

Executive Summary

Evaluation of Florida's Prepaid Mental Health Plan

Year 2 Report

David L. Shern, Ph.D. and Patricia Robinson, M.S.W.

Overview of the Study

In this report we summarize the results and recommendations from the second year of our evaluation of the Florida Managed Mental Health Care Initiative. Under a 1915(b) Medicaid waiver, the Agency for Health Care Administration (AHCA) established two differing approaches to managing mental health care in the Tampa Bay Area (AHCA Area 6). We conducted a multi-method evaluation that assessed the degree to which these differing approaches have affected access, cost, quality and outcomes of care.

We contrasted two financing conditions in the demonstration area and one in a comparison area, AHCA Area 4 (Jacksonville and Daytona Beach), that continues to use a largely unmanaged, fee for service system for financing mental health services. In the first managed care condition (the Prepaid Mental Health Program, PMHP) a specialty mental health organization manages a comprehensive mental health benefit for its enrollees. The benefit is financed through a pre-paid, risk adjusted premium. Health and pharmacy benefits for PMHP enrollees continue to be reimbursed on a fee for service basis. The second financing condition consists of HMOs that receive an integrated, risk adjusted premium to provide the full range of health and mental health services to their enrollees. HMOs also are at risk for pharmacy benefits.

Implementation of Managed Care in the Demonstration Area

Complex organizational and financial arrangements characterize the two managed care models. However, HMOs have the most complex and changeable relationships. Two HMOs manage their mental health services directly, while five use sub-capitated risk arrangements with Behavioral Health Organizations (BHOs) to purchase their mental health services. One HMO has two additional layers of management between it and its service provider network. These multi-level, risk-shifting structures diffuse accountability and may ultimately decrease resources available for services. During years one and two, HMOs experienced 13 major organizational changes – six in the second year- while the PMHP remained unchanged organizationally in both years.

The management information systems within these organizations continue to be problematic, especially in the HMO condition. There continue to be problems with determining current enrollees in a particular plan as well as authorizations and payments for services. We conducted a special study of services provided by the service providers (the Community Mental Health Centers, CMHCs) that

were uncompensated by the HMOs. We found that from 17% to 36% of the services provided by the CMHCs were uncompensated. Data from case studies of 30 children indicated that almost all (97%) of the uncompensated services were not authorized. Prompt payment was also a concern. The degree to which services are uncompensated complicates the comparison of costs and outcomes between the financing conditions.

Access to Services

In the first year of the evaluation we concluded that the characteristics of enrollees differed among the financing conditions and that access to services had not improved following implementation of the demonstration. We also identified some special concerns regarding service access for adults on SSI.

In the second year evaluation, a greater proportion of enrollees in all three financing conditions were SSI recipients than during the first year. Forty three percent of enrollees in both the PMHP and Area 4 MediPass conditions were SSI beneficiaries as contrasted with 27% in Area 6 HMOs. This may signal a more disabled population in all three financing conditions.

Differences in overall penetration rates for any mental health service were found among the financing conditions. The PMHP and the Area 4 MediPass condition had average monthly penetration rates near 17% as contrasted with a 10% rate for the HMOs. Interestingly, these differences in penetration rates existed before the onset of the demonstration.

Mail survey data revealed significant differences among the financing conditions related to the utilization of mental health services for people with self identified mental health needs. HMOs had the lowest penetration rates. Finally, we found that adults with severe mental illnesses who were enrolled in HMOs used services at a significantly lower rate than persons in either the PMHP or Area 4 MediPass conditions.

We continue to see differences between the conditions in access to services. Generally, access is poorest in the HMO condition with small and often insignificant differences in access between the PMHP and Area 4 MediPass conditions.

Cost of Services

The PMHP and HMOs have been effective in containing costs when compared to their historical expenditures and to the traditional fee for service condition. Using a standard rate table for mental health services created from Area 4 data, we estimated that HMOs are expending approximately 60% of the funds spent by the PMHP on services. We are still trying to determine the percent of premium received that is spent on services. However, we need to develop more sensitive

methods for costing services in order to more adequately contrast expenditures in the different financing conditions. We also found that persons in the managed care conditions were much more likely to use informal resources than were persons enrolled in MediPass in Area 4. This finding may be a possible indicator of *cost shifting* from the formal system of services to the informal system, an important concern in managing care.

Quality and Outcomes

We found differences in patterns of services provided and continuity of care among the financing conditions. While we continue to have concerns regarding the completeness of the data, we found that persons served in HMOs were significantly less likely to have an outpatient appointment within 30 days following an inpatient discharge than individuals in the other financing conditions. We also found that persons with schizophrenia enrolled in the HMO condition were significantly less likely to receive the newer, more effective but costly anti-psychotic medications than individuals in other financing conditions that are not at risk for pharmacy expenditures.

In the first year, in our case study of thirty children with SED, we identified significant differences in the quality of services provided to the children enrolled in HMOs and their counterparts enrolled in the PMHP. In this year's analyses we noted differences in outcomes among those same 30 children. The children enrolled in HMOs experienced poorer outcomes than children enrolled in the PMHP. It is important to remember that these children received their services from the same service providers.

While we again noted that persons who received services generally improved over time, we found weak evidence that children served in the managed care conditions (both HMO and PMHP) experienced better outcomes on functional scales than children served in the Area 4 MediPass condition. Adults on SSI enrolled in both managed care conditions in Area 6 also experienced better functional outcomes than persons served in Area 4 MediPass. Interestingly, adults enrolled in HMOs reported greater satisfaction with services than individuals in the other conditions.

Conclusions and Recommendations

After the first two years of the evaluation we conclude that the PMHP has achieved its objectives with regard to cost containment and that we have no indications that these cost containment strategies have resulted in poorer outcomes for PMHP enrollees. We have some evidence that persons served by the PMHP may experience better outcomes than persons in the fee for service condition.

We therefore recommend that:

The PMHP continue to operate in much the same way as it has during the first two years of the demonstration including the active oversight of AHCA and the ADM program.

Similarly, we conclude that expanding the managed care model represented by the PMHP throughout other areas of Florida may be a viable strategy for helping to contain costs while not sacrificing access, quality or outcomes.

However, it is critical that any expansion of the managed care models be mindful of many of the problems that have characterized the HMO financing condition. It is also important to note that these problems are not necessarily endemic to the use of HMOs as risk bearing managed care organizations. Given our observations of the problems that have been experienced in the HMO condition we further recommend that:

Vendors selected to implement the managed care intervention have demonstrated capacity to serve persons with severe mental illnesses.

AHCA provide at least one year for implementation of any expansion.

AHCA give preference to managed care plans with simple organizational structures that promote flexibility at the level of clinical decision making.

Any expansion of managed care strategies should be treated as experimental and rigorously evaluated, looking at both users and non-users of services.

It is essential that vendors have demonstrated MIS capacity to administer the managed care programs.

Given some of our preliminary data regarding the relationships between premiums and expenditures in the managed care conditions, we recommend that:

AHCA work with the evaluation team and the participating agencies to develop methods for appropriately monetizing services so that costs may be meaningfully compared across conditions.

Evaluation of Florida's Prepaid Mental Health Plan Year 2 Report

David L. Shern, Ph.D. and Pat Robinson, M.S.W

with

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John Ward, Ph.D. and Tim Boaz, Ph.D.

Background

Publicly financed health and mental health systems are undergoing dramatic changes throughout the nation. All but four states are now implementing some form of managed care for behavioral health services (Lewin 1998). This represents a 76% increase since 1996. Most of these reforms involve the Medicaid financing system with 36 states operating 46 Medicaid waivers for behavioral health care. In ten states, fee for service billing for mental health or substance abuse services has been virtually eliminated (Lewin, 1998).

While the development of these managed care strategies are driven largely by concerns with cost containment, these changes involve the development of new organizational forms, financing arrangements, clinical and business management strategies that fundamentally differ from those that have been used traditionally. While complex and highly variable across settings, these changes typically involve capping the state's financial liability for identified populations through prospective payment schemes. Generally, the financial risk for service utilization is shifted from the state to insurers or service providers who have profit incentives for assuming this risk. The ultimate goal of these changes is to reduce the cost of care and to maintain or improve access and quality of care through improved clinical management techniques. While we now know from several states' experiences that it is possible to reduce costs using these strategies, very little is known about their effects on service quality or enrollee outcomes.

Florida Context

Resonating to these national trends, Florida's Agency for Health Care Administration (AHCA) has engaged in several strategies for better managing care and its costs. In AHCA Area 6, which includes Hillsborough, Polk, Manatee, Hardee and Highlands counties, AHCA implemented a demonstration Prepaid Mental Health Plan (PMHP) in March 1996, under the authority of a 1915b waiver from the Federal Health Care Financing Administration. The Louis de la Parte

Florida Mental Health Institute (FMHI) was selected by the Florida Agency for Health Care Administration to evaluate the effects of the Florida Prepaid Mental Health Plan. Under contract from AHCA and with additional support from the Substance Abuse and Mental Health Services Administration and the National Outcomes Roundtable, we are conducting a series of integrated evaluation projects. These projects are designed to assess the effects of the PMHP on access, cost and quality of services relative to alternative managed care arrangements that are in use in the demonstration area (AHCA Area 6) and to the traditional financing arrangements that are in use in AHCA Area 4. In this integrative summary of the second year of the evaluation, we synthesize the major findings from these studies as they relate to the effects of the demonstration on access, quality, enrollee outcomes and cost.

Several alternative financing and management arrangements for mental health services are in use in Florida. In the demonstration area Medicaid enrollees may have their mental health services financed through a fee for service system or through one of two managed care arrangements. The fee for service system is used by several groups of enrollees who are excluded from the demonstration and by newly certified Medicaid clients who have not yet selected or been assigned to a managed care condition. All other Medicaid clients are enrolled in one of two managed care conditions. The first is a behavioral health care 'carve out' plan in which a specialty behavioral health managed care organization (the Florida Health Partnership or FHP) provides or arranges for all mental health services for plan participants. In this arrangement FHP is paid by AHCA through a fixed monthly fee per enrollee. We will discuss this condition as the Prepaid Mental Health Plan or PMHP. In the second managed care condition that is operating in the demonstration area, Health Maintenance Organizations (HMOs) receive a premium that includes both the general health and specialty mental health component. These HMOs provide all health and mental health services to their enrollees. This is characterized as a 'carve in' arrangement. Both the PMHP and HMOs in Area 6 are at risk for the mental health service utilization of their enrollees.

Outside of the demonstration area, comprehensive mental health services for Medicaid recipients are reimbursed through a fee for service mechanism in which the state is at risk for mental health service utilization. For Medicaid participants who are enrolled in HMOs outside of Area 6, inpatient and physician services for mental health are included in their benefits. As with all other Medicaid recipients outside of Area 6, mental health services, other than inpatient and physician services, are reimbursed through a fee for service payment system for HMO enrollees. With the exception of mental health services provided by PMHP and the HMOs in Area 6, prior authorization for inpatient admissions are managed statewide by a utilization management firm – First Mental Health. This utilization management system was initiated in January 1997 immediately prior to the second year of the evaluation.

Evaluation Design and Methods

We are using a non-equivalent comparison group design to investigate the effects of the differing financing conditions on access, cost and quality of services and enrollee outcomes. In this design we selected the Jacksonville area (AHCA Area 4) as the area of Florida that most closely resembles AHCA Area 6 in its demographic characteristics and in the composition of its health and mental health care markets.

Table 1: Risk Arrangement by Financing Condition

Financing Condition	Risk Arrangement		
	Health	Mental Health	Pharmacy
Area 6			
MediPass/PMHP	No Risk	At Risk	No Risk
HMO	At Risk	At Risk	At Risk
Area 4			
Medipass	No Risk	No Risk	No Risk




Table 1 summarizes the differential risk arrangements that characterize the three financing conditions that are contrasted in the evaluation. The financing conditions differ in their risk arrangements for medical care, mental health care and pharmacy. The HMO condition in Area 6 is fully at risk for all three categories of services while the PMHP/MediPass condition and MediPass in Area 4 are not at risk for medical or pharmacy benefits. Of course, the MediPass/PHMP condition is fully at risk for mental health utilization.

Sub-studies Comprising the Evaluation

In order to document the characteristics of the different financing conditions and understand their effects on access, cost, quality and outcomes, we are completing a set of five interrelated studies. Julienne Giard, Pat Robinson and Susan Ridgely continued the implementation analysis in the second year

evaluation. They completed site visits and key informant interviews with representatives of the managed care organizations and the community mental health centers (CMHCs) in Areas 6. They continued to review contracts and other pertinent documents. They chronicled changes within the system and conducted a special study to document the degree to which providers were not compensated for care they delivered to HMO adult clients. In that special study of uncompensated care, billing records were collected from CMHCs. Also, utilization management and claims records were collected from HMO/BHOs (Behavioral Health Organizations) for a sample of individuals with severe mental illness (SMI) who were enrolled in the HMO condition between 9/1/97 and 2/28/98 and had received services from one of the CMHCs in Area 6. Each contact between the CMHC and the consumer was classified as compensated or uncompensated based upon receipt of payment from the HMO.

Mary Armstrong and Mary Ann Kershaw continued to study the 30 children with SED whose cases were examined during the first year of the evaluation. In this second year of the case study they also investigated the issues of uncompensated care by abstracting information from agency and HMO/BHO records about the services delivered to those 30 children. As with the adult study, they determined the payment and authorization status for all services delivered to these children during the period of 1/1/97 – 3/31/97 for one provider and 4/1/97 – 6/30/97 for the second provider. Additionally, they collected information on the status of each of the 30 children as of January 1998. Blind reviewers classified each case as either improved, unchanged or worsened during the one year follow-up period. With these data we can link the ratings of quality that we obtained during the first year evaluation with the outcomes that these clients experienced during the following year.

Paul Stiles, Kristen Snyder, Mary Murrin and their colleagues continued the analysis of the administrative data during the second year of the evaluation. These analyses focus on questions of access to and cost of services as well as changes in the patterns of service. They rely on data provided by AHCA, PMHP and the HMO's. AHCA enrollment and claims data are combined with paid claims data from FHP and the HMOs to describe patterns of services, costs and penetration rates. As in year 1, we continue to experience difficulty obtaining complete data from all of the HMOs involved in the study. While all of the HMOs submitted data during the second year of the evaluation, their review of our preliminary findings indicated that the data we received were not complete with regard to the volume of services that were received. Following this initial presentation of the findings from the second year evaluation, the HMOs and their Behavioral Health Organizations (BHOs) completed a special study to estimate the degree to which the paid claims data that were provided to us were accurate.

In this special study, all sources of information for 50 sampled cases per HMO were assessed to determine the degree to which the data submitted to us accurately represented the services that were provided. Not all HMOs provided

data to us on the 50 sampled cases within the time constraints necessary for the production of this second year report. However, data were obtained from all of the BHOs that served these HMOs. We found that the degree of correspondence between the data submitted to us initially and the data gathered in the special study differed markedly among the HMOs. Some HMOs had only minor underrepresentation of services while others found that the data we had received grossly underrepresented the services provided. We have adjusted our estimates for each of the HMOs to reflect this underreporting of their service data. The continuing difficulty in obtaining complete volume of service data from the HMOs is an ongoing concern for both the evaluation and the administration of the program.

Tom Massey, Michael Dow, John Ward and Tim Boaz analyzed data collected as part of the statewide outcome monitoring system to describe the characteristics of persons who received services and to assess their treatment outcomes. As with last year, they employed data from the Functional Assessment Rating Scales (FARS), the Global Assessment of Functioning, the Child and Adolescent Functional Assessment Scales (CAFAS), the Children's Global Assessment Scale (CGAS) to both describe service recipients at admission to treatment and to examine the degree to which they improved during care. In addition, during the second year of the evaluation, data were employed from the statewide study to help estimate the degree to which the client characteristics and outcomes that were obtained in the two study areas paralleled those obtained throughout the remaining service areas in Florida. These data will help to establish a context for understanding the evaluation results for service recipients in AHCA Areas 4 & 6.

Roger Boothroyd and his colleagues continued analysis of the population based outcome data. Their work involved several data sets that have been assembled specifically for this research including mail survey data from Medicaid enrollees and an intensive follow-up study with 688 adults with severe mental illness. Data from these studies are used to estimate service utilization inside and outside of the Medicaid program as well as inside and outside of the formal treatment and support system. Additionally these data can be used to assess the outcomes experienced by individuals who are enrolled in the program.

During the second year of the evaluation over 5,000 mail survey responses were obtained from adults and children who were eligible for Medicaid through participation in the WAGES and the SSI program. This represents approximately 47% response rate for the survey, adjusted for undeliverable surveys and respondents who were deceased. Survey respondents were asked to provide general information about their health and mental health status, their quality of life and general functional well being as well as to report on the degree to which they received services that they felt they needed. These data will provide us with an overview of the population's health status that is not dependent upon individuals using services that are financed through the Medicaid system.

Implementation Analyses

During the first year evaluation we identified the key organizational and financial features of the managed care arrangements in Area 6. Among our most important observations were that

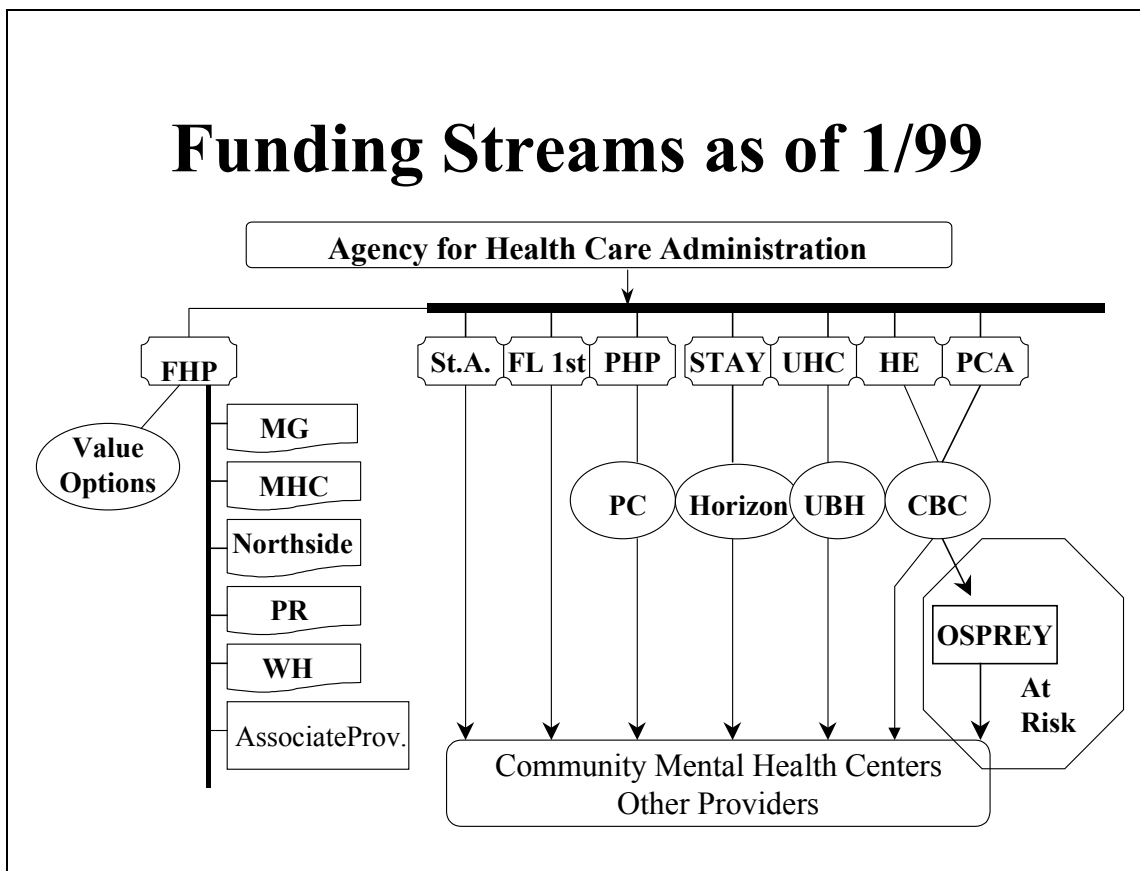
- Complex financial and organizational administrative arrangements were employed in the HMOs,
- Integrated health and mental health premiums often did not result in integrated services,
- The HMOs/BHOs purchase services from the same specialty mental health organizations (i.e. CMHCs) that are involved in the PMHP and
- Substantial instability in organizational relationships characterized the HMO condition in Area 6.

During the second year evaluation we observed that many of these trends continued. First, the HMO condition continued to be characterized by substantial organizational instability. During the first two years of the demonstration, the HMOs experienced 13 major changes, six in the second year, while the PMHP evidenced no major organizational changes. These changes included:

- One HMO closing,
- Two HMOs being purchased by other HMOs that were originally outside this market,
- One merger between two of the BHOs, and
- Nine BHO and other subcontractor changes for mental health services among 5 HMOs.

Often these changes occurred with little advanced notice and required re-credentialing of the CMHC staff, the cancellation of existing service authorizations and implementation of new administrative procedures between the CMHCs and the HMOs.

In Figure 1 we display the organizational and risk arrangements that characterized the demonstration area on January 1999. As may be seen from this figure substantial variability exists between the HMOs in their organizational and financial arrangements. Two of the HMOs do not use BHO intermediaries for the provision of mental health services. The remaining HMOs employ BHOs who assume the risk for the provision of mental health services to the Medicaid beneficiaries who are enrolled by the HMO.



During the second year of the evaluation, however, the risk arrangements became even more complex than during the first year. One BHO entered into full risk contracts with CMHC provider agencies for outpatient services (inpatient services remained reimbursed on a fee for service basis). These arrangements were desirable for the CMHC providers since it assured reimbursement for services rendered and provided them flexibility in determining which services to provide enrollees rather than having to seek authorization and negotiate payment for each of the services. It is interesting to note that one of the arrangements involves a third fiscal intermediary OSPREY Health Care Inc., which is at-risk for the provision of services. OSPREY further has an at risk contract with the CMHC providers for these consumers. During the second year of implementation, therefore, risk for services has become further complicated with one instance in which four risk bearing entities occur between AHCA and the Medicaid enrollee.

Difficulties continued in the administration of the HMO financing conditions including denials and constraints on psychotropic medications, and ongoing problems with the management information systems. Paralleling the difficulties that we experienced in obtaining the service data needed for the evaluation, we observed one or more instances of an:

- Inability of the HMOs to provide CMHCs with current lists of the HMOs' Medicaid members on a monthly basis,

- Medicaid billing codes not being incorporated into all of the computer systems resulting in difficulties in reimbursement for services provided,
- Utilization management systems that were not linked to claims systems,
- Service authorizations provided without a unique identifying number making it difficult to link them to claims
- Claims paid without unique identifiers.

These MIS problems continued to plague the relationships between the HMOs and the CMHCs who provided services to HMO enrollees.

Uncompensated Care

Since the CMHCs generally are providing services to HMO/BHO enrollees on a fee for service basis requiring prior authorization and because there were reported difficulties in the payment for services provided, we undertook two special studies of uncompensated care – one for adults and one for children. In both of these studies we reviewed all of the billing records for a sample of enrollees and determined for each billing record whether and when the CMHC was reimbursed for services they had rendered. Additionally, for the children's sample we also were able to determine if the services that were provided were appropriately authorized.

We selected 32 adults with severe mental illness who were enrolled in the HMO condition and reviewed 238 fee for service claims that had been issued for services they had received. Seventeen percent of the claims were never paid. We do not know the number of claims that were authorized. Of the claims that were paid, 74% were paid after 35 days, with the average delay in payment being 70 days.

The children who were studied in the uncompensated care component of the study were the same 30 children in the case study. For the 15 children who were enrolled in an HMO and whose services were to be reimbursed on a fee for service basis, we found that 36% of the services billed for these children were not paid by the HMO. Ninety-one percent of claims were paid after 35 days with an average delay of 94 days between initial billing and final payment. We also were able to obtain information regarding the authorization of services. We determined that 97% of the care that was uncompensated was not authorized. Additionally, according to the HMO/BHO data, all of the children's claims received a response within the 35 days required although that response typically did not involve payment.

Regardless of the reasons for the uncompensated care, it is clear that a great deal of the care being provided to these HMO clients ultimately is not reimbursed by the HMOs. If this finding generalizes to other population groups, this has important implications for the interpretation of the data from the administrative and outcome components of the study, since the paid claims data provided by

the HMOs/BHOs may substantially underestimate the actual volume of services that are provided to clients. Similarly, cost estimates for the HMO clients may importantly understate the costs borne throughout the system for these individuals.

Access to Services

As we have defined access in this evaluation it generally encompasses two types of questions. The first relates to the characteristics of individuals who are enrolled and/or served in each of the financing conditions – the case mix. It is important to understand the characteristics of the enrolled population and who is actually receiving services. The second question relates to the *rate* at which individuals in need of care received services. We estimate these penetration rates from both administrative data and from population based survey data.

In the first year of the evaluation, the lack of administrative data from the HMOs compromised several of the access analyses. Using the data that were available, however, we concluded that:

- Differences existed among the characteristics of enrollees and service recipients across financing conditions,
- Access to services had not improved following the implementation of managed care arrangements, and
- Access may be of concern for adults enrolled in the SSI program relative to their self-identified mental health needs.

In the second year analysis we have:

- Obtained administrative data from the HMOs,
- Completed surveys from a sample of the overall Medicaid population as contrasted with just the adult SSI Medicaid population that was surveyed in the first year, and,
- Implemented a case mix adjustment procedure to control for differences in enrollee characteristics among the different financing conditions.

In the case mix adjustment procedures, we adjust the estimates by a proportional weighting strategy that accounts for age, sex, race, eligibility status (SSI vs. WAGES) and service utilization.¹ These procedures help to assure that observed differences between financing conditions do not simply result from

¹ For each variable that we wish to adjust, we calculate the statistic of interest (e.g. mean, proportion, etc.) for each of the groups specified by the unique combinations of the adjustment variables (e.g. young, female, African American, WAGES, service users). We then aggregate these groups within financing condition by weighting each group estimate by the proportion that the group represents of the overall population enrolled in the three financing conditions and summing these weighted estimates. Estimates for each financing condition, therefore, should be interpreted as the statistic that would have been obtained if the characteristics of the persons served in that financing condition exactly represented those for the population enrolled in the three financing conditions.

differences between the characteristics of persons that are enrolled. Both case mix adjusted and unadjusted estimates will be provided throughout this report.

Access to Services - Enrollment Trends

During the second year of the project, the overall size and composition of the Medicaid population continued to change. The size of the population has decreased. Also, MediPass enrollments in both Areas 4 and 6 decreased by approximately 10%. However, HMO enrollment increased in Area 6 by 5%.

Most likely reflecting the effects of welfare reform and the consequent reductions of those on Medicaid because of eligibility for WAGES, the proportion of SSI recipients participating in Medicaid continued to increase. In March 1998, 43% of individuals enrolled in the Area 4 MediPass and Area 6 MediPass/PMHP programs were SSI recipients. About 27% of Area 6 HMO enrollees participated in the SSI program.

Based in part of the differences between AFDC/WAGES and SSI populations, the caseloads also differed with regard to age and ethnicity. A relatively greater number of African Americans and children are enrolled in HMOs than in the MediPass conditions in Areas 4 and 6. These trends are quite consistent with the composition of the population during the first year of the evaluation.

Access to Services – Clinical Characteristics of Service Recipients

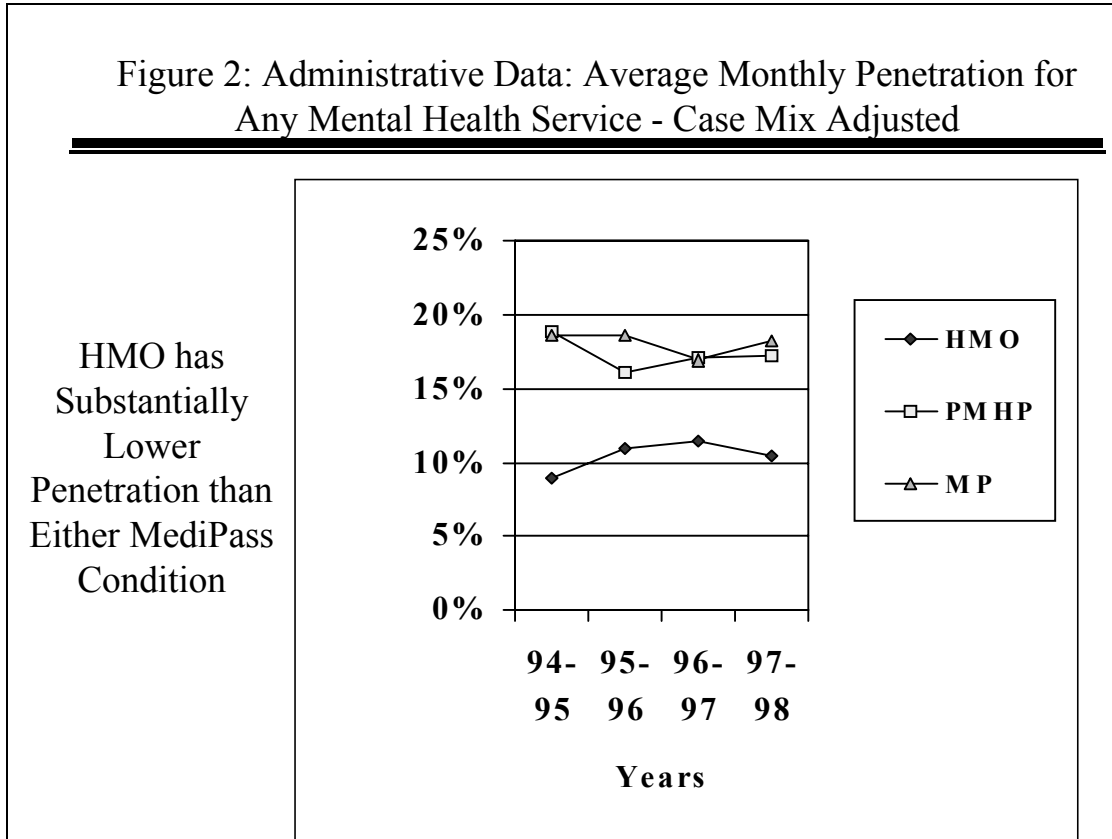
We used data from the statewide performance measurement system to estimate the clinical characteristics of persons at admission to specialty mental health programs. No significant differences in severity of impairment were obtained between the children who received services that were financed by the differing financing conditions. Similarly, the children who are served in the Area 4 and Area 6 conditions are generally representative of children served throughout the state with respect to their impairment due to mental illness.

In contrast, adults who are served in the Area 6 HMOs and the PMHP are generally less impaired than adults served in Area 4 MediPass. Also, adults in Areas 4 and 6 appear to be less severely impaired at admission to the mental health system than adults served throughout the rest of the state. No differences were obtained between PMHP and HMO service recipients in Area 6. However, it is important to note that the proportion of adults with a severe mental illness diagnosis (Schizophrenia, Major Depression) varies markedly between the financing conditions in Area 6. The PMHP has approximately twice the proportion of persons with SMI than the HMOs (8% PMHP vs. 4 % HMOs). This is consistent with the differences in the rates at which they enroll persons on SSI.

As we make comparisons between the financing conditions, therefore, we should be mindful of these differences in eligibility status (SSI vs. WAGES) and the

severity of illness among adults. In many analyses eligibility status will be controlled by case mix adjustment.

Access to Services - Penetration Rates



In Figure 2 we display case mix adjusted penetration rates for each of the three financing conditions. These rates are obtained from the paid claims data provided by each of the managed care plans and by AHCA for Area 4 fee for service. They reflect the average monthly penetration rates for each of the managed care conditions in Area 6 and for the Area 4 MediPass condition. As is clear from the figure, no consistent differences are obtained between the Area 6 PMHP and the Area 4 MediPass conditions over the four years. However, the penetration rates for persons enrolled in the HMOs are substantially lower than either the PMHP or Area 4 MediPass. No dramatic change in penetration rate has occurred following implementation of the demonstration; overall penetration has not been adversely affected. It is also interesting to note that the difference in the rate of mental health service use between the HMOs and the PMHP existed prior to the implementation of the waiver and the requirement that the HMOs provide the full range of mental health services to their enrollees. It therefore reflects a pre-existing difference between the financing conditions rather than an effect due to the change in the management of benefits.

While these penetration rates reflect the overall rate of utilization in the enrolled population, we can also estimate penetration from our population mail surveys. We asked individuals if they felt that they needed a mental health service and whether or not they received the service that they needed. In Table 2 we present the rates of service use among individuals who reported they needed a mental health service.

Table 2: Mail Survey Rates of Mental Health Service Utilization Among Individuals who Reported Needing a Mental Health Service – Case Mix Adjusted	
Financing Condition	Rate of Utilization
Area 4 – MediPass	88 %
Area 6 – MediPass/PMHP	84 %
Area 6 – HMO	75 %

The results of these analyses generally parallel those obtained during year 1 with the Area 6 managed care conditions showing slightly lower mental health penetration rates than the fee for service condition. However, the only significant difference in the table occurs between the Area 4 MediPass condition and the HMOs. Persons enrolled in the HMOs report significantly poorer access to needed services than individuals in the fee for service MediPass program. Interestingly, the utilization of medical services was not significantly different among the financing conditions and averaged over 95% penetration, indicating that the Medicaid program is successful in meeting the vast majority of self defined medical needs.

If, as in last year’s analyses, we restricted our investigation to just adults on SSI, we continue to note that they receive mental health services for self defined needs at a significantly lower rate if they are enrolled in a managed care plan rather than a fee for service arrangement. For this population, significant differences in penetration rates are obtained between all three financing conditions. These analyses are based upon 4,860 returned mail surveys from adults on SSI.

In addition to these population estimates from the mail survey, we also obtained estimates of the rates at which persons with severe mental illness obtained a mental health service. These rates are depicted in Table 3. As in the previous analysis, persons with SMI who are enrolled in the HMO condition receive services at a significantly lower rate than individuals in either of the other two MediPass conditions.

Table 3: Proportion of Adults with Severe Mental Illness Who Reported Receiving any Mental Health Service	
Financing Condition	Rate of Utilization
Area 4 – MediPass	67 %
Area 6 – MediPass/PMHP	70 %
Area 6 – HMO	58 %

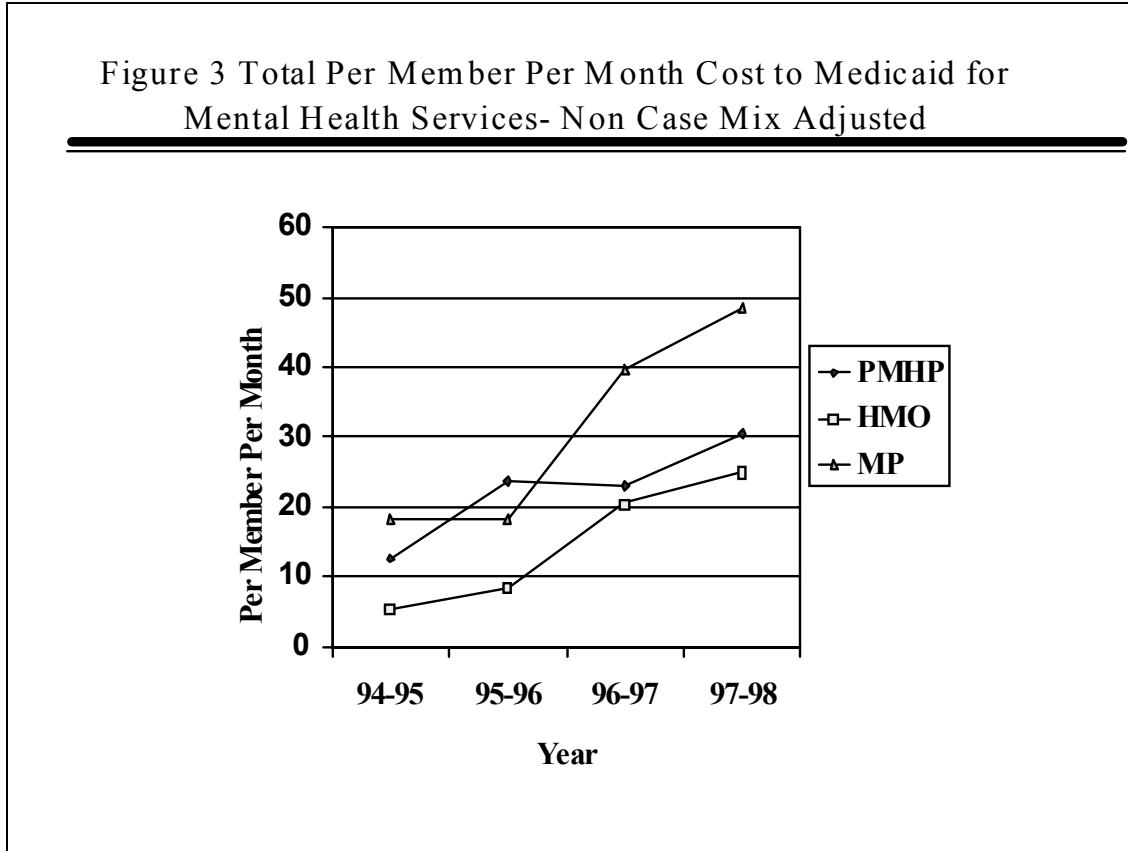
Access Findings – Summary

From these data we conclude that access to mental health services has not changed dramatically since the first year of the study. Access patterns have remained relatively flat across years. The PMHP and the Area 4 fee for service conditions evidence greater access to services than the HMO condition. We continue to be concerned regarding adults with severe mental illness who are enrolled in the HMO condition. They report substantially lower utilization rates than their counterparts enrolled in the other conditions. Similarly, adults on SSI in the PMHP and HMOs continue to show a generally depressed rate of mental health service utilization as opposed to adults on SSI in the fee-for-service condition.

Cost of Services

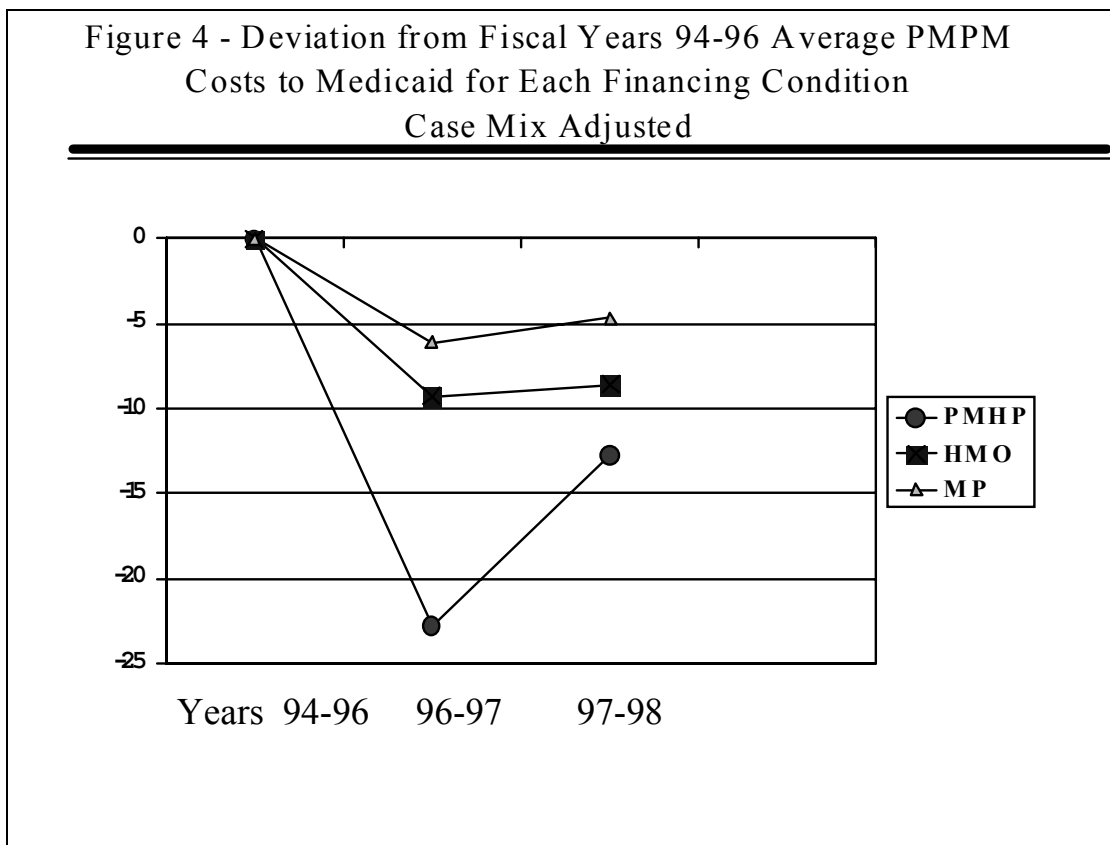
A primary goal of managed care interventions is to control growth in the cost of mental health programs relative to more open-ended fee for service reimbursement methods. We investigated the degree to which mental health costs have been controlled by calculating the average per-member per month (PMPM) expenditures for the three financing conditions. These cost estimates reflect Medicaid costs for all services delivered to persons enrolled in one of the three conditions. A service was identified as a mental health service if it met any one of five criteria including: a mental health diagnosis (290 – 316), mental health provider, mental health procedure, appropriations code, or BHO claim type. This is an inclusive strategy for identifying mental health services and includes services that are provided for developmental disorders (excluding mental retardation), organic brain conditions and dementia, alcohol and substance abuse disorders as well as the other Axis I and II diagnosis.

Costs include the PMPM expenditures for the HMO and PMHP conditions as well as any mental health services that are billed and paid on a fee for service basis. As such, these cost estimates are broadly inclusive of behavioral health related services. These results are displayed in Figure 3.



As was the case last year, it appears from these non-case mix adjusted data that the managed care plans have resulted in an overall containment of costs relative to the fee for service system in AHCA Area 4. However, when we case mix adjust the data to reflect the current population that is enrolled in the three financing conditions, we find a somewhat different pattern of results. The case mix adjusted data indicate substantial and consistent differences among the financing conditions prior to the onset of the demonstration in 1996. The dramatic increase that occurs in Area 4 in 96-97 is not apparent in the case mix adjusted data indicating that this increase was largely attributable to changes in the characteristics of the caseload in Area 4 during 96-97.

In Figure 4 we portray the changes in the costs of mental health services relative to their costs prior to the demonstration. In order to calculate these change scores, we first estimated the average PMPM costs for the two pre-demonstration years (94-95 and 95-96). We then subtracted this average PMPM cost from the post demonstration PMPM cost average in each of the financing conditions and expressed this change as a percent of the pre-demonstration costs. Negative percentiles therefore represent decreases in cost from the pre-demonstration levels.



Using these procedures with the case mix adjusted cost data, all three financing conditions show a decrease in per member per month costs in the two post demonstration years. The differences are relatively greater for the two managed care conditions in Area 6 than for fee for service in Area 4, with the greatest decrease in costs occurring in the PMHP. Cost containment objectives, therefore, appear to have been realized.

While the first set of cost analyses focused exclusively on the total cost to Medicaid for the services provided to persons who are enrolled in the three financing conditions, the second set of cost analyses estimate the cost of the services that were actually provided within the PMHP and HMOs. In order to estimate these costs and to compare them across the financing conditions, we developed a standard rate table in which cost estimates for each type of service were calculated. This standard unit cost was derived from the cost data in Area 4. Using these standard rates we created a "standard" cost estimate for the services that are provided in each financing condition. This rate is roughly equivalent to the cost to provide this array of services in Area 4. It is important to note that while these cost estimates may be used for comparing the patterns of services across conditions, the relationship of these estimates to the actual costs to the plans for providing services is unknown.

We first compared the ratio of standard costs between the HMO and PMHP conditions.² Based upon this analysis we found that HMOs spend, on the average, about 61% of the resources that are expended by the PMHP for mental health services. In addition, our preliminary analysis suggests that we should also be concerned about the amount of premium that is actually spent to provide services. However, before definitive information can be derived, we will need more complete data and methods of estimating such costs.

While the HMOs appear to be spending substantially less on mental health services than the PMHP, these differences may in part reflect incomplete reporting of the services that they have delivered. Depending upon the degree of under-representation in the HMO condition, the differences between it and the PMHP may be overstated. Uncompensated care that is being received by HMO enrollees further complicates these analyses. If the costs for uncompensated care were attributed to the HMOs, the disparity between the two conditions might also be reduced. These analyses indicate important differences between the financing conditions in their expenditure patterns and strongly suggest the need to develop some standard procedures for costing services that will allow more meaningful comparisons.

Costs and Changing Patterns of Service

Figures 5 and 6 present data for how the patterns of care for some services have been changing in the three financing conditions across time. Figure 5 displays the average number of day treatment units provided per user per month during the last four years. Clearly the rate at which day treatment services have been provided has declined after implementation of the demonstration (March 1996). The rate decreased almost equally for persons in the HMO and PMHP conditions. In contrast, the rate increased in the first post demonstration year in Area 4 and has stabilized during 97-98.

Figure 6 presents information for targeted case management. Substantial baseline differences exist between Areas 4 and 6 with regard to their use of this service. It is interesting to note that the rate at which the service is provided has decreased following the inception of the demonstration in Area 6 but has not fallen appreciably in Area 4. This is a bit surprising since targeted case management can be used to help manage inpatient utilization by intensively following individuals who are experiencing difficulties in the community. While a slight increase in the service occurs in the PMHP during Year 4, the general trend is toward decreasing use of this service.

² This ratio was calculated as the weighted average of the ratios (HMO/PMHP) for each cell in the 2X2 matrix defined by age (Children vs. Adults) and eligibility status (SSI vs. WAGES). As with all of the case weighting strategies, the proportion of the population enrolled in each age by eligibility category was used as the weight in this calculation.

Figure 5: Patterns of Service Day Treatment Services

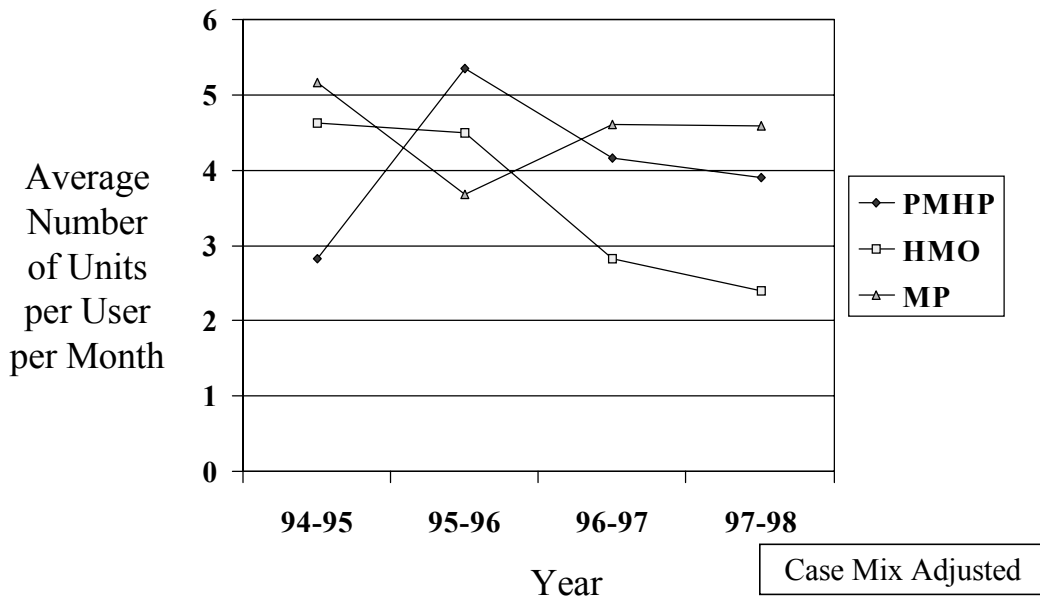
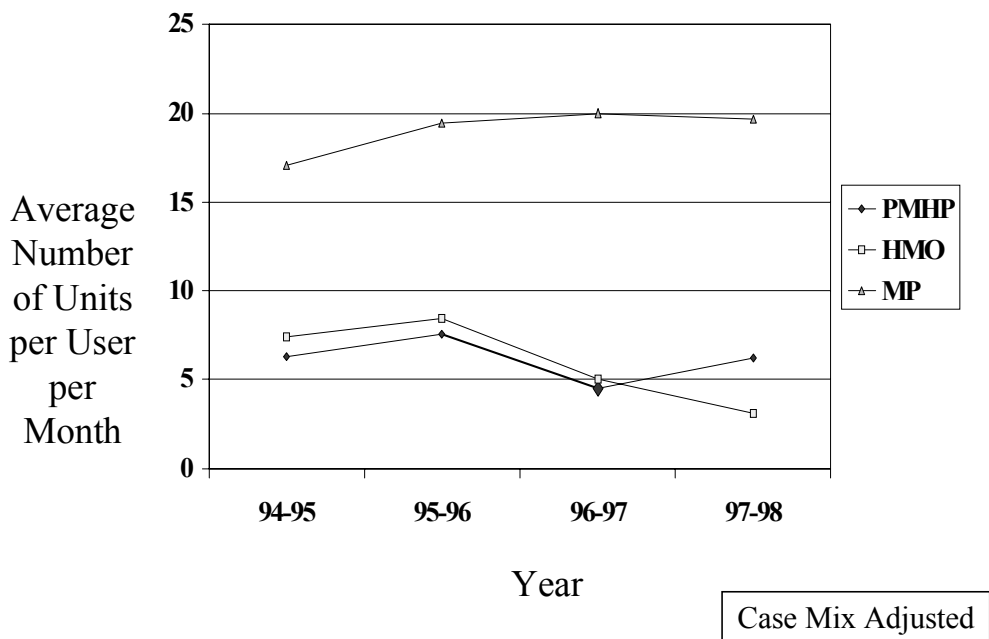


Figure 6: Patterns of Service Targeted Case Management



In Table 4 we present data on the use of atypical anti-psychotic medications and Selective Serotonin Re-uptake Inhibitors (SSRIs) by the different financing conditions. These data reflect the rate at which someone with a diagnosis of either schizophrenia or major depression receives either atypical antipsychotic agents (such as Risperidol) or SSRIs (like Prozac). According to clinical guidelines these are the first line choice pharmaceuticals for the treatment of these disorders.

Table 4: Volume of Services- Pharmacy

Condition	% of Persons with Schizophrenia who Receive Atypical Anti-psychotic Medications	% of Persons with Major Depression who Receive SSRI's
HMO	13.1%	54.2%
PMHP	28.9%	56.6%
MP	20.4%	57.8%

Persons with at
least one
pharmacy claim

It is important to remember that the three financing conditions differ in the way in which pharmacy benefits are reimbursed. The HMOs are at risk for pharmacy benefits while persons in the PMHP and Area 4 MediPass conditions are not at risk.

While no differences are obtained for the SSRI's with all of the plans showing approximately a 55% usage rate, there are strong effects of management on the use of atypical agents. Persons with schizophrenia who are served in HMOs receive atypicals at about half the rate of persons in the PMHP and about two thirds of the rate for those individuals enrolled in Area 4 MediPass. Given the side effect profile for these pharmaceuticals and the likelihood that they will improve compliance with treatment, the conventional wisdom is that about 50% of persons who are diagnosed with schizophrenia should be using these drugs.

In a national study of persons with severe mental illness who are served in managed care programs, approximately 54% of respondents are using the atypical agents. The overall rate of usage in Florida therefore appears to be lower than national figures. It is particularly low in the HMO condition.

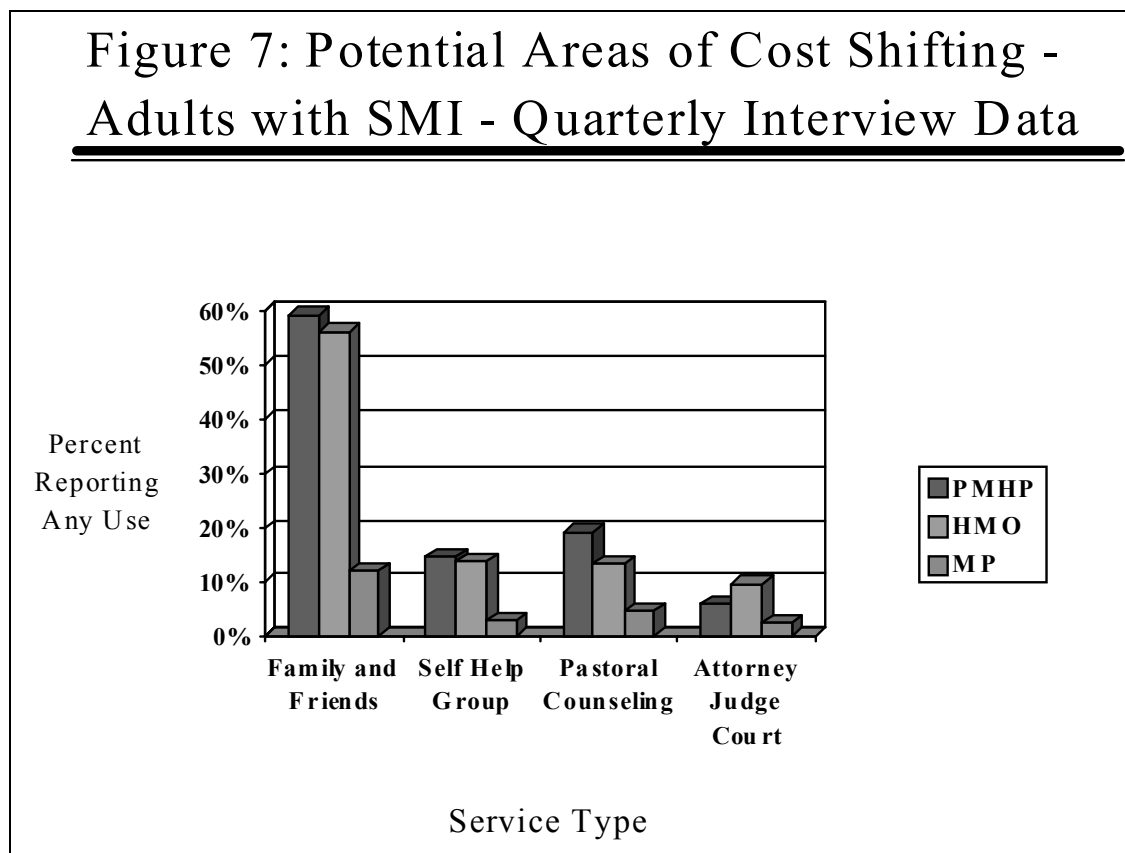
In Table 5 we display the rates at which individuals who are discharged from an inpatient setting are seen within 30 days in any outpatient setting. The HEDIS standard is less than 30 days. As with other indicators, there is important variation among the financing conditions. Interestingly, the Area 4 MediPass condition in which the program is not at risk for inpatient care, has a higher rate of follow-up within 30 days than either of the managed care conditions in Area 6. Persons served in the HMOs appear to have the poorest continuity of care while the rates for the PMHP are intermediate between Area 4 MediPass and the HMOs. As with all data that rely on comprehensive MIS information these rates are only as accurate as the information systems from which they are derived. While HMO representatives have indicated that they believe these percentages understate the true rate at which persons receive community care following discharge, our attempts to obtain additional data that would support that claim were unsuccessful. We are also aware that providers' efforts to contact individuals who fail to keep their appointments are not reported in the managed care conditions.

Table 5: Patterns of Service - Continuity of Care

	PMHP - A6	HMO - A6	FFS - A4
<30 days	66.7%	44.5%	81.9%
30-60 days	8.7%	7.3%	3.6%
60-90 days	4.4%	2.9%	1.8%
>90 days	20.2%	45.3%	12.6%

A final set of analyses in the cost component of the evaluation relates to the rate at which adults with severe mental illness obtain services through informal mechanisms. The use of informal systems may represent cost shifting, an important concern in managed care situations. Thus, we are completing a special study to estimate the overall treatment and support costs for persons served in the differing financing conditions. As a first step in these analyses, we are interviewing each of the 688 adults with severe mental illness who are enrolled in our prospective follow-up study. We attempt to re-interview them every two months. The data that are included in Figure 7 reflect responses from the first wave of interviews.

There are surprising differences in the use of informal resources among enrollees of the different financing conditions. In each instance, except legal services, persons who are enrolled in either HMOs or the PMHP show rates of informal support that are from 4 to 5 times greater than persons who are enrolled in Medipass in Area 4. At this point we are not sure how to interpret these findings except to note that they may indicate cost shifting onto families or informal support systems. It may also reflect legitimate attempts to integrate persons into their communities and decrease their reliance on formal support systems. Next year we will complete the cost study that will help us to monetize these differences and to understand the effects of these differential patterns of service use on client outcomes.



Cost Analyses Summary

These cost data are complex. It appears as though the cost containment objectives are being achieved. In the light of the overall cost containment objectives, the relationship between services provided and premiums is a concern. As with other cost data, we need to further explore the relationship between true costs in the HMO and PMHP conditions and the costs that we are estimating from the standard rate table. Developing reasonable estimates of expenditures for services relative to revenue is key to understanding how the business of managed care is proceeding.

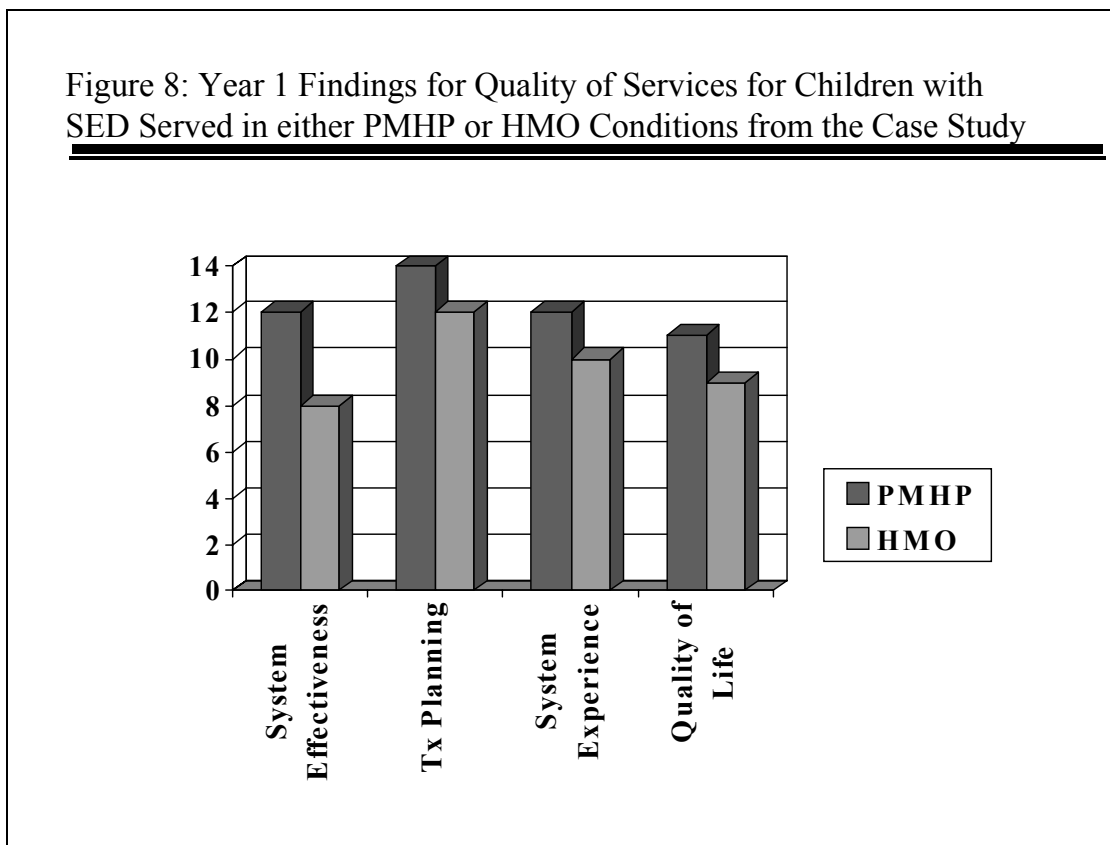
The pharmaceutical and continuity of care data begin to refocus our discussion on the quality of services that are provided from the perspective of patterns of service. As with many areas of the analysis, we have concerns about the effects of financial incentives on the provision of atypical antipsychotic agents. We are also concerned by our current estimates of continuity of care – particularly for the HMO condition.

Quality and Outcomes of Services

We have utilized four differing data sets to estimate the quality and outcomes of services:

- An intensive case study of 30 children with SED,
- The statewide mental health outcomes data base to measure changes in functioning and satisfaction with services,
- The mail survey data set to estimate changes in clinical status, quality of life and other indicators of well being for persons in the three financing conditions, and, finally
- Interview data from a sample of nearly 700 individuals with severe mental illness who we are following in the community.

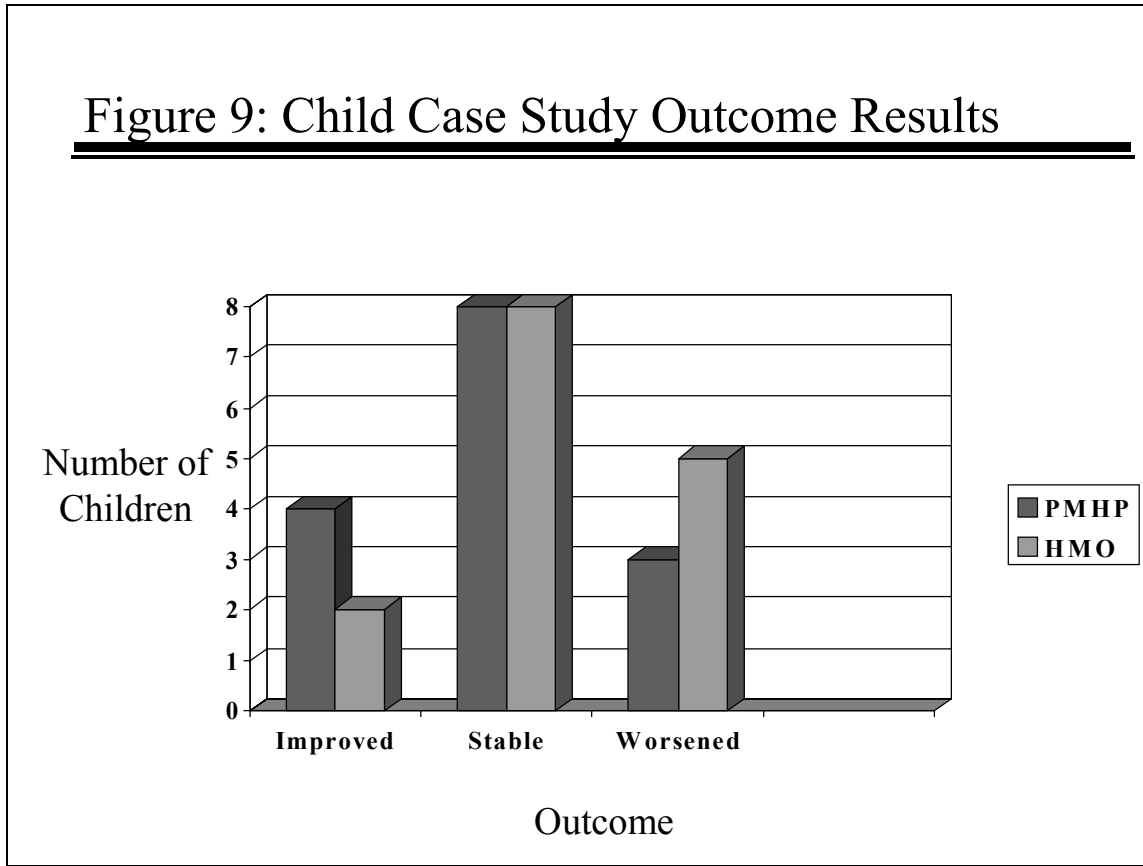
During the first year evaluation, we identified concerns with the quality of the services provided to children in the HMO condition. We have reproduced Figure 8 from last year's report to summarize how we scored the PMHP and HMO on four dimensions of quality following an intensive and comprehensive case study. Although these studies by their nature involve a small number of cases, we found consistent differences in quality among the financing conditions. The PMHP services were judged to be superior on all four rating dimensions. We interpreted some of the differences between the conditions as perhaps reflecting start-up problems in the HMOs.



In the second year evaluation, we again collected data on the status of the 30 children whose cases we had studied during the first year. We conducted record reviews in order to construct a comprehensive picture of the child's status and service utilization during the ensuing one-year period. After collecting these data, three raters, who did not know the financing conditions in which the children were enrolled, classified each case as improved, about the same or worsened during the one-year interval. Their summary ratings are displayed in Figure 9.

As may be seen from the figure, consistent outcome differences were obtained on these 30 children that strongly parallel results from the case study regarding the quality of services that they received.

Six children were judged to have improved during the one-year follow-up, 4 of whom were enrolled in the PMHP. Sixteen children were judged to have remained stable during the one-year interval with equal numbers in each of the financing conditions. Finally, eight children were judged to have worsened during the year. Over half of these children (5) were enrolled in the HMO condition. These data, while on a small and severely impaired population, support the relationship between the judgments regarding the quality of services and outcomes that children experience. It is important to recall that children in both financing conditions received their services from the same community agencies.



Quality – Outcomes from the Statewide Outcome Data Base

As with last year's findings, it is important to note that both children and adults improved with care in all three financing conditions. Overall, their functioning improved from admission to follow-up. The statewide outcome data provides weak evidence that children who received services in the managed care conditions (both HMOs and PMHP) experienced better outcomes than children who were enrolled in the Area 4 MediPass program. This is true for both children with and without the SED classification. For adults on SSI we found evidence that persons served in Area 6 experienced better outcomes than persons served in Area 4. (All of these findings are case mix adjusted.) No differences in outcomes were obtained for either children or adults between persons served in the PMHP or in the HMO financing condition. It is always important to recall that the same agencies are providing services to both HMO and PMHP clients and that clients in the HMO condition may be receiving a substantial number of services for which the CMHCs are not compensated. To the degree to which outcomes are effected by volume of services, uncompensated care will blunt any differences between the financing conditions and overestimate the efficiency of the HMO condition.

Quality of Service - Satisfaction Data

We have two sources of satisfaction data. The first is from the statewide outcomes database while the second involves satisfaction ratings that are obtained from individuals who respond to our mail survey. The case mix adjusted findings from the statewide data base and the mail survey indicate that there are no differences in satisfaction among children and their families who have used services. Similarly, there are no differences among financing conditions for adult service users who responded to the mail survey. However, adults who returned a Behavioral Health Rating of Satisfaction Scale (BHRS) did report a difference. Adult enrollees in HMOs were more satisfied with their services than individuals whose services were financed in either the PMHP or Area 4 MediPass.

Outcomes of Service – Mail Survey Data of Enrollee Status

During the second year of the evaluation we completed two mailings to Medicaid enrollees. The mailings were approximately six months apart. In each mailing we asked persons to answer standard questions to characterize their health and mental health status. We also asked them about their quality of life using a variation of a standard measurement. Using these data it is possible to determine if individuals are improving at different rates across the financing conditions. Our results at this point do not indicate any significant differences in outcomes on these measures for the overall Medicaid population in Areas 4 & 6 when we case mix adjust the data.

Finally, through our interviews we have determined that adults with severe mental illness whose care is financed through HMOs report a greater frequency of psychiatric symptoms than individuals who are enrolled in the PMHP or in the Area 4 MediPass condition. This finding is consistent with the differential rate of services that these persons receive as well as consistent, at least in part, with the pharmacy and continuity of care data. It is difficult; however, to interpret the differences between financing conditions since they reflect only a measure at a point in time. In the third year of the evaluation we will be able to estimate differential rates of change for these individuals who are served in the differing financing conditions, which is a more sensitive measure of treatment outcome than the current method.

Quality and Outcomes Summary

As with last year, the outcome data indicates that persons served in the managed care conditions did no worse and, in the case of adults on SSI, did better than individuals served in the fee for service system. The child case study outcome data, when linked with the observations of the differential quality between the two managed care conditions, underscore a relationship between the quality of services provided and the outcomes that are obtained. Finally, the

results for adults with severe mental illness who are enrolled in HMOs indicate that their mental health status is worse than individuals who are enrolled in either the PMHP or Area 4 MediPass. Given the relatively lower rate, at which they access services and use the atypical antipsychotic drugs, this difference may reflect characteristics of the incentives and organizational arrangements that characterize the HMO condition.

Discussion and Recommendations

The results of the second year evaluation are generally quite consistent with those obtained during the first year. In the implementation analysis we continue to note the changing of HMO organizational structures and business arrangements. Their changing business strategies lead to systemic inefficiencies owing to the impacts of changes on service authorizations, utilization management and payment of claims. These problems are further exacerbated by continuing difficulties with the management information system capacity of the HMOs/BHOs and their incompatibilities with those of the providers.

With regard to access, we again conclude that it has not improved following the implementation of the intervention. We find continuing evidence that the overall access rates differ among the financing conditions with HMOs having the lowest utilization rates in every comparison that we have constructed. Interestingly, this low rate of utilization of mental health services was in existence prior to the inception of the demonstration and therefore reflects a long-term characteristic of the HMOs caseload. Nonetheless, we continue to have some concerns with these differential rates of access, particularly since we now have some data to indicate that lower rates of access among persons with severe mental illness and among adult respondents in the mail survey are associated with poorer outcomes.

The cost analyses yielded some new information this year - particularly related to the availability of data from the HMOs. Consistent with our conclusions from the first year evaluation, we again concluded that the managed care interventions were successful in containing costs. This year we also presented data that attempted to contrast the financing conditions with regard to the cost of the services that they provided for their members. In terms of the data that were reported to us, we found clear differences among the financing conditions. The HMOs apparently spend approximately 40% less for mental health services than does the PMHP. Although complicated by the difficulty in accurately measuring true costs, both the HMO and PMHP conditions appear to be spending significantly less than their premium on the services that they are purchasing for their enrollees. These results suggest the need for a careful cost study to estimate the actual expenditures for services in the two managed care conditions to determine how these expenditures relate to the premiums paid to each of the plans.

We also have some indication that the risk arrangements in the managed care conditions might be related to the increased use of informal or legal resources as well as decreased access to state of the art medications for persons with schizophrenia.

Finally, the outcome data again seem to indicate that within the sensitivity of the measures that we have included in the study, we can discern few differences among the financing conditions. Adults on SSI who are served in Area 6 have better outcomes than their counterparts in Area 4, but are also less impaired at admission than the Area 4 comparison group. Adults with severe mental illness in HMOs have poorer mental health status than those in the PMHP or Area 4 MediPass. They also report lower rates of service utilization. A small sample of children with SED also appears to have better outcomes when served in the PMHP. This difference in outcomes parallels the differences in quality between the PMHP and the HMOs that we found in the children's case study last year.

Recommendations

After two years of analysis it now seems clear that the PMHP has achieved its objectives with regard to cost containment, with no indication that these cost containment strategies were detrimental to its members in any way that we can detect with our multiple measures. It has maintained access at levels that are quite comparable with the fee for service condition. We have some indication that its performance is superior for persons with more severe disorders. While we have some concerns with regard to its level of expenditures relative to its premiums, our data are not adequate to reach an unambiguous conclusion regarding costs. Based on these observations we recommend that:

The PMHP continue to operate in much the same way as it has during the first two years of the demonstration including the active oversight of AHCA and the ADM program.

We also believe that the data about the HMOs has been consistent during the first two years of the evaluation. We have continued to note instability in their organizational forms and inefficiencies in their operation with the CMHCs. As we noted last year, the integration of the health and mental health premium generally has not resulted in integrated service networks or integrated services. In fact, the multiple fiscal intermediaries that are used by most HMOs seem to diffuse accountability and complicate purchasing arrangements. Our expenditure data indicate that these complex financial arrangements functionally reduce the resources available for the provision of services. While our analyses are compromised by the difficulty in costing services, they also suffer from incomplete data provided by the MIS from a number of the HMOs/BHOs.

The HMO condition also has the lowest rate of access to mental health services, has poorer outcomes for the small sample of SED children receiving targeted case management services in our case studies and evidences a poorer mental

health status for adults with severe mental illness. In short, we have identified multiple concerns with regard to the HMO financing condition that need further exploration, both from an evaluation and an oversight perspective.

It is important to remember that, although we discuss the HMO financing condition as a unitary entity, it is comprised of 7 different HMOs and a total of 12 different organizations. The organizational structures and business practices of the various HMOs operating in Area 6 differ widely. Unfortunately, our study was not designed to powerfully relate the nuances of HMO structure or practices to access, costs, quality and outcomes. Without completing more detailed analysis and appreciating the important differences among the HMOs represented in this sample, we are not in a position to draw a conclusion about HMOs in general or their appropriateness as vendors for the broad range of mental health services.

However, there are a few observations that we can make that might be helpful.

An important differentiation between the PMHP and the HMOs relates to their experience in serving the needs of persons with more severe mental disorders. The HMOs' primary experience appears to have been in managing care for more incidental mental health users in commercially insured populations. As such, we would recommend that:

Experience and/or demonstrated capacity for managing the mental health treatment needs of more severely impaired populations be included as a criteria for selecting managed care organizations to serve Medicaid populations.

Another important distinction between the PMHP and the HMOs was the extended start up period that the PMHP used to establish their management systems and relationships before implementation. That time appeared to be an essential element for a smooth transition. Therefore we would recommend that:

No less than one year be used to implement any expansion of the demonstration (waiver).

Our findings in the implementation analysis and the recent developments of sub capitation arrangements between some of the CMHCs and BHOs suggest that capitated plans that provide the greatest flexibility at the provider level with regard to constructing service packages offer the greatest benefits to consumers. We therefore recommend that:

Preference be given to managed care approaches that provide the greatest flexibility at the provider level, with appropriate accountability.

During the start up phase of the waiver the PMHP had opportunity to establish agreed upon treatment protocols with their managed care organization. It

appears that this helped to make the transition to managed care less difficult. Therefore we would recommend that:

Evidence be required that a managed care organization and its providers have agreed upon treatment protocols before implementation of any expansion of the waiver.

We are concerned with our initial observations from the pharmacy data which imply that the atypical anti-psychotic agents are used at an overall rate below that of several other states and that financing arrangements which place MCOs at risk for pharmacy benefits may further depress the utilization of these drugs. During the third year of the evaluation, we will examine patterns of care the further evaluate them against national standards. We recommend that:

AHCA continue to examine the relationships between financial incentives and clinical practices relative to established clinical guidelines and further explore the relationships between patterns of care and enrollee outcomes. Continued refinement of enrollee functional status will be required to link interventions to outcomes.

Although the cost data that we have collected are not definitive with regard to actual expenditures, we are concerned by the wide variance among the managed care plans with regard to their expenditures relative to one another and to their premium. In part, we believe that these disparities are related to the complex purchasing and risk structures that are used among most of the HMOs. We therefore recommend that:

Preference be given to developing plans with simple financial structures. Multi-level plans with risk bearing fiscal intermediaries between the managed care organization and the ultimate providers of service may be relatively inefficient compared to simpler business structures.

We also believe that systematic and rigorous oversight is a key element in the performance of these plans and that this oversight has identified and addressed problems. We therefore recommend that:

Expansion of capitated managed care arrangements throughout the state continue to be treated as experimental interventions which have diligent oversight from AHCA as well as a rigorous external evaluation. It is critical that the external evaluation monitors the mental health status of the enrolled populations (both service recipients and non-users).

We have attempted to compare costs for the different financing conditions but it has proven to be very difficult because of the way data are captured in capitated

arrangements. Our best efforts thus far suggest that we need to look more carefully at the amount of premium used to purchase services. Therefore we recommend that:

AHCA work with the organizations that are participating in the managed care demonstration to determine the accuracy of their MIS systems in capturing the volume of services provided and develop methods for appropriately “monetizing” the services that are provided so that sensitive cost comparisons may be completed.

Throughout the course of the evaluation we have struggled with obtaining data that would help us compare issues of cost, access and quality of care across financing conditions. In our efforts to investigate levels of service and issues related to who paid for what, we were frustrated by the lack of adequate data systems. Competent MIS systems are critical for the accountable management of managed care organizations. We have repeatedly noted the difficulties that MIS problems have created for the management of these systems. We therefore recommend that:

In the selection of vendors to participate in managed mental health interventions AHCA rigorously investigate the adequacy of the MIS of potential vendors.

Further, AHCA should develop a set of MIS standards to assure adequate MIS structures and functioning for all managed care organizations.

Although market competition was not obtained in this demonstration, strategies that provide real choices for consumers would be preferred over those that don't provide competition. However, selecting MCO's that ultimately purchase services from the same provider organizations does not produce meaningful competition. We recommend that:

AHCA carefully examine the markets for specialty mental health services in any areas that are being considered for the expansion of managed care strategies and preferentially fund managed care strategies that stimulate competition and offer consumer choice in services.

By attempting to blend strategies that emphasize consumer education and choice with approaches that increase flexibility in service provision and assure competent clinical and fiscal management of at risk organizations, Florida's managed care initiatives continue to hold promise for improving the mental health status of our citizens while responsibly controlling mental health expenditures.