Using Research to Shape Future Directions of Children’s Managed Mental Health Care

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Introduction

Through a contractual arrangement with the Florida Agency for Health Care Administration (AHCA), the Louis de la Parte Florida Mental Health Institute (FMHI) has conducted studies of Florida’s implementation of managed mental health care over the past 11 years (1996–2006). This policy brief is the product of a comprehensive review of 19 studies and yields a more global view of the impact of managed mental health care in the state of Florida on children with serious emotional problems and their families. Summative findings, trends, and policy and practice recommendations from studies regarding children’s managed mental health care are presented.

Consistent with national trends, the general goals of managed care in Florida are to manage costs more effectively and, improve quality and access, as well as the outcomes of care (Hutchinson & Foster, 2003; Stroul, Pires, & Armstrong, 2004). Florida’s Medicaid program has used managed care strategies for physical health services since 1984. At that time, Florida began contracting on a capitation basis with HMOs to provide Medicaid health services, pharmacy, as well as limited mental health services (inpatient and physician services) to a defined population of enrolled beneficiaries. In 1996, Florida began using managed care strategies to provide comprehensive mental health services to individuals eligible for Medicaid. For children’s mental health services, Florida’s managed care excludes intensive out-of-home care such as therapeutic group care services (TGC), statewide inpatient psychiatric programs (SIPP), and behavioral health overlay services (BHOS).

Prepaid mental health plans (PMHPs) and health maintenance organizations (HMOs) are the two forms of managed care arrangements primarily used in Florida for the provision of mental health services. PMHPs represent a mental health care ‘carve out’ plan in which a managed care organization (MCO) provides or arranges for a range of mental health services for plan participants. Participants receive their physical health benefits provided through fee-for service (FFS) from Medipass. In this arrangement, the PMHP managing entity is paid by AHCA through a risk-adjusted, fixed monthly fee per enrollee.

Medicaid HMOs provide the same range of mental health services as those in the PMHP ‘carve-out’, but the HMO risk-adjusted monthly premium also includes general health as well as pharmacy benefits. Since HMOs receive an integrated premium for these three components of the benefit, these arrangements are often characterized as a ‘carve in’ purchasing arrangement. HMOs organize and deliver physical health, mental health, and pharmacy services for their enrollees through sub-contractual agreements either directly with providers or through behavioral health organizations (BHOs).
contracting with service providers in their ‘service networks.’ In other instances, the HMOs subcontract with a behavioral health organization that in turn, contracts directly with mental health providers. HMOs or their BHOs generally reimburse their mental health providers under FFS arrangements or sub-capitation contracts. Prior authorizations for certain services are often required by the HMOs.

In December 2005, a bill was passed to pilot Florida’s Medicaid Reform Pilot Program in two counties. The goal of the reform is to move towards a defined contribution model where beneficiaries can receive credit to spend in the marketplace, and to create a competitive health care market driven by more educated consumers that are empowered to make purchasing decisions for themselves. In February 2007, child welfare recipients began to receive their behavioral health benefits through the Child Welfare Prepaid Mental Health Plan (CW-PMHP), a statewide plan legislatively created (s. 409.912, F.S.) to provide comprehensive mental health services to children enrolled in HomeSafeNet, the information system for the state’s child welfare system.

The continued, and now full, implementation of PMHPs in the state of Florida has allowed researchers a unique view of managed care. Figure 1 below represents a snapshot of the way Florida’s Medicaid system operates today. This brief, however, does not reflect studies pertaining to Medicaid Reform or the CW-PMHP which are in early stages of implementation.

Studies included in this report did not always examine the same variables, geographic areas, or the same managed care entities or areas of Florida, and findings were not always consistent across time. In addition, it should be noted that the synthesis includes information which is representative of earlier stages of implementation, typically characterized as “an initial awkward stage” (Joyce and Showers, 2002). Thus, each study reviewed is essentially a snapshot of a stage of implementation of managed care in an Area, or in multiple Areas of the state.

The content areas from the 19 studies published between 1998–2006 and included in the review are broadly represented by the following areas:

- Quality of Care
  - Access
  - Consumer Engagement
  - Appropriateness of Services
  - Child Outcomes
- Differences Across Managed Care Arrangements (HMO vs. PMHP)
- Service Penetration Rates/Service Use
- Satisfaction
- Ethnic and Racial Disparities
- Mental Health Literacy

### Methodology

The studies reviewed utilized a variety of methods. Yearly studies on the implementation of the PMHPs focused in one Area involved the use of comparison site(s) (an Area, or Areas, that had yet to implement the PMHP) while other yearly implementation studies compared plans within an Area or Areas where managed care had been implemented. Methodology across studies was mixed and included administrative data analyses (Medicaid eligibility and claims data), mail surveys, caregiver and provider interviews, focus groups and file reviews. The following section represents a synthesis of findings derived from the various studies and represents the views of parents/caregivers as well as service providers and other stakeholders.
Findings

Quality of Care

– Access

• Strengths of providers identified by caregivers include cultural competence, identification of children’s mental health needs, and positive regard for case managers and therapists.
• Some providers consistently offered extended office hours and have an established protocol for communication with schools to provide greater access to services.
• Both providers and caregivers expressed concern regarding families with fluctuating incomes going over the income eligibility limit and their child’s Medicaid coverage being eliminated. Caregivers are sometimes unable to get clear answers as to what level of income will make them ineligible, which causes families much anxiety as they attempt to negotiate employment.

In their efforts to make it more efficient, you know, it’s also made it harder, less accessible. I mean, the one thing that’s really frustrating is when kids are found temporarily ineligible for Medicaid, and then the kids are off of medication for a month or two. When kids go off their medicine things fall apart and then sometimes it leads to hospitalization. I mean, while they’re still on Medicaid, everything goes smoothly, but they’ll just be stopped suddenly. You know, with no ability, with almost no ability to prepare.”  – Provider

• Caregiver respondents note that there are too few child psychiatrists in rural areas.
• Provider respondents indicate a need for more Spanish-speaking staff to enable them to increase access to their services for Spanish-speaking children and families.
• The formularies for psychotropic medications for each MCO indicate different authorization and monitoring requirements for the same medications. Described as complex, incomplete, and continuously changing, the varying formularies result in children losing or having to change their medication, even if they were stable on a current medication.

– Consumer Engagement

• Caregivers generally report that providers offered explanations related to the child’s condition, treatment, and medications; that providers solicited and incorporated their input in the child’s treatment plan, and that providers respected client confidentiality.
• Caregivers report a need for additional strategies and techniques aimed at behavior management and stress reduction.

The doctors are too interested in just giving medication and not talking to a person. He never talked to her. They just give medicine, any kind of medicine. It doesn’t work [that way].”  – Caregiver

• Providers facilitate consumer engagement by educating families on treatment.
• Caregivers state their satisfaction with provider efforts to solicit and incorporate family input into their children’s treatment.

They let him know that just because he has this particular problem, it doesn’t have to hinder him from doing anything he wants to do. He don’t [sic] have to change [his aspirations]. It just helps him better himself to do what he wants to do.”  – Caregiver

– Appropriateness of Services

• Caregivers generally report a preference for a combination of medication and therapy and individualized services based on their child’s needs.
• To ensure that services offered to children and families are appropriate, providers report efforts to individualize children’s treatment goals.
• The majority of providers offer supervision from licensed professionals, as well as training in various topical areas related to treatment guidelines and best practices for children with serious emotional problems.
• Caregivers report problems resulting from changes in treatment providers. Not receiving continuous care from the same provider damages the development of a therapeutic relationship and takes away from the feeling that the provider is an emotional safety net for the child and family.

I would like her to be able to have more therapy, but they used to come to the house but they quit doing that and it is very hard for me to go all the way over there for her therapy. I don’t know what I am going to do in the summertime because right now school is taking her there and all I have to do is pick her up. They are talking about gas going up to $3.00 a gallon.”  – Caregiver
– Child Outcomes

- Caregivers consistently note areas of improvement in their child’s functioning and in family functioning over time due to services. Examples of areas where children reportedly improved are: anger/behavior management, emotional stability, and personal relationships.
- Child and family outcomes are tracked by providers informally (e.g., number of face-to-face visits with child in the home, communication with key people in child’s life) and formally (outcome scales and assessments). Providers note the importance of meeting children’s and families basic needs to sustain their support and engagement in the child’s treatment and ongoing stability. Basic needs include finding housing and appropriate daycare, assessing the need for social supports, and aiding in employment.

Differences Across Managed Care Arrangements (HMO vs. PMHP)
- HMO providers report that the authorization process for services and medications should be re-evaluated and streamlined.
- Provider respondents from both HMOs and PMHPs perceive several barriers that prevent them from using treatment guidelines at the practice level. Some clinicians state that there is a lack of exposure to the protocols, others resent that treatment protocols call into question their clinical judgment, training and expertise. There is concern that the protocols are so comprehensive that there is no way a service provider will be able to consistently be in compliance with them, and that protocols may not reflect relevant and/or current research.
- Little difference is seen by providers across managed care arrangements in a caregiver’s ability to obtain needed medication for their child.

Service Penetration Rates/Service Use
- Service penetration rates decline greatly when children with a serious emotional disturbance (SED) or a less severe diagnosis transition into adult services. Service penetration rates for children with SED level off to near zero after transitioning to adult services whereas children with a less severe diagnosis have penetration rates that recover to pre-transition levels and keep increasing.

"If you can’t access a service, then you can’t get served. It doesn’t matter if it’s good or bad [quality]. You’re just sort of dead in the water.” – Provider

- Children enrolled in an HMO have lower penetration rates for anti-depressant medications than children enrolled in a PMHP.
- Implementation of managed care increases paperwork and adds administrative infrastructure costs to provider organizations. These increases in administrative and overhead costs result in less resources being available for services.

"90% of the work is paperwork now. Even if I do work on my weekends doing paperwork, my time should be spent with my clients, not paperwork. Paperwork does not help them.” – Provider

- Children who have been sexually maltreated were much more likely to receive substance abuse counseling than outpatient mental health services. In cases of sexual maltreatment, children were more likely to receive medication management as a treatment option than outpatient sexual abuse counseling.

– Satisfaction

- Only 34% to 59% of caregivers across three years (FY04-05 through FY06-07) were satisfied to very satisfied with the effectiveness of mental health medications taken by their children.
- Some studies found that caregivers enrolled in a PMHP were generally more satisfied with the mental health services received by their children than were those enrolled in an HMO.
- Caregivers have an overall high trust in all types of providers across managed care plans.
  – Trust in providers is typically higher when the child receiving services is younger.

Ethnic and Racial Disparities
- The three most prevalent disorders among Medicaid-eligible children were, in rank order: attention deficit disorder, conduct disorder, and depression disorder. Children who were either Hispanic or Black were significantly less likely than their White counterparts to have received a diagnosis of any of the three most prevalent disorders.
- Overall, children who were Hispanic had significantly fewer hospitalization episodes and significantly shorter length of stays than White children.
- Through the use of geographic information system (GIS) mapping, Medicaid primary care providers and non-HMO Medicaid beneficiaries in each zip code in Florida were geographically displayed. Almost 9% of children enrolled in a PMHP reside in areas, both rural and urban, where there are no Medicaid primary care providers. Within these areas significantly more White children reside as compared to Black or Hispanic children.
Mental Health Literacy

Mental health literacy includes caregiver knowledge of how to obtain mental health information and treatment, their knowledge of risk factors, causes, and treatment of mental disorders, as well as factors such as beliefs and attitudes about mental disorders that promote appropriate help-seeking, and the ability to recognize specific disorders. In relation to providers, mental health literacy includes the ability to give caregivers the chance to make decisions about treatment, communicating health information to caregivers, having helpful beliefs that make them more literate and effective practitioners, and being able to match their treatment recommendations to the child and family's personal situation. Focus group and interview findings expand this definition as follows.

- Literate caregivers possess helpful personal beliefs and attitudes in four categories: a belief in their own capabilities, a belief that they have rights, a belief in one's own value, and a belief in the goodness of professional help.
- Literate caregivers are viewed as knowing how to express their rights. This includes being able to: navigate the managed care systems, communicate with providers and officials in the different systems, and advocate for themselves and their children in all of the systems in which they are engaged. They need to know how to persist in seeking help from the systems and, therefore, need to be competent communicators.
- Literate providers are able to convey information to consumers about their diagnoses and treatments and actively listen to consumers talk about their symptoms and situations in a way that allows them to make both a diagnosis and treatment recommendations.

While the above section represents salient and important findings from studies over the years, the trends identified below represent consistent findings across the years in quantitative as well as qualitative data. Trends are especially important as they highlight findings representative of multiple Areas, years, stages of implementation, and sources of data.

- **Trends**
  - Instability is associated with the first stages of implementation of managed mental health care. This has been a trend noticeable throughout the first one to two years of implementation in each Area. There are typically problems in accessing accurate information, in caregivers' understanding of which plan they are covered by, and in adjusting administrative costs.
  - Analysis of Medicaid administrative claims data found that children enrolled in HMOs have significantly lower penetration rates of mental health services than children enrolled in PMHPs.
  - Across the managed care arrangements (carve-out and carve-in) there are no significant differences in child outcomes across time (as measured by at least one of the following instruments: the Child Health Questionnaire, the Children's Global Assessment Scale, and the Pediatric Symptom Checklist).
    - Across nine years of studies no significant differences in child outcomes were found five times; children enrolled in the PMHP had better overall outcomes twice, and children enrolled in an HMO had better overall outcomes once.
  - Children receiving Temporary Assistance to Needy Families (TANF) have better outcomes than children receiving Supplemental Security Income (SSI). This difference in child outcomes is not unexpected as those children enrolled in TANF are members of a low income family, while children receiving SSI have a mental health or other disability.
  - Providers report a marked increase in paperwork post-implementation of managed care and that this increase is a barrier to serving families.
  - Caregivers consistently express a desire for family involvement in treatment planning. This preference is mirrored by providers who consistently state the importance of caregiver agreement with, and input into, the child's treatment plan.
  - Availability of transportation for caregivers to get children to appointments is continually problematic. Transportation services that are in place, most notably the Medicaid cab, have restrictions that make use difficult (examples reported include: two adults cannot ride with one child, children and families cannot be transported to an office without a full-time doctor on staff, only available when the child cannot ride on public transportation or the caregiver is disabled).

As managed care is now fully implemented statewide in Florida, the following recommendations are designed around shaping the future directions of managed care.
Recommendations

- Managed care entities and their provider networks need to demonstrate a capacity to serve enrolled children with serious emotional problems and their families. A number of workforce issues that should be addressed in order to increase capacity include:
  - Greater funding and recruitment to increase the number of available child and adolescent psychiatrists
  - Trained professionals on staff and/or available as consultants to treat children who have been sexually abused
  - Increasing the number of Spanish-speaking providers available to serve children
- There should be fiscal incentives for providers/clinicians to implement, and sustain with fidelity, evidence-based and promising practices/treatment interventions.
- Providers should continue their efforts to balance medication and psychosocial interventions (as appropriate) in such a way as to meet the individualized needs of the child and family.
- Although service providers are not required by Medicaid to provide childcare and transportation assistance, these remain important issues for families and should be addressed regionally by the system of care. The availability and stability of supports offered to caregivers impacts the well being of the child and family.
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- Make childcare services available to caregivers. Although providers report making efforts to accommodate caregivers that must bring siblings to appointments, caregivers and providers continue to report issues in this area of access to services.
- Through creative solutions, increase the availability of transportation to and accessibility of providers to increase caregiver access to services. Providers should consider locating their offices on or near bus routes and making transportation options available for caregivers who must bring along other children in addition to those receiving services. Finally, flexible funding should be available for caregivers to assist with transportation needs in order to improve client compliance with treatment and presence at appointments.
- Public education about available services, such as the Medicaid cab or other public transportation may be helpful to caregivers in need of transportation. An alternative would be to establish community outreach and public health approaches that offer home-based mental health services.
- Examine the cost/benefit ratio of providing home visits for Medicaid billable services (child therapy, family counseling, and behavior management). Home-based services may be more cost effective, reduce the number of missed appointments, increase access, and alleviate transportation problems for families receiving these services.
- For HMOs the authorization process for services and medications should be re-evaluated and streamlined to ensure that children’s needs are met in an effective and timely manner.
- Information about available mental health services should be better disseminated to caregivers. Caregivers express that typically they find information about services through the internet, or by attending parent trainings and workshops. For information given to caregivers to be seen as useful, it should be readily accessible, given by their provider, and assist them in understanding their child’s diagnoses. The information should also provide suggestions for resources or services (i.e., behavior management, stress reduction strategies).
- MCOs should solicit feedback from network providers (if not currently doing so) on satisfaction with MCO policies and procedures and seek provider input on what works best and what needs improvement in order to serve children with SED and their families in a more collaborative manner.
- Input should be obtained from providers and caregivers prior to changing Medicaid policies and procedures in order to better understand the potential impact on service delivery and access to services.
- Medication formularies and policies governing access to medications should be made consistent across managed care plans so all children receiving pharmacological treatment have equal access to necessary medications. These policies should be made available to families in order to assist them in making informed choices about psychotropic medications within a treatment planning process.
- Paperwork should be standardized across managed care plans. MCOs should work together to produce uniform documentation requirements of service providers in order to reduce the amount of time and effort spent on paperwork, thereby allowing more time for direct client contact.
- Yearly income requirements for Medicaid eligibility should be clearly explained and provided to families. Incorporating month-to-month flexibility may help alleviate the disruptions in medication and other services that children experience as a consequence of going on and off of Medicaid services monthly.
Almost 9% of the children enrolled in a PMHP reside in an area without a Medicaid primary care provider which can create a potential problem in accessing physical health care by this population. Either the high density of the Medicaid population in the area or the lack of primary care providers can limit a child’s access to care. It is important to find ways to increase the availability of primary care providers according to community needs.

As adolescents transition into using adult services, links to mental health services need to be constructed. Procedures need to be developed and applied to youth still in the children’s Medicaid system to plan their transition into the adult mental health system and their transition to any alternative services that they may require. Males should be specifically targeted within the transition planning process as they have a higher probability of dropping out of services.

Pre-treatment assessments need to be consistently done in order to determine the needs of children and youth and how best to serve them.

Reduce barriers to the use of treatment protocols by offering providers additional education and training in the content of treatment guidelines and the expected clinical utility of the guidelines in practice. In addition to education about the guidelines, discussion groups or meetings between clinicians and administrative staff (in agency settings) may also be a way of addressing any concerns providers have about treatment guidelines.

To increase mental health literacy, caregivers should be given the opportunity to learn skills to help them navigate managed care systems, to communicate with providers and officials in the different systems, and to advocate for themselves and their children in all of the systems in which they are involved. They need to know how to persist in seeking help from complex systems and, therefore, need to be competent communicators.

For providers to increase their mental health literacy, they need to acquire skills and abilities that include being able to put themselves in the caregiver’s shoes, understand how a caregiver’s/child’s culture affects their beliefs about, and experiences of, mental illness, and to increase their ability to work with other professionals to help children and their families.

List of Terms

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHCA</td>
<td>Agency for Health Care Administration</td>
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<tr>
<td>BHO</td>
<td>Behavioral Health Organization</td>
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<td>CW-PMHP</td>
<td>Child Welfare Prepaid Mental Health Plan</td>
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<td>FMHI</td>
<td>Louis de la Parte Florida Mental Health Institute</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<td>MCO</td>
<td>Managed Care Organization</td>
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<td>PMHP</td>
<td>Prepaid Mental Health Plan</td>
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<tr>
<td>SOBRA</td>
<td>Sixth Omnibus Budget Reconciliation Act</td>
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<td>TANF</td>
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References


Works Consulted


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