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Medicaid Managed Mental Health Care Arrangements in AHCA Area 6: Organizational, Financial and Clinical Structures

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MEDICAID MANAGED MENTAL HEALTH CARE ARRANGEMENTS IN AHCA AREA 6: ORGANIZATIONAL, FINANCIAL AND CLINICAL STRUCTURES

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1.0 INTRODUCTION

1.1 Background

Nationally, public spending for Medicaid totaled $160 billion in fiscal year 1996 — four times the national Medicaid expenditures in fiscal year 1986 (GAO, 1997). By fiscal year 1996, Medicaid expenditures accounted for more than 20 percent of state budgets (GAO, 1997).

In Florida, Medicaid expenditures have been growing dramatically over the past 11 years. From fiscal year 1985-86 to fiscal year 1996-97, Florida Medicaid expenditures (state and federal share) grew from $1 to $7 billion (Florida Senate, 1996). The annual growth rate of Florida's state share in that same period exceeded 15 percent each year and the growth rate was 25 percent per year in four of the eight years. During the same time period Florida's state general revenue growth remained constant at about 8.5 percent per year (Florida Senate, 1996). Such fiscal pressures have been an important impetus for states to begin experimenting with **managed care programs** to decrease the pressure on Medicaid resources while expanding health care access for the poor.

Since the 1981 passage of the Omnibus Budget Reconciliation Act (OBRA), more states have been experimenting with managed care systems. By 1993 over 40 States were operating or developing managed care programs for at least some of their Medicaid enrollees (Freund & Hurley, 1995) and by 1996, 36 states had mandated enrollment for some portion of their Medicaid population (GAO, 1997). By July 1996, 17 states had begun serving more *vulnerable populations* (e.g., aged and disabled, including people with mental disabilities) under managed care arrangements (GAO, 1997).

States have adopted a variety of approaches to managing care under Medicaid programs. According to the Health Care Financing Administration, as of June 1996, a total of 11 million Medicaid beneficiaries were enrolled in capitated managed care programs.

Another 4 million Medicaid beneficiaries were enrolled in non-capitated programs (GAO, 1997).

These approaches have continued to evolve as the states gain experience and grapple with the sometimes conflicting goals of improving access, reducing costs, bringing more providers into the system and encouraging coordination of health care. Florida has chosen to employ both *capitated* (e.g., health maintenance organizations or HMOs) and *non-capitated* (Medicaid Physician Access System or MediPass) approaches to providing *general health benefits* to Medicaid enrollees. According to estimates reported this year by the Kaiser Family Foundation, by early 1996, roughly two-thirds of all Medicaid beneficiaries in Florida were enrolled in one of these two programs (Gold, Aizer & Salganicoff 1997).

In addition, in Florida's Agency for Health Care Administration (AHCA) Area 6, the State is experimenting with two approaches to the provision of *mental health benefits:* a *carve out* in which the mental health benefit is managed by a specialty behavioral health organization and a *carve in* approach in which the mental health benefit is included with general health benefits in a capitated arrangement with HMOs. Prior research has produced no definitive findings on the relative cost effectiveness of either *carving in* or *carving out* mental health benefits in public sector health-care programs.

This evaluation, funded by AHCA and the federal Substance Abuse and Mental Health Services Administration (SAMHSA), is designed to evaluate the effects of the experimental Prepaid Mental Health Plan (*carve out*) and contrast this plan's effect on access, services, and costs with the effects associated with enrollment in an HMO or with care under fee-for-service Medicaid (in Jacksonville). In order to answer these questions, **we must be able to specify the managed care interventions being studied**, especially with respect to essential features that might explain any observed differences in enrollment patterns, service patterns and outcomes.

1.2 Organization of this Report

This report, the first full report on the organizational, financial and clinical structures of the managed mental health care interventions in AHCA Area 6, is presented in the following sections. In **Section 2** , we describe the methods used to identify, obtain and analyze information on the nine managed care plans operating in Area 6. In **Section 3**, we provide a chronology of events related to Medicaid managed care and then describe the Medicaid service delivery system in AHCA Area 6, providing contextual data on the number of Medicaid recipients enrolled in managed care plans, the number of MCOs and their enrollment, as well as a summary of the trends in enrollment. **Section 4** provides a review of factors that are common across the *carve in* and *carve out* plans —- that is, the benefit package, the performance indicators, the rate setting formula, and the service networks. **Section 5** provides a detailed analysis of each of the nine managed care plans, focusing on the following key aspects of their operations: corporate affiliation and managed care organization (MCO) structure; functions, including the roles of subcontractors; geography and enrollment of the plan; network composition; payment and risk arrangements; clinical management structures; and coordination with general

health care. As will be seen, there is much variability across the *carve out* and *carve in* conditions as well as within the *carve in* (HMO) condition. **Section 6** provides a synthesis of the relevant findings organized around public policy concerns. **Section 7**summarizes the public policy implications and **Section 8** presents concluding remarks.

2.0 METHODOLOGY

The design of the Evaluation of Florida's Prepaid Mental Health Plan is multi-faceted, with both systems level and client level studies, and incorporating data from a variety of sources, including Medicaid enrollees, service recipients, clinicians, provider agencies, managed care organizations, payers, and the Medicaid claims and MCO service encounter data bases. The evaluation design includes four inter-related sub-studies, two at the **systems level** (the Qualitative Implementation Analysis and the Quantitative Service System Analysis) and two at the **member level** (the Service Recipient Study and the Member Mail Survey). This report provides an analysis of findings from the systems level **Implementation Analysis**.

The Implementation analysis documents and describes how the important aspects of the managed care plans are operationalized. A key objective is to understand administrative and clinical operations with a special emphasis on the effects of different financing mechanisms on agency behavior. These data provide insights into issues that arise in implementing the managed care plans and how these issues are resolved. The descriptions of the alternative systems (*carve in* and *carve out*) will allow us to better understand the important functional differences of the models and to better specify their practices, which will be key to understanding the outcome results.

The Implementation Analysis uses two key methods: *multistage interviewing* and *documentary review*. The sources of information for these analyses are enumerated in Table 2.1 and described below.

In order to identify the essential features of the managed care arrangements in AHCA Area 6, over the last year we employed a multistage interviewing process which included interviews at three levels: *purchasers/payers* (AHCA); *managed care organizations* (Florida Health Partnership, HMOs BHOs); and *key service provider agencies* (Community Mental Health Centers).

Table 2.1 - Information Sources on Managed Behavioral Healthcare Arrangements.

Interviews with AHCA, ADM, MCOs, providers
Medicaid Waiver Applications
AHCA Request for Proposals
Contracts between AHCA and MCOs
Subcontracts between MCOs and BHOs
Subcontracts between MCOs/BHOs and providers
Policy and Procedure Manuals
Member Handbooks
Florida Department of Insurance Reports

The interviews were conducted by faculty and staff of Florida Mental Health Institute (FMHI) using a semi-structured interview protocol to organize data collection. This interview method has been used successfully by the study director and her colleagues in a number of national multi-site studies of large-scale changes in the provision of mental health, alcohol and drug abuse services (Goldman, Morrissey & Ridgely 1994; Orwin et al. 1994). The following interviews were conducted over the past year of the evaluation:

- Face-to-face interviews in the fall of 1996 with staff of the key provider agencies (day-long site visits at the five CMHCs);
- Brief telephone interviews in the fall of 1997 with staff of the five CMHCs to gather additional information on HMO/BHO clinical management practices;
- Face-to-face interviews in the fall of 1997 with staff of the AHCA Division of Medicaid Program Development (Tallahassee), the Bureau of Managed Health Care (Tallahassee), and AHCA staff in Area 6 (Tampa);
- Face-to-face interviews in the fall of 1997 with the ADM Program Supervisors in the two participating DCF Districts (Districts 6 and 14);
- Face-to-face interviews during the summer and fall of 1997 with staff of Florida Health Partnership;
- Telephone interviews in the summer and fall of 1997 with staff of the HMOs (10 telephone interviews) and their BHOs (12 telephone interviews); and
- Telephone interviews with AHCA analysts and other AHCA officials with HMO/BHO oversight responsibility (7 telephone interviews).

In addition to interviewing key informants, we also undertook an extensive review of documents related to the implementation of the managed care arrangements. The document review was conducted using a structured protocol developed by the study director under a separate grant from the Center for the Study of Issues in Public Mental Health (New York). The structured protocol was developed through an extensive review

of the managed care literature and a consensus process involving an 18-member national panel of experts in the area of managed behavioral health care.

Using our initial series of interviews in Florida, the managed care literature, and consultation with the national expert panel, we derived a classification scheme to describe the essential elements of managed care arrangements, including information on organizational, financial and clinical structures at multiple levels.

A team of FMHI faculty and staff obtained, catalogued and reviewed all relevant contracts, including the contracts between AHCA and managed care organizations ; between MCOs and specialty behavioral health care organizations (BHOs), and between MCOs or BHOs and the agencies in their service provider networks. In addition to contracts, the main sources of documentation acquired directly from MCOs/BHOs included: member handbooks, provider manuals or handbooks, and policy and procedure manuals. Additional documentation was acquired from AHCA (Florida Medicaid Handbooks, monthly Medicaid enrollment reports) and from the Florida Department of Insurance.

Strategies for increasing the rigor of this qualitative study have been employed, including providing a sufficiently detailed and structured methodology, creating a multi-disciplinary contract review and interview team, conducting field debriefings of interviews, verifying interview data with relevant documents and documentary information by interview, and providing for external review by the agencies and organizations being studied (Silverman, Ricci & Gunter, 1990).

The design of this qualitative aspect of the evaluation relies upon multiple sources of data and a strategy of triangulation of data to assess implementation of managed care arrangements and to assess managed care system performance. These multiple sources of data help to compensate for limitations or biases associated with each source or method of data collection. Information derived from these qualitative measures provides a context for understanding data derived in other parts of the evaluation of the Prepaid Mental Health Plan.

3.0 THE MEDICAID PROGRAM IN AHCA AREA 6

As noted by the Kaiser Family Foundation, Florida had a well developed managed care infrastructure for the commercial and Medicare populations (Gold, Aizer & Salganicoff 1997), but the development of managed care in the Medicaid program is a more recent occurrence and one that was stimulated by the State's desire to entice managed care

organizations into the Medicaid marketplace.

After its initial introduction, Medicaid managed care for *general health* rapidly expanded throughout the state, although many of the systems developed to serve Medicaid beneficiaries are in their infancy. In Area 6, where the comprehensive Medicaid *mental health* benefit is being managed, the managed care market is in considerable flux, with Medicaid HMOs entering and leaving the market, and engaging and then switching specialty BHOs. Table 3.1 (at the end of this report) provides an overview of some of the key dates in the development of Medicaid managed care in AHCA Area 6 and provides a context for a description of the Area 6 Medicaid program.

Under Florida's 1915(b) waiver (see Table 3.1), Medicaid recipients in a number of Medicaid eligibility categories (e.g., Aid to Families with Dependent Children, AFDC, and Supplemental Security Income, SSI) may enroll or be assigned to managed care plans. As of July 1997, AHCA enrollment reports show that 125,436 or 67% of the 185,994 Medicaid recipients in Area 6 have enrolled or have been assigned to a managed care plan. Figure 3.1 provides a pictorial representation of the percentage of Area 6 Medicaid recipients enrolled in managed care. Of those recipients whose care is managed, 29% (54,620 people) are enrolled with MediPass physicians and Florida Health Partnership (the Prepaid Mental Health Plan) and a slightly higher percentage (38%) are enrolled in HMOs (70,816 people). Thirty-three percent of Medicaid recipients in Area 6 (60,558 people) remain in the *general eligibility* category — not under either of the managed care arrangements. These recipients include those eligible for assignment (but not yet assigned) as well as those recipients who are not eligible for assignment (e.g., people in nursing homes or Intermediate Care Facilities for Persons with Mental Retardation, ICF-MRs, etc.).

Figure 3.2 shows these enrollment figures by eligibility category. As Figure 3.2 indicates, HMOs have a slightly higher percentage of AFDC recipients than MediPass/PMHP (80% to 71%), whereas MediPass/PMHP has a substantially higher percentage of SSI recipients than the HMOs. Although *eligibility category* is not a perfect proxy for disability status, these figures indicate that there are higher numbers of disabled recipients served by MediPass/PMHP than by the HMOs. Of the 20 percent of SSI individuals served by HMOs, 5% were SSI/Medicare recipients. (HMOs are eligible to enroll these dually eligible members — FHP is not).

Turning to the enrollment in HMOs, Figure 3.3 provides a picture of the Area 6 enrollment by HMO plan. (These percentages include SSI with and without Medicare. Florida 1st is omitted from the chart because enrollment as of July 1997 was less than 50 persons). Staywell has the largest percentage of Area 6 enrollees (33% or 22,983 people) with PCA and PHP both at 24% (about 17,000 people). No other HMO has more than 7% of the eligible Medicaid recipients. When these figures are analyzed by eligibility category, (see Figure 3.4), among HMOs, United Healthcare of Florida has the highest percentage of SSI enrollment (approximately 30% or 290 people) compared to the average of other HMOs (20 to 25%), however, United has only 1% of the total HMO enrollment.

Table 3.2 breaks these enrollment figures out by county and by managed care condition.

As of July 1997, HMOs tended to have the majority of enrollees in the large counties (Hillsborough and Polk), while MediPass/PMHP dominated in the rural counties (Manatee, Highlands and Hardee). Higher MediPass enrollment in rural areas of AHCA Area 6 mirrors MediPass rural enrollment statewide.

In summary, Medicaid managed care plans in AHCA Area 6 share a small pool of covered lives (only 125,000 covered lives served by nine plans). HMOs are serving a higher percentage of the total number of covered lives and have higher enrollment in the more urban counties, while MediPass/PMHP has higher enrollment in the more rural counties.

It is important in understanding a managed care plan to identify the proportion of beneficiaries who are in various eligibility groups (e.g., aged, AFDC, SSI). Our review of the AHCA enrollment reports through July 1997 indicates that there is a trend toward more SSI recipients (individuals with disabilities) being enrolled in MediPass/PMHP than are enrolled in HMOs. This, combined with the overall decline in AFDC enrollment means that the PMHP may come to serve an even higher proportion of individuals with disabilities over time.

If such *risk segmentation* becomes more pronounced, for example, if the majority of adults and children with mental disabilities accumulate into one plan (the PMHP), the adequacy of the current rate setting methodology may be questioned. The current methodology does allow for adjustment of the rate based on eligibility category (e.g., SSI). However, eligibility category is an imperfect marker for risk of high service utilization (and therefore high cost).

The current rate setting methodology assumes an equal probability that high-risk individuals will enroll in each of the plans. The accumulation of a majority of individuals with specific disabilities (e.g., severe mental illness) into one plan increases the probability that high cost individuals (who are potentially *outliers* in terms of costs) will be present in that one plan, potentially putting that plan at additional financial risk.

4.0 MANAGED MENTAL HEALTH CARE IN AHCA AREA 6

As mentioned in the Introduction, in Area 6, AHCA is experimenting with two approaches to the provision of Medicaid *mental health* benefits: a *carve out* in which the mental health benefit is managed by a specialty behavioral health organization and a *carve in* approach in which the mental health benefit is included with general health benefits in a capitated arrangement with health maintenance organizations.

While there are notable differences in the structure and function of the plans making up

the *carve in* and *carve out* conditions (see Section 5 below), there is also a number of factors that are common across the two approaches. Among these are three that resulted from decisions by AHCA. The other similarity (the use of the same set of core service providers) resulted from choices made by the managed care plans themselves. Each will be discussed in turn below.

4.1 Benefit Plan

Table 4.1 (at the end of this report) includes information from the AHCA/HMO Model Contract and AHCA's contract with Florida Health Partnership (Prepaid Mental Health Plan). As Table 4.1 illustrates, the mental health benefit plans under the Prepaid Mental Health Plan and under the HMO arrangements are identical.

4.2 Performance Indicators for Plans

Table 4.2 provides a summary of the mental health performance indicators and reporting requirements from the AHCA/HMO Model Contract and AHCA's contract with the Florida Health Partnership (PMHP). As Table 4.2 illustrates, the performance indicators and reporting requirements are substantially the same, with the exception that HMOs are required to report on a subset of HEDIS 2.5 and Medicaid HEDIS indicators in addition to the other service utilization measures. There are some differences, however, in the numbers of AHCA staff assigned to monitor plan performance. There are 3 full-time monitors for the PMHP - 2 in Tampa and 1 in Tallahassee. These AHCA employees spend 3-4 days each quarter on site at Options Service Center (FHP) in Brandon and at the CMHCs. In contrast, each HMO has an analyst in Tallahassee (who also has responsibility for other HMOs) and there is one AHCA staff assigned to these plans locally. HMO performance is reviewed on a quarterly basis, with a site visit if necessary

4.3 Rate Setting Methodology for Capitation

The rate-setting methodologies used for developing capitation rates for the HMOs and for Florida Health Partnership are the same.

For the HMOs, the 1997-1998 AHCA/HMO Model Contract states:

> The capitation rates to be paid are developed using historical rates paid by Medicaid fee-for-service for similar services in the same geographic area, adjusted for inflation, where applicable. The rates to be paid do not exceed that amount which would have been paid, on an aggregate basis, by Medicaid under fee-for-service for the same services to a demographically similar population of recipients.

Capitation rates were set at 92% of the Medicaid fee-for-service (FEE-FOR-SERVICE) costs two years prior to the rate setting (the most current complete Medicaid data set). Each HMO is paid capitation payments based on the agency operational area (or rate zone) and age group. So, for each AHCA Area, there are 30 cells to calculate capitation payment, i.e., (5 eligibility groups) x (6 age groups). This is shown in Table 4.3.

Table 4.3 - Matrix to Calculate Capitation Payment in AHCA Arrangements.

	0-11 mos	1-5 yrs	6-13 yrs	14-20 yrs	21-54 yrs	55+ yrs
AFDC	$	$	$	$	$	$
SSI - No Medicare	$	$	$	$	$	$
SSI - Part B	$	$	$	$	$	$
SSI - Parts A&B	$	$	$	$	$	$
Frail/Elderly	$	$	$	$	$	$

For Florida Health Partnership (PMHP), according to the AHCA/FHP Contract, there are 24 cells to calculate each month's capitation payment to FHP, i.e., (4 eligibility groups) x (6 age groups). This is shown in Table 4.4.

Table 4.4 - Matrix to Calculate Capitation Payment in PMHP Arrangements.

	0-11 mos	1-5 yrs	6-13 yrs	14-20 yrs	21-54 yrs	55+ yrs
AFDC	$	$	$	$	$	$
SSI - No Medicare	$	$	$	$	$	$
OBRA Children	$	$	$	$	$	$
Foster Care Children	$	$	$	$	$	$

Capitation rates for both HMOs and Florida Health Partnership are risk adjusted by age and by eligibility group. However, as discussed in Section III, eligibility group is an imperfect marker for risk of service utilization.

4.4 Service Networks

There are five Community Mental Health Centers (CMHCs) that are the traditional mental health service providers for the ADM Districts 6 and 14 (which make up AHCA Area 6). Each of these are private, not-for-profit corporations, although most historically have relied on public payers for the majority of their revenue. Below are the particulars on the five CMHCs that are the principal service providers for all nine plans:

Mental Health Care, Inc.
Established: 1949
Location: Tampa
Catchment area: Hillsborough County
Staffing: 528 FTEs
Accreditation: JCAHO
FL Licensure for CSU

Northside Mental Health Hospital/Northside Mental Health Center, Inc.
Established: 1976
Location: Tampa

Catchment area: Hillsborough County
Staffing: 182 FTEs
Accreditation: JCAHO

Manatee Glens Corporation
Established: 1962
Location: Bradenton
Catchment area: Manatee County
Staffing: 288 FTEs
Accreditation: JCAHO
FL Licensure for CSU

Winter Haven Hospital
Established: 1926
Location: Winter Haven
Catchment area: Polk and Highlands Counties
Staffing: 300 FTEs
Accreditation: JCAHO
FL Hospital Licensure

Peace River Center for Personal Development, Inc.
Established in 1947
Location: Bartow
Catchment area: Polk and Hardee Counties
Staffing: 377 FTEs
Accreditation: JCAHO
FL Licensure for CSU

As will be discussed in Section V below, these CMHCs have an organizational and financial stake in the Florida Health Partnership. In addition, they have been chosen as the principal service providers for the comprehensive mental health benefit by the HMOs/BHOs. Table 4.5 provides information on the funding of these CMHCs in Fiscal years 1995-96 and 1996-97.

5.0 THE STRUCTURE OF MANAGED MENTAL HEALTH CARE IN AHCA AREA 6

In this section of the report, we will document and describe the structures employed by the managed care organizations operating in the AHCA Area 6 Medicaid managed care marketplace. Our objective is to identify the key administrative, financial, and clinical operations with a special emphasis on the following aspects of their operations: corporate affiliation and MCO structure; functions, including roles of their subcontractors; geography and enrollment; network composition; payment and risk arrangements; clinical management structures; and coordination with general health care. **Each managed care organization's structures will be discussed relative to the management of the *mental health* benefit only** (with the exception of the final section on coordination with general health care).

As Figure 5.1 illustrates, there are currently nine managed care organizations that have contracts with the Agency for Health Care Administration to manage the Medicaid ***mental health*** benefit in AHCA Area 6. These are:

Prepaid Mental Health Plan:

Florida Health Partnership [hereinafter FHP];

Health Maintenance Organizations:

1. St. Augustine Health Care, Inc.[St. Augustine];
2. Florida 1st Health Plans, Inc. [Florida 1st];
3. Physicians Healthcare Plan, Inc. [PHP];
4. Ultramedix Healthcare Systems, Inc. [Ultramedix];
5. Staywell Health Plan/Well Care HMO, Inc. [Staywell];
6. HealthEase/Tampa General Health Plan, Inc. [HealthEase];

7. PCA Family Health Plan, Inc. [PCA]; and
8. United HealthCare of Florida, Inc. [United].

For these Health Maintenance Organizations, Table 5.1 (at the end of the report) provides contextual information on the HMOs total statewide premiums, percent of Medicaid versus Medicare or commercial business, and the number of counties each HMO serves.

5.1 The Prepaid Mental Health Plan (*carve out*)

Persons who are enrolled in MediPass in AHCA Area 6 receive their general health services through the MediPass Program (see Appendix in the following report: *A Description of the MediPass Program*) and their mental health care through the Florida Health Partnership.

5.1.1 Florida Health Partnership

5.1.1.1 Corporate Affiliation and MCO Structures

Florida Health Partnership (FHP) is a partnership of Options Health Care, Inc. (Options) and Florida Behavioral Health, Inc. (FBH). Florida Health Partnership was established in October 1993 and started providing services on March 1, 1996. Options is the managing partner and serves as system representative and contract manager for the contract between AHCA and FHP.

Options is a private, for-profit, national managed behavioral health care organization founded in 1987. It is a wholly owned subsidiary of First Hospital Corporation (FHC) with headquarters in Norfolk, Virginia. Options organizes mental health care for approximately 4 million covered lives, including commercial and CHAMPUS contracts, as well as Medicaid contracts in 5 states other than Florida.

Florida Behavioral Health (FBH), incorporated in November 1992, is a not-for-profit corporation comprised of 5 private, non-profit CMHCs. The five CMHCs composing FBH are:

- Northside Mental Health Center, Inc. (Hillsborough County)
- Mental Health Care, Inc. (Hillsborough County)
- Manatee Glens Corporation (Manatee County)
- Peace River Center for Personal Development, Inc. (Polk and Hardee Counties)
- Winter Haven Hospital/Behavioral Health Division (Polk and Highlands Counties)

5.1.1.2 Role of Florida Health Partnership

As the managing general partner, Options, operates a Regional Service Center in

Brandon. Functions performed by Options can be divided into two general categories: *administrative services* and *clinical management*. Administrative services include verification of enrollment, claims processing, MIS functions, and network management. Clinical management services include utilization management (see "Clinical Management Structures" below), assessments and referrals, provider relations, continuous quality improvement, and a 24-hour access line. The five CMHCs (that make up FBH) are the core service network, providing mental health services under contract to FHP. (See Florida Health Partnership Figures 5.2 and 5.3).

5.1.1.3 Geography and Enrollment

According to provisions in AHCA's contract with FHP, FHP operates only in the five counties that make up AHCA Area 6. One hundred percent of FHP's membership are Medicaid enrollees. The July 1997 AHCA enrollment report lists the following enrollment for MediPass/PMHP:

Hillsborough County	28,638
Manatee County	6,240
Polk County	13,588
Highlands County	3,139
Hardee County	3,015
AHCA Area 6 Total	**54,620**

5.1.1.4 Network Composition

The core service network for FHP are the five community mental health centers (listed above). Each CMHC has a geographical catchment area determined by zip code. FHP assigns members to CMHCs according to their zip code. Members have a choice of clinicians within the CMHC.

Options contracts with *associate providers* such as inpatient facilities and independent practitioners (for services not provided by the CMHCs), and has agreements with 11 DCF-funded agencies and 12 other agencies. When *associate providers* are utilized, CMHCs are responsible for *linkage* and *discharge*.

AHCA's contract with FHP requires one direct service provider for every 1,500 members at each provider site and one psychiatric community hospital bed for every 2,000 members. Case manager provider ratios for targeted case management are 1 provider for 20 children and 1 provider for 40 adults.

5.1.1.5 Payment Arrangements

The contract between AHCA and FHP is a *capitation contract*.

Florida Health Partnership has capitation arrangements for both administration and service provision, along with fee-for-service arrangements with *associate providers*. For administrative and clinical management services, FHP has a capitation contract with Options. Options is at risk for cost overruns associated with its administrative and

clinical management services. Options has no financial incentive to deny or restrict care through its utilization management mechanisms because Options would not share in any profits derived from reduced service utilization. Any profits from reduced service utilization belong to the capitated service provider agencies.

FHP has capitation contracts with each of the five CMHCs (see Figure 5.4) and pays *associate providers* under fee-for-service contracts.

5.1.1.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to Florida Health Partnership.

Between FHP and the CMHCs:

1 **Risk Pool:** 4% of each CMHC capitation payment is withheld and paid to FBH. This pool is for excess charges the CMHC may incur from the provision of services that are authorized by FHP. CMHCs are eligible to receive fifty cents on each dollar of excess charges up to a total reimbursement amount equal to their original risk pool contribution. If they exceed their total contribution to the risk pool, they are eligible for a 25% reimbursement on each dollar.

2 **Stop loss cap:** After reaching the stop loss cap amount, CMHCs can draw from the risk pool.

3 **Withhold:** At the time that the first capitation payment was made, FHP withheld $25,000 and deposited it in a "non-RCC [CMHC] Provider Reserve." FHP pays non-CMHC providers for the services they render to enrollees who reside in the applicable CMHC's zip code area, provided that the services were authorized in advance by the applicable CMHC or were emergency services.

5.1.1.7 Clinical Management Structures

FHP uses different utilization review procedures for CMHCs (under capitated contracts) and *associate providers* (under fee-for-service arrangements).

CMHCs provide services under capitation contracts. Because they bear the risk of cost overruns for service utilization, utilization review principally is handled by the CMHCs themselves. Florida Health Partnership, in consultation with the CMHCs, has established length of stay guidelines, medical necessity review points, focus of care criteria (e.g., stabilization, rehabilitation, or maintenance) and diagnostically based treatment protocols. All of these are tools for the CMHCs to use in making service utilization decisions, however, since the CMHCs are under capitation arrangements they may provide any services they deem necessary. CMHCs call the Options Service Center to receive *authorization* that is, in effect, simply a notification to the Service Center. The only financial penalty the CMHC may face relates to distributions from the FBH risk pool. Services that are not *authorized* by FHP (i.e., are not in compliance with the length of stay criteria, focus of care criteria, or diagnostically based treatment protocols) do not count towards the CMHC's stop-loss cap and the CMHC cannot draw compensation from the FBH risk pool to subsidize the costs of these expenditures.

Associate providers have fee-for-service arrangements with FHP. Prior authorization and concurrent review are necessary for inpatient services and prior authorization is necessary for all outpatient services, except in the case of emergencies (providers must notify FHP within 24 hours of providing emergency services).

5.1.1.8 Coordination with General Health Care

Enrollment of Medicaid recipients into FHP coincides with their enrollment into MediPass in AHCA Area 6. The MediPass physician contract requires that the MediPass provider:

a. Ask the patient if s/he is receiving treatment or long term supports from another agency or organization and obtain authorization to seek further information from the service provider.

b. Contact providers who are providing additional treatments and long term supports to seek information, determine the type of treatment provided and review this information to determine the possibility of inconsistencies or the need to coordinate care. **Coordination is required** for persons on medications for behavioral issues or for whom a behavioral program has been prescribed for serious problems.

It does not appear that this contract provision is being followed in a systematic way by MediPass physicians nor is it enforced consistently by AHCA.

FHP and the CMHCs have developed a protocol for coordinating care with MediPass primary care physicians (as a group) and a mechanism for identifying and notifying each FHP enrollee's MediPass physician of the member's treatment when psychotropic medications have been prescribed and if there is a medical problem that needs treatment.

5.2 Health Maintenance Organizations (*carve in*)

5.2.1 St. Augustine Health Care, Inc.

5.2.1.1 Corporate Affiliation and MCO Structures

St. Augustine Health Care, Inc. (St. Augustine) is a for-profit, physician owned and operated health care network developed in 1994 by 36 physicians, many of whom are current providers. Shortly thereafter, St. Augustine contracted with Oxford Health Plans, a northeast-based company. Oxford Health Plans is a licensed Third Party Administrator (TPA) in the State of Florida. Oxford Health Plans currently owns 19% of St. Augustine and in the future plans to take a majority ownership, at which time St. Augustine will become Oxford Health Plans of Florida. Presently, Oxford Health Plans provides management information system (MIS) services and management services to St. Augustine.

5.2.1.2 Role of St. Augustine Health Care, Inc.

St. Augustine provides its own utilization management, claims administration, clinical record management and network management for behavioral health services. The providers in the service network are responsible for service provision and clinical record keeping. St. Augustine does not contract with a specialty behavioral health care organization.

5.2.1.3 Geography and Enrollment

The July 1997 AHCA Enrollment Report lists the following total AFDC and SSI enrollment for St. Augustine and Attachment VIII of their 1997-1998 AHCA contract lists the following maximum enrollment levels allowed at this time:

Hillsborough County	4,085	[Contractual maximum is	5,400]
Manatee County	-0-	[Contractual maximum is	2,600]
Polk County	-0-	[Contractual maximum is	2,600]
Hardee County	-0-	[Contractual maximum is	-0-]
Highlands County	-0-	[Contractual maximum is	-0-]

According to the Florida Department of Insurance Report, the figures shown in Table 5.2 represent the percentage of St. Augustine Medicaid enrollees per county as of June 30, 1997.

Table 5.2 - St. Augustine Heath Care, Inc. Enrollees - July 1997.

County	Commercial	Medicare	Medicaid	Total	Medicaid % of Total
Hillsborough	149	-0-	3,845	3,994	96
Manatee	-0-	-0-	-0-	-0-	-0-
Polk	-0-	-0-	-0-	-0-	-0-
Hardee	-0-	-0-	-0-	-0-	-0-
Highlands	-0-	-0-	-0-	-0-	-0-
Area 6 Total	**149**	**-0-**	**3,845**	**3,994**	**96**

5.2.1.4 Network Composition

St. Augustine has contracts or other arrangements with the following CMHCs as their core service network:

Northside Mental Health Center, Inc. (contract for Hillsborough County)
Mental Health Care, Inc. (contract for Hillsborough County)
Peace River Center for Personal Development, Inc. (letter of agreement for Polk County)

St. Augustine also has arrangements with *associate providers* and with inpatient facilities.

AHCA's Model Contract with the HMOs (Attachment VI in the 1997-1998 contract refers to the comprehensive mental health benefit) does not create provider to member ratios, but rather calculates the sufficiency of the network by reference to the need for "personnel sufficient to provide the covered services...throughout the geographic area, within 30 minutes typical travel time." Additionally, contract provisions require access to a "designated emergency service facility per county," "at least one [Baker Act] receiving facility in each county," at least one adult and one child psychiatrist "available within 30 minutes...of all enrolled recipients" and that a specific array of specialty areas for adults and children are included. Only in the case of targeted case management are their staffing ratios 1:20 for children and 1:40 for adults.

5.2.1.5 Payment Arrangements

The contract between AHCA and St. Augustine is a capitation contract. St. Augustine has fee-for-service arrangements with service providers in their provider network (see Figure 5.5).

5.2.1.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to St. Augustine. No risk is transferred to the providers.

5.2.1.7 Clinical Management Structures

St. Augustine requires pre-authorization for non-emergency inpatient services. Concurrent review of non-emergency inpatient services is conducted by the St. Augustine case manager for continuing length of stay and discharge planning. St. Augustine requires pre-authorization of outpatient services and provides that authorization on a monthly basis (based on a review of the current treatment plan).

5.2.1.8 Coordination with General Health Care

The AHCA/HMO model contract says that the plan "shall be responsible for the management of medical care and continuity of care for all enrolled Medicaid recipients," including documentation of referral to specialists and monitoring of ongoing medical conditions. However, unlike the provision in the MediPass physician's contract, there is nothing in the HMO contract that stipulates that it is also an HMO primary care physician's responsibility to provide for continuity of care regarding mental health services.

St. Augustine enrollees may either seek referral from their primary care physician or seek mental health care directly from St. Augustine. A St. Augustine psychiatrist will see an enrollee to determine whether referral to a specialty provider (e.g., CMHC) is necessary. St. Augustine then provides their member with the name and address of the specialty provider to which they are being referred. Coordination of care is handled by the St. Augustine case manager, who makes sure that enrollees get to the mental health service provider and reviews the clinical records to ensure that they receive the appropriate care. All records for enrollees receiving mental health services from network providers are shared with the St. Augustine case manager.

5.2.2 Florida 1st Health Plans, Inc.

5.2.2.1 Corporate Affiliation and MCO Structures

Florida 1st Health Plans, Inc. (Florida 1st), a nationally accredited HMO, was licensed as a Florida HMO in 1985 and commenced business in 1986. Florida 1st is a for-profit IPA (independent practice association), based in Winter Haven, Florida. Florida 1st's parent company is Mid-Florida Medical Services, also based in Winter Haven. Mid-Florida Medical Services is a non-profit health care organization consisting of two hospitals and several satellite medical care facilities. Mid-Florida Medical Services provides financial backing to Florida 1st which operates as Mid-Florida's for-profit arm.

Mental health services are provided to Florida 1st enrollees through the Behavioral Health Division (BHD) of Winter Haven Hospital. (Winter Haven Hospital is one of Mid-Florida Medical Services' two hospitals). (See Figure 5.6).

5.2.2.2 Role of Florida 1st and Subcontractors

The Behavioral Health Division of Winter Haven Hospital provides mental health services, as well as utilization management, claims reporting, and clinical record management for Florida 1st Medicaid enrollees who access behavioral health services. Because the Behavioral Health Division is the sole provider, there is no provider network to manage. Florida 1st HMO pays claims and conducts other activities related to claims administration.

5.2.2.3 Geography and Enrollment

The July 1997 AHCA Enrollment Report lists the following total AFDC and SSI enrollment for Florida 1st and Attachment VIII of their 1997-1998 AHCA contract lists the following maximum enrollment levels allowed at this time:

Hillsborough County	-0-	[Contractual maximum is	-0-]
Manatee County	-0-	[Contractual maximum is	-0-]
Polk County	37	[Contractual maximum is	2,300]
Hardee County	-0-	[Contractual maximum is	-0-]
Highlands County	-0-	[Contractual maximum is	450]

According to the Florida Department of Insurance Report, the figures shown in Table 5.3 represent the percentage of Florida 1st Medicaid enrollees per county as of June 30, 1997:

Table 5.3 - Florida 1st Health Plan, Inc. Enrollees - July1997.

County	Commercial	Medicare	Medicaid	Total	Medicaid % of Total
Hillsborough	16	-0-	-0-	16	-0-
Manatee	-0-	-0-	-0-	-0-	-0-
Polk	4,161	-0-	31	4,192	1

Hardee	182	-0-	-0-	182	-0-
Highlands	1,101	-0-	-0-	1,101	-0-
Area 6 Total	**5,460**	**-0-**	**31**	**5,491**	**1**

5.2.2.4 Network Composition

Behavioral Health Division of Winter Haven Hospital (located in Polk County) is the sole provider of mental health services for Florida 1st.

Attachment VI in the 1997-1998 AHCA/HMO Model Contract applies (see Section "Network Composition" under the St. Augustine description above).

5.2.2.5 Payment Arrangements

The contract between AHCA and Florida 1st is a capitation contract. The contract between Florida 1st and Winter Haven Hospital/BHD is currently a fee-for-service arrangement (involving less than 50 covered lives). It is anticipated that as the number of covered lives increases, the parties will move to a capitated arrangement.

5.2.2.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to Florida 1st. No risk is transferred to Winter Haven/BHD at this time.

5.2.2.7 Clinical Management Structures

The Behavioral Health Division operates its own utilization management system in accordance with the Florida 1st UM Program and Peer Review Program. Pre-authorization is required for all non-emergency services. Concurrent review is conducted on all services, and retrospective review is used on inpatient admissions, emergency room visits and for care of individuals with complicated mental health care issues.

5.2.2.8 Coordination with General Health Care

Provisions of the AHCA/HMO Model Contract apply (see Section "Coordination with General Health Care" under the St. Augustine description above).

It is Behavioral Health Division policy to communicate with the primary care physician for those clients who receive mental health services.

5.2.3 Physicians Healthcare Plan, Inc.

5.2.3.1 Corporate Affiliation and MCO Structures

Physicians Care Plan (PHP) is the Medicaid product of Physicians Healthcare Plan, Inc. PHP was incorporated in 1992 and commenced business in late 1993. PHP became a Florida-licensed HMO in August 1994. PHP contracted with PsychCare as their specialty behavioral health care organization until August 31, 1997 and currently contracts with FPM Behavioral Health, Inc. (See Figure 5.7).

FPM is a subsidiary of Ramsay Healthcare, Inc. FPM manages behavioral health for PHP's commercial and Medicaid business. Prior to its contract with PHP, FPM had not handled Medicaid enrollees and is currently developing new policies and procedures.

5.2.3.2 Role of PHP and Subcontractors

PHP provides oversight as required by its contract with AHCA. FPM does the network management, utilization management, and claims administration.

5.2.3.3 Geography and Enrollment

The July 1997 AHCA Enrollment Report lists the following total AFDC and SSI enrollment for PHP and Attachment VIII of their 1997-1998 AHCA contract lists the following maximum enrollment levels allowed at this time:

Hillsborough County	13,771	[Contractual maximum is	18,000]
Manatee County	-0-	[Contractual maximum is	-0-]
Polk County	3,361	[Contractual maximum is	9,250]
Hardee County	-0-	[Contractual maximum is	-0-]
Highlands County	-0-	[Contractual maximum is	-0-]

According to the Florida Department of Insurance Report, the figures in Table 5.4 represent the percentage of PHP Medicaid enrollees per county as of June 30, 1997.

Table 5.4 - Physicians Healthcare Plan, Inc. Enrollees - July 1997.

County	Commercial	Medicare	Medicaid	Total	Medicaid % of Total
Hillsborough	2,745	-0-	13,792	16,537	83
Manatee	41	-0-	-0-	41	-0-
Polk	122	-0-	3,318	3,440	96
Hardee	-0-	-0-	-0-	-0-	-0-
Highlands	-0-	-0-	-0-	-0-	-0-
Area 6 Total	**2,908**	**-0-**	**17,110**	**20,018**	**85**

5.2.3.4 Network Composition

FPM has contracts or other arrangements with the following CMHCs as their core service network:

Northside Mental Health Center, Inc. (Hillsborough County)
Mental Health Care, Inc. (Hillsborough County)
Manatee Glens Corporation (Manatee County)
Peace River Center for Personal Development, Inc. (Polk and Hardee Counties)
Winter Haven Hospital/Behavioral Health Division (Polk and Highlands Counties)

FPM also has arrangements with a few independent practitioners.

Attachment VI in the 1997-1998 AHCA/HMO Model Contract applies (see Section "Network Composition" under the St. Augustine description above).

5.2.3.5 Payment Arrangements

The contract between AHCA and PHP is a capitation contract. The contract between PHP and its specialty behavioral health care organization (FPM) is also a capitation contract. The payment arrangement between FPM and its service providers is reimbursement on a fee-for-service basis.

5.2.3.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to PHP and from PHP to FPM. No risk is transferred to service providers.

5.2.3.7 Clinical Management Structures

FPM agreed to approve all requests for service for the first 60 days of their contracts with the CMHCs. Since that time FPM has required prior authorization of all non-emergency services. Concurrent review of inpatient care is also required.

5.2.3.8 Coordination with General Health Care

Provisions of the AHCA/HMO Model Contract apply (see Section "Coordination with General Health Care" under the St. Augustine description above).

No particular procedures were specified.

5.2.4 Ultramedix Healthcare Systems, Inc.

5.2.4.1 Corporate Affiliation and MCO Structures

Ultramedix Health Care Systems, Inc. (Ultramedix), was founded as a Florida for-profit corporation in May 1992. Expansion into the commercial market began in October 1995 when Ultramedix was licensed as a Florida-licensed HMO. In January 1996, United American Healthcare Corporation, a for-profit health care management company with 400,000 members nationwide, acquired a majority interest in Ultramedix. (This acquisition did not directly affect Ultramedix membership). Currently Ultramedix has 20,000 commercial and Medicaid covered lives in Florida.

Ultramedix contracts with Professional Psychological Services (PPS) as its specialty behavioral health care organization (see Figure 5.8). PPS is owned by its founders and by Horizon Mental Health Management of Texas (Horizon). Horizon is a large contract manager of mental health programs offered by general and acute care hospitals in the United States. PPS is a Florida based company (located in Clearwater) with a core clinical and administrative staff.

5.2.4.2 Role of Ultramedix and Its Subcontractors

Ultramedix contracts with PPS to coordinate the provision of behavioral health care to Ultramedix's Medicaid enrollees in AHCA Area 6. PPS does the network management, utilization management, and claims administration.

5.2.4.3 Geography and Enrollment

The July 1997 AHCA Enrollment Report lists the following total AFDC and SSI enrollment for Ultramedix and Attachment VIII of their 1997-1998 AHCA contract lists the following maximum enrollment levels allowed at this time:

Hillsborough County	2,153	[Contractual maximum is	3,200]
Manatee County	-0-	[Contractual maximum is	-0-]
Polk County	1,177	[Contractual maximum is	7,900]
Hardee County	-0-	[Contractual maximum is	-0-]
Highlands County	-0-	[Contractual maximum is	-0-]

According to the Florida Department of Insurance Report, the figures in Table 5.5 represent the percentage of Ultramedix Medicaid enrollees per county as of June 30, 1997:

Table 5.5 - Ultramedix Healthcare Systems, Inc. Enrollees - July 1997.

County	Commercial	Medicare	Medicaid	Total	Medicaid % of Total
Hillsborough	834	-0-	2,184	3,018	72
Manatee	1,352	-0-	-0-	1,352	-0-
Polk	106	-0-	1,178	1,284	92
Hardee	-0-	-0-	-0-	-0-	-0-
Highlands	2	-0-	-0-	2	-0-
Area 6 Total	**2,294**	**-0-**	**3,362**	**5,656**	**59**

5.2.4.4 Network Composition

PPS has contracts or other arrangements with the following CMHCs as their core service network:

Northside Mental Health Center, Inc. (Hillsborough County)
Mental Health Care, Inc. (Letter of Intent for Hillsborough County)
Peace River Center for Personal Development, Inc. (Polk and Hardee Counties)

PPS also has arrangements with a few *associate providers*.

Attachment VI in the 1997-1998 AHCA/HMO Model Contract applies (see Section "Network Composition" under the St. Augustine description above).

5.2.4.5 Payment Arrangements

The contract between AHCA and Ultramedix is a capitation contract. The contract between Ultramedix and PPS is also a capitation contract. The payment arrangement between PPS and its service providers (both inpatient and outpatient) is fee-for-service reimbursement. Inpatient, partial hospitalization, day treatment and intensive outpatient services are paid on a per diem basis.

5.2.4.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to Ultramedix and from Ultramedix to PPS. No risk is transferred to the providers for outpatient care. Those CMHCs who provide inpatient care under a capitation arrangement with PPS are at risk for cost overruns for inpatient care.

5.2.4.7 Clinical Management Structures

Pre-authorization is required for all non-emergency inpatient and outpatient services. Concurrent review is conducted for non-emergency services and emergency inpatient.

Utilization review is conducted by the PPS Care Management Team. Treatment plans are reviewed and provide the basis for monthly authorizations. The authorizations are released in *blocks of service units*.

5.2.4.8 Coordination with General Health Care

Provisions of the AHCA/HMO Model Contract apply (see Section "Coordination with General Health Care" under the St. Augustine description above).

PPS requires that its specialty providers coordinate care by providing updates to the primary care physicians.

5.2.5 Staywell Health Plan/Well Care HMO, Inc.

5.2.5.1 Corporate Affiliation and MCO Structures

Staywell Health Plan is the Medicaid Division of Well Care HMO, Inc. (Staywell), a for-profit independent practice association (IPA). Well Care HMO, Inc. is a Florida based HMO serving clients in many counties throughout Florida. It was incorporated in 1985 and licensed as a FL HMO in 1986.

Staywell has contracted with Professional Psychological Services (PPS) as its specialty behavioral health organization since 8/97 (see Figure 5.8). (Prior to 8/97, Staywell contracted with CompCare).

PPS is owned by both its founders and by Horizon Mental Health Management of Texas. Horizon is a large contract manager of mental health programs offered by general and acute care hospitals in the United States. PPS is a Florida based company (located in Clearwater) with a core clinical and administrative staff.

5.2.5.2 Role of Staywell and Subcontractors

Staywell contracts with PPS to coordinate the provision of behavioral health care for Staywell's Medicaid enrollees in AHCA Area 6. PPS does the network management, utilization management, and claims administration.

5.2.5.3 Geography and Enrollment

The July 1997 AHCA Enrollment Report lists the following total AFDC and SSI enrollment for Staywell and Attachment VIII of their 1997-1998 AHCA contract lists the following maximum enrollment levels allowed at this time:

Hillsborough County	8,766	[Contractual maximum is	13,000]
Manatee County	-0-	[Contractual maximum is	-0-]
Polk County	14,217	[Contractual maximum is	17,000]
Hardee County	-0-	[Contractual maximum is	-0-]
Highlands County	-0-	[Contractual maximum is	-0-]

According to the Florida Department of Insurance Report, the figures in Table 5.6 represent the percentage of Staywell Medicaid enrollees per county as of June 30, 1997.

Table 5.6 - Staywell Plan/Well Care HMO, Inc. Enrollees - July 1997.

County	Commercial	Medicare	Medicaid	Total	Medicaid % of Total
Hillsborough	5,323	-0-	8,604	13,927	62
Manatee	-0-	-0-	-0-	-0-	-0-
Polk	2,054	-0-	13,976	16,033	87
Hardee	-0-	-0-	-0-	-0-	-0-
Highlands	-0-	-0-	-0-	-0-	-0-
Area 6 Total	**7,377**	**-0-**	**22,583**	**29,960**	**75**

5.2.5.4 Network Composition

PPS has contracts or other arrangements with the following CMHCs as their core service network:

Northside Mental Health Center, Inc. (Hillsborough County)
Mental Health Care, Inc. (Letter of Intent for Hillsborough County)
Peace River Center for Personal Development, Inc. (Polk and Hardee Counties)
Winter Haven Hospital/Behavioral Health Division (Polk and Highlands Counties).

PPS also has arrangements with a few *associate providers*.

Attachment VI in the 1997-1998 AHCA/HMO Model Contract applies (see "Network Composition" under the St. Augustine description above).

5.2.5.5 Payment Arrangements

The contract between AHCA and Staywell is a capitation contract. The contract between Staywell and PPS is also a capitation contract. The payment arrangement between PPS and its service providers (both inpatient and outpatient) is fee-for-service reimbursement. Inpatient, partial hospitalization, day treatment and intensive outpatient services are paid on a per diem basis.

5.2.5.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to Staywell and from Staywell to PPS. No risk is transferred to the providers for outpatient care. Those CMHCs who provide inpatient care under a capitation arrangement with PPS are at risk for cost overruns for inpatient care.

5.2.5.7 Clinical Management Structures

Pre-authorization is required for all non-emergency inpatient and outpatient services. Concurrent review is conducted for non-emergency services and emergency inpatient.

Utilization review is conducted by the PPS Care Management Team. Treatment plans are reviewed and provide the basis for monthly authorization in *blocks of units of service(s)*.

5.2.5.8 Coordination with General Health Care

Provisions of the AHCA/HMO Model Contract apply (see Section "Coordination with General Health Care" under the St. Augustine description above).

PPS requires that its specialty providers coordinate care by providing updates to the primary care physicians.

5.2.6 HealthEase/Tampa General Health Plan, Inc.

5.2.6.1 Corporate Affiliation and MCO Structures

HealthEase is the Medicaid product of the Tampa General HealthPlan, Inc. HealthEase/TGH is directly owned by the Hillsborough County Hospital Authority. In October 1997, Tampa General Hospital became a private institution and there has been some restructuring, although those changes have not affected HealthEase as of yet. HealthEase was licensed as a Prepaid Health Plan (PHP) in 1994 and they obtained their commercial HMO license from the state of Florida 6/28/97. Tampa General Health Plan, Inc. does not currently have commercial or Medicare members.

HealthEase contracts with Comprehensive Behavioral Care, Inc. (CompCare) as its specialty behavioral health care organization (see Figure 5.9). CompCare is a managed care subsidiary of Comprehensive Care, Inc., a Nevada corporation. CompCare is a national managed behavioral health organization headquartered in Tampa. (Note: As of 12/1/97, HealthEase contracts with PPS as its specialty behavioral health care organization.)

5.2.6.2 Role of HealthEase and Its Subcontractors

HealthEase contracts with CompCare to coordinate the provision of behavioral health care to HealthEase's Medicaid enrollees in AHCA Area 6. CompCare does the network management, utilization management, and claims administration. HealthEase maintains overall overseer responsibility.

5.2.6.3 Geography and Enrollment

The July 1997 AHCA Enrollment Report lists the following total AFDC and SSI enrollment for HealthEase and Attachment VIII of their 1997-1998 AHCA contract lists the following maximum enrollment levels allowed at this time:

Hillsborough County	4,401	[Contractual maximum is	6,400]
Manatee County	-0-	[Contractual maximum is	-0-]
Polk County	658	[Contractual maximum is	5,100]
Hardee County	-0-	[Contractual maximum is	-0-]
Highlands County	-0-	[Contractual maximum is	-0-]

(Florida Department of Insurance figures are not available as HealthEase was not licensed as a FL HMO until July 1997).

5.2.6.4 Network Composition

CompCare has contracts or other arrangements with the following CMHCs as their core service network:

Northside Mental Health Center, Inc. (Hillsborough County)
Mental Health Care, Inc. (Hillsborough County)
Manatee Glens Corporation (Manatee County)
Peace River Center for Personal Development, Inc. (Polk and Hardee Counties)

Attachment VI in the 1997-1998 AHCA/HMO Model Contract applies (see Section "Network Composition" under the St. Augustine description above).

5.2.6.5 Payment Arrangements

The contract between AHCA and HealthEase is a capitation contract. The contract between HealthEase and CompCare is also a capitation contract. The payment arrangement between CompCare and most of its service providers (CMHCs, inpatient providers, and independent practitioners) is fee-for-service reimbursement, however, CompCare has recently negotiated a capitation contract with Mental Health Care, Inc. Under that contract, MHC receives a capitated amount for the provision of outpatient services, however, admissions to the CSU still require pre-authorization and are paid retrospectively on a fee-for-service basis.

5.2.6.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to HealthEase and from HealthEase to CompCare. Providers paid on a fee-for-service basis do not share any risk, however, MHC, Inc. has chosen to bear risk for the utilization of outpatient services under its new contract with CompCare.

5.2.6.7 Clinical Management Structures

For all service providers (except MHC, Inc.), pre-authorization is required for all non-

emergency services (inpatient and outpatient). Concurrent review for inpatient services is performed on a bi-daily basis.

The utilization review procedures for outpatient services for MHC, Inc. changed when MHC, Inc. entered into a capitation arrangement with CompCare. Currently, MHC, Inc. must get prior authorization from CompCare for the initial service but then, after the initial authorization, MHC, Inc. provides its own internal utilization review without need of further authorizations from CompCare.

5.2.6.8 Coordination with General Health Care

Provisions of the AHCA/HMO Model Contract apply (see Section "Coordination with General Health Care" under the St. Augustine description above).

CompCare requires that all network providers make every effort to obtain consent from the member and relay information on diagnosis and prescribed psychotropic medications in a timely manner to the primary care physician.

5.2.7 PCA Family Health Plan, Inc.

5.2.7.1 Corporate Affiliation and MCO Structures

PCA is a for-profit independent practice association (IPA). PCA was incorporated and began business in Florida in 1984, and was licensed as a FL HMO in 1986. In September of 1997, Humana bought PCA and PCA is now a fully owned subsidiary of Humana. (Prior to the acquisition, Humana did not have a Medicaid product.)

PCA contracts with Comprehensive Behavioral Care, Inc. (CompCare) as its specialty behavioral health care organization. CompCare is a managed care subsidiary of Comprehensive Care, Inc., a Nevada corporation. CompCare is a national, managed behavioral health organization headquartered in Tampa.

CompCare contracts with AuroraCare as a specialty behavioral health care organization for the management of inpatient behavioral health services. AuroraCare is a for-profit *utilization management* organization licensed by AHCA. It is owned by a consortium of eight CMHCs in the Dade county area. (See Figure 5.10). (Note: This contract was in effect 7/12/97-10/31/97. As of 11/1/97, CompCare began to manage both inpatient and outpatient services again. AuroraCare continues with that arrangement with PCA for other parts of the state, but not Area 6.)

5.2.7.2 Role of PCA and Its Subcontractors

PCA contracts with CompCare to coordinate the provision of behavioral health care to PCA's Medicaid enrollees statewide. CompCare does the network management, utilization management, and claims administration for outpatient mental health services.

For inpatient services, CompCare contracts with AuroraCare to do the network management, claims administration, and most of the utilization management.

5.2.7.3 Geography and Enrollment

The July 1997 AHCA Enrollment Report lists the following total AFDC and SSI enrollment for PCA and Attachment VIII of their 1997-1998 AHCA contract lists the following maximum enrollment levels allowed at this time:

Hillsborough County	7,336	[Contractual maximum is	35,000]
Manatee County	5,085	[Contractual maximum is	11,500]
Polk County	4,040	[Contractual maximum is	22,050]
Hardee County	-0-	[Contractual maximum is	-0-]
Highlands County	788	[Contractual maximum is	5,700]

According to the Florida Department of Insurance Report, the figures in Table 5.7 represent the percentage of PCA Medicaid enrollees per county as of June 30, 1997.

Table 5.7 - PCA Family Health Plan, Inc. Enrollees - July 1997.

County	Commercial	Medicare	Medicaid	Total	Medicaid % of Total
Hillsborough	4,511	-0-	7,523	12,034	63
Manatee	308	-0-	5,033	5,341	94
Polk	547	-0-	4,042	4,616	88
Hardee	387	-0-	-0-	387	-0-
Highlands	1,684	-0-	806	2,490	-0-
Area 6 Total	**7,464**	**-0-**	**17,404**	**24,868**	**70**

5.2.7.4 Network composition

CompCare has contracts or other arrangements with the following CMHCs (as well as *associate providers*) for outpatient services for PCA members:

Northside Mental Health Center, Inc. (Hillsborough County)
Mental Health Care, Inc. (Hillsborough County)
Manatee Glens Corporation (Manatee County)
Peace River Center for Personal Development, Inc. (Polk and Hardee Counties)
Winter Haven Hospital/Behavioral Health Division (Polk and Highlands Counties. Note: this contract ends 2/11/98.)

AuroraCare contracts with four providers for inpatient mental health services for PCA members, three of whom are CMHCs: Manatee Glens Corporation (Manatee County), Peace River Center for Personal Development (Polk County), and Winter Haven Hospital/BHD (Highlands County); and Charter Hospital (Hillsborough County).

Attachment VI in the 1997-1998 AHCA/HMO Model Contract applies (see Section "Network Composition" under the St. Augustine description above).

5.2.7.5 Payment Arrangements

The contract between AHCA and PCA is a capitation contract. The contract between PCA and CompCare is also a capitation contract.

The payment arrangement between CompCare and most of its service providers (CMHCs, independent practitioners) is fee-for-service reimbursement, however, CompCare has recently negotiated a capitation contract with Mental Health Care, Inc. Under that contract, MHC receives a capitated amount for the provision of outpatient services.

The contract between CompCare and AuroraCare for management of inpatient services is a capitation contract. AuroraCare pays Manatee Glens Corporation on a case-rate basis (a flat fee per admission) and pays the three other inpatient providers on a fee-for-service basis. (Note: This contract ended on 10/31/97).

5.2.7.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to PCA, who then transfers full risk to CompCare. CompCare retains the risk for outpatient mental health services, but transfers full risk for inpatient services to AuroraCare.

Two of the service providers are at risk under their payment arrangements. MHC is at risk because they are paid for outpatient services on a capitated basis. In addition, for Manatee Glens, there is some assumption of risk on a per admission basis. Because AuroraCare pays Manatee Glens for inpatient services on a case rate per admission, if the length of stay exceeds the case rate amount Manatee Glens is at risk for the costs above the case rate amount.

CompCare withholds 5% of AuroraCare's monthly cap amount to Aurora for a contingency fund to be used for the reimbursement of covered inpatient services which are rendered out of the service area upon emergency conditions and/or for out of network costs. If the cost of these services exceeds the contingency fund, CompCare can deduct from AuroraCare's capitation fee. If there is leftover money in the contingency fund, then Aurora receives 50% of that remaining amount and the rest remains in the fund for the coming year.

5.2.7.7 Clinical Management Structures

CompCare requires prior authorization for all non-emergency outpatient mental health services. AuroraCare requires prior authorization for all inpatient care. Inpatient providers (with the exception of Manatee Glens that is paid on a case rate basis) have concurrent review on a bi-daily basis by AuroraCare. AuroraCare also performs retrospective review, quarterly, on 10% of the cases, to yield information about trends and patterns.

AuroraCare also identifies certain patients as *high risk* (see definition below) and assigns an AuroraCare *high risk case manager* to assist in discharge planning and to enhance treatment compliance (by, for example, reminding patients of outpatient appointments and establishing resources and supports).

To be identified as *high risk*, one of the following criteria have to be met: (1) length of inpatient stay is greater than 5 days; (2) have been readmitted to inpatient facility within 30 days; or (3) have multiple suicide attempts. The case manager follows high-risk patients for approximately 3 months.

5.2.7.8 Coordination with General Health Care

Provisions of the AHCA/HMO Model Contract apply (see Section "Coordination with General Health Care" under the St. Augustine description above).

CompCare requires all network providers to make every effort to obtain consent from the members and to relay information on diagnoses and prescribed psychotropic medications in a timely manner to the primary care physician.

5.2.8 United HealthCare of Florida, Inc.

5.2.8.1 Corporate Affiliation and MCO Structure

United HealthCare of Florida, Inc. (UHC of FL), a health maintenance organization, and United Behavioral Health, Inc., (UBH), their specialty behavioral health care organization, are both owned by United HealthCare Corporation (UHC), which has its headquarters in Minneapolis, MN. The parent company has commercial plans licensed as HMOs in 28 states, Medicare plans in 22 states (including Florida), and Medicaid plans in 11 states (including Florida) plus Washington D.C. and Puerto Rico. UHC began business in 1974.

United HealthCare acquired Ramsay HMO in 1994 and MetraHealth in 1995. In July 1996 the plan name was changed to United HealthCare of Florida, Inc. UHC serves more than 875,000 Floridians.

UBH was formed in February 1997 by joining together the parent company's two managed behavioral health subsidiaries: United Behavioral Systems, founded by UHC in 1985; and U.S. Behavioral Health, founded in 1979 and acquired by UHC in 1995. UBH headquarters are in San Francisco and Minneapolis. UBH serves approximately 13 million people nationwide through its employer, health plan, and public sector divisions.

UBH contracts with AuroraCare as a specialty behavioral health care organization. AuroraCare is a for-profit *utilization management* organization licensed by AHCA. It is owned by a consortium of eight CMHCs in the Dade county area. AuroraCare has a contract with UBH for UBH's Medicaid members in AHCA Area 6 only**.** (See Figure 5.11).

5.2.8.2 Role of United HealthCare and Its Subcontractors

UHC of FL delegated management of behavioral health services to UBH, but retains responsibility for handling grievances.

UHC of FL contracts with UBH to coordinate the provision of behavioral health care to UHC's Medicaid enrollees in AHCA Area 6. UBH conducts semi-annual audits of its contractor, and AuroraCare is responsible for credentialing, network management, claims

administration, and most of the utilization management for both inpatient and outpatient mental health services.

UBH and AuroraCare have worked together since July 1996. By policy, UBH and AuroraCare staff meets regularly, but no less frequently than quarterly.

5.2.8.3 Geography and Enrollment

The July 1997 AHCA Enrollment Report lists the following total AFDC and SSI enrollment for United and Attachment VIII of their 1997-1998 AHCA contract lists the following maximum enrollment levels allowed at this time:

Hillsborough County	-0-	[Contractual maximum is	-0-]
Manatee County	-0-	[Contractual maximum is	-0-]
Polk County	-0-	[Contractual maximum is	-0-]
Hardee County	-0-	[Contractual maximum is	-0-]
Highlands County	941	[Contractual maximum is	2,700]

According to the Florida Department of Insurance Report, the figures in Table 5.8 represent the percentage of United Medicaid enrollees per county as of June 30, 1997.

Table 5.8 - United HealthCare of Florida, Inc. Enrollees - July 1997.

County	Commercial	Medicare	Medicaid	Total	Medicaid % of Total
Hillsborough	45,170	5,260	-0-	50,430	-0-
Manatee	3,194	-0-	-0-	3,194	-0-
Polk	15,685	-0-	-0-	15,685	-0-
Hardee	230	-0-	-0-	230	-0-
Highlands	507	-0-	949	1,456	65
Area 6 Total	**64,786**	**5,260**	**949**	**70,995**	**1**

5.2.8.4 Network Composition

AuroraCare has contract or other arrangements with two CMHCs (as well as *associate providers*) for inpatient and outpatient mental health services for UHC enrollees:

Winter Haven Hospital/BHD (Polk and Highland Counties - Note: this contract ended 1/1/98)
Peace River Center for Personal Development, Inc. (Polk and Hardee Counties)

Inpatients are principally served at Winter Haven Hospital; however, if there is an overflow of inpatient clients at Winter Haven Hospital, AuroraCare utilizes Peace River Center's CSU.

Attachment VI in the 1997-1998 AHCA/HMO Model Contract applies (see Section "Network Composition" under the St. Augustine description above).

5.2.8.5 Payment Arrangements

The contract between AHCA and UHC is a capitation contract. The contract between UHC and UBH is a capitation contract. The contract between UBH and AuroraCare is also a capitation contract.

The payment arrangement between AuroraCare and its service providers (CMHCs, independent practitioners) is fee-for-service reimbursement.

5.2.8.6 Risk Sharing Arrangements

Full risk is transferred from AHCA to UHC, which then transfers full risk to UBH, which in turn transfers full risk to AuroraCare. None of the providers are at risk as all are paid on a fee-for-service basis.

5.2.8.7 Clinical Management Structures

AuroraCare requires prior authorization for all non-emergency inpatient and outpatient mental health services. Inpatient providers have concurrent review on a bi-daily basis by AuroraCare. AuroraCare also performs retrospective review, quarterly, on 10% of the cases, to yield information about trends and patterns.

AuroraCare also identifies certain patients as *high risk* and assigns an AuroraCare *high risk case manager* to assist in discharge planning and to enhance treatment compliance (by, for example, reminding patients of outpatient appointments and establishing resources and supports).

5.2.8.8 Coordination with General Health Care

Provisions of the AHCA/HMO Model Contract apply (see Section V.B.1.h."Coordination with General Health Care" under the St. Augustine description above).

No particular coordination procedures are specified.

Tables 5.9 and 5.10 **provide summaries of the main features of the managed care arrangements in AHCA Area 6.** Table 5.9 is a side-by-side summary of the key features that differentiate fee-for-service Medicaid and the two managed care conditions. Table 5.10 highlights the variability within the HMO condition. In the next section of the report, we will highlight the important findings from this review of the organizations rendering mental health services to Medicaid enrollees in the Tampa Bay area.

6.0 SYNTHESIS OF RELEVANT FINDINGS

The findings of public policy relevance from our review of the nine managed care arrangements in AHCA Area 6 are summarized below:

6.1 Integration of General Health and Mental Health Care Has Not Occurred

Our structural analysis suggests that the integration of the health and mental health premium has not resulted in the integration of general health and mental health care for Medicaid recipients in Florida.

The conventional wisdom is that HMOs provide integrated health and mental health care. Yet our analysis of Florida Medicaid HMOs indicates that the majority of HMOs are *carving out* their mental health benefits. As Table 5.10 reveals, only two HMOs are managing the mental health benefit themselves. The other six have subcontracted with either one or two specialty behavioral health care organizations to manage the mental health benefit. The conventional wisdom about *carve in* versus *carve out arrangements* does not appear to apply to Florida, if, indeed, it applies elsewhere.

Coordination of care between general health and mental health is an issue for all of the managed care arrangements — both the PMHP and the HMOs. As we stated earlier, the MediPass physician's contract requires that the primary care physician "coordinate" care for "persons on medications for behavioral issues or for whom a behavioral program has been prescribed for serious problems." There is no evidence that this contract provision is being followed in a systematic way by MediPass physicians or enforced by AHCA. Florida Health Partnership and the CMHCs have developed and implemented a protocol for coordinating care, however, it is too early to determine whether that plan is working.

There is no specific provision in the AHCA/HMO contract that directly addresses primary care physician responsibility for continuity between general health and mental health care. However, many of the BHOs indicated that they have a policy for coordinating care between their specialty mental health providers and the HMO primary care physicians. It is unclear how these policies are monitored or enforced.

One of the BHOs did a study to see how well their policy was being followed and found a less than 20 percent compliance rate (when compliance was defined as having documentation in the specialty mental health provider's chart that the provider had notified the primary care physician). These figures cannot be extrapolated to all BHOs**,** but this study does suggest that **there may be a gap between policy and practice.**

6.2 Behavioral Health Care Providers Have Different Structures in Area 6

The managed care structures developed by MCOs to provide behavioral health care in AHCA Area 6 are very complex and there appear to be distinct differences between Area 6's carve out and carve in arrangements.

Area 6 has one *carve out* model, which is the Prepaid Mental Health Plan implemented by the Florida Health Partnership. In addition, there are eight HMOs that represent *carve*

in plans operating in Area 6. These two types of arrangements (PMHP and HMO) differ more fundamentally than a simple recitation of their financing, risk, and clinical structures might imply.

The Florida Health Partnership is more than a set of purchase of service agreements — it is an integrated administrative and service system based on a *shared clinical model*, with financial and regulatory mechanisms specifically designed to support that clinical model. The clinical model was developed in a consensus process between the equal partners (Options Health Care, Inc. and the five CMHCs), is clearly articulated in writing, and incorporates standards for *under-utilization* as well as *over-utilization* of services under the benefit plan. The developmental process was not without problems. However, the approach to problem solving was negotiation among equals within a collaborative organizational structure.

In contrast, the development of behavioral health care delivery structures under the HMOs has not had a simple developmental course. Six of the eight HMOs have chosen to contract with specialty BHOs to arrange for the provision of mental health care and several of the HMOs have switched BHOs within the first 16 months of implementation of the expanded mental health benefit. Clinical management and claims payment processes have been troubled and little improvement has been evidenced over the 16 months of the implementation. The HMO/BHOs and their service providers are not integrated service systems. Their relationships depend on a series of purchase of service agreements, some of which are temporary agreements.

These differences, however, do not appear to be based on organizational type. By that we mean that HMOs/BHOs/service providers could develop more integrated service systems by developing a *shared clinical model* and structuring their financial and regulatory mechanisms to support that model. We simply observe that they have not and that the result has been a difficult developmental course for the HMO/BHOs and their service providers.

6.3 Real Costs of Mental Health Care Are Unclear

The costs to the Medicaid program of these complex organizational structures are unclear at this time.

Six of the eight HMOs decided to organize the provision of mental health services through a *carve out*. Each of the six has contracted with a BHO and has put that organization at risk for the costs of mental health care. Each of those BHOs have, in turn, contracted with the traditional Medicaid mental health service providers in Area 6 (the CMHCs).

Decisions about *carving out* may have been due to the pressure of a quick implementation of the comprehensive mental health benefit, but may also be the result of a desire on the part of HMOs to transfer both the responsibility and the risk for specialty mental health care, especially inpatient care. Because HMOs have generally used the BHOs for their commercial business, it may have been a natural extension to transfer their Medicaid business as well. In addition, these HMOs have relatively little

experience in managing long-term behavioral health services.

Adding another layer (or, in the case of two of the HMOs, two additional layers of subcontractors) may have provided HMOs with the specialty expertise of BHOs but it also may have affected the overall costs of administering mental health services (although we do not know this empirically at this point).

At every layer of these structures there are administrative costs associated with contract performance. Certainly some level of administrative costs is necessary. Under-funding the administration of these organizations, especially *clinical* administration, could affect the organization's ability to *manage* mental health care. However, policy makers may be concerned about an MCO's balancing of administrative and service costs. Use of simplistic measures of *medical loss ratio* to measure plan performance should be avoided (Robinson 1997), but cost studies that adequately approximate the division of revenues between *insurance functions* and *service delivery functions* would be a useful tool for state policy makers. **It is expected that the distribution of the capitation amount should follow the assumption of the managed care responsibility and risk.**

6.4 Instability of Care Arrangements Exists

There has been considerable instability in the HMO/BHO/service provider managed care arrangements over time.

There are a number of BHOs operating in the AHCA Area 6 Medicaid market and there have been a number of changes of HMO/BHO relationships over time. Only two HMOs have stayed with their initial BHO. Four other HMOs have either changed BHO during the 16 months of the expanded mental health benefit or have added another BHO to their structure. The effect that these changes may have had for continuity of care of HMO enrollees is unknown but any effects may have been blunted by the fact that all BHOs are using the same set of CMHCs as their core providers. The effect of BHO changes on CMHCs themselves has been negative, according to the CMHCs. One of the implementation problems cited in our April (1997) report, which persists today, has been the lack of clinical consensus among BHOs and their CMHC providers -- affecting authorizations for care and denial of claims. When HMOs switch BHOs these problems are exacerbated when CMHC providers must adapt to a new set of UR procedures.

AHCA has suggested that the *carving out* to BHOs may be the effect of rapid implementation of the comprehensive mental health benefit. However, our analysis suggests that the HMOs are contracting with BHOs for both their commercial and Medicaid business. This argues against the idea that quick implementation of the comprehensive mental health benefit forced HMOs to create *carve outs*. Again, because the HMOs have successfully transferred the risk of mental health care to other organizations with specialty expertise, there may be pressure to keep the *carve outs* in place even though carving out may increase overall administration costs.

6.5 Rules for Accessing Care and Flexibility are Key

Benefit design, per se, is less important under managed care plans than are the rules for accessing services. Flexibility in clinical management and assumption of risk are closely linked in these managed care arrangements.

The mental health benefit for the PMHP and the HMOs is identical, however, benefit design may not be a good predictor of services available to a plan's members. Benefit design *per se* is less important under managed care arrangements than are the *rules* for accessing services, including the operationalization of *medical necessity criteria* and the implementation of *utilization review*.

The issues of utilization review and assumption of risk are closely linked in these managed care structures. Where providers are at risk for the costs of over-utilization of services (in the contracts between FHP and CMHCs, and between CompCare and MHC, Inc.), utilization review procedures allow the provider who is assuming the risk to have more flexibility in determining what services are necessary for a particular individual at a particular time.

The service providers desire this clinical flexibility. The application of pre-authorization and concurrent review procedures by HMO/BHOs (as well as the resulting claims disputes) have caused ongoing disputes between HMO/BHOs and their providers, resulting in requests from CMHCs for further AHCA oversight of the prior authorization and claims payment processes.

6.6 Difficulties in Contract Terms Raise Concerns about Continuity of Care

HMO/BHOs and CMHCs have had difficulty coming to terms over contracts and CMHCs are beginning to cancel contracts and agreements with BHOs, raising concerns about continuity of care for HMO plan beneficiaries.

Another area of concern is the stability of the letters of agreement and contracts that underpin many of the BHO/provider relationships. **In our review we often found that there are *letters of intent* and *letters of agreement* in place rather than contracts, and that some of these agreements have expired.** This fact may be exacerbating some of the UR and claims administration problems that have continued over the 16 months of implementation.

Contracts articulate the rights and responsibilities of the parties to an agreement and are enforceable; *letters of intent* and *letters of agreement* may not be similarly enforceable creating ambiguity in the business relationship.

The lack of contracts was initially seen to be an implementation problem but the fact that it has persisted may be evidence of a more longstanding disagreement about the clinical management and financing of mental health services under HMO/BHO structures. It is interesting to note that at least one of the BHOs has negotiated a capitated financing

arrangement with one of the CMHCs, which lessens the burden of UR and claims payment for both the BHO and the CMHC.

In general, though, the CMHCs have had to absorb the additional administrative costs for staffing (associated with the coordination of UR with BHOs) and MIS system upgrades (for claims payment). These costs are borne by the service providers and not by the BHOs.

HMO/BHOs and the CMHCs have had difficulty in negotiating *contracts* for provision of mental health services to plan beneficiaries. From the point of view of at least one of the BHOs, CMHCs were reluctant to contract with HMOs because of their financial interest in the Florida Health Partnership.

Concerns expressed by the CMHCs include the rates of payment for services offered by HMO/BHOs, lack of clarity in clinical criteria, early problems in the operationalization of clinical management procedures, disagreements about the appropriateness of particular types and amounts of services (e.g., *targeted case management*), and the lack of claims payment.

One reason for the difficulties may be that HMOs/BHOs are using primarily commercial contracts in implementing their Medicaid business. Most contracts supplied to us by HMOs were commercial contracts to which the Medicaid population had been added by use of addenda. Few changes were made to take into account the addition of a population of adults with severe mental illness and children with severe emotional disturbances.

6.7 AHCA Policies May Impact Free Market Decisions

AHCA policy decisions on mandatory assignment may be blunting the effect of the free market on MCO behavior.

As of February 1997, AHCA instituted mandatory enrollment into HMOs. (Prior to February all mandatory assignments were made to MediPass/PMHP). This policy decision was made in an attempt to achieve balance between HMO and MediPass enrollment statewide and to create stability in plans. However, an unintended consequence of this policy may be that MCOs (both FHP and HMOs) are protected from market pressures to improve their services. One of the reasons Medicaid recipients were given a 30-day *lock in* is so that they can "vote with their feet" and leave MCOs that provide poor or unresponsive care.

If MCOs are, in effect, held harmless by AHCA's decision to balance mandatory assignment, there will be little market pressure for FHP and the HMOs to address quality issues in their customer and clinical services. However, some less direct market pressure remains - because FHP has a time limited contract that must be rebid, and HMO contracts could be affected by consumer complaints to AHCA.

6.8 Care Provider Competition Is Not Evident

If one of the goals of the Medicaid managed care waiver was to bring more provider competition into the Medicaid marketplace - this goal has not been realized in Area 6.

As the Kaiser Family Foundation noted in its recent report (1997), one of the goals of the expansion of managed care in Medicaid *(general health care)* may have been to bring new providers into the Medicaid marketplace, thereby increasing the number of providers available to Medicaid recipients.

In the case of the PMHP in AHCA Area 6, this was not realized. The CMHCs who were the traditional providers of Medicaid mental health services in Area 6 are the principal providers for all of the nine managed care plans. On the positive side, these CMHCs are the *safety net* providers, they have access to ADM general revenue funds to provide services that are not specifically covered under the Medicaid benefit package (e.g., housing and vocational programs). Additionally, they have the most experience in serving Medicaid recipients who have mental illnesses, especially severe mental illnesses. Their continuation as the principal providers has meant that most Medicaid recipients have been able to continue treatment with the same service provider they had seen prior to the advent of managed care, enhancing continuity of care.

On the other hand, Medicaid recipients in Area 6 were not presented with a new range of provider choices and thus were not able to choose a new mental health provider or to avoid a service provider with whom they may have been dissatisfied in the past.

6.9 Placement of Financial Risk Is Uncertain

The State of Florida has successfully shifted virtually all of the risk of the costs of Medicaid-funded mental health services to private organizations licensed by the State to bear risk. Most of those organizations have, in turn, shifted that risk to other parties.

While there are larger societal issues having to do with risk (such as the risk to society of untreated mental illness and the political risk of transferring public responsibility to private agencies), like other investigators, we have focused our analysis on the sharing of financial risk for the costs of service utilization among three sets of parties: the State, the managed care organizations, and the service providers.

In the case of AHCA Area 6, the State has shifted virtually all of the risk to private managed care organizations. Most of these MCOs have, in turn, shifted that risk to other parties (either BHOs or service providers). The State of Florida remains at risk, however, if the structures they have put into place are not providing the minimum required by the federal Medicaid statute and regulations.

In PMHP, virtually all of the risk for service provision has been assumed at the provider level but, in exchange for taking on the risk, there is considerable flexibility for providers to make clinical decisions and to manage care. In addition, because of the way the

Florida Health Partnership is structured, there is no incentive for Florida Health Partnership to deny or restrict care (because there are separate capitation arrangements for administration and for services. Service providers are at significant risk but the Florida Behavioral Health (FBH) structure provides some financial protection for providers through access to a risk pool, but without creating financial incentives for the delivery of care outside of the clinical consensus guidelines.

On the HMO side, two of the HMOs retain all of the risk, but for the other six, all risk is shifted to the BHO. Because they are at full risk, there is strong incentive for the BHOs to aggressively manage care in order to stay within their capitation rate. The BHOs do not share the risk with service providers. There are no formal risk sharing arrangements in the HMO/BHO financial structures, however, at least one HMO has reported giving a BHO an increase in their capitation rate based on higher than projected service utilization by enrollees. Providers, with few exceptions noted earlier, bear little risk and consequently have very little flexibility in making clinical decisions. Such flexibility is greatly desired by providers. As we have noted, one of the BHOs has negotiated a capitation arrangement with one CMHC and that may be a harbinger of what is to come as these relationships mature.

6.10 AHCA Enforcement Is Key to Quality of Care

Given that AHCA has created powerful incentives for organizations to benefit from plan development, and that it is unlikely that the market can be an effective regulator, AHCA's role as enforcer of the system is key.

There are a variety of levels at which there may be structures or processes that would increase accountability. Types of mechanisms that may be developed at different levels include: (1) allowing Medicaid recipients to "vote with their feet" by providing them information about plan performance and allowing them choice of plans and providers; (2) MCO adoption and implementation of best practice standards or utilization review mechanisms to standardize care; (3) Medicaid contract deliverables in the form of plan performance and client outcome measures; and (4) government regulation.

Where contractual requirements are made, the presence of particular mechanisms in a contract is not sufficient to create accountability. Contract requirements must be coupled with the knowledge that these provisions will be enforced and that there will be negative consequences for failing to meet accountability standards.

As we have discussed earlier in this report, some of AHCA's policy decisions have decreased the likelihood that the market can be an effective regulator of quality of plans. Therefore, the bulk of the responsibility for oversight will fall to AHCA staff, who has oversight responsibility for all commercial managed care plans as well. **Because the managed care market is rapidly expanding, and because many of the managed care organizations choose to operate with multiple organizational layers, there will continue to be stress on AHCA's oversight capabilities.** In most areas, AHCA's contract provisions are comprehensive, however, the mere existence of a contract provision does not mean that it is being implemented or enforced.

7.0 POLICY IMPLICATIONS

AHCA has "created powerful incentives for individuals or organizations to benefit through plan development," (Gold et al. 1997), and there are large sums of public money involved in these managed care arrangements. Given the vulnerability of the population, and the fact that mentally ill people and their families often lack the ability to advocate on their own behalf, **AHCA's role as monitor and enforcer of the system is key**.

Our analysis leads to some questions the State needs to consider in response to issues raised in the implementation of the PMHP (March 1996) and the expansion of the HMO mental health benefit in AHCA Area 6 (August 1996). Is there adequate oversight by AHCA, given that AHCA regulates both commercial and Medicaid managed care plans? Are there sufficient *mental health-related performance indicators* in the contracts? Is AHCA paying sufficient attention to the development of payment or risk structures that create incentives to restrict care?

As the state prepares to implement the comprehensive community mental health benefit through Medicaid HMOs in other parts of Florida, **the lessons from the Area 6 implementation suggest that is it necessary to *go slow* with major policy changes.** Specialty mental health providers need to be involved in the planning and negotiation processes from the beginning. This caution is especially important for those MCOs with little or no prior Medicaid experience and providers who have little or no managed care experience (who are not familiar with or may not be appropriately staffed to deal with utilization review and reporting requirements). A lack of lead-time may result in conflicts between providers and HMO/BHOs and may reduce the quality of care for enrollees during some period of implementation.

A cost study is needed to complete this analysis of managed care arrangements. However, the cost study must go beyond simplistic measures of *administrative costs.* Care must be taken in assigning costs to *cost centers*. For example, is the cost of implementing UR an *administrative cost* or a *service cost*?

One of the key policy questions is, how much of the PMPM paid to FHP and the HMOs is actually used for service provision, and how much is allocated to *administrative* or *insurance* costs and at which levels of the structures? This is not meant to imply that all administrative costs are of questionable value, but rather that the State should know what it is purchasing with public money.

8.0 CONCLUSION

The application of managed care principles to public sector Medicaid programs has excited some mental health advocates even as it has caused concern for others. The potential for enhancement of mental health treatment is clear: (1) if managed care means an end to arbitrary benefit limits as a strategy to manage costs; (2) if it promotes the development of comprehensive continua of care, as well as innovative new service approaches; (3) if it improves efficiencies through capitated financing; and (4) it improves coordination of health and mental health care, Medicaid mental health systems

would be vastly improved over the status quo (Ridgely & Goldman, 1996).

However, if, in the implementation of managed care: (1) a different set of arbitrary limits are instituted that result in denial of care as a cost saving strategy; or (2) if there is restriction of non-medical and supportive services that many people with severe disorders need to remain stable in the community, or (3) if the structures in place continue or exacerbate the discontinuities in care systems, then the fears of managed care's detractors will be realized.

As Mechanic has warned, "ultimately...managed care is simply an enabling structure for making decisions" and that quality will depend on the specific incentive structures, providers, reviewers and responsiveness of the managed care organization (Mechanic, Schlesinger & McAlpine 1995).

Clearly, research such as that undertaken in this evaluation is needed to assess the efficacy of various types of managed care plans, and to determine which components of those plans are most actively helpful or detrimental to achieving an accessible, adequately financed, and comprehensive Medicaid mental health care system.

As James Robinson recently wrote in *Health Affairs*, warning of the dangers of the use of the *medical loss ratio* statistic as a simple measure of managed care plans:

> The single greatest gap in the health care data systems is in **descriptive information on the structure of provider networks and the mechanisms for utilization management used by competing health plans**...The most obscure of all are the methods used by health plans (and their contracting organizations) to monitor and manage the utilization patterns of individual patients and physicians...Information is complex, difficult to codify, difficult to quantify, easily misinterpreted, and subject to rapid obsolescence (Robinson, 1997).

Taking Robinson's counsel, one step in the right direction is to identify a series of important domains and to collect information systematically over time. This is the first in a series of such reports documenting the managed care arrangements in AHCA Area 6.

The next step for the evaluation of the organizational, financial and clinical structures as a whole is to integrate this qualitative information with the study's quantitative data (Medicaid claims and HMO encounter data) to see if there are any correlations among enrollment, service utilization patterns, outcomes and the factors we have studied. **It is only through the integration of these data sets that we can understand the effect that key aspects of the managed care arrangements are having on the lives of Medicaid recipients.**

Findings from these qualitative analyses must be treated as preliminary until we have access to analyses from these additional data sets. At this point we can describe differences in organizational and financial arrangements and only speculate about what their impact might be, based on the managed care literature and our own knowledge of mental health systems. However, we can only confirm or refute these speculations when we can triangulate this qualitative data with data from other studies within the evaluation.

There are many ways that organizations can structure themselves to achieve their goals. Assessments of the utility of specific arrangements should be based on whether or not they achieve the access, quality and cost goals AHCA has set out for them. Especially critical in the analysis is the extent to which public monies paid to these organizations reach Florida's Medicaid recipients who are in need.

In the next report in the ***Implementation Analysis*** we will describe and compare AHCA Area 4 (the Jacksonville comparison site) managed care arrangements with those in Area 6 (Tampa Bay), and describe the general revenue ADM service system in Areas 6 and 4.

We will then focus our attention on two key issues: (1) the **mechanisms of utilization management** employed by the managed care organizations and their subcontractors; and (2) the **boundaries** between the Medicaid mental health system and the general revenue ADM service system.

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