



THE LOUIS DE LA PARTE FLORIDA MENTAL HEALTH INSTITUTE



## **Evaluation of Florida's Medicaid Managed Mental Health Plans: Integrated Summary**

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# Evaluation of Florida’s Medicaid Managed Mental Health Plans: Integrated Summary

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### List of Acronyms

ABH	Access Behavioral Health
AHCA	Agency for Health Care Administration
APA	American Psychological Association
BA	Baker Act
BHO	Behavioral Health Organizations
CMHS	Community Mental Health Services
FHP	Florida Health Partnership
FMHI	Louis de la Parte Florida Mental Health Institute
FFS	Fee-For-Service
HEDIS	Health Plan Employer Data and Information Set
HMO	Health Maintenance Organizations
MCO	Managed Care Organization
NCQA	National Committee for Quality Assurance
PMHP	Prepaid Mental Health Plan
PSC	Pediatric Symptom Checklist
SED	Severe Emotional Disturbance
SMI	Serious Mental Illness
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families

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# Evaluation of Florida's Medicaid Managed Mental Health Plans: Integrated Summary

## Executive Summary

This report provides a brief, integrated summary of the findings from four evaluation components comprising the 2006-2007 evaluation of Florida's implementation of mental health managed care. The evaluation was conducted by staff at the Louis de la Parte Florida Mental Health Institute (FMHI) under a contract with the Florida Agency for Health Care Administration (AHCA). This represents the tenth year that staff at FMHI has been evaluating Florida's implementation of mental health managed care. The report is divided into five primary sections. The first offers a brief national context in which to understand Medicaid managed care. Section two details the implementation of mental health managed care in Florida. The third section provides an overview of the evaluation activities that were conducted during 2006-2007. Section four summarizes the findings from each evaluation component in conjunction with the major foci of the evaluation: organizational and financial issues, access to care, recipient outcomes, and quality of care. The report concludes with a list of the major insights that have emerged over the ten years of this evaluation.

In terms of organizational issues, key informants from both managed care organizations (MCOs) and provider agencies acknowledged issues related to efficiency of preauthorization and billing procedures. However, MCO and provider agencies had different views regarding why these issues exist and who is primarily responsible for them. From the MCO perspectives, new providers who have difficulty following procedures are responsible for service authorization and payment issues. In contrast, providers state that vastly different procedures across MCOs which are overly complex, burdensome, and lack clarity are at the center of these issues. Both groups reported increased burdens that necessitated the hiring of additional administrative staff.

Examination of access to care using administrative data revealed declines in community mental health services among adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED). These declines are a potential cause for concern given the vulnerability of these recipients. However, there were no consistent declines in the provision of inpatient services after the implementation of managed care, which is contrary to what one would expect given the high costs associated with inpatient care. Interestingly, the caregivers of children with SED who were surveyed reported more favorable assessment of service access than did practitioners at provider agencies. Some providers reported that since the implementation of managed care, fewer services were being provided to recipients.

Findings associated with recipient outcomes found increased rates of Baker Act evaluations post implementation of managed mental health care among

adult Medicaid recipients diagnosed with SMI. Increases were not found among children with SED. Importantly, the implementation of mental health managed care was not associated with increased arrests among Medicaid managed care recipients. Caregivers' assessments of their children's behaviors suggest that a substantial percentage of them continue to experience challenges at school and home, and only a small percentage of caregivers noted improvement in their children's functioning over time. Caregivers reported a need for services to assist them in mitigating family stress and a desire for increased collaboration among families, schools, and service providers.

In terms of quality of care, the provision of post-hospital discharge follow-up mental health services fell below desired Health Plan Employer Data and Information Set (HEDIS) levels, although they were generally consistent with the national average for a Medicaid population. Practitioners and caregivers had different opinions regarding the quality of the mental health services that children with SED receive. Practitioners generally reported a higher quality of care relative to caregivers. While most practitioners indicated obtaining input from family members during treatment planning, caregivers believed providers needed to better inform them about the child's condition, discuss treatment options with them and offer a choice of treatments.

Given the complexity of the findings, readers are encouraged to refer to the individual evaluation reports associated with each component for greater detail about the evaluation methods and results.

## Introduction

This report is intended to provide an integrated, non-technical summary of the 2006-2007 findings derived from the evaluation of Florida's implementation of mental health managed care. The findings are based on four distinct, yet interrelated sub-studies conducted by FMHI under a contract with the AHCA. This represents the tenth year that staff at FMHI has been evaluating Florida's implementation of mental health managed care.

This report is divided into five sections. Section one provides a brief national summary of Medicaid's financing of mental health services, its recent growth, and highlights the need for cost containment efforts. Section two offers a brief history of Florida's implementation of managed mental health care. The third section of this report provides a concise description of the multi-faceted evaluation activities conducted by FMHI staff during 2006-2007. Readers should be aware that this section oversimplifies the nature and scope of these evaluation activities, and are thus referred to the individual reports associated with each evaluation sub-study for greater detail on the technical aspects of each evaluation component. These individual reports are listed at the end of this report. Section four of this report synthesizes and integrates the principal findings and insights that emerged from this year's work. Finally, section five of this report offers the conclusions and recommendations based on this year's as well as previous years' evaluation results.

## Health Care Costs and Medicaid Budgets

State mental health authorities and Medicaid agencies fund a range of inpatient, ambulatory, and emergency behavioral health services. To finance this array of services, states have, over time, increasingly leveraged state general fund expenditures by matching them with federal funds for services to Medicaid recipients (Rowland, Garfield, & Elias, 2003). This leveraging strategy has expanded the resources available for the treatment of persons with behavioral health disorders. Medicaid is now the largest payer of public mental health services in the nation (Mark, Coffey, Vandivort-Warren, Harwood, King, et al., 2005). State Medicaid authorities are important payers for mental health services for individuals who are impoverished or who have disabilities (Buck, 2003; Mechanic, 2003). For state-funded mental health services, Medicaid budgets comprise 44% of ambulatory mental health expenditures—a full 10% more than state general fund expenditures for these services (Lutterman, Hollen, & Shaw, 2004). Clearly, if states are going to provide efficient and effective services in the public sector and reduce the disabilities associated with mental illnesses, Medicaid financing must be a key component of the strategy.

Nationally, federal and state Medicaid expenditures grew by about one-third: from \$206 billion to \$276 billion between fiscal years 2000 and 2003 (Holahan & Ghosh, 2005). Such fiscal pressures were the impetus for states to begin experimenting with managed care programs within Medicaid in order to contain costs. Overall, managed care enrollment among Medicaid recipients has grown dramatically, with 23 million, or 57.5%, now enrolled in managed care (Draper,

Hurley, & Short, 2004). Almost all states now mandate managed care enrollment for some portion of their Medicaid population. In general, the goals of managed care are to manage expenditures more effectively and improve quality of care and access to care.

Managed care, however, is not a single strategy. It involves a wide variety of organizational forms, financing schemes, and management practices (Ridgely, Giard, Shern, Mulkern, & Burnam, 2000). Perhaps the hallmark of contemporary managed care arrangements is prospective capitation payment in which managed care organizations (MCOs) are paid a premium for each enrollee each month, regardless of the enrollee's service use. With such arrangements, the MCO assumes financial risk for the provision of services included in the capitation rate and needed by their enrollees during the month. Regardless of various risk-sharing arrangements, MCOs have profit incentives for reducing utilization from historical averages.

### **Managed Mental Health Care in Florida**

The continued expansion of managed care strategies throughout Florida provides the context in which this evaluation of the implementation and impact of managed care plans on Medicaid recipients continued. Although Florida began using managed care strategies for comprehensive mental health services in 1996 by establishing Prepaid Mental Health Plans (PMHPs), the Medicaid program has used managed care strategies for physical health services since 1984. Approaches include a physician case management program, MediPass, which was implemented in 1991; Provider Service Networks; Children's Provider Networks; Minority Physician Networks; and Exclusive Provider Organizations. These strategies provide primary care services, care coordination, and authorization of specialty care for Medicaid recipients. The largest percentages of Medicaid recipients, however, are still in Medicaid health maintenance organizations (HMOs) (almost 50%) and MediPass (49%) (Agency for Health Care Administration, 2005).

The initial PMHP was established in 1996 in AHCA Area 6, the Tampa Bay region under a 1915(b) waiver from the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) (Ridgely, Giard, & Shern, 1999). Four eligibility groups were included in the demonstration; Social Security Income [SSI], Temporary Assistance for Needy Families [TANF], Sixth Omnibus Budget Reconciliation Act Medicaid [SOBRA: i.e., Medicaid coverage to pregnant women and children up to the age of 19 years], and Foster Care. Medicaid recipients who did not choose a plan were assigned to one on a mandatory basis. The PMHP was responsible and at-risk for providing their Medicaid recipients with comprehensive mental health services including inpatient and psychiatric office visits.

The 2000 Florida Legislature authorized the expansion of the Medicaid PMHP demonstration and Area 1, the Panhandle region comprising Escambia, Santa Rosa, Okaloosa and Walton Counties, was selected as the new implementation site and began operating its PMHP in November 2001. In Area 1, there were three primary behavioral health providers and one HMO operating

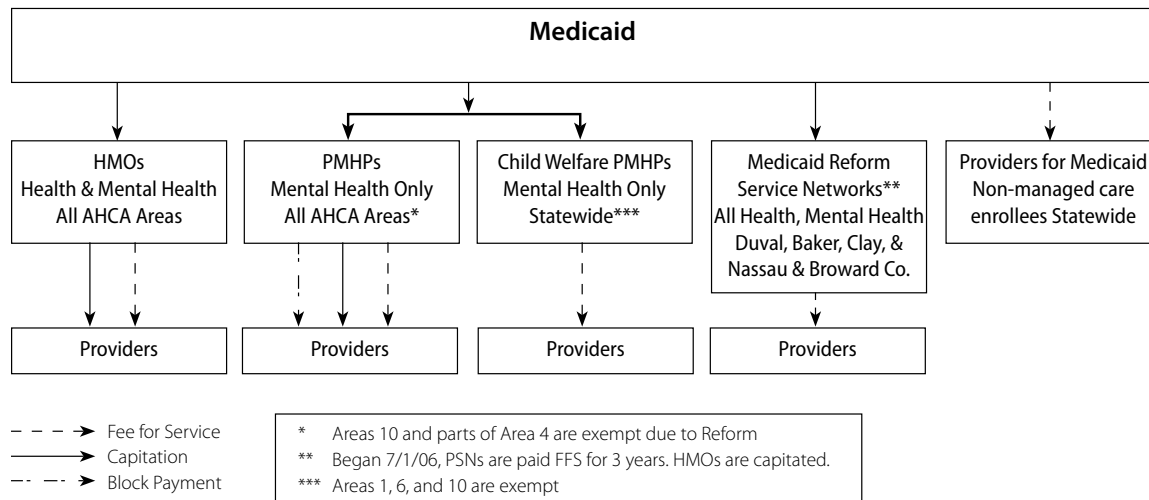
in the region. Unlike Area 6, where the managing entity for the PMHP was a separate incorporated entity, the managing entity in Area 1, Access Behavioral Health (ABH), was a component of one of the service-providing agencies. ABH subcontracted with the other providers on a subcapitated, risk-adjusted basis.

In its 2004 session, the legislature passed HB 1843 that authorized the AHCA to establish PMHP services for individuals not enrolled in Medicaid HMOs in each AHCA area and to require that all Medicaid HMOs provide the same comprehensive behavioral health services to their recipients. At the end of fiscal year FY 2004-2005, Florida Health Partners (FHP) was selected as the vendor to provide PMHP services in AHCA Areas 5 and 7. HMOs assumed responsibility for the same comprehensive mental health benefits in all areas of the state where they operate, as they met readiness requirements established by AHCA.

Additionally, the amendment of Florida Statute 409.912 (4) (b) (8) stipulated that by July 1, 2005, child welfare recipients receive their behavioral health benefits through a specialty PMHP. During 2006-2007, AHCA expanded PMHPs statewide, with the exception of the counties in which Medicaid Reform has been introduced (Area 4 – Duval, Clay, Baker and Nassau Counties and Area 10 – Broward County). The PMHPs have area-wide responsibility, within their AHCA areas, for providing the comprehensive mental health benefits to individuals enrolled in MediPass.

In addition to the PMHPs, Medicaid (HMOs) and their behavioral health organizations (BHOs) have expanded their mental health benefits to include comprehensive mental health services in AHCA areas throughout Florida. Every AHCA area now has at least one HMO providing expanded mental health care benefits; however, there are still several counties within AHCA areas, particularly in the more rural areas, where there are no HMOs operating. Figure 1 presents a graphical summary of the principal Florida Medicaid financing strategies for physical health and mental health.

**Figure 1**  
**Florida Medicaid Financing Strategies for Physical Health & Mental Health**



## Sub-Studies Comprising the 2006-2007 Medicaid Managed Care Evaluation

To document the characteristics of the different managed care financing conditions and to understand their effects on access, cost, quality, and outcomes, four interrelated sub-studies were conducted during this contract year. Although this section provides a brief description of each sub-study, readers can obtain detailed descriptions about the specific methods and procedures of each sub-study by referring to the individual evaluation reports associated with each activity.

The four evaluation sub-studies conducted during FY 2006-2007 included:

- Implementation analysis to document and describe the nature of the managed care interventions, how they have been implemented in various areas of the state, and how they have changed over time. The objectives of this sub-study are to :
  1. Detail the financial, structural, and clinical aspects of the managed care conditions,
  2. Describe the successes and challenges in how the Medicaid managed care is being implemented, and
  3. Provide contextual information to aid in interpreting the findings from the other evaluation studies.

The general implementation analysis methodology involved semi-structured interviews (in person or by telephone) conducted with key stakeholders (e.g., administrators and providers) in AHCA Areas 2, 3, and 11, follow-up electronic surveys with MCO staff in Areas 5 and 7, and two focus groups with adult Medicaid recipients in Areas 5 and 7.

- Administrative data analyses examined data provided to FMHI by AHCA to describe the characteristics of the enrolled population, their service utilization patterns, and estimate program costs. In addition, this sub-study examined other centrally collected administrative data systems including Baker Act (BA) Registry (mental health involuntary examinations) and Florida Department of Law Enforcement arrest records, to assess population-based outcomes for Medicaid recipients. These analyses focus heavily on adults diagnosed with SMI and children with SED. The primary goals of the administrative data analysis sub-study were to:
  1. Describe the characteristics of the enrolled population;
  2. Summarize service penetration rates;
  3. Depict patterns of services;
  4. Summarize service costs; and, to the extent possible,
  5. Document enrollee outcomes (e.g., health and mental health status, satisfaction).

In previous years, investigators obtained enrollment and fee-for-service claims

data from AHCA. These data were combined with encounter data provided to FMHI by the managed care plans. This year, all encounter data were provided by AHCA.

- Population mail survey employed systematic mail survey techniques to determine if differences existed in recipients’ access, health status, or satisfaction are associated with how services are financed (e.g., HMOs versus PMHP). A stratified random sample of approximately 3,800 Medicaid recipients in AHCA Areas 5, 7, and 11 were surveyed. It is important to note that this component of this evaluation, unlike the administrative data analyses, included all Medicaid recipients and was not specifically focused on recipients with known mental health needs. The goals of this sub-study were to:
  1. Monitor the health and mental health status of Medicaid recipients,
  2. Assess the level of recipient satisfaction with the health care plans, and
  3. Determine if these outcomes were associated with how services are financed and if they changed over time
- Children’s Quality of Care built on two previous years’ efforts to understand the quality of care received by children enrolled in the Medicaid system more effectively and how it is impacted by various financing strategies. In addition to examining caregiver and provider perceptions of the quality of care for children with SED, the first two years of FMHI’s work in this area sought to identify quality-of-care indicators important to providers and caregivers (Vargo, Sharrock, Pedraza, Dhont, et al., 2005) and to obtain input from MCO administrators and providers on specific ways to measure quality of care (Vargo, Sharrock, Pedraza, Reyes, et al., 2006). The overall goals of this sub-study were to:
  1. Assess the quality of behavioral health services received by children with SED and their families in Area 7,
  2. Determine if the quality of care is associated with financing condition,
  3. Obtain providers’ perceptions regarding the provision of quality behavioral health services,
  4. Identify the similarities and differences between caregivers’ and providers’ perceptions of quality, and
  5. Identify the facilitators and barriers associated with the provision of quality behavioral health services.

Given the findings presented in this summary cut across the evaluation sub-studies and are based on different AHCA Areas and varying time periods, Table 1 is provided assist the reader.

**Table 1**  
**Evaluation Components, AHCA Areas, and Time Periods**

Evaluation Component	AHCA Area	Time Period
Implementation Analysis		
• New Area Implementation	2, 3, 11	2006-2007
• Follow-up Survey	5, 7	2006-2007
• Adult Recipient Focus Groups	5, 7	2006-2007
Administrative Data Analysis		
• Recipient Characteristics	2, 3, 11	2004-2006
• Penetration	5, 7	2004-2005
• Outcomes (Baker Act rates/Arrests)	5, 7	2004-2005
Child Quality of Care Study	7	2006-2007
Mail Survey to Medicaid Recipients	5, 7, 11	2005-2006

## Summary of Principal Findings from the 2006-2007 Evaluation

The primary findings from this year's evaluation activities are summarized below in four sections organized according to the major foci of this evaluation: 1) organizational and financial issues, 2) access to care, 3) quality of care, and 4) recipient outcomes. Following the presentation of the findings in each area, a brief discussion of their implications is presented.

### Organizational and Financial Issues

#### Findings

As previously noted, the 2006-2007 evaluation activities associated with the *Implementation Analysis* were focused on primarily examining the organizational structures of the new MCOs operating in AHCA areas 2, 3, and 11 and relationships with their service providers. Currently, there are ten Medicaid HMOs/BHOs overseeing the community mental health services offered through the provider networks in these areas. There are also three PMHPs operating in these areas. They include North Florida Behavioral Health Partners (Area 3); Magellan Behavioral Health of Florida (Areas 2 and 11); and The Public Health Trust of Dade County whose behavioral health services are managed by University of Miami Behavioral Health (Area 11). The implementation of the PMHPs in Area 11 is unique compared with other areas of the state; while other areas of the state are served by one PMHP, Miami-Dade County has two in operation because of the size of their population.

During interviews with staff from these MCOs, they reported having to add administrative staff to accommodate the demands associated with adding new sites, establishing new relationships, and engaging new providers (some of which had little experience with managed care arrangements prior to the implementation of Medicaid managed mental health care in their areas). Their comments, however, suggest they believe they are meeting these challenges successfully.

In contrast, service providers conveyed a different perspective. They identified prior authorization for services and billing procedures associated with some of the FFS financing arrangements as problematic. In terms of prior authorization, they reported procedures among MCOs vary significantly and lack sufficient clarity which results in confusion about what is required and by whom. Providers noted that billing procedures were complex and overly burdensome.

Providers also reported that MCOs were denying many services under their FFS arrangements and that they were experiencing significant delays in receiving payments for services rendered. As a result, at least two providers stated they have begun negotiating sub-capitated arrangements with one MCO, Harmony Behavioral Health. Other providers have threatened to terminate their contracts with particular MCOs.

A number of providers indicated that the implementation of managed care has resulted in reductions in their Medicaid revenues caused by: 1) the decrease in overall Medicaid dollars under managed care, 2) larger provider networks which spreads out available Medicaid service dollars over more providers, and 3) delays in and denial of payments from MCOs for services provided. As a result of these fiscal issues and increased administrative demands, many providers reported that they had to reorganize their staffing to meet the increased administrative burdens associated with prior authorization and billing which had to be offset with reductions in clinical services to meet these administrative demands. In some instances, providers also reported having to lay-off staff. It is important to note that other providers indicated that they have not yet had to curtail services or lay-off staff. It seems that larger providers were better able to avoid staff lay-offs or the reductions/elimination of services while smaller or more rural providers were impacted more dramatically.

## Discussion

Key informants interviewed from the MCOs and the provider agencies both acknowledge the issues related to efficiency of preauthorization and billing procedures. Both MCOs and service providers reported increased organizational burdens that necessitated the hiring of additional administrative staff to ease these issues. However, the groups had somewhat different views regarding why these issues exist and who is primarily responsible for them. From the MCO key informants' perspectives, providers who are relatively new to managed mental health care and who have experienced difficulties following prescribed procedures are the principal causes for authorization and payment issues. However, providers report that the primary causes for these problems are the prior authorization and billing procedures that vary significantly across MCOs, which are also unclear, overly complex and burdensome.

## Medicaid Recipients' Access to Care

### Findings

This section summarizes the evaluation findings associated with recipients' access to care within the context of the expansion of Medicaid mental health managed care. The personal assessments of access to care were obtained from various subgroups of Medicaid recipients as part of the Children's Quality of Care study, the Implementation Analysis, and the Mail Survey evaluation components. In the Children's Quality of Care Study, survey responses were obtained from 145 caregivers of children who have been diagnosed with SED in Area 7. Although caregivers' responses to questions on access to mental health services clearly show room for improvement, their overall assessment indicates a slightly favorable assessment of their children's access to care. Caregivers of children receiving services from Amerigroup rated their children's access to mental health care significantly better compared to caregivers of children enrolled in United. Six specific areas where caregivers reported a need for improvements associated with access include: 1) greater recognition of family customs and traditions, 2) having

interpreters available for families, 3) availability of providers to see patients right away when needed, 4) greater access to necessary medications, 5) provision of assistance to families when dealing with multiple providers and/or service systems, and 6) availability of providers to talk with caregivers when called. Additionally, caregivers identified three systemic barriers that impede their ability to access care for their children. These included: 1) problems with transportation, 2) lack of affordable childcare, and 3) having to take time off work to obtain care.

As part of the Implementation Analysis, the perceptions of adult recipients diagnosed with SMI were obtained during two focus groups conducted in Areas 5 and 7. Participants acknowledged that Medicaid eligibility increased their ability to get mental health services. They indicated that while Medicaid offered less choice for services than the private sector, it made it easier to access medications through the mail-order pharmacies. Participants also cited a number of problems related to access to care. Specific issues included: 1) difficulty getting to see doctors between appointments, 2) long waiting times for appointments, and 3) difficulty getting group or one-on-one counseling. These adult participants also identified some of the same systemic barriers cited by caregivers of children with SED such as difficulty getting assistance with transportation and housing needs.

Finally, recipients access to care was examined using responses from 508 adult Medicaid recipients and caregivers of child recipients in AHCA Areas 5 and 7 who completed surveys as managed care was being implemented and a second time about one year after implementation. It is important to note that the survey component of this evaluation sampled all Medicaid recipients and is not specifically focused on recipients with known mental health needs. Of the eight access indicators Medicaid recipients assessed, significant declines were found on two, both reported by caregivers of children enrolled in Medicaid. However, neither of these indicators was specifically related to access to mental health services.

Medicaid claims and encounter data were used in the Administrative Data Analysis to evaluate the impact of implementing mental health managed care in AHCA Areas 5 and 7 on recipients' access to care. Access was assessed by examining penetration rates to various mental health services for adults diagnosed with SMI and children diagnosed with SED. Administrative analyses were focused on these two subgroups of Medicaid recipients given they are individuals more likely to be affected by changes in the financing and delivery of mental health services relative of other Medicaid recipients. Generally, the penetration rates of community mental health services (CMHS) for both adults and children declined from pre-implementation of Medicaid mental health managed care to the post periods. This decline in penetration was most dramatic for recipients in Amerigroup (both adults and children) and was consistent across both Areas 5 and 7. The one exception to this was among adults diagnosed with SMI served by the FHP in area 5, who had a 15% increase in CMHS.

With one exception (i.e., children with SED in Area 5), recipients in HMOs had higher penetration rates for psychiatric office visits after the implementation of managed care compared to FHP enrollees. Penetration of the psychiatric office visits was generally lower for recipients in Amerigroup relative to recipients in the

other HMO's. However, Amerigroup recipients who accessed psychiatric office visits had more visits than did users of this service in the other plans. Contrary to expectations related to the impact of managed mental health care, there was an inconsistent decline in the penetration of inpatient services in the post implementation of managed care compared to the pre-implementation periods. Penetration of emergency services tended to be higher for Healthsease and Staywell compared to Amerigroup and the FHP in the post implementation periods.

Providers' perspectives regarding recipients' access to services were also examined. As part of the Implementation Analysis, ten key informant interviews were conducted with administrators of provider agencies in AHCA Areas 2, 3, and 11. Some providers reported that since the implementation of managed care, fewer services were being provided to recipients (especially case management and psychosocial rehabilitation) relative to pre-managed care levels. Providers concerns were increased for Medicaid recipients in HMOs. In some instances, providers reported having to lay off staff. Other providers indicated that they had not yet curtailed services or laid-off staff. It seems that larger providers were better able to absorb these increased administrative requirements and avoid staff lay-offs and/or reductions/elimination of services while smaller, more rural providers were affected more dramatically.

As part of the Children's Quality of Care Study, 41 practitioners from provider agencies in Area 7 were surveyed and asked to assess the quality of care of Medicaid-funded children's mental health services. Providers' responses were generally consistent with those of administrators and raise some concerns regarding access to care. Providers rated access to services lower than the other three quality domains examined in this study (i.e., consumer engagement, appropriateness, and outcomes). Although 78% of practitioners indicated that in general children they served were getting their needs met through the mental health services being provided, only 49% reported that children received all the services they needed. Providers' overall assessment of availability of children's mental health services suggested they perceived children have a moderate level of access under managed care.

## Discussion

The failure to observe consistent declines in the provision of inpatient services after the implementation of managed care is contrary to what one would expect. However, the decline in CMHS observed after the implementation of managed care among adults with SMI and children with SED is a potential cause for concern given the vulnerability of these recipients and should be closely monitored. The lower penetration rates of CMHS, emergency services, and psychiatric office visits among recipients in Amerigroup may be problematic. However, the higher frequency of psychiatric office visits by Amerigroup recipients may indicate their ability to identify and provide increased access to recipients most in need. These findings may also be explained by any underreporting of service encounter data.

Interestingly, caregivers in the Children's Quality of Care Study reported more

favorable assessment of service access than did practitioners at provider agencies. This may suggest that to date, practitioners have been able to successfully shield recipients from the access issues and concerns they encounter organizationally. Given that caregivers of children receiving services from Amerigroup rated their children's access to mental health services consistently higher than other plans, this might further support Amerigroup's ability to identify and serve those recipients most in need.

The systemic problems of child care and transportation raised by caregivers of children with SED and adults with SMI are issues that emerge on an annual basis. While it should be noted that these barriers are not the making of the MCOs and that they are not contractually responsible for ameliorating them, they represent challenges that need to be collectively addressed by public and private entities on both state and local levels.

## Medicaid Recipients' Outcomes

### Findings

Adult and child outcomes were assessed as part of the administrative data analysis by examining rates of BA evaluations and arrests by health care plan and Area. Although not statistically significant, the findings suggest some evidence of deterioration in outcomes for adults with SMI from the pre to post implementation periods, as indicated by increases in BA rates for recipients in Healthsease in both areas and for Healthsease and Staywell in Area 7. Rates of BA evaluations for recipients with SMI in FHP tended to improve pre- to post-managed care implementation. Pre to post differences were significant for Area 5. No change was observed for Amerigroup recipients. In terms of arrest, no consistent patterns of change were found among Medicaid recipients with an SMI. Not surprisingly, BAs and arrest rates for children diagnosed with SED children were lower than for adults with an SMI. No pattern of change in the outcomes of children with SED were observed in BAs and arrests when compared pre and post implementation of managed care.

In the Children's Quality of Care Study caregiver opinions on various aspects of their children's functioning and mental health status were obtained. Additionally, they were asked to provide a self-report assessment of their children's mental health status using Pediatric Symptom Checklist (PSC Jellinek, Murphy, & Burns, 1986). Overall, caregivers' responses indicated that 75% the children exceeded the cut off scores indicative of higher levels of impairment. Importantly, however, there were no significant differences among MCOs in the percentage of children with SED with scores above this threshold. Less than half of the caregivers of children diagnosed with SED reported they were functioning positively with friends. School functioning (including getting into less trouble at school, having more interest in school, and improved grades and attendance) was rated as positive by only 37% to 53% of caregivers. Caregivers' responses to questions regarding whether their children had gotten better and if things were good for their children elicited relatively low positive responses (38% and 40% respectively). Findings for the latter item included a significantly higher mean

score for FHP compared to both United and Harmony.

Eighty percent of the practitioners responding to the Children's Quality of Care Survey reported that they monitored and tracked the overall stability, functioning, and quality of life of children with SED who they served. Despite this, practitioners reported a need to review the outcome measurement tools used to track and monitor children's progress.

As part of the population-based mail survey, self-report health and mental health status measures were obtained on 508 adult and child Medicaid recipients residing in Areas 5 and 7. Overall, adult Medicaid recipients' physical health status fell well below the average that would typically be expected in a general adult population. Similarly, adult Medicaid respondents' mental health status, as assessed by two different measures, was found to be poorer than would be expected in a general adult population. Importantly, however, of the three adult health-related indicators examined, no significant decline was observed in adults' health or mental health status on these measures between the 2005 and 2006 mailings. Also no significant differences in adults' health or mental health status were found between those living in Areas 5 and 7 or between adults served by HMOs or the PMHP.

Caregivers' reports of their children's health and mental health status were also examined. Children's physical health status rated as average. Children's mental health status (as assessed by the score on the PSC) indicated that, across both survey years, approximately 34% of the children in Areas 5 and 7 were assessed above the criterion score on this measure, suggesting a need for further psychosocial evaluation. It should be noted that, in a general pediatric population, approximately 20% of the children screened would fall above this criterion score. This suggests that Medicaid-enrolled children in Areas 5 and 7 have poorer psychosocial functioning than would be expected in a general pediatric population. No significant change in reported mental health status was noted over time. Additionally, no significant differences in children's mental health status were found associated with health care plan or area of residence.

## Discussion

Increased rates of BA evaluations post-implementation of managed mental health care among adult Medicaid recipients diagnosed with SMI offer some cause for concern and suggest some evidence of deterioration in outcomes. Increased BA rates were not found among children with SED. However, caregivers self-reports of their children's behavior suggest that a substantial percentage of them continue to experience challenges at school and home. Importantly, only a small percentage of caregivers' perceived improvement in their children's functioning over time. Caregivers reported a need for services to assist them in mitigating family stress and a desire for increased collaboration among families, schools, and service providers. These findings are important given they are directly related to recipients who are most likely to be impacted by managed mental health care. In contrast, results from the population-based mail survey provide no evidence of decline in the health or mental health status of the

general Medicaid population. Despite the fact that most practitioners reported the agencies monitor children's functioning, they cited a need to review the monitoring tools that are used to track children's progress.

## Medicaid Recipients' Quality of Care

### Findings

Within the administrative data analysis component, the quality of mental health care in Areas 5 and 7 was evaluated using three indicators. The first indicator was the percentage of recipients discharged from inpatient care with a psychiatric diagnosis who had at least one follow-up ambulatory care visit within 30 days of discharge. This performance measure is one of the standards put forth in the HEDIS established by the National Committee for Quality Assurance (NCQA, 2004). The second indicator extended this timeframe to six months. The third quality indicator was the percentage of people discharged from the hospital in each plan who were readmitted to a deep-end service during their follow up periods.

In terms of 30 day follow-up, plans provided ambulatory services to between 60% and 70% of people discharged from the hospital within 30 days. Although below the desired HEDIS goal of 90%, these rates exceed the national average for Medicaid recipients of 56% (NCQA, 2004). The Amerigroup plan is the one exception, serving only 44% of discharges in Area 5 and 30% in Area 7 within 30 days of discharge. Healthease in Area 7 also served only 44% of discharged recipients within 30 days.

When the time span for service provision was extended to six months, most recipients in all plans in Area 5 received some community services after their inpatient discharge. FHP recipients had the smallest percentage of recipients receiving no services and Healthease had the largest, but all were below 11%. In Area 7, we see a similar pattern for FHP, Healthease and Staywell. All had fewer than 10% of discharges receiving no services with Healthease and Staywell performing slightly better than FHP. However, in Area 7, 28% of Amerigroup recipients discharged from inpatient care received no community-based mental health services during the six-month follow-up period.

Given that a major goal of service delivery following hospital discharge is to reduce the frequency of readmission to an inpatient or other deep-end service, the percentage of hospital discharges readmitted to a deep-end service in each plan was examined. FHP recipients had the lowest "readmit rate" in Area 7; Amerigroup was the lowest in Area 5. Healthease and Staywell had the highest rates in Area 5 and more moderate readmission rates in Area 7. Despite the lack of follow-up care experienced by Amerigroup recipients, their readmission rate was the lowest in Area 5. It was comparatively high in Area 7, but still below Healthease which appeared to do much better follow-up service delivery.

As part of the Children's Quality of Care Study, the 145 caregivers of children with SED assessed the adequacy of their engagement in the treatment process. Their responses revealed a specific need for providers to: better inform families

about the child's condition, medication, and/or treatment; talk with caregivers about ways to manage their child's behavior and stress; discuss treatment options with families and offer a choice of treatments; and offer or provide a copy of the treatment plan to caregivers.

Caregivers provided several recommendations which they believe would improve the appropriateness of services their children with SED received. These recommendations included: increasing family involvement in deciding what treatments their children receive, better individualization of treatment plans, enhanced focus on incorporation children's strengths in the treatment plans, and improving communications between providers or agencies/systems to ensure continuity of care.

As might be expected, practitioners participating in the Children's Quality of Care Study reported more positive views about the quality of mental health care provided to children with SED and their families, relative to caregivers. Almost all responding practitioners reported soliciting input from the child and family during the treatment planning process, taking child and family opinions into consideration when working with children with SED, and incorporating caregiver suggestions/input into the child's treatment plan as much as possible. Fewer practitioners reported that caregivers always signed their child's treatment plan and that caregivers were always offered or given a copy of the treatment plan.

As part of the population-based survey component of the evaluation, adult Medicaid recipients, who used mental health services in the six months preceding the survey, were asked to rate their level of satisfaction with these services. Overall, adult respondents reported being somewhat to moderately satisfied with the mental health services they received. No significant differences in satisfaction with mental health services were found associated with respondents' health care plan, area of residence, and no changes were noted pre- to post-implementation of managed care. Caregivers were also asked to rate their satisfaction with the mental health services their children received. Similar to adult respondents, caregivers also reported being somewhat to moderately satisfied with the mental health services their child had received. Again, no significant differences were observed among caregivers regarding their level of satisfaction with the mental health services their children received associated with health care plan, geographic area, or over time.

Findings from the Implementation Analysis indicated few changes have occurred in providers' quality assurance procedures. Of those who have implemented changes, one provider created procedures that facilitate compliance with client grievances, complaints and satisfaction surveys. Another provider said they have focused more on tracking outcomes and rates of recidivism. One provider described efforts to augment coordination between staff and their clients' primary care physicians. Another has been "CARF accredited" for three years, which is a requirement of the HMOs. Two providers reiterated the concern regarding a significant amount of administrative time spent/"wasted" providing data to multiple sources, completing duplicate reports and meeting quality assurance requirements.

Most providers reported little to no changes to the clinical guidelines and said they follow American Psychological Association guidelines and incorporate any changes APA makes. Many also said they operate within the clinical guidelines the HMOs and PMHPs created.

### **Discussion**

Although the provision of post hospital discharge follow-up mental health services fell below desired HEDIS levels, they were generally consistent with the national average for a Medicaid population. The lower rates of follow-up service provision among recipients in Amerigroup could be the result of under reporting of encounter data by this MCO. Importantly, the implementation of mental health managed care had no association with arrests. Not surprisingly, practitioners and caregivers reported different opinions regarding the quality of the mental health services children with SED receive, with practitioners generally indicating a higher quality of care relative to caregivers. Caregivers' ratings of MCOs suggest a need for improvement in each of the four quality domains examined; access, engagement, appropriateness, and outcomes. While most practitioners indicated obtaining input from families during treatment planning, caregivers reported that providers need to better inform them about their child's condition, discuss treatment options with them and offer a choice of treatments.

## Cumulative Evaluation Findings

For the past ten years, researchers at FMHI have conducted a series of integrated evaluation projects to assess the effects of these mental health managed care programs on Medicaid recipients' access, cost, quality, and outcomes of services. Although there have been many insights obtained during the evaluation of Florida's implementation of Medicaid mental health managed care, the following eight insights have emerged most consistently across the years:

1. Generally, the implementation of Medicaid mental health managed care has resulted in cost savings for the Florida Agency for Health Care Administration.
2. The transition to managed care, in any form, is enhanced with a sufficient period of planning and readiness preparation by government entities, managed care organizations, and service providers.
3. There is an initial period of significant instability, confusion, and frustration in the service delivery systems associated with the implementation of managed mental health care.
4. A number of implementation issues have been consistently observed across AHCA areas. They presence are most dramatic in situation where MCOs and providers operate under a fee-for-service arrangement. The most notable issues relate to the timing and administrative burden associated with the preauthorization of services and with billing procedures.
5. Services utilization, as measured by penetration rates, differs by the plan in which individuals are served. In general, lower penetration rates have been noted among recipients in HMOs relative to recipients in a PMHP. Managed care recipients (i.e., both HMO and PMHP) have lower penetration rates relative to individuals enrolled in fee-for-service.
6. Despite the lower service penetration rates noted among recipients in managed care, there is no clear and consistent evidence of any negative effects on recipients' health-related outcomes.
7. There is some evidence of compensatory non-Medicaid funded services being received by Medicaid recipients that is associated with the extent to which services are managed.
8. There in little evidence that the array of services available to Medicaid recipients has expanded, the quality of care recipients receive has improved, or recipients' choice of providers has increased.

## For More Information

Readers can obtain more detailed information regarding the methods, findings, and conclusions derived from each of these four evaluation sub-studies conducted during the 2006-2007 fiscal year by referring to the individual study reports listed below.

Boothroyd, R. A., (2007). *Evaluation of Florida's Medicaid Managed Mental Health Plans: Mail Survey Component*. Tampa, FL: Louis de la Parte Florida Mental Health Institute. University of South Florida.

Constantine, R., Murrin, M. R., Guo, J., & Wang, Y. (2007). *Evaluation of Florida's Medicaid Managed Mental Health Plans Year 10 Report: Administrative Data Component*. Tampa, FL: Louis de la Parte Florida Mental Health Institute. University of South Florida.

Robinson, P., Sasser, A., Suleski, J., Batsche, C., (2007). *The Ongoing Expansion of Florida's Medicaid Managed Mental Health Care: An Implementation Analysis*. Tampa, FL: Louis de la Parte Florida Mental Health Institute. University of South Florida.

Sharrock, P., Vargo, A. C., Vergon, K. S., Roggenbaum, S., Boothroyd, R., Pedraza, J., & LeBlanc, A. (2007). *A study of the quality of children's mental health services within Florida's behavioral health care plans: FY06-07*. Tampa, FL: University of South Florida.

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- Vargo, A. C., Sharrock, P., Pedraza, J., Dhont, K., Armstrong, M., Boothroyd, R., et al. (2005). *A study of the quality of children's behavioral health services within Florida's behavioral health managed care plans* (Agency for Health Care Administration Report Series (AHCA Series) No. 220-56). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.
- Vargo, A. C., Sharrock, P., Pedraza, J., Reyes, F., Roggenbaum, S., & Kershaw, M. A. (2006). *A study of quality of children's behavioral health services within Florida's Prepaid Mental Health Plan: Phase I: Measure development* (Agency for Health Care Administration Report Series (AHCA Series) No. 220-xx). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.

