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Louis de la Parte Florida Mental Health Institute

The Louis de la Parte Florida Mental Health Institute at the University of South Florida has a mission to strengthen mental health services throughout the state.

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

Implementation Analysis Sub-Study of the 2007–2008 Evaluation of Florida’s Medicaid Managed Mental Health Care Plans

June 2008

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Implementation Analysis Sub-Study of the 2007–2008 Evaluation of Florida’s Medicaid Managed Mental Health Care Plans

Executive Summary

Implementation of managed care programs for Medicaid-funded mental health services began in Florida in 1996. Currently, there are over one million individuals enrolled in these plans across the state. Since 1997, the **Agency for Health Care Administration (AHCA)** has contracted with the **Louis de la Parte Florida Mental Health Institute** at the University of South Florida to examine the organizational, structural, financial, and operational features of implementing managed care for Medicaid-funded mental health services in Florida. Findings from these previous years’ implementation studies have revealed a number of challenges that have been consistently reported by stakeholders in their implementation efforts. As a result, the current study focused on furthering the understanding of these challenges and generating possible solutions to ameliorate the issues.

A questionnaire and an introductory letter were sent via electronic mail to directors of managed care organizations (health maintenance organizations [HMOs], behavioral health organizations [BHOs], and prepaid mental health plans [PMHPs]) and mental health provider agencies statewide who participated in the previous ten years of implementation analyses and those in the most recently implemented areas (AHCA Areas 8, 9, and Volusia, Flagler, and St. Johns Counties in Area 4). Overall, 69% of managed care organizations (MCOs) and provider agencies surveyed completed the questionnaire. Participants were asked to describe their experiences with implementation issues identified through previous evaluations as well as any strengths of the current Medicaid managed mental health care system. Ideas for possible solutions to challenges were also solicited from participants.

All MCOs and three-fourths of responding providers identified features of the current managed mental health care plans that facilitated their ability to provide high quality, effective mental health services to recipients. These strengths are highlighted below.

- Providers and MCOs described maintaining positive working relationships and ongoing communication with each other and with AHCA as important factors in their ability to provide quality care.
- Providers identified flexible and innovative plan features (especially in capitated arrangements) relevant to the array and provision of services that allowed them to focus on the needs and well-being of recipients.

- Providers also noted that capitated arrangements allowed them to budget more efficiently and place an emphasis on serving recipient needs.
- Managed care organizations reported that expanded provider networks had increased recipient access and choice of mental health services.
- While there were continuing challenges revealed in questionnaire responses regarding prior authorization and auditing requirements, a few providers and MCOs commented on the value of these review processes as a means to heighten the quality of mental health care provided to recipients.
- Managed care organizations reported that managed care offered cost savings and a more efficient use of services.

In addition to identifying the strengths of providing mental health services within the managed care arena, respondents reported experiencing continuing challenges in the following areas:

- Inability of providers and MCOs to accurately determine a recipient's current plan in a timely fashion especially as recipients change plans frequently and the accuracy of eligibility data are sometimes in question.
- Providers completing excessive paperwork and time-consuming follow up to obtain timely prior authorizations. MCOs receiving sometimes incomplete or poor quality prior authorization requests.
- Providers managing the differing billing requirements and procedures between MCOs resulting in increased administrative work.
- Providers diverting resources from services to administration in order to meet managed care requirements for billing, reviews, tracking claim payments, authorizations, and denials.
- Insufficient rates being paid to MCOs and providers to cover the rising costs of providing services especially for psychiatric services and administrative work.
- Timely payments not being received by providers from MCOs and increased time to troubleshoot claims denials resulting in additional administrative work. Additional work by MCOs to resolve claims that were not properly submitted, were duplicative, or were not submitted in a timely manner.
- Uncompensated care resulting from low rates and issues with prior authorizations and billing procedures.
- Hesitancy of primary care physicians and recipients to participate in efforts to integrate mental health and other services.
- MCO concerns about the quality of services offered by providers including the lack of clinical expertise, care coordination issues, a lack of adherence to evidence-based practices, and lack of available providers in rural areas.

- Provider issues related to determining drug formulary benefits caused by differences between plan formularies, frequent changes and difficulty in obtaining the most current versions of formularies, and differences in prior authorizations processes or overrides for non-formulary medications or doses.
- MCOs receiving inaccurate or incomplete FARS/CFARS data from providers that are required by AHCA and DCF.

It was clear from participant responses that many of the challenges resulted in increased administrative work for mental health providers and managed care organizations, which reportedly has led to the diversion of financial resources from clinical services to administration. Feedback from mental health providers indicated that the provision of uncompensated care has resulted from other challenges described in this study including eligibility issues, reimbursement rates, timeliness of payments, and prior authorizations. In addition, recipients were reportedly being affected by the reductions in services resulting from most of the challenges detailed in this study.

It was also apparent that a number of the ongoing challenges identified by providers and MCOs noted in this year's report were related to the model of management. Some MCOs have chosen to enter into sub-capitated arrangements with some of their service providers shifting risk to the provider level, while others continue to pay for services on a fee-for-service basis. Providers have reported that sub-capitation arrangements with MCOs generally allow them more flexibility and are administratively easier to manage. Fee-for-service arrangements with MCOs that require prior authorization for services and individual service billings are generally associated with more administrative and fiscal challenges. However, some of the concerns noted as ongoing challenges by both providers and MCOs, such as the perceived low Medicaid rate structure and the data related problems (e.g., the receipt of accurate and timely member eligibility information, the accurate determination of drug formulary benefits and the receipt of accurate data from providers) are not necessarily related to the financing model of either capitation or fee-for-service. Low rates and data issues are more systemic and may be better addressed at levels beyond any particular plan. The administrative and fiscal challenges associated with fee-for-service arrangements that require prior authorization and individual service billings are more amenable to change at the plan level as providers and MCOs work together to streamline and improve both processes or as the plans move to establish more sub-capitated arrangements.

Recommendations

When asked how issues could be addressed, study participants acknowledged that AHCA, MCOs, and providers all had a part to play in effectively implementing managed mental health care and addressing the ongoing challenges. Of the recommendations offered by respondents regarding the ongoing concerns, several consistent themes emerged:

- AHCA should improve its monitoring of MCOs, especially their processes for billing and authorization of services as well as their claims payment histories. They should also closely monitor the requirement that MCOs spend 80% of their capitation for community mental health services.
- AHCA should improve its data systems to ensure that accurate and timely eligibility and plan enrollment data are readily available to MCOs and providers. MCOs should make also their current drug formulary information readily available to providers.
- AHCA should encourage and facilitate the standardization of billing and prior authorization processes among the MCOs to ameliorate administrative burdens for both MCOs and providers. Electronic billing capacity should be encouraged and developed.
- Providers and MCOs should ensure that their respective staff are trained in the procedures for appropriate billing and obtaining prior authorizations. AHCA should also help educate providers and MCOs about medical necessity criteria.
- Providers, MCOs and AHCA should develop ongoing opportunities for communicating and building relationships with each other. Quarterly Advisory meetings are helpful, but having state level AHCA staff attend in person rather than by phone was preferred.
- Improvements in the rate structure for services should be addressed by AHCA as well as the MCOs. Providers should also find ways to improve their internal operations to be more cost effective. Providers (and others) should continue to advocate for rate increases while seeking other fund sources.

In addition, the following recommendations are offered for consideration:

- AHCA, managed care organizations, and mental health provider agencies should continue to work together to resolve the ongoing challenges noted in this report. The solutions suggested by respondents in this study offer a framework to begin that process and should be given serious consideration.
- AHCA, managed care organizations, and mental health provider agencies should remain flexible and creative in the development of specific solutions to ongoing challenges.

- While it may not be possible to fully ameliorate all of the challenges identified in this study, AHCA, managed care organizations, and mental health provider agencies should work towards developing and implementing strategies that minimize the administrative burdens of prior authorizations, billing, reporting requirements and auditing that are part of managed care and that maximize their ability to effectively provide quality services to recipients.
- AHCA and managed care organizations should seriously consider moving toward some level of uniformity and standardization in the various procedures and requirements to which mental health provider agencies are expected to conform, to help reduce their increasing administrative efforts.
- Mental health provider agencies (and MCOs) could benefit from each other's experiences of coping with the challenges of managed care. They should communicate with one another to share ideas for effective service provision and solutions to ongoing concerns.

Background

Implementation of managed care programs for Medicaid-funded mental health services in Florida began in 1996 under a 1915(b) waiver from the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services). These programs have included Health Maintenance Organizations (HMOs) that provide health, mental health, and pharmacy benefits; and the Prepaid Mental Health Plan (PMHP) that serves as a mental health carve-out.

The contracted entities administering these plans, also referred to as managed care organizations (MCOs), are at full financial risk for a comprehensive range of mental health services. Although they receive a risk-adjusted, capitated monthly payment for each recipient, MCOs may contract with mental health service providers in a sub-capitated or fee-for-service arrangement. The HMO and PMHP managed mental health care models have been implemented over time in all areas of the state with the exception of Baker, Clay, Duval, Nassau (Area 4), and Broward (Area 10) Counties due to implementation of the Medicaid Reform initiative in those areas. Aside from these four geographic areas, the PMHP is present in every AHCA area statewide; however, not every Florida county is served by an HMO.

The National Implementation Research Network has defined implementation as a purposeful set of processes “designed to put into practice an activity or program of known dimensions” (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005, p.5). In an effort to differentiate various aspects of implementing managed care programs, researchers developed a conceptual model in which they identified contextual factors (characteristics of enrolled populations and Medicaid plans), structural factors (organizational characteristics of MCOs and the compositional features of network providers), and procedural aspects (utilization management, financial and risk arrangements of and between MCOs and service providers, and clinical management) that are key in managed behavioral health care environments (Ridgely, Giard, Shern, Mulkern, & Burnam, 2002). Similar elements relevant to the relationships between plans and services providers (organizational and contractual relationships, financial arrangements, and procedural arrangements) were identified in a study on the impact of managed care (Pincus, Zarin & West, 1996). Over the last decade, these essential factors have provided a framework from which to examine the implementation of managed mental health care in Florida.

Since 1997, the Agency for Health Care Administration (AHCA) has contracted with the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida, to examine the organizational, structural, financial, and operational features of implementing managed care for Medicaid-funded mental health services in Florida. The implementation component of the multi-year evaluation was intended to describe the implementation of managed mental health care as it was put into place across the state. This report represents the final year of studying the implementation of Medicaid managed mental health care in Florida as all AHCA areas now have managed mental health care plans operating.

Findings from previous years' implementation studies have revealed a number of challenges that have been consistently reported by stakeholders in their implementation efforts. The primary purpose of this year's evaluation is to better understand the impact of these challenges and to obtain the views of providers and managed care organizations about possible solutions to ameliorate the issues.

The findings are intended to guide providers, MCOs, and AHCA in resolving some of those challenges.

Methods

In accordance with the study objectives, the following research questions guided research activities:

1. What are the continuing challenges/issues in implementing Medicaid-funded managed mental health care and how do they impact providers' ability to effectively serve recipients?
2. How do these issues impact recipients of Medicaid-funded mental health services?
3. What can key stakeholders (AHCA, MCOs, and mental health provider agencies) do to ameliorate these issues?

Electronic Mail Questionnaire

A questionnaire and an introductory letter were sent via electronic mail to directors of managed care organizations and mental health provider agencies statewide who participated in the previous ten years of implementation analyses and those in the most recently implemented areas (AHCA Areas 8, 9, and Volusia, Flagler, and St. Johns Counties in Area 4). A total of ten managed care organizations (HMOs, behavioral health organizations [BHOs], and PMHPs) and 54 mental health provider agencies across Florida were included in the study.

Separate protocols were developed for MCOs and providers, each designed specifically for their perspectives. Protocols for each stakeholder group began with a request for subjects to detail the strengths of working in Florida's managed care environment to provide Medicaid-funded mental health services. Subjects were asked to describe their experience with each of the implementation issues (nine for MCOs and ten for providers) that had been reported consistently as problematic over the years of implementation studies conducted by FMHI. Some of the identified issues were common among MCOs and providers; others were specific to each group (see **Table 1** below). Subjects were asked to indicate whether each issue was one with which their agency continued to experience difficulty, or one that they had either resolved or never experienced. In addition, respondents were asked how each issue impacted their agency and how it directly impacted recipients. Finally, possible solutions were solicited from participants to address each issue, particularly related to what each stakeholder group (AHCA, MCOs, mental health provider agencies) could do to affect positive change.

Respondent Group	Implementation Issue		
MCO and Service Provider	Determining current plan	Prior authorization	Managing billing requirements
	Capitation or fee-for-services rates	Timely payments	Coordinating/Integrating care
Service Provider	Diverting resources	Uncompensated care	Determining formulary benefits
MCO	Quality services	Accurate service provider data	Relationships with providers

Respondents had the option of returning their completed questionnaires electronically or by mail. They were also offered the opportunity to complete it over the telephone with a research team member. Telephone interviews were audio-taped with the subject’s verbal permission (documented by research staff) and transcribed to ensure accuracy of data recording and analysis. This study was judged by the University of South Florida Institutional Review Board (IRB) as being “exempt” from human subject protections. However, the introductory letter sent to subjects described the purpose of the study and other elements of informed consent required by the IRB. After the questionnaire was initially sent, three waves of follow-up contacts were made by research staff (two via electronic mail and one via telephone) to ensure that all subjects had ample opportunity to participate if desired.

Administrative Data

To provide a descriptive context for this study, administrative data from the April 2008 AHCA enrollment reports and April-June 2007 managed care eligibility and claims files were used to identify demographic characteristics of Medicaid mental health managed care recipients by plan across the state. The demographic data of interest include age, gender, race, ethnicity, eligibility category (SSI), and certain mental health conditions such as severe mental illness for adults and serious emotional disturbance for children.

Findings

All ten MCOs (100%) and 34 of the 54 (63%) provider agencies participated in the study resulting in an overall response rate of 69%. Data from four of the providers were obtained in telephone interviews. There was participant representation from every AHCA Area across the state (excluding Area 10 and Area 4 counties where Medicaid Reform has been implemented). The following information reflects the findings from the analysis of administrative data and provider and MCO surveys.

Medicaid Managed Mental Health Care Enrollment Data

April 2008 enrollment figures obtained from the AHCA website for each of the PMHPs as well as the Medicaid HMOs and the BHOs that manage their behavioral health benefits are reflected in **Table 2**. These figures exclude the Medicaid Reform sites (Area 4 – Baker, Clay, Duval, and Nassau Counties; Area 10 – Broward County) as well as individuals who are served in the Child Welfare Prepaid Mental Health Plan.

PMHP figures include individuals enrolled in Netpass, Access, and Pediatric Associates which are Provider Service Networks (PSNs) operating in non-Medicaid Reform sites that provide health benefits to their members; the behavioral health services are provided through the PMHPs. Also, because there are two PMHPs operating in Area 11 (Dade-Monroe Counties), the Medicaid enrollment figures for MediPass and the PSNs for that area are not segregated by plan.

There are other individuals who are not eligible to be served through the PMHP. People who are dually enrolled in Medicaid and Medicare, individuals enrolled in the Medically Needy programs, and individuals receiving hospice services, are excluded. In addition, Medicaid recipients who are receiving services in special programs such as 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 are disenrolled from the managed care plans.

For individuals who fail to choose a plan (either MediPass or a Medicaid HMO), Medicaid is statutorily required (Chapter 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 based on the preferences of recipients made in the previous period. One MCO participating in the current study expressed dissatisfaction with the disproportional assignment process.

Table 2 Medicaid Managed Mental Health Care Plan Enrollment	
Managed Care Organization	Medicaid Enrollment
Medipass/PMHP*	
Florida Health Partners (Areas 5, 6, 7, 8)	178,708
Magellan/Public Health Trust (Area 11)***	118,502
Magellan (Areas 2, 4,**9)	108,488
North Florida Health Partners (Area 3)	81,920
Access Behavioral Health (Area 1)	32,022
HMO/BHOs	
Harmony (HealthEase/Staywell)	274,554
Amerigroup	127,870
United Behavioral Health (United Health)	73,757
PsychCare (Buena Vista/Humana/Total Health)	52,689
CompCare (Citrus Health Care)	20,317
MH Net (Healthy Palm Beaches/Universal)	8,328
*Includes recipients enrolled in Netpass, Access, Pediatric Associates and MediPass ** Excludes four counties in Reform (Baker, Clay, Duval and Nassau Counties) ***Enrollment report does not differentiate between the two plans	

Characteristics of Recipients in Medicaid Managed Mental Health Care Plans

Various descriptive characteristics of individuals enrolled in the Medicaid mental health care plans included in this study are provided in **Table 3**. There were no noticeable differences between the PMHP and HMO plans in the gender or ages of recipients. The slight majority of recipients in all plans were female. A greater percentage of younger individuals (less than 21 years of age) were served across plans, while a very small minority were ages 55 to 64. There was greater variation in the ethnicities of recipients between the PMHP and HMO plans, however. The percentage of individuals identified as Hispanic, ranged from 4% in one PMHP (Access Behavioral Health) to 65% in another (Public Health Trust). In the HMO plans, the percentage of individuals who were Hispanic ranged from 24% (HealthEase/Staywell) to 34% (Public Health Trust-JMH). The percentage of individuals identified as African American ranged from 21% to 33% in the PMHPs and 26% to 55% in the HMOs.

The data indicated that the PMHPs had a greater proportion (ranging from 4% to 10%) of individuals with a documented serious mental health diagnosis (SMHD) than HMOs which ranged from 2% to 4%. Mental health disorders for these individuals included schizophrenia, bipolar disorder, major depression, attention deficit hyperactivity disorder, and oppositional defiant disorder. This trend also existed for those individuals receiving Supplemental Security Income (SSI). The PMHPs had larger proportions of their enrollment receiving SSI (between 16% and 21%) than HMOs (between 2% and 12%).

Table 3
Characteristics of Recipients in Medicaid Managed Mental Health Care Plans

Plan	Recipient Characteristic						
	Females	Age <21	Age 55-64	Hispanic	African American	SSI	SMHD
PMHP							
Access Behavioral Health	54%	80%	2%	4%	33%	17%	4%
Florida Health Partners	52%	83%	2%	31%	22%	20%	5%
Magellan	53%	81%	2%	35%	28%	17%	7%
North Florida Health Partners	54%	79%	2%	10%	31%	16%	6%
Public Health Trust	52%	78%	5%	65%	21%	21%	10%
HMO/BHO							
Amerigroup	53%	84%	1%	31%	36%	12%	3%
CompCare (Citrus Health Care)	55%	79%	1%	26%	28%	8%	2%
Harmony BH (HealthEase/Staywell)	54%	82%	1%	24%	37%	11%	4%
MH Net (Healthy Palm Beaches/Universal)	54%	79%	1%	28%	43%	2%	3%
PsychCare (Buena Vista/Humana/Total Health)	55%	80%	1%	33%	49%	9%	3%
Public Health Trust-JMH	55%	77%	2%	34%	55%	12%	4%
United Behavioral Health (United Health)	55%	79%	1%	25%	26%	9%	2%

Strengths of the Managed Care Environment in Providing Medicaid-Funded Mental Health Services

A questionnaire sent to mental health service provider agencies and managed care organizations began with an opportunity for respondents to describe any features of the Medicaid managed mental health care system that have enabled them to provide high quality, effective mental health services to their recipients. Overall, all of the MCOs and approximately three-fourths of responding providers identified various strengths of the current managed care environment.

The perspectives of each respondent group that noted positive experiences of providing mental health care within the managed care arena are summarized below.

Relationships

Provider perspective

Good communication and the development of positive working relationships with MCOs and AHCA were cited by slightly more than one-fourth of responding providers as important factors in providing quality recipient care and the identification and resolution of issues. One provider noted that previous “competitive” relationships with other community mental health centers have matured into stronger partnerships since

implementation of the PMHP. Another provider commented that it was “wonderful” having accessible HMO care managers to consult on cases and assist with navigating medical necessity criteria. It was also acknowledged that, “Some of the managed care plans have staff that contact recipients and assist them with coordinating their care, especially if they are receiving care from multiple providers.” Finally, one provider reported that managed care agency personnel “seem to be interested in the client’s welfare and mental health” and “try their hardest to provide me with information that I need to get services to the client.” The assistance offered by AHCA was also recognized as a strength. One provider indicated that they receive “personal, hands-on help” when calling AHCA, that their questions are “answered in a prompt manner,” and that they are “always directed to the appropriate person.”

MCO perspective

Approximately one-third of the MCOs also recognized the relationships they had built with their network providers as a strength of the current managed care environment. These relationships, along with ongoing communication, were seen as facilitating the provision of quality care to recipients. Community mental health centers were cited as having the “experience and range of programming” necessary to serve recipients. One MCO also reported working with providers to “develop best practices and further enhance level of care guidelines.” This same MCO also mentioned the value of building collaborative relationships with staff at AHCA and the Florida Department of Children and Families (DCF) as an added means of ensuring that Medicaid recipients are served appropriately. The experience of having participated in community-related meetings such as the quarterly Medicaid Advisory Council and SEDNET (Network for Students with Emotional Disabilities) meetings was also cited by one MCO as beneficial.

Flexibility and Innovation

Provider perspective

The responses of seven providers reflected a certain amount of flexibility and innovation offered through managed care, particularly as it related to the array and provision of services. Providers indicated that the flexibility with which services can be provided (especially in the capitated model/prepaid plans) allowed them to focus on the well-being of their recipients with less emphasis on administrative concerns. This was evident in a comment about providing more therapeutic behavioral onsite services (TBOS) to children that could potentially divert admissions into residential care. One PMHP was given credit for adding two service codes for specialized case management and emergency intervention. An HMO was credited with allowing TBOS for adults, which reportedly decreased hospitalizations and aided recipients in maintaining functionality in their communities. This same HMO was also praised by the respondent for authorizing a generous amount of service units at the beginning of treatment.

Other features of the various managed mental health care plans mentioned by some providers reportedly permitted flexibility in the mechanics of service planning and billing. These included the ability to electronically submit and track recipient eligibility, prior authorizations, re-authorizations, and claims.

MCO perspective

The majority of MCOs commented on various elements of their managed care plans related to offering flexible and innovative care. Reportedly, increased recipient access and choice have resulted from expanded provider networks and services. In addition to traditional services, MCOs indicated that they link recipients to other community-based services. One respondent stated that although they had expanded their network “beyond the traditional community centers,” they still utilized them “as experts in delivering care to the most complex cases.” In order to promote recipient access to care, one MCO reported imposing no limits on the number of visits for traditional out-patient services and only “requiring the minimum amount of information necessary to make a level of care determination” for more intensive services. In addition, increased recipient involvement in training and clinical practices, and increased employment opportunities for recipients, were noted as strengths within one plan.

One managed care organization proudly commented on their development of a mobile crisis team that had reduced the recurrence of in-patient hospitalizations and had increased post-discharge treatment follow-up. Another referred to a care management program focused on resiliency and recovery and mentioned having conducted trainings on this topic across the state. The use of a quality management program that emphasizes prevention programming, utilizing best practices, and managing recipient outcomes was mentioned by another MCO.

Coordination of care was also cited by some MCOs as a strength of the current managed care environment. One MCO commented specifically on the intensive case management services offered to recipients who were considered to be high risk which allowed for coordination with primary care physicians (PCPs) and fewer occurrences of relapse and re-hospitalizations.

This MCO also noted that they had expanded outreach and training activities to PCPs to enhance their assessment and referral of individuals with mental health and substance abuse issues.

Review Processes

Provider perspective

Four providers commented on the usefulness of standards and review processes established within the current managed care plans. When discussing the PMHP, one respondent stated that standards for access and recipient satisfaction challenged them to increase their effectiveness and efficiency in these areas. Another provider indicated that the audits conducted by a PMHP confirmed areas where they excelled and identified opportunities for improvement in other areas. A more general comment from one provider

referred to record audits as giving them “another set of eyes to assess clinical quality and continuity.” Increased reviews of services rendered to recipients who were considered high risk or high service users was also noted as a strength of the managed care environment.

MCO perspective

Two MCOs specifically mentioned their review processes as a means of facilitating the provision of quality care. One MCO stated that the utilization of prior authorizations and concurrent reviews allowed for more intensive levels of service to be provided for individuals with more acute needs. Another MCO indicated that the technological, clinical, and quality processes developed in partnership with their providers allowed them to use administrative data and chart information to monitor access, appropriateness of services, service utilization by plan and provider, outcomes, critical incidents, and grievances.

Financing

Provider perspective

The strengths of a capitation financing strategy in the managed mental health care system were noted by five providers. Since they knew what to expect in revenues, providers stated that having a sub-capitation arrangement with plans allowed for “more efficient budgeting for clinical positions” and better cash flow management. It was also described as being cost effective and facilitating service provision based on recipient needs rather than “determined with an emphasis on meeting budget goals.”

MCO perspective

While most MCO comments on the strengths of the managed care environment were focused on other aspects of the system, there were a few MCOs that mentioned cost savings. Two MCOs referred to more efficient use of services as a means to this end. Another MCO stated that managed care would “help bring down the cost of the Medicaid program while ensuring that quality care is provided to its members.”

Challenges in Providing Medicaid-Funded Mental Health Services in the Managed Care Environment

In addition to identifying strengths of the current system, managed care organizations and mental health service providers were invited to describe the challenges they experienced in providing Medicaid-funded mental health care to their recipients within the current managed care environment. Their responses, along with their ideas for addressing the issues, are summarized below according to each area needing improvement.

Determining Current Plan

Provider perspective

Approximately three-fourths of responding providers stated that determining a recipient's current Medicaid plan was a challenge they continued to experience. Many providers discussed the ongoing challenge of tracking plan enrollment of recipients who frequently switched plans, often without the provider's knowledge. Providers indicated that some recipients had been listed as members of multiple plans, sometimes without MCOs knowledge, and that recipients' plans were sometimes changed without the recipients' knowledge. In addition, providers discussed how children in the foster care system may not be enrolled in the plan serving that system or were disenrolled from that plan when there had been no change in their foster care status. It was also noted that the eligibility records obtained by providers from AHCA and MCOs were sometimes conflictive and that the MEVSNET system (the electronic data interchange service allowing providers to verify Medicaid eligibility for recipients) was not always accurate.

These issues reportedly caused confusion about which MCO a provider should contact for authorization and billing, resulting in delays or denials of services, additional administrative costs associated with unnecessary billing and re-submissions of authorizations and claims, gaps in service provision, and uncompensated care when current plans would not cover services that had already been provided. Overall, it was suggested that AHCA ensure that the most accurate eligibility data are given to providers and MCOs in a timely manner. Other recommendations from providers for AHCA to consider included: establishing a no-cost, web-based system for verifying eligibility; including social security numbers in eligibility files; allowing services authorized under one plan to be carried over to the new plan; requiring that providers be notified when a recipient changes plans; and allowing recipients to change plans only once a year.

MCO perspective

Three-fourths of the MCOs reported that determining a recipient's current Medicaid plan was a continuing challenge and commented on similar issues discussed by providers. MCOs noted their concerns with recipients frequently changing plans or gaining and losing eligibility from month to month. Additionally, they reported experiences with eligibility records which indicate a recipient as active with a specific MCO although the MCO either had no record of the recipient or showed that the individual had terminated with them. A few MCOs noted the existence of outdated contact information (addresses, telephone numbers) in the eligibility files. It is important to note, however, that one MCO said that while it remained an ongoing challenge, AHCA had improved the eligibility identification of recipients and it is less of an issue than it was one year ago.

Similar to the impacts reported by providers, MCOs stated that these issues resulted in the delay or denial of authorizations and claims causing MCOs to spend extra time contacting AHCA and providers to resolve inaccuracies and re-process claims. A few MCOs specifically mentioned that they had authorized treatment “in good faith”, under the assumption that the recipient was still enrolled in their plan. They also stated that they had “retro-authorized” treatment that they previously denied because they learned that the recipient was indeed a member of their plan. Again, these efforts were described by MCOs to be time-consuming and complex. In terms of how this issue affects recipients, several respondents noted the potential for delays in services if the current plan for the recipient could not be readily determined.

Many MCOs stated that AHCA should work to improve the accuracy of the information in the eligibility verification system (possibly through collaboration with DCF). One MCO suggested that AHCA consider a new eligibility status category for recipients who are, or could be, temporarily losing eligibility and subsequently, AHCA could establish processes to enhance accurate service authorizations and claims payments. One managed care organization who reported that they did not experience difficulty in determining a recipient’s current Medicaid plan commented that when potential eligibility issues developed, they worked closely with AHCA to address them and described AHCA as very cooperative.

Prior Authorizations

Provider perspective

More than half of the providers that responded to the questionnaire agreed that obtaining prior authorizations for services from the MCOs was a continuing problem. Specifically, providers were concerned with receiving authorizations after having delivered services without any assurance that the authorization would be back-dated to the time of the request. Excessive paperwork and time-consuming follow-up regarding requests were often noted by providers as being a problem. Providers reported that these excessive administrative demands had caused them to shift personnel and resources from direct service to administration.

Also of concern was the amount of services being authorized, compared to what was requested and believed by providers to be needed, as well as the limited time periods for which the authorizations were granted. In both instances, providers were concerned that recipients with serious illnesses needed more services for longer periods of time than were being authorized. Authorizations for Therapeutic Behavioral Onsite Services (TBOS) and psychosocial rehabilitation (PSR) were identified as being especially problematic. As one provider noted, “We have yet to see how the quality of any person’s care has been improved by prior authorizations.”

Providers agreed that the problems associated with obtaining prior authorizations for services often resulted in delays, reductions, or denials of services. However, they also noted that they have often continued to provide services, without assurances of being paid by the MCO, by using other sources of funding. At least one provider indicated that they now tended to provide services that did not require prior authorization.

These concerns were resolved for some providers by the MCOs relaxing their requirements for prior authorization or by negotiating sub-capitation contracts. In some cases, providers reported terminating their arrangements with the MCO.

When asked about what AHCA could do to help resolve these issues, providers noted that AHCA should monitor the MCOs more closely with respect to the timeliness of their service authorizations and the limitation or denials of services. In addition, it was recommended that AHCA should closely monitor the MCOs' adherence to the requirement that 80% of the resources they receive for mental health benefits be spent on services. Providers suggested that AHCA could establish minimum levels of services for children with serious emotional disturbances and recipients with serious mental illnesses as well as to better define medical necessity. It was further recommended by providers that AHCA consider establishing standardized prior authorization forms and procedures, as well as standardized authorization time periods and numbers of units for certain services.

Providers also indicated that MCOs should provide more timely responses to authorization requests and that when necessary, back-date authorizations to cover services that have already been provided, especially while eligibility files were being updated. It was suggested that MCOs should provide clear and consistent policies and procedures regarding obtaining prior authorizations. In addition, providers recommended that MCOs reduce the paperwork involved with obtaining authorizations along with reducing the number of services which require authorization (e.g., routine services). They suggested that MCOs could manage providers identified as outliers in terms of the services they provide rather than requiring every provider to request prior authorization for services. Ultimately, providers felt that MCOs should allow greater numbers of services for longer periods of time because of the needs of the recipients with serious mental illnesses being served.

Service providers were asked what they could do to resolve the problems associated with prior authorizations and most agreed that they had to continue working proactively with the MCOs to address the issues. They also commented on the importance of continuing to establish internal utilization management procedures, and training their staff on obtaining and submitting timely and accurate prior authorization requests. Providers also believed that they should continue to educate MCOs about their needs, the needs of the recipients they serve, and the need for more flexibility in serving them.

MCO perspective

Managed care organizations were asked a slightly different version of the question related to obtaining prior authorization for services. Specifically, they were asked if they had experienced difficulty with providers not obtaining prior authorizations appropriately. Almost half of the respondents indicated that this was an ongoing challenge, especially for continuing authorization requests. MCOs who had either resolved problems with providers related to prior authorizations or who had not experienced the issue had either only experienced the problem after initial start-up or did not require service authorizations. Of those who indicated that it was an ongoing challenge, they reported that authorization requests from providers were sometimes incomplete, of poor quality, or were submitted on the wrong forms. They noted that some providers also had difficulty tracking authorizations. Reportedly, this has caused MCOs to invest in time-consuming training and re-training of provider staff. The MCOs also acknowledged that following up on authorizations is costly for both the MCO and providers and can result in delays or denials of services to recipients.

When MCOs were asked about what AHCA could do to help resolve the problems with providers obtaining prior authorizations, they believed AHCA should play a role in educating providers (especially new ones) regarding managed care expectations and the importance of ongoing training. They also suggested that AHCA should promote education and discussions about medical necessity and levels of care. The MCOs believed that they themselves should be building good relationships with providers, perhaps by establishing contact persons for each provider as one MCO had done, and continuing to provide ongoing training and consultation on prior authorization procedures.

Managed care organizations recommended that providers continue to work with the MCOs in resolving the issues associated with prior authorization and to take advantage of trainings offered by MCOs. Additionally, providers should ensure that their staff understand authorization processes, submit timely requests, and track authorizations. It was also noted that providers could improve the documentation they provide when requesting authorizations.

Managing Billing Requirements and Procedures

Provider perspective

Slightly less than half of the responding providers indicated that they continue to experience challenges with managing the different billing procedures across managed care organizations. Sources of difficulties included: different provider identification numbers and different coding systems required on claims, authorization numbers are required for some claims and not on others, and some MCOs accept electronic billing while others require paper forms. In addition, a few providers mentioned difficulties with MCOs receiving billing data from clearinghouses after it was submitted by providers. It was reported that one MCO had implemented a useful

verification process to confirm that all billing submitted to the clearinghouse had been received by the MCO. One provider also commented that the difficulty they experienced in submitting claims electronically required additional time and assistance from the MCOs to address. It was suggested that all MCOs be required to have proven electronic systems in place to successfully accept billing data prior to becoming operational.

Two providers commented on the varying time periods instituted by MCOs within which providers should submit claims, explaining that billing errors or claim denials require additional administrative work which may not allow them to adhere to the submission timelines. One provider indicated that they prefer to audit their billing prior to submission; however, the submission deadline often precludes the completion of this activity, which then results in additional errors and denials. Another provider stated that although they verify recipient eligibility prior to submitting claims, inaccurate eligibility data either results in the denial of a claim or, in many instances, the provider is asked to refund benefits already paid. When contacting managed care organizations for assistance with billing or denial issues, a few providers commented that some MCO staff are ill-equipped to answer questions and that they may receive different information or documentation requests from different MCO staff. Another provider mentioned that it was a challenge to maintain trained staff at their own agency to handle the various issues arising from managing different procedures among plans.

The most commonly reported concern was the increase in administrative time needed to address these issues which diverts resources from clinical services. The reduction in clinical staff was identified by some as resulting in fewer services being available to recipients. Providers also indicated that the difficulty in managing different billing procedures increases the potential for billing errors and claims denials, which then delays payment to providers resulting in a negative impact to their cash flow and reserves.

The solution suggested most often by providers to ameliorate these issues was to standardize billing requirements and procedures according to Medicaid guidelines and across MCOs. One provider indicated that he had offered this solution to three MCOs and that they seemed enthusiastic about the idea. It was also suggested that MCOs make efforts to ensure that their staff are properly trained to answer questions about billing and claim denials so that helpful and consistent answers can be provided regardless of the MCO staff person taking the call. Until these or other solutions can be developed and implemented, some providers specifically stated that they would maintain their current efforts to resolve issues and adhere to MCO policies and procedures.

In addition to the solutions detailed above, providers who indicated that these issues were not continuing challenges for them offered the following suggestions for amelioration. Although state level AHCA representatives participate in Advisory Forums via telephone it would be helpful if they attended in person. MCOs should hold regular provider meetings to discuss

issues (one provider stated that this strategy was currently employed by at least one MCO which helped facilitate communication among stakeholders). A uniform set of denial codes should be instituted system wide. Providers should consider availing themselves of the MCOs' Provider Relations staff to discuss ongoing problems and providers should reach out to other provider agencies to foster better communication and collaboration on issue resolution. A helpful strategy implemented by one provider was to create a billing and authorization procedure flowchart for staff to follow.

MCO perspective

Managed care organizations were asked about any challenges they had experienced with providers' lack of adherence to billing requirements and procedures. Three of the ten MCOs reported having continuing issues in this area. One ongoing challenge that was reported was the difficulty for some providers to complete fields in the proper character length required for electronic claims submission. However, the MCO noted that there have been vast improvements in providers adhering to billing procedures over time. It was also stated that if electronic submission errors are not identified by providers in a timely fashion, it can result in denial of claims and extra work for providers and the MCO. In their efforts to address this issue, the managed care organization reported that they continue to provide training to new providers (as well as linkages to Electronic Data Interchange [EDI] specialists), and ongoing training and technical assistance to established providers. The MCO also noted that most providers have information technology resources available to assist with EDI processes.

Other continuing issues reported by MCOs included receiving duplicate billings and batch billing which creates spikes in processing efforts; as well as providers having difficulty with billing in a timely fashion, submitting 'clean' claims, and verifying current eligibility of recipients. It was stated that these issues can result in delayed payments to providers as well as the potential for a decrease in the amount of funding available for the provision of care due to costs associated with additional processing efforts.

Suggested solutions to address these issues included the MCO providing one-on-one in-service trainings to providers and increasing efforts between MCOs and providers to effectively implement electronic billing activity. Managed care organizations that had reported these issues as resolved commented on the value of maintaining an ongoing, educational, cooperative dialogue with provider agencies to effectively address issues that may arise.

Diverting Resources from Services to Administration

Provider perspective

Over half of the responding providers indicated that having to divert resources from services to administration was a continuing challenge and only a few said that this challenge had been resolved. A caveat for consideration is that in arrangements where prior authorizations are not required, the likelihood of diverting resources from clinical service to administration is reduced.

A common theme that emerged from provider responses was having to downsize clinical staff to offset the cost of adding administrative personnel to meet managed care demands for billing, reviews, tracking claim payments, authorizations, and denials. One provider commented on the difficulty with obtaining authorizations from one MCO for in-patient psychiatric care and the subsequent administrative resources required to provide “unnecessary justification for medically necessary psychiatric services.” It was also reported that clinical staff had been transferred to utilization management departments to conduct these types of tasks. The productivity of direct care staff apparently declined as well due to increased administrative duties related to paperwork and phone calls for service authorizations. Additionally, it was noted that agency directors and program managers sacrificed clinical oversight and supervision to review authorization paperwork, track service units and authorizations, and keep staff updated so that direct care hours would not exceed allotted service quotas in order to avoid non-reimbursement of services. The impact on recipients was reported to be fewer services or a delay in services.

Providers commented on MCOs having differing procedures for incident reporting, satisfaction surveys, and filing reports that resulted in additional administrative work. According to one provider: “It is impossible to meet the demands of each MCO: to create different forms, collate all the data, file the reports, and credential staff for each provider. In addition, each provider wants our agency to make revisions to our central data system ... which can easily cost from \$2500 for a very minor change, to upwards of \$50,000.” Other providers reported on the additional administrative effort required to meet the differing audit requirements and report formats of multiple MCOs that tax agency staff and resources

Despite these challenges, providers commented on their efforts not to turn away recipients. However, they also said that having to divert clinical resources resulted in a reduction in the array of community mental health services, fewer available appointments, and less treatment which ultimately adversely affected recipients’ progress on meeting treatment plan goals and objectives.

When asked what AHCA could do address the issue of providers having to divert resources to accomplish increased administrative tasks and cover subsequent costs, providers made a number of recommendations. AHCA

was encouraged to: require all MCO's to use the same standardized methods, forms, and procedures; develop forms related to data reporting, outcome measures, clinical measures that would be accepted by ACHA, MCOs, and the State; convene a committee of AHCA staff and community mental health professionals to review and revise the Medicaid Community Mental Health Handbook with a goal of reducing paperwork by a minimum of 25%; review prior authorization processes and require MCOs to develop standards for authorizations that are more user friendly for providers; require improvement in claims processes and payment; review records to determine if medically-necessary care is being denied; increase Medicaid reimbursement rates; more closely monitor the 80% spending requirement of the MCOs; encourage MCOs to follow Medicaid's processes; and have AHCA representatives meet directly with providers about problems.

In terms of what MCOs could do to address the issue of diverting resources to administration, one provider cautioned MCO's to consider that all changes have consequences and they "should think about a effect to consumers and service agencies." Specific recommendations for MCOs included: working with providers and AHCA to standardize procedures and reduce administrative requirements for AHCA, MCOs, and the State contract; collaborating with other MCOs to develop one report to cover each topic (e.g., one targeted case management report, one staffing report, etc); allowing on-line initial authorizations; allowing greater flexibility in authorizations processes (e.g., backdating of authorizations when necessary); and lobbying for an increase in the Medicaid reimbursement rate.

In addition to acknowledging their responsibility in sharing solutions to decrease administrative costs with AHCA and MCOs, providers commented on their part in complying with authorization requirements, continuing to provide needed services even when they are denied by MCOs; continuing to lobby for an increase in Medicaid rates; developing systems to allow efficient completion of prior authorization processes, and renegotiating contracts and make appeals based on the provider manual when needed.

An implied recommendation by one provider was to make better use of the quarterly AHCA meetings to share beneficial information among providers. This provider noted that when staff from his agency attended these meetings, he gained more support for directives he had been giving to staff since they now had had the opportunity to better understand the context of managed care requirements. It was stated that providers staying informed about current state and federal regulations is quite helpful in remedying issues and that it is a provider's responsibility to do so. Strategies such as ensuring clean claims "at the front end" and centralizing administrative functions including obtaining and managing authorizations were offered as proactive ways to address increased administrative issues. Promoting better clinical documentation was also reported as improving the ability of well-trained non-clinical staff to translate information onto managed care forms, thereby reducing overall administrative time and costs.

Low Capitation or Fee-for-Service Rates

Provider perspective

As many of the responding providers were reimbursed by MCOs on a fee-for-service basis using Medicaid rates, many of the provider comments were focused on the inadequacy of the current Medicaid rates and the inadequacy of the capitation rates which were paid to MCOs for mental health services. Almost three-quarters of the providers who participated in the study indicated that low rates were a continuing challenge, with fee-for-service rates being the biggest problem. Providers expressed concern that the rates they received did not cover the rising costs of providing services, especially for psychiatric services and administrative work. They also noted that rates have not changed over time. This continuing problem reportedly has resulted in reductions in services, changes in practice patterns (less volume and frequency of services), longer waiting lists for services, and providers having to support Medicaid services with other revenue sources. As one provider noted, “The State has not been a good partner in the managed care arena. We know we have to serve the patients enrolled in the plans, so we do, even if reimbursement does not cover costs. The State gets free service, the patient gets the care he needs, and the mental health agency staff works harder and longer.” In some instances, inadequate rates have caused providers to refer recipients to other providers.

In terms of the impact of low rates on provider organizations, it was noted by some that salary levels are not competitive, making it difficult to recruit and retain qualified staff and that the increase in paperwork and administrative responsibilities associated with fee-for-service reimbursement has added to staff stress and burnout. One provider commented, “...we struggle even trying to keep staff because we don't pay like some other places pay and it is very, very, very difficult, really we are in [sic] dire straits than I think we have ever been.” According to one provider, it may ultimately result in fewer providers being willing to offer mental health services through Medicaid, which would ultimately affect recipient choice and access.

Of the few providers that indicated that the issue of low rates had been resolved, one indicated that they had initially experienced the problems associated with low rates, but had reduced services accordingly. Another provider responded that they had advocated for and received an increase in the capitation rate from the MCO.

When asked what AHCA could do to ameliorate the continuing problem of low rates, most providers responded that AHCA should simply increase rates. It was also recommended that AHCA develop a more realistic basis for setting capitation rates and update rates to reflect present costs. Providers suggested that AHCA more closely monitor the degree to which resources are spent on administrative costs associated with the PMHP and HMOs as opposed to services. Another suggestion was that AHCA reduce the paperwork burden and streamline the Medicaid Handbook in an effort to reduce administrative costs.

One provider recommended that MCOs incentivize providers that achieve good outcomes with funds that could be used more flexibly. Another provider suggested that MCOs establish higher rates for certain services. Others suggested that MCOs could increase the rates paid to providers through their profits or management fees. It was also suggested that providers and MCOs work together in advocating for increased rates and more standardization of rates across the state.

Providers also offered ideas on what they could do to address the ongoing challenges of low rates, such as providing services in the most efficient and effective manner, using best practices, and ensuring that high service users are receiving the services they need. While working within their current budgets, providers believed they should seek additional funding from other sources while continuing to advocate for rate increases. Providers also noted that they may need to re-negotiate contracts with MCOs to secure better rates.

MCO Perspective

Only one MCO reported that they continued to experience difficulties in negotiating capitation or fee-for-service rates with providers. The remaining MCOs reported that this was an issue that had either been resolved or that they had never experienced it. Nonetheless, MCOs reported that difficulties in negotiating rates with providers can cause delays in billing and problems with authorizations problems, service interruptions, and service coverage in certain geographic areas. While one MCO acknowledged that the Medicaid rates they were using to reimburse providers were seen as too low by many providers, most of the other MCOs believed that providers were “OK” with the MCOs’ use of Medicaid rates for service reimbursement.

When asked for possible solutions, one MCO suggested that AHCA should help providers in new areas understand what is involved in managed care and explain the importance of working cooperatively with MCOs. They believed that they and providers should continue to work cooperatively to reach mutually beneficial agreements and should remain flexible in contract negotiations. Managed care organizations also commented that, if necessary, contracts should be re-negotiated.

Timely Payments

Provider perspective

Almost two-thirds of the providers noted they were continuing to have difficulties with receiving timely payments from HMOs for claims. Several providers commented that payments for claims were not being received for at least 30 days from submission and some were delayed over 90 days. One provider reported having just begun receiving payments from one MCO for claims over 120 days in arrears and then only having obtained about one third of what was owed.

The time required to troubleshoot claims denials reportedly has resulted in significantly increased administrative costs, frustrations for providers, and the need to divert resources from clinical programming to administrative needs. Providers identified internal MCO payment processing problems among the reasons for delays. According to one provider, “We continue having problems with one MCO because the arm of the organization that authorizes services and the arm of the organization where claims are mailed for payment don’t appear to communicate effectively.” Other examples of processing problems cited by providers included MCOs failing to pay because of a lack of authorization when the provider had a current authorization in their system; notification that the recipient was not a member, but MEVSNET indicated that they were; and denials due to not having an authorization even though no authorization was required. Providers reported that even when these issues were addressed, MCOs often took a great deal of time to re-process and pay the claims.

The billing formats of MCOs were also identified as barriers to receiving timely payments. Apparently, paper claim forms for at least one MCO must be manually entered into the MCO’s system, resulting in at least a 30 day time lapse between the billing date and the receipt of payment. It was reported that some MCOs offered the option for electronic billing, but that created an additional expense to some providers who must then submit claims through a clearinghouse. It was also noted that because none of the MCOs offered payments electronically, they must be manually entered into the providers’ MIS systems.

Providers reported that even though they made efforts to submit error free claims and adhere to MCO requirements to submit claims within a certain time from the date of service, the administrative oversight to monitor submissions and timelines was time-consuming and created added expense. One provider made the following observation, “In addition to a loss of payment of legitimate bills that would take too much of our resources (time, monies) in order to be able to collect, there is also the cash flow issue created by late payments.”

Despite the often significant delays in getting reimbursed for services, it appeared that providers remained committed to providing care and most recipients reportedly were unaware of this issue. However, one respondent commented that when direct care staff positions are eliminated to divert resources to collecting payments, recipients feel the impact. One provider noted the dilemma of having to consider whether to continue contracting with an MCO that does not pay claims on time or terminating the contract and recipients not getting needed services.

Providers were asked what AHCA could do to help resolve these issues. A frequent suggestion was for AHCA to evaluate payment guidelines and require all MCOs to follow the same rules and regulations. Other suggestions were for AHCA to hold MCOs accountable for paying claims in a timely

basis, possibly by imposing financial penalties for non-compliance, reduce the reimbursement time frame from 90 to 60 days, and require MCOs to provide more immediate notification to providers of whether claims would be paid or denied.

When asked what MCOs could do about delays in payments, suggestions included paying or denying claims in a more timely fashion; providing options for both electronic billing and electronic payments; improving systems that identify members and ensuring authorizations are recognized and entered correctly into their system; and developing a procedure to acknowledge receipt of claims. At least one provider recommended that they, MCOs and claims clearinghouses continue to work together to resolve data issues. Finally, it was suggested that MCOs ensure that their claims department have an appropriate number of trained staff to address problems in a timely manner.

In terms of what they as providers could do to address these challenges, they recommended contacting HMO contract managers to report problems and request meetings to discuss and resolve issues. If needed, it was suggested that providers may also consider terminating their contract with an MCO if payment issues cannot be resolved. Providers emphasized the importance of continued lobbying efforts for electronic billing and electronic payment, and shorter established timeframes for reimbursement. It was also suggested that providers consider billing on days that were slower for the MCOs.

MCO perspective

MCOs were asked about any difficulties they experienced in processing claims payments in a timely manner. One MCO characterized the issues of claims processing as “an industry-wide top priority.” Slightly more than half of the MCOs reported this as an ongoing challenge. Some MCOs noted the additional administrative work required to address issues of receiving claims that were not “clean”, were duplicative, or not received in a timely manner. Another MCO offered the example of an issue related to provider names on authorizations and claims not matching which resulted in payment delays.

They further reported that they were working to resolve this issue. One MCO reported that providers sometimes wait months before they bring an ongoing issue to their attention and another noted that a significant number of claims are received more than 90 days after the date of service. As one MCO pointed out, “It requires a lot of extra work researching why providers are not receiving payment when it shows in our system that the claims had been sent for payment some time earlier.”

Reportedly, issues related to payment delays significantly affected efficiency as denied claims require additional time to re-process. Evidently, some providers have refused to work with certain MCOs because of the delay in receiving payments. While the overall consensus of MCOs was that recipients should not be directly affected by payment problems, there was an acknowledgement of the additional administrative time and cost required by providers to address these issues as well.

When asked what AHCA could do to help resolve the problems associated with claims processing, one MCO recommended that AHCA hold quarterly meetings to review MCO activities such as claims and service authorization problems. It was also suggested that AHCA encourage providers to transition to electronic billing (when the MCO accepts it).

MCOs were also asked what they could do to address this challenge. Several MCOs reported working with AHCA or individual providers to resolve issues. Another MCO suggested working with other MCOs and provider agencies to identify appropriate resolutions. One MCO reported that they were considering revisions to their current authorization processes to help ensure that providers submit clean and timely claims. This MCO also stated that they continue to offer training to providers in claims processes.

The ability of providers to access the status of claims electronically was mentioned as a strategy offered by one MCO to assist providers in their billing efforts. Another MCO indicated that they continue to encourage providers to submit claims electronically, if possible, and to submit as quickly as possible following the date of service.

In terms of what providers could do to address payment delays, one MCO emphasized that the “electronic submission of claims is key to reducing errors.” It was also suggested that providers submit claims promptly for payment and continue to work with the MCOs and report any claims issues as soon as they are discovered.

Uncompensated Care

Provider Perspective

The issue of providing uncompensated care is related to low rates and the challenges providers experience with authorizations and billing procedures of MCOs. A large majority of providers reported that uncompensated care continues to be a problem for them. According to providers, lack of payment from HMOs has resulted from invalid claim denials; their unwillingness to back date authorizations; low capitation rates; denials of claims for people in crisis stabilization units awaiting placement in a state treatment facility; correct information regarding recipients’ eligibility, address, and enrolled plan being received too late to get authorizations for services already provided; and data problems. One provider noted that they are experiencing adverse selection (i.e., recipients with more serious mental health problems are switching plans in order to receive the services they need). Presumably, this higher level of need is straining the provider’s resources. Some providers have reportedly covered the uncompensated care that they have provided to HMO recipients by using other sources of funds.

Another provider raised the issue of two MCOs not authorizing payment of inpatient care for recipients who were court ordered into state hospitals. While the MCOs reportedly claimed that these recipients did not meet the

criteria for acute care, the provider argued that they would “decompensate and require re-admission” if not treated appropriately. The provider’s suggestion was for MCOs and DCF to collaborate on the issue and for MCOs to authorize the full 45 days available to these recipients.

Reportedly, the provision of uncompensated care has resulted in restrictions or reductions in services, a decrease in the timeliness of service delivery, and in some cases, referrals to other agencies. Uncompensated care provided to Medicaid recipients was also reported to drain provider resources and make it more difficult for them to recruit and retain qualified staff. As a result of the uncertainty of whether or not they were going to be reimbursed for services, one provider noted that, “It really changed the focus of care from making clinical decisions about what services the recipient would benefit from to what do we need to do to get services authorized and paid for.”

For those few providers who reported that uncompensated care was a resolved issue, two of them had experienced problems similar to those identified by providers who were continuing to struggle with this issue. However, the uncompensated care problem had been resolved because the MCOs had agreed to backdate their authorizations for services. A third provider noted that they had resolved the problem by terminating their contract with the MCO. Only three providers indicated that they had not experienced uncompensated care as a problem.

When providers were asked what AHCA could do to address this ongoing concern, a consistent theme was that AHCA should more closely monitor the MCOs regarding their denials, lack of payment, and payment histories.

They suggested that AHCA could more carefully monitor the requirement that MCOs spend 80% of the funds they receive for mental health on mental health services. In addition to increasing Medicaid rates, providers believed that AHCA should allow them access to databases for more current and accurate information regarding recipients’ plan and eligibility. It was further noted that AHCA should consider payment for extended stays in crisis stabilization units while recipients await placement at the state hospital and to allow for retroactive capitation transfers.

Providers thought that the MCOs could help address the problem of uncompensated care by: reducing paperwork and streamlining prior authorization processes as well as clarifying the necessary documentation; requiring authorization only for the most costly services and allowing backdating of prior authorizations for two weeks; ensuring their websites are working; and paying claims on a timely basis and standardizing reporting requirements. Providers also suggested that MCOs reduce their profit margins or administrative costs and pass more of the resources on to providers. Providers indicated that they thought MCOs should continue to work towards resolving the problems that providers have identified associated with uncompensated care, in part, by hiring and training their own staff to deal with these issues.

Providers also commented that they themselves needed to continue to participate in efforts to resolve the ongoing issue of providing uncompensated care. Suggestions included: economizing their operational costs, using technologies to reduce personnel costs, and finding other ways to operate more efficiently. When necessary, it was recommended that providers should also help individuals apply for or regain Medicaid eligibility and assist recipients with referrals to other agencies. Finally, a provider suggested that they should offer services only to those individuals for whom services are paid or consider terminating contracts with the MCOs if the problems cannot be resolved.

Integrating Mental Health and Other Services

Provider perspective

Almost half of provider respondents reported that coordination of mental health and other services (physical health, substance abuse, etc.) was an ongoing challenge. Their responses reflected their belief that integration of services improved care, but that various issues made it difficult to implement consistently.

Several mental health providers discussed their efforts to coordinate services with PCPs – sending them requests for records and making referrals, but often not receiving any responses, even after multiple attempts to contact them. They emphasized that this was a critical issue because it was difficult to properly treat recipients without knowing their complete mental health and physical health history. Even one provider who did not indicate this as an ongoing challenge stated that PCPs did not welcome any information from them. Some providers suggested that they, MCOs, and AHCA participate in efforts to encourage PCPs to be more responsive to the need for coordination and integration of mental and physical health care. Providers also noted that they should continue their efforts to effectively communicate with AHCA, MCOs, and other agencies.

Another issue reported by providers was that they do not always know who the recipient's PCP is. Without this information, any medications prescribed by the mental health provider may be duplicative or contraindicated to that which the recipient may be receiving from their PCP. It was also noted that some recipients do not appear to have PCPs assigned to them. One provider reported that while PCPs for recipients in one MCO were listed in Medifax, this was not the case for two other MCOs with whom they contract. In addition, one provider commented that they were not informed when recipients under current mental health treatment were hospitalized. It was suggested that one system be established and maintained where all providers could identify other mental/physical health care services received by recipients, prescribed medications, and assigned primary care physicians.

Two providers specifically mentioned the hesitancy of some recipients to authorize the sharing of their personal health information between the PCPs and mental health care providers. They also noted that some recipients prefer to receive physical and mental health care from their PCP rather than two different entities. Also related to integrating and coordinating care, two providers commented on the need for allowing case managers to assist recipients with coordinating their medical care. One stated that their case managers would assist recipients with this, but the MCO would not cover that specific service because “it’s not the CM’s [case manager’s] responsibility.” Another suggested that it could be offered as “specialized case management” instead of requiring recipients to qualify for targeted case management which requires extensive intake paperwork and is expensive to deliver. To address these issues, it was recommended that additional financial resources be identified to provide outreach and education to recipients to minimize their resistance to having their information shared between providers, as well as allowing payment for case managers to assist recipients with coordinating their medical care.

The lack of funding for substance abuse treatment and developmental disabilities was also reported by one provider, stating that it makes “true co-occurring treatment very difficult” and results in agencies saying, “not mine”, and recipients either not receiving all the services they need or a lack of coordination and continuity of care. One other provider noted a paucity of physicians who accept Medicaid in their county, resulting in many recipients not receiving needed services. They suggested that additional negotiations be focused on increasing the number of medical providers in their areas.

Transportation was an issue mentioned by a few providers. One provider reported difficulties coordinating transportation for recipients, explaining that the plans used different transportation providers who had different procedures and contact information. Other providers reported either the lack of transportation, the lack of recipient education on the availability of transportation benefits, or the inconsistency of transportation services (i.e., recipients waiting for hours to be picked up or not being picked up at all). A recommendation was made to establish one call center number to contact for transportation issues. Another suggestion was for MCOs to follow up on complaints about transportation providers.

Almost half of the responding providers reported that they had not experienced challenges in integrating mental health and other services. In fact, one provider stated, “MCOs excel in this area.”

MCO perspective

Almost all of the MCOs participating in the study discussed various challenges to integrating mental health and physical health services for their recipients. Many shared some of the same concerns that providers reported,

such as the need for improvement in the areas of communication between medical professionals and behavioral health care providers, and recipients consenting to have their personal health information shared between providers.

MCOs discussed the importance of service coordination between physical and mental health providers to benefit recipients, otherwise prescribed services may be duplicated or contraindicated and important clinical information could be lost. One MCO specified that coordination of care was a challenge because they were “a network model and communication between behavioral and medical practitioners is at the discretion of the practitioner.” It was also noted by one MCO that those recipients with dual diagnoses (substance abuse and mental health issues) require significant care management and that separate management of the substance abuse benefit is “problematic at times.” Recipient confidentiality concerns (recipients not consenting to providers sharing their information) were also cited by MCOs as an impediment to coordination of care. They explained that these issues can particularly restrict the tracking of medically complex cases where mental health services are received.

Current efforts reported by MCOs to address these challenges included ongoing discussions with and distribution of various written materials to their health plans and providers to encourage communication between medical and mental health care professionals; monitoring continuity of care through quarterly reviews of outpatient treatment records and/or quarterly and annual evaluations of coordination of care efforts; and offering providers pharmacy and service utilization reports to assist in integration efforts. It was suggested that providers continue educating recipients on the importance of integrating behavioral-physical health care and that AHCA and MCOs emphasize this as a priority in provider meetings. Another recommendation was for AHCA to “encourage medical providers to support member consent” and possibly obtain agreements with them to enhance the integration of physical health/behavioral health services. In order to better serve recipients with dual diagnoses, it was suggested that AHCA consider having all behavioral health diagnoses and benefits managed together. One MCO requested that AHCA allow them direct access to the physical health data for their recipients. Providers were also encouraged to augment their intake screenings to include information on all clinical care their recipients receive (if not already obtained).

Another specific challenge to integrating physical and mental health care discussed by one MCO resulted from their medical and behavioral health departments not using the same information system and not being located in the same office. They reportedly addressed this issue by ensuring that each department had access to the each other’s information systems, scheduling weekly meetings with both teams, and developing referral procedures between them.

One MCO claimed to have achieved improved member satisfaction and clinical outcomes for recipients through behavioral-medical activities such as intensive case management and coordinated pharmacy management. Another MCO respondent reported using specific assessment tools containing “risk assessment in the physical, behavioral, and social domains” to facilitate service integration and increase the likelihood that recipients receive comprehensive care. They also stated that “attention is given to co-morbidities” and many cases are co-managed by nurses and behavioral health providers.

Quality of Care

MCO Perspective

Managed care organizations were asked to comment on the variability of the quality of services offered by provider agencies. Almost all of the MCOs indicated that service quality was an ongoing challenge. One MCO pointed out that “variability in the quality of services exists in all specialties of health care across the U.S. and Florida due to differences in...geographical access, community standards of care, and qualities in health care expertise.” MCOs noted that they see the variability in quality through their case reviews, the documentation that is submitted to them in the prior authorization process, and when analyzing claims. They noted the lack of clinical expertise, problems with care coordination, and a lack of adherence to evidence-based practices. The use of non-licensed staff and the lack of available providers in rural areas also contributed to their concerns about the quality of care.

According to MCOs, their concerns about service quality have led to denials for services because of insufficient clinical information, which reduces access to care and decreases the likelihood that the recipient will get the level of services which meets their need. A provider’s failure to offer quality services also reportedly impedes the provider’s ability to develop an effective plan of care among multiple providers. MCOs believe this ultimately impacts recipient outcomes and can result in increases in acute care.

One managed care organization indicated that they had not experienced problems with service quality. They stated, “We have found that services tend to not be that different from provider to provider. It may be that our best practices measures are not sufficiently exacting, but we have not noted any significant differences.”

To address the variability in the quality of care provided, MCOs suggested that AHCA formally evaluate the quality of mental health services and promote quality among providers by approving best practices. It was further recommended that AHCA examine credentialing requirements for licensure of mental health provider agencies and MCO requirements for auditing providers. Another suggestion was for AHCA to review requests for coverage of new services and more broadly, involve providers and MCOs in revising the Community Mental Health Handbook accordingly.

Managed care organizations reported that their role in addressing quality concerns should be to expand quality management practices and clinical auditing as well as to increase their emphasis on outcomes. In addition, MCOs indicated that they could offer training on evidence-based practices and work with network providers to re-examine outcomes measures to improve the quality and consistency of services. Continued collaboration was also considered to be a key strategy in improving the quality of services, especially between MCOs, providers, AHCA, DCF, and the Substance Abuse and Mental Health Corporation.

Providers were indicated to have a role in addressing issues related to the quality of care as well. Managed care organizations suggested that providers increase the educational levels of their direct care staff, conduct staff training, develop measures of quality that verify treatment effectiveness, and focus on developing and maintaining quality medical records. It was also recommended that providers work with MCOs on quality initiatives to improve services, participate in MCO trainings when offered, and request consultation from the MCO when needed.

Determining Drug Formulary Benefits

Provider perspective

Over a third of responding providers reported experiencing continuing challenges with the various formularies utilized across Medicaid managed mental health care plans. Specific issues related to differences between plan formularies, frequent changes and difficulties in obtaining the most current versions of formularies, and prior authorizations or overrides for non-formulary medications or doses. These issues were reported to affect provider agencies as well as recipients.

The lack of uniformity between plan formularies, including restrictions on accessing medications, were reported as influencing what a physician may prescribe depending on the managed care plan in which the recipient is enrolled. Instead of being able to prescribe according to best practice and the recipient's individual needs, "Certain plans only cover a limited number of medications..., limiting the ability of the doctors to effectively practice medicine." Sometimes, a 'fail first policy' is implemented, where "one must show a failed prior treatment history in hopes of being able to be treated with the appropriate medication." This inability to initially treat a recipient with a preferred medication was indicated as compromising recipient recovery and resulting in "relapse and re-hospitalization." Another issue related to accessing medications mentioned by providers was quantity restrictions placed on medications (e.g., 30 pills per month). A specific example offered was if 20 milligrams of a medication is prescribed to be taken daily, but the pill is only manufactured in a 10-milligram dose (requiring two pills per day), then a prior authorization is required for the recipient to obtain 60 pills per month if the current allowance is only 30 pills per month. This, in turn, requires

additional paperwork to be completed by the prescriber. One provider described the impact of the differences between plan formularies by stating, “Again, it changes the focus of care from what will work/help most to what will be paid for.”

Provider responses indicated that these challenges can be further exacerbated by the frequency with which formularies change (sometimes without notice to providers) and the difficulty experienced by some providers in obtaining the most current versions of formularies. One provider stated that although numerous attempts had been made to obtain updated formularies from the plans, they did not have current versions until a recipient(s) brought them in. It was further noted that if a physician is unknowingly working from an outdated formulary, this may not be realized until the recipient is denied the medication at the pharmacy.

It was also reported that a prescription denial requires investigation by the provider (taking away from clinical time that could be spent with recipients) and further requires either a prior authorization for the desired medication or a change in the recipient’s medication regimen (even if the recipient has already been stabilized on the medication). Another reported consequence of prescription denials is that it requires the recipient to make additional trips to the pharmacy.

Some providers commented on the differing authorization paperwork requirements between plans and even though a recipient may be stabilized on a specific medication, a re-submission of all original paperwork may be required in order to obtain a re-authorization, taking additional time and effort by the provider agencies. As reported by providers, obtaining prior authorizations may result in delayed treatment depending on whether samples of the medication can be provided to the recipient. This delay in treatment also applies to the appeals process. Providers commented on the time period within which MCOs have to respond to appeals (providers reported periods of 30 to 45 days). They explained that during this time, recipients may go without the preferred medication or any medication at all if providers do not have samples to offer. It was additionally noted that if an appeal is not approved, a less effective medication may be substituted, thereby compromising the recipient’s opportunity for recovery and the quality of care received. One provider also stated that although they may receive formulary overrides from a plan, sometimes the override is for a smaller quantity than necessary or the approval continues to be denied at the pharmacy.

Providers suggested a number of solutions to address the challenges with formulary differences and are summarized as follows. AHCA and MCOs should collaborate to develop a standardized formulary to be used across all plans (including the Medicaid Preferred Drug List). This would eliminate the need for providers to track changes in and obtain updated copies of numerous formularies. This new formulary should also be expanded to include the most frequently prescribed medications and dosages to decrease required paperwork for prior authorizations and appeals. Providers should be

automatically notified when changes are made to the formulary and updated versions should also be readily available to providers. If the authorization and appeals processes were also made uniform across all plans, this would ease the current burden on providers to comply with different paperwork requirements. The time period allowed for appeals to be answered by MCOs and any 'fail first' policies should be reconsidered so recipients may have access to the most appropriate medications in a timely manner to enhance the opportunity for recovery and stabilization.

Providers' current efforts to address these challenges included providing samples, when possible, until prescribed medications are approved; diligently completing prior authorization forms and writing appeals; providing ongoing education to physicians and staff about the differences among formularies; employing staff specifically to manage differences among plan benefits; and communicating and collaborating with MCOs by inviting their staff to their agency to more fully educate them on the services they provide and the populations they serve. In addition to those providers who continue to experience challenges with formulary differences, two providers reported that the issues had been resolved by either medications being added to the formularies or the formularies had become more stable.

Receiving Accurate Data from Providers

MCO perspective

Over half of the MCOs reported experiencing ongoing challenges with obtaining accurate or complete FARS/CFARS (Functional Assessment Rating Scale/Children's Functional Assessment Rating Scale) outcomes data from provider agencies. According to MCOs, providers are required to submit identical outcomes data to DCF and the MCOs, but in different formats. Reportedly, this results in additional administrative work for the providers that could detract from direct service time with recipients and additional effort by MCOs in making ongoing attempts to obtain this data from providers. When incomplete data are received by MCOs, the value of the data that is subsequently submitted to AHCA and the ability to evaluate quality of care is limited. To address this issue, MCOs proposed the development of one standardized format for providers to utilize in submitting identical FARS/CFARS data to MCOs and DCF. It was further suggested that this endeavor be a collaborative effort between AHCA and DCF, and ideally would include MCOs and provider agencies as well. The AHCA Area Advisory Forums were also mentioned as a venue in which this issue can continue to be discussed. Until an appropriate and acceptable solution is agreed upon and implemented, some MCOs specifically stated that they would continue to offer consultation and training to providers to assist in their submission efforts and that providers should be diligent in adhering to current reporting requirements (i.e., timely and accurate data).

Developing Relationships with Community Providers

MCO perspective

Almost half of the MCOs participating in the study reported that developing relationships with community providers was a continuing challenge. These MCOs said that despite their efforts to educate and/or partner with them, providers remained skeptical of their intentions. Some MCOs discussed how their decisions are guided by what is in the best interest of recipients, but that some providers perceived them to be focused solely on cost management and service reduction. Several MCOs suggested that AHCA and MCOs support opportunities for further relationship building including the development of collaborative agreements between MCOs and providers. One MCO said that they planned to hire staff to work with providers in creating new services and another MCO reported offering consultation and training to providers as well as onsite visits to address issues that may arise.

Several MCOs indicated that they had resolved the challenge of developing relationships with community providers. They noted that most providers were amenable to partnering with them. The various initiatives cited by MCOs to foster relationships included attending individual and group meetings, trainings, and participation in AHCA Advisory Forums and in other community activities. One MCO noted that they created positions in all contract areas called Community Systems Integrators, whose specific purpose is to support relationships with community providers. Another MCO discussed how enhanced communication with providers has enabled them to develop best practices, level of care guidelines, and pilot projects.

Summary and Conclusions

Medicaid managed mental health care has been successfully implemented across the state as every AHCA area now has managed care plans in place that provide community mental health benefits. Examinations of this implementation over the past ten years have revealed a number of persistent challenges for MCOs and provider agencies. The current study focused on furthering the understanding of these challenges and obtaining possible solutions from the MCO and provider perspective. A questionnaire sent to managed care organizations and mental health care providers across the state began with an opportunity for respondents to comment on the strengths of providing Medicaid-funded mental health services within the current managed care environment. All MCOs and three-fourths of responding providers identified features of the current managed mental health care plans that facilitated their ability to provide high quality, effective mental health services to recipients. These strengths fell into four categories: relationships, flexibility and innovation, review processes, and financing. Providers and MCOs described maintaining positive working relationships and ongoing communication with each other and with AHCA as important factors in their

ability to provide quality care. In terms of flexibility and innovation, providers identified plan features (especially in capitated arrangements) relevant to the array and provision of services that allowed them to focus more on the well-being of recipients, such as providing more TBOS services. Managed care organizations reported that expanded provider networks and services have increased recipient access and choice of mental health services. Although continuing issues relevant to prior authorization and auditing requirements were discussed, some providers and MCOs also commented on the value of these review processes as a means to heighten the quality of mental health care provided to recipients. One provider characterized it as having “another set of eyes to assess clinical quality and continuity.” Regarding financing strategies, providers noted that capitated arrangements allowed them to budget more efficiently and emphasize serving recipient needs. Managed care organizations commented that managed care offered cost savings and a more efficient use of services.

Strengths identified by respondents may prove useful in stakeholder efforts to ameliorate continuing challenges. For example, the existing positive working relationships and ongoing communication between providers, MCOs, and AHCA can be strong factors in working collaboratively toward solutions. Just as flexibility and innovation were identified qualities of enhanced provider networks and services, so too should the development of solutions be approached in a flexible and innovative manner. It may also be beneficial to identify the potential value of MCO review processes while discussing ways to reduce the burden of implementing such processes. Similarly, the value of capitated financial arrangements between MCOs and providers should be considered more closely.

In addition to identifying the strengths of providing mental health services within the managed care arena, respondents were invited to describe their experiences with a number of challenge areas that had been consistently reported in past studies of implementing Medicaid-funded managed mental health care. Not surprisingly, many respondents reported experiencing continuing challenges in the following areas:

- Inability of providers and MCOs to accurately determine a recipient's current plan in a timely fashion especially as recipients change plans frequently and the accuracy of eligibility data are sometimes in question.
- Providers completing excessive paperwork and time-consuming follow up to obtain timely prior authorizations. MCOs receiving sometimes incomplete or poor quality prior authorization requests.
- Providers managing the differing billing requirements and procedures between MCOs resulting in increased administrative work.
- Providers diverting resources from services to administration in order to meet managed care requirements for billing, reviews, tracking claim payments, authorizations, and denials.
- Insufficient rates being paid to MCOs and providers to cover the rising costs of providing services especially for psychiatric services and administrative work.

- Timely payments not being received by providers from MCOs and increased time to troubleshoot claims denials resulting in additional administrative work. Additional work by MCOs to resolve claims that were not properly submitted, were duplicative, or were not submitted in a timely manner.
- Uncompensated care resulting from low rates and issues with prior authorizations and billing procedures.
- Hesitancy of primary care physicians and recipients to participate in efforts to integrate mental health and other services.
- MCO concerns about the quality of services offered by providers including the lack of clinical expertise, care coordination issues, a lack of adherence to evidence-based practices, and lack of available providers in rural areas.
- Provider issues related to determining drug formulary benefits caused by differences between plan formularies, frequent changes and difficulty in obtaining the most current versions of formularies, and differences in prior authorization processes or overrides for non-formulary medications or doses.
- MCOs receiving inaccurate or incomplete FARS/CFARS data from providers that are required by AHCA and DCF.

It was clear that many of these challenges resulted in increased administrative work for mental health providers and managed care organizations, which has reportedly led to the diversion of financial resources from clinical services to administration. It was evident from mental health providers' feedback that the provision of uncompensated care has resulted from other challenges discussed in the study, including eligibility issues, reimbursement rates, timeliness of payments, and prior authorizations. Recipients were also reportedly being affected by the reductions in services resulting from many of the challenges discussed in this study.

It was also apparent that a number of the ongoing challenges identified by providers and MCOs noted in this year's report were related to the model of management. Some MCOs have chosen to sub-capitate with some of their service providers, shifting risk to the provider level, while others continue to pay for services on a fee-for-service basis. Providers have reported that sub-capitation arrangements with MCOs generally allow them more flexibility and are administratively easier to manage. Fee-for-service arrangements with MCOs that require prior authorization for services and individual service billings are generally associated with more administrative and fiscal challenges. However, some of the concerns noted as ongoing challenges by both providers and MCOs, such as the perceived low Medicaid rate structure and the data related problems, (e.g., the receipt of accurate and timely member eligibility information, the accurate determination of drug formulary benefits and the receipt of accurate data from providers) are not necessarily related to the financing model of either capitation or fee-for-service. Low rates and data issues are more systemic and may

be better addressed at levels beyond any particular plan. The administrative and fiscal challenges associated with fee-for-service arrangements that require prior authorization and individual service billings are more amenable to change at the plan level as providers and MCOs work together to streamline and improve both processes or as the plans move to establish more sub-capitated arrangements.

Recommendations

When asked how issues could be addressed, study participants acknowledged that AHCA, MCOs, and providers all had a part to play in effectively implementing managed mental health care and addressing the ongoing challenges. Of the recommendations offered by respondents regarding the ongoing concerns, several consistent themes emerged:

- AHCA should improve its monitoring of MCOs, especially their processes for billing and authorization of services as well as their claims payment histories. They should also closely monitor the requirement that MCOs spend 80% of their capitation for community mental health services on services.
- AHCA should improve its data systems to ensure that accurate and timely eligibility and plan enrollment data are readily available to MCOs and providers. MCOs should also make their current drug formulary information readily available to providers.
- AHCA should encourage and facilitate the standardization of billing and prior authorization processes among the MCOs to ameliorate administrative burdens for both MCOs and providers. Electronic billing capacity should be encouraged and developed.
- Providers and MCOs should ensure that their respective staff are trained in the procedures for appropriate billing and obtaining prior authorizations. AHCA should also help educate providers and MCOs about medical necessity criteria.
- Providers, MCOs and AHCA should develop ongoing opportunities for communicating and building relationships with each other. Quarterly Advisory meetings are helpful, but having state level AHCA staff attend in person rather than by phone was preferred.
- Improvements in the rate structure for services should be addressed by AHCA as well as the MCOs. Providers should also find ways to improve their internal operations to be more cost effective. Providers (and others) should continue to advocate for rate increases while seeking other fund sources.

In addition, the following recommendations are offered for consideration:

- AHCA, managed care organizations, and mental health provider agencies should continue to work together to resolve the ongoing challenges noted in this report. The solutions suggested by respondents in this study offer a framework to begin that process and should be given serious consideration.

- AHCA, managed care organizations, and mental health provider agencies should remain flexible and creative in the development of specific solutions to ongoing challenges.
- While it may not be possible to fully ameliorate all of the challenges identified in this study, AHCA, managed care organizations, and mental health provider agencies should work towards developing and implementing strategies that minimize the administrative burdens of prior authorizations, billing, reporting requirements and auditing that are part of managed care and that maximize their ability to effectively provide quality services to recipients.
- AHCA and managed care organizations should seriously consider moving toward some level of uniformity and standardization in the various procedures and requirements to which mental health provider agencies are expected to conform, to help reduce their increasing administrative efforts.
- Mental health provider agencies (and MCOs) could benefit from each other's experiences of coping with the challenges of managed care. They should communicate with one another to share ideas for effective service provision and solutions to ongoing concerns.

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