

PRELIMINARY RECOMMENDATIONS AND FINDINGS ON MEDICAID BEHAVIORAL MANAGED HEALTHCARE

September 30, 2004

“The extensive literature that the Surgeon General’s report reviews and summarizes leads to the conclusion that a range of treatments of documented efficacy exists for most mental disorders. Moreover, a person may choose a particular approach to suit his or her needs and preferences. Based on this finding, the report’s principal recommendation to the American people is to seek help if you have a mental health problem or think you have symptoms of a mental disorder. As noted earlier, stigma interferes with the willingness of many people—even those who have a serious mental illness—to seek help. And, as documented in this report, those who do seek help will all too frequently learn that there are substantial gaps in the availability of state-of-the-art mental health services and barriers to their accessibility.” **Mental Health: A Report of the Surgeon General, 1999**

Substance abuse and dependence is a complex disorder, with associated biological, psychological, and social causes and effects. Historically, this disorder has been treated as a social problem while the psychological and biological aspects largely have been ignored. However, the deterioration of functionality within each of these aspects of the disorder requires that treatment and intervention address the entire biopsychosocial continuum. In addition, substance abuse and dependence is a chronic, relapsing illness. Although many of the symptoms and associated illnesses require that a client receive specialized or acute care, these systems might not be prepared to treat the chronic elements of the illness. **Improving Substance Abuse Treatment: The National Treatment Plan Initiative, Substance Abuse and Mental Health Services Administration, 2004**

Introduction

During a strategic planning session on June 3, 2004 the Substance Abuse and Mental Health Corporation Chairperson, Dr. Dorothy Lewis, appointed an Ad Hoc Committee on Medicaid Behavioral Managed Healthcare. The Corporation was given a charge by the 2004 Legislature to analyze the shift to behavioral managed care for Medicaid beneficiaries and its impact on the publicly funded mental health system.

The Corporation, in collaboration with the Department of Children and Families (DCF), the Agency for Healthcare Administration (AHCA), the Pre-Paid Plans and the Health Maintenance Organizations (HMOs), will be establishing baseline data so that outcomes and performance may be assessed throughout 2005, as intended by the 2004 Legislature.

HB 1837, Section 21 states:

In order to implement Specific Appropriation 372 of the 2004-2005 General Appropriations Act, the annual report required by section 394.655 (10), Florida Statutes, for 2004-2005 shall include a specific analysis of managed care contracts and the impact of these contracts on the mental health service delivery system in Florida. Provider and client outcomes must be assessed from the perspective of cost effectiveness, quality of care, and access to care. Additionally, a comparison of levels of benefit packages must be included. This paragraph expires July 1, 2005.

The Ad Hoc Committee comprised of David Miller, Chair, The Honorable Rocky Rodriguez, Dr. William Mellan and Joseph George, Esquire, met for three days, June 21-23, 2004, in Tampa. The Committee invited 30 participants to the meeting, which was formatted as a roundtable workgroup.

The stakeholders at the meeting -- representing diverse interests of the various substance abuse treatment and mental health providers, advocates, consumers and managed care organizations -- came together to discuss the change in the delivery of Medicaid mental health services. Florida is moving towards two models of behavioral managed healthcare -- Pre-Paid Plans (in which behavioral healthcare is separate from physical healthcare) and Health Maintenance Organizations (in which behavioral care is carved in with physical healthcare). These two models currently do not include children in the HomeSafeNet system and Medicaid substance abuse treatment services.

It was clear from the workgroup meeting, that stakeholders are willing to work with the Corporation, the State, and one another to build a better, more efficient behavioral healthcare system in Florida. However, a major challenge for the State will be providing consistent services throughout the state for adults and children with psychiatric disabilities (the State's target population) regardless of payer source (Medicaid or funded only with General Revenue funds).

There is much to be learned from Area 6's experience with the managed care pilot programs. The Corporation has reviewed reports and received a presentation from Dr. David Shern, Florida Institute of Mental Health, regarding the managed care pilot programs there. It is important to duplicate the successes in District 6 and avoid the mistakes.

During the 2003 and 2004 Legislative Session, legislators passed SB 2404 (2003) and HB1837 (2004). In doing so, the Legislature is moving the publicly funded behavioral healthcare system from fee-for-service to managed care. It appears the Legislature mandated AHCA and DCF implement managed care to achieve cost savings and uniformity of services and access. The 2004 Legislature removed \$26 million expected in Medicaid savings from the Medicaid behavioral healthcare funding for State fiscal year, 2004-2005.

With careful implementation, vigilant monitoring by the State, and appropriate funding of the system, this shift to managed care can be an opportunity to design a system of care that is committed to recovery and rehabilitation for individuals with psychiatric disabilities and eventually individuals with chronic substance abuse issues. This mandated change can also provide an opportunity to gain a level of uniformity of services throughout the state. However, a recovery-based system of care and equal access to services across the state cannot be accomplished without additional funding of both the Medicaid and non-Medicaid systems.

The Corporation's recommendations are focused on protecting vital consumer services and rights and ensuring that proper State monitoring and oversight is conducted of Request for Proposals (RFPs), contracts, implementation and the actual experiences of members of both the Pre-Paid managed care plans and the HMOs.

As the Corporation found by reviewing the side by side analysis conducted by Health Management Associates, the current existing contracts for the Pre-Paid Plans and the HMOs in Area 6 are very similar, lengthy and prescriptive.

The Corporation regards its recommendations as means to the goals articulated for the workgroup by Celeste Putnam, Deputy Secretary of Substance Abuse and Mental Health, DCF, on Friday, July 23. Ms. Putnam said that DCF wants to work with all providers and plans so that there is no differentiation between the care and services the consumers and families receive, regardless of which agency is paying for the services. DCF is looking for a full partnership (as required by law) with AHCA on the shift of the entire Medicaid behavioral healthcare system to managed care. Ms. Putnam said that DCF is interested in performance measures for the system such as: penetration rate, access to care, satisfaction with services, functional improvement, functioning in school (days in school, dropout rate, and linkages), employment (competitive employment, days at work, unemployment), days in the community, quality of housing, access and integration with physical healthcare, the usage rate of Crisis Stabilization Unit (CSU) beds and the eventual statewide use of personal outcome measures (currently being piloted in DCF District 8).

During its three days of meetings, the Ad Hoc Committee received information that should be disseminated to the public. This information may found in the section entitled, *Findings*, at the end of this report.

At its August meeting, the Corporation received a draft report from the Ad Hoc Committee on Managed Behavioral Healthcare. Even though the Corporation requested that AHCA refrain from implementation of behavioral managed healthcare until it has had an opportunity to present

its report to the Legislature and Governor, AHCA is proceeding with implementation of the two models of managed care throughout the state.

At the recommendation of the Ad Hoc Committee on Behavioral Managed Care, and with the agreement of the Corporation, Dr. Lewis appointed another Ad Hoc Committee of the Corporation on data. The Committee is to review and study what data is currently being collected, by which agency, for what purpose, and who has access to that data. The Committee also is to determine what reports are being produced and who receives those reports. Finally, the Committee is to determine whether appropriate data is being collected. The Ad Hoc Committee on Data will facilitate a workgroup of diverse stakeholders, including state agencies, to make recommendations to the full Corporation in December.

The Corporation made the following preliminary recommendations in an attempt to guide AHCA and DCF in the planning and implementation phase of behavioral managed healthcare. DCF and AHCA have to be equally responsible for the access to services for adults and children in the targeted population served by the HMOs, the Pre-Paid Plans and the General Revenue funded system.

System expectations and management must be established before implementation and enrollment begins. DCF and AHCA also must provide leadership to the managed care plans in identifying what kinds of linkages they will need to create with other community providers to help create a more integrated system of care.

The Corporation hopes that its recommendations on behavioral managed healthcare will result in new ways of doing business that position consumers and families for success, now and into the future.

Preliminary Recommendations of the Corporation on Behavioral Managed Care

The Corporation made the following recommendations:

1. The State's (AHCA and DCF) expectations of the managed care plans need to be clearly articulated. The expectations should be realistic and developed in collaboration with all stakeholders.
2. Before managed healthcare is approved by the Legislature for HomeSafeNet children and substance abuse treatment services and then implemented by AHCA and DCF, the Corporation should be consulted and asked for recommendations.
3. The Corporation recommends that HMOs inform their members of all changes and advise them in writing of their right to disenroll in the behavioral healthcare component if their behavioral healthcare providers are not part of the HMO network. DCF and AHCA can assist by widely publishing definitions of good cause disenrollment criteria and explaining them to consumers and families. DCF and AHCA may contract with consumer and family organizations to assist with the dissemination of information regarding managed behavioral healthcare options.

4. The Corporation is concerned that people might be disenrolled too easily or quickly because of non-compliance or because of their behavior. Therefore, the Corporation recommends that the Pre-Paid contract language mirror the HMO language which, although seemingly more permissive, requires AHCA's approval to disenroll an individual. (Please see the side-by-side analysis of the contracts, commissioned by the Corporation. The analysis is available at the Corporation's website: www.samhcorp.org.)
5. A list of Medicaid providers needs to be made available as soon as possible to the HMOs and the Pre-Paid Plans, so that they may begin to contact existing Medicaid providers.
6. To promote the concept of recovery and rehabilitation, AHCA, DCF, the Pre-Paid Plans and the HMOs need to include consumers and families in the development of the general concepts of the RFPs, appeals process, peer choice counseling and grievance procedures. Consumers and families must feel empowered and included in the treatment planning process as well.
7. The Corporation recommends the contracts for both the Pre-Paid Plans and HMOs include the requirement that the Governing Boards of those entities include individuals in recovery with a severe persistent mental illness and/or a family member of a child with a severe emotional disturbance.
8. The Corporation recommends that Medicaid managed care advisory committees for behavioral healthcare be established in all districts and that all relevant stakeholders be represented, including consumers, families, advocacy groups, providers, DCF, Department of Juvenile Justice (DJJ), AHCA and managed care representatives. This oversight function is critical in identifying what is happening in the community related to access and barriers to care, payment issues and systems issues. DCF and AHCA to ensure that the committees do not duplicate already existing local community planning committees must establish guidelines for the advisory committees.
9. The Corporation recommends the use of consumer run services, including drop-in centers and clubhouses (when appropriate using the International Center for Clubhouse – ICCD – accreditation, www.iccd.org).
10. The Corporation encourages the use of psychiatric care advance directives and suggests that managed care contracts require that information on psychiatric advance directives, which is available from the Advocacy Center for Persons with Disabilities, be provided to Pre-Paid Plans and HMO members.
11. The Corporation recommends that AHCA prioritize the submission of a Customer Service Request (CSR) to allow access to pharmacy data for the managed care plans.
12. The Corporation recommends the State find a better method than simple utilization rates to determine capitation rates because of the variances in the utilization, penetration, and capitation rates throughout the state. The Corporation recommends that AHCA ensure that rates are risk adjusted based on the characteristics and use rates of the individual. The

Corporation recommends that AHCA begin to look at normalizing the use portion by eligibility and other characteristics of the capitation rate across geographic areas to promote equal access care across the state.

13. The Corporation recommends that the State contract with an experienced and qualified actuarial company to conduct a sound rate study. This study should be completed as soon as possible.
14. The Corporation recommends that the capitation rates across the state be made more equitable, through planned expansion with predictable and managed expenditures each year. The Corporation notes that many states around the country have invested some of the savings garnered from managed care back into the system of care to strengthen recovery-based services.
15. The Corporation recommends a planned phase-in, which provides that increases in the capitation rates be used for more investment in the system to promote recovery based services, access to less restrictive crisis services, supportive employment and supportive housing.
16. The Corporation recommends that increases in the capitation rates be used for more aggressive outreach to ensure that individuals who need behavioral healthcare receive it. This would result in promoting greater access to care and helping to preserve the State's behavioral healthcare safety net system.
17. The Corporation recommends that AHCA seek to maximize federal Medicaid funding for recovery services since the current Medicaid services still remain more clinically and medically model-based. This would promote more recovery-based services in the system of care.
18. The Corporation recommends that AHCA seek to maximize federal Medicaid funding for substance abuse treatment services, particularly for individuals with co-occurring disorders (mental illness and substance abuse) and for children. The State of Florida (DCF) received a Robert Wood Johnson Foundation grant to work on this issue.
19. The Corporation recommends that standard performance measures, standard encounter data, standard functional assessments and standard satisfaction surveys be utilized for DCF funded providers, the Pre-Paid Plans and the HMOs.
20. The Corporation recommends that DCF be involved in the development of RFPs, selection of the contractor, readiness reviews and monitoring of contracts. The Corporation requests a report on the progress of the DCF/AHCA interagency taskforce at each of its upcoming meetings. The report should include information regarding collaboration between DCF and AHCA and the involvement of stakeholders in the process.
21. The Corporation recommends that DCF district staff be utilized for readiness reviews and monitoring visits.

22. The Corporation recommends that the existing memorandum of agreement (MOA) between DCF and ACHA, written in a fee-for-service environment, be amended to reflect the current changes to identify the roles of AHCA and DCF in co-managing the behavioral healthcare system.
23. The MOA must be amended immediately so that stakeholders and the managed care plans will know and understand what the expectations are for Medicaid covered services, Non-Medicaid covered services and the linkages and access for the HMO and Pre-Paid members to the General Revenue funded system. The Corporation requests a follow up report on the progress of these discussions at its December meeting.
24. The Corporation recommends that the readiness reviews be made public so that all stakeholders can assess the readiness of any particular network and be able to provide feedback to the appropriate agencies.
25. The Corporation recommends and encourages further discussion about linkages between the Pre-Paid Plans, the HMOs, and other community and state providers such as schools, state hospitals, substance abuse treatment providers, homeless shelters, local hospitals, child residential treatment centers, the criminal and civil court system and clerks of the court.
26. These linkages should focus on the goal of restoring Medicaid eligibility as quickly and smoothly as possible after an interruption of eligibility.
27. The Corporation recommends for tracing purposes that behavioral healthcare Medicaid dollars be kept separate and distinct from the physical healthcare Medicaid dollars under the HMO contracts and that DCF and AHCA be able to track and report on the expenditure of those Medicaid behavioral healthcare dollars.
28. The Corporation recommends that DCF and AHCA monitor the use of CSU beds to ensure that indigent patients are not displaced by Pre-Paid Plan or HMO members. The Corporation recommends that the HMO contracts have the same ratio of 2:1 for CSU bed usage as the Pre-Paid Plans. CSU beds may be used as a downward substitution for inpatient psychiatric care when determined medically appropriate.
29. The language in the Pre-Paid Plan and the HMO contracts regarding emergency services varies slightly. The Corporation recommends that the Pre-Paid Plan language be used in the HMO contract. (Please see the side-by-side analysis of the contracts, commissioned by the Corporation. The analysis is available at the Corporation's website: www.samhcorp.org.)
30. The Corporation recommends the State refrain from imposing protocols that have definitions and methodologies that could be used to inappropriately deny care. However, the Corporation does not intend to prevent the statewide use of evidence-based appropriate protocols, including the medication algorithm protocols being piloted in DCF District 1.

31. The Corporation recommends that readiness reviews relative to capacity and standards of care be very specific and provide access to the full continuum of care that the plan provides to beneficiaries. The Corporation requests regular updates regarding the readiness reviews.
32. The Corporation recommends that the implementation of the Medicaid Encounter Data System, which is required by the federal government, be accelerated by AHCA. AHCA informed the Committee that the agency requested an annual appropriation of \$5 million to implement the encounter data system. If the encounter data system is not implemented, federal Medicaid funds could be jeopardized.
33. The Corporation recommends a baseline set of utilization measures be established and closely monitored by DCF and AHCA.
34. The Corporation recommends that the HMOs and the Pre-Paid Plans have the ability to negotiate freely with panels of providers.

Findings of the Ad Hoc Committee on Behavioral Managed Care

The Ad Hoc Committee on Behavioral Managed Care gained extensive information regarding the State of Florida's implementation plans and readiness for managed behavioral healthcare. The Committee presented the following findings to the Corporation:

1. Last year AHCA requested five new positions to assist current AHCA staff in managing and monitoring the Pre-Paid Plans, but received no additional positions. Currently, AHCA has three staff persons working on the pre-paid behavioral managed care roll out.
2. The AHCA HMO monitoring contract staff has two vacancies. There is a plan to fill those positions with individuals who have behavioral healthcare clinical backgrounds.
3. The HMOs and the Pre-Paid Plans will be directed from two separate and distinct programs of AHCA.
4. Bob Maryanski, Bureau chief for Medicaid Services, AHCA, laid out the following tentative implementation schedule and indicated that may it be subject to change:
 - a. The procurement document (the RFP) will be available November 1, 2004 for Areas 5 and 7 (St. Petersburg and Orlando). A readiness review, implementation, and enrollment would take place approximately six months later – April 1, 2005.
 - b. RFP will be available April 1, 2005 for Area 11 (Miami/Dade)
 - c. RFP will be available August 1, 2005 for Areas 2, 3 and 4 (Tallahassee, Jacksonville, and Gainesville).
 - d. RRP will be available January 1, 2006 for Areas 8, 9, 10 (Ft. Lauderdale, Ft. Myers, and Palm Beach).

5. Several steps are required before HMOs may start providing behavioral healthcare services to their members: (1) capitation rates must be approved by the federal government; (2) contract amendments must be approved; (3) a 10-page readiness review must be completed by AHCA and DCF; and (4) provider networks must be approved.
6. Funding for the Medicaid Options program, used to educate Medicaid beneficiaries about their managed care choices for both physical and behavioral healthcare, has been reduced from \$14 million to \$7 million over the last several years. However, involuntary placement/enrollment, which occurs when a beneficiary does not exercise his/her choice, has not increased despite the reduction in funding. AHCA is now researching the Committee's question regarding the percentage of involuntary enrollees that have psychiatric disabilities.
7. During the 2004 Legislature, AHCA's Medicaid behavioral healthcare budget was reduced by \$26 million (providing funding for 91 percent of past Medicaid expenditures for mental health services). Therefore, the HMOs and the Pre-Paid Plans are not going to have available funds to allow investment in the publicly funded behavioral healthcare system that is already under-funded.
8. The current safety net providers -- including community mental health centers, local hospitals and the CSUs -- need all of their current sources of funding to make the safety net system function.
9. AHCA informed the Ad Hoc Committee that it would require the managed care plans operating in urban areas for individuals with severe and persistent mental illness and children with severe emotional disturbance to provide access to a psychiatrist within a 30 minute drive-time instead the current 60 minutes allowed in the contracts.
10. AHCA informed the Ad Hoc Committee that the 80 percent medical loss ratio for behavioral healthcare for the HMO plans does not include the Medicaid codes of inpatient hospital, outpatient hospital and physician services, but includes only targeted case management and Medicaid community mental health center services. For the Pre-Paid Plans, the 80 percent medical loss ratio will include inpatient hospital, outpatient hospital, physician services, targeted case management and Medicaid community mental health services.
11. The Ad Hoc Committee believes that because of the eight-year pilot that took place in Area 6, negative and positive outcomes in the FMHI Data should be carefully considered.
12. Wellcare and Amerigroup, two of the HMOs operating in Florida, already have current relationships with approximately two-thirds of the community mental health centers.
13. Hospital emergency rooms are already under stress and are part of the public safety net. Emergency rooms are frequently holding individuals because there is no available bed at a CSU. The 2004 Legislature appropriated an additional \$20 million for CSU beds which should help alleviate the problem to some extent.

14. The Florida Hospital Association (FHA) expressed concern about prompt payment, best efforts for determination of eligibility and retrospective denials for Medicaid beneficiaries. During the 2004 Legislature, the FHA sought to redefine an emergency (Fl. Statute 641). FHA will follow up by providing the Corporation with additional information and the new language.
15. In a report entitled *Road Map to Excellence in Contracting*, the Executive Office of the Governor in June 2003 documented that in almost 500 audits of seven state agencies, controls over contracting are in a state of disorder. The majority of problems identified by auditors fall into three core activities: performance monitoring, procurement methodology, and contract writing.
16. It is probable that the Pre-Paid Plans will have more members that have a more severe level of psychiatric disability. The Committee expressed concern about the potential impact upon the Prepaid Plans.
17. Both the HMOs and the Pre-Paid Plans requested access to a list of the existing Medicaid providers from AHCA so they may begin to contact them. If contact is established early in the process, it is more likely that providers currently serving Medicaid beneficiaries for behavioral healthcare will be included in the managed care networks and there will be continuity of care for consumers and families.