Access, Integration and Quality of Care for Individuals with Serious Mental Health Challenges Enrolled in Florida's Managed Medical Assistance Program

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List of Abbreviations Used in the Report

AHCA – Agency for Health Care Administration

CSHCN – Children with special health care needs

CMS – Centers for Medicare and Medicaid Services

COS – Community Outreach Specialist

DCF – Department of Children and Families

FQHC – Federally Qualified Health Center

HCFA – Health Care Financing Administration

HEDIS – Healthcare Effectiveness Data and Information Set

HMO – Health Maintenance Organization

HPSA – Health Professional Shortage Area

LTC – Long-term Care

MediPass – Medicaid Physician Access System

MCO – Managed Care Organization

MMA – Managed Medical Assistance

NCQA – National Committee for Quality Assurance

PCMH – Patient Centered Medical Home

PCP – Primary Care Provider

PMHP – Prepaid Mental Health Plan

PSM - Propensity Score Matching

PSN – Provider Service Network

SBIRT – Screening, Brief Intervention, and Referral to Treatment

SMMC – Statewide Medicaid Managed Care

SMI – Serious Mental Illness

Executive Summary

This study evaluates access to health care, the coordination of physical and behavioral health services, and quality of care for individuals with serious mental illness (SMI) who are enrolled in Florida's Managed Medical Assistance (MMA) program. A primary objective was to compare operations and impacts of the SMI Specialty plan operated by Magellan Complete Care with Standard MMA plans that serve enrollees with SMI.

The report begins with a brief literature review that summarizes the research on care coordination, which is a required benefit in all MMA plans. The review defines care coordination, discusses implementation challenges, and summarizes the literature about its importance for individuals with SMI. The next section provides background information on Medicaid programs, both at the national and Florida levels, and concludes with a description of the MMA program.

The report examines whether there are differences between the SMI Specialty plan and Standard plans in terms of their service delivery strategies and the perspectives of their enrollees with regard to access, quality, and integration of care. The data sources for this study included provider and enrollee handbooks and the expanded benefits lists for the SMI Specialty plan and the Standard plans and interviews with key informants, such as MMA plan administrators, network providers, and enrollees. In the review of member handbooks, no meaningful differences were found between the information provided in the member handbooks of the Standard plans and the SMI Specialty plan in terms of the level of detail about enrollee benefits or care coordination. The Magellan Complete Care handbook was assessed to be slightly more detailed in terms of its descriptions of behavioral health services compared to most Standard plan handbooks. The Amerigroup and SMI Specialty plan provider handbooks included more comprehensive information on covered services compared to the other Standard plan provider handbooks examined. Although there was some variability in terms of the specificity of information on care coordination services, no meaningful differences were noted in this domain between (or among) the Standard plans and the SMI Specialty plan.

The findings from the interviews with administrators and providers identified common structural arrangements and contractual requirements across the Standard plans and the SMI Specialty plan. Differences emerged regarding the use of organizational strategies that promote care coordination between the Standard plans that subcontract rather than directly administer behavioral health services. From the perspective of provider respondents, the SMI Specialty plan is perceived as the most useful

plan for serving individuals with SMI because of its engagement and outreach with providers and enrollees. No major differences were identified between the SMI Specialty plan and Standard plans in quality assurance programs or in strategies that promote care coordination. There is some variability across plans in their communication strategies and resources. The SMI Specialty plan has a more comprehensive approach to communicating with and engaging new enrollees. Providers respond favorably to the use of provider relations specialists who are assigned to specific providers, and believe that the SMI Specialty plan has more useful communication strategies than the Standard plans. The enrollee focus groups identified both strengths and challenges with all plans. Many strengths were expressed by enrollees regarding the SMI Specialty plan including transportation, access to dental care, assistance with making appointments, and effective communication mechanisms.

The final section includes both descriptive and multivariate analyses to describe the SMI population and make comparisons between the SMI Specialty plan and Standard plans in terms of program quality and enrollees' access to care, service use, and outcomes. The treatment group included all Medicaid recipients who were initially enrolled in (or assigned to) the SMI Specialty plan and stayed at least 60 days. Recipients who initially enrolled in the SMI Specialty plan but switched to a Standard plan and remained enrolled for at least 60 days in that plan comprised the comparison group. Significant differences in gender, race, age, AHCA region, and diagnoses were found between SMI Specialty plan enrollees and Standard plan enrollees. Women, young (<18) and older (>39) enrollees, and Hispanic enrollees were all more likely to switch to a Standard plan. Annualized total payments by the plans to providers were greater for enrollees in the SMI Specialty plan ($7,658 versus $5,452) but annualized units of service did not differ significantly. Among mental health services, recipients enrolled in the SMI Specialty plan received more services and payments were also greater. Among physical health services, units of service were greater for enrollees with SMI in the Standard plans and total payments were greater among enrollees in the SMI Specialty plan.

Outcomes were also examined. Recipients who remained enrolled in the SMI Specialty Plan were more likely to have a Baker Act examination, psychiatric inpatient, and juvenile justice involvement (age <18). Rates of psychiatric inpatient use and juvenile justice involvement were more than twice as high among SMI Specialty Plan enrollees. The combination of higher mental health service use and poorer outcomes suggests that the functioning of Medicaid recipients who remained enrolled in the SMI Specialty Plan was very different than recipients with SMI who switched to a Standard plan. Recipients who remained enrolled in the SMI Specialty plan apparently had much poorer mental health functioning and more complex needs.

Introduction

Purpose

The purpose of this study was to evaluate access to health care, the coordination of physical and behavioral health services, and quality of care for individuals with serious mental illness (SMI) who are enrolled in Florida's Managed Medical Assistance (MMA) program. A primary objective was to compare operations and impacts of the SMI Specialty plan operated by Magellan Complete Care with the Standard MMA plans that also serve enrollees with SMI. This report begins with a brief literature review that summarizes the research on care coordination, which is a required benefit in all MMA plans. The next section provides background information on Medicaid programs and the implementation of the Statewide Medicaid Managed Care (SMMC) program. The remaining sections describe the current study, including our research questions, methods, results, conclusions, and recommendations.

Literature Review

Our previous evaluation report on the implementation of the SMI Specialty plan provided an extensive summary of the research literature on the integration of physical and behavioral health services (Armstrong et al., 2015). For the current project, we supplemented this original review by examining literature focused on care coordination and case management, which are required benefits that are specified in the contract between the Agency for Health Care Administration (AHCA) and the health plans. Specifically, the contract states that health care plans must have "written policies and procedures that address components of effective behavioral health care coordination/case management including, but not limited to: anticipation, identification, monitoring, measurement, evaluation of enrollees' behavioral health needs, and effective action to promote quality of care" (AHCA, 2015, p. 78). In order to enhance understanding of these benefits, we will define care coordination and explain how it is implemented, and this will be followed by a review of SMI and a discussion of the importance of care coordination for this population.

Definition of Care Coordination

According to Au et al. (2011), care coordination does not have a single, consistent meaning across the medical, health services research, and disability literatures. In addition, many related terms are used interchangeably with care coordination, such as collaborative care, continuity of care, disease management, case management, care management, and care or patient navigation (Friedman et al.,

2016). Moreover, there are numerous models of care coordination that vary in terms of which services are coordinated, who coordinates care, how often services are coordinated, how information is exchanged between providers and care coordinators, and the involvement of patients and their families in decision making (Au et al., 2011). Despite these ambiguities, there are certain elements that are consistent across disciplines. As McDonald et al. (2007) report, care coordination typically involves the organization of patient care between two or more participants (including the patient) in order to facilitate the appropriate delivery of health care services. Organizing care involves a team-based approach that is often managed by the exchange of information among participants responsible for different aspects of care.

Care Coordination Implementation

McDonald et al. (2014) noted that there are nine activities that are necessary for achieving care coordination and include: (a) establishing accountability or negotiating responsibility; (b) communicating; (c) facilitating transitions; (d) assessing needs and goals; (e) creating a proactive plan of care; (f) monitoring, following up, and responding to change; (g) supporting self-management goals; (h) linking to community resources, and (i) aligning resources with patient and population needs. In order to accomplish these tasks, a collaborative team is created and typically includes a primary care provider, care coordinator (e.g., nurse, clinical social worker, or psychologist), and a psychiatric consultant (Unutzer, 2013). The team is responsible for tracking each patient's progress and adjusting treatment as needed. The care coordinator often has multiple job functions, including identifying patients in need of care coordination; outreach to patients by phone or mail; conducting face-to-face patient encounters; providing support to patients; collecting, managing, and exchanging patient data; supporting physicians; and backing up clinical and administrative staff (Friedman et al., 2016). Typical responsibilities also include physical and behavioral health screenings; patient engagement and education; close follow-up focusing on treatment adherence; treatment effectiveness, and treatment side effects; brief counseling using evidence-based techniques; regular review of all patients who are not improving as expected; facilitation of communication between the primary care provider and psychiatric consultant, and facilitation of referrals to and coordination with outside agencies (Unutzer et al., 2013).

Despite the care coordinator's awareness of what needs to happen, it is clear that there are many barriers to the effective implementation of care coordination. For example, collaborative care requires frequent communication between mental and physical health care teams, which is typically not reimbursed and requires a supportive communication infrastructure and added attention to HIPAA compliance (Morden et al., 2009). Friedman et al. (2016) noted that a lack of functionality with

information technology, challenges in identifying community resources, clinician or facility resistance, and patient lack of trust and inattention to self-care are all important barriers that need to be overcome before care coordination can be successful.

Serious Mental Illness

Serious mental illness has been operationally defined as a "diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified in DSM-IV [Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition] (APA [American Psychiatric Association], 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities" (SAMHSA, 2014). In 2013, an estimated 10 million adults (4.2% of the adult population) met the criteria for SMI (Crowley et al., 2015). Schizophrenia, major depression, and bipolar disorder are diagnostic categories that are often associated with SMI. Persons with SMI are more likely to have shortened life spans, issues with substance abuse, and physical comorbid conditions than the general population. Social issues such as homelessness and unemployment are disproportionately found in this population.

Care Coordination for the SMI Population

The importance of effective case management for individuals with SMI has been acknowledged for many years. In their review of research on case management, Mueser et al. (1998) reported that two approaches to case management (i.e., assertive community treatment and intensive case management) reduced time in the hospital, improved housing stability, and improved symptomatology and quality of life. Similarly, Friedman et al. (2016) reported that care coordination leads to reduced hospital admissions, improved quality of chronic disease management, improved patient satisfaction, and better access to specialty care. In addition to these positive outcomes, researchers have noted that care coordination is needed to eliminate the early mortality gap for individuals with SMI (Morden et al., 2009). Thus, it is clear that efforts to coordinate care are likely to improve the physical and behavioral health outcomes of the SMI population.

Background on Medicaid and Florida's SMMC Program

Medicaid: The National Context

In 1965, the Social Security Act was amended by the Federal Government to establish Medicaid and Medicare programs to provide health insurance for low-income children and their caretakers as well as for individuals who were elderly, blind, and disabled. Medicaid is an optional program for the States and is a cooperative venture jointly funded by the federal and state governments. The Federal

government established certain requirements for the State Medicaid programs but the States administer their own programs, determine the eligibility of applicants, provide mandatory services and decide which optional services to cover, set provider reimbursement rates, pay for a portion of the total program, and process claims.

Mandated services include, but are not limited to, physician services, inpatient and outpatient hospital services, laboratory and x-ray services, federally qualified health center and rural health clinic services, and transportation services. In addition, states have the option to cover a variety of additional services such as prescription drugs and rehabilitation services (Klees, Wolfe, & Curtis, 2009). Medicaid is the primary publicly financed health care program for low-income Americans who lack private health insurance and currently provides coverage to more than 62 million people, or 1 in 5 Americans (Kaiser Family Foundation, 2013).

State Medicaid programs are important payers for behavioral health services for individuals who are impoverished and/or who have disabilities (Buck, 2003; Mechanic, 2003). State Medicaid programs fund a range of inpatient, ambulatory, and emergency behavioral health services. In order to finance this array of services, states have increasingly leveraged state general revenue expenditures by matching them with federal funds to provide services to Medicaid recipients (Rowland, Garfield, & Elias, 2003). This leveraging strategy has expanded the resources available for the treatment of persons with behavioral health disorders. As a result of this financing strategy, Medicaid has become the single largest payer of behavioral health services in the nation accounting for 26% of these expenditures in 2009 (Substance Abuse and Mental Health Services Administration, 2013). As states continue to strive to provide efficient and effective public sector behavioral health services, Medicaid financing will continue to be a key component of this strategy to reduce the disabling effects associated with behavioral health disorders.

Nationally, federal and state Medicaid expenditures grew from $206 billion to $276 billion between fiscal years 2000 and 2003 (Holahan & Ghosh, 2005) and are projected to reach $854 billion by 2022 (Centers for Medicare & Medicaid Services, 2013). Increasing fiscal pressures were one factor associated with states beginning to experiment with managed care strategies within Medicaid in order to contain costs. Overall, managed care enrollment among Medicaid recipients has grown dramatically, from 23 million nationally in 2004 (Draper, Hurley, & Short, 2004) to 44.5 million in 2013 (Kaiser Family Foundation, 2015), an increase of 91%. Today, almost every state mandates managed care enrollment for some portion of its Medicaid population. In fact, in 2013, 71.7% of all Medicaid recipients nationally were enrolled in some form of managed care (Kaiser Family Foundation, 2015).

In general, the goals of managed care are to manage expenditures more effectively, to improve coordination of care and quality of care, as well as to improve access to care. Managed care, however, is not a single strategy and involves a wide variety of organizational forms, financing strategies, and management practices (Ridgely, Giard, Shern, Mulkern, & Burnam, 2002). Perhaps the hallmark of contemporary managed care arrangements is prospective capitation payments in which managed care organizations (MCOs) are paid a premium for each enrollee each month, regardless of the enrollee's use of services. With such arrangements, the MCO assumes financial risk for the provision of services that are needed by their enrollees during the month. Regardless of various risk-sharing arrangements, because MCOs assume financial risk, they have an incentive to reduce the utilization of non-medically necessary services from historical averages to remain solvent (Ridgely, et al., 2002).

Medicaid: The Florida Context

For the 2015-16 State Fiscal Year, the federal share of Florida Medicaid expenditures was approximately 60.5%, with the state share being 39.5%. Florida Medicaid expenditures in 2015-16 accounted for 29.9% of the total state budget (20.19% of state General Revenue). As of October 2015, there were 3,072,561 people enrolled in the MMA program, approximately 80% of all Florida Medicaid recipients (Senior, October, 2015).

Medicaid managed care was first introduced in Florida in Palm Beach county in 1981 (AHCA, 2014). In 1984 Florida was one of five states selected to receive a grant from the Health Care Financing Administration (HCFA, now known as the Centers for Medicare and Medicaid Services or CMS) to implement a managed care demonstration. Over the next six years, Florida Medicaid recipients had the option to enroll in Medical Health Maintenance Organizations (HMOs) for their physical health care. During this same period, Florida established a primary care case management program to expand Medicaid managed care into areas in which HMOs were not available and to provide recipients with an alternative managed care option (Florida Medicaid AHCA, 2014).

In 1990, HCFA approved Florida's original 1915(b) waiver proposal that allowed for the statewide implementation of the Medicaid Physician Access System (MediPass) a primary care case management program in which physicians provided Medicaid recipients with their primary care services, care coordination, and authorization for specialty care services (AHCA, 2014). Since the initial 1915(b) waiver was approved, a number of different managed care approaches evolved that included Prepaid Ambulatory Health Plans, Provider Service Networks (PSN), Children's Medical Services, Minority Physician Networks, and Disease Management Programs, to name a few.

Managed care strategies for comprehensive mental health services, however, were not introduced in Florida's Medicaid system until 1996 when the initial Prepaid Mental Health Plan (PMHP) was established in the Tampa Bay Region (AHCA Region 6), under the 1915(b) waiver approved by HCFA (Ridgely, Giard, & Shern, 1999). Four eligibility groups were included in this waiver: Social Security Income, Temporary Assistance for Needy Families, Sixth Omnibus Budget Reconciliation Act Medicaid [i.e., Medicaid coverage to pregnant women and children up to the age of 19 years], and Foster Care.

During the initial implementation of the waiver in Region 6, most Medicaid enrollees had their mental health services provided through one of two alternative managed care arrangements. The first was the PMHP, a behavioral health care "carve out" plan in which a behavioral health managed care organization was responsible and at financial risk for providing Medicaid recipients with comprehensive mental health services, including inpatient and psychiatric office visits. PMHP enrollees continued to receive their physical health services on a fee-for-service basis through MediPass. In this arrangement, the PMHP was paid through a fixed monthly per enrollee capitation payment. In the second managed care arrangement operating in AHCA Region 6, HMOs received a premium to expand the services they provided to their enrollees from physical health, to also include all mental health services. This was characterized as a "carve in" arrangement. Eligible Medicaid recipients who did not choose a PMHP or an HMO were assigned to a plan on a mandatory basis.

Both the PMHP and HMOs in Region 6 (i.e., Hardee, Highlands, Hillsborough, Manatee, and Polk counties) were at financial risk for the mental health service utilization of their enrollees. Beginning in 2000, the availability of PMHPs was expanded into other regions of the state. As this regional expansion occurred, the HMOs operating in those regions also expanded their mental health benefits to be comparable to the benefits provided by the PMHPs, and certain eligibility groups in these regions were required to select an HMO managed care plan.

In 2006 Florida received approval through an 1115 research and demonstration waiver to implement a project that "encouraged individual choice of health plan networks, emphasized personal responsibility for health, and rewarded healthy behaviors" (AHCA, 2014). Known as Medicaid Reform, the project was implemented in two counties with permission to expand the demonstration to three other counties. At the time, approximately 16% of Florida's Medicaid recipients resided in these counties (Winter Park Health Foundation, 2005).

In 2011, the Florida Legislature established a new program called Statewide Medicaid Managed Care (SMMC). SMMC is comprised of two programs and requires mandatory enrollment in managed care statewide for most Medicaid recipients. The first program is the Long-term Care (LTC) program,

designed to provide LTC services to recipients needing a nursing facility level of care. The second program is the Managed Medical Assistance (MMA) program designed to expand the five-county Medicaid Reform demonstration statewide (with modifications) to provide comprehensive Medicaid services to recipients. The federal government approved the MMA program in June 2013.

Statewide Medicaid Managed Care Program

The six goals of the SMMC program are to: (1) improve coordination of care; (2) improve the health of recipients; (3) enhance accountability; (4) provide Medicaid recipients with a choice of both plans and benefit packages; (5) provide plans with flexibility to offer services not otherwise covered; and (6) enhance prevention of fraud and abuse through contract requirements (Kidder, 2015). Statewide implementation of SMMC began in August 2013 and was completed in August 2014. In SFY 2016-17 it is estimated that the SMMC program will serve 4.2 million Florida Medicaid recipients at an annual cost of $24.9 billion (Senior, October, 2015).

Medicaid recipients who qualify and become enrolled in the MMA program receive all health care services other than long-term care from a health care plan. Medicaid recipients who qualify and become enrolled in the LTC program receive their long-term care services from a long-term care health plan. The MMA program covers most recipients of any age who are eligible to receive full Medicaid benefits and the LTC program covers most recipients 18 years of age or older who need nursing facility level of care (Senior, March, 2015). Some health plans, designated as comprehensive plans participate in both the MMA and LTC programs.

Managed Medical Assistance (MMA) Program. The goals of the MMA program are to: (1) improve recipient outcomes through care coordination; (2) improve program performance; (3) improve access to coordinated care; and (4) enhance financial predictability and financial management (AHCA, 2013). The MMA program is comprised of managed care plans that are responsible and accountable for health care provision and costs and are held to particular performance standards. Within the MMA program, health plans can operate as a Standard health plan or as a Specialty health plan. The implementation of the MMA component of the SMMC program began during May 2014 with the final implementation occurring during August 2014. As of January 2016, there were 11 Standard plans and 6 Specialty plans participating in the SMMC program.

Standard Plans. Most Medicaid recipients are required to enroll in an MMA Standard plan that is available in their region. Recipients may choose to either remain in their current plan or select a new plan by a specified date, otherwise a plan will be selected on their behalf. Choice Counselors are available by telephone to assist recipients in determining which plan is best suited for their health care

needs. In-person visits are also available by request for recipients with special needs. Some Medicaid recipients are not required to enroll in an MMA plan, but may elect to enroll in one if they meet the enrollment requirements. Medicaid recipients can change plans during the first 120 days of their enrollment. After that period, recipients are only able to change plans during the 60-day open enrollment period each year that begins on the anniversary date of their first enrollment or with a State-approved good cause reason. More recently, AHCA has implemented express enrollment for the MMA program. According to Secretary Dudek this process "will eliminate the need for new enrollees to wait before accessing the benefits our health plans offer…" (AHCA Communications Office, January 2016).

Each Standard MMA plan offers the same core benefits; however, plans may offer additional services beyond these core services. Core services provided by all plans under the MMA program include, but are not limited to, physician services; prescription drugs; inpatient and outpatient hospital services; emergency services; ambulatory surgical treatment center services; mental health services; substance abuse treatment services; optical, hearing, and dental services; laboratory and imaging services; renal dialysis services; physical, occupational, respiratory, and speech therapy services; respiratory equipment; medical supplies equipment, prosthesis, and orthoses; rural health clinic services; and transportation to access covered services.

Most of the health plans offer some level of expanded benefits for members. For example, most standard plans as well as the SMI Specialty plan provide expanded dental, hearing and/or vision services and over the counter medications. In addition, a few Standard plans offer alternative therapies such as art, equine, and/or pet therapy. Although these therapies are not available to members enrolled in the SMI Specialty plan, the SMI Specialty plan has home and community-based services available for its members. A complete listing of expanded benefits by plan can be found at: http://www.ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Expanded_Benefits.pdf

Specialty Plans. A Specialty plan is a specific type of MMA plan for Medicaid recipients who have a chronic medical condition or a specific diagnosis. MMA Specialty plans are required to offer all of the same health care services as the Standard MMA plans, but they must also (1) provide a care coordination program designed to meet the specific needs of recipients in the plan, and (2) offer an increased number of Specialty providers or primary care physicians in their provider network to meet the unique needs of these recipients. Specialty health plans serve populations with HIV/AIDS, serious mental illness, dual eligibles with chronic conditions, youth in the child welfare system, and children with special needs.

When a recipient qualifies for more than one MMA Specialty plan, Florida law stipulates that the

Agency must automatically assign them to the Specialty plan listed highest on the ranking. However, even though recipients are automatically assigned to these plans if they do not choose another plan, they can still choose from any of the other Standard MMA plans in their region if they prefer. Although eligibility for the Medicaid program is determined by the Florida Department of Children and Families (DCF), eligibility for enrollment in the Specialty plans is based on algorithms used by AHCA to identify eligible recipients who meet specific age, medical condition and/or diagnosis criteria. The algorithm to identify Medicaid enrollees meeting criteria for the SMI Specialty plan is based on the presence of certain mental health diagnoses in medical claims and the use of certain psychiatric pharmaceuticals.

Serious Mental Illness Specialty Plan. The Specialty plan for individuals with serious mental illness (SMI) is operated by Magellan Complete Care and is available in eight of Florida's 11 regions (Regions 2, 4, 5, 6, 7, 9, 10, and 11) which comprise 40 of the State's 67 counties. AHCA has contracted with Magellan Complete Care through 2018 to administer the SMI Specialty Plan, and Magellan contracts directly with participating provider agencies to deliver physical health, behavioral health (i.e., mental health and substance abuse), dental, and pharmacy services. Magellan's specified goals are to: (1) improve the health and well-being of its recipients, (2) lower the cost of care by providing better access and care coordination, (3) decrease the utilization of institutional care by providing more community-based services, and (4) create system accountability through data sharing and outcome tracking (Magellan Complete Care, 2014).

To be enrolled in Magellan Complete Care, Medicaid recipients must be six years of age or older and (a) be diagnosed with psychotic disorder, bipolar disorder, major depression, schizo-affective disorder, delusional disorder, or obsessive-compulsive disorder; or (b) be treated with a medication commonly used to treat these disorders. In SFY 2014-15, the SMI Specialty plan had over 40,000 enrollees, approximately one-quarter of enrollees were children and youth, and 60% were female (Armstrong et al., 2015). The most common diagnostic categories among the enrollees were depressive disorders (43%), bipolar disorders (28%), and schizophrenia (22%).

Previous research suggests that individuals with SMI tend to have higher rates of morbidity and mortality due to co-occurring medical conditions and socioeconomic risk factors that impair their ability to comply with treatment (Bazelon Center for Mental Health Law, 2004; Hogg Foundation for Mental Health, 2008; The Kaiser Commission, 2014). In order to effectively meet the needs of this population, Magellan Complete Care provides behavioral health and primary care through a care coordination team that establishes goals in conjunction with recipients, their doctors, counselors, family, and caregivers to enhance well-being and quality of life. The team also includes a health guide, peer support specialist,

and case manager to assist recipients in navigating the health care system by scheduling appointments, arranging transportation to appointments, and assisting with adherence to treatment plans. The care coordination program is a required element for all MMA Specialty plans (Agency for Health Care Administration, 2015).

In addition to enhanced care coordination for its members, Magellan has several unique field positions designed to support providers and engage the community. Provider Support Specialists (PSS) build and maintain positive relationships with providers; broker interactions between behavioral and physical health providers, provide assistance with complaints, claims, and credentialing; and offer orientation, training, and education to providers (Magellan Complete Care, 2014). They also work closely with providers who are ready to pursue an integrated model of care by fostering partnerships and co-locations (Magellan Complete Care, personal communication, November 12, 2015). Another field position is the Community Outreach Specialist (COS), who is responsible for identifying possible partnerships within communities, building and maintaining community resources, and providing information on Medicaid programs and benefits. The COSs also actively link members with community-based resources to enhance the "traditional" Medicaid treatment services (Magellan Complete Care, personal communication, November 12, 2015). The efforts of these specialists are important as Magellan works toward its goal of having a fully integrated service model. In addition, Magellan is in the process of launching a peer support initiative that will promote recovery and resiliency for its members.

Current Study

Purpose

The purpose of this study was to evaluate access to health care, the coordination of physical and behavioral health services, and quality of care for individuals with serious mental illness (SMI) who are enrolled in Florida's Managed Medical Assistance (MMA) program. A primary objective was to compare operations and impacts of the SMI Specialty plan operated by Magellan Complete Care with the Standard MMA plans that also serve enrollees with SMI. The study had three objectives with eight research questions. We begin with Objective 2, which consisted of descriptive analyses to determine if there are differences between the SMI Specialty plan and the Standard plans in terms of their service delivery strategies and the perspectives of their enrollees with regard to access, quality, and integration of care. Next, we discuss Objectives 1 and 3, which consisted of both descriptive and multivariate

analyses to describe the SMI population and make comparisons between the SMI Specialty plan and the Standard plans in terms of program quality and enrollees' access to care, service use, and outcomes.

Objective 2: Service Delivery Strategies and Enrollee Experiences

Research Questions

The research questions for Objective 2 included:

2a. Are there differences in service delivery strategies between the specialty and standard/comprehensive plans?

2b. Are there differences in the perspectives of enrollees and other stakeholders in the specialty and standard/comprehensive plans with regard to access, quality, and integration of care?

Data Sources

The data sources for research question 2a included provider and enrollee handbooks and the expanded benefits lists for the SMI Specialty plan and the Standard MMA plans. The data sources for research question 2b included interviews with key informants, such as MMA plan administrators, network providers, and enrollees. Additional information about these data sources is provided below.

Methods

The method used to answer research question 2a was a comparative review of each plan's benefits. For research question 2b, the research team conducted semi-structured interviews with MMA plan administrators and network providers, and focus groups with individuals enrolled in the SMI Specialty and Standard plans. The focus groups consisted of enrollees from the SMI Specialty plan or from the Standard plans. The data from the enrollee focus groups was used to describe and compare responses of individuals served by the Specialty plan and Standard plans. Network providers and focus group participants were recruited with assistance from Magellan Complete Care, and we received contact information for MMA plan administrators directly from AHCA. As Magellan Complete Care suggested the providers to be interviewed, these provider responses may not be representative of all providers. Additional information about the methods is provided below.

Results

Service Delivery Strategies. The Member and Provider Handbooks from six Standard MMA plans (i.e., Amerigroup Florida, Inc., Coventry Health Care of Florida, Humana Family Florida Medicaid, Staywell, Sunshine Health, and United Healthcare Community Plan) and the SMI Specialty plan (Magellan Complete Care) were reviewed to provide a comparative analysis of the information provided to enrollees in terms of: (a) access to care, (b) covered services/benefits, and (c) care

coordination/management strategies. Five of the Standard plans (i.e., Amerigroup Florida, Inc., Humana Family Florida Medicaid, Staywell, SunshineHealth, and United Healthcare Community Plan) were selected because they had the largest number of enrollees meeting criteria for SMI, whereas Coventry was selected as it represented a plan with a limited number of enrollees with SMI.

As part of this document review, the information contained in the member handbooks on the domains listed in Table 1 was qualitatively evaluated as being substantial, partial, minimal, or none/not available based on the level of detail of the information provided. It is important to note that the term "substantial" ***was not*** used to denote that all relevant information on this domain was provided but that the information included a higher level of detail than the other ratings denote. The review was conducted both manually as well as through the use of word searches in electronic copies of these documents obtained from the plan websites. The core services detailed in the core contract provisions of the MMA plan contract were used to assess the extent to which detailed information was provided on core services/benefits. The expanded services listed in AHCA's table of expanded services was used to evaluate the extent to which detailed information was provided on expanded services/benefits (https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Expanded_Benefits.pdf).

Table 1: *Information Provided in the Member Handbooks*

	Information Provided	Standard Plans						SMI Specialty Plan
		Amerigroup	Coventry	Humana	Staywell	Sunshine	United	Magellan Complete Care
Access to Care	Member/Customer assistance (e.g., days/time of operation)	**S**	**S**	**S**	**S**	**S**	**S**	**S**
	24/7 assistance	**S**	**S**	**P**	**S**	**S**	**S**	**S**
	Location of information from other sources (e.g., website, call center)	**S**	**S**	**S**	**S**	**S**	**S**	**S**
	Emergency care do not require preauthorization/approval	**S**	**S**	**S**	**S**	**S**	**S**	**S**
	Behavioral health services do not require a PCP referral	**S**	**S**	**S**	**S**	**S**	**S**	**S**
	Need for prior authorization/PCP referral	**S**	**S**	**P**	**P**	**S**	**S**	**S**
	Timeframes for receipt of care	**S**	**S**	**S**	**S**	**P**	**S**	**S**
	Translation/interpreter services	**S**	**S**	**S**	**S**	**S**	**S**	**S**
	Explanation on benefit/service limits	**P**	**S**	**P**	**P**	**P**	**P**	**M**
	Out of network/area services	**S**	**P**	**S**	**P**	**S**	**P**	**S**
	Out of area emergencies	**S**	**S**	**S**	**S**	**S**	**S**	**S**
Services Available	Core services listed	**S**	**P**	**S**	**S**	**S**	**P**	**S**
	Core services described	**S**	**M**	**M**	**S**	**P**	**M**	**S**
	Core behavioral health services listed	**S**	**S**	**P**	**S**	**M**	**S**	**S**
	Core behavioral health services described	**M**	**M**	**N**	**P**	**M**	**P**	**P**
	Expanded services listed	**S**	**S**	**S**	**S**	**S**	**S**	**S**
	Expanded services described	**S**	**M**	**P**	**S**	**P**	**S**	**S**
	Expanded behavioral health services listed	**S**	**N**	**S**	**S**	**S**	**N**	**S**
	Expanded behavioral health services described	**S**	**N**	**N**	**P**	**P**	**N**	**P**
	Medications/Pharmacy	**P**	**M**	**P**	**M**	**P**	**P**	**P**
	Transportation	**S**	**P**	**S**	**S**	**S**	**S**	**S**
	Prevention/education programs	**S**	**P**	**S**	**P**	**P**	**M**	**M**
	Other resources (e.g., health materials)	**P**	**N**	**M**	**N**	**N**	**N**	**M**
Care Coordination	Continuity/Transition of Care	**S**	**S**	**S**	**S**	**S**	**S**	**S**
	Case/Care Management	**S**	**P**	**S**	**S**	**S**	**P**	**P**
	Disease Management	**S**	**M**	**S**	**S**	**S**	**P**	**P**
	Heath care coordination professionals (e.g., health guides)	**P**	**N**	**S**	**S**	**S**	**S**	**S**
	Electronic Health Records	**N**	**N**	**N**	**M**	**N**	**N**	**N**
	Sharing medical information	**S**	**S**	**M**	**S**	**S**	**S**	**S**

Note. S = Substantial; P = Partial; M = Minimal; N = None/Not Available

What information is provided to enrollees in the member handbooks related to access to care/services? To what extent do the descriptions regarding access to care services differ between the member handbooks of the Standard plans examined compared to the member handbook of the SMI Specialty plan?

Table 1 provides a summary of the review of the member handbooks. As is shown in this table, there are some slight variations among the member handbooks of the Standard plans and the SMI Specialty plan in terms of the level of specificity of the information provided to enrollees related to various components of access to care. In general, each member handbook provided substantial information to enrollees on customer assistance (e.g., days/time of operation); the availability of 24/7 assistance; location of other sources for plan information (e.g., website, call center); that emergency care does not require preauthorization/approval, and that behavioral health services do not require a primary care provider (PCP) referral; the availability of translation/interpreter services, and accessing care during emergencies that occur out-of-the area. The presentation of this information sometimes differed in format with some handbooks devoting a specific section to the issue whereas others contained information on the issue in different sections throughout the handbook. Some slight variations were noted among the member handbooks in terms of the level of specificity provided to enrollees regarding the need for prior authorization and/or need for a PCP referral, accessing out of network or area services, and explanation of benefit/service limits. The information provided to enrollees in the handbooks associated with the explanation of benefit/service limits was judged to be the least specific of any domain examined.

No meaningful differences were found between the information provided in the member handbooks of the Standard plans and the information provided in the member handbook of the SMI Specialty plan in terms of the level of detail of the information provided about enrollee benefits.

What services are described in the member handbooks? To what extent do the descriptions of services differ between the member handbooks of the Standard plans examined compared to the member handbook of the SMI Specialty plan?

The second area examined as part of the review of the member handbooks focused on the information provided to enrollees about their covered services/benefits. As shown in Table 1, greater variability was found across member handbooks associated with the detail of the information provided on covered services/benefits. This variability is best explained by the fact that the information provided in some member handbooks consisted of listing broader categories of services/benefits, often with a

few specific service examples, compared to other handbooks in which a more detailed listing of the covered services was provided. In addition, some of the member handbooks also contained more detailed descriptions in an effort to explain what the services were for or when the services were needed, although this occurred much less frequently compared to simply listing the services. Some member handbooks contained separate sections focused on core and expanded services whereas other member handbooks did not differentiate between these two categories of service. The listing and description of behavioral health services/benefits (both core and expanded) was, in general, somewhat less detailed than were those of service types such as physical health and dental. The availability of emergency and non-emergency transportation services was judged to be the most consistently well documented benefit in the member handbooks, whereas medications and other available resources such as health education materials were the least consistently documented.

The Magellan Complete Care handbook was assessed to be slightly more detailed in terms of its descriptions of behavioral health services compared to most Standard plan handbooks. Information on preventative/educational programs and other health-related materials such as the availability of health guides was the least well documented. It should be noted that in all of the handbooks, members were encouraged and provided with the telephone number(s) to call to obtain more information or have questions answered about their benefits.

What information is provided in the member handbooks regarding continuity of care and care coordination services available through the plan? To what extent do the descriptions of continuity of care and care coordination services differ between the member handbooks of the Standard plans examined and the member handbook of the SMI Specialty plan?

Information on care coordination efforts and continuity of care was the final area examined during the member handbook review. This information is also summarized in Table 1. All of the plans included substantial information for enrollees about continuity of care. The handbooks noted that new enrollees can continue to receive medically necessary care from doctors outside of the plan's provider network or that enrollees who have a PCP who leaves the network while they are receiving medically necessary treatment can continue to receive care from that provider for up to 60 days. All of the member handbooks provided some information on care/case management and disease management services. Little information was found in the member handbooks pertaining to electronic health records.

Although there was some variability among the member handbooks in terms of the specificity of information provided on care coordination services, no meaningful differences were noted in this domain between (or among) the Standard plans and the SMI Specialty plan.

What information related to access to care/services is provided in the provider handbooks? To what extent do the descriptions regarding access to care/services differ between the provider handbooks of the Standard plans examined compared to the provider handbook of the SMI Specialty plan?

The results of the review of the provider handbooks are summarized in Table 2. As presented in this table, there is some variability regarding the level of specificity of the information available to providers associated with various components of access to care. In general, each provider handbook included partial to a substantial amount of information related to the location of other sources for plan information (e.g., website, call center), that emergency care does not require preauthorization/approval, that behavioral health services do not require a PCP referral, the need for prior authorization/PCP referral, timeframes for receipt of care, and the availability of translation/interpreter services. The amount of information included on the availability of provider services and access to 24/7 resources was judged to be more sporadic and less detailed. In addition, information on accessing out-of-network or area services, explanation of benefit/service limits, and out of area emergency services was also less detailed compared to the amount of information on these topics contained in the member handbooks.

Table 2: *Information Provided in the Provider Handbooks*

	Information Provided	Standard Plans						SMI Specialty Plan
		Amerigroup	Coventry	Humana	Staywell	Sunshine	United	Magellan Complete Care
Access to Care	Provider services (e.g., days/time of operation)	**S**	**M**	**S**	**M**	**S**	**P**	**S**
	24/7 assistance	**S**	**M**	**P**	**M**	**P**	**P**	**S**
	Location of information from other sources (e.g., website, call center)	**S**	**S**	**P**	**S**	**S**	**S**	**S**
	Emergency care do not require preauthorization/approval	**S**	**S**	**P**	**S**	**S**	**S**	**S**
	Behavioral health services do not require a PCP referral	**S**	**S**	**P**	**S**	**S**	**S**	**S**
	Need for prior authorization/PCP referral	**S**	**S**	**P**	**S**	**S**	**S**	**S**
	Timeframes for receipt of care	**S**	**S**	**S**	**S**	**S**	**S**	**S**
	Translation/interpreter services	**S**	**S**	**P**	**S**	**S**	**S**	**S**
	Explanation on benefit/service limits	**P**	**M**	**P**	**P**	**M**	**P**	**P**
	Out of network/area services	**M**	**M**	**P**	**M**	**S**	**M**	**M**
	Out of area emergencies	**P**	**M**	**P**	**M**	**S**	**M**	**S**
Services Available	Core services listed	**S**	**S**	**S**	**S**	**M***	**S**	**S**
	Core services described	**N**	**N**	**N**	**N**	**N**	**P**	**N**
	Core behavioral health services listed	**P**	**S**	**M**	**M**	**N***	**M**	**P**
	Core behavioral health services described	**N**	**N**	**N**	**N**	**N**	**N**	**N**
	Expanded services listed	**S**	**S**	**S**	**S**	**N**	**S**	**S**
	Expanded services described	**P**	**N**	**N**	**P**	**N**	**S**	**M**
	Expanded behavioral health services listed	**N**	**P**	**P**	**S**	**N**	**N**	**P**
	Expanded behavioral health services described	**N**	**N**	**N**	**M**	**N**	**N**	**P**
	Medications/Pharmacy	**P**	**P**	**P**	**P**	**N**	**M**	**P**
	Transportation	**S**	**S**	**S**	**S**	**S**	**M**	**S**
	Prevention/education programs	**P**	**M**	**S**	**S**	**S**	**P**	**P**
	Other resources (e.g., health materials)	**S**	**M**	**M**	**M**	**S**	**M**	**M**
Care Coordination	Continuity/Transition of Care	**S**	**S**	**S**	**S**	**S**	**P**	**S**
	Case/Care Management/Coordination	**S**	**S**	**S**	**S**	**S**	**P**	**S**
	Disease Management	**P**	**S**	**S**	**S**	**S**	**M**	**P**
	Heath care coordination professionals (e.g., health guides)	**S**	**M**	**M**	**M**	**M**	**M**	**S**
	Electronic Health Records	**N**	**N**	**N**	**P**	**N**	**N**	**N**
	Sharing medical information	**S**	**S**	**M**	**S**	**S**	**P**	**S**

Note. S = Substantial; P = Partial; M = Minimal; N = None/Not Available. *Providers are referred to the Sunshine website and the Cenpatico Provider Manual for information on covered services.

What services are described in the provider handbooks? To what extent do the descriptions of services differ between the provider handbooks of the Standard plans examined compared to the provider handbook of the SMI Specialty plan?

The information included in the provider handbooks associated with covered services/benefits was the second area examined as part of this review. As shown in Table 2, there was greater variability found across provider handbooks, especially within the Standard plans, associated with the level of detail on information provided on covered services/benefits. The Amerigroup and SMI Specialty plan provider handbooks were judged to include more comprehensive information on covered services compared to the other Standard plan provider handbooks examined. The information contained in the provider handbooks on covered physical health services was generally more detailed compared to the information provided on covered behavioral health services. This may in part be due to the fact that some plans contract with a separate behavioral health entity to oversee the provision of behavioral health services to their enrollees. Medication and pharmacy benefits were the least consistently well documented and the provider manual often referred providers to a website for the current formulary and other related information. Compared to the member handbooks, the level of detail on covered services and benefits was less in the provider handbooks. It is important to note that all of the plans offered more extensive information to providers on covered services, pharmacy, and benefit limits through their web-based portals.

What information is included in the provider handbooks regarding continuity of care and care coordination services available through the plan? To what extent do the descriptions of continuity of care and care coordination services differ between the provider handbooks of the Standard plans examined and the provider handbook of the SMI Specialty plan?

The final area examined during the review of the provider handbooks was an assessment of the information that was included on care coordination efforts and continuity of care efforts. This information is also summarized in Table 2. All of the plans included a substantial amount of information for providers about their continuity of care efforts. The handbooks informed providers that new enrollees can continue to receive medically necessary care from doctors outside of the plan's provider network for up to 60 days and that enrollees who have a PCP who leaves the network while they are receiving medically necessary treatment can continue to receive care from that provider for up to 60 days. All of the provider handbooks provided some reference to or information on care/case management and disease management services. In some instances, these programs were not described

in the provider handbook but providers were informed where they could obtain addition information about these programs. With one exception, there was no information about electronic health records included in the provider handbooks.

Although there was some variability among the provider handbooks in terms of the specificity of information provided on care coordination services, no meaningful differences were noted in this domain between (or among) the Standard plans and the SMI Specialty plan.

Perspectives of Administrators and Providers. Semi-structured stakeholder interviews were conducted in person or via telephone with eight representatives from the six MMA plans and five staff members from five provider agencies. In addition to the SMI Specialty plan, the Standard MMA plans were selected by reviewing the number of SMI enrollees in each plan and selecting the plans with the highest number of SMI enrollees as well as one plan with a small number of SMI enrollees. The five Standard plans that were selected and participated in the stakeholder interviews are Aetna/Coventry, Amerigroup Florida, Humana, Sunshine Health, and WellCare. The providers were recruited with assistance from representatives of Magellan Complete Care who identified providers that serve individuals with SMI, regardless of their MMA plan. Providers included both behavioral health providers and providers who offer both medical care and behavioral health services.

Two of the interviews included more than one participant. The interviews focused on the organizational structure of the plan, quality assurance mechanisms, strategies to ensure care coordination, communication and resource sharing, and strategies to ensure access to services and a match between identified needs and services (see Appendices C and F for interview protocols).

Faculty at the University of South Florida (USF) conducted the stakeholder interviews. Audio files were uploaded to a secure, shared site and files were then transcribed. All participants provided fully informed consent according to USF Institutional Review Board policy (see Appendix G for informed consent document).

Interview data were coded using the domains from the conceptual framework that has guided the project (see Appendix A for conceptual framework). Interviewee responses were classified into codes that comprehensively represented participants' responses to each question. The two team members who coded the data participated in an interrater reliability process that achieved a reliability score of 68%. Selective coding was applied to pull specific examples from transcripts that were illustrative of key points. This report includes the most commonly found patterns and themes from the interviews.

The findings from the interviews are organized by the following domains from the study's conceptual framework: organizational structure and contractual relationships; quality assurance; communication and resource sharing; and care coordination strategies including ensuring access and meeting member's needs. It should be noted that these findings cannot be generalized to all administrators or providers given the small, non-random sample.

Organizational Structure and Contractual Relationships. As noted earlier in this report, in addition to providing the required core services provided by Standard health plans, Specialty health plans must also (a) provide a care coordination program designed to meet the specific needs of recipients enrolled in the plan, and (b) offer an increased number of Specialty providers or primary care physicians in their provider network to meet the unique needs of these Medicaid recipients. With the exception of these two provisions, the SMI Specialty plan has the same contractual requirements with AHCA as the Standard plans. For example, its provider network, including specialty and ancillary services, must meet certain access requirements based on the number of enrollees in a region. Adequacy of the network for both medical and behavioral health services dictates the number of enrollees that can be assigned to the plan. Credentialing, the claims payment process, use of the AHCA approved pharmacy formulary, and performance standards are other contractual requirements that the SMI Specialty plan shares with other plans.

A common finding across all plans is their strategies for provider payment arrangements. Respondents reported that in most cases there are capitated arrangements (risk-based monthly per member per month payments) with physical health providers and fee-for-service payments with behavioral health providers. One plan noted that their physical health providers earn bonuses based on quality metrics that are based on the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Although provider data submission requirements with plans are also reportedly similar, encounter data must include diagnosis and procedure codes. The data is used by plans for quality reviews, risk adjustment, claims payment, and to identify members who may need case management services.

When asked about the stability of provider networks, the common response was that the network in Florida (both for medical care and behavioral health) is relatively stable. Different strategies were reported about efforts to fill service gaps. Several plans reported that their networks include all of the Community Mental Health Centers (CMHCs) in an area because most enrollees with SMI (typically about 70% to 80%) use and are comfortable with CMHCs. A few plans reported that they include small

clinical practices and individual psychiatrists in their networks so that other behavioral health options are available for enrollees. Several respondents noted that they actively identify and fill service gaps. One plan has a process called Find-A-Provider. When an enrollee calls about not being able to find a specialist, clinical staff first verify whether there is a service gap. If there is a specialist needed, field contractors are deployed to the area to help fill the gap.

Plans differed in the proportion of their enrollees who have SMI, and in the number of AHCA areas where they operate. The number of regions covered by the plans ranges from one region to 9 regions. One of the differences from other plans is that all enrollees of the SMI Specialty plan must meet the SMI criteria. This feature results in a population of enrollees who are seriously disabled, high users of services, and very often, individuals with complex physical and behavioral health conditions. Other challenges of this population identified by respondents include difficulty locating members due to changes of address and homelessness as well as non-compliance with treatment. The SMI Specialty plan has developed a variety of outreach strategies to engage enrollees, including hiring a firm to go out on the streets and locate these individuals. For enrollees that are difficult to engage in services, staff will meet with them in whatever community setting is comfortable so that they can have a conversation with the individual about their care and encourage them to become involved in treatment.

Among the other plans that were interviewed, one major difference that emerged is whether behavioral health services are operated directly by the plan or managed and financed through a subcontract with another organization. Three of the plans have retained administration of behavioral health services, and one plan is moving to directly administer these services by the end of 2016. The other plan subcontracts the management of behavioral health services to another entity; the plan uses two different vendors in different regions for the subcontracted services. For the plans that directly administer behavioral health services, organizational structures that support coordinated care were identified, such as having the directors of the medical care department and the behavioral health department report to the same senior leader. Another strategy reported by two of the plans is holding joint rounds regularly on complex cases with both medical directors and psychiatrists participating with the case manager. The plan with the subcontracted arrangement did not identify structural strategies that would promote care coordination.

All of the providers that were interviewed reported that they have contracts with all MMA plans in their catchment area. The reasons for this decision are continuity of care, ability to serve any individual who approaches the agency, and to have as much business as possible. “We didn’t want to be turning people away who were presenting for the services that they need. We also didn’t want to be

faced with taking people who had been receiving services from us for a period of time and having to send them away after MMA went into effect". One provider reportedly serves all SMI clients, others serve a mix of clients with some proportion (ranging from 65% to 80%) identified as SMI.

Credentialing was noted as a challenging and time consuming process by both plans and providers. One plan reported that their credentialing team tracks re-credentialing deadlines and does active outreach with providers to make sure that the process is timely. From the provider perspective, one challenge is that the same individual who is credentialing an endocrinologist is also credentialing a licensed mental health clinician. This results in a lack of clarity and/or information about what is needed, and repeated back and forth submission of documents. Another challenge is that each plan requires its own roster of clinicians whose credentials have been reviewed and approved by the plan rather than a roster that is shared across multiple plans. Moreover, some plans' credentialing systems are cumbersome and time consuming.

Providers reported many challenges across the plans with the claims submission process. For example, when claims are submitted, there are often technicalities or questions that preclude payment. In general, the claim is eventually paid. Another problem reported by several providers is that enrollees are listed under the wrong plan, and "no one seems to know how to fix this." One provider noted that the SMI Specialty plan is more responsive than the other plans and more engaged in problem solving to resolve the issue. However, another provider noted an unresolved claims issue with the SMI Specialty plan. Their agency was flagged as capitated by mistake and fixing this error means that the provider must find all previous billing records and re-submit them. Another challenge with the SMI Specialty plan that was mentioned by a provider is an administrative deficiency in billing practices that is not yet resolved.

Three providers reported that from their perspective, the SMI Specialty plan is best equipped to deal with the SMI population. Their staff "seem to understand the population" including what services are standard care for individuals with chronic and severe psychiatric problems. In addition, a few providers reported that some standard plans are limiting day treatment and psychosocial rehabilitation services. Another observation was that the SMI Specialty plan is one of few plans that manages and coordinates medical care and behavioral health care. Providers also expressed satisfaction about their overall relationship with the SMI Specialty plan. Strengths identified include an assigned provider specialist who becomes familiar with provider operations and actively problem solves with the provider to identify covered specialists, locate specific forms that are needed, send a team person to locate a missing enrollee, and engage the enrollee in services. It was also noted that the SMI Specialty Plan has

community resource specialists who are engaged with providers and participate in community events. Finally, in contrast with other plans, the SMI Specialty plan conducts audits that are not punitive, identifies strengths, and offers constructive feedback on areas needing improvement. One provider who was interviewed indicated that compared to the Standard plans, the provider support specialists from the SMI Specialty Plan are easier to access and more willing to assist when problems arise: "Always around and always available."

One provider identified no provider relationship mechanisms with the plans except for the SMI Specialty plan. There is no contact with a provider representative from the Standard plans; communication is limited to an online portal. However, this provider did not view this as problematic and felt little need for direct contact.

Both plan and provider-level respondents identified several strengths of the MMA program. One is the decision to give plans responsibility for the management of substance abuse. Given that a high proportion of individuals with serious mental health problems have co-occurring substance use problems, this decision supports identification of co-occurring disorders and integrated treatment approaches that address both mental health and substance abuse problems. One standard plan has launched a substance abuse disorder coaching pilot program that has developed an intervention protocol using motivational interviewing and engagement strategies. Another common element identified across plans is a recognition of the value of the high performance standards of the MMA program regarding quality of care. Several interviewees noted that there are fiscal consequences if they do not adhere to some standards, and that these requirements are taken very seriously by plans. These indicators include timely service authorization mechanisms and several HEDIS quality measures.

In general, respondents noted and discussed administrative burdens of the MMA program for both plans and providers that may not be necessary and sometimes result in service limitations. These elements include the claims billing process, credentialing, and service authorization procedures.

In summary, there are common structural arrangements and contractual requirements across the Standard plans and the SMI Specialty plan. Differences emerged regarding the use of organizational strategies that promote care coordination between the Standard plans that subcontract rather than directly administer behavioral health services. From the perspective of provider respondents, the SMI Specialty plan is perceived as the most appropriate and useful plan for serving individuals with SMI.

Quality Assurance. Plan respondents reported using similar multiple ways to monitor the adequacy and quality of provider networks: running GeoAxis reports for membership and review of network composition for adequacy; review of claims and utilization data; and review of member

satisfaction surveys. For example, one plan has a quality team reporting directly to the senior medical director. The team is composed of advisors who work directly with providers to improve performance on the HEDIS quality measures. In addition, the team has work plans related to medication management and acuity, and behavioral health/medical care integration. The system has alerts for when an adult enrollee has not filled a prescription for 3 months. When this happens, the issue is raised with the provider and problem solving begins. The team also includes four patient care advocates who reach out directly to enrollees to promote their engagement with care.

Several plan and provider respondents noted that one of the strengths of the MMA program is the large number of contractual health plan standards related to HEDIS measures, provider credentialing and claims processing. Some standards include fiscal penalties. The plans noted that one common task is to educate providers about these expectations and, if there is non-performance, to work actively with providers to improve performance. One respondent reported that the plan has no penalties or sanctions for providers, but there are performance incentive agreements with most providers. The plan pays a bonus to providers achieving thresholds for certain quality metrics. This plan reported that quality is now their number one priority. In addition to the bonuses, strategies to promote quality include: exchange of information with enrollees so that they know who to reach out to if there is a problem with services, offering resources to providers to do a better job with care management, and identifying providers with whom they want to do more business. One respondent noted that one limitation of HEDIS is that the majority of the quality measures are physical health-related. The perception of this respondent is that additional behavioral health HEDIS measures that everyone is accountable for would promote coordinated care.

Plans differ in the type and amount of training and educational opportunities related to coordinated care that are available for their provider networks. The SMI Specialty plan uses its provider support specialists to educate medical practices, primary care physicians, and CMHCs about its expectations related to care coordination. One plan has a training unit that includes clinicians; the unit is developing a full curriculum that includes topics such as comorbidity, peer support and recovery. Another plan offers an annual training event for PCPs on coordinated care. Several plans have educational materials and resources on integrated care and other topics on their provider portals. For example, one plan has developed a HEDIS Resource Guide for providers that is available on their provider portal. One plan has not offered any training for contracted providers on coordinated care.

Providers reported a number of quality assurance activities that they perform internally. Providers conduct internal peer reviews, have utilization management teams that ensure that

authorization requests are filled out properly, and conduct internal formal audits of programs. In addition to the plan requirements, some providers have internal performance indicators. When these are different from the plan requirements, the indicator that is more stringent is applied. Two providers reported that they use secret shoppers who call a program and check to see whether and when someone answers the phone, and whether an appointment is offered in a timely manner.

Some providers offer an array of educational and training opportunities for their employees. One provider, for example, uses Reliance Learning, an online training program with an extensive catalogue of competency-based training modules on topics such as care coordination, recovery, wraparound services, and trauma. The catalogue is available for all staff. Licensed staff can get continuing education credits (CECs) through this resource; all direct care staff have trainings that they are assigned to take initially and annually.

In summary, no major differences in quality assurance programs were identified between the Specialty plans and Standard plans.

Communication and Resource Sharing. The plans reported a number of strategies for communication with enrollees. The SMI Specialty plan, for example, sends a welcome kit to new members including a member handbook with a summary of benefits. Within 30 days the new enrollee gets a call to see if there are any questions. If the member is looking for a PCP, the plan will help set up an appointment. The telephone contact also includes a screening measure that is used to evaluate the level of care management services for which the enrollee is qualified. Other strategies for sharing information with enrollees identified by the Standard plans include monthly newsletters, on-line resources, and telephonic outreach to enrollees.

All plans reported similar strategies for handling grievances that follow contractual guidelines. Grievances can be reported by phoning the plan's call center or by letter, and may be reported by either an enrollee or their provider. Plans must respond within five days to a grievance, and have 60 days to resolve grievances. One plan reported using a software system that tracks turnaround times and notification times. Several plans noted that AHCA has strict requirements about responses to grievances and that grievances are taken very seriously.

Respondents reported many challenges about the use of electronic health records for information sharing across medical care and behavioral health care. Unless there is a common platform that providers can use, there cannot be any electronic sharing. Both federal and Florida laws limit the types of information that can be shared. One plan with affiliated companies reported that each company has access to the other's electronic care management record, but this platform is not shared

with subcontracted providers. All information in the system can be used with providers in managing enrollees' care.

Plans reported that they place much emphasis on information sharing with their providers. They encourage providers to communicate telephonically with one another and to use faxes to share reports of what has occurred. There is agreement that electronic health records are somewhat easier to develop when there is co-location of services. Reportedly, there are a few providers with both a CMHC and a Federally Qualified Health Center (FQHC), such as Citrus Health in Miami, that have integrated electronic health records.

Regarding communication by plans with providers, some plans have provider network specialists assigned to specific providers. Two providers reported that the most helpful communication strategies related to care coordination are those used by the SMI Specialty plan. As some providers noted, "Magellan's better at it than the others". Some plans also have an assigned clinical contact with a provider who reviews all authorization requests; this was viewed as a helpful strategy in getting authorizations approved.

Providers also reported several communication challenges with plans regarding issues such as the credentialing process, confirmations of authorization requests and billing issues. Some providers stated that they have experienced waits of at least 45 minutes when calling one plan's billing department. According to the providers, these issues sometimes mean needing to hire more administrative staff.

In summary, there is some variability across plans in the communication strategies and resources that are used. The SMI Specialty plan has a more comprehensive approach to communicating with and engaging new enrollees. Providers respond favorably to the use of provider relations specialists who are assigned to specific providers, and believe that the Specialty plan has more useful communication strategies than the Standard plans.

Care Coordination. This section includes findings related to access to care including matching enrollee needs with appropriate services, and coordination of care between medical care and behavioral health care.

All plans identified many strategies and resources that are used to promote access to care. One set of common strategies across plans is related to ensuring the adequacy of provider networks. All plans reported running geo-Access maps against their membership levels to make sure that there are enough providers of all types in each area to serve members. Plans reportedly are always searching for new providers. On the behavioral health side, plans have contracts in place with CMHCs and are

recruiting individual psychiatrists and smaller practices to improve access. Plans use negotiated single rate agreements with specialty providers who are not in the network but offer a needed service, such as treatment for eating disorders and applied behavior analysis. Plans also reported numerous avenues for members to contact them about any issues related to access. When a call comes in, for example, plans must adhere to certain service levels including average speed to answer, abandonment rate, and hold rates. With calls related to access, a plan representative reaches out to providers and arranges services.

A challenge reported by many plans is accessibility based on availability. Gaps that were identified include child psychiatrists, eating disorders specialists, and waiting lists for targeted case management, specialized therapeutic foster care, and outpatient therapy in some areas of the state. Some plan staff reported that some providers have closed shop because provider reimbursement rates are very low. Some plans are pursuing the use of telemedicine for rural areas of Florida and the Keys. Some plan staff reported that there are some barriers to implementation of telemedicine.

Strategies to improve the service authorization process were identified by some plans. All plans reported that behavioral health emergency services do not require pre-authorization so that access can be immediate; and plans have comprehensive inpatient and crisis stabilization unit (CSU) networks. Plans follow up post hospital discharge to ensure that a meeting with an outpatient provider occurs within 7 days. One plan has a whole program in place to conduct ambulatory follow-up post discharge from an inpatient setting. “When a member reaches out for services, the sooner we get them involved in services, the greater likelihood of patient compliance”. Another plan uses a specialty provider, Health Integrated, to operate a 24-hour behavioral health crisis hotline where enrollees or a family member can access a licensed clinician who makes sure that the enrollee is safe and has easy access to local emergency services. Case management follows up with the enrollee and/or family on the day after a health crisis hotline call.

Plans reported that pre-authorization is generally not required for behavioral health services except for inpatient treatment, psychosocial rehabilitation, targeted case management, and therapeutic behavioral on-site services. One plan has no authorizations for assessment, evaluation, treatment planning, or for referrals from the enrollee’s PCP: “We want easy access.” The plan also has decided that as of 3/1/16, no registration is required for service authorizations for outpatient or case management; their system will automatically calculate the amount of service that can be offered. Clinical oversight will be initiated after 200 units of service/15 minute units. This decision is based on the system’s finding that 95% of members use less than this amount of service units.

The SMI Specialty plan has a division, Magellan RX, with pharmacists on call who take calls from pharmacies for prior authorizations while the member is at the pharmacy. The decision is made on the spot about the necessity for a particular drug. With members who are on high-cost, psychotropic medications, the plan promotes rapid authorization and getting the medication authorization to the pharmacy quickly; the plan may even deliver the medication to the enrollee's home. This is based on the belief that use of the medication will prevent hospitalization. In their discussion of this issue, one plan commented that they would prefer that its formulary team, which includes pharmacists and medical directors, develop its own formulary based on medical information and best practices, rather than following a prescribed standard formulary that requires using medications in AHCA's stepped process.

The service authorization process was an area of concern for most providers. Several providers reported that plans are not authorizing or are seriously limiting authorizations for psychosocial rehabilitation programs. One provider expressed a concern related to all plans, including the SMI Specialty plan. Providers reported that there are a small number of adult clients who are dually diagnosed, at very high risk and in danger of overdosing. These individuals need residential care with treatment options and good supervision; providers reported that it is difficult to get authorization for this level of care. Another provider expressed the belief that some plans are using medical necessity criteria to deny specialty services needed by a SMI population. One example is a provider requesting authorization from one plan for psychosocial rehabilitation (i.e., intensive treatment), but receiving authorization for a club house (i.e., peer support) as a downward substitution. Because a denial letter was not sent, technically this is not a service denial. Another challenge is that sometimes it is a few weeks before service authorization requests are approved. The provider must then make a choice to either not see the client or offer services without knowing whether the services will be reimbursed. More than one provider reported that calls to one plan regarding service authorizations may be put on hold for at least 45 minutes.

Care coordination strategies were described at both plan and provider levels. One care coordination strategy at the plan level is combined rounds with both the medical director and the psychiatrist participating; both the medical and clinical needs of enrollees are discussed. Both plans using this strategy report that the enrollee's care manager is "in the room" and can engage with the enrollee later about the service plan. Another plan has 200 case management staff that manage its complex cases; i.e., the top 1% of its members based on acuity. The teams are geographically based and cases are managed through integrated teams. Integrated rounds are held every Wednesday telephonically with the teams: "What can we do to move the needle? What have we not thought of?

What can we do differently? What's going on with the family? What social services do they need?" Care coordinators can be case managers, community health workers, telephone case managers, on-site nurses—a suite of roles that all function under the senior medical director and that manage complex populations—either behavioral or medical. Most case management is not telephonic. Case managers are in the community, at people's homes or at homeless shelters.

The SMI Specialty Plan is implementing a new care coordination strategy. Currently all members of the SMI Specialty plan are automatically assigned a PCP. The plan has re-evaluated this practice, and will soon be assigning all members or will ask the member to select a behavioral health primary provider as well as a PCP. The plan is also re-structuring its case management team so that behavioral health and medical care managers are on each team. In a similar arrangement, a Standard plan assigns both a medical care case manager, usually a nurse, and a behavioral health case manager, as well as a licensed mental health clinician, to co-manage the care of members with comorbid mental health, substance use, and medical care needs.

All plans are reportedly encouraging co-location of primary care and behavioral health care, although progress is slow. There are many challenges, including the fact that there are two primary types of Medicaid providers (CMHCs and FQHCs) that have historically operated independently. Some plans report identifying and encouraging the use of CMHCs with PCPs in their practice. Other strategies, short of co-location, are encouraging providers to hold joint rounds, and to increase communication strategies and mechanisms.

One strategy used by some plans to promote care coordination is incentives to promote a behavioral health home model. For example, one plan has a pilot project with 8 providers that offer both behavioral health and medical care services in one entity. These providers operate both CMHCs and FQHCs and are certified by the National Committee for Quality Assurance (NCQA) as a Patient Centered Medical Home (PCMH). The pilot providers receive a per-member per-month (PMPM) payment for a population and are incentivized for performance measures. The pilot requires a subcontract amendment for a value-based purchasing arrangement; the amendment is not yet approved and operational.

One Standard plan has contracted with some medical homes to promote care coordination; these are providers who are primarily medical with some on-site behavioral health services. The plan has a pilot project with one medical home; PCPs are using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tools to conduct brief screenings for substance abuse disorders. Another plan reports having several field-based employees working with providers to get certified as PCMHs. The plan

has incentive and reimbursement programs to assist the provider in attaining the certification. Once certified, the plan transfers members to the provider as they have capacity. This plan currently has 87 providers with 2,894 PCPs that are certified PCMHs.

Providers also reported strategies to promote care coordination. If a person has a targeted case manager with one provider, part of the treatment plan is for the enrollee to reach out to and enroll with a PCP. This strategy was re-enforced by the SMI Specialty plan by setting a target that every member see a PCP within a certain time period. The provider has added a box to the electronic health record where the targeted case manager adds notes regarding the status of contacts with a PCP. The provider also lends office space to a PCP who comes on site. Members can choose this person as their PCP and see him on-site. Another provider commented that the targeted case manager is "pretty much the last piece of the puzzle on behalf of the client". The targeted case manager coordinates care with all outside providers including primary care.

Providers also identified ways that plans can be helpful with care coordination. All plans participate in care coordination when an enrollee is hospitalized, although it was noted that the SMI Specialty plan is most helpful by initiating lots of coordination including tracking the member, calling the member, and making sure that the member keeps the appointment. It was also noted that when one of the provider's clients is hospitalized, the SMI Specialty plan lets the provider know and makes sure that the provider follows up with the client. One provider noted that this notification does not happen with the Standard plans.

Providers noted challenges related to offering coordinated care. One behavioral health provider's mission is recovery for adults with SMI; it has been difficult for them to see a path for providing primary care directly. Two providers reported that they rarely get any information back from PCPs after sending out releases of information for new clients. Providers also reported strategies that were not successful. One provider piloted with having a Nurse Practitioner on site but it was difficult to fill her schedule. The provider also engaged a community health center to come on-site but was not successful.

In summary, there were few differences between the Specialty plan and the Standard plans in their use of strategies to ensure access to services and in their promotion of care coordination.

Perspectives of Enrollees. Seven focus groups were conducted in person at two different locations with individuals enrolled in the MMA program. The participants in three focus groups were enrolled in the SMI Specialty plan (*N* = 18); the participants in three other focus groups were enrolled in

Standard plans (*N* = 27), and one focus group included caregivers of recipients enrolled in both the SMI Specialty plan and Standard plans (*N* = 3).

The focus group questions were related to access to services, care coordination between medical health and behavioral health, communication and resource sharing, match between needs and services, and quality of care (see Appendices D and E for focus group protocols). For each question, participants were asked to identify strengths and challenges.

Team members from the University of South Florida (USF) conducted the focus groups. Audio files were uploaded to a secure, shared site and files were then transcribed. All participants provided fully informed consent according to USF Institutional Review Board policy (see Appendix H for the focus group informed consent document).

Focus group data were coded using the appropriate domains from the conceptual framework that has guided the project. Focus group responses were classified into codes that comprehensively represent participants' responses to each question. Selective coding was applied to pull specific examples from transcripts that were illustrative of key points. This report includes the most commonly found patterns and themes from the focus groups.

The findings from the focus groups are organized by the following domains from the study's conceptual framework: ensuring access and meeting enrollees' needs, quality of care, care coordination, and communication and problem solving.

Access to Services. Participants in the SMI Specialty plan focus groups identified a number of ways that the plan has been helpful in ensuring their access to services by matching their needs with appropriate services. Transportation to scheduled services, both medical and behavioral health, was one strength identified by many participants. Comments were that the transportation service was on time and available when needed after appointments. In general, participants agreed that getting needed medical and behavioral health services was easy once enrolled in the plan. Examples offered include getting appointments promptly (including with specialist providers), transportation, caseworkers making appointments at times that are convenient, and caseworkers providing transportation on occasion. One participant commented that when a PCP no longer accepted the insurance, the SMI Specialty plan helped the enrollee to quickly find a new doctor. Two participants noted that the SMI Specialty plan was helpful in arranging dental care and appointments.

A few participants enrolled in the SMI Specialty plan expressed challenges with getting transportation for appointments, especially when the provider is in another county. Other gaps

identified are the inability for over-the-counter medications to be sent through the mail, and a lack of access to chiropractors.

Participants in the Standard plan focus groups identified both strengths and challenges in accessing services. Strengths that were noted include caseworkers who make appointments for the enrollee, access to needed medications, and providing transportation to appointments. One participant noted the ability to get dental appointments. Challenges included getting medications and eye glasses, lack of case management services, and for some participants, lack of transportation for appointments. One participant noted being new to the area and that the case manager was not helpful in identifying where services are located.

Participants in both the SMI Specialty and Standard plans expressed frustration about primary care physicians and other providers who are not contracted with their plan. Another common challenge is accessing behavioral health services on evenings and weekends; participants in one focus group noted that in one community there can be long waits on weekends for the mobile crisis unit.

Quality of Care. Participants in the SMI Specialty plan noted many positive aspects related to quality of care. One enrollee with a history of drug abuse commented that his psychiatrist takes this into consideration when he requests a medication. Rather than prescribing the medication without asking any questions, she discusses with him her concerns about relapse and proposes some alternative methods for reducing anxiety, “So she won’t just give me whatever I ask for”. In general, participants reported that they are treated with respect by doctors and while waiting in the reception area. Another participant noted that her PCP had been “considerate of my feelings” by asking the right questions, such as, are medications working, am I taking the medications: “I can tell her what’s working, what’s not working, what I need, what I don’t need”.

Standard plan participants also noted many strengths related to quality of care. Strengths including feeling supported, knowledge of child’s treatment plan, follow up on whether a medication is working and any side effects. A challenge identified is situations where providers are not listening or are not helpful in coming up with solutions.

Care Coordination. In general, participants in both types of plans did not know whether any care coordination is happening between their medical care specialist and their behavioral health care specialist. SMI Specialty plan participants identified some facilitators of care coordination that they have experienced. One participant’s previous medical doctor discontinued participation in the SMI Specialty plan. The doctor called this individual and told him to make sure that he signs the consent form, so that information on his health is sent to the new PCP. Another participant reported that the primary doctor

always asks what types of medications the mental health specialist has given him and vice-versa. In addition, four participants in the SMI Specialty plan reported that there was regular communication between their medical doctor and their therapist: “Right; they call back and forth”.

Communication and Problem Solving Strategies. Some participants in both the SMI Specialty plan and Standard plans expressed initial confusion in understanding the system; e.g., knowing who to call about which issues, needing to talk to too many individuals to get help. Some participants in Standard plans identified communication issues with the plan including waiting for at least 45 minutes when calling the plan, being transferred to another plan without any notification, and waiting 30 days after enrollment in a new plan before services can be initiated. In general, enrollment in a new plan can be confusing for both enrollees and caregivers, and disruptive to receipt of services including medications. In spite of the fact that plans are required to furnish new enrollees with new enrollee procedures and materials, one request that was made during a focus group was for plans to send letters to new enrollees with detailed explanations about what is happening, rather than enrollees calling to get the information. “But it’s like you have to keep calling, trying to get information…instead of them keeping you updated on what’s going on”. In general, participants in Standard plans expressed that they would like to be kept updated about their status, rather than calling and not knowing who to speak with or how to get the information.

Participants in the SMI Specialty plan identified the following strengths related to communication with the plan: assistance with identifying new providers as needed, communication about services that were being billed and verifying that they have been received, calling to get appointments scheduled, and assistance with getting an insurance card. ”I like Magellan because they keep me informed”.

In summary, the enrollee focus groups identified both strengths and challenges with all plans. However, the SMI Specialty plan was perceived as more effective in providing transportation, ensuring access to dental care, offering assistance with making appointments, and in their overall communication mechanisms.

Objectives 1 and 3: Access, Service Utilization, and Outcomes

This analysis evaluated access to health care, service use and expenditures, and outcomes for individuals with SMI who are enrolled in Florida’s MMA program. The primary purpose of this analysis was to compare impacts of the SMI Specialty plan with Standard MMA plans that serve enrollees with

SMI. The research design consisted of quantitative methods and included analyses of administrative data to describe characteristics of enrollees with SMI, service utilization patterns, and outcomes across plans.

Research Questions

The research questions for Objectives 1 and 3 included:

1a. What are the demographic and diagnostic characteristics of individuals with SMI that are enrolled in the Specialty and Standard/Comprehensive plans?

1b. Are there differences between Specialty and Standard/Comprehensive plan enrollees with SMI in terms of access to care?

1c. Are there differences between Specialty and Standard/Comprehensive plan enrollees with SMI in terms of service use patterns?

1d. Are there differences in program quality between the Specialty and Standard Comprehensive plans?

3a. Are there differences in outcomes of individuals with SMI enrolled in the Specialty plan as compared to enrollees in Standard/Comprehensive plans?

3b. Do outcomes vary for individuals with SMI in the Specialty and Standard/Comprehensive plans based on social determinants of health?

Data Sources

The analysis utilized enrollment and encounter data starting in SFY 2014-15. The population included all Medicaid recipients who were initially enrolled in (or assigned to) the Magellan Complete Care SMI Specialty plan based on criteria used by AHCA. Recipients who were enrolled in the SMI Specialty plan for at least 60 days and who did not switch to a Standard plan were considered to be the treatment group. Recipients initially enrolled in the SMI Specialty plan but who switched to a Standard plan and remain enrolled for at least 60 days comprised the comparison group. We used encounter data for all recipients for one year beginning with the date they enrolled in their plan (SMI Specialty plan for the treatment group and the date they switched for the Standard plan comparison group). Services were classified as physical health or mental health based on the primary diagnosis on the claim/encounter. Expenditures/payments were the reported payments made by the Specialty and Standard plans to providers. For the analysis of program quality, aggregate data on performance measures submitted by the MMA plans were reviewed and compared to national standards.

Limiting the analysis to people who had been assigned to the SMI Specialty plan excluded two groups of people from the analysis. First, Medicaid recipients with SMI in the three AHCA Regions not

served by the SMI Specialty plan were not included, as it would not be possible to compare recipients receiving services from the SMI Specialty and Standard plans in these three regions. Recipients were also excluded if they actively chose a Standard plan prior to auto-enrollment in the SMI Specialty plan. These recipients were never enrolled in the SMI Specialty plan and thus, were not part of the analysis. In addition, we expect that these recipients would have much higher levels of functioning than recipients who were auto-enrolled in the SMI Specialty plan. The research methods used in this report would likely not be adequate to compare such different groups.

Methods

Descriptive statistics and tests of significance (e.g., chi-square for categorical variables, t-test for continuous variables) were computed for all variables. The proportion of enrollees receiving services was calculated and compared across the SMI Specialty and Standard/Comprehensive plans. Significant differences in descriptive statistics required propensity score matching (PSM) to create comparable samples. This is a procedure where recipients were matched such that comparisons were made between recipients with similar baseline characteristics. Logistic regression was used to compute the predicted probability of remaining enrolled in the SMI Specialty plan based on observed individual characteristics. The sample was divided into five groups based on the predicted probability. Thus, comparisons of service use and payments were between recipients with similar observed characteristics. The social determinants of health/outcomes were also examined using logistic regression with adjustment for plan choice.

Results

Table 3 compares descriptive statistics for recipients enrolled in the SMI Specialty plan and the Standard plans. The sample contains 47,329 Medicaid recipients who were enrolled in the SMI Specialty plan. Of those originally enrolled in the SMI Specialty plan there were 20,727 recipients who switched from the SMI Specialty plan to a Standard plan and 26,602 enrollees who did not switch.

Significant differences in gender, race, age, AHCA region, and diagnoses were found between SMI Specialty plan enrollees and Standard plan enrollees. Among individuals that switched to a Standard plan, 34.4% were male and 65.6% were female. Individuals that remained in the Specialty plan were 40.2% male and 59.8% female. Among the 17,810 men (7,125+10,685), 40.0% switched (7,125/17,810) to a Standard plan and 60.0% remained in the Specialty plan. Of the 29,519 women originating with the SMI plan, 46.1% switched (13,602/29,519) to a Standard plan and 53.9% stayed in the Specialty Plan (i.e., were part of the treatment group).

Post hoc tests were used to examine differences between race, age, and diagnostic groups. Whites were more likely than Blacks or Hispanics to remain in the SMI Specialty plan, whereas Blacks were significantly more likely to remain with the SMI Specialty plan compared to Hispanic enrollees. Individuals that switched to a Standard plan were 27.8% White 23.8% Black, and 28.5% Hispanic. Individuals that remained in the Specialty plan were 38.0% White, 26.3% Black, and 17.0% Hispanic. Sixty-four percent of Whites remained in the Specialty plan compared to 58.6% of Blacks and 43.3% of Hispanics. The age distribution varied between individuals that switched to a Standard plan and individuals that remained in the Specialty plan. Thirty-four percent of individuals that switched to a Standard plan were ages 18-39, compared to 44.4% of the individuals remaining in the Specialty plan. Twenty-two percent of individuals that switched to Standard plan were less than 18 and 40.1% were ages 40-64. Eighteen percent of individuals that remained in the Specialty plan were under 18 and 35.8% were ages 40-64. Enrollees ages 18-39 were most likely to remain with the SMI Specialty plan with 62.9% remaining in the Specialty plan. Individuals 65 and older were least likely to remain in the Specialty plan (33.3%). The diagnostic profiles also differed between individuals who switched to a Standard plan and remained in the Specialty plan. Among individuals that switched to a Standard plan, 8.2% had a schizophrenia diagnosis and 23.4% of an episodic mood disorder diagnosis. Among individuals that remained in the Specialty plan, 17.7% had a schizophrenia diagnosis and 28.6% had an episodic mood disorder diagnosis. Enrollees were also more likely to remain in the SMI Specialty plan if they received a diagnosis for a Serious Mental Illness after MMA enrollment (e.g., Schizophrenia, 73.4%; Mood disorders, 61.1%). It is important to note that because only MMA data were used in this analysis, the diagnoses only include those diagnoses received while enrollees were in the MMA plan. Some individuals did not have a diagnosis consistent with a SMI in this time frame, particularly among individuals that switched to a Standard plan. However, recipients may have received additional diagnoses prior to the implementation of the MMA program that would not be captured in this analysis.

The December 2015 enrollment files were used to determine enrollees' residence (AHCA region). Some recipients changed regions since their original enrollment in the SMI Specialty plan. Thus, some recipients are listed in AHCA regions in which the SMI Specialty Plan was not offered (e.g., Regions 1, 3, and 8). Overall, there were considerable diagnostic differences between recipients who remained enrolled in the SMI Specialty plan and the comparison group of recipients who switched to a Standard plan. However, there were unexpected differences in demographic characteristics between enrollees who remained in the SMI Specialty plan and those who switched, including differences in gender, age,

and race. Why there were such differences in switching patterns is an important question for future research.

Table 3: *Sample Characteristics*

	Individuals that Switched to Standard Plan (N=20,727)		Individuals that Remained in SMI Specialty Plan (N=26,602)		
	N	%	N	%	*p*-value
Gender					<.001
Female	13,602	65.6	15,917	59.8	
Male	7,125	34.4	10,685	40.2	
Race					<.001
Asian	110	0.5	161	0.6	
Black	4,931	23.8	6,993	26.3	
Hispanic	5,901	28.5	4,514	17.0	
Native American	30	0.1	76	0.3	
Unknown	3,680	17.8	4,329	16.3	
Other	305	1.5	417	1.6	
White	5,770	27.8	10,112	38.0	
Age					<.001
<18	4,555	21.9	4,821	18.1	
18-39	6,976	33.7	11,817	44.4	
40-64	8,313	40.1	9,524	35.8	
65+	883	4.3	440	1.7	
AHCA region					<.001
Unknown	50	0.2	133	0.5	
1	31	0.2	16	0.1	
2	293	1.4	1,891	7.1	
3	172	0.8	157	0.6	
4	1,327	6.4	4,045	15.2	
5	486	2.3	2,984	11.2	
6	961	4.6	5,271	19.8	
7	7,365	35.5	3,841	14.4	
8	75	0.4	40	0.2	
9	2,681	12.9	2,082	7.8	
10	1,864	9.0	2,038	7.7	
11	5,422	26.2	4,104	15.4	
Mental Health Diagnosis					<.001
Dementia	22	0.1	37	0.1	
Alcoholic psychoses	52	0.3	139	0.5	
Drug psychoses	155	0.8	290	1.1	
Transient organic psychotic conditions	216	1.0	454	1.7	

	Individuals that Switched to Standard Plan (N=20,727)		Individuals that Remained in SMI Specialty Plan (N=26,602)		
	N	%	N	%	*p*-value
Other organic psychotic conditions	54	0.3	74	0.3	
Schizophrenia	1,706	8.2	4,711	17.7	
Episodic mood disorders	4,843	23.4	7,604	28.6	
Paranoid states	29	0.1	74	0.3	
Other nonorganic psychoses	741	3.6	1,846	6.9	
Psychoses specific to childhood	79	0.4	80	0.3	
Neurotic disorders	1,983	9.6	2,244	8.4	
Personality disorders	56	0.3	115	0.4	
Sexual deviations and disorders	11	0.1	18	0.1	
Alcoholic dependence syndrome	121	0.6	334	1.3	
Drug dependence	410	2.0	735	2.8	
Nondependent abuse of drugs	603	2.9	1,257	4.7	
Physiological malfunction from mental factors	9	0.0	13	0.1	
Special symptoms not elsewhere classified	153	0.7	220	0.8	
Acute reaction to stress	36	0.2	47	0.2	
Adjustment reaction	799	3.9	896	3.4	
Specific nonpsychotic mental disorders following organic brain damage	24	0.1	21	0.1	
Depressive disorder	1,449	7.0	2,016	7.6	
Disturbance of conduct	405	2.0	444	1.7	
Disturbance of emotions specific to childhood and adolescence	235	1.1	245	0.9	
Hyperkinetic syndrome of childhood	1,366	6.6	1,364	5.1	
Specific delays in development	63	0.3	14	0.1	
Psychic factors associated with diseases classified elsewhere	3	0.01	0	0.00	
Mild mental retardation	2	0.01	3	0.01	
Other specified mental retardation	4	0.02	5	0.02	
Unspecified mental retardation	12	0.06	15	0.06	

The second research question relates to access to services. We addressed access by examining the time from the enrollment date until the receipt of first service (See Table 4). Physical health and mental health services were considered separately. We hypothesized that the time until services were received would be shorter for recipients enrolled in the SMI Specialty plan. Indeed, the time until receipt of mental health services was shorter for SMI Specialty plan enrollees. SMI Specialty plan enrollees averaged 57.1 days until their first mental health service (median=30 days) compared to 66.7 days for enrollees with SMI in the Standard plans (median=33 days). However, the time until the first physical

health service was received was shorter for Standard Plan enrollees. SMI Specialty plan enrollees averaged 70.7 days until their first physical health service (median=41 days) compared to 62.2 days for Standard plan enrollees with SMI (median=31 days). Thus, despite the shorter time until receipt of a mental health service and the emphasis on coordination of care, the SMI Specialty plan did not shorten the length of time until the enrollee received their first physical health service.

Table 4: *Time to Treatment (in days)*

	Switched to Standard Plan		Remained in SMI Specialty Plan		
	Mean	Median	Mean	Median	*p*-value
Physical Health Service	62.2	31.0	70.7	41.0	<.0001
Mental Health Service	66.7	33.0	57.1	30.0	<.0001

The significant differences in demographic and diagnostic characteristics suggest that comparisons of service utilization and outcomes must account for such differences. Thus, propensity score matching (PSM) was used to create comparable groups. Before discussing the PSM results, descriptive statistics are presented on service use for recipients enrolled in the SMI Specialty plan and those who switched to a Standard plan. Table 5 presents the average total service use (average units of service and dollars) as well as total physical health care service use and total mental health care service use. Dollars are the payments by the plan to providers for the services as reported in the MMA encounter data.

The units of service were higher for enrollees with SMI in the Standard plans (164.7 for Standard plan enrollees versus 131.3 for SMI Specialty plan enrollees) but total payments were higher among those enrolled in the SMI Specialty plan ($5,831 versus $5,101). Units and payments for mental health services were significantly greater among individuals enrolled in SMI Specialty plan. SMI Specialty plan enrollees had 99.5 units of service and $3,177 in service payments, compared to 87.1 units and $1,838 for enrollees with SMI in the Standard plan. Units of physical health care services were greater for individuals with SMI the in Standard plans. Standard Plan enrollees with SMI averaged 122.8 units of service compared to 75.0 units for SMI Specialty plan enrollees. Interestingly, despite that all Medicaid recipients in the sample qualified for enrollment in the SMI Specialty plan, physical health expenditures were higher than mental health expenditures regardless of whether the recipient was enrolled in the SMI Specialty plan or a Standard plan.

One challenge was that recipients were enrolled in their plan for different lengths of time. We observed some recipients for the entire year but others were enrolled for shorter periods of time. SMI Specialty plan enrollees were observed, on average, for 257 days whereas Standard plan enrollees were observed for 339 days. This would suggest that Medicaid recipients assigned to the SMI Specialty plan early in the transition process were more likely to switch plans, while more recent assignees were less likely to switch. Thus, as is common in research on healthcare expenditures, annualized units of service and annualized dollars were computed. In essence, for Medicaid recipients in the sample for less than 365 days, their expected service use was computed assuming they had been observed or the full year. For example, if an enrollee was in the sample for three months, their services and payments were multiplied by 4. Such an approach creates some statistical issues, as the expected variance for enrollees observed for shorter periods of time is greater. To address this problem, all observations were weighted by the proportion of the year for which data were present. This use of annualized dollars is common in the literature (Robst, Levy, & Ingber, 2007).

Thus, the bottom portion of Table 5 contains annualized service use for enrollees currently in the SMI Specialty plan and recipients who were originally there but subsequently switched to a Standard plan. Annualized total payments were greater for enrollees in SMI Specialty plan ($7,658 versus $5,452) but annualized units of service did not differ significantly. Among mental health services, recipients enrolled in the SMI Specialty plan received more services, and payments were also greater. Specialty plan enrollees averaged 119.7 units of service and $3,822 in service payments, compared to 92.8 units and $1,957 for Standard plan enrollees with SMI. Among physical health services, units of service were greater for enrollees with SMI in the Standard plans and total payments were greater among enrollees in the SMI Specialty plan. Standard plan enrollees with SMI averaged 130.7 units of service and $4,560 in service payments, compared to 98.0 units and $5,632 for enrollees in the SMI Specialty plan. Similar to the unadjusted results, annualized payments for physical health services were greater than annualized dollars for mental health services.

Table 5: *Service Utilization – Descriptive Statistics*

	Switched to Standard Plan			Remained in SMI Specialty Plan			
N		Mean	Std Dev	N	Mean	Std Dev	*p*-value
Total Health Care							
20,727	Units	164.73	662.06	26,602	131.31	407.91	<.0001
	Payments	5,101.18	14,899.67		5,831.82	16,228.94	<.0001
Physical Health Services							

Switched to Standard Plan				Remained in SMI Specialty Plan			
N		Mean	Std Dev	N	Mean	Std Dev	*p*-value
17,543	Units	122.80	638.60	18,119	75.02	342.46	<.0001
	Payments	4,285.33	14,687.99		4,311.11	15,625.51	0.8725
Mental Health Services							
9,839	Units	87.14	245.64	14,272	99.51	302.85	0.0008
	Payments	1,837.81	4,391.97		3,176.90	7,486.40	<.0001
Annualized Units and Payments							
Total Health Care							
20,727	Units	176.05	771.79	26,602	172.42	434.93	0.5909
	Payments	5,451.72	15,630.02		7,658.17	18,262.39	<.0001
Physical Health Services							
17,543	Units	130.67	755.49	18,119	98.00	380.27	<.0001
	Payments	4,560.06	15,423.96		5,632.07	17,868.80	<.0001
Mental Health Services							
9,839	Units	92.81	249.01	14,272	119.72	306.09	<.0001
	Payments	1,957.42	4,550.89		3,821.88	7,934.19	<.0001

As previously noted, given the considerable demographic and diagnostic differences, it is important to account for such differences when comparing the SMI Specialty plan and Standard plans. Table 6 contains the logistic regression results used to generate the propensity scores. The dependent variable is coded as 1 if the recipient remained enrolled in the SMI Specialty plan.

Consistent with the descriptive statistics, females were less likely than males to remain enrolled in the SMI Specialty plan (Odds ratio (OR)=.723, CI .692-.755). Hispanic recipients (OR=.711, CI .670-.755) were less likely than whites to remain enrolled in the SMI Specialty plan, and age was inversely associated with the likelihood of remaining in the SMI Specialty Plan (OR=.992, CI .991-.994). There were also significant differences in enrollment patterns across AHCA regions. Compared to the reference region, Region 11, enrollees in Regions 2, 4, 5, 6 and 10 were all more likely to remain in the SMI Specialty plan. Compared to the reference diagnosis of schizophrenia, recipients with episodic mood disorders (OR=1.286, CI 1.213-1.363), alcoholic dependence (OR=1.533, CI 1.206-1.948), and non-dependent abuse of drugs (OR=1.163, CI 1.035-1.307) were more likely to remain in the SMI Specialty plan, whereas enrollees with adjustment disorders (OR=.668, CI .596-.748), conduct disorders (OR=.690, CI .590-.808), ADHD (OR=.542, CI .492-.597), and delays in development (OR=.254, CI .138-.467) were less likely to remain enrolled in the SMI Specialty plan.

Table 6: *Logistic Regression Results for Plan Choice*

	OR	95% CI	
Age			
	0.992	0.991	0.994
Gender (ref: Male)			
Female	0.723	0.692	0.755
Race (ref: White)			
Asian	1.085	0.826	1.424
Black	0.979	0.925	1.035
Hispanic	0.711	0.670	0.755
Indian/Native American	1.078	0.677	1.716
Not reported	0.803	0.753	0.855
Other	1.004	0.849	1.187
AHCA Region (ref: AHCA Region 11)			
1	0.617	0.333	1.144
2	8.346	7.299	9.542
3	1.179	0.940	1.478
4	4.059	3.748	4.396
5	8.135	7.297	9.069
6	7.589	6.981	8.249
7	0.667	0.629	0.709
8	0.718	0.484	1.065
9	0.959	0.890	1.033
10	1.290	1.192	1.396
Mental health diagnosis (ref: 295, Schizophrenia)			
Dementia	1.033	0.577	1.849
Alcoholic psychoses	1.249	0.868	1.798
Drug psychoses	1.018	0.814	1.273
Transient organic psychotic conditions	1.208	1.006	1.449
Other organic psychotic conditions	0.883	0.590	1.321
Episodic mood disorders	1.286	1.213	1.363
Paranoid states	1.354	0.851	2.155
Other nonorganic psychoses	1.987	1.797	2.198
Psychoses with origin specific to childhood	0.782	0.548	1.115
Neurotic disorders	0.681	0.631	0.736
Personality disorders	1.308	0.916	1.869
Sexual deviations and disorders	1.206	0.531	2.737
Alcoholic dependence syndrome	1.533	1.206	1.948
Drug dependence	1.049	0.913	1.205
Nondependent abuse of drugs	1.163	1.035	1.307
Physiological malfunction arising from mental factors	1.317	0.519	3.344
Special symptoms or syndromes, not elsewhere classified	0.855	0.674	1.084
Acute reaction to stress	0.829	0.508	1.354

	OR	95% CI	
Adjustment reaction	0.668	0.596	0.748
Specific nonpsychotic mental disorders following organic brain damage	0.518	0.264	1.013
Depressive disorder, nec	0.83	0.764	0.902
Disturbance of conduct	0.69	0.590	0.808
Disturbance of emotions specific to childhood and adolescence	0.691	0.560	0.852
Hyperkinetic syndrome of childhood	0.542	0.492	0.597
Specific delays in development	0.254	0.138	0.467
Psychic factors associated with diseases classified elsewhere	<0.001	<0.001	>999.999
Mild mental retardation	0.837	0.124	5.666
Other specified mental retardation	0.868	0.209	3.612
Unspecified mental retardation	0.949	0.422	2.135

*Dependent variable: Remained Enrolled in SMI Specialty plan

The logistic regression results were used to compute the predicted probability that a recipient remained enrolled in the SMI Specialty plan. Recipients were placed into one of five equally sized groups based on the predicted probability. Recipients in the first quintile had the highest probabilities of switching plans, whereas recipients in the fifth quintile had the highest probability of remaining in the SMI Specialty plan.

Table 7 compares annualized service utilization and payments in each of the five quintiles. The first quintile contains recipients with the greatest probability of switching. Total healthcare payments were greater for recipients enrolled in the SMI Specialty plan ($5,833 versus $4,872). The difference was primarily due to the significantly greater payments for mental health services ($2,775 versus $1,600). Recipients with SMI enrolled in the Standard plans received more units of physical health services (121.1 versus 95.3). Similarly, in the second, third and fourth quintiles, total payments were higher among recipients enrolled in the SMI Specialty plan, although in these quintiles, payments were significantly higher for both physical and mental health services. In the fourth quintile, units of service were higher among SMI Specialty plan enrollees for mental health services (152.3 versus 124.7), while the units of physical health services were higher among enrollees with SMI in the Standard plans (130.9 versus 112.5). The fifth quintile contained recipients most likely to remain enrolled in the SMI Specialty plan. Total healthcare and mental healthcare payments remained higher for SMI Specialty plan enrollees. Physical healthcare payments did not differ significantly. Units of total services and physical health services were greater among Standard plan enrollees with SMI.

In summary, enrollees of the SMI Specialty plan received more mental health services in three quintiles, and had higher mental health service payments in all five quintiles. There were no quintiles in

which enrollees in the SMI Specialty plan received fewer mental health services or had lower payments. Enrollees with SMI in the Standard plans received more physical health services in three quintiles, but had lower payments for physical health services in two quintiles. There were no quintiles in which Standard Plan enrollees with SMI received fewer units of physical health services or had higher payments for physical health services compared to enrollees in the SMI Specialty plan.

Table 7: *Service Utilization - Propensity Score Matching*

	Switched to Standard Plan			Remained in SMI Specialty Plan			
N		Mean	Std Dev	N	Mean	Std Dev	p value
1st quintile							
Total Health Care							
6,824	Units	145.87	438.64	2,631	126.30	407.70	0.1267
	Payments	4,872.39	12,984.47		5,832.87	18,087.63	0.0238
Physical Health Services							
5,846	Units	121.17	419.55	1673	95.29	394.45	0.0397
	Payments	4,420.09	12,934.99		5,063.95	18,223.97	0.1377
Mental Health Services							
1,879	Units	82.22	201.16	593	96.54	231.77	0.1651
	Payments	1,600.23	3,221.77		2,775.27	5,517.82	<.0001
2nd quintile							
Total Health Care							
6,058	Units	182.65	1234.96	3,418	150.06	361.35	0.2150
	Payments	5,032.19	19,448.18		6,504.85	17,423.71	0.0022
Physical Health Services							
5,006	Units	141.15	1240.29	2268	88.24	278.06	0.0587
	Payments	4,297.52	19,510.09		5,391.45	17,601.34	0.0317
Mental Health Services							
2,839	Units	84.68	247.35	1,728	103.60	306.04	0.0281
	Payments	1,616.58	4,173.34		2,530.84	6,204.93	<.0001
3rd quintile							
Total Health Care							
4,347	Units	202.66	491.71	5,119	220.05	470.70	0.1092
	Payments	6,296.88	14,673.83		8,259.06	21,652.83	<.0001
Physical Health Services							
3,688	Units	129.60	424.61	3,712	94.76	342.51	0.0002
	Payments	5,023.23	14,338.21		5,830.31	22,344.40	0.0770
Mental Health Services							
3,306	Units	99.47	271.70	4,305	154.45	375.22	<.0001
	Payments	1,967.59	4,477.57		3,836.41	7,759.23	<.0001
4th quintile							

		Switched to Standard Plan			Remained in SMI Specialty Plan		
N		Mean	Std Dev	N	Mean	Std Dev	p value
Total Health Care							
2,197	Units	189.62	434.32	7,269	191.11	477.53	0.9115
	Payments	6,317.90	13,959.02		9,239.97	19,227.81	<.0001
Physical Health Services							
1,876	Units	130.91	353.93	4,921	112.53	438.41	0.1364
	Payments	4,761.21	13,058.81		6,238.43	17,935.73	0.0029
Mental Health Services							
992	Units	124.72	281.13	2,698	152.35	319.33	0.0236
	Payments	3,390.95	6,493.60		6,161.05	10,317.72	<.0001
5th quintile							
Total Health Care							
1,301	Units	188.12	619.85	8,165	140.31	400.51	0.0013
	Payments	6,001.39	14,423.73		6,995.00	14,773.29	0.0456
Physical Health Services							
1,127	Units	136.64	583.65	5,545	94.49	380.47	0.0042
	Payments	4,619.64	13,694.09		5,277.32	14,018.19	0.1775
Mental Health Services							
823	Units	81.41	210.84	4,948	75.03	223.63	0.4702
	Payments	2,242.68	5,436.21		3,140.81	7,120.98	0.0011

The research team attempted to determine whether we could explain why there were such distinctive differences in service use patterns between enrollees with SMI in the SMI Specialty and Standard plans. In particular, we wanted to explore why some enrollees in the Standard plans tended to get more physical health services but still had lower payments for services. Thus, Table 8 contains service use and average payments (total dollars in the service category divided by number of users) by type of service. Procedure codes and claim types from encounters were used to place encounters into service categories.

Units of service and payments were annualized. The *p*-values were from regressions that control for the propensity score, as well as differences in recipient characteristics (age, race, gender, AHCA region, diagnosis). We controlled for the propensity score in a regression framework because sample sizes would become too small if we divided the sample into five groups, and the sheer volume of results would make them difficult to interpret.

Among the physical health services, average per person payments for crisis care (e.g., ER) and inpatient services were significantly higher among SMI Specialty plan enrollees. Payments averaged $11,859 among 4,370 Specialty plan enrollees who required inpatient care, compared to $9,260 among

4,053 enrollees with SMI in Standard plans who required inpatient care. Payments for crisis care averaged $587 for 10,677 Standard plan enrollees with SMI, and $1,021 for Specialty plan enrollees. Although there were other statistically significant differences in expenditures (e.g., DME, lab, outpatient, and radiology), the magnitude of the differences was much smaller. Units of service were much higher among Standard plan enrollees with SMI for Durable Medical Equipment (DME) and outpatient services. Thus, although units of physical health services tended to be higher for Standard Plan enrollees with SMI in Table 7, the differences tended to be for lower cost services. Thus, the significant difference in high cost inpatient services led to SMI Specialty plan enrollees having higher payments for physical health services.

Among mental health services, inpatient services also had a substantial effect on the overall results. Mental health inpatient services were more likely to be used by SMI Specialty Plan enrollees (1,079 Standard plan enrollees with SMI and 2,966 SMI Specialty plan enrollees used mental health inpatient services), and among those that used inpatient services, average payments were also higher for SMI Specialty Plan enrollees ($8,137 versus $3,936). Once again, although there were other statistically significant differences between enrollees in the SMI Specialty and Standard plans, the magnitude of the differences was much smaller. SMI Specialty plan enrollees also averaged more units of mental health services in Table 7. This result seems to be driven by fact that SMI Specialty plan enrollees were more likely to use many of the services. Penetration rates for assessment, crisis care, inpatient, lab, outpatient, targeted case management, and treatment planning all appear much larger among SMI Specialty Plan enrollees. Among users of services, the average number of units does not differ in a systematic manner.

Table 8: *Service Utilization by Type of Service*

		Switched to Standard Plans			Remained in SMI Specialty Plan			
		N	Mean	Std Dev	N	Mean	Std Dev	*p*-value
Physical Health Services								
Anesthesia	Units	2,536	137.89	1,361.64	1,593	157.14	225.06	0.5938
	Paid		270.95	372.06		284.52	401.44	0.3698
Crisis Care	Units	10,677	5.25	7.61	12,123	6.83	9.92	<.0001
	Paid		587.62	952.03		1,021.46	1,609.36	<.0001
DME/Supplies	Units	5,383	76.59	464.15	4,227	30.99	115.94	<.0001
	Paid		593.17	1,363.41		544.21	897.31	<.0001

		Switched to Standard Plans			Remained in SMI Specialty Plan			
		N	Mean	Std Dev	N	Mean	Std Dev	*p*-value
Home Health	Units	318	49.95	385.52	296	27.69	88.12	0.8370
	Paid		1,748.05	5,020.59		1,591.34	3,533.41	0.8372
Inpatient	Units	4,053	46.17	711.96	4,370	64.88	501.01	0.3033
	Paid		9,260.21	26,373.88		11,859.65	30,701.80	0.0008
Laboratory	Units	12,951	32.03	60.44	13,183	35.17	59.98	0.7758
	Paid		247.06	511.86		296.05	592.65	<.0001
Nursing Home	Units	488	6.77	8.81	715	8.29	7.94	0.0008
	Paid		2,326.80	9,237.45		1,349.39	4,639.78	0.0473
Outpatient	Units	15,788	45.52	272.68	14,554	24.43	224.00	<.0001
	Paid		1,134.90	3,040.00		1,029.33	3,162.09	0.0009
Radiology	Units	11,170	7.09	10.28	10,514	7.69	10.99	0.9084
	Paid		426.23	1,026.70		485.75	1,069.05	0.0004
Surgery	Units	5,796	3.62	8.34	4,102	3.25	5.73	0.0771
	Paid		677.18	1,804.41		649.84	1,383.81	0.7579
Transportation	Units	1,721	11.04	62.68	1,989	2.76	5.70	<.0001
	Paid		303.98	542.08		344.83	462.15	0.4412
Mental Health Services								
Assessment	Units	5,318	32.31	49.92	7,695	26.03	42.88	0.0020
	Paid		632.97	796.20		515.41	690.92	0.0019
Clubhouse	Units	20	812.81	861.04	46	1,228.94	1,034.94	0.3801
	Paid		4,042.31	4,294.37		6,210.68	5,270.25	0.3740
Crisis Care	Units	1429	2.46	2.77	2855	3.66	5.16	<.0001
	Paid		312.34	439.17		871.82	1606.06	<.0001
DME/Supplies	Units	146	11.06	99.59	319	8.61	72.78	0.8196
	Paid		272.89	252.76		272.98	192.08	0.2392
Developmental Disability Care	Units	347	253.43	294.78	219	195.51	167.97	0.8308
	Paid		2,592.68	1,618.14		2,305.18	1,559.92	0.8361

		Switched to Standard Plans			Remained in SMI Specialty Plan			
		N	Mean	Std Dev	N	Mean	Std Dev	*p*-value
Inpatient	Units	1,079	10.60	15.62	2,966	21.16	73.32	0.0028
	Paid		3,936.26	6,288.51		8,137.32	11,046.73	<.0001
Laboratory	Units	1,896	16.91	50.46	4,082	28.58	117.02	0.0009
	Paid		145.08	693.19		285.33	1,821.87	0.0029
Methadone Maintenance	Units	113	24.11	14.76	106	34.89	15.29	0.0379
	Paid		1,625.21	996.16		2,366.43	1,037.10	0.0305
Out of home MH	Units	138	43.33	76.92	250	28.94	50.72	0.2318
	Paid		12,005.32	17,796.91		11,978.29	17,205.20	0.3919
Outpatient	Units	7,797	43.77	212.20	11,881	65.37	251.02	<.0001
	Paid		602.34	1,900.54		877.47	2,369.49	<.0001
Radiology	Units	337	1.71	1.44	628	2.00	2.04	0.9812
	Paid		176.93	257.95		860.88	2,199.81	<.0001
Targeted Case Management	Units	1,565	143.31	129.26	2,703	127.38	112.68	0.6527
	Paid		1,745.89	1,569.19		1,539.02	1,361.06	0.9768
Transportation	Units	452	5.47	9.96	911	2.02	2.46	<.0001
	Paid		280.46	273.90		261.80	255.69	0.0003
Treatment Planning	Units	4,150	1.64	0.89	6,802	1.74	0.91	<.0001
	Paid		116.04	61.42		116.93	64.29	<.0001

Note: p-values are from GLM regression that controlled for the propensity score, age, gender, race, AHCA region, and diagnosis. All observations were weighted by the proportion of the year enrolled in the SMI Specialty/Standard plan.

Outcomes. Select outcomes are displayed in Table 9. Descriptive statistics were provided with statistical significance assessed using logistic regressions that controlled for the propensity score, age, gender, race, AHCA region, and diagnosis. Recipients who remained enrolled in the SMI Specialty Plan were more likely to have a Baker Act exam, psychiatric inpatient, and juvenile justice involvement (age <18). Rates of psychiatric inpatient use and juvenile justice involvement were more than twice as high among SMI Specialty Plan enrollees.

The combination of higher mental health service use and poorer outcomes suggests that the functioning of Medicaid recipients who remained enrolled in the SMI Specialty Plan was very different

than recipients with SMI who switched to a Standard plan. Recipients who remained enrolled in the SMI Specialty plan appear to have much poorer mental health functioning and more complex needs.

Table 9: *Outcomes*

	Switched to Standard Plan		Remained in SMI Specialty Plan		
	N	%	N	%	*p*-value
Baker Act Exam	821	4.0	1935	7.3	<.0001
Psychiatric inpatient	1079	5.2	2966	11.2	<.0001
Residential/Out-of-home treatment	138	0.7	250	0.9	0.1377
Out of home treatment (age < 18)	69	1.5	80	1.7	0.6355
Juvenile justice (age < 18)	137	3.0	337	7.0	0.0008

Note. p-values for logistic regression that controlled for the propensity score, age, gender, race, AHCA region, and diagnosis. All observations were weighted by the proportion of the year enrolled in the SMI Specialty/Standard plan.

Social Determinants of Outcomes. The last research question involved the importance of social determinants of health. The data for social characteristics are from the Health Services and Resources Administration's 2014 Area Resource File (ARF). The ARF contains a wide variety of county-level data that can be used to measure the social environment in each county. We considered several categories of variables relating to: 1) income/poverty, 2) supply of medical care resources, 3) education, and 4) job conditions/employment. Note that these were all characteristics of the county in which the Specialty Plan and Standard Plan enrollees reside; they do not necessarily reflect the individual's characteristics. For example, there can be substantial differences in income, education, and employment between individuals within a county. However, the goal of this research question was to assess the importance of the social environment in determining outcomes, particularly mental health outcomes for individuals with a Serious Mental Illness.

The following variables were used to define social characteristics. First, there are two categorical variables denoting whether the county is a Health Professional Shortage Area (HPSA). One variable assesses the supply of primary care workers, and the second assessed the availability of mental health professionals. The HPSA variables can have the values of 0 - none of the county is designated as a shortage area, 1 – the whole county is designated as a shortage area, or 2 – some of the county is designated as a shortage area. The remaining variables are dichotomous variables (yes/no variables)

that measure whether a high proportion of the county exhibits housing stress (e.g., a high portion of income is required for housing), low education (failure to achieve high school diploma/GED), low employment (high unemployment or low labor force participation), and poverty (low incomes in county).

Table 10 contains descriptive data for county-level characteristics in which SMI Specialty and Standard plan enrollees with SMI reside. SMI Specialty plan enrollees resided in counties that were more likely to be HPSAs. The magnitude of the difference was larger for mental health care than for physical health care. In addition, 4.4% of SMI Specialty plan enrollees reside in counties with high poverty compared to 1.6% of Standard plan enrollees; 75.0% of Standard plan enrollees were in counties with high housing stress compared to 52.8% of Specialty plan enrollees; 27.0% of Standard plan enrollees were in counties with low education compared to 17.8% of Specialty plan enrollees, and 26.3% of Standard plan enrollees were in low employment counties compared to 16.3% of Specialty plan enrollees.

Table 10: *Social Characteristics*

		Switched to Standard Plan		Remained in SMI Specialty Plan			
		N	%	N	%	Chi sq	*p*-value
HPSA Primary Care Shortage Area	All	101	0.5	482	1.8	146.5	<.0001
	Some	20,576	99.5	25,987	98.2		
	None	0	0.0	0	0.0		
HPSA Mental Health Shortage Area	All	661	3.2	2,981	11.3	1,166.5	<.0001
	Some	19,212	92.9	22,458	84.9		
	None	804	3.9	1,030	3.9		
Housing Stress		15,503	75.0	13,964	52.8	1,379.9	<.0001
Low Education		5,578	27.0	4,699	17.8	572.7	<.0001
Low Employment		5,443	26.3	4,300	16.3	708.1	<.0001
High Poverty		331	1.6	1,154	4.4	266.9	<.0001

Note. 'All' indicates the entire county of residence is a Primary Care (Mental Health) Shortage Area. 'Some' indicates a portion of the county of residence is a Primary Care (Mental Health) Shortage Area. 'None' indicates that no portion of the county of residence is considered a Primary Care (Mental Health) Shortage Area.

Table 11 contains the logistic regression results examining the relationship between social characteristics and outcomes. All logistic regressions also included controls for the propensity score, age, race, gender, whether the county is in a Metropolitan Statistical Area or a Micropolitan Statistical Area, and mental health diagnosis. The primary difference between this regression specification and prior ones in this report is that we replaced AHCA region with the Metropolitan Statistical Area and Micropolitan Statistical Area variables. A Metropolitan Statistical Area has one or more urbanized areas of 50,000 or more people and includes a surrounding area that is highly integrated with the core as measured by commuting ties. A Micropolitan Statistical Area is similar to a Metropolitan Statistical Area conceptually, but only has an urban cluster of at least 10,000 but less than 50,000 population. AHCA region was removed from the specification because the variable captures much of the inter-county variation that we seek to examine in this section. Two of the social characteristics (low education and low employment) were found to exhibit a very high correlation (*r*=.93) and thus, were combined into a single 'low education/employment' variable coded as 1 if the county of residence was a low education or low employment county.

Baker Act exams were less common in counties that were HPSA Mental Health Shortage Areas, but were more common in counties that were classified as HPSA Primary Care Shortage Areas. Baker Act exams were less common in counties with high housing stress (OR=.685, CI: .684-.686), and more common in counties with low education/employment (OR=1.06, CI: 1.058-1.063) and high poverty (OR=1.358, CI: 1.349-1.366).

Psychiatric inpatient stays were less common in counties with high housing stress (OR=.788, CI: .696-.892), but were more common in counties with low education/employment (OR=1.677, CI: 1.486-1.893). Residential treatment was also less common in counties with high housing stress (OR=.788, CI: .696-.892), and more common in counties with low education/employment (OR=1.677, CI: 1.486-1.893). Among youth, the use of out-of-home mental health treatment and involvement in the juvenile justice system were not associated with county characteristics.

Overall, it was challenging to draw strong conclusions. Housing stress could indicate a poorer community (e g., lack of plumbing) but could also indicate a more affluent community where individuals have to spend a high proportion of income on housing. If we assume that the second reason was more typical, then the results for housing stress, low education/employment, and high poverty are fairly consistent. Individuals residing in economically challenged counties were more likely to have involuntary examinations, psychiatric inpatient stays, and to use residential treatment services. Residing in a county with a primary care or mental health provider shortage did not have a strong association with most

outcomes. The one exception was Baker Act exams, where a primary care shortage increased the likelihood of a Baker Act exam but a mental health provider shortage decreased the likelihood.

The analysis of social determinants of health outcomes could examine many different issues. We used the Area Resource File definitions for housing stress, low education, low employment and high poverty, and the HRSA definitions for shortage areas. These definitions apply to the general population, and may or may not apply to individuals with a serious mental illness. In addition, the focus on medical supply and economic outcomes is narrow and could be broadened to incorporate other factors (e.g., environment, crime).

Table 11: *Impact of Social Determinants on Outcomes*

	OR	95% CI	
Baker Act			
Standard Plan	0.766	0.765	0.768
HPSA Primary Care Shortage Area – All	1.252	1.239	1.265
HPSA MH Shortage Area – All	0.919	0.915	0.923
HPSA MH Shortage Area – Some	0.912	0.911	0.913
Housing Stress	0.685	0.684	0.686
Low Education/Employment	1.060	1.058	1.063
High Poverty	1.358	1.349	1.366
Psychiatric Inpatient			
Standard Plan	0.499	0.449	0.555
HPSA Primary Care Shortage Area – All	0.905	0.505	1.623
HPSA MH Shortage Area – All	1.107	0.798	1.537
HPSA MH Shortage Area – Some	1.092	0.848	1.405
Housing Stress	0.788	0.696	0.892
Low Education/Employment	1.677	1.486	1.893
High Poverty	1.217	0.841	1.761
Residential/Out-of-home Treatment			
Standard Plan	0.875	0.684	1.120
HPSA Primary Care Shortage Area – All	<.001	<.001	>999
HPSA MH Shortage Area – All	1.421	0.493	4.098
HPSA MH Shortage Area – Some	1.868	0.834	4.187
Housing Stress	0.659	0.485	0.896
Low Education/Employment	2.343	1.796	3.057
High Poverty	1.105	0.343	3.558
Out-of-home Treatment (age < 18)			
Standard Plan	0.922	0.615	1.382
HPSA Primary Care Shortage Area – All	<.001	<.001	>999
HPSA MH Shortage Area – All	0.604	0.161	2.267

	OR	95% CI	
HPSA MH Shortage Area – Some	1.100	0.409	2.958
Housing Stress	0.716	0.452	1.135
Low Education/Employment	1.270	0.759	2.125
High Poverty	0.872	0.182	4.174
Juvenile Justice (age < 18)			
Standard Plan	0.468	0.357	0.613
HPSA Primary Care Shortage Area – All	2.035	0.697	5.941
HPSA MH Shortage Area – All	0.991	0.512	1.916
HPSA MH Shortage Area – Some	0.782	0.463	1.322
Housing Stress	0.872	0.647	1.174
Low Education/Employment	0.716	0.493	1.039
High Poverty	0.780	0.323	1.883

Note. The logistic regressions controlled for the propensity score, age, gender, race, MSA status, and diagnosis. All observations were weighted by the proportion of the year that they were enrolled.

For the analysis of program quality, aggregate data on performance measures submitted by the MMA plans were reviewed. These data are collected and reported by health plans for the Healthcare Effectiveness Data and Information Set (HEDIS), which is managed by the National Committee on Quality Assurance (NCQA). Often referred to as "HEDIS" measures, these indicators of health care performance are submitted to AHCA annually by July 1, and the measures cover the previous calendar year. In addition to the standard measures, AHCA requests its own specific measures, such as those pertaining to rates of readmission to acute care facilities for a mental health diagnosis. The HEDIS measures were incomplete when the data were received in August 2015 because the MMA plans had not been in operation for a full calendar year. Our objective was to compare behavioral health HEDIS measures between the Standard and SMI Specialty plans; however, data limitations prevented a comprehensive analysis. However, it is possible to make comparisons between some of the measures reported by the plans, as shown in Table 12. The rate for initiation of alcohol and other drug dependence treatment was higher for the SMI Specialty plan as compared to most of the other plans and national standards, but this is not surprising given that substance use and SMI often occur together (Shinn et al., 2001). The rate of mental health readmissions for the SMI Specialty plan was slightly higher than most other MMA plans. For the measures on follow-up after hospitalization for a mental illness, the SMI Specialty plan ranked in the middle.

Table 12. *Plan Performance Measures in 2014*

	Standard Plans												SMI Specialty Plan	National Medicaid HMOs
	Amerigroup	Better Health	Coventry	Humana	Integral	Molina	Prestige	Simply Healthcare	SFCCN	Staywell	Sunshine Health	United Health	Magellan Complete Care	
Initiation of alcohol and other drug dependence treatment – total	61.8%	53.0%	35.6%	34.4%	N/A	35.5%	35.0%	43.0%	44.2%	43.2%	N/A	47.7%	58.8%	38.3%
Engagement of alcohol and other drug dependence treatment – total	12.5%	8.2%	5.7%	4.2%	N/A	2.0%	4.0%	1.7%	8.0%	8.1%	N/A	9.5%	7.0%	11.3%
Mental health readmission rate	42.2%	50.0%	22.3%	12.7%	13.0%	26.0%	12.7%	30.2%	24.9%	21.2%	29.6%	26.1%	30.8%	N/A
Follow-up after hospitalization for a mental illness – 7 days	37.7%	14.2%	10.2%	8.9%	31.2%	19.4%	14.9%	13.0%	22.2%	33.5%	43.9%	35.3%	15.9%	N/A
Follow-up after hospitalization for a mental illness – 30 days	57.3%	25.1%	22.8%	19.2%	46.5%	33.3%	35.8%	22.7%	41.5%	52.2%	56.8%	52.3%	30.4%	N/A

Note. N/A = not available.

Summary and Conclusions

This project evaluated access to health care, the coordination of physical and behavioral health services, and quality of care for individuals with serious mental illness (SMI) who are enrolled in Florida's Managed Medical Assistance (MMA) program. A primary objective was to compare operations and impacts of the SMI Specialty plan operated by Magellan Complete Care with the Standard MMA plans that also serve enrollees with SMI. The research team reviewed and compared MMA plan handbooks, interviewed MMA plan administrators and service providers, facilitated multiple focus groups with MMA plan enrollees diagnosed with a serious mental illness, and conducted an analysis of administrative data to describe characteristics of enrollees with SMI, penetration rates, service utilization patterns, and outcomes across plans.

Conclusions from the Qualitative Analysis

The member handbooks of the Standard plans and the SMI Specialty plan were similar in their level of detail about enrollee benefits, although the handbook for enrollees in the SMI Specialty plan was slightly more detailed in its description of behavioral health services. Although there was some variability among the member handbooks in terms of the specificity of information regarding care coordination services, no meaningful differences were noted in this domain between (or among) the Standard plans and the SMI Specialty plan. For the provider handbooks, the Amerigroup and Magellan Complete Care (SMI Specialty plan) handbooks had more comprehensive information on covered services compared to the other handbooks that were examined.

The interviews with MMA plan administrators and service providers verified the common structural arrangements and contractual requirements across the Standard plans and the SMI Specialty plan. Differences emerged regarding the use of organizational strategies that promote care coordination between the Standard plans that subcontract rather than directly administer behavioral health services. From the perspective of a few provider respondents, the SMI Specialty plan is perceived as the most appropriate and useful plan for serving individuals with SMI. According to the providers, the SMI Specialty plan employs staff who understand the population, and is one of the few plans that manages and coordinates medical care and behavioral health care. No major differences in quality assurance programs were identified between the Specialty plans and Standard plans or in strategies that promote care coordination. There was some variability across plans with regard to communication strategies and

resources. The SMI Specialty plan has a more comprehensive approach to communicating with and engaging new enrollees through the implementation of various outreach strategies. The interviews also indicated that providers have a favorable opinion of the provider relations specialists employed by the SMI Specialty plan, which contributes to their view that the SMI Specialty plan has more useful communication strategies than many of the Standard plans. The enrollee focus groups identified both strengths and challenges with all plans. Many strengths were expressed regarding the SMI Specialty plan and Standard plans including transportation, access to dental care, assistance with making appointments, and effective communication mechanisms.

Conclusions from the Quantitative Analysis

The differences found in enrollee health status and service utilization between the Standard plans and SMI plan have potentially serious implications. Healthier enrollees appear to be selecting out of the SMI Specialty plan. One possible explanation is that the algorithm used to assign Medicaid recipients to the SMI Specialty plan included some recipients that did not truly have a SMI or did not have an ongoing SMI. Many of these recipients would likely switch to a Standard plan. Indeed, the diagnoses reported on MMA encounters were consistent with the idea that not everyone who switched to a Standard plan had a SMI.

However, many who switched to a Standard plan did have diagnoses indicative of a serious mental illness; plan selection based on functional status can create problems for the future viability of the SMI Specialty plan. Risk adjustment payment methods attempt to address enrollee selection by paying plans more for less healthy enrollees. Selection may be problematic when models do not adequately account for enrollee health, especially in specialty plans that focus on recipients with a specific diagnosis or diagnoses. For example, recipients with mood disorders can differ considerably in health and use of services. If 'healthier' recipients with mood disorders leave the SMI Specialty plan and 'sicker' enrollees with mood disorders remain in the SMI Specialty Plan, risk adjustment payment methods could overcompensate the Standard plans and undercompensate the SMI Specialty Plan. The current analyses cannot conclude whether there are actually differences in functional status or whether quality of care in plan varied. However, the service use patterns in this report (even when addressing member choice using propensity score matching) are consistent with this hypothesis. Indeed, among people with mood disorders, average mental health payments were significantly higher for Specialty Plan members than Standard Plan members ($4,692 versus $2,392, $p<.0001$). The significant difference in mental health costs for recipients with mood disorders was also found in each of the five propensity

score groups. A similarly large difference in mental health service costs was found for recipients diagnosed with schizophrenia.

While the results are consistent with a hypothesized difference in functioning between the Specialty and Standard plans, there are other viable hypotheses that should be considered. For example, it is also possible that functional status did not vary; instead some enrollees may have left the SMI Specialty plan because they received poorer quality care (and thus the need for more expensive emergency services) and that once they were enrolled in a Standard plan they received better quality, more coordinated care which may have resulted in better outcomes compared to those enrollees who remained in the SMI Specialty plan.

Thus, it is important for future research to test these hypotheses and perform a more detailed analysis of differences in health among Medicaid recipients with SMI who opt out of the SMI Specialty plan and those who remain, while taking into account AHCA's risk adjustment model. If differences in health status and functioning can be shown for recipients with the same diagnosis, then payments might need to be adjusted to accurately compensate both the SMI Specialty and Standard plans. If differences in health status and functioning cannot be found, then further investigation into the different service patterns is warranted.

Recommendations

Based on the findings of this study, the following policy recommendations are offered.

- Given the ongoing challenges identified in the study findings regarding coordination of physical health and behavioral health services, AHCA and the plans should consider fiscal incentives for network providers that are willing to become certified as Patient-Centered Medical Homes.
- Both AHCA and the plans should continue to promote and incentivize the use of Electronic Health Records that are accessible in real-time by AHCA, the plans, and provider networks.
- Given the study findings about service gaps in rural areas of Florida, AHCA and the plans should continue to promote the use of telemedicine. This support should include addressing known barriers such as the prohibition about doctors prescribing through telemedicine.
- If Standard plans continue to serve enrollees with SMI, offer educational opportunities for the plans on the long-term community based specialized services needed for this population.
- Given the challenges identified regarding the credentialing process, consider the option of standardizing the process across plans, including the use of a shared roster of credentialed providers so that clinicians do not have to be certified by each plan.
- Given the challenges identified regarding service authorization processes, the plans should consider the development of algorithms to assess a provider's quality of care performance. For providers that rate high, implement a more lenient service authorization process.
- Comparisons of health plan performance measures should be undertaken with caution. The SMI Specialty plan serves a population that is seriously disabled with complex physical and behavioral health conditions. Thus, it is unreasonable to expect performance measures for this plan to be similar to other plans or national standards.

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Appendix A

Detailed Project Framework

1. The organizational structure of the MMA plans, involving and including the coordination of physical health and behavioral health	
2. The contractual arrangements and relationships (including financial arrangements), especially as they relate to physical and behavioral health provider networks	
Dimensions	Organizational structure of the MMA plans showing hierarchy & relation of each entity to others; and financial arrangements (graphic portrayal)
	Operational structure of the MMA plans describing specific contractual operations between each entity and others (e.g., physical/behavioral health integration, quality assurance mechanisms, co-location of services, etc.) (graphic portrayal)
	Clinical structure of MMA plans describing specific clinical processes/operations (assessment thru discharge & continuity of care) between specific plan/provider positions and child/adult enrollees (graphic portrayal)
	Types of services available to MMA plan enrollees with SMI (including emergency 24/7, EBPs, telemedicine)

3. Stakeholder roles, relationships, and expectations	
Dimensions	AHCA, MMA plans, providers, direct care staff, and enrollees with SMI have a clear understanding of each other's roles & specific responsibilities regarding providing/managing physical/behavioral health care services and coordination under the MMA program
	Providers receive orientation and ongoing training regarding the MMA plans' vision, operations, and requirements

4. Planned and implemented strategies to ensure coordination of behavioral and physical health care	
Dimensions	Organizational philosophy related to serving enrollees with SMI. Possible elements: (1) understanding of the target population, (2) person-centered medical home, (3)evidence-based practices, (4) care coordination by health care team, (5) stepped care[1], (6) motivational interviewing, (7) integrating primary and behavioral care, (8) whole health approach, (9) cultural & linguistic competency, & (10) recovery & resilience / peer support

[1] Stepped care refers to a construct that is widely used in integrated care models. This concept holds that, except for acutely ill patients, health care providers should offer care that (1) causes the least disruption in the person's life; (2) is the least extensive needed for positive results; (3) is the least intensive needed for positive results; (4) is the least expensive needed for positive results; and (5) is the least expensive in terms of staff training required to provide effective service. In stepped care, if the patient's functioning does not improve, the intensity of services is increased and continues to progress until the patient appropriate improvement is demonstrated (Collins, Hewson, Munger, & Wade (2010).

	MMA plans have written policies and procedures (P&Ps) for each component of coordinated physical/behavioral health care
	Commitment to coordination of physical/behavioral health care
	Services provided by care coordinators assigned to enrollees with SMI. Possible elements: (1) care coordination, (2) assistance with scheduling appointments and follow-up, (3) enrollee advocacy, (3) coordination of needed community resources
	Services provided by Provider Support Specialists assigned to provider networks (SMI Specialty plan only). Possible elements: (1) education and consultation regarding integrated care, (2) promotion and development of coordinated services, co-located services, health homes
	Development of physical/behavioral health service co-locations
	Development of health home arrangements
	Relevant MMA plan staff, provider staff, & direct care providers are trained on co-occurring effects of mental health, substance use, and other health conditions and implications for treatment/wellness management (including EBP & holistic approaches)

5. Communication, problem solving, and decision-making mechanisms	
Dimensions	Communication mechanisms utilized by MMA plans/providers/direct care staff/enrollees with SMI to provide/manage care physical/behavioral health care to enrollees with SMI. Possible elements: (1) team meetings, (2) individual communications, (3) regional meetings
	Communication mechanisms utilized between MMA plans/providers in any other aspects of operations/processes relevant to enrollees with SMI
	Problem-solving/decision-making mechanisms utilized by MMA plans/providers related to providing/managing physical/behavioral health care to enrollees with SMI
	How enrollee information (electronic or hard copy) is accessible in real time by all staff involved in the enrollee's care
	Problem-solving strategies to address issues related to: (1) provider credentialing, (2) billing and required documentation

6. Information and resource sharing among stakeholders (including health record management)	
Dimensions	How all relevant information is documented/managed in an integrated physical/behavioral health record for each enrollee with SMI. Possible elements: (1) behavioral assessment results, (2) test order/results/labs, (3) referrals, (4) physical/behavioral care plans, (5) physical/behavioral progress notes, & (6) prescriptions. Sharing of this information in electronic health records (EHR)
	Any secure interactive website/portal for enrollees (accessibility, usefulness, key features, physical/behavioral health appointments)
	Any data that MMA plans require from providers and frequency/schedule of provision. How data is used & shared with providers/enrollees
	Any changes providers make (including to their information systems) as a result of contracting with MMA plans to serve enrollees with SMI

7. Utilization management, utilization review strategies, quality assurance/improvement procedures, staff development	
Dimensions	How AHCA evaluates/monitors the MMA plans in complying with their contracts
	How the MMA plans evaluate/monitor providers. Possible elements: (1) complying with contract, (2) quality & performance, (3) medical necessity, (4) appropriateness of physical/behavioral health care service use
	Providers' internal evaluation/monitoring procedures. Possible elements: (1) compliance with contract, (2) quality of service planning/provision, (3) medical necessity, (4) appropriateness of physical/behavioral health care service use
	Provider processes to examine quality of functioning between care team members
	AHCA, MMA plans, provider, direct care commitment to quality physical/behavioral health care
	Any clinical guidelines providers/direct care staff use in providing treatment to enrollees with SMI
	Provider/staff training & staff development related to opportunities to enhance quality services. Possible elements: (1) staff development plan, (2) system-wide plan, (3) MMA plans' and providers' expectations for staff development & training, & (4) who offers training and frequency

8. Eligibility requirements and plan selection process	
Dimensions	Availability of updated eligibility files for MMA plans & providers
	Eligibility criteria for SMI Specialty Plan and standard MMA plans
	Specific diagnostic codes and pharmaceuticals used to identify individuals with SMI
	Number/percentage/characteristics of recipients identified by AHCA as eligible for SMI Specialty plan
	Number/percentage/characteristics of enrollees in SMI Specialty plan (age, gender, race/ethnicity, previous Medicaid plan, AHCA region)
	AHCA policies related to changing plans
	MMA plan enrollment process

9. Strategies to ensure access to services, especially during plan transition	
Dimensions	Any service authorization procedures and how well they are working or not (strengths/challenges)
	How enrollees are assessed/referred for physical health conditions and behavioral health conditions
	Provider intake procedures
	Time periods within which requests for care/referrals must be answered; and are occurring (by service type, if applicable). Possible elements: warm hand off, referral tracking
	Any specific provider triage protocols related to prioritizing need and access to services
	Access to services

	Multiple appointments (e.g., physical health visits, labs; behavioral health visits) can be and are coordinated during one office visit
	Any procedures for "warm hand-off" between physical and behavioral health providers; and usage
	A secure interactive website/portal exists that allows enrollees with SMI to request physical/behavioral health appointments
	Any telemedicine services provided and access/usage

10. Strategies to ensure a match between identified needs and service delivery (plan case management/coordinator processes)	
Dimensions	How physical/behavioral health treatment plans are individualized to enrollees identified needs
	Processes/strategies to ensure match between physical/behavioral needs & services
	Policies & procedures to coordinate physical/behavioral care. Possible elements: (1) lab and test tracking, (2) referral tracking, (3) medication reconciliation, (4) reminder system, (5) transitions between levels of care, (6) case plan reviews, (7) tracking of services post-discharge from inpatient care; (8) care team meetings

Appendix B

Document Review Protocol

1. What types of services are available to adults with SMI and youth with serious emotional disturbance (SED) enrolled in the SMI Specialty Plan and the standard/comprehensive plans? (Includes covered and expanded benefits)

2. What types of services are NOT available to enrollees with SMI?

3. What services are provided by Personal Health Guides assigned to adult-SMI/youth-SED SMI Specialty Plan enrollees? (Look for similar roles/elements in other plans)
    Possible elements:
    a. Physical/behavioral care integration
    b. Enrollee advocacy
    c. Physical/behavioral health continuity of care
    d. Recovery- and resilience-oriented
    e. Self-directed care
    f. Peer support

4. What services are provided by Care Collaborators assigned to patient-centered health home providers? (Look for similar roles/elements in other plans)
    Possible elements:
    a. Support
    b. Information
    c. Training

5. Description of any physical/behavioral health home (i.e., medical home) services available.

6. (If applicable): How are relevant Magellan staff, provider staff, and direct care providers trained on co-occurring effects of mental health, substance use, and other health conditions and implications for treatment/wellness management?

7. Is there a secure interactive website/portal for plan enrollees (adult-SMI/youth-SED and family) to request appointments?

8. Have any guidelines been established for creating/maintaining/sharing Electronic Health Records? If so, what are they?

9. Are there any clinical guidelines that providers/direct care staff use in providing treatment to enrollees with SMI? If so, what are they?

10. What do staff development and training plans entail?
    a. Understanding of adult-SMI/youth-SED population
    b. Person-centered medical/health home

c. Evidence-based practice
d. Cultural competence
e. Care coordination by health care team
f. Stepped care
g. Motivational interviewing
h. Integrating primary and behavioral care
i. Whole health approach
j. Recovery- and resilience-oriented

11. Are there any service authorization procedures? If so, what are they?

12. (If applicable): How are adults-SMI/youth-SED screened/referred for physical health conditions and behavioral health conditions?

13. What are the provider service intake procedures?

14. What are the time periods within which requests for care/referrals must be answered?

15. Are there any specific provider triage protocols related to prioritizing needs and timeliness in access to services? If so, what are they?

16. Describe the availability of any emergency and crisis services (e.g., 24 hours a day, 7 days a week).

17. Can multiple appointments (e.g., physical health visits, labs, behavioral health visits) be coordinated during one office visit?

18. Are there procedures for "warm hand-off" between physical and behavioral health providers?

19. Have policies and procedures been developed to address consumer walk-ins to provider agencies? Describe.

20. Description of any telemedicine services provided.

21. Have policies and procedures been developed to coordinate physical/behavioral health care?
Possible elements:
a. Lab and test tracking
b. Referral tracking
c. Medication reconciliation
d. Reminder system
e. Transitions between levels of care
f. Case plan reviews
g. Service plan reviews
h. Care team meetings

Appendix C

Administrator Interview Guide

Population Served

1. What percentage of plan enrollees have a serious mental illness? Of these, how many are adults and how many are under the age of 18?
2. What geographic areas are covered by the plan?

Service Access and Availability

3. How does the plan ensure that services (including emergency services) are accessible and available to enrollees throughout the service area? *Prompt: How are problems with access and availability handled?*
4. How does the plan ensure that the network of behavioral health providers, facilities, and programs is adequate to meet the needs of its enrollees?
5. What are the plans' expectations regarding how providers triage/prioritize patient needs and subsequent access to services?

Service Authorizations

6. How does the plan ensure that providers can request authorizations for behavioral health services?
7. Please describe the authorization process for prescriptions. How is this benefit coverage communicated to enrollees?
8. How does the plan ensure that timely authorization mechanisms are in place for medically necessary care?

Grievances

9. Please describe the plan's grievance system. How are grievances documented, tracked, and resolved? How are enrollees informed of the procedure for processing and resolving grievances?

Strategies to Ensure Integration and Care Coordination

10. What processes have been established for the sharing of information and coordination of care between and among medical and behavioral health providers? *Probe: How does this impact referrals?*
11. To what extent are health homes being used to integrate behavioral and physical health services? What have the facilitators and barriers been?

12. Does the plan actively promote co-location of services? Please explain.
13. What supports and trainings are provided to clinicians by the plan regarding co-occurring diagnoses in mental health, substance use, and physical health? Please describe the frequency of trainings, nature (mandatory or voluntary), and the type of delivery (e.g., in person, online, etc.).

Communication and Problem Solving

14. How does the plan inform enrollees about how to obtain mental health services? *Probe: Does the plan provide interpretation and translation services?*
15. What mechanisms are used to ensure that the plan maintains open communication with providers regarding clinical care, daily operations, and processes (e.g., webinars, conference calls)? *Probe: Does the plan distribute information about SMI to providers?*
16. What types of action does the plan take when providers encounter problems with credentialing and billing or timely submission of documentation? What procedures exist to resolve discrepancies and grievances with providers? What are the factors that facilitate or inhibit timely resolution of these issues?

Utilization and Quality Management Procedures

17. Does your plan contract include specific performance indicators or standards for service providers? Please describe. What are the sanctions for non-performance?
18. How does the plan ensure that it meets the needs of enrollees with regards to continuity of care?
19. Please describe the plan's quality assurance program. What corrective actions are undertaken by the plan when performance goals are not met?
20. What types of staff development opportunities does the plan offer to providers aimed at enhancing quality of services?

Information Sharing

21. What are the plan's expectations for providers with regard to developing, implementing, and sharing integrated physical and behavioral health records?
22. What data are providers required to submit to the plans? Has this changed since the early implementation of the MMA program?
23. Is there anything else you would like to share about the plan that we haven't already discussed?

Some items adapted from:

California Department of Managed Health Care. (2015). *Health Plan Compliance/Medical Surveys*. Retrieved from: https://www.dmhc.ca.gov/LicensingReporting/HealthPlanComplianceMedicalSurvey.aspx#.Vko6CXbnvcs

Appendix D

SMI Enrollee Focus Group Guide

Outreach and Access

Our first set of questions is about outreach and access. We would like to know more about the factors that have made it easier or harder for you to get the services you need in the past 12 months.

1. Convenience
    a. In the past 12 months, have you been able to schedule appointments with a doctor or therapist at times that are convenient for you and your family?
    b. In the past 12 months, has there been a time when you were not able to see a doctor or therapist when you felt you needed care?
2. Location
    a. Is there a designated location where you usually go to get care?
    b. How easy is it for you to get to the place where you usually receive care? Are you able to get there on your own or do you need assistance?
    c. Do you usually see the same doctor when you go there?
    d. Are you able to get different kinds of services in one location? For example, are your physical health visits in the same place as your behavioral health visits?
3. Scheduling
    a. How long do you usually have to wait in the waiting room before you are seen by a doctor/nurse? Are you satisfied with the waiting time?
    b. Are you satisfied with the amount of time you spend with the doctor and staff?
    c. Have you received information about what to do if you need care during evenings, weekends, or holidays, or in case of emergency?
4. Enrollment process
    a. Have you voluntarily changed the managed care plan to which you were originally assigned? If so, why?
    b. Were you able to choose your primary care doctor?

   c. Have you needed to see a specialist in the past 12 months? Were you able to choose your specialist? Were you able to get an appointment? Please describe your experiences.

5. Wellness
   a. Has anyone talked with you about tobacco use, weight loss, alcohol consumption, or provided any other healthcare skills training?

Quality of Care and Treatment Planning

The next set of questions is about the quality of the care you have received in the past 12 months. We also want to know about any treatment planning services you have received.

6. Recovery- and Resilience-Oriented
   a. Has your doctor helped you develop objectives or short-term goals? Have you talked with your doctors about specific goals for your health? Have you talked with them about things that make it hard for you to take care of your health?
7. Communication
   a. Do health care providers use respectful language during appointments? Do they explain things in a way that is easy to understand?
   b. Do you feel that staff are sensitive to your cultural, ethnic, or linguistic background?
8. Patient- and Family-Centered Care
   a. How often did your primary doctor ask you for your ideas about managing your health care?
   b. Have your preferences and values been considered? Does your primary doctor show respect for what you have to say?
   c. Has your doctor or therapist encouraged you to use natural and community supports to help in your recovery?
   d. Has your doctor helped you find the right combination of medications based on your input?
9. Patient Satisfaction
   a. Would you recommend your managed care plan to family and friends?

Care Coordination and Integration

Next, we would like to ask you about the coordination of your behavioral health and physical health care services.

10. Have you seen your primary doctor in the past 2 months? Past 6 months?

11. Has your therapist asked you about your physical health? Has your doctor asked you about your mental health?
12. Do you have someone working for the managed care plan that helps you navigate the health care system to get the care you need (i.e., Health Guide)?
13. How easy is it to get in touch with your personal Health Guide? How often do they contact you? Do they help you get what you need? Do you feel they are knowledgeable?
14. Have you been introduced to a certified peer recovery specialist? Are you actively working with one? How satisfied are you? Have they been easy to access?
15. In general, do you feel that the care you receive addresses your overall health rather than just a single problem?
16. For those of you who have seen a specialist in the past year, did your primary care doctor know about the care you received from the specialist? Did they ask you about it?
17. Do you always get your prescription medications easily? If not, what kinds of problems do you typically experience?

Availability of Services/Gaps in Services

Our last set of questions is about your perceptions regarding any services that are not available under your plan or any limitations regarding services.

18. Service Gaps
    a. Which services do you consider to be necessary but are not currently covered under your managed care plan?
19. Limits to Duration of Services
    a. Have you felt that you needed more of a particular service but it was only available for a limited time or a limited number of visits?
20. Availability of Psychotropic Medications
    a. In the past 12 months, have you experienced any difficulty in filling your prescriptions for psychotropic medications? Please explain.

Appendix E

SMI Caregiver Focus Group Guide

Outreach and Access

Our first set of questions is about outreach and access. We would like to know more about the factors that have made it easier or harder for your child to get the services he/she needs in the past 12 months.

1. Convenience
    a. In the past 12 months, have you been able to schedule appointments with a doctor or therapist at times that are convenient for you and your family?
    b. In the past 12 months, has there been a time when your child was not able to see a doctor or therapist when you felt he/she needed care?
2. Location
    a. Is there a designated location where your child usually goes to get care?
    b. How easy is it for you and your child to get to the place where he/she usually receives care? Are you and your child able to get there on your own or do you need assistance?
    c. Does your child usually see the same doctor when he/she goes there?
    d. Is your child able to get different kinds of services in one location? For example, are his/her physical health visits in the same place as his/her behavioral health visits?
3. Scheduling
    a. How long do you and your child usually have to wait in the waiting room before being seen by a doctor/nurse? Are you satisfied with the waiting time?
    b. Are you satisfied with the amount of time you and your child spend with the doctor and staff?
    c. Have you received information about what to do if your child needed care during evenings, weekends, or holidays, or in case of emergency?
4. Enrollment process
    a. Have you voluntarily changed the managed care plan to which your child was originally assigned? If so, why?
    b. Were you able to choose your child's primary care doctor?

c. Has your child needed to see a specialist in the past 12 months? Were you able to choose the specialist? Were you able to get an appointment? Please describe your experiences.

5. Wellness
    a. Has anyone talked with your child about tobacco use, weight loss, alcohol consumption, or provided any other healthcare skills training?

Quality of Care and Treatment Planning

The next set of questions is about the quality of the care your child has received in the past 12 months. We also want to know about any treatment planning services your child has received.

6. Recovery- and Resilience-Oriented
    a. Has your child's doctor helped him/her develop objectives or short-term goals? Have you talked with your child's doctors about specific goals for his/her health? Have you talked with them about things that make it hard for your child to take care of his/her health?
7. Communication
    a. Do health care providers use respectful language during appointments? Do they explain things in a way that is easy to understand?
    b. Do you feel that staff are sensitive to your cultural, ethnic, or linguistic background?
8. Patient- and Family-Centered Care
    a. How often did your primary doctor ask you for your ideas about managing your child's health care?
    b. Have your preferences and values been considered? Does your primary doctor show respect for what you have to say?
    c. Has your child's doctor or therapist encouraged you to use natural and community supports to help in your child's recovery?
    d. Has your doctor helped your child find the right combination of medications based on your input?
9. Patient Satisfaction
    a. Would you recommend your child's managed care plan to family and friends?

Care Coordination and Integration

Next, we would like to ask you about the coordination of your behavioral health and physical health care services.

10. Has your child seen a primary care doctor in the past 2 months? Past 6 months?
11. Has your child's therapist asked him/her about his/her physical health? Has your doctor asked him/her about his/her mental health?
12. Do you have someone working for the managed care plan that helps you navigate the health care system to get the care your child needs (i.e., Health Guide)?
13. How easy is it to get in touch with your child's personal Health Guide? How often do they contact you? Do they help you get what your child needs? Do you feel they are knowledgeable?
14. Have you been introduced to a certified peer recovery specialist? Are you actively working with one? How satisfied are you? Have they been easy to access?
15. In general, do you feel that the care your child receives addresses his/her overall health rather than just a single problem?
16. For those of you whose child has seen a specialist in the past year, did your primary care doctor know about the care he/she received from the specialist? Did they ask you about it?
17. Do you always get your prescription medications easily? If not, what kinds of problems do you typically experience?

Availability of Services/Gaps in Services

Our last set of questions is about your perceptions regarding any services that are not available under your plan or any limitations regarding services.

18. Service Gaps
    a. Which services do you consider to be necessary for your child but are not currently covered under his/her managed care plan?
19. Limits to Duration of Services
    a. Have you felt that your child needed more of a particular service but it was only available for a limited time or a limited number of visits?
20. Availability of Psychotropic Medications
    a. In the past 12 months, have you experienced any difficulty in filling your child's prescriptions for psychotropic medications? Please explain.

Appendix F

Provider Interview Guide

Organizational Structure and Contracts

1. Please briefly describe the structure of your practice (e.g., staff roles, responsibilities, and qualifications; staff training and supervision; and staff structure).
2. What percentage of your consumers have a serious mental illness? Of these, how many are adults and how many are under the age of 18?
3. Do you have a contract with more than one MMA plan? How many? Which ones? *Probe: How did you decide which plans to join?*[1]
4. Does the degree of communication vary by plan? Which ones communicate most/least effectively? Why?[1]
5. How do you get paid by the health plans? Have there been any issues with claim submissions and payments?[1]

Services Provided

6. Please describe the services (i.e., covered and expanded benefits) that your practice currently provides to consumers with SMI.
7. Have you provided services to individuals with SMI who are enrolled in Magellan Complete Care? If yes, please describe your overall experiences collaborating with MCC.
8. Have you provided services to individuals with SMI who are enrolled in any other MMA plan? If yes, please describe your overall experiences collaborating with these other plans.

Strategies to Ensure Integration and Care Coordination

9. Please describe the care coordination processes you use (e.g., assessment/triage, service plan development, service implementation, and transition/discharge). Are there differences in these processes based on the MMA plan to which a member is assigned?
10. How are physical and behavioral health services integrated for consumers in your practice? What have been the strengths and challenges of care integration?
11. Please tell me about any services for your consumers that are being co-located. What are the expectations regarding co-located services? What are the factors that facilitate or impede co-location?

12. Please describe any additional supports and trainings provided to clinicians serving consumers with co-occurring diagnoses in mental health, substance use, and physical health conditions. *Probe: Ask about Magellan's Provider Support Specialists.*

Communication and Problem Solving

13. What mechanisms are used to ensure that providers and plans maintain open communication regarding clinical care, the care transition process, and daily operations (e.g., webinars, conference calls)?
14. What types of actions does the provider network take when problems are encountered (e.g. credentialing and billing, timely submission of documentation)? What procedures exist to resolve discrepancies and grievances? What are the factors that facilitate or inhibit timely resolution of these issues?

Information and Resource Sharing

15. What are your roles and responsibilities with respect to developing, implementing, and sharing integrated physical and behavioral health records?
16. As a provider, what data are you required to submit to the MMA plans? Has this changed since the early implementation of the MMA program?

Utilization and Quality Management Procedures

17. How is your contract managed by the MMA plans with respect to a) contract compliance, b) quality and performance, c) whether enrollees meet medical necessity criteria, and d) appropriateness of services? What are the standards and criteria used in the monitoring process? What happens if providers fail to meet these standards?
18. What are the facilitators and challenges to ensuring quality of care among the participating providers since implementation of the MMA plans began?
19. Please describe your performance improvement process (e.g., approaches used to assess and monitor staff performance, procedures used for receiving and resolving member complaints, and any changes made to improve the quality of care coordination). How has your performance improvement process changed since the implementation of the MMA program?

Strategies to Ensure Access to Services

20. In your opinion, has consumer access to care changed since the start of the MMA program? If yes, please describe.
21. What is your understanding of the MMA plans' expectations regarding how providers triage/prioritize patient needs and subsequent access to services?

22. How do the plans address issues that arise with respect to access to services?
23. Is there anything else you would like to share about your experiences serving SMI patients under the MMA program that we haven't already discussed?

Appendix G

Interview Consent Document

Script for Obtaining Verbal Informed Consent for Access, Integration and Quality of Care for Individuals with Serious Mental Health Challenges Enrolled in Florida's Managed Medical Assistance Program

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. We are asking you to take part in a research study that is called: Access, Integration and Quality of Care for Individuals with Serious Mental Health Challenges Enrolled in Florida's Managed Medical Assistance Program.

You are being asked to take part in a study of health plan operations and services that impact individuals with serious mental illness (SMI) who are enrolled in Florida's Managed Medical Assistance (MMA) Program.

The people in charge of this study are Mary Armstrong (813-974-4601) and Roger Boothroyd (813-974-1915). However, other study staff are also involved and can act on behalf of the individuals in charge.

Study Purpose: The purpose of this study is to better understand the ability of the MMA Program to meet the needs of individuals with SMI. This study will evaluate access to care, primary and behavioral health care integration, and quality of services received by enrollees with SMI.

The study is being sponsored by the Florida Agency for Health Care Administration (AHCA).

Study Procedures: You are being asked to participate in an interview via telephone that will take approximately 1 hour. Interviews may be audiotaped for accuracy in reporting, if you agree to this. Digital audio recordings will be professionally transcribed and the recordings will be erased once the transcriptions are verified for accuracy. You will only be asked to participate in one interview; however, study staff may want to re-contact you if further information or clarification is needed. Your participation in this study is voluntary.

You have the alternative to choose not to participate in this research study.

You should only take part in this study if you want to volunteer and should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

Benefits: While you may not receive any direct benefit by taking part in this study, the information you provide will help study staff develop a comprehensive understanding and description of how the MMA program is operating and impacting stakeholders. The only cost to you will be the time you take to participate in an interview. You will not receive compensation for taking part in this study.

Risks: This is a minimal risk study which means that the risks associated with this study are the same as what you face every day. There are no known additional risks to you by taking part in this study.

Compensation: We will not pay you for the time you volunteer while being in this study.

Privacy and Confidentiality: We will keep study records private and confidential as allowed by law and your name will not be included in the study report that will be sent to AHCA. Study findings will be summarized and reported in aggregate form. We may also publish what we learn from this study, but if we do, we will not include your name or other personally identifiable information.

However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator, and all other research staff.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety. These include:
    - The University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
    - The Department of Health and Human Services (DHHS).

If you have any questions about this study, you can contact the investigator, Dr. Mary Armstrong at 813-974-4601. If you have question about your rights as a research participant please contact the USF IRB at 813-974-5638.

Would you like to participate in this study? [PI will record if verbal consent is given.]

Appendix H

Focus Group Consent Document

Informed Consent to Participate in Research Involving Minimal Risk

Pro # 00023227

You are being asked to take part in a research study. Research studies include only people who choose to take part. This document is called an informed consent form. Please read this information carefully and take your time making your decision. Ask the researcher or study staff to discuss this consent form with you, please ask him/her to explain any words or information you do not clearly understand. The nature of the study, risks, inconveniences, discomforts, and other important information about the study are listed below.

We are asking you to take part in a research study called:
Access, Integration, and Quality of Care for Individuals with Serious Mental Illness

The person who is in charge of this research study is Dr. Mary Armstrong. This person is called the Principal Investigator. However, other research staff may be involved and can act on behalf of the person in charge.

The research will be conducted at a location that is convenient for all participants.

This research is being sponsored by the Florida Agency for Health Care Administration.

Purpose of the study
The purpose of this study is to learn more about the services provided by different Medicaid managed care plans for people living with a serious mental illness.

Why are you being asked to take part?
We are asking you to take part in this research study because you or your child has been diagnosed with a serious mental illness and is enrolled in a Medicaid managed care plan.

Study Procedures:
If you take part in this study, you will be asked to answer questions about your experiences, knowledge, and opinions regarding the health care services you (or your child) has received over the past 12 months. You will be asked to participate in a group discussion that will take about one hour. The discussion may be audiotaped for accuracy in reporting, if you agree to this. Participants must agree to not share information about the group with others. You will only be asked to participate in one focus group; however, study staff may want to re-contact you if further information or clarification is needed.

Total Number of Participants
About 80 individuals will take part in this study.

Alternatives / Voluntary Participation / Withdrawal
You do not have to participate in this research study. You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

Benefits
We are unsure if you will receive any benefits by taking part in this research study.

Risks or Discomfort
This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.

Compensation
You will be compensated $25 in cash for your participation in the focus group discussion. If you withdraw for any reason from the study before completion, you will still receive $25.

Costs
It will not cost you anything to take part in the study.

Privacy and Confidentiality
We will keep your study records private and confidential. Certain people may need to see your study records. Anyone who looks at your records must keep them confidential. These individuals include:

- The research team, including the Principal Investigator, study coordinator, research nurses, and all other research staff.
- Certain government and university people who need to know more about the study, and individuals who provide oversight to ensure that we are doing the study in the right way.
- Any agency of the federal, state, or local government that regulates this research.
- The USF Institutional Review Board (IRB) and related staff who have oversight responsibilities for this study, including staff in USF Research Integrity and Compliance.
- The sponsors of this study and contract research organization.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you are. Please be aware that the project staff cannot make sure that other group members will not talk about what is said in the group.

You can get the answers to your questions, concerns, or complaints
If you have any questions, concerns or complaints about this study, or experience an unanticipated problem, call Dr. Mary Armstrong at (813) 974-4601.

If you have questions about your rights as a participant in this study, or have complaints, concerns or issues you want to discuss with someone outside the research, call the USF IRB at (813) 974-5638.

Consent to Take Part in this Research Study
I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me. Out of respect to other group

members, I also agree to not share information with others that could identify another group member or his/her comments. I agree to not talk about any specifics about the group with others who did not attend.

_____ _____
Signature of Person Taking Part in Study Date

_____
Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent
I have carefully explained to the person taking part in the study what he or she can expect from their participation. I confirm that this research subject speaks the language that was used to explain this research and is receiving an informed consent form in their primary language. This research subject has provided legally effective informed consent.

_____ _____
Signature of Person Obtaining Informed Consent Date

_____
Printed Name of Person Obtaining Informed Consent

Appendix I

Social Determinants of Care

The following are descriptions taken directly from the Area Resource File Manual for the variables used.

Supply of Medical Resources – Health Professional Shortage Areas (HPSA)

HPSA data for Primary Care and Mental Health Professionals are defined as follows:

1) **Primary Care Practitioners** include non-Federal doctors of medicine (M.D.) and doctors of osteopathy (D.O.) providing direct patient care who practice principally in one of the four primary care specialties-general or family practice, general internal medicine, pediatrics, and obstetrics and gynecology. Those physicians engaged solely in administration, research and teaching will be excluded. A geographic area will be designated as having a shortage of primary medical care professionals if the following three criteria are met:
    A. The area is a rational area for the delivery of primary medical services.
    B. One of the following conditions prevails within the area:
        1. The area has a population to full-time-equivalent primary care physician ratio of at least 3,500:1.
        2. The area has a population to full-time-equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and has unusually high needs for primary care services or insufficient capacity of existing primary care providers.
    C. Primary medical care professionals in contiguous areas are overutilized, excessively distant or inaccessible to the population of the area under consideration.

    The criteria for psychiatric HPSAs were expanded to **Mental Health HPSAs** in 1992 as published in the *Federal Register*, Vol. 57, No. 14; Wednesday, January 22, 1992. Professionals include those psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists who meet the definitions set forth in the ruling. To be designated as having a shortage of mental health professionals, a geographic area must meet the following three criteria where non-Federal core mental health professionals provide mental health patient care (direct or other, including consultation and supervisory) in ambulatory or other short-term care settings to residents of the area:
    A. The area is a rational area for the delivery of mental health services.
    B. One of the following conditions prevails within the area:
        1. The area has:
            a) population-to-core-mental-health-professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1 or
            b) a population-to-core-professional ratio greater than or equal to 9,000:1 or
            c) a population-to-psychiatrist ratio greater than or equal to 30,000:1;

2. The area has unusually high needs for mental services, and has:
   a) population-to-core-mental-health-professional ratio greater than or equal to 4,500:1 and a population-to-psychiatrist ratio greater than or equal to 15,000:1 or
   b) a population-to-core-professional ratio greater than or equal to 6,000:1, or
   c) a population-to-psychiatrist ratio greater than or equal to 20,000:1;

C. Mental health professionals in contiguous areas are overutilitized, excessively distant or inaccessible to residents of the area under consideration.

HPSA Codes are defined as follows:

0 = None of the county designated as a shortage area;
1 = The whole county designated as a shortage area;
2 = One or more parts of the county designated as a shortage area.

Housing, Poverty, Education, and Employment

Housing stress: 30 percent or more of households had one or more of these housing conditions in 2000: lacked complete plumbing, lacked complete kitchen, paid 30 percent or more of income for owner costs or rent, or had more than 1 person per room.

Low-education: 25 percent or more of residents 25 through 64 years old had neither a high school diploma nor GED in 2000.

Low-employment: Less than 65 percent of residents 21 through 64 years old were employed in 2000.

Persistent poverty: 20 percent or more of residents were poor as measured by each of the last 4 censuses: 1970, 1980, 1990 and 2000.

Source. User Documentation for the County Area Health Resources File (AHRF) 2014-2015 Release, U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis