthcase, and Amerigroup. The MCOs were selected because they were operational for at least six months as of February 1, 2006. Claims data from a sample of 50 children with SED (30 males and 20 females) who ranged in age from 9 to 17 were requested from each MCO involved in the study. A total of 42 semi-structured interviews using a fixed protocol were conducted with caregivers from the sampled families. Provider agencies serving children in AHCA Area 5 were identified using the claims data provided by the MCOs. Thirty interviews were conducted with providers from identified provider agencies. The interviews with both caregivers and providers addressed implementation of the program, access to care, appropriateness of services, family engagement, and child/family outcomes. Narrative responses were recorded verbatim and independently analyzed by two coders who developed themes and summarized the findings. A total of 29 file reviews were also conducted using the sample of 50 children obtained from each MCO. A full report of the findings may be found in Vargo, Sharrock, et al, (2006).

Findings

Implementation of Managed Care

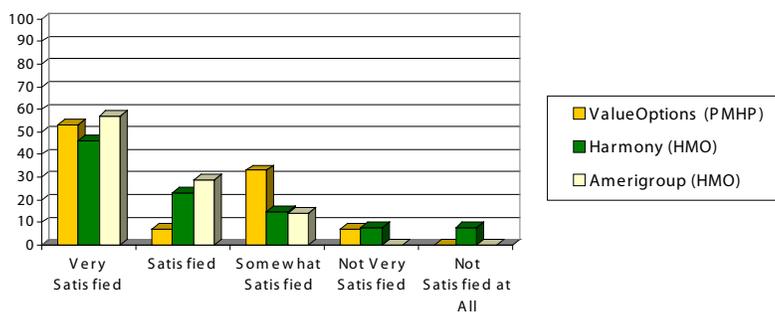
Although some providers indicated that certain aspects of managed care policies and procedures facilitated effective service delivery, both providers and caregivers expressed a variety of concerns. Changes, such as reductions in the volume and variety of services, as well as difficulties obtaining desired medication caused problems for some families. Mirroring the results from the overall implementation evaluation, providers reported that additional paperwork requirements, delays in service authorization, delays in payment, and confusion over plan specific requirements negatively impacted the quality of services they were able to provide. Providers and caregivers also expressed frustration at the lack of support during the transition to a managed care system and felt that insufficient notice of the changes was provided. Families' experiences with managed care did not appear to differ between the two financing conditions.

Access to Services

Caregivers indicated that the location and time of services were convenient; providers and caregivers both mentioned the availability of evening and weekend hours offered by most of the provider agencies in AHCA Area 5. However, interviews revealed that although provider agencies offered evening and weekend hours, it was sometimes difficult to obtain appointments during these times and caregivers often had to schedule earlier appointments which forced them

to miss work and/or take children out of school. Forty percent, 23%, and 29% of ValueOptions, Harmony, and Amerigroup caregivers, respectively, indicated they had missed time from work or other activities due to mental health services needed by their child. Some caregivers mentioned having to use sick or vacation time while others indicated that they lost their job due to the number of days they were absent for appointments and other activities related to the care of their child. Although caregivers reported several problems in accessing care, overall, they were generally satisfied with the mental health services provided to their children (Figure 4).

Figure 4
Caregiver Satisfaction with Mental Health Services Provided to Their Children



Some caregivers also indicated that they had been put on a wait list prior to receiving services. ValueOptions clients reporting being put on a wait list the most often (46%) compared to Harmony (8%) or Amerigroup (0%). Families and providers also expressed frustration at the limited number of treatment resources in Pasco County. The Harbor Behavioral Health is the only community mental health center in Pasco County. Families either had to utilize services from the Harbor or drive out of the county, which resulted in transportation problems for some caregivers.

Additional issues raised by caregivers and providers in both Pasco and Pinellas County included long wait lists, the elimination of some in-home counseling services, confusion related to the Medicaid cab service, and the reduction in the number of case managers willing to transport clients to and from services. Although bus service is available in Pasco and Pinellas County, caregivers and providers indicated that it was inadequate, citing an inconvenient bus schedule relative to appointment times and the challenge of transporting children with behavioral problems on the public bus system.

Childcare for siblings of children receiving services was also raised as an issue. Although the majority of providers indicated that they allowed caregivers to bring siblings to appointments, providers felt this was distracting and not conducive to providing quality care. In addition, caregivers and providers experienced challenges with the Medicaid cab when transporting siblings for appointments; some cab drivers were only willing to transport one adult and one child. This forced caregivers to find childcare for children not receiving services.

In addition to childcare expenses, other costs mentioned by caregivers included fees for missing or being late to appointments and lost time from work. Providers mentioned that families had to pay prescription co-payments, however, more than one managed care organization reported that there were no prescription co-pays. Although the medication co-pays were normally relatively low (about five dollars), providers were concerned that this expense might be significant when clients had to fill multiple prescriptions more than once a month. In addition, caregivers mentioned that some providers charged a late or cancellation fee, normally ten dollars, if the appointment was not cancelled twenty-four hours ahead of time. This could be detrimental to already financially challenged families. Caregivers also expressed frustrations that they could be just a few minutes late and lose their appointment, but not be able to reschedule for several months. It is important to note that these complaints relate to the provider agencies that contract with the MCOs and not the MCOs themselves. In addition, it may be the case that providers interviewed were confusing plans regarding the medication co-pay issue (i.e., Amerigroup also has regular insurance plans that may charge a \$5 co-pay). However, as purchasers of care from these agencies and/or partners with them in the PMHP case, the MCOs are in a powerful position to impact provider policies, and perhaps the level of confusion over changes in policies.

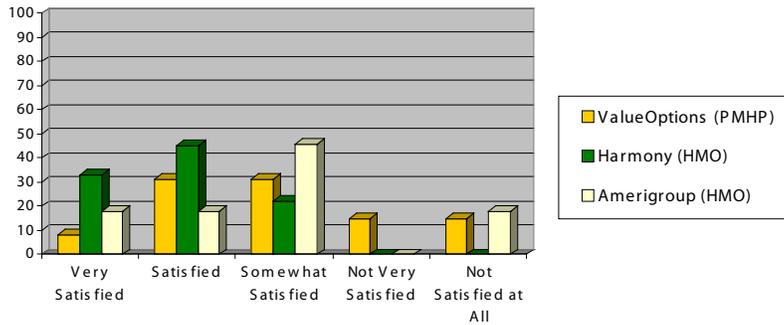
Most providers reported that there was sufficient staff to provide services, but many expressed a need for more licensed staff. This observation was especially prevalent in Pasco County where, according to provider interviews, there has been a significant population increase that has strained provider agencies. As well, unlicensed providers are supervised by licensed staff on a regular basis, but the frequency of supervision varied by agency.

Providers also raised concerns regarding the diversity of staff, pointing out that the lack of diversity among staff may be a deterrent for potential clients. Specifically, providers felt the need for more bilingual staff. Providers did report, however, that they received training on cultural competency and most seemed to be aware of cultural differences among the populations they serve.

Appropriateness of Services

The majority of children in the study were taking medication and most caregivers indicated that they were somewhat to very satisfied with the effectiveness of these medications (Figure 5).

Figure 5
Caregiver Satisfaction with Effectiveness of Medications



However, several caregivers and providers also indicated major problems related to the changing formularies used by the managed care organizations. Although the MCOs cover the same medications, the formularies for each managed care organization indicate different authorization and monitoring requirements for the same medications. Described as complex, incomplete, and continuously changing, the varying formularies resulted in children losing or having to change their medication, even if they were stable on their current medication. This caused major problems for some children who were forced to try several different medications that did not work, often causing them to deteriorate emotionally and behaviorally, before being allowed to return to their original medication.

With regard to psycho-social interventions, the majority of caregivers reported that providers discussed their child’s interests and/or strengths with them. In many cases, providers had employed best practices and standards, in conjunction with or to supplement evidence-based practice techniques.

Provider interviews revealed that managed care organizations encouraged training in and application of treatment guidelines and best practices in children’s mental health and providers reported that the managed care organizations conducted quarterly monitoring to ensure providers were following appropriate treatment guidelines. Perhaps not surprisingly, given this organizational focus, most providers indicated that they used treatment guidelines when working with clients. Providers reported learning how to implement treatment guidelines from hands-on trainings and reading books and journals. The majority of providers felt they had sufficient experience and training to work with child and adolescent populations, with 77% reporting training to work specifically with children with SED. Most providers reported participating in continuing education or in-service training during the year; licensed professionals indicated that they were required to participate in continuing education each year. In addition, all of the provider agencies involved in the evaluation reported conducting their own quality improvement process.

Consumer Engagement

Caregivers indicated that their choice of managed care plans was based on the availability of their desired physicians in the plan's network and/or the coverage of specific medication or treatment options they felt were most critical for their child. Caregivers reported choosing Amerigroup due to coverage of specific doctors and medications. Caregivers reported choosing Harmony because of the quality of care, location of doctors, the quick response time, ten dollars toward the cost of medication each month, and the fact that they were provided with a list of available doctors. Caregivers reported choosing ValueOptions because they felt they had to deal with fewer mandatory referral requirements.

Providers reported that both Amerigroup and Harmony had limits on the number of times providers could see children before they had to request authorizations and all three MCOs instituted utilization management, only paying for a certain number of hours or units of services per child per month. During data analysis, it became clear that different research participants (e.g., MCOs, providers, family members) used different definitions for the term "capitation." The primary concern here is not that one system is capitated over another, but that families and providers noticed that there were more restricted services under the HMOs and more work was required to request authorization, in contrast to the PMHP.

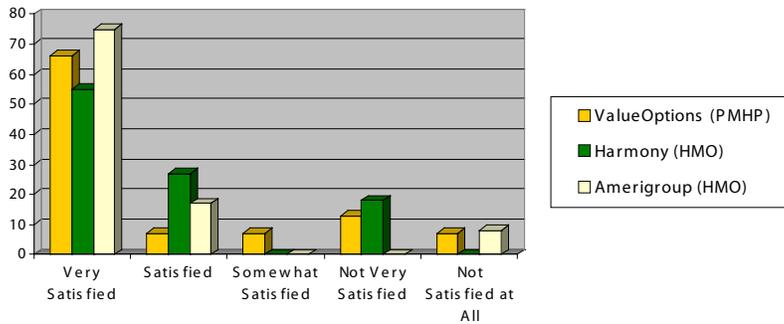
Caregivers and providers expressed concern regarding the authorization of services, reporting that children were denied services or that it took a long time to begin services due to the authorization process. Providers reported that ValueOptions did not require authorization of services and that this allowed more time with ValueOptions clients. In addition, providers reported that ValueOptions no longer covers case management services, over which caregivers and providers expressed concern. However, in the implementation analysis of managed mental health care across Florida included earlier in this report, it was noted that reductions in staff (such as case managers) was a decision made by provider agencies in order to avoid incurring deficits, rather than a decision made by managed care organizations.

Although plan restrictions limited the services providers were able to offer, providers were able to maintain caregiver input into treatment planning. Seventy-three percent, 54%, and 57% of ValueOptions, Harmony, and Amerigroup caregivers, respectively, stated that their child's provider discussed treatment options with them and the majority of caregivers reported that their specific requests were included in their child's treatment. Ninety-seven percent of providers also tried to ensure that families were aware of available services by providing a brochure or booklet listing services or discussing different options at intake. Providers also reported that they explained the treatment plan, most had the family sign it, and provided families with a copy of the treatment plan upon request. However, a small number of caregivers reported not having a treatment plan or were not aware of one being developed for their child.

Most caregivers indicated that they were offered coping strategies or suggestions on how to manage their child's behavior or the stress that resulted

from it (93% ValueOptions, 69% Harmony, 79% Amerigroup), while far fewer reported being offered trainings on how to deal with their child’s behavior (27%, 25%, and 36% respectively). Regardless, the majority of caregivers reported that they were satisfied with their level of involvement in treatment planning (Figure 6); although, some caregivers still reported that they had not been completely engaged by providers when selecting services for their child.

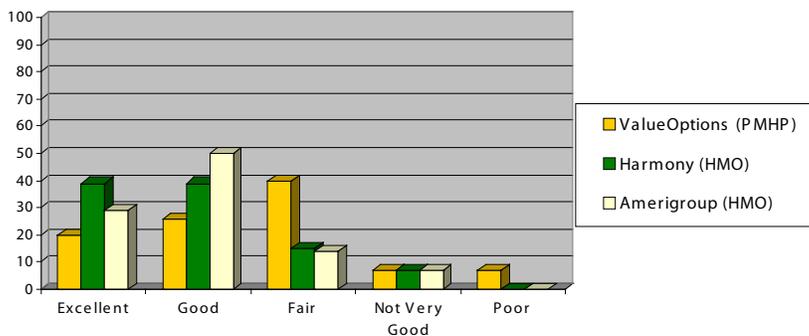
Figure 6
Caregiver Satisfaction with Involvement in Treatment Planning



Outcomes

Overall, child functioning since receiving mental health services was rated as fair to excellent by most caregivers (Figure 7), with caregivers reporting that their child’s needs were being met by the mental health services they were receiving (60% ValueOptions, 85% Harmony, 79% Amerigroup).

Figure 7
Caregiver Perception of Overall Child Functioning



Caregivers noted the following dimensions in which their child had shown positive improvements during the time they received services under managed care: increased ability to manage anger and outbursts, emotional stability, growth of personal relationships, increased socialization and interest in sports and hobbies, and a longer attention span which results in fewer behavior problems at school and better academic achievement. Caregivers attributed these positive outcomes to medication, psychosocial interventions, and the subsequent improvement in the

child's relationships and activities. However, some caregivers reported no change and, in a few cases, a negative change. Specifically, caregivers mentioned problems with depression, violent rages, mood swings, and auditory hallucinations.

Although caregivers generally reported that services had helped improve their child's behavior, they did request the following: in-home services (Harmony), anger management (Harmony), mentors (Harmony), group treatment (Amerigroup), tutors (Amerigroup), and summer recreation programs with low staff to child ratios geared toward children with SED. Two things are important to note. First, requests may not reflect a lack of available services from a specific managed care organization and that caregivers may or may not have shared these requests with their provider agency. Second, mentors, tutors, and summer recreation programs are no Medicaid allowable services so the provision of services such as these would have to be paid for through other funding sources.

Caregivers indicated that, for the most part, family well being had also improved as a result of services. Caregivers reported less stress, an increased ability to display better parenting techniques, and increased ability to take time for themselves to avoid or decrease the likelihood of burnout. The majority of providers recognized the importance of ensuring that a family's most basic needs were met in order to sustain their support and engagement in the child's treatment and ongoing stability. Providers reported helping families with housing, assisting with transportation and childcare needs, and generally monitoring of the family functioning.

Providers used several methods to track child and family progress including conducting in-home visits where they were able to assess family interactions at home and determine whether the home environment was appropriate. Providers also consulted with individuals important in the child's life, such as caregivers, grandparents, and teachers. Several providers indicated that they also reviewed previous documents related to the child's services. Providers also stressed the importance of observing caregivers, siblings, and children communicating with each other before, during, and after each therapy session.

Summary

The transition to managed behavioral health care, as well as some other changes in Medicaid policies related to pharmaceuticals, caused disruptions in care for children with SED and their caregivers. A changing authorization process and service array caused confusion and discontinuity in care. These disruptions, however, were not strongly associated with a specific plan. In fact, ratings of the Value Options (PMHP) plan, were about the same as those for the HMO providers.

The confusion regarding Medicaid formularies that existed at the beginning of fiscal year 2005-2006 further compounded these transitional issues. Caregivers reported that difficulties obtaining medications that were working for their children caused clinical deterioration as well as significant increases in family distress and disruption. Emphasizing successful continuity in care is clearly preferable to changes in care driven by fluctuating reimbursement policies.

Additional themes related to access to care emerged from the data. As with the transition issues, these access problems did not appear to be related to financing condition, but rather involved agency policies regarding after hours appointments, missed appointments, as well as a general difficulty accessing care if a planned sequence of appointments was disrupted. Given these insights, the plans should work with providers to continue to improve the accessibility of care – particularly for persons with limited resources and subsequent transportation and work absence related problems.

In spite of the disruptions that were associated with the transition to managed care and changing medication policies, caregivers generally reported that their children's behavioral health functioning improved during the year and that they were generally satisfied with the care they received.

Pre-implementation Mail Survey: Enrolled Population Health Status

As in previous years, we used a mail survey methodology to contact a sample of Medicaid enrollees in the new expansion sites, AHCA Areas 5 and 7, in order to estimate their need for and receipt of services as well as their health and mental health status, satisfaction with services and quality of life. Five hundred and six adults and 473 caregivers of child Medicaid enrollees living in AHCA Areas 5 and 7 participated in the mail survey. The goal of this component of the evaluation is to obtain and monitor a variety of Medicaid enrollee indicators in order to assess changes in these indicators over time that may be associated with the implementation of managed care programs. The findings presented here are based on a survey conducted in AHCA Areas 5 and 7 during the Spring 2005 (February through April) just as the implementation of managed mental health care in those areas was beginning. The Prepaid Mental Health Plan was not yet operational and the HMOs were just beginning to provide a full range of community mental health services. Thus, these findings reflect the status of enrollees just prior to the implementation of managed mental health care and will serve as a pre-measure in the evaluation. We provide a summary of the methods and main findings in this section. A more complete report of the mail survey may be found in Boothroyd (2006).

Methods

The sample of Medicaid enrollees was obtained from the 2004 Medicaid eligibility data. A random sample of 3,840 Medicaid enrollees was selected, stratifying on six variables: Age (2 strata; children [5-21], adults [over 21]), Area (2 strata; Area 5, Area 7), Plan (2 strata; MediPass, HMO), Eligibility Status (2 strata; SSI, TANF), Gender (2 strata; male, female), and Race/Ethnicity (3 strata; White, Black, Other) resulting in a 96 cell sampling matrix. Forty enrollees were selected from each cell in the matrix resulting in an initial sample of 3,840 respondents.

We used a highly systematic mail survey procedure after those extensively tested by Dillman (1978) and Salant and Dillman (1994). Typically, these techniques have resulted in response rates near 50% for Medicaid populations.

Completed questionnaires were obtained from 506 adults for a response rate of 29.2%. When adjusted for incorrect addresses and deceased individuals (n=260), the response rate was 30.5%. For children, completed questionnaires were obtained from 473 caregivers for a response rate of 24.6%. When adjusted for incorrect addresses and deceased individuals (n=293), the response rate was 29.1%. For unknown reasons, the response rates obtained during this mailing are lower than we anticipated and have experienced in previous years. Given these response rates, the desired comparisons can still be made, but larger effects will be necessary to identify significant differences, given the increased margin of error and reduced statistical power. In an effort to improve response rates, we increased the reimbursement for participation in the survey.

Questionnaire

Parallel questionnaires, (one version for adults and one version for children) were developed that were specifically tailored to the needs of this Medicaid evaluation. As part of the questionnaire development process, Medicaid enrollees participated in focus groups during which they reviewed and commented on a draft of the questionnaire developed by the evaluation team. The questionnaires were translated into Spanish. The cover letter was written at an 8th grade reading level and the questionnaire was written at a 6th grade reading level. Detailed information on the standardized scales included in the questionnaire can be found in Boothroyd, (2006).

Findings

The following two tables (Tables 8 and 9) provide a summary of the findings for both adult and child enrollees on each access, status, and outcome indicator associated with the main effects related to health care plan and eligibility status. To help facilitate interpretation of these tables, the SF-12 includes measures of both physical and mental health functioning in adults, the Colorado Symptom Index assesses adult respondents' mental health symptoms, the Child Health Questionnaire assesses health functioning, and the Pediatric Symptom Checklist measures children's psychosocial functioning (See the Supplemental Mail Survey Component report for a detailed discussion of each measure included in the adults' and children's questionnaires).

Table 8
Summary Differences Between Health Care Plans

Plan Effects on Access Indicators	Adults	Children
Medical penetration rate	None	None
Mental health penetration rate	None	MediPass +
Unmet medical needs	None	None
Unmet mental health needs	None	HMO +
Problems getting physical health medications	None	HMO +
Problems getting mental health medications	None	None
Plan Effects on Status Indicators		
SF-12 physical health	None	
SF-12 mental health	None	
Colorado Symptom Index	None	
Child Health Questionnaire		None
Pediatric Symptom Checklist		None
Plan Effects on Outcome Indicators		
Satisfaction with plan overall	None	None
Satisfaction with mental health services used	None	MediPass +
Satisfaction with medical services used	None	MediPass +
Trust in health care provider	None	None
Quality of life	None	None

An examination of this table reveals that overall, 5 of 27 comparisons (18%) examined were statistically significant. All five of the significant plan comparisons were associated with child Medicaid enrollees; none were found among adult respondents. Additionally, all five significant health care plan effects favored the MediPass plan over the HMO plan. These differences suggest that compared to caregivers of children enrolled in the MediPass plan, caregivers of children enrolled in an HMO reported a lower penetration rate of mental health services, higher levels of unmet mental health needs, more difficulty getting their child's physical health medications, and lower levels of satisfaction with both the physical and mental health services their child had used in the previous six months.

It is possible that these findings reflect the different financing strategies used by HMOs and MediPass programs. The HMOs are at financial risk for pharmacy services while enrollees in the MediPass plan had their pharmacy benefits paid for on a fee-for-service basis. Given that there were significant differences in caregivers' responses associated with pharmacy benefits, i.e., difficulty getting medications for physical health, the findings may reflect these differing financial structures used by the two programs. However, one would expect to find similar results among adult enrollees given the risk structure for pharmacy was the same for both adults and children. However, that was not case.

The differences found between health care plans related to aspects of mental health service access and satisfaction are more difficult to explain, given that community-based mental health services were paid on a fee-for-service basis for both HMO and MediPass enrollees when this survey was conducted.

Across both adult and child enrollees, significant differences associated with Medicaid eligibility status were found in 11 of 25 comparisons (41%) examined. These are summarized in Table 9. In general, TANF respondents had significantly better health and mental health status measures, lower service penetration rates, and more unmet mental health needs, while enrollees receiving SSI reported higher levels of satisfaction with mental health services used.

Among adults, 7 of 14 eligibility status comparisons (50%) were significant. Specifically, adults receiving SSI reported higher use of both physical and mental health services and higher levels of satisfaction with the mental health services they had received compared to TANF recipients. In contrast, adult TANF recipients reported having better health and mental health status as well as more unmet mental health needs compared to SSI recipients. Significant differences associated with eligibility status were found in 4 of 13 comparisons (31%) among the caregivers of children surveyed. A significantly higher percentage of caregivers of children receiving SSI reported their child had used mental health services in the six months preceding the survey and also reported higher levels of satisfaction with these mental health services compared to caregivers of children receiving TANF. Caregivers of children on TANF reported their children were in better health and mental health compared to caregivers of children receiving SSI.

The significant differences found between TANF and SSI recipients related to health status are not surprising given that SSI recipients are individuals with some type of disability. Like SSI recipients, TANF recipients are also poor, but they may

Table 9
Significant Differences Between SSI and TANF Respondents

Eligibility Status Effects on Access Indicators	Adults	Children
Medical penetration rate	SSI +	None
Mental health penetration rate	SSI +	SSI +
Unmet medical needs	None	None
Unmet mental health needs	TANF +	None
Problems getting physical health medications	None	None
Problems getting mental health medications	None	None
Eligibility Status Effects on Status Indicators		
SF-12 physical health	TANF +	
SF-12 mental health	TANF +	
Colorado Symptom Index	TANF +	
Child Health Questionnaire		TANF +
Pediatric Symptom Checklist		TANF +
Eligibility Status Effects on Outcome Indicators		
Satisfaction with plan overall	None	SSI +
Satisfaction with mental health services used	SSI +	None
Satisfaction with medical services used	None	None
Trust in health care provider	None	None
Quality of life	None	None

be otherwise healthy. Similarly, the higher service penetration rates among SSI recipients are consistent with their poorer health and mental health status, as well as disability status. The more favorable levels of satisfaction among SSI recipients may be attributable to the greater use of health-related services compared to TANF recipients.

Finally, no significant differences were found among adult or child enrollees in any of the 27 comparisons examined associated with the AHCA area (either Area 5 or 7) in which respondents resided and received services. This suggests that, from an enrollee perspective, self-reported access to services, general health and mental health status, and level of satisfaction with services received did not differ by the geographic area in which they resided and received care.

Summary

The mail survey pre-implementation data therefore indicates some differences between enrollees in the differing financing conditions for children. Caregivers for children enrolled in the HMOs report greater unmet needs, more difficulty accessing services and greater dissatisfaction with both health and mental health services than MediPass enrollees. Interestingly, none of these differences were obtained for adult respondents and all were observed prior to the changes in the mental health benefit. These differences, nonetheless, suggest concerns with access to services for children in the HMO condition. Perhaps integration of the premium will improve access to mental health services. These data will be used to evaluate changes in the program following implementation of the integrated benefit and PMHP in the 2007 evaluation using data collected in the spring of 2006.

Differences between SSI and TANF recipients are consistent with our expectation regarding their differential health/mental health status and service utilization. These findings may best be regarded as validations of the sensitivity of our measures since they should clearly differentiate persons with disabilities from individuals participating in the TANF income support programs. Interestingly, persons with disabilities are generally more satisfied with their health programs than individuals enrolled in TANF. All of these data will be used to observe changes following the full implementation of managed mental health care.

Focus on Measure Development in AHCA: Administrative Data Analyses

Background

Over the last 8 years we have evaluated the performance of managed care organizations in delivering mental health services in AHCA Areas 1 and 6 using administrative data. The data sets utilized included eligibility, institutional, pharmacy and services files. The primary domains evaluated were access, expenditures on services, and outcomes. Periodically, efforts were made to measure and compare the quality of care delivered by the different managed care plans.

In anticipation of the statewide implementation of managed behavioral health care in FY 05-06 and 06-07, we decided to design and test the usefulness of new and more detailed methods for measuring the access, outcomes, and quality dimensions. Specifically, we have categorized services into four separate groupings that may better reflect the impact of the changes in the managed care benefit structures. Also, in these developmental analyses we examine service, outcome, and quality measures for different sub-populations in addition to the Medicaid population overall. The sub-populations of interest include adults (broken down by gender) with serious mental illnesses (SMI) and children with serious emotional disturbances (SED). These sub-groups may more sensitively reflect the effects of benefit changes than the general population of Medicaid enrollees.

Because the phase-in of new AHCA encounter data systems would not yield sufficient data for these new analyses, we tested the new methods using historical Area 1 data covering the period from 2001 to 2004. The resulting analysis is not intended as a re-evaluation of the performance of the plans in Area 1. Rather, the Area 1 data were used to test the usefulness of new approaches because data were available for several years and were relatively current. If the new analytic methods appear to be useful, we will propose to use them in the evaluation of the statewide rollout over the next several years.

Findings

A summary of these findings from these analyses are presented here. A full presentation along with technical appendices detailed definitional and analytic issues may be found in Constantine (2006).

Access

The measure of access continues to be service penetration rates. However, in these analyses, separate rates are calculated for four different categories of services including (1) inpatient, emergency care and psychiatrists office visits, (2) traditional community mental health services, (3) behavioral health services delivered in the general medical sector, and (4) services excluded from managed care, such as assertive community treatment and specialized foster care. By defining services in this detailed way, we hoped to see if enrollees in different plans accessed different kinds of services and whether their access changed over

time. In addition, penetration rates are calculated separately for adults with a serious mental illness and children with a serious emotional disturbance. Penetration rates were examined using seven, six-month intervals, beginning on 1/02 (just after the implementation of managed care in Area 1) and ending on 6/04. The findings are summarized below.

After managed care implementation, HMO penetration rates for adults and children (including those with SMI and SED) increased significantly for psychiatrist office visits and decreased for traditional community mental health services, resulting in major shifts in the kinds of services enrollees received. Figures 8 and 9 illustrate these shifts.

Figure 8
Penetration of Psychiatric Inpatient, Emergency Services and Psychiatric Physician Services

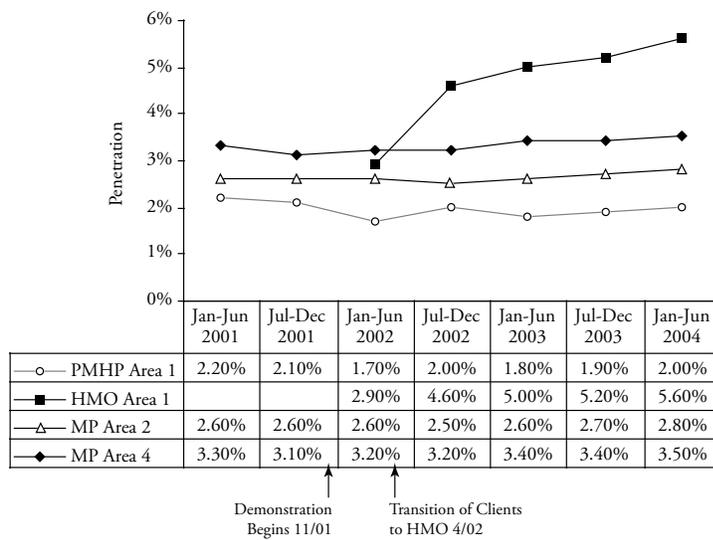
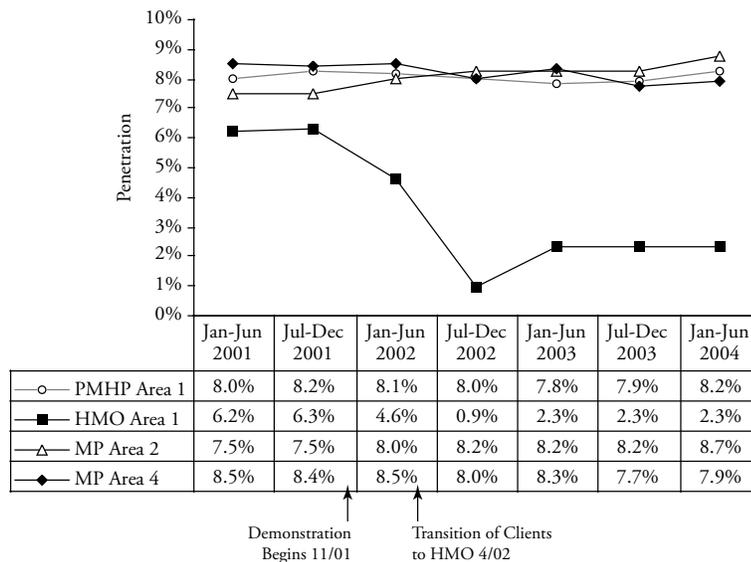


Figure 9
Penetration of Community Mental Health and Targeted Case Management Services



In the first figure, there is a significant increase in the use of psychiatric services for HMO enrollees (adults and children) between the January-June and July-December 2002 periods. In the second figure, there is a significant drop in the provision of community mental health and targeted case management services in that same period. This shift likely reflects the nature of the HMO network, which is comprised mostly of solo and small group practices, rather than the community mental health center.

The differential patterns of service penetration between HMO and PMHP enrollees were also observed for adults with SMI enrolled in the HMO and children with SED in the HMO, i.e., they also had more psychiatric office visits and fewer CMH services. In addition, we found that penetration rates for psychiatric services for HMO adults with SMI and children with SED were much higher than those of the general population of Medicaid enrollees. For people enrolled in the PMHP, their penetration rates for both psychiatric visits and community mental health services remained relatively stable over time and were similar to the fee-for-service comparison areas (AHCA Areas 2 and 4).

We found no differences between plans regarding penetration for mental health services delivered in the general medical sector and no evidence that either the HMO or the PMHP shifted financial responsibility by shifting expensive enrollees into services not included in their capitation payments (e.g., Assertive Community Treatment).

Outcomes

In the exploratory analysis of outcomes, we continued to use Baker Act evaluations and arrest rates as indicators of adverse outcomes. We also added DJJ referrals as an outcome measure for children. Outcomes were studied using the traditional pre-post implementation plan comparisons. In addition, the outcomes of all enrollees that had six months of continuous enrollment in Medicaid over any of the seven, 6-month time intervals studied, regardless of their pre-managed care enrollment status, were also analyzed. Here also, adults with SMI and children with an SED were studied separately. In all outcomes analyses, we used rates calculated as number of instances (e.g., arrests) per 100 enrollees so that the impact of individuals experiencing multiple instances could be appropriately expressed. The findings are summarized below.

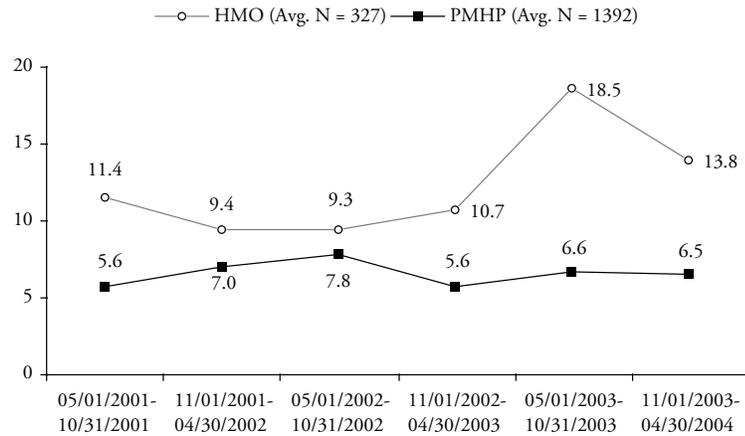
Adverse Events

As can be seen in Figures 10 and 11 below, HMO enrollees with SMI experienced more Baker Act evaluations and arrests both before and after managed care implementation than their PMHP counterparts.

Baker Act Evaluations

Figure 10 shows that the outcomes for males with SMI in the HMO, as measured by Baker Act evaluations, deteriorated after managed care implementation and became significantly worse than for those same outcomes for their PMHP counterparts. In contrast, the number of Baker Act evaluations experienced by males with a SMI in the PMHP was relatively stable over the course of the study.

Figure 10
Baker Act Evaluations for Adults with Serious Mental Illnesses (case mix adjusted)



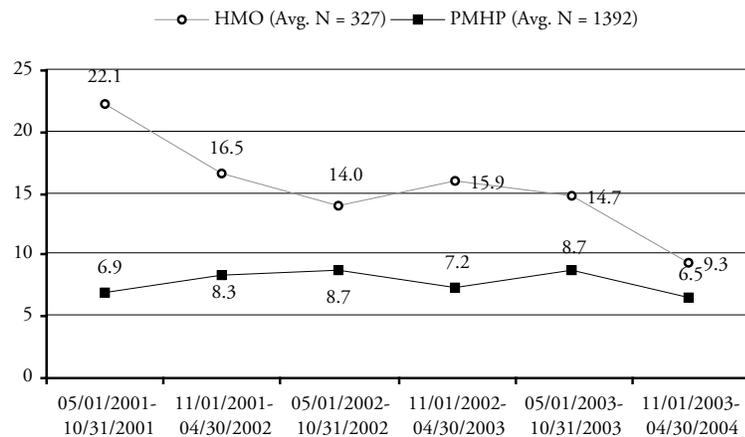
We found no significant changes observed for females with an SMI, and no differences between plans with regard to Baker Act rates for children. The differences in Baker Act evaluations between plans appeared shortly after the changes in service penetration described earlier. The outcomes for males with SMI, as measured by Baker Act evaluations, in the HMO condition deteriorated.

Rates of Arrest

In Figure 11, we see that HMO enrollees with SMI had higher arrest rates than their PMHP counterparts across all time periods; however, rates for HMO enrollees improved over time, while the PMHP enrollee rates remained relatively stable. We also found that arrest rates for HMO adult females with a SMI declined over time, while the rate for males remained relatively high. In comparison, arrest rates were lower and relatively stable for males and females in the PMHP.

Referrals to the Department of Juvenile Justice (DJJ) for children and youth are also considered adverse events in these analyses. We found that although service penetration rates of children with SED in the two plans differed significantly, we found no differences in Department of Juvenile Justice referrals over time.

Figure 11
Arrest Rates for Adults with Serious Mental Illnesses



Revisiting the Quality Issue

In another effort to look at quality, we selected the receipt of post hospital discharge services as one indicator of quality care. Thus, for the 3 year period following the implementation of managed care, we examined all the claims for mental health services that were provided to individuals within six months after their discharge from a hospital stay. The focus was on receipt of community behavioral health (CBH) services that included assessment, treatment planning, intensive outpatient, basic outpatient and targeted case management. Two indicators of quality were utilized (1) whether the enrollee received any CBH services in the 6 months following discharge and (2) the relative richness of the CBH services received during the same six-month period. The major findings are summarized below.

- Nineteen percent of all hospital discharges in both plans in Area 1 received no CBH service during the six months after discharge. There was a significant difference between the HMO and the PMHP in the receipt of CBH services post discharge; twenty-four percent of HMO discharges and 17% of PMHP discharges received no CBH services following discharge.
- Persons in the two managed care conditions were less likely to receive CBH services during the follow-up period than their fee-for-service counterparts in comparison Areas 2 and 4.
- Among those who actually received services, PMHP enrollees appeared to have received a richer array of CBH services post discharge. However, no direct inferences can be made from this observation due to questions about service intensity and substitutability, i.e., how much of a particular service they have received or the appropriateness of the array of services they received.
- A far greater percentage of HMO enrollees saw a primary care physician (a non-CBH service) after discharge compared to PMHP enrollees, indicating a shift from CBH services to services delivered in the general medical sector.
- Thirteen percent of PMHP discharges and 15% of HMO discharges received no CBH service or only deep-end services (for example inpatient care) following discharge.

Summary

These exploratory analyses indicate differences between the financing conditions in the provision of follow-up services after hospital discharge. In general, persons served in the managed care conditions are less likely to receive services following discharge than persons in the fee-for-service conditions. This is surprising, given the financial risk for inpatient services and the presumed desire for at-risk entities to avoid re-hospitalization. Nonetheless, the rationale underlying these differential patterns of follow-up care should be explored to better refine this quality measure and understand the relationship between financing incentives and quality of care indicators.

Overall Summary – Year 9 Report

This report reflects an important transition in the development of managed care programs in Florida. While it is the ninth in the series of evaluation studies of managed mental health care, it is the first that tracks the statewide implementation of these initiatives. Although we have several years of experience in implementing these programs, some common concerns emerge regarding the new start-ups.

First, the implementation of managed care is associated with disruptions in care. Both the providers and the caregivers in the children's study report that the implementation of the mental health managed care programs was associated with changing procedures for the authorization of care or changes in the availability of certain types of services, such as case management. It is not always clear that the disruptions were related to new benefit structure, utilization management procedures or changes in the resource base. However, it is clear from the reports of caregivers and clinicians that the availability of services was perceived to have changed negatively following the implementation of managed mental health care.

Second, establishing new relationships between HMOs/BHOs and the traditional community mental health providers is also characterized by confusion and disruption in service payments. As was the case in Area 6, CMHC administrators complain about difficult and confusing procedures for service authorization and billing. Representatives of the HMOs/BHOs offer training in their procedures and also expressed frustration at the pace at which these new provider agencies adapt to their authorization and claiming processes. Like the Area 6 implementation, these disruptions cause revenue problems for the CMHCs as their receivable account balances grow. Uncompensated care may become an increasing problem if these administrative procedures are not streamlined and mastered.

Third, the integration of the mental health and general health premium has not resulted in the integration of service networks. The 'carved in' mental health premium is generally carved out and the financial risk for care is passed from the HMO to a BHO, which is either a subsidiary of the parent company or a separately incorporated, for profit entity. As was the case in the early Area 6 implementation, BHOs are purchasing services on a fee-for-service basis from the providers, which has resulted in some of the billing difficulties discussed earlier. Ultimately, in Area 6, the CMHCs assumed at-risk contracts with the HMOs, which were seen as preferable to the fee-for-service claiming and authorization system.

Fourth, the implementation of HMO comprehensive community mental health benefit has been accompanied by increased administrative costs reported both by the MCOs and the provider agencies. Both report having to add staff in order to accommodate the implementation of the program.

While many of these problems also characterized the start-up phase in Area 6, several implementation issues seem to have improved in the most recent efforts. Consumer and family involvement is improved relative to the initial offerings in

Area 6. The PMHP has formally incorporated consumers into their management processes. The HMO/BHOs seem to be increasingly aware of the importance of consumer involvement in care and some have begun processes to better engage them in the oversight of the program

The BHO market may have stabilized relative to the early years of the Area 6 implementation when multiple BHOs competed for HMO business. While it is too early to conclude that the market will remain stable, such stability will likely be of great help in overcoming the confusion that characterized this start-up period.

The HMOs/BHOs were successful in negotiating service relationships with the traditional community mental health providers. While providers reported that some clients were lost in the transition to the HMO comprehensive benefits, the disruption was likely not as substantial as was experienced in Area 1 where a new panel of mental health providers had to be created.

Unlike the initial implementation in Area 6, the in-depth case study of children with SED and their families did not find large differences between the quality of care or consumer outcomes financed by the HMOs and the PMHP. Consistent with the findings of the implementation study, families reported disruptions in care related to the transition, but the transition problems were not unique to either of the financing conditions. The apparent confusion with other changes in the Medicaid program related to pharmacy caused further disruptions and was reported to be associated with adverse consequences for children and their families. Similarly, provider agency policies regarding scheduled appointments and cancellations also frustrated access to services. While these are not uniquely associated with either financing condition, they may be areas for service improvement.

Consistent with earlier findings, we observed some differences between HMO and PMHP enrollees. Most notably, PMHP enrollees are much more likely to be SSI enrollees than HMO enrollees and to meet diagnostic criteria for severe mental illness. Some initial differences were also detected in the population mail survey of enrollees that indicated for children, greater levels of unmet need for mental health services and lower satisfaction with both mental health and medical services for families enrolled in the HMO. Interestingly, none of these differences were detected for adults. These pre-existing differences can not relate to the financing of the carve-out mental health services, but are associated with at-risk general health and pharmacy services. To the degree to which the new 'carved-in' premium may provide an incentive to better integrate general and mental health care and to broker more comprehensive community mental health services, these differences for children may be ameliorated.

Finally, the new approaches to the analysis of encounter data that we tested with Area 1 data indicated both the value of the approach and some potential concerns regarding effects of differing service networks on types of services delivered and consumer outcomes. Specifically, the data indicated that when the HMOs established a service network that was independent of the traditional community mental health providers, profound differences in service patterns occurred. Additionally, these changes were associated with increases in involuntary

evaluations – particularly for adult males with SMI. In contrast, arrest rates declined for HMO adults, particularly females, following the implementation of the comprehensive HMO benefits and the establishment of the new services networks. It is important to note that, although the rates declined, they ultimately equaled those of the PMHP enrollees. It would be helpful to look behind the aggregate statistics in order to determine if the changing service networks and the resulting change in access to community mental health services mediates these outcome differences. These new evaluation approaches, however, appear to more sensitive than those used in the Year 8 evaluation and will continue to be pursued next year.

Recommendations

Most of the recommendations from this year's evaluation parallel those from earlier years. They relate to careful monitoring of the implementation of the program, its performance and the outcomes experienced by enrollees. Clearly, the transition from the fee-for-service to the prepaid system was accompanied by confusion and disruption in services. Since multiple AHCA areas are anticipating implementation in the coming year, we recommend that:

- AHCA continue careful monitoring of the payment and service authorization process in Areas 5 and 7 as well as active oversight of any new implementation areas. Any procedures that can reduce the error in these processes and increase timely authorization and payment will increase service access and system efficiency. Facilitated discussions and training sessions among the providers and purchasers may be explored in a process to support the transition.
- Since at least some of the disruption associated with the transition resulted from misunderstandings between providers, purchasers, and AHCA, and, since these misunderstandings resulted in service disruptions and negative outcomes for children and their families, AHCA should explore new methods for educating providers, including line clinical staff, regarding the implications of overall changes in the Medicaid system. Better knowledge regarding the implications of system changes (like the pharmacy benefit) will not only assure more effective implementation of these changes, but also reductions in inappropriate service disruptions resulting from the misunderstandings. Additionally, AHCA will profit by direct interaction with service providers regarding the clinical implications of its policies.
- AHCA should continue to monitor service penetration rates with the minimal goal of maintaining pre-implementation levels of service. Constantine (2006) makes specific suggestions regarding the corridors within which penetration for specific types of services should be maintained and further suggests that we provide data on penetration on a timelier basis than we have in years past. Establishing concrete targets for penetration will help to assure access at, or above, that experienced prior to the implementation of prospective payment.
- AHCA should continue efforts to obtain and improve the quality of encounter data from the managed care organizations so that such real time monitoring can occur. Health, as well as mental health data, should be collected in order to better understand the integration of care and the provision of mental health services in the general health sector.

Given the suggestive relationships between the provision of specialized community mental health services and adverse outcomes for adults with SMI, we further recommend that AHCA work with FMHI to

- Actively monitor the nature of the service networks that are formed and the types of services that are provided. To the degree to which providers that have not traditionally treated populations with severe illnesses or disabilities related to mental illnesses join panels, AHCA should assure their ability to deliver the treatment, supportive, and rehabilitative services needed by these individuals.
- With the assistance of FMHI, AHCA should actively monitor administrative outcome indicators for vulnerable populations. To the degree to which these indicators change, as they did in Area 1, AHCA should work collaboratively with the MCOs to complete case studies that examine the linkage between patterns of service provision and outcomes. Based on these studies, intervention strategies should be tailored to reduce the likelihood of adverse events.
- Relatedly, AHCA should examine strategies for collecting enrollee specific data on clinical status and functioning that would help in the interpretation of the administrative indicators and provide a direct indicator of client outcomes.

AHCA should continue to pursue recommendations from earlier evaluation studies as well as those consistent with emerging standards of competent mental health care.

- AHCA should encourage the active involvement of consumers and families in program oversight and direction to help assure accessible and effective services. The educational strategies that we suggested for providers and insurers would also benefit consumers.
- While it is too early to determine if the flexibility inherent in prospective payments results in flexible services that are outside of the conventional procedure-bound Medicaid system, AHCA should continue to encourage service strategies that respond to consumer needs. More flexible, recovery oriented services were ultimately developed in Area 6, although they were not originally part of their service continuum. To the degree to which these prove helpful in Area 6, their more rapid adoption in the other areas of Florida is sensible.
- In the mail survey, unmet need for mental health services occurred at twice the rate for unmet need for physical health services. This persistent finding underscores the importance of improving access to mental health services. Problems with transportation, service hours, missed appointment policies, should all be investigated to improve access.

Following the release of the President's New Freedom Commission report on mental health, Florida and other states began efforts to transform their mental health systems. Medicaid financing strategies are central to the transformation efforts. Mental health managed care programs should embrace the vision of system transformation, the promotion of resilience for those without disabilities and recovery for persons who have experienced disability related to mental illnesses. In a resource constrained environment that only promises to become more constrained, it is essential that Medicaid managed care strategies be optimally used to promote efficiency and the delivery of effective services to foster population well-being.

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