THE LOUIS DE LA PARTE FLORIDA MENTAL HEALTH INSTITUTE

The Ongoing Expansion of Florida's Medicaid Managed Mental Health Care: An Implementation Analysis

Pat Robinson, Ph.D.
Airia Sasser, M.P.H.
Janet Suleski, M.S.W.
Catherine Batsche, Ph.D.

USF UNIVERSITY OF SOUTH FLORIDA

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University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3807

For more information, call 813-974-1913
or visit the Website: http://fmhi.usf.edu

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List of Acronyms

AHCA	Agency for Health Care Administration
PMHPs	Prepaid Mental Health Plans
HMOs	Health Maintenance Organizations
BHOs	Behavioral Health Organizations
MCOs	Managed Care Organizations (Includes PMHPs, HMOs, and BHOs)
FFS	Fee-for-Service
PA	Prior Authorization
SSI	Supplemental Security Income
SMI	Serious Mental Illness
ADHD	Attention Deficit Hyperactivity Disorder
QI	Quality Improvement
QA	Quality Assurance
FARS	Functional Assessment Rating Scale
CFARS	Child Functional Assessment Rating Scale
TBOS	Therapeutic Behavioral Health Overlay Services
CSUs	Crisis Stabilization Units
APA	American Psychiatric Association
PSNs	Provider Service Networks
NFBHP	North Florida Behavioral Health Partners

The Ongoing Expansion of Florida's Medicaid Managed Mental Health Care: An Implementation Analysis

Executive Summary

Since 1996, Florida's Medicaid Authority, the Agency for Health Care Administration (AHCA), has been implementing managed mental health care through Prepaid Mental Health Plans (PMHPs). The initial PMHP was established in 1996 in AHCA Area 6, the Tampa Bay region; in 2001, the PMHP was initiated in Area 1, the Panhandle area. During 2006-2007, AHCA expanded the PMHPs statewide, with the exception of the counties where Medicaid Reform had been introduced (i.e., Area 4 – Duval, Clay, Baker, and Nassau Counties; Area 10 – Broward County). The organizations that administer the prepaid plans have area-wide responsibility for providing comprehensive mental health benefits to individuals enrolled in MediPass.

In addition to the PMHPs, Medicaid health maintenance organizations (HMOs) and their behavioral health organizations (BHOs) have expanded their mental health benefits to include community mental health services in all AHCA areas throughout Florida. Every AHCA area now has at least one HMO providing comprehensive mental health care benefits; however, there are still several counties within AHCA Areas, particularly in the more rural areas, where no HMOs are operating.

To document the implementation of these managed care plans in Areas 2, 3, and 11 during 2006-2007, we conducted the following methods of data collection/analyses:

- Semi-structured, in-person and telephone interviews with key administrative staff from the PMHPs, HMOs, and BHOs and a sampling of provider organizations in their networks.
- Administrative data analyses regarding recipient characteristics in Areas 2, 3, and 11.
- Follow-up electronic surveys with agencies, managed care organizations (MCOs), and providers that had been interviewed in 2005-2006.
- Focus groups in Areas 5 and 7 with adult recipients of Medicaid managed care to obtain perspectives from service recipients.

Ten Medicaid HMOs/BHOs oversee comprehensive mental health services through their provider networks in Areas 2, 3, and 11 as well as in other areas of the state. Currently, three PMHPs operate in Areas 2, 3, and 11, including North Florida Behavioral Health Partners (Area 3); Magellan Behavioral Health of Florida (Areas 2 and 11); and The Public Health Trust (Area 11) of Dade County, whose behavioral health services are managed by University of Miami Behavioral Health (UMBH). The implementation of the PMHPs in Area 11 is unique compared with other areas within the state because, unlike other AHCA areas

that are served by one PMHP, Miami-Dade County has two PMHPs because of the size of its population.

Areas 2 and 3 have twice as many Medicaid recipients enrolled in MediPass than in the HMOs (Area 2: 70% MediPass and 30% HMOs; Area 3: 68% MediPass and 32% HMOs). In contrast, slightly more recipients are enrolled in HMOs (51%) than in MediPass (46%) in Area 11, and 3% of recipients are in provider service networks. The majority of enrollments in both the PMHPs and the HMOs in all three areas are composed of individuals younger than 21 years of age; females represent slightly more than half of the enrollments, and there are more recipients of Supplemental Security Income (SSI) in the PMHPs than in the HMOs in Areas 2 and 3. Consistent with the differences in SSI rates, the MediPass conditions are more likely to have persons with diagnoses of serious mental health illnesses as indicated by the data in the AHCA pre-managed care fee-for-service (FFS) files. Hispanic and African Americans are represented in both the PMHPs and the HMOs; however, there are higher concentrations of Hispanics in Area 11 and more African Americans in Areas 2 and 3.

As we have found in previous years, providers reported problems with prior authorization (PA) for services and billing procedures associated with some of the FFS financing arrangements with the managed care entities. Providers reported that many services are being denied by managed care organizations (MCOs) under their FFS arrangements and that the MCO billing procedures are complex and overly burdensome. They also reported experiencing significant delays in payments. As a result of these problems, at least two providers have begun negotiating subcapitated arrangements with one HMO, Harmony Behavioral Health. Other providers have threatened to terminate their contracts with particular MCOs, including Magellan (the PMHP). Also, providers reported that the procedures for obtaining PA for services vary significantly among the managed care entities and that they are not always clear about what the MCOs require. In addition, providers indicated that reductions in Medicaid revenues, the service costs to their organizations, and the billing and reporting requirements of the MCOs have caused them to reorganize their staffing, in some cases, by reducing clinical services to meet extensive administrative demands. Some providers, however, indicated that they have not yet had to curtail services or lay off staff. From some providers' perspectives, service provision has diminished with the implementation of managed mental health care.

In this latest round of expansion during 2006-2007, MCOs reported that they also had to add administrative staff to accommodate the demands of adding new sites, establishing new relationships, and engaging providers. However, their comments suggested that they believed they were meeting these challenges successfully. In contrast, providers reported frustration with having to add administrative capacity while having to adjust to reductions in Medicaid revenues and, in some instances, clinical staff layoffs and/or the curtailment or elimination of services. Although larger providers were more likely to avoid staff layoffs or the reduction/elimination of services, one smaller, more rural provider was affected more dramatically. Their experience reportedly affected access to services.

Unlike the mixed optimism reported by providers in previous years, providers in these areas were not hopeful that these issues would be resolved quickly. Some have begun to question whether they will be able to continue to contract with at least some of the MCOs to provide mental health services.

Despite the fact that providers reportedly have continued to provide services without assurances of being compensated, service recipients may be aware of and be affected by these changes in financing. Medicaid recipients described problems in accessing services and were concerned about the limits placed on services. They also reported being concerned about staff turnover in case management (a service that many providers reportedly have reduced). Although most recipients reported being satisfied with the quality of the services they received, several reported that the services were not as good as they used to be.

As a result of our findings, the following recommendations are offered:

- AHCA should closely monitor the bill-paying performance of MCOs to ensure that providers are reimbursed for Medicaid services within the timeframe required in their contracts.
- The use of common, standardized protocols for both billing and PA among the MCOs would help alleviate some of the problems that providers have experienced in working with the different MCOs. However, the unique business practices of MCOs may make the use of common protocols or procedures unrealistic. AHCA should require that MCO procedures are made available to providers in writing when providers are added to their networks. MCOs should send procedural changes in writing to providers on a timely basis.
- AHCA should examine issues that may be unique to rural areas, such as the availability of providers and transportation to services, in order to determine any special provisions that can be made to assure adequate access to services. Accessibility issues in rural areas should be regularly monitored.
- The quarterly Area Advisory meetings can be an important forum for providers as well as recipients and their families, to discuss concerns and resolve issues. These meetings should therefore be accessible in terms of the times they are held and their locations. All Area offices should consider holding some meetings after regular business hours to allow individuals who are working to attend. Additionally, the Area offices should explore the possibility of providing child care as well as transportation for recipients who have no other means of attending the meetings. To further enhance problem-solving and communication, additional opportunities for feedback, such as AHCA-sponsored provider forums and family discussions or focus groups should also be explored.
- Recommendations from the recipient focus groups include:
    - Have "real" people answer HMO help lines rather than automated systems.
    - Staff should be better trained in customer service.
    - Locate services in safe neighborhoods.

- Shorten wait times for MH and medical appointments.
- Make services available without having to go into Crisis Stabilization Units.
- Make more group and one-on-one counseling services available.
- Find ways to have doctors available for longer sessions and not rush people through.
- Provide more choices in services and service providers.
- Increase the number of physicians who accept Medicaid.

Background

Since 1996, Florida's Medicaid Authority, the Agency for Health Care Administration (AHCA), has been implementing managed mental health care through Prepaid Mental Health Plans. The initial PMHP was established in 1996 in AHCA Area 6, the Tampa Bay region, in 2001, the PMHP was initiated in Area 1, the Florida Panhandle area. During 2006-2007, AHCA expanded PMHPs statewide, with the exception of the counties in which Medicaid Reform has been introduced (i.e., Area 4 – Duval, Clay, Baker, and Nassau Counties and Area 10 – Broward County). The organizations administering the PMHPs have area-wide responsibility for providing comprehensive mental health benefits to individuals enrolled in MediPass.

In addition to the PMHPs, Medicaid HMOs expanded their mental health benefits to include comprehensive community mental health services in AHCA Areas throughout Florida. By 2007, every AHCA Area had at least one HMO providing expanded mental health care benefits; however, there were still several counties within the AHCA Areas, particularly in the more rural areas, where no HMOs were operating. In the areas of focus for this study (AHCA Areas 2, 3, and 11); at least half of the counties do not have HMO penetration. With the exception of Monroe County (the Keys), these counties are large rural areas of the state that have relatively fewer Medicaid recipients.

Tables 1, 2, and 3 show the PMHP and the HMOs (and their BHOs) that are providing managed mental health care in Areas 2, 3, and 11 and the date they began implementation.

Table 1
Implementation of Managed Mental Health Care AHCA Area 2

	Managed Care Organizations			
Counties	**Buena Vista (PsychCare)**	**HealthEase (Harmony)**	**PMHP Magellan**	**Universal (MHNet)**
Area-wide			10/1/06	
Calhoun		6/1/05		
Liberty	3/1/06	6/1/05		
Gadsden	3/1/06	6/1/05		3/1/06
Leon	3/1/06	6/1/05		3/1/06
Madison	3/1/06	6/1/05		
Wakulla	3/1/06	6/1/05		3/1/06
Jefferson	3/1/06			3/1/06

*Bay, Franklin, Gulf, Holmes, Jackson, Taylor, and Washington counties have no HMO penetration.

Table 2

Implementation of Managed Mental Health Care AHCA Area 3

	Managed Care Organizations		
Counties	**HealthEase (Harmony)**	**Staywell (Harmony)**	**PMHP North Florida Behavioral Health/ ValueOptions**
Area-wide			10/1/06
Putnam	5/1/05		
Citrus	5/1/05		
Hernando		5/1/05	
Marion	5/1/05		
Lake	5/1/05		

*Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Sumter, Suwannee, and Union counties have no HMO penetration.

Table 3

Implementation of Managed Mental Health Care AHCA Area 11

Managed Care Organizations	Start Date
Amerigroup	6/1/05
Buena Vista (PsychCare)	3/1/06
HealthEase (Harmony)	9/1/06
Humana(PsychCare)	4/1/06
Public Health Trust of Dade County JMH Health Plan (UMBH)	3/1/06
Preferred (PsychCare)	4/1/06
Staywell (Harmony)	9/1/05
Total Health Choice (PsychCare)	4/1/06
United (UBH)	6/1/06
Vista of South Florida (PsychcCare)	3/1/06
Magellan/PMHP	8/1/06
Public Health Trust/PMHP (UMBH)	8/1/06

*Monroe County has no HMO penetration.

This implementation analysis describes the organizational structures, financing arrangements, and program features of the PMHPs and the various HMO plans that added comprehensive mental health benefits as of December 31, 2006. AHCA Areas in this analysis include Area 2 (Holmes, Jackson, Washington, Bay, Calhoun, Liberty, Franklin, Wakulla, Leon, Jefferson, Madison, and Taylor counties), Area 3 (Hamilton, Suwannee, Columbia, Union, Bradford, Lafayette, Dixie, Gilchrist, Alachua, Levy, Citrus, and Hernando, Marion, Lake, and Sumter counties), and Area 11 (Dade and Monroe counties). In addition, data were collected in 2006-2007 from providers, managed care organizations (MCOs), and service recipients as a follow-up to the 2005-2006 study.

Methods

To document the implementation of the new managed care plans in Areas 2, 3, and 11 during 2006-2007, the following methods were conducted:

- Semi-structured, in-person and telephone interviews with key administrative staff from the PMHPs and HMOs/BHOs operating in the areas as well as a sampling of provider organizations in their networks.
- Administrative data analyses regarding recipient characteristics in Areas 2, 3, and 11.
- Follow-up electronic surveys with agencies (MCOs and providers) that had been interviewed in 2005 and 2006.
- Focus groups in Areas 5 and 7 with adult recipients of Medicaid managed care to obtain perspectives from service recipients.

Interviews

Provider Interviews

AHCA provided a list of managed care organizations that had implemented community mental health services between January 1 and December 31, 2006, which included Areas 2, 3, and 11. The MCOs that manage mental health services in Areas 2, 3, and 11 were asked to provide a list of high-volume providers within their networks. From those lists, we selected a sample of 10 providers to be interviewed who provided services for more than one managed care plan (e.g., two HMOs or an HMO and the PMHP). Of the provider interviews, one was conducted with a large comprehensive provider in Area 2, three were conducted with providers in Area 3, and six were conducted with providers in Area 11. Additional interviews were conducted in Miami-Dade County because of the high concentration of service recipients in Area 11.

MCO Interviews

We conducted four in-person or telephone interviews with the new managed care organizations (HMOs/BHOs and PMHPs) that had been approved by AHCA to manage comprehensive mental health benefits in the three AHCA Areas. They included Magellan, the Public Health Trust in Dade County/University of Miami Behavioral Health, PsychCare, and Mental Health Net (MHNet). The latter two organizations managed the mental health services for several HMOs.

Electronic surveys were sent to HMOs/BHOs that were managing mental health services in Areas 2, 3, and 11, but were not new to the Medicaid managed mental health care market and were interviewed last year.

MCO and provider interview protocols developed for the 2005-2006 study were updated for use in this study. The MCO and provider protocols included the following domains:

- Organizational structures and relationships.
- Financial arrangements.
- Clinical management strategies, including utilization management processes and clinical guidelines.
- Management information systems.
- Consumer and family involvement issues.
- Implementation issues.

Individuals who participated in either the telephone or in-person interviews were asked to sign an informed consent form. All interviews were audio taped. We subjected all interviews to summarization and content analyses to identify common themes.

Administrative Data

We used administrative data from AHCA enrollment and pre-managed care claims files to describe the characteristics of the enrolled populations in Areas 2, 3, and 11 with respect to gender, age, eligibility status, race, ethnicity, and diagnoses. Data from the administrative files were obtained for the 6-month period before the specific implementation dates in the expansion sites for each of the managed care plans. Baseline data were not available for one HMO, Total Health Choice, in Area 11. In addition, it was not possible to differentiate baseline data between the two PMHPs (Magellan and the Public Health Trust) in Area 11 because there was only one MediPass plan.

E-mail/Online Follow-up Survey

We conducted an e-mail follow-up survey to assess 1 year post-implementation with the MCOs and providers whom we interviewed in-person or via telephone in 2005-2006. The follow-up protocols requested updated information in the same domains as were covered in the previous year and were similar to those included in the surveys for new MCO and providers. We also developed a Web-based version of each survey for those who preferred to complete the survey online. We conducted the content analysis on the data obtained from survey respondents. Sixteen of the seventeen surveys distributed were returned, for a response rate of 94%. (Please see the Appendix for a listing of organizations that received the e-mail follow-up survey.)

Focus Groups

In collaboration with the Florida Peer Network, a statewide consumer organization, two focus groups with adults enrolled in the managed care plans operating in Pinellas County (Area 5) and Orange County (Area 7) were conducted to get recipients' perspectives on their access to services, the integration of their services, and their satisfaction with the quality of the services they received. Areas 5 and 7 were selected because the PMHP had been operational for more than one year and Medicaid beneficiaries would have had more time

to experience the transition to managed mental health care. The Florida Peer Network recruited individuals from drop-in centers and provider agencies in both counties.

Limitations

The information in this report generally describes differences between the PMHPs and HMOs/BHOs and treats the HMOs/BHOs as a single group. However, we recognize that there are significant distinctions among the operations of HMOs, BHOs, and PMHPs. Whenever possible, we identified the specific agency that was referenced in comments by interview participants, but in most cases the concerns identified in this report reflect the views of administrators across the AHCA areas included in this study.

Interviews were successfully conducted with only a small sample of providers in the MCO networks. Therefore, we caution against overgeneralization of these findings. In addition, we conducted most of our interviews with administrative staff, as opposed to direct service or program staff. Consequently, we are able to report very limited information regarding how direct service staff or services have been affected by these managed care strategies. Also, although we conducted focus groups this year in Areas 5 and 7 as a follow-up to the implementation of managed mental health care more than a year ago, we do not suggest that their views represent the views of all service recipients.

Results/Discussion

AHCA Areas 2, 3, and 11

Both Areas 2 and 3 are large geographic locations that are mostly rural, with population densities ranging from 8 residents per square mile in Liberty County to 359 residents per square mile in Leon County. This is in sharp contrast to Area 11, where the population density of Dade County is estimated at 1,158 residents per square mile. The largely rural nature of Areas 2 and 3 is an important consideration in the implementation of managed mental health care in these areas.

Area 2

AHCA Area 2 is composed of 14 counties including Holmes, Jackson, Washington, Bay, Calhoun, Gadsden, Liberty, Franklin, Gulf, Leon, Jefferson, Wakulla, Madison, and Taylor counties. Leon County is the most populated among the counties, with slightly more than 245,000 people. Gadsden County is the second smallest county geographically but is the most culturally diverse. Fifty-six percent of its population of slightly more than 46,000 is African American, and almost 8% is Hispanic. It also has the highest proportion of individuals younger than 18 years (26%) and one of the highest percentages of individuals living below the poverty level (18%) in the area (U.S. Census Bureau, 2000). Approximately 90,936 Medicaid recipients reside in Area 2 (AHCA Enrollment Report, February 2007).

Area 3

AHCA Area 3 is composed of 16 counties, including Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Union, Bradford, Alachua, Levy, Marion, Putnam, Citrus, Sumter, Hernando, and Lake (US Census Bureau, 2000). Marion, Lake, and Alachua are the three most populated counties (303,000, 277,000, and 224,000, respectively). Hamilton County is the most ethnically and racially diverse, with 36% of its population being African American and slightly more than 8% being Hispanic. Hamilton County has the highest percentage of people living below the poverty line (22%). Among the 16 counties, Putnam and Columbia counties have the largest proportion of people younger than 18 years (24%) (U.S. Census Bureau, 2000). There are 182,691 Medicaid recipients in Area 3 (AHCA Enrollment Report, February 2007).

Area 11

AHCA Area 11 consists of two counties; Dade County encompasses the Greater Miami area, and Monroe County consists of the Florida Keys. According to the AHCA February 2007 Enrollment Report, approximately 427,000 Medicaid recipients live in the two-county area, with fewer than 5,000 recipients residing in Monroe County. Dade County has almost 2.7 million people living within the 2,000-square-mile area, making it densely populated (1,158 per square mile). Dade County also has a highly diversified population, with 21% being African American and 61% being Hispanic. Slightly more than 10% of Dade County residents live below the poverty level, and almost 25% of its population is

younger than 18 years (US Census Bureau, 2000).

Health Maintenance Organizations

Ten Medicaid HMOs/BHOs oversee the full array of community mental health services through their provider networks in Areas 2, 3, and 11 as well as in other areas of the state. They include the following organizations:

- **Amerigroup Florida, Inc.**
- **Buena Vista Medicaid**, a part of Vista Health Plan, Inc., whose behavioral health services are managed by PsychCare.
- **HealthEase and Staywell**, sister HMOs within the Wellcare organization, whose behavioral health services are managed by Harmony Behavioral Health.
- **Humana Family**, a part of Human Medical Plan, Inc., whose behavioral health services are managed by PsychCare.
- **Preferred Medical Plan**, whose behavioral health services are managed by PsychCare.
- **The Public Health Trust of Dade County Jackson Memorial Health Plan**, whose behavioral health services are managed by University of Miami Behavioral Health (UMBH).
- **Total Health Choice**, whose behavioral health services are managed by PsychCare.
- **United Health Care of Florida, Inc.**, whose behavioral health services are managed by United Behavioral Health.
- **Universal Health Care, Inc.**, whose behavioral health services are managed by Mental Health Net.
- **Vista South Florida**, whose behavioral health services are managed by PsychCare.

HMOs have created large networks that include comprehensive community mental health centers as well as individual and small group practices. Three HMOs reported having more than 100 providers listed in their networks within Area 11.

Prepaid Mental Health Plans

Below is a list of three PMHPs currently operating in Areas 2, 3, and 11:

- **North Florida Behavioral Health Partners**, which operates in Area 3.
- **Magellan Behavioral Health of Florida**, which operates in Areas 2 and 11.
- **The Public Health Trust of Dade County Jackson Health Systems**, whose behavioral health services are managed by University of Miami Behavioral Health (UMBH) and which operates in Area 11.

The implementation of the PMHPs in Area 11 is unique compared with other

areas within the state. Unlike other AHCA Areas that are served by one PMHP, Miami-Dade County has two PMHPs. The Public Health Trust was designated in legislation as one of the two plans in Area 11, and the second PMHP was competitively procured. Enrollment with the PMHPs in Area 11 is not distinguished either by geographic location or by characteristics of enrollment. Medicaid recipients can choose to enroll in either plan. If they do not make a choice, they are assigned randomly to either plan. Many mental health providers in that area work with both PMHPs.

Characteristics of Enrollment

According to AHCA's February 2007 Enrollment Reports, Areas 2 and 3 had twice as many Medicaid recipients enrolled in MediPass than in the HMOs (Area 2: 70% MediPass and 30% HMOs; Area 3: 68% MediPass and 32% HMOs). In contrast, Area 11 had slightly more Medicaid recipients enrolled in HMOs (51%) than in MediPass (46%). Three percent of the Medicaid recipients in Dade County are enrolled with a PSN.

For individuals who fail to choose a plan (either MediPass or a Medicaid HMO), Medicaid is statutorily required (Chap 409.9122 F.S.) to assign individuals to one of the two plans until the eligible enrollment reaches 35% in Medipass and 65% in HMOs. Once that balance has been achieved, assignments are to be based on the preferences of recipients made in the previous period. The following table reflects the numbers of Medicaid recipients enrolled in the various plans in Areas 2, 3, and 11.

As noted in reports from previous years, not everyone enrolled in MediPass is eligible to participate in the PMHP. For example, individuals who are dually enrolled in Medicaid and Medicare, enrolled in the Medically Needy programs, and receiving hospice services are excluded. In addition, Medicaid recipients who are receiving services in 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). Also, as of February 1, 2007, AHCA implemented a special statewide

Table 4
Medicaid Health Plan Enrollments

Area	Health Plan	Enrollment*
2	Buena Vista (PsychCare)	8,570
	HealthEase (Harmony)	8,870
	Universal (MHNet)	1,316
	MediPass/PMHP	44,303
Total Medicaid Recipients in Area 2		*90,936*
3	HealthEase (Harmony)	24,358
	Staywell (Harmony)	6,469
	United	7,714
	Universal	868
	MediPass/PMHP	85,574
Total Medicaid Recipients in Area 3		*182,691*
11	Amerigroup	14,691
	Buena Vista (PsychCare)	8940
	HealthEase (Harmony)	17,401
	Humana (PsychCare)	21,654
	Public Health Trust of Dade County JMH Health Plan (UMBH)	13,864
	Preferred (PsychCare)	12,998
	Staywell (Harmony)	18,679
	Total Health Choice (PsychCare)	262
	United (UBH)	17,006
	Vista of South Florida (PsychcCare)	14,221
	MediPass/PMHPs	125,654
Total Medicaid Recipients in Area 11		*426,711*

*Includes MediKids Population
Source: Agency for Health Care Administration, Bureau of Managed Care, Data Analysis Unit, February 2007.

PMHP for children in Home SafeNet (child welfare). Children engaged in child welfare receive their mental health services in the Child Welfare Prepaid Mental Health Plan and are exempt from enrollment in either the other PMHPs or the HMOs for mental health services (except in Areas 1 and 6, where they were already included).

We examined demographic differences of the enrolled populations in the two financing conditions in Areas 2, 3, and 11 (PMHPs and HMOs) before implementation of managed mental health care. These findings are presented in Tables 5, 6, and 7. As we have seen in past evaluations in other areas, we found similarities in the demographic characteristics of the HMO and PMHP enrollees. For example, in all three areas (2, 3, and 11), the majority of the enrollments in both the PMHPs and HMOs consisted of individuals younger than 21 years (ranging from 59% in the Universal plan in Area 2 to 83% in the Staywell and Vista of South Florida plans). In addition, females comprised slightly more than half of the enrollments of all plans in all three areas. Areas 2 and 3 also had more SSI recipients in the PMHPs than in the HMOs.

In a similar fashion and consistent with the differences in SSI rates among Medicaid recipients who used services, people enrolled in MediPass were more likely to have a serious mental health diagnoses of schizophrenia, bipolar disorder, major depression, attention deficit hyperactivity disorder (ADHD), or oppositional defiant disorder. Hispanic individuals were similarly represented in both the PMHP and HMOs in Area 2 (4% to 5% of enrollments). In Area 3, Hispanic recipients comprised between 12% and 18% of enrollments. In Area 11, Hispanic individuals represented 25% of Staywell's enrollment and 66% in the PMHPs. The percentages of African Americans enrolled in the plans in Area 2 ranged from 35% in the PMHP to 72% in the HealthEase plan. In Area 3, African Americans represented between 12% (Staywell) and 28% (HealthEase) of enrollments. In Area 11, African Americans represented between 21% (MediPass) and 65% (Staywell) of HMO enrollments before implementation of managed mental health care.

Table 5

Area 2 Medicaid Recipient Characteristics

Recipient Characteristics	Magellan (PMHP)	Buena Vista (PsychCare)	HealthEase (Harmony)	Universal (MHNet)
Females	53%	58%	59%	64%
Age <21	81%	75%	71%	59%
Age 55-64	2%	<1%	<1%	<1%
Hispanic	5%	4%	4%	4%
African American	35%	65%	72%	63%
SSI	13%	8%	10%	6%
Serious MH Diagnoses	6%	3%	4%	3%

Table 6
Area 3 Medicaid Recipient Characteristics

Recipient Characteristics	North Florida Behavioral Health Partnership (PMHP)	HealthEase (Harmony)	Staywell (Harmony)	United (UBH)	Universal (MHNet)
Females	54%	56%	56%	55%	55%
Age <21	79%	74%	78%	79%	61%
Age 55-64	2%	<1%	<1%	1%	<1%
Hispanic	12%	12%	12%	18%	13%
African American	24%	28%	12%	22%	14%
SSI	14%	7%	6%	8%	4%
Serious MH Diagnoses	6%	4%	4%	2%	3%

Table 7
Area 11 Medicaid Recipient Characteristics

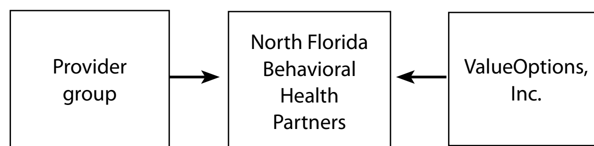
Plan	Recipient Characteristics						
	Females	Age<21	Age 55-64	Hispanic	African American	SSI	SMI
Amerigroup	54%	82%	2%	45%	46%	10%	6%
Buena Vista (PsychCare)	54%	77%	1%	44%	43%	8%	4%
HealthEase (Harmony)	57%	78%	<1%	39%	54%	7%	4%
Humana	54%	81%	2%	42%	47%	11%	5%
Public Health Trust of Dade County JMH Health Plan (UMBH)	54%	79%	2%	37%	54%	9%	5%
Preferred (PsychCare)	54%	79%	<1%	47%	44%	6%	4%
Staywell (Harmony)	56%	83%	<1%	25%	65%	13%	6%
Total Health Choice (PsychCare)	Figures not available for the pre-implementation period						
United (UBH)	54%	78%	2%	53%	32%	8%	3%
Vista of South Florida (PsychCare)	54%	83%	<1%	52%	36%	5%	3%
*Magellan (PMHP)	53%	77%	4%	66%	21%	20%	12%
*Public Health Trust (UMBH) (PMHP)							

New Prepaid Mental Health Plans

Magellan Behavioral Health of Florida was awarded the Medicaid PMHP contract for Areas 2 and 11. One of the four current PMHPs in the state, Magellan was incorporated in Florida in 2004. To respond to its new responsibilities for the management of Medicaid mental health services, Magellan established a new site in Miami-Dade County, hired new staff, and developed the Medicaid managed care arm of its business.

In Area 3, provider organizations partnered with ValueOptions to create North Florida Behavioral Health Partners (NFBHP). The provider group and ValueOptions each own 50% of NFBHP, which means they have equal voice in determining how the PMHP will operate. NFBHP was awarded the contract for the Prepaid Plan in AHCA Area 3 effective October 1, 2006. Figure 1 illustrates the organizational structure of NFBHP.

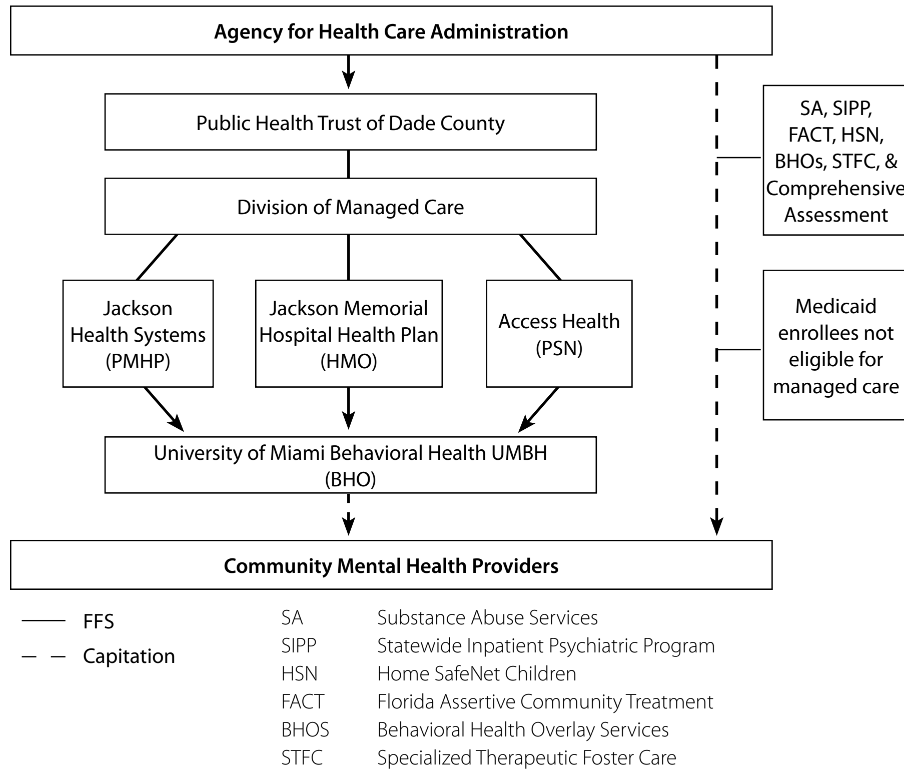
Figure 1
Organizational Structure of
North Florida Behavioral Health Partners



Jackson Health Sytems, one of the two PMHPs in Area 11, operates under the Division of Managed Care of the Public Health Trust of Dade County. Its mental health services are managed by University of Miami Behavioral Health (UMBH), which also manages other behavioral health contracts on behalf of the Public Health Trust. UMBH subcontracts with community mental health service providers in Area 11 on behalf of the PMHP. Figure 2 represents the relationship of the PMHP to other managed care arrangements within the Public Health Trust.

The PMHPs (Magellan, NFBHP, and the Public Health Trust) structured their business relationships with their providers differently. NFBHP developed partnership arrangements with the more comprehensive providers in their networks that share decision-making among the partner agencies. In contrast, Magellan and the Trust used a more typical managed care organizational approach, in which providers are not part of the operational decision-making of the PMHP and are generally paid on a fee-for-service basis. This year, for the first time, providers were critical of the PMHPs, which may be a reflection of the more traditional managed care model used by Magellan and the Trust. Finally, unlike its Magellan counterpart and HMOs operating in Area 11, the Public Health Trust is a nonprofit organization with a contractual affiliation with the University of Miami.

Figure 2
Organizational Structure of the Public Health Trust



New Health Maintenance Organizations/Behavioral Health Organizations

There are seven new Medicaid HMOs and three new BHOs that provide comprehensive mental health benefits in Areas 2, 3, and 11. The HMOs include Buena Vista Medicaid, Humana Family, the Public Health Trust of Dade County, Jackson Memorial Hospital Health Plan, Preferred Medical Plan, Total Health Choice, Universal Health Care, and Vista Health Plan of South Florida. The BHOs include Mental Health Net (MHNet), PsychCare, and University of Miami Behavioral Health (UMBH). MHNet reported that it has been in Florida for 25 years as a commercial provider for Medicare and was formerly a provider of inpatient services. It began operating in Areas 2 and 3 on behalf of Universal Health Care, Inc., on March 1, 2006. PsychCare, established in 1991 as a subsidiary of Psychiatric Holdings, represents Buena Vista, Humana, Preferred Medical Plan, Total Health Choice, and Vista Health Plan of South Florida. UMBH represents the Jackson Memorial Health Plan.

Organizational Structures and Relationships

With regard to organizational changes that have occurred with the implementation of managed mental health care benefits, MCOs and providers alike reported having to add staff to meet the demands associated with the expansion of managed care, though for different reasons. HMOs and BHOs reported adding staff to accommodate their expansion to new areas of the state. Providers, on the other hand, added administrative staff (in some cases, as many as 12 to 14 new people) to manage PA for services and billing for the various HMOs and BHOs with which they contract. Some providers reported that they had to eliminate clinical positions to create the needed administrative positions.

Figures 3, 4, and 5 graphically represent the financial relationships that comprise the managed mental health care plans in Areas 2, 3, and 11, respectively. The managed care plans have different structures for their behavioral health business. Amerigroup contracts directly with their providers, whereas the other HMOs contract through a behavioral health organization that is either a subsidiary of a larger organization (e.g., Harmony Behavioral Health, a subsidiary of Wellcare, or United Behavioral Health, a subsidiary of United Health Care) or an independent agency such as PsychCare, MNHet, or UMBH. Unlike the other arrangements between the HMOs and BHOs, MHNet oversees administrative services only on behalf of the Universal plan; they are not responsible for claims payments.

Figure 3
Area 2 Funding Streams as of 5/07

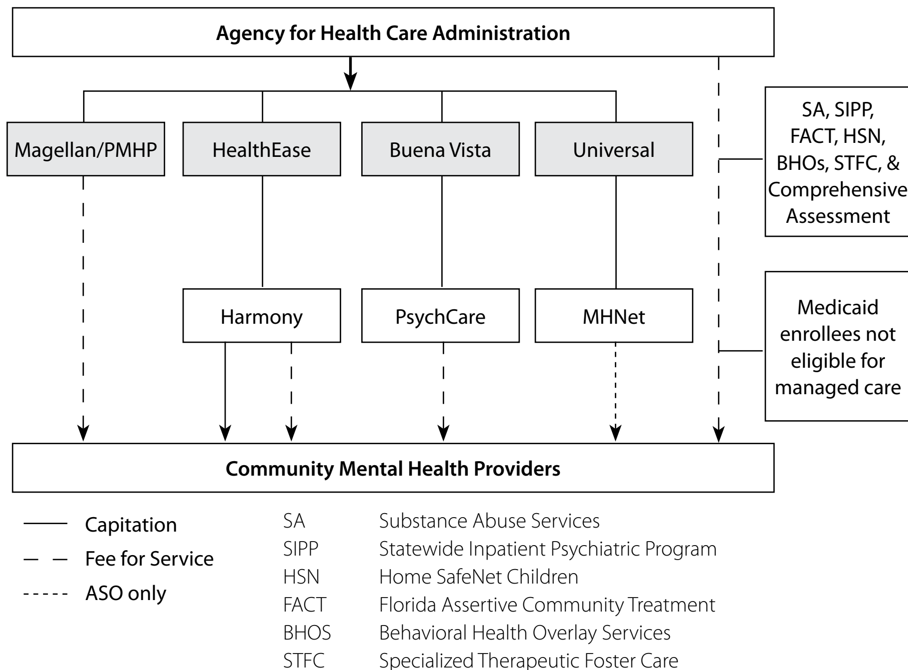


Figure 4
Area 3 Funding Streams as of 5/07

Agency for Health Care Administration

NFBHP/PMHP
STAY
HE
Univ
AmG
UHC

SA, SIPP, FACT, HSN, BHOs, STFC, & Comprehensive Assessment

HMY
MHNet
UBH

Medicaid enrollees not eligible for managed care

Community Mental Health Providers

Capitation
Fee for Service
ASO only
Block Payment

SA Substance Abuse Services
SIPP Statewide Inpatient Psychiatric Program
HSN Home SafeNet Children
FACT Florida Assertive Community Treatment
BHOS Behavioral Health Overlay Services
STFC Specialized Therapeutic Foster Care

Figure 5
Area 11 Funding Streams as of 5/07

Agency for Health Care Administration

JMH
Amer
VSF
Pref
HUM

SA, SIPP, FACT, HSN, BHOs, STFC, & Comprehensive Assessment

Mag/ PMHP
PHT/ PMHP
HE
SW
Buena Vista
United
THC

HCN
UMBH
Harmony
PsychCare
UBH

Medicaid enrollees not eligible for managed care

Community Mental Health Providers

Capitation
Fee for Service

SA Substance Abuse Services
SIPP Statewide Inpatient Psychiatric Program
HSN Home SafeNet Children
FACT Florida Assertive Community Treatment
BHOS Behavioral Health Overlay Services
STFC Specialized Therapeutic Foster Care

Magellan contracts directly with providers in Area 2 on a FFS basis and has a subcapitated, non--risk-adjusted arrangement with the Health Choice Network (a provider network consisting of nine provider agencies) in Area 11 (Dade County) for outpatient services. All other providers in Area 11 are reimbursed through FFS service arrangements that are generally based on Medicaid rates. Magellan reported that it has broadened its Medicaid provider network beyond the traditional community providers and has invited other providers to participate.

North Florida Behavioral Health Partners has subcapitated arrangements for outpatient services with its member partners. The rates are based on the providers' historical rates of service provision (i.e., numbers served, units provided, and dollars spent). It also offered subcapitation arrangements to nonpartner members of its network; one agency currently operates under such an agreement. Other providers are reimbursed on a FFS basis using current Medicaid FFS rates. Although inpatient services are also paid on a FFS basis, they are based on negotiated rates.

The Public Health Trust of Dade County currently reimburses all of its providers on a FFS basis using established Medicaid rates and has no immediate plans to move to subcapitation arrangements. Like other HMO and PMHP plans, inpatient services are paid on a FFS, negotiated rate basis.

Most HMOs are reimbursing providers on a FFS basis, with rates that are commensurate to Medicaid rates; however, it was reported that AHCA rate increases are not always passed along to providers. Inpatient services are generally paid at a negotiated rate.

Financial Arrangements

As we have found in previous years, providers reported that many services are being denied by MCOs under their FFS arrangements and that the MCO billing procedures are complex and overly burdensome. Providers also reported experiencing significant delays in payments. One provider reported outstanding payments as high as $100,000 per month. As a consequence, at least two providers have begun negotiating subcapitated arrangements with one MCO, Harmony Behavioral Health. Other providers have threatened to terminate their contracts with particular MCOs, including North Florida Health Partners (the PMHP). One provider in Area 11 reported that on the day of the interview, it had a meeting scheduled to cancel its service contract with one MCO because of concerns about reporting and billing requirements. One provider in Dade County also said it was uncertain at times who to bill for specific services that were not allowed by MCOs. This provider also reported that it was not always paid in accordance with the state rates for services. These problems were not universal, however. MCOs that were reported as having more reasonable procedures included Amerigroup, UMBH in Area 11, and United Behavioral Health.

The MCOs, however, reported that despite considerable efforts on their part to train and assist providers with billing procedures, multiple problems continued with providers failing to submit accurate billings and obtaining proper authorizations for services. As a result, providers continued to experience delays in reimbursement or denial of payments.

Utilization Management Procedures

Similar to our findings from earlier studies in new sites of implementation, providers reported significant concern about services that require PA by some MCOs. Providers reported that the procedures for obtaining PA for services varied significantly among the managed care agencies, and the requirements were not always clear. Some providers reported that all services required PA by some MCOs, whereas others reported that only certain services required PA (e.g., inpatient services, therapeutic behavioral health onsite services, targeted case management, psychosocial rehabilitation, and psychological assessments). PMHPs and HMOs that have subcapitated arrangements for outpatient service with providers or networks, generally only require PA for inpatient care. However, providers reported that the processes for obtaining PA from the various MCOs were time consuming and costly, which often required them to devote scarce staff resources to track the requests. Providers consistently reported receiving training from Amerigroup, United Behavioral Health (on behalf of United Health Care of Florida), and University of Miami Behavioral Health (on behalf of the Public Health Trust of Dade County) on their authorization and billing procedures, whereas other MCOs were reported to have offered minimal to no training.

In contrast, MCOs reported that they do not require PA for more routine services such as outpatient visits. United Behavioral Health used a "bucket system" to approve services upfront. Several providers in Area 11 reported that United's system was helpful because it minimized the number of PAs needed for services. A few providers reported that the minimal authorization procedures and other benefits, such as transportation provided by United Behavioral Health and Amerigroup, made working with those MCOs more appealing.

Service Provision

Some providers reported that the implementation of managed care resulted in the provision of fewer services (especially case management and psychosocial rehabilitation) to individuals than before implementation of managed care, especially for recipients of HMOs. One rural provider indicated that it had to lay off case managers and therapists and reduce salaries and vacation time for remaining staff. In addition, providers indicated that reductions in Medicaid revenues, the service costs to their organizations, and the billing and reporting requirements of the MCOs have caused them to reorganize staff responsibilities to meet administrative demands, resulting in a reduction of clinical services. Some providers, though, have indicated that they have not yet had to curtail services or lay off staff. However, from some providers' perspectives, the level of service provision seems to have diminished with the implementation of managed mental health care.

Providers indicated that they made attempts to shield recipients from any financial or other difficulties they encountered in providing their services, but were not always successful. One provider stated that services were sometimes postponed until authorization was received from the MCO. The process of rescheduling appointments for recipients because of delays in obtaining authorization had caused individuals to not receive appropriate services on a timely basis and, in a few cases, not receive treatment at all.

Guideline Use and Quality of Care

MCOs reported that they have provided treatment guidelines (often the American Psychiatric Association Guidelines) to their providers, but do not necessarily require them or monitor their use. Some providers, however, reported that they do use the guidelines provided by the MCOs. They also reported that the definition of medical necessity, the standard criteria for justifying the provision of services, is generally derived from the Medicaid handbook.

The MCOs reported that they use mechanisms such as consumer and stakeholder satisfaction surveys, random file and chart audits, and quality improvement initiatives to help assess the quality of care. Providers generally reported that they received minimal, if any, feedback from the MCOs regarding the data that they submit to them, although NFBHP (the PMHP in Area 3) was cited as an exception and provided numerous reports and considerable feedback to their providers.

Providers reported that their efforts to improve the quality of services included conducting specific initiatives in quality improvement, analyzing and reporting functional and clinical outcomes for service recipients through the use of the Functional Assessment Rating Scale (FARS) and the Child Functional Assessment Rating Scale (CFARS) instruments, clinical treatment record evaluations, practitioner quality performance reviews, and member satisfaction surveys. However, some providers raised concerns about the inconsistent reporting requirements for the FARS and CFARS among the MCOs. They were aware that AHCA requires MCOs to collect FARS and CFARS data and to report that information in their encounter data submissions, but the data-reporting requirements were inconsistent among the MCOs.

Continuity/Coordination of Care

The network providers for the PMHP and the MCOs in Areas 2, 3, and 11 offered a variety of community mental health and substance abuse services. They also reported having longstanding relationships with other service agencies in their communities. If a recipient needs a service that a provider cannot offer and the provider is in a subcapitated arrangement with the MCO, the provider generally expected to pay for that service from its capitation rate. If the provider is in a FFS arrangement with the MCO, it generally refers the individual back to the MCO or to another provider that will be reimbursed on a FFS basis, either from the MCO (if the provider is in network) or AHCA, if the service is not a benefit under managed care.

As we have reported in previous years, the coordination of physical and mental health services is dependent on the service provider obtaining the recipients' permission to contact their primary care physician and following through with notification. Providers have agreed that this area continues to need significant improvement.

Management Information Systems (MIS)

MCOs reported that they have not had to make major changes to their management information systems to accommodate the expansion to the new sites, although some have hired additional staff. One MCO reported that it was considering a new management information system, but has not made other major changes thus far. Providers reported that they had to add new software or modify their existing management information systems to accommodate the changes to managed mental health care.

Although changes in the MIS systems of providers and MCOs did not seem to be significant, providers consistently reported the need to hire or reassign and train staff to meet the information needs of the new managed care system. One provider had so few Medicaid recipients that it decided to cancel its contract with one MCO because of the high administrative demands for providing services to those recipients. Other providers reported ongoing struggles meeting administrative demands.

Recipient/Family Involvement

The MCOs reported that they expect that providers will involve recipients and families in their treatment, and some of them monitor providers for the involvement of service recipients in treatment record audits. Most MCOs have reported minimal involvement of consumers and families in their own organizations, although they have expressed interest in increasing their participation.

Recipient and family involvement at the provider level vary among the expansion sites. Few providers reported recipient participation in their board of directors or other advisory committees, although most reported that they had tried to engage recipients in decision making. Some providers reported having employed consumers in their programs. All providers reported that recipients and their families were supposed to be involved in creating their treatment programs and should agree to the program before any service is initiated. Recipients were also supposed to be included and should approve of changes made to their treatment programs. However, the extent to which that actually happens is unknown.

Cultural Competency

The PMHPs and MCOs reported that materials, such as their member handbooks, satisfaction forms, and other information were printed in English and Spanish. In Area 11, materials were available in additional languages, including Creole. MCOs reported that they have tried to ensure that their providers have bilingual or multilingual staff, depending on the communities served, and several MCOs collect information from providers regarding their staff profiles on a regular basis.

Providers reported having access to interpreters who can accommodate individuals who speak a variety of languages. They also reported that they could provide adaptive services for individuals with hearing and visual impairments.

They reported having bilingual staff, but despite MCO requirements that they employ staff of various racial and ethnic backgrounds, some providers indicated that they have great difficulty recruiting diverse staff. Such diversity is more available in Area 11 than in either Areas 2 or 3. The providers reported that, because of low wages and stringent expectations for employees, they have been unable to hire and retain culturally and linguistically diverse employees in competition with other agencies.

Follow-up with MCOs and Providers

As noted earlier, we conducted an electronic survey with MCOs and providers who had been interviewed in Areas 5 and 7 either in person or by phone in 2005 and 2006. Harmony Behavioral Health, Florida Health Partners (PMHP), Amerigroup, and United Behavioral Health completed the electronic survey. Many of the issues that were identified in the 2005-2006 report were repeated in this 1-year follow-up. A summary of the MCO responses follows.

MCOs

Structure and Relationships

Two of the four MCOs said that they continue to manage mental health care the same way in each AHCA area. All continue to contract directly with providers, with two using only FFS arrangements. One MCO has begun contracting on a subcapitated basis with providers in Area 6 and continues to have a private FFS network in Area 1. Three of the four MCOs reported having added executive, management, and/or professional positions to manage the implementation.

Financial Arrangements and Utilization Management

Prompt payments and billing and PA procedures were identified as problems by providers and MCOs in the 2005-2006 report. This year, two MCOs stated that they strongly encourage electronic billing for prompt payment of claims. One MCO said its authorization system on the Internet helped providers receive prompt authorizations. Others said they followed payment guidelines in accordance with AHCA requirements for reimbursing FFS providers and paid subcapitated providers within a week of receiving payment from AHCA. Three of the four MCOs said their utilization management procedures had not changed in the past year and were the same for all providers. One MCO noted that it does not require PA for any level of care offered by PMHP partner providers, but that it does require PA for inpatient and outpatient services by non-partner providers.

Service Quality

All four MCOs stated that their quality assurance/QI procedures were the same for all providers. Three of the four said they have had no changes in the past year, whereas one MCO said that it continually updates its QI reports and activities. Another MCO reported that it had implemented a case management system to integrate behavioral and medical case management more effectively.

Management Information Systems

Three MCOs described several ways they had enhanced their management information systems and operations to update reporting and/or meet additional behavioral health requirements. One MCO added staff to help providers prepare monthly electronic FARS/CFARS and to address AHCA reporting requirements.

Access

The PMHP noted that it expects providers to serve their members in rural as well as in urban areas, to engage homeless people when they are in inpatient services, to make home visits when feasible, to partner with outreach and prevention programs to ensure that members know how to access behavioral health care, and to encourage them to seek services.

Consumer/Family/Community Involvement

One MCO said that it had made no changes in how it involves consumers and families. However, two MCOs mentioned their attempts to move towards a recovery focus. One described its efforts to educate providers and members regarding recovery-based treatment planning and AHCA-approved recovery-based mental health case management. Another MCO has staff that attends the Department of Children and Family Resiliency and Recovery meetings to encourage participation in advisory groups.

Some MCOs noted the important role of their consumer affairs coordinators or advocates. One said that its consumer advocate is a full voting member of their Quality Improvement Committee and Medical Advisory Committee. It continues to use an annual Member Satisfaction Survey and a Stakeholder Survey to evaluate its services. In addition to the surveys, this MCO receives recommendations for improvements from managed care advisory councils, psychiatrists on the Medical Advisory Committee, and members who attend the Quality Improvement/Community Mental Health Center meetings.

All of the MCOs had experienced issues with developing collaborative relationships with their community providers and described this as a continuing challenge that they believe they are addressing successfully. They cited implementing integrated care into treatment, educating providers regarding working within the managed care system, and learning about local behavioral health delivery systems.

Providers

MCO/Provider Relationships

Providers expressed a wide range of opinions about their relationships with the HMOs and PMHPs. Some said they had good or excellent relationships with HMOs and PMHPs, whereas others were not as favorable. Most providers did not identify specific HMOs or the PMHP; however, one said that Amerigroup was the most cooperative, whereas another provider said Amerigroup was difficult to work with because it denies Therapeutic Behavioral Health Onsite Services (TBOS) services for eligible children. One provider described its relationship with Florida Health Partners (the PMHP in Areas 5 and 7) as excellent. This same provider said that the payments and authorization problems it had with Harmony last year had improved.

Service Provision

Many providers reported reduced revenue or funding losses, which resulted in services and positions at all levels being cut. Case management; TBOS and psychosocial rehabilitation programs were the services most commonly identified as being reduced. One agency said it needed to eliminate, or hold vacant, 43 positions, with bachelor's level counselors and case managers being the positions most frequently affected. Another provider said it cut nine positions because of the decrease in "Medicaid eligibles." The only jobs that providers added were those to manage the increased demands of billing and PA. The majority of providers reported reductions in services, some very significant, including the closure of programs. Many said they were providing the same types of services, but fewer services in the past year. One provider, who closed its drop-in center and psychosocial rehabilitation program and reduced several other services, captured the sentiment of many when it described the subsequent increase in caseloads because of reductions in staff and recipients having less time with staff, all of which it attributed to cuts in funding because of the implementation of managed care. Another provider said that when a Medicaid recipient's well-being was at risk, it provided services without authorization and absorbed the loss.

Most of the providers continued to offer services to homeless, indigent, or otherwise underserved or unserved populations, although some providers reported being financially strained because of reductions in Medicaid revenues or the denials and limitations of services by MCOs.

Financial Issues

One respondent reported that rates had increased on its PMHP contract by approximately 6% based on increases passed from ACHA; only one provider reported an annual rate increase from the HMOs. One provider said the capitation rate for its area was the lowest in the state and was about half the rate of other providers; as a result, this provider needed to modify its services during the year. Many of the providers stated that the timeliness of payments was still "poor" or "terrible" with the HMOs, although one said that Staywell (managed by Harmony) was the most prompt. Providers also discussed the ongoing challenges

and costs of working with multiple payers. As one provider stated, "The effort and costs we now expend to manage receivables is significantly higher, with about one third less Medicaid business than we used to have. Our net cash flow is far worse than it has been for years." Another provider reported that it has had to hire more staff to assist in the PA process (which is not a reimbursable service) and in the billing and finance departments to manage the HMO requirements.

Utilization Management

Most providers said that HMOs still required PA for some, or all, services. Each HMO and PMHP has different authorization procedures for specific services. A few providers specifically identified Harmony as requiring authorizations for all services, and one described Harmony's authorization process as difficult. A few providers said that Amerigroup, in contrast, does not require any PA or just for certain services, such as TBOS. Two providers said that the PMHP does not require PA; one of them said the only exception was for CSU services beyond 4 days, which does require authorization.

Half of the providers reported no changes in how they defined medical necessity, or how levels of care and length of stay were determined. However, a few said that the HMOs dictate what is considered medically necessary. Because of the low capitation rate under the PMHP, one provider monitors volume of service and length of stay more closely by assigning a standard amount of service units to each member, although there is no restriction on the volume of service in their contract. Another provider established a Managed Care Committee to review complex cases and hospitalizations and to coordinate discharges.

Service Quality

About half of the providers said that they have made no changes in their quality assurance procedures. Of those who have made changes, one provider created procedures to facilitate recipient grievances and complaints and was using recipient satisfaction surveys. Another provider said it has focused more on tracking outcomes and rates of recidivism. One provider described efforts to augment coordination between staff and clients' primary care physicians. Two providers reiterated the concern regarding the significant amount of administrative time spent or "wasted" providing data to multiple sources, completing duplicate reports, and meeting quality assurance requirements.

Most providers reported little to no changes in their clinical guidelines and said they follow APA guidelines and incorporate any changes that APA makes. Many also said they operated within the clinical guidelines that the HMOs and PMHPs provided, but some expressed dismay as they said they were told the HMOs would abide by Medicaid standards and then found out they would have had to absorb the expense of retraining staff to learn the new HMO guidelines.

Management of Information Systems (MIS)

More than half of the providers discussed changes they have made to address the expansion and complexities of billing changes and data requirements. Some

have incurred substantial expenses for new hardware and software and staff training to learn the new processes. As one provider noted:

> "The implementation of managed care has dramatically increased the amount of reports which need to be submitted to the managed care entities. Each managed care organization has different forms and reporting requirements resulting in the need to report the same data in a different format. We have had problems with our software due to all of these differing reports, which has caused us to have to spend a significant amount of money consulting with our vendor to modify the software to meet the demands of the various managed care entities."

Implementation Issues

Almost all of the providers said the most significant challenge was lower revenues. One provider stated, "The major challenge is to provide quality services with a fraction of the funding that was previously received under a fee-for-service program." Another provider reported a struggle to balance the need for services with fixed dollars or limits on treatment. Providers also expressed concern about delayed payment of claims, managing the rapid adjustment from FFS, and services being delayed while awaiting authorization and/or they are limited or denied altogether. One provider specifically identified the decrease in case management services as a major challenge. Another challenge was the number of times that recipients changed Medicaid plans. One provider reported that recipients changed plans as often as six times during one year.

Successes

Despite these concerns and issues, providers noted their success in managing the changes that they have experienced. They also expressed pride in being able to maintain their focus on quality care and consumer involvement while enhancing their utilization management procedures. Others were less optimistic. One provider said that success is the wrong word; it has been "learning survival skills."

Recipient Focus Groups

Two focus groups with adult recipients were held in Areas 5 and 7. Areas 5 and 7 were chosen because the PMHP had been in operation for more than one year, making it more likely that recipients had experienced the transition to managed mental health care. The Florida Peer Network recruited participants from Drop-In Centers in those two areas. There were eight participants in Area 7 and only one participant in Area 5. The following is a summary of their perspectives about their access to services, the coordination and quality of the services they receive, and their suggestions for making the services more responsive to their needs.

Access

Most participants agreed that being eligible for Medicaid increased their ability to get services, although some noted that they had no particular problems accessing services before being eligible for Medicaid. They indicated that although Medicaid offered less choice for services than the private sector, Medicaid made it easier to access medications through the mail-order pharmacies. The participants also identified the following other problems in accessing services:

- It is difficult to get services such as classes on living skills, nutrition, and housing.
- "Sometimes in order to get counseling or mental health education, you have to sign yourself into inpatient services and crisis units."
- You cannot get extensions of services beyond the limited time.
- There is difficulty in getting to see doctors between regular appointments.
- There are long waiting times for appointments.
- Getting group or one-on-one counseling is difficult.
- Waiting time is up to 7 months to get a Medicaid card once you are enrolled.
- System favors children in getting services.
- Sometimes doctors prescribe medications that are not paid for by Medicaid.
- Difficult to get assistance with housing and transportation needs.
- Some services are only available in dangerous parts of town. Therefore, people sometimes forego services.
- The services that are offered are very different from one provider to another, even though they may be called the same.
- Often the phone lines for HMOs are busy, or you get transferred from one person to another to get answers to questions.
- The information that is provided by the HMOs is often inaccurate or confusing.
- There is too much red tape and paperwork required to get services.
- Case managers change frequently, so it is difficult to establish a relationship with them.

- HMO companies offer cash and gifts as inducements to consumers to persuade them to change companies.
- HMO representatives make false claims about availability of services to convince them to make the change.

They also noted that that the following were helpful in accessing services:

- Case managers are helpful in getting needed services.
- Advocates working in drop-in-centers are helpful.
- Sometimes law enforcement is helpful.
- Sometimes the HMO helplines provide assistance.
- Participants doing their own research online.

Service Coordination

Participants reported the following related to the coordination of their services:

- Psychiatrists do not work with physical health doctors as much as they should.
- Because case managers change so often, it is difficult to address multiple issues, although case managers can be helpful in coordinating services.
- Mental health services and substance abuse services are not coordinated.

Service Quality

Most participants agreed that they were relatively satisfied with the quality of the specific services they received; however, they felt that services were not as good as they used to be and that services in Florida were not as good as they are in other states. One participant noted that the quality of the counseling services was not as good as they would like and that they would prefer having access to a psychologist.

Conclusions and Recommendations

At the time this report was written, the PMHPs had been in operation in Areas 2, 3, and 11 for less than a year in these expansion sites, whereas some of the HMOs had been providing comprehensive mental health services in these areas for more than a year. As we saw in the early phases of implementation of managed mental health care in other AHCA areas, the transition from traditional FFS to managed care was difficult for both MCOs and providers alike. In the new areas, MCOs had to add administrative staff to accommodate the demands of adding new sites, establishing new relationships, and engaging new providers. However, it appears from their comments that MCOs believed they were meeting these challenges successfully. In contrast, providers reported frustration with having to add administrative capacity to respond to the unique requirements and procedures of the various MCOs with which they contract while having to adjust to reductions in Medicaid revenues, and in some instances, clinical staff layoffs and/or the curtailment or elimination of services.

Problems persist with PA and billing procedures associated with some of the FFS financing arrangements. The issues generated in our discussions with MCOs and providers this year replicated many of the same concerns expressed in previous years. These issues have dominated the conversations regarding the implementation of managed care since it was first implemented more than a decade ago. Although larger providers may manage to avoid staff layoffs or the reduction or elimination of services, smaller or more rural providers may be impacted more dramatically. As one rural provider noted, "We just keep doing it [providing services] until we can't do it anymore." Unlike the mixed optimism reported by providers in previous years, providers in these areas were not hopeful that these issues will be resolved quickly. Some have begun to question whether they will continue to contract with at least some of the MCOs to provide mental health services to their Medicaid recipients. Some providers expressed doubt that their concerns would be taken seriously and would result in change. As one mental health provider in Area 11 noted, "If you ask me, whether I think anything is going to change with this [report], my answer is no. I think it is going to read good [sic], but meanwhile we have reduction of services … and we are going to continue to have the same situation in the state of Florida."

The reductions in services that have been reported by providers are of concern generally, especially in a system that is leanly funded. However, based on the experience of one smaller rural provider, there is reason to be especially concerned about recipients' access to services in the rural areas of the state.

Despite the fact that providers reported that they have continued to provide services without assurance of compensation, recipients seem to be aware of and are affected by these changes in financing. Although Medicaid recipients who participated in the focus groups indicated that being Medicaid eligible made it easier for them to get Medicaid services, they still described problems in accessing services and were concerned about the limits placed on services. They were also concerned about the staff turnover in case management (a service that many

providers reportedly have reduced). Most recipients reported being satisfied with the quality of the services they receive, but several reported that the services were not as good as they used to be.

Recommendations

Recommendations from this year's Implementation Analysis are derived from the findings obtained from interviews conducted in Areas 2, 3, and 11 as well as the follow-up data collected from Areas 5 and 7 and are consistent with the recommendations from previous years' studies. While statewide implementation of PMHPs will be accomplished in FY 2007-2008, there are continuing issues that need to be addressed and that warrant close monitoring.

- As we have found in previous years, the timely payment for services continues to be a significant problem for many providers who are operating in FFS arrangements with MCOs. Some providers reported accumulating large outstanding balances that strained their ability to provide services. AHCA should closely monitor the bill-paying performance of MCOs to ensure that providers are reimbursed for Medicaid services within the timeframe required in their contracts.
- The variability in administrative practices of the managed care organizations, especially those related to prior authorizations for services and billing, are a source of significant frustration and concern for many of the provider agencies interviewed. Providers operating under FFS arrangements with MCOs reported that they had to add administrative capacity to accommodate the new demands while reducing services. The use of common, standardized protocols for both billing and PA among the MCOs would help alleviate some of the problems that providers have experienced. However, realizing that the unique business practices of MCOs may make the use of common protocols or procedures unrealistic, AHCA should require that MCO procedures are made available to providers in writing when providers are added to their networks. MCOs should send procedural changes in writing to providers on a timely basis.
- Information obtained this year highlighted concerns regarding access to mental health services in rural areas. AHCA should examine issues that may be unique to rural areas, such as the availability of providers and transportation to services, in order to determine any special provisions that can be made to assure adequate access to services. Accessibility issues in rural areas should be regularly monitored.
- The quarterly Area Advisory meetings can be an important forum for providers as well as recipients and their families, to discuss concerns and resolve issues. These meetings should therefore be accessible in terms of the times they are held and their locations. All Area offices should consider holding some meetings after regular business hours to allow individuals who are working to attend. Additionally, the Area offices should explore the possibility of providing child care as well as transportation for recipients who have no other means of attending the meetings. To further enhance problem-solving

and communication, additional opportunities for feedback, such as AHCA-sponsored provider forums and family discussions or focus groups should also be explored.

- Recommendations from the recipient focus groups include:
  - Have “real” people answer HMO help lines.
  - Staff should be better trained in customer service.
  - Locate services in safe neighborhoods.
  - Shorten wait times for MH and medical appointments.
  - Make services available without having to go into CSUs.
  - Provide more group and one-on-one counseling available.
  - Find ways to have doctors available for longer sessions and not rush people through.
  - Provide more choices in services and service providers.
  - Increase the number of physicians who accept Medicaid.

References

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Appendix

MCOs and Providers Surveyed via Email

MCOs

Amerigroup

Harmony/Staywell & HealthEase

United Health Care/United Behavioral Health

Florida Health Partners

Providers

The Harbor (Baycare)

Ruth Cooper Center

Lakeside Alternatives

Seminole CMHC

Park Place

Circles of Care

Devereaux

Suncoast Center for Community Mental Health

Directions for Mental Health

Coastal Behavioral Health Center

Miami Behavioral Health

Multilingual Psychotherapies Centers

Gift of Life