

# Florida's Medicaid Reform Pilot Programs: Challenges with Mental Health Services

## Florida's Experience with

# MEDICAID REFORM

## Overview of Findings

*The unique flexibility of the reform pilots' managed care contracts may leave persons with mental illnesses without assurances of critical services.* In a broader sense, the state's contracting approach raises questions about where accountability lies for the services the state is purchasing.

*Without public discussion, the rules have changed governing the portion of mental health payments that managed care companies can spend on overhead and profits.* This change raises broader questions about the voice of policymakers and other stakeholders in critical administrative changes.

*Mental health providers in Broward and Duval counties report that Medicaid reform has resulted in significant new administrative burdens that divert time and financial resources away from delivering care.* These concerns echo those voiced previously by other providers.

## Introduction

As the Florida Legislature, other policymakers and the public track the Medicaid reform pilot programs operating in Broward, Duval and surrounding counties, it is important to assess how this unique managed care model works for some of the diverse populations affected by reform. One key population is persons with disabilities.

While offering the potential to improve quality if done right, there are fundamental challenges associated with using managed care to meet the needs of people with disabilities, such as those with mental illnesses. People with disabilities typically have conditions that are lifelong and require ongoing management and, therefore, tend to use more services and cost more than others. Thus, managed care, with its combination of capitated (per-person-per-month) payments and benefit limits, also has the potential to restrict access to necessary services. Additionally, the plans responsible for managing the care of those with disabilities may not have the expertise, or the capacity, to meet their needs.

This policy brief focuses on people with mental illnesses, who represent a large and important subgroup of the larger population participating in the Florida's Medicaid reform pilots. Because these individuals may be especially vulnerable if their health needs are not well managed, it is important to consider whether Medicaid reform has helped or hindered their access to quality, effective service-

## Key Findings

- Contract flexibility may put those with mental illness at risk.
- Contract rules regarding mental health have been changed without public input.
- Mental health providers report new administrative burdens.

es. But this population also offers a useful lens on the broader question of how well the reform pilots are working and whether the state is doing enough to ensure that public dollars are being spent effectively.

## Managed care and the challenges of mental illness

The treatment of serious mental illness is a modern-day success story. New and more effective treatment approaches that combine therapy and counseling, prescription drugs, case management and other services are quite successful in treating many people with serious mental illnesses, and supporting them in maintaining their recovery. For some individuals, "recovery" is the ability to live a fulfilling and productive life despite a disability. For others, "recovery" means the reduction or complete remission of symptoms.<sup>1</sup>

But the factors that make mental health treatment today "successful" – variable and highly customized treatment approaches, as well as ongoing, long-term support and case management – make it particularly difficult to administer through managed care.

Most managed care models were developed to serve healthy workers and their families who may occasionally suffer acute physical health conditions. Such conditions, whether illness or accident related, typically have a somewhat predictable course of treatment and a clearly defined endpoint.

### THE COMPLEXITIES OF MENTAL HEALTH CARE

A Jacksonville mental health care provider offers the case of "Alex" (not his real name) to illustrate the complexities of mental health care.

Alex is 11 years old. He has multiple mental health and behavioral issues. He is not eligible for any private insurance program. Medicaid is the sole funder of his health care.

Alex comes from a family with a long history of mental illness. He was born to a mother who abused drugs and alcohol while she was pregnant – including crack cocaine. This has led to developmental challenges for him.

Additionally, Alex started life with significant economic, social, and educational disadvantages. Before the age of two, he experienced extreme physical and sexual abuse.

Alex has been diagnosed with post-traumatic stress disorder, intermittent explosive disorder, reactive attachment disorder, and attention deficit hyperactivity disorder.

His behavior problems are severe. He requires weekly therapy sessions to learn social skills training if he is ever to be able to manage his own conditions. He also requires psychotropic medication to control flashbacks and to help him to manage his anger.

With proper care, Alex should be able to finish school and live independently.

The Jessie Ball duPont Fund has commissioned researchers from Georgetown University's Health Policy Institute to examine the impact of changes to Florida's Medicaid program in Broward and Duval counties. This policy brief is the fifth in a series and provides insight into how the changes have impacted those with disabilities, including individuals with mental illnesses.

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Effective mental health treatment, by contrast, requires a more individualized course of treatment and often involves ongoing long-term management. Failure to provide these ongoing services can lead to relapse, and declining health, which ultimately drives up health costs.

These challenges are exacerbated for Medicaid programs. Studies have indicated that low-income Medicaid beneficiaries in managed care programs tend to be poorer, have more health problems, and experience more access problems than low-income privately-insured individuals.<sup>2</sup> Further, their low-incomes may pose challenges in paying required co-pays and may limit their capacity to pay for non-covered services.

Managed care companies may be additionally challenged by the range and incidence of co-occurring chronic diseases (e.g., asthma, diabetes, heart disease, etc.) among those with mental illness. This population often requires far more extensive physical and mental health services than other enrollees, and managed care organizations may be required to deliver a variety of non-medical services that are not widely used by other populations. For example, some individuals with functional impairments may require mental health skills training, in which children and adults with mental illnesses work with skills trainers on specific, individualized treatment goals. Some may address various anger management skills and coping skills, or work with an individual who is suicidal to find ways to keep him/her safe. Such services typically are offered in community settings.

Provision of case management services further illustrates the clash that can sometimes occur between managed care systems and those with mental illnesses.

The complexity of treatment plans and the duration of treatment argue for careful case management to assure efficient and appropriate access to needed medical, social, educational, and other services. For example, many people with mental illness are stabilized through a pharmaceutical regimen. They see a psychiatrist on an occasional basis (such as once every six months), and they have intermittent need for other services. Some individuals may feel that they are at risk of relapse and need temporary access to therapy services, or they may need to participate in a partial hospitalization program—which is a treatment approach where individuals receive intensive outpatient services during the day, while avoiding the need for a costly inpatient stay. Case management is often the glue that holds together all of the various services a person receives.

But mental health providers in Duval and Broward counties told Georgetown University researchers they have experienced challenges both in initiating case management and sustaining case management.<sup>3</sup> In Duval County, providers reported that it is difficult to convince managed care organizations to authorize the use of case management. Providers perceived health plans as having a narrow, clinical orientation and not understanding the benefits of paying for case management services. In Broward County, provider challenges tended to be around sustainability of case-management services. Providers reported that managed care organizations did not seem to understand that this service would be needed on an ongoing basis. One provider indicated that his agency now uses fewer than half as many case managers as it did prior to reform, due to managed care organizations' reluctance to authorize use of case management services.

## Do Florida's managed care contracts adequately assure accountability?

Medicaid managed care programs seek to improve access to appropriate providers and services and increase accountability by establishing legally binding relationships with managed care organizations. A widespread view is that under fee-for-service systems, individuals are free to select any health care provider who will serve them, but no one is responsible for actively managing their care, leading to over-use and duplication of services and waste. Under managed care, managed care organizations are responsible for ensuring all of their enrollees receive adequate and appropriate services.

### Pilot Program Model Contract Falls Short in Areas of Critical Importance

**Crisis Services:** State's model contract lacks specificity regarding which types of crisis services must be covered. For example, there is no requirement that plans provide for walk-in crisis services or mobile outreach crisis services.

**Adequate Provider Networks:** State's model contract requires each managed care organization to have one certified adult psychiatrist and one child psychiatrist. This may be inadequate for plans with large enrollments, such as HealthEase in Duval County, which had 35,242 enrollees in March 2008.

**Mental Health Treatment Guidelines:** State's model contract contains no requirement for plans to provide services consistent with national or international mental health treatment guidelines.

**Enrollee Safeguards:** State's model contract does not include key safeguards for persons with mental illnesses, such as special protections to ensure alcohol or substance abuse treatment data are not improperly disclosed.

**Prescription Drugs:** State's model contract contains incomplete protections to ensure continued access to medications in emergencies and on discharge from an inpatient or residential facility. For example, there is no requirement to ensure that individuals discharged from an inpatient treatment setting are provided a small quantity of drugs on discharge to prevent against treatment interruptions.

*Examples cited are illustrative examples only. Additional information on this comparison can be found at [hpi.georgetown.edu/floridamedicaid](http://hpi.georgetown.edu/floridamedicaid)*

In theory, managed care organizations expand access by negotiating with providers, ensuring that clients receive the appropriate level of care, minimizing more costly services through prevention strategies, and eliminating over-use of services. (The cost-effectiveness of managed care for people with extensive needs remains subject to controversy. Moreover, studies of the cost-effectiveness of managed care programs for people with disabilities and chronic conditions are limited and merit further analysis.<sup>4</sup>)

The primary tool for ensuring accountability – in other words, ensuring that the managed care organization delivers on its promises to provide efficient and appropriate care – is the contract between the state and the managed care organization.

Generally, Medicaid managed care programs define a set of covered benefits and responsibilities for all managed care organizations serving Medicaid beneficiaries. The state seeks to ensure that the organizations live up to their contractual responsibilities. A key lesson of Medicaid managed care contracting in other states has been that specificity is critical.<sup>5,6</sup> A state cannot hold a managed care organization

or other entity accountable for providing a specific service or performing a specific function unless the contract clearly defines this responsibility.

Florida's Medicaid reform pilots, however, have taken a different approach to contracting.

In the reform pilots, Florida has relied on two types of managed care organizations to provide care – provider-sponsored networks (PSNs) and for-profit health maintenance organizations (HMOs). The state has provided “model contracts” for these organizations to follow, but has given the organizations discretion to vary benefits and has placed comparatively few specific requirements into the organizational contracts.

These model contracts also appear to fall short in defining levels of care for mental health services.

Georgetown researchers compared the model contract that the state uses with model purchasing specifications developed for the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) by researchers at George Washington University.<sup>7</sup> These specifications were developed to help states and other purchasers do a better job of defining managed care organizations' contractual responsibilities with respect to mental health services.

Researchers examined five topics of critical importance to persons with mental illnesses (see box on page 2).<sup>8</sup> The review shows that the pilot program model

contract permits managed care organizations to cover a broad range of behavioral health services, but contains insufficient requirements to ensure that they cover the full scope of services, or to ensure that they cover these services in adequate amounts.

In a broader sense, the variability of contracting details raises questions about accountability.

The underlying theory of Medicaid reform was that beneficiaries would choose the managed care organization that best met their needs, and that market competition would effectively punish those organizations that underperformed.

A consequence of this approach, however, is that the state has not fully used the contract tool to ensure accountability for providing the full scope of services that Medicaid beneficiaries need.

The discretion given these organizations to decide, for example, which behavioral health services to cover and in what amounts, can create confusion when individuals are denied services. Beneficiaries select plans without full knowledge of the plan's coverage policies, preauthorization requirements, and other information. This hands-off approach also does not ensure that the state is maximizing value for public dollars spent.

## Are public dollars appropriately directed toward provision of services?

Even before the Medicaid pilots were initiated, there was concern that excessive overhead and administrative costs under managed care could take public dollars away from paying for critical mental health services. Florida state law established a requirement called the "80:20 rule" to ensure that Medicaid spending on mental health is used primarily to deliver services.<sup>9</sup> The law requires Medicaid managed care organizations to spend at least 80 percent of their mental health payments on direct services. If overhead and administrative costs exceed 20 percent of the mental health payment, the managed care organization must return the excess overhead and administrative costs to the state. The state has recouped money from insurers that have not satisfied this requirement.<sup>10</sup>

The 80:20 rule has been controversial and there have been efforts to eliminate this requirement in the Florida Legislature. In May 2007, Governor Crist vetoed legislation that would have repealed the 80:20 rule. His veto letter stated that repeal would eliminate a very effective tool, "thereby obfuscating transparency and accountability in the Medicaid program."<sup>11</sup>

In the context of the pilot program, however, it appears that the 80:20 rule is not inviolate.

Managed care model contracts published in January 2007 included a requirement that managed care organizations comply with the 80:20 rule. In October 2007, however, model contracts contained no such requirement.<sup>12</sup>

Officials at the Agency for Health Care Administration have stated that the statute authorizing the reform pilots does not direct them to include the 80:20 requirement.<sup>13</sup>

Various stakeholders in Florida who have been monitoring the pilot programs were unaware of the various changes to contract requirements. They noted that the state's contract materials showing changes from the previous contract did not address the 80:20 rule. This raises broader questions about the transparency of state actions, and whether or not other significant policy changes are being put into effect without public awareness and input.

## How has reform affected mental health providers?

None of the providers interviewed indicated they thought the Medicaid reform pilots have improved the delivery of mental health services. "The state seems to be managing to the lowest common denominator," said one. "They send money to MCOS [managed care organizations] ... they offer loose contracts ... and they see what happens."

Indeed, providers indicated that the pilot program has greatly increased time spent on administrative activities, limiting time and financial resources for direct patient care. In particular, the abundance of managed care organizations (as many as 15 in Broward) has increased the administrative burden, as providers must comply with varied and competing rules.

"The process for getting services authorized is horrendous," said one provider. "We have staff people who have to spend 45 minutes on the phone working on a single authorization, and if they turn us down and the doctor needs to call, she/he needs to go through the same material."

Providers also voiced concerns about not getting paid promptly by managed care organizations. One provider said, "I know of one organization whose revenue fell by \$2 million in one year after reform began." Another provider pointed out that, "smaller provider agencies may have over a million dollars in receivables, and when they cannot get paid in a timely manner, it threatens the viability of their business."

These challenges prompted several providers to express concern about reductions in care. Administrative and payment burden, they theorized, may prompt some providers to simply stop treating Medicaid beneficiaries.

Concerns about paperwork burdens, inadequate reimbursement, and limits on access to care echo findings from a physician survey conducted last year and reported in the Medicaid Briefing Paper of May 2007.<sup>14</sup>

## What improvements could be made?

The transition to Medicaid reform has not been smooth for many individuals with mental illnesses and the providers who serve them. Some of these challenges are transitional and will be resolved over time. Questions remain, however, over whether the model of managed care employed in the pilot program will lead to an accountable, efficient, and high quality system for providing mental health services. Going forward, state policymakers may wish to consider the following issues:

**Ensure adequate funding.** Policymakers are often reluctant to acknowledge the possibility that their state is not spending enough on mental health services to meet community needs and ensure high quality care. Florida starts out with a poorly funded mental health system. It ranked in the middle (20<sup>th</sup>) of the states (including the District of Columbia) on the basis of per capita income in 2005,<sup>15</sup> but it ranked near the bottom of states (48<sup>th</sup>) in per person spending on mental health services.<sup>16</sup> Thus, Florida's investment in mental health services falls below that of most other states.

**Restore the 80:20 requirement for reform plans.** Administrative actions to exempt reform managed care organizations from spending at least 80 percent of their mental health payments on direct services creates an uneven playing field between reform and non-reform counties. Given the Governor's position that this requirement is an effective tool for achieving accountability, and given concerns over adequate resources, it is important for the state to use all of its available tools to maximize the effectiveness of public resources.

**Develop specialized programs for persons with serious mental illnesses.**

Outside of the pilots, the state has experimented with various prepaid behav-

ioral health programs. Though Georgetown researchers have not analyzed the success or merits of these initiatives, they may provide a path to improving mental health services. One option would be to have reform managed care organizations continue to provide behavioral health services to most enrollees, but for the state to serve beneficiaries with serious mental illnesses in specialized plans that are better equipped to meet their needs.

**Enhance the role of the Department of Children and Families.** Federal law requires states to operate their Medicaid programs through a single state agency, but permits states to assign significant responsibilities to other agencies, as long as the Medicaid agency is ultimately responsible for setting policy and adjudicating complaints from beneficiaries and contractors. The Department of Children and Families (DCF) is the state agency with lead responsibility for mental health policy. State policymakers may wish to explore opportunities for strengthening coordination between AHCA and DCF so that AHCA can benefit from the specialized mental health expertise that exists within DCF.

## Conclusion

People with disabilities and chronic conditions, including persons with mental illnesses, present challenges for managed care organizations. It appears that the complexities of delivering evidence-based, recovery-oriented mental health services were not fully considered when state officials developed the Medicaid reform pilot program. This review suggests that the state may need to take a more active role in ensuring that Medicaid beneficiaries receive the types and level of mental health services they need.

Policymakers have options beyond the pilots and a completely unmanaged fee-for-service financing system. Florida should be encouraged to seek increased accountability within Medicaid, even as challenges to fund mental health services adequately and improve capacity to provide services continue.

## ENDNOTES

<sup>1</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. DHHS Pub. No. SMA-03-3932. Rockville, MD: 2003. Available at [www.mentalhealthcommission.gov/reports/reports.htm](http://www.mentalhealthcommission.gov/reports/reports.htm).

<sup>2</sup> Lillie-Blanton, M. and Lyons, B. "Managed Care and Low-Income Populations: Recent State Experiences," *Health Affairs*, (17) 1998. Note: This study involved a five-state survey including Florida, Minnesota, Oregon, Tennessee, and Texas.

<sup>3</sup> Georgetown researchers interviewed numerous stakeholders, including representatives of six major mental health agencies operating in Broward and Duval counties that collectively serve well over half of Medicaid enrollees with mental illnesses participating in the pilots.

<sup>4</sup> See, for example, the limited number of studies on SSI and related populations in *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies*, prepared by the Lewin Group for America's Health Insurance Plans, July 2004.

<sup>5</sup> HHS Office of the Inspector General, January 2000.

<sup>6</sup> Rosenbaum, S., Wilenski, S., Shin, P., and Whittington, R. *Managed Care and Medi-Cal Beneficiaries with Disabilities: Assessing Current State Practices in a Changing Federal Policy Environment*, Department of Health Policy, School of Public Health and Health Services, George Washington University for the California Endowment, June 2006.

<sup>7</sup> The Medicaid Reform Health Plan Model Contract, 2006-2009 (October 2007) can be accessed at

[www.fdhc.state.fl.us/Medicaid/medicaid\\_reform/provider/draftcontracts.shtml](http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/provider/draftcontracts.shtml) and *Optional Purchasing Specifications: Adults with Behavioral Health Needs*, George Washington University School of Public Health and Health Services, under contract with the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), 2001, is available at [www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/newsps/adultbhs/](http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/newsps/adultbhs/).

<sup>8</sup> Examples cited are illustrative examples only. They do not represent a comprehensive comparison of the model contract with the model purchasing specifications. Additional information on this analysis can be found at [www.hpi.georgetown.edu/floridamedicaid](http://www.hpi.georgetown.edu/floridamedicaid)

<sup>9</sup> Fla. Stat. § 409.912(4)(b)

<sup>10</sup> For example, In May 2007, Amerigroup Florida paid a \$5.3 million settlement to the state for failing to comply with the 80:20 rule. In 2006, WellCare Health Plans and UnitedHealthcare each paid the state more than \$1 million for failing to spend enough on direct mental health services. Dolinski, C. and Gentry, C. "Crist Veto Pulls Plug on HMO Proposals, *Tampa Tribune*, May 26, 2007

<sup>11</sup> Veto letter from Governor Charlie Crist to Secretary of State Kurt S. Browning dated May 24, 2007.

<sup>12</sup> See Section VI. Behavioral Health Care, Q. Community Behavioral Health Services Annual 80/20 Expenditure Report in Medicaid Reform DRAFT Model Capitated Health Plan Contract, January 2007 (2006-2009), available at [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/provider/prepaid\\_medicaid\\_reform\\_health\\_plan\\_contract\\_013107.pdf](http://ahca.myflorida.com/Medicaid/medicaid_reform/provider/prepaid_medicaid_reform_health_plan_contract_013107.pdf) and compare to Medicaid Reform Health Plan Model Contract, October 2007 (2006-2009), available at [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/provider/medicaid\\_reform\\_capitated\\_health\\_plan\\_contract\\_october\\_2007.pdf](http://ahca.myflorida.com/Medicaid/medicaid_reform/provider/medicaid_reform_capitated_health_plan_contract_october_2007.pdf) wherein the Community Behavioral Health Services Annual 80/20 Expenditure Report has been deleted from the October 2007 contract.

<sup>13</sup> In the spring of 2008, ACHA posted Medicaid reform contract amendments to its website (dated 03/14/08). Item #50, on page 9, of General Amendment 1 made it appear that the state was reinstating the 80:20 rule for the pilot program. This is not the case. Follow-up email correspondence from Dyke Snipes, Deputy Secretary for Medicaid, on May 19, 2008, stated that General Amendment 2 removes the 80:20 rule from applying to the pilot program.

<sup>14</sup> See Alker, J and Hoadley, J. *Waving Cautionary Flags: Initial Reactions from doctors and patients to Florida's Medicaid Changes Jesse Ball DuPont Fund*, May 2007. Available at [hpi.georgetown.edu/floridamedicaid](http://hpi.georgetown.edu/floridamedicaid).

<sup>15</sup> *Personal Income Per Capita in Current Dollars, 2005*, 2008 Statistical Abstract, U.S. Census Bureau, available at <http://www.census.gov/compendia/statab/ranks/rank29.htm>.

<sup>16</sup> FY 2005 State Mental Health Revenue and Expenditures Study, National Association of State Mental Health Program Directors Research Institute, November 2007, available at: <http://www.nri-inc.org/projects/Profiles/RevenuesExpenditures.cfm>.

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It may be found online at [www.dupontfund.org](http://www.dupontfund.org) and at [hpi.georgetown.edu/floridamedicaid](http://hpi.georgetown.edu/floridamedicaid)



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