

1998

Quantitative Component Year One Report: Medicaid Enrollee Characteristics, Service Utilization, Costs, and Access to Care in AHCA Areas 4 and 6

Paul Stiles

University of South Florida, stiles@usf.edu

Kristen Snyder

Mary R. Murrin

University of South Florida, murrin@usf.edu

Follow this and additional works at: https://digitalcommons.usf.edu/mhlp_facpub



Part of the [Health Law and Policy Commons](#), and the [Mental Disorders Commons](#)

Scholar Commons Citation

Stiles, Paul; Snyder, Kristen; and Murrin, Mary R., "Quantitative Component Year One Report: Medicaid Enrollee Characteristics, Service Utilization, Costs, and Access to Care in AHCA Areas 4 and 6" (1998). *Mental Health Law & Policy Faculty Publications*. 777.
https://digitalcommons.usf.edu/mhlp_facpub/777

This Technical Report is brought to you for free and open access by the Mental Health Law & Policy at Digital Commons @ University of South Florida. It has been accepted for inclusion in Mental Health Law & Policy Faculty Publications by an authorized administrator of Digital Commons @ University of South Florida. For more information, please contact digitalcommons@usf.edu.

QUANTITATIVE COMPONENT YEAR ONE REPORT: MEDICAID ENROLLEE CHARACTERISTICS, SERVICE UTILIZATION, COSTS, AND ACCESS TO CARE IN AHCA AREAS 4 AND 6

Paul Stiles, J.D., Ph.D., Kristen Snyder, Ph.D., Mary Murrin, M.A.

TABLE OF CONTENTS

1.0 INTRODUCTION.....	2
2.0 METHODS	3
2.1 STUDY QUESTIONS	3
2.1.1 Recipient Characteristics.....	3
2.1.2 Service Utilization.....	3
2.1.3 Access to Services.....	3
2.1.4 Cost of Services	4
2.2 STUDY POPULATION	4
2.3 TUDY DESIGN	4
2.4 DATA SETS	5
3.0 RESULTS AND DISCUSSION	5
3.1 RECIPIENT CHARACTERISTICS	6
3.1.1 Question 1	6
3.1.1.1 MediPass Group.....	6
3.1.1.2 HMO Group.....	10
3.1.1.3 General Eligibility Group.....	14
3.1.2 Summary of Question 1 Findings.....	18
3.2 SERVICE UTILIZATION	18
3.2.1 Question 2 and Question 3	19
3.2.2 Question 4	20
3.2.3 Question 5	20
3.2.4 Question 6	20
3.2.5 Summary of Findings from Questions 2, 3, 4, 5, and 6.....	21
3.3 ACCESS TO SERVICES.....	21
3.3.1 Question 7	21
3.3.2 Summary of Question 7 Findings.....	23
3.3.3 Question 8	23
3.3.3.1 Overall Financing Condition Switching.....	24
3.3.3.2 Directional Patterns of Financing Condition Switching.....	25
3.3.3.3 Non Switching	27
3.3.3.4 Summary of Question 8 Findings	28
3.4 COST OF SERVICES.....	28
3.4.1 Question 9	28

3.4.1.1 General Eligibility Group Costs.....	29
3.4.1.2 MediPass General Health Costs.....	31
3.4.1.3 MediPass Mental Health Costs.....	32
3.4.1.4 Summary of Question 9 Findings.....	34
4.0 SUMMARY OF FINDINGS.....	35
5.0 RECOMMENDATIONS AND FUTURE ANALYSES.....	36
Appendix A: Service Category Definitions.....	37

I. Introduction^[1Z1]

The Florida Mental Health Institute is responsible for conducting the independent evaluation of the Florida Prepaid Medicaid Mental Health Plan Demonstration currently being implemented in the Florida Agency for Health Care Administration (AHCA) Area 6 (Tampa Bay area). There are several components^[1Z2] to the evaluation designed to comprehensively assess system level effects of the demonstration as well as recipient/member level effects. The Quantitative Component of the evaluation is involved primarily with compiling, integrating and analyzing the administrative databases (*e.g.*, claims, encounter and eligibility data sets) associated with running and managing the Medicaid mental health system in Florida.

Using primarily a cross-sectional design, the analyses conducted in this Quantitative Component provide data plotted over time to examine the impact of changes in the managed care landscape in both the demonstration Area (Area 6^[1Z3] – Tampa Bay area), and the comparison Area (Area 4 – Jacksonville area). The information details changes in the systems level service use among Medicaid recipients over a period of three years, using enrollment and claims level data, from **March 1, 1994 to February 28, 1997** (two years prior to implementation of the demonstration and one year following initial implementation). It is not anticipated that many changes in the service levels will be reflected in the data at this time. Changes are more like to be detected in the second and third years of implementation, which will be examined at a later date.

The original design of this study was to examine differences between the MediPass and HMO financing conditions in both Areas 4 and 6 among AFDC and SSI eligibles. However, since the initial conceptualization, two major changes have affected the design. First, we were asked to include an examination of the General Eligibility fee for service condition as well, given that there are a number of recipients (proportion unknown) in this category who will eventually enroll in either MediPass or an HMO. There are several caveats that are presented in Section 2.3 that addresses this issue further. Second, there were difficulties obtaining encounter data from some of the HMOs, and of the data that we did receive, much of it was unusable for the types of analyses necessary in this study. Because of this HMOs were not included in the utilization and cost analyses. These two changes altered our design, and ultimately the findings that we are able to provide to the State at this time.

This report is divided into five sections: (1) Introduction; (2) Methods; (3) Results and Discussion; (4) Summary; and (5) Recommendations and Future Analyses for the next and final report. A separate technical report has been prepared that addresses the data procurement problems, as the well as the data fidelity methods and findings (see accompanying Technical Report (Stiles, Snyder, Murrin, 1998)).

2. Methods

2.1 Study Questions

Nine primary questions were identified for this Quantitative Component of the evaluation, which were

categorized into four subdomains. The subdomains and questions are as follows:

2.1.1 Recipient Characteristics

1. What are the number and characteristics of Medicaid eligible persons overall and by financing condition?

2.1.2 Service Utilization

2. What types of services are utilized by adults and children?
3. What changes in patterns of service are reflected in the population across financing conditions?
4. What are the patterns of inpatient care?
5. What is the level of use of less intensive services?
6. What are the linkages between inpatient care and community mental health after discharge?

2.1.3 Access to Services

7. What is the rate of penetration across financing conditions and age categories?
8. What are the patterns of financing condition switching between MediPass, HMOs and General Eligibility (FFS)?

2.1.4 Cost of Services

9. What is the cost of services across financing conditions and Areas?

2.2. Study Population

The population examined in the Quantitative Component included all Medicaid eligible children (ages 5–20) and adults (ages 21–64) who were eligible in one of two categories: Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) and who were enrolled in one of the following financing conditions: MediPass, HMO or General Eligibility in AHCA Areas 4 and 6.

The population was categorized into a 2 (area) x 2 (age category) x 3 (eligibility plan) x 2 (eligibility category) x 4 (service utilization type) matrix (96 cells) in preparation for analysis. For each month over the three year time frame of the analysis, each recipient was categorized into one of the cells. Table 2.1 provides the categories for the 96 cell matrix.

Table 2.1. Matrix of Four Study Parameters in Two Areas

.Geographic Area	Age Group	Eligibility Financing condition	Eligibility Category	Service Utilization Type
AHCA Area 4	Child (5–20)	MediPass	AFDC	Specialty MH User
AHCA Area 6	Adult (20–64)	HMO	SSI	General MH User
		General Eligibility		Non-MH user only

				Non-user
--	--	--	--	----------

2.3. Study Design

A cross-sectional design was employed as the primary method to answer the nine questions. This approach involved taking month long *snap-shots* of the entire system in both Areas 4 and 6 to examine how the system and people in the system function and change over time. Comparisons were made among three financing conditions¹ in two geographical areas:

Area 4: MediPass, HMO, General Eligibility

Area 6: MediPass/PMHP, HMO, General Eligibility

Cross-sectional analyses were conducted for each month, starting on March 1, 1994 through February 28, 1997 (36 months). Results were generated and used to plot the changes over time in the three financing condition groups in both geographical areas, as well as the three other population categories (age group; eligibility category; and service utilization type). Below is a brief overview of the five primary domains examined for this report:

Recipient Characteristics —gender, race, age group, and eligibility category calculated monthly.

Service Patterns —The number of person days per user receiving any of the twenty seven Medicaid mental health services calculated monthly.

Penetration — number of persons receiving services divided by the number of eligibles was estimated for all mental health services and any service. Penetration rates were calculated in year long intervals (3/1/94–2/28/95; 3/1/95–2/28/96; 3/1/96–2/28/97).

Financing condition Switching — the total number of recipients switching financing conditions each month and the direction of the switches for each of the population groups was calculated (i.e., HMO to MediPass; General Eligibility to MediPass, etc.).

Cost — simple cost estimates were calculated for Mental Health (MH) Services, and Other Services (general medical) over time.

2.4 Data sets

Six data sets were identified to complete the analyses: Medicaid eligibility files; Medicaid claims files; Florida Health Partnership (FHP) encounter data; HMO encounter data; statewide hospital discharge data; and state mental health agency events data. . Of those, only three were submitted to FMHI in time. The completed analyses incorporated Medicaid eligibility, Medicaid Claims and FHP files. We recognize that any credible

¹ Analyses involving service utilization data were conducted on MediPass and General Eligibility groups only since the HMO data were unavailable (see Technical Report).

report based upon secondary data must provide a discussion of the data sets analyzed, as well as analytic techniques employed to test the data for accuracy and completeness. This discussion is provided in a separate technical report submitted concurrently with this report.

3. Results and Discussion

In the following section, data are provided to address the nine research questions that guided this initial study. The questions were answered to the extent that data were made available and accurate. The findings are organized by evaluation domain and question and are based on data from the first year of implementation and two years prior only. The information is therefore preliminary and will no doubt stimulate additional questions and analyses for the next report.

3.1 Recipient Characteristics

3.1.1 (Q1): What is the number and characteristics of Medicaid eligible persons in MediPass, HMOs, and General Eligibility in Areas 4 and 6?

The number and characteristics of Medicaid eligible persons was examined overtime, from March 1994 to March 1997. This analysis represents monthly unduplicated counts of eligible persons in each of the three Medicaid financing conditions: MediPass, HMO, and General Eligibility². Within each of the financing conditions, enrollees were examined according to race, age group, and eligibility status within AHCA Areas 4 and 6. Six race categories were examined (White, Black, Native American, Asian, Hispanic, Other)³; two age categories were used: children (ages 5–20) and adult (ages 21–64); and two eligibility categories: AFDC and SSI were compared.

² General Eligibility is the Fee-For-Service group into which all Medicaid eligible persons are placed up to thirty days. Those who are eligible for enrolling in the MediPass or HMO plan are given 30 days in which to select a plan and PCP. At the end of thirty days, if a person has not selected a plan, they will be assigned to one automatically. AHCA has identified three other types of eligible persons who also remain in the General Eligibility plan, including dual eligible persons (Medicare/Medicaid), ICFMR and nursing home residents. It should be noted that the numbers represented in this analysis of the General Eligibility plan does not distinguish between those enrollees who will enter into MediPass or HMOs from those who will remain. Because of this, the General Eligibility group is likely over representative of those recipients who will never be in MediPass or an HMO.

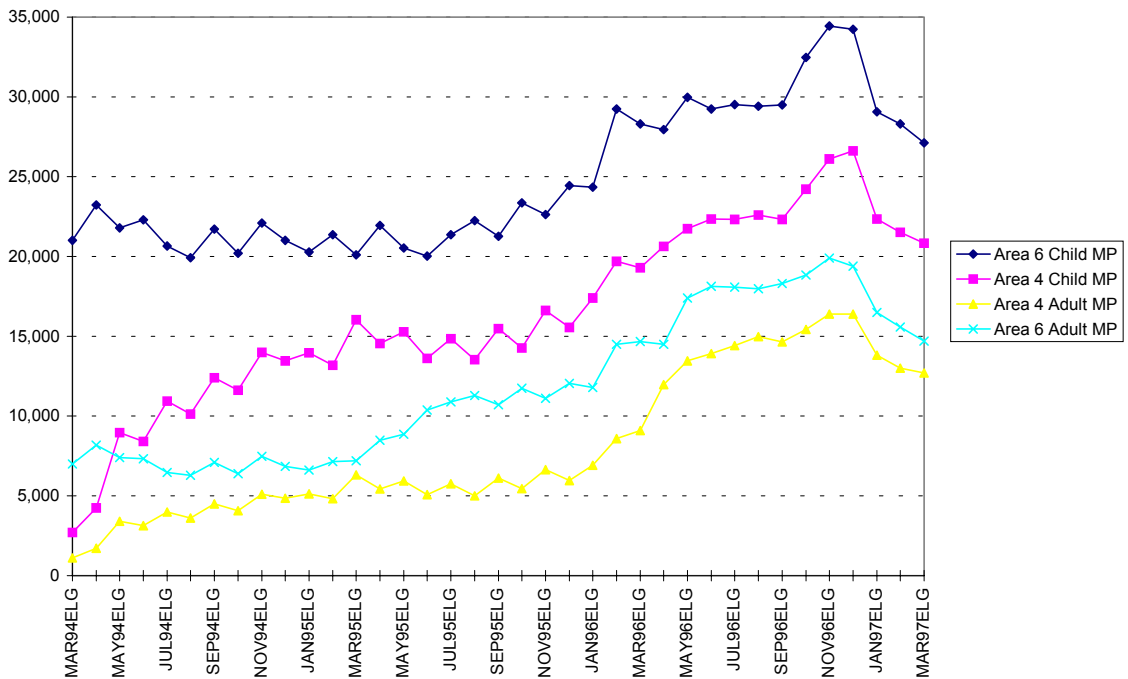
³ The enrollment trends among the six race groups were similar in both areas across plan. The largest differences were found among blacks and whites. To streamline the report, we chose to report findings from the two race categories, black and white, as reflective of the trends in all race categories.

The findings will be provided according to the three financing conditions: MediPass, HMO, and General Eligibility. Comparisons will be made between the two geographic areas within each of the financing conditions. A summary of the comparative findings across the three financing conditions and two areas will be provided at the end of this section.

3.1.1.1 MediPass Group

In Figure 1a, the eligibility pattern among MediPass enrollees is fairly consistent across the two geographic areas. There is a steady increase in the number of children and adult enrollees (this does not represent number of users of services) over time. Children represent a higher proportion of the MediPass population, approximately 3:1. In March 1994, children represented 75% of the MediPass population in both areas and adults represented 25%. This proportion remained constant over the three years of data.

Figure 1a: Number of Persons Enrolled in MediPass by Area and Age Group



Looking at Race patterns in MediPass, in Figures 1b and 1c, there were more white adults enrolled in MediPass than blacks in both Areas, and the patterns over time were similar. Among children, the pattern was slightly different: there were more whites than blacks in Area 6 over time. However, in Area 4, there were more black enrolled children than whites until February 1996, at which time the proportions reversed slightly.

Figure 1b: Number of MediPass Eligible Adults by Area and Race

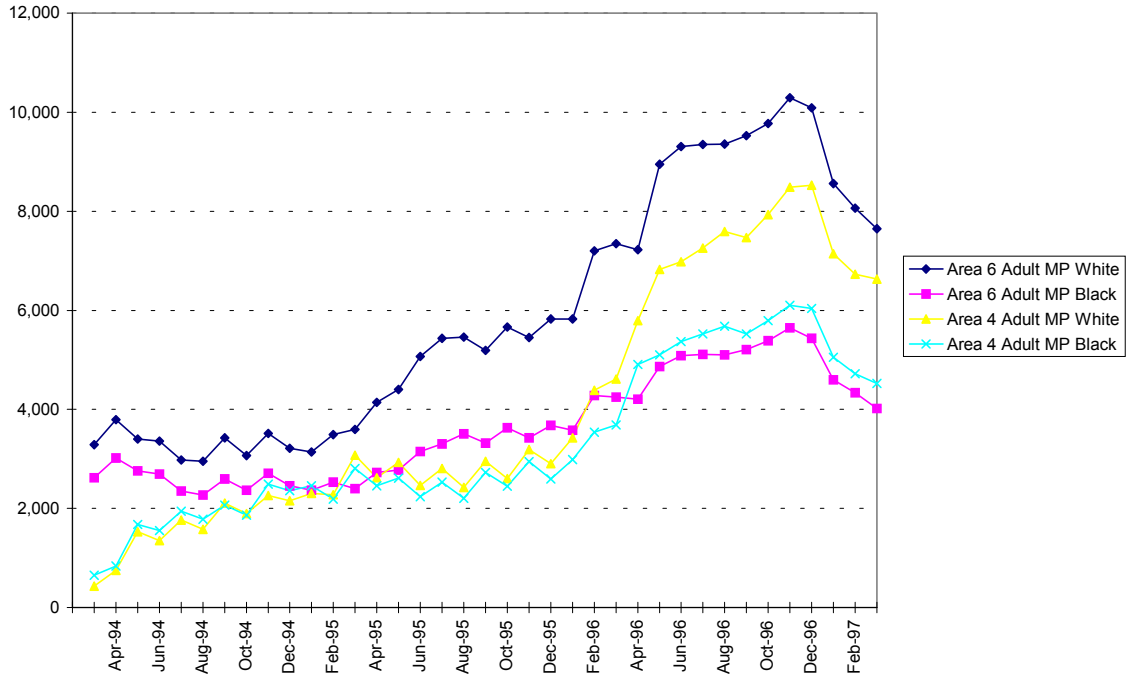
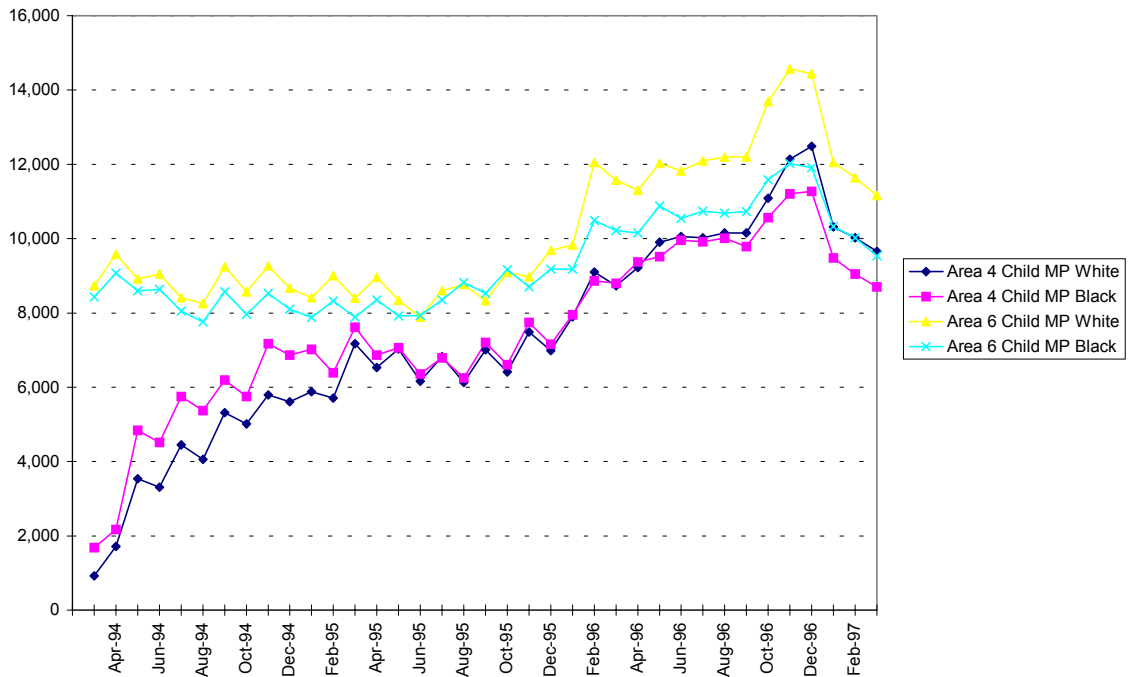


Figure 1c: Number of MediPass Eligible Children by Area and Race



In Figures 1d and 1e, there were more AFDC enrollees than SSI enrollees in both areas over time. In March 1994, 81% of the MediPass population were AFDC eligibles and 19% were on SSI. Over time AFDC enrollment declined and SSI enrollment increased. By March 1997, 50% of the population were on AFDC and the other 50% were on SSI.

Among AFDC eligibles, children represented a greater proportion consistently overtime, exceeding adults by 3:1. Among SSI eligibles, children represented a greater percentage prior to the implementation (approximately 57% in March 1999). By March 1997, the majority of SSI eligibles were adults (60%).

Figure 1d: MediPass Enrolled Children by Area and Eligibility Category

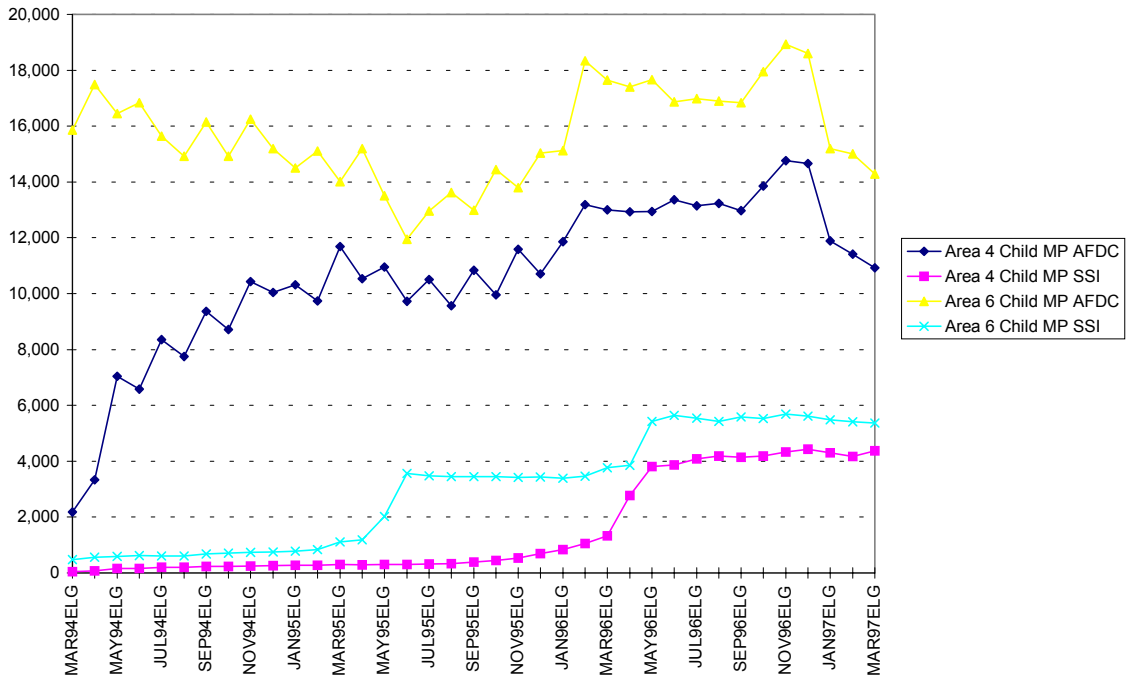
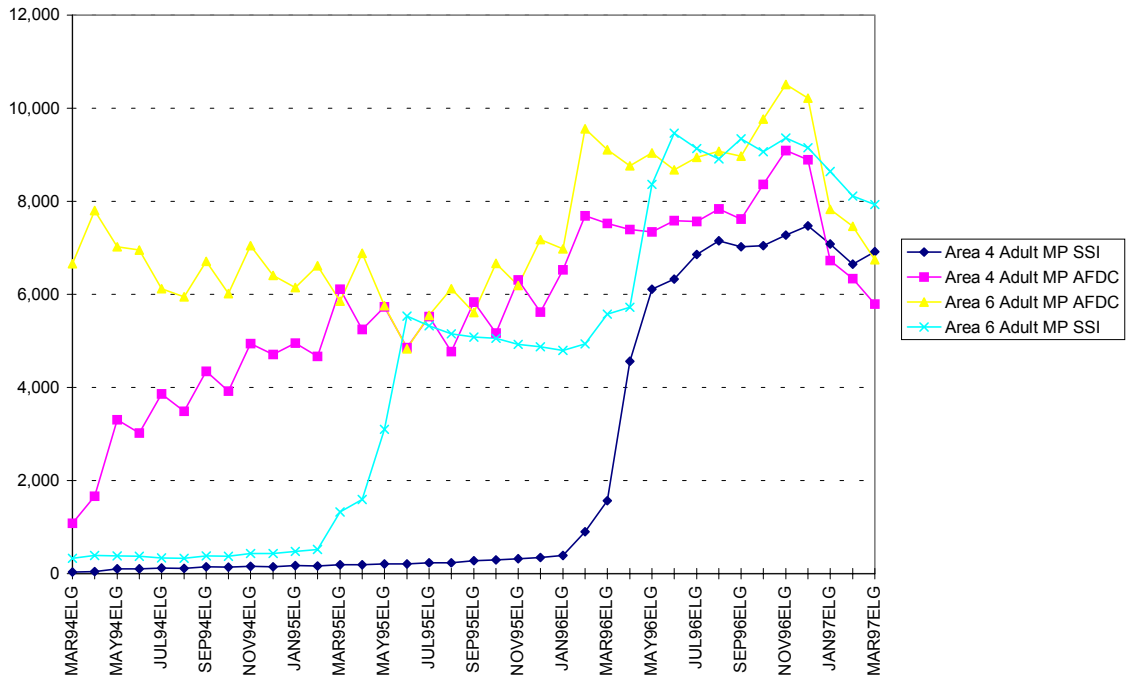


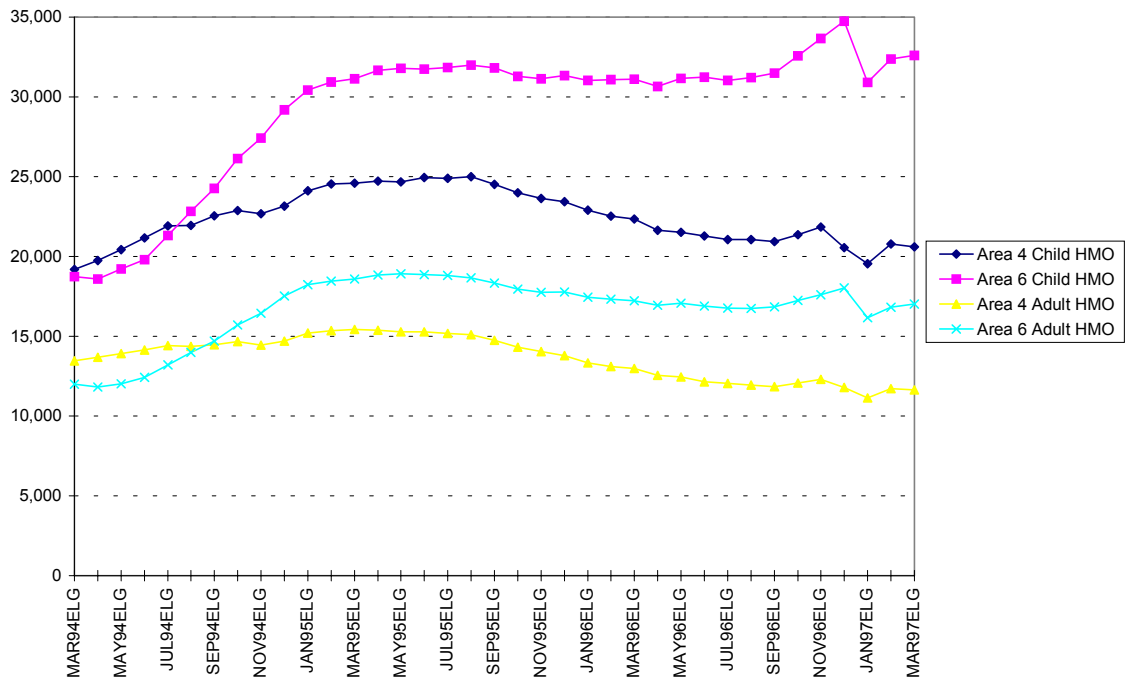
Figure 1e: Number of MediPass Enrolled Adults by Area and Eligibility Category



3.1.1.2 HMO Group

Figure 1f shows that the enrollment pattern in the HMO condition was fairly stable over time across both geographic regions. There were more children than adults enrolled in HMOs, with a steady increase in the number of children in Area 6 over time from approximately 18,000 to 35,000. The pattern was similar in Area 4 through August 1995, at which time there was a slight steady decline. There was less fluctuation among adults in both areas.

Figure 1f: Number of Persons Enrolled in HMOs by Area and Age Group



Looking at Race patterns in HMOs, in Figures 1g and 1h, there were more black children enrolled in HMOs than whites in both Areas 4 and 6. The largest increase occurred in Area 6 among black children between March 1994 to March 1997. The remainder of enrolled children remained fairly stable. Among adults, the pattern was slightly different. The number of black and white enrollees in Area 6 was similar averaging approximately 6,900 a month over time. However, there was a steady decrease in the number of white adults in Area 4 from 5,800 to 4,000 over time.

Figure 1g: Number of HMO Enrolled Children by Area and Race

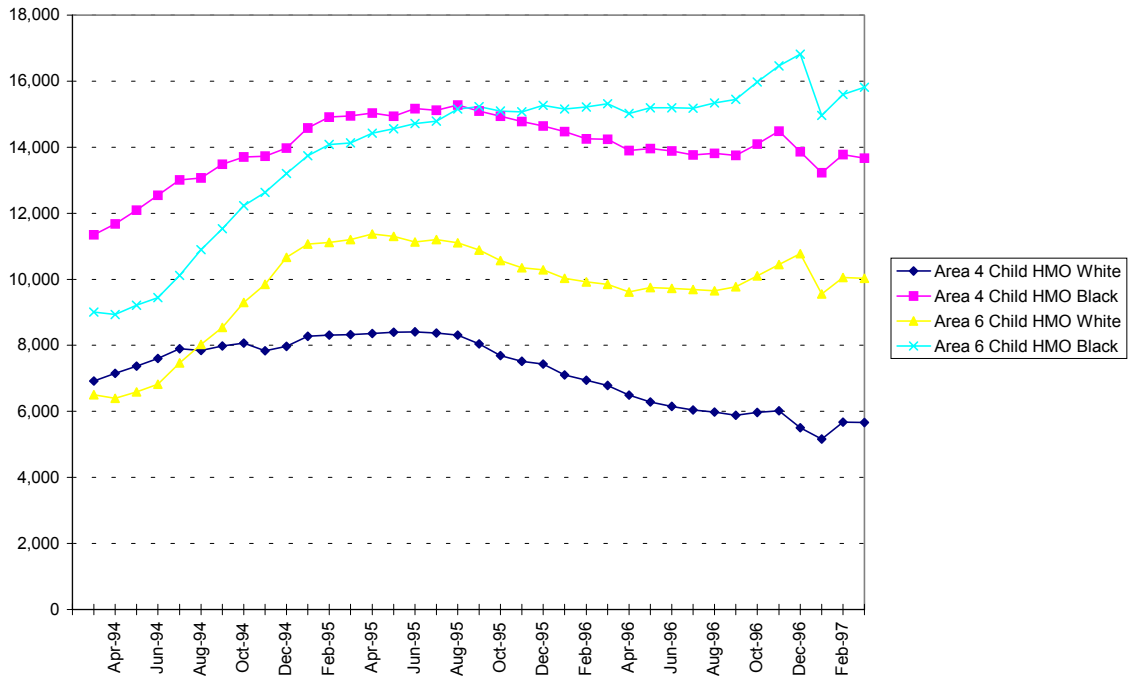
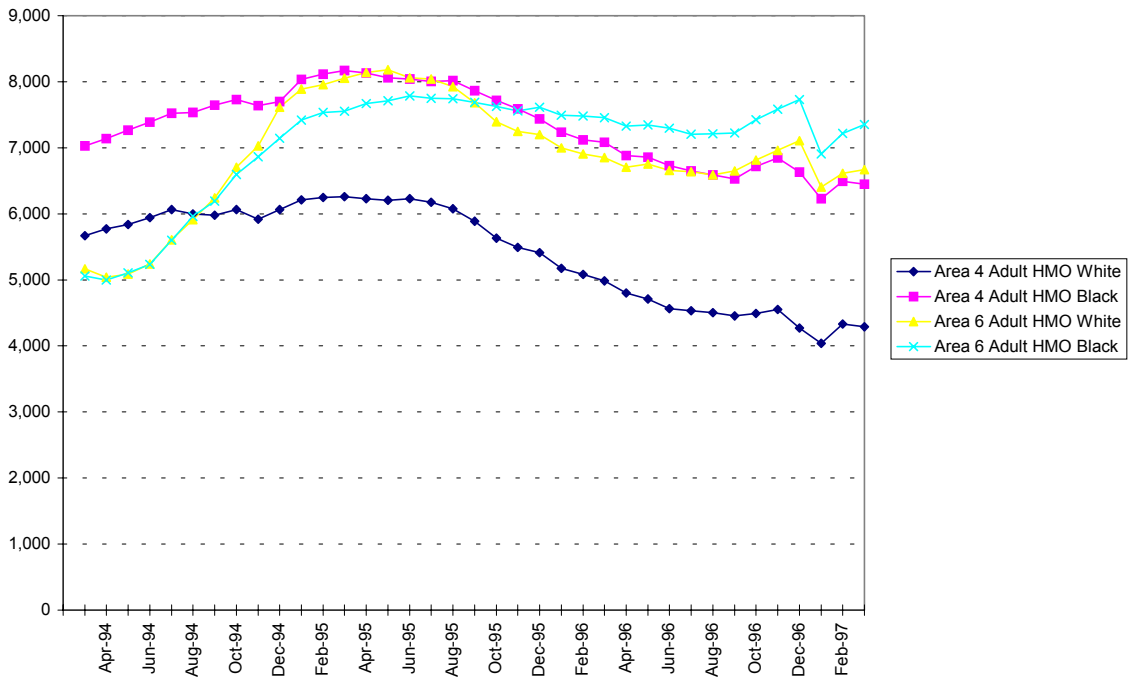


Figure 1h: Number of HMO Enrolled Adults by Area and Race



Similar to MediPass, there were more AFDC enrollees than SSI enrollees as indicated in Figure 1i and 1j. The number of AFDC children (61%) exceeded AFDC adults (39%) by approximately 11,000, whereas the number of SSI adult (66%) enrollees exceed the number of children (34%) in both Areas. There was a steady decrease in the number of AFDC eligibles and an increase (although less marked) in the number of SSI enrollees over time in both Areas and age groups.

Figure 1i: Number of HMO Enrolled Children by Area and Eligibility Category

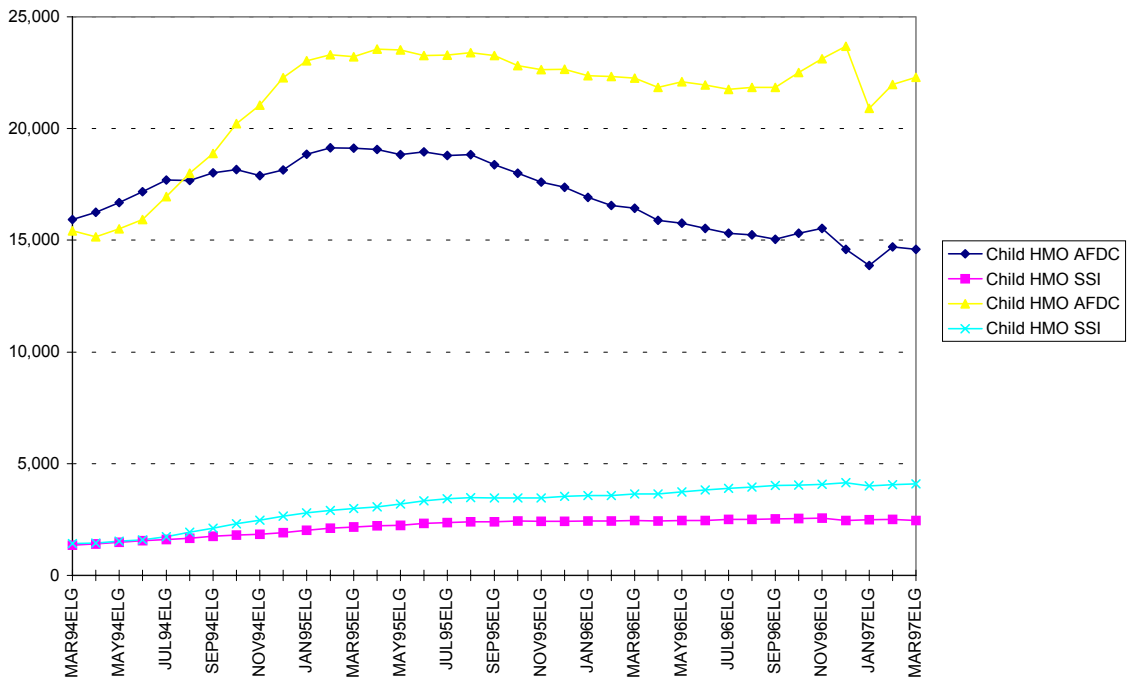
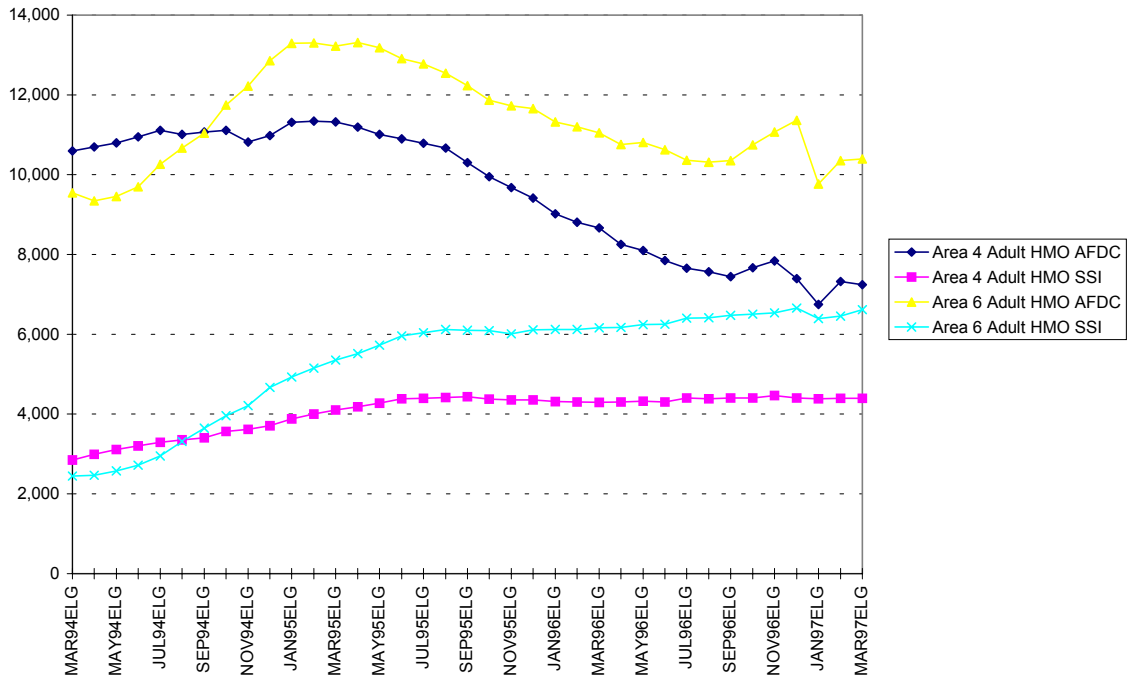


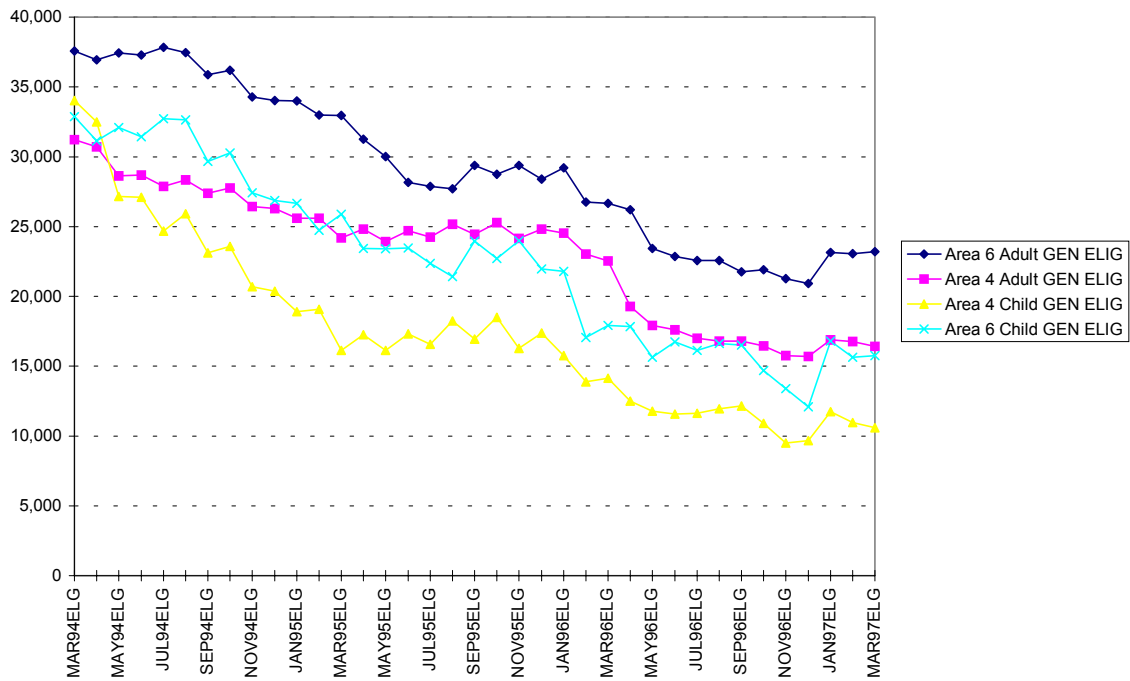
Figure 1j: Number of HMO Enrolled Adults by Area and Eligibility Category



3.1.1.3 General Eligibility Group

Figure 1k shows that the number of persons in the General Eligibility condition decreased steadily from March 1994 to January 1997 in both geographic areas. There were more adults than children in both areas, with adults exceeding children enrollment levels by approximately 9,000. This may be explained in part by the presence of Medicare enrollees, who are only in the General Eligibility condition.

figure 1k: Number of Persons Enrolled in General Eligibility by Area and AgeGroup



In Figures 1l and 1m, it is apparent that there were more whites enrolled than blacks in both areas, which is characteristic of the general population. The proportion of whites to blacks was greater among adults than children in both areas as well. Figures 1n and 1o indicate that there were differences among AFDC and SSI enrollees. AFDC enrollees were more represented by children in both areas, whereas SSI was comprised of more adults. The number of AFDC enrollees decreased steadily over time, a potential result of the changes in Welfare. Conversely, the number of SSI enrollees was more stable, decreasing slightly for short periods then reaching a plateau. Overall, the trends are the same for both AFDC and SSI enrollees in General Eligibility: a decrease in enrollment over time.

Figure 11: Number of General Eligible Children by Area and Race

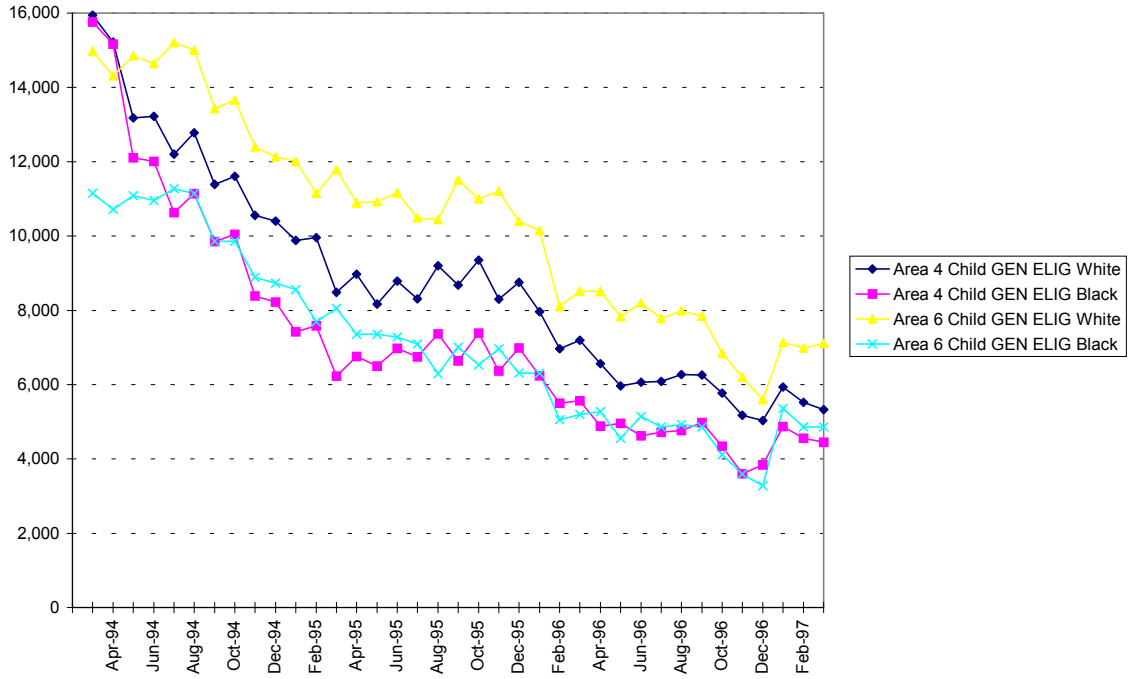


Figure 1m: Number of General Eligible Adults by Area and Race

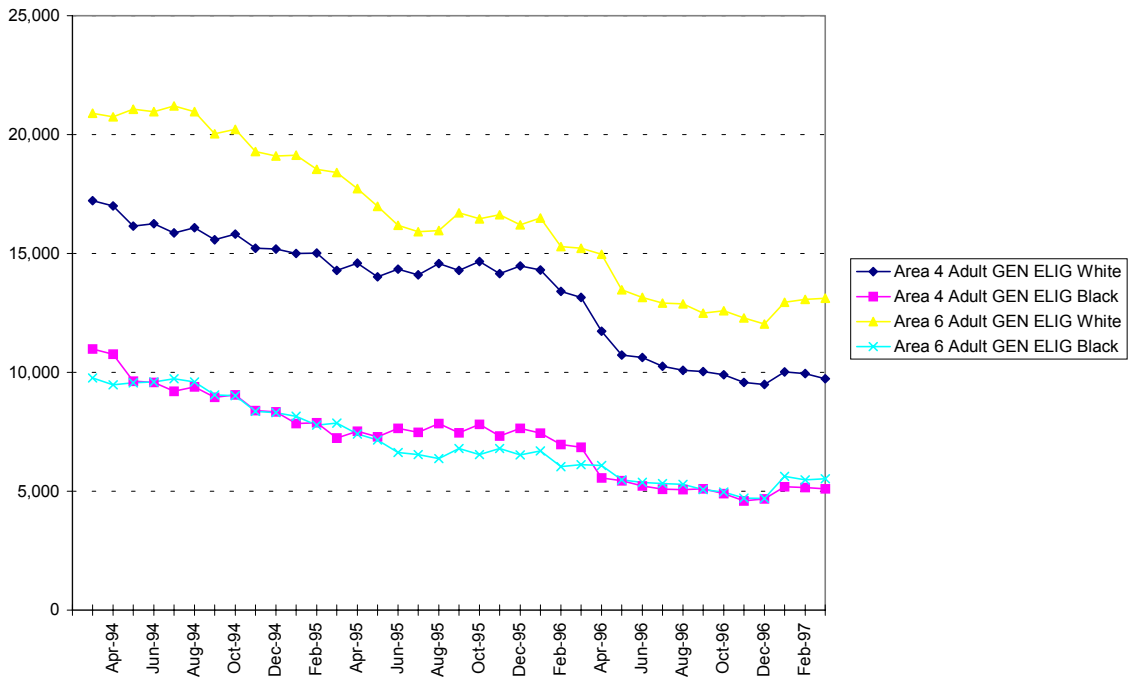


Figure 1n: Number of General Eligible Children by Area and Eligibility Category

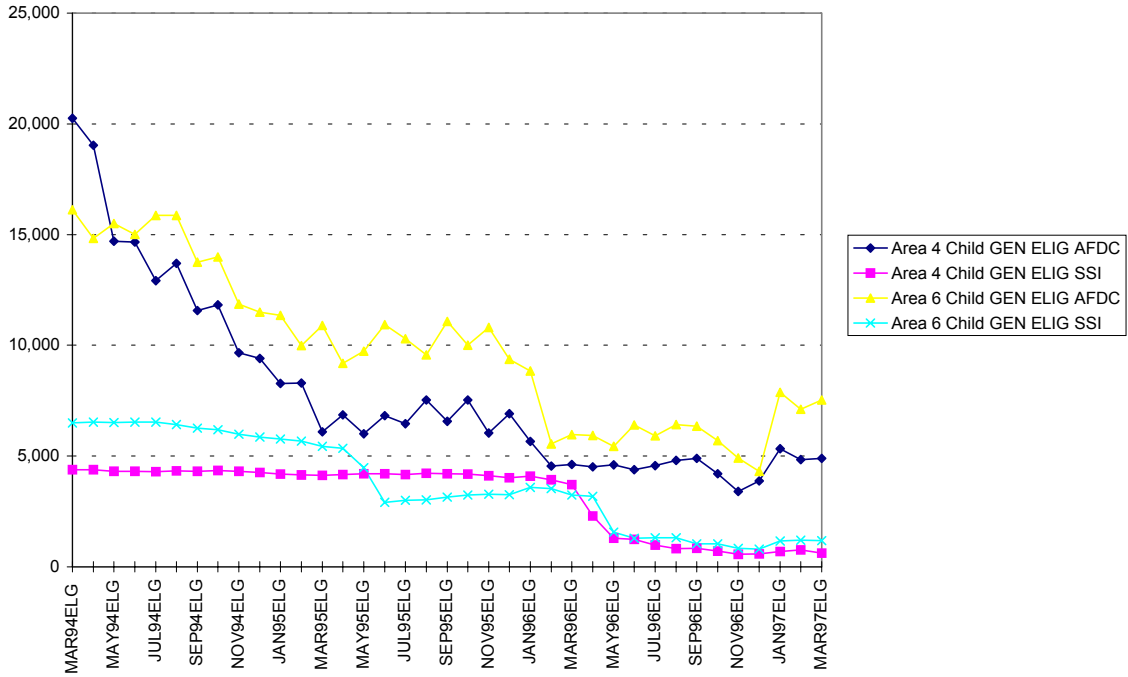
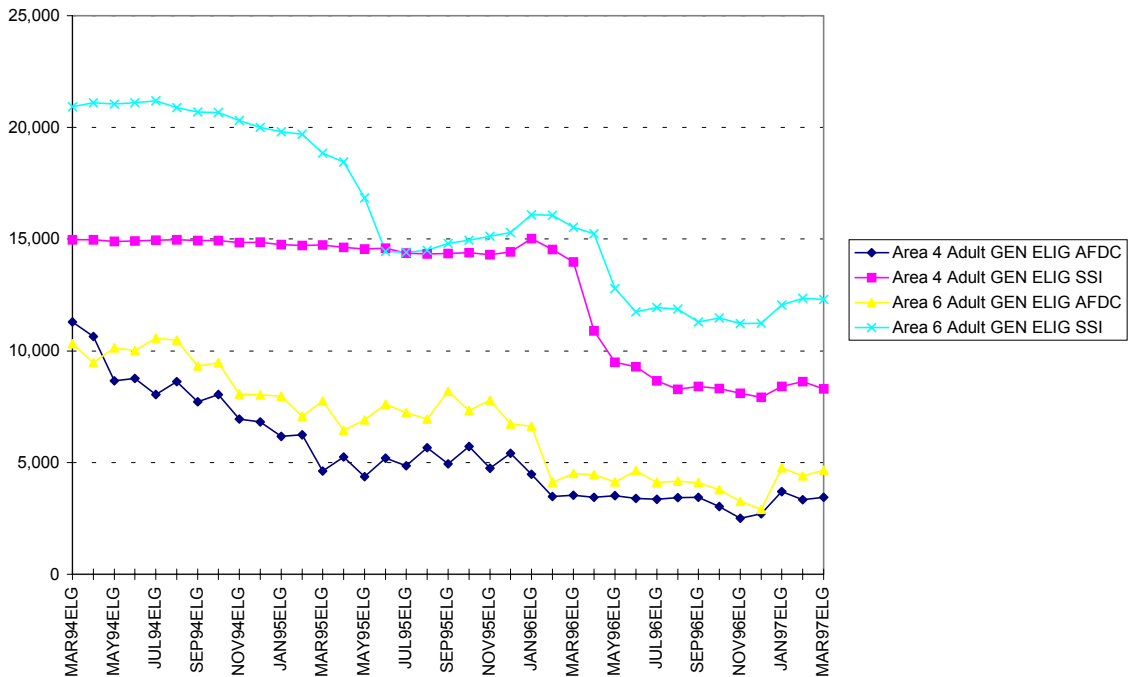


Figure 1o: Number of General Eligible Adults by Area and Eligibility Category



3.1.2 Summary of Question 1 Findings

These findings indicate that there are different patterns in enrollment between the three financing conditions over time. MediPass enrollment continued to increase, HMO enrollment remained fairly stable, and General Eligibility enrollment steadily decreased. HMOs consistently served more black enrollees than white enrollees over time. MediPass shifted from serving primarily white enrollees to serving a greater cross section of both black and white enrollees. Children were enrolled in both MediPass and HMOs than in General Eligibility. Conversely, there are more adults in General Eligibility than children. There is a greater proportion of AFDC than SSI enrollees in both geographic areas, and the difference is represented by children. There do not appear to be any substantial differences among the financing conditions across Areas 4 and 6. Differences in enrollment tend to be guided more by demographic characteristics. The significant trend that raises the most question is the increase in MediPass enrollment and the stableness of HMO enrollment in the context of a continuously decreasing General Eligibility enrollment.

3.2 Service Utilization

We had anticipated conducting a comprehensive analysis of service utilization patterns using the units of service provided over time in the two Medicaid Areas across financing conditions. Unfortunately, because of missing data, we must forgo such a comprehensive analysis at this time. With increased participation and a renewed focus on better data quality, we will be able to carry out a more complete service utilization analysis for the second year report next year.

Because we can not be confident of calculations using service units, we instead have decided to approach service utilization by counting people instead of service units. We decided to use a *person-day* unit to represent the amount of service provided. That is, if a particular enrollee used a specific service on one day, one person-day of that service was added to the aggregate sum of service units. For services where units are equivalent to days (*e.g.*, inpatient or day treatment), the number of person-day units added to the aggregate sum of service units is the actual number of units indicated on the unduplicated (by admission date) claims. Unfortunately this approach to estimating volume of service will underestimate those services where multiple units could be performed in one day (*e.g.*, case management). Nevertheless, this seemed to be the best approach given the restrictions in the data set. Moreover, to account for fluctuations in the size of the enrolled population, we converted the service units into rates per enrollee who used a particular service, rather than overall volume of service. This essentially gives us a length of stay or intensity of treatment over time. It is hoped that we will have better claim indicators in the second year analysis, so that such involved procedures for obtaining a gross estimate of service volume is not necessary.

Finally, twenty-seven service categories have been derived from the types of service required in Florida Medicaid contracts. Algorithms for identifying the categories are outlined in Appendix A. As this evaluation's primary focus is on mental health services, the great bulk of the twenty-seven service categories are mental health procedures.

3.2.1 (Q2): What types of services are utilized by adults and children? and (Q3): What changes in patterns of service are reflected in the population across financing conditions?

The overall trends in almost all the service categories were fairly flat, indicating consistent levels of service use per user over time. For most services, use, as measured in person-days per user, did not change much over the three year study window. Specific service trends, other than inpatient trends, (see question 4 below) are outlined in Table 3.1[124]. No significant changes in service patterns were directly attributable to the PMHP implementation. If a trend was more pronounced in the implementation year (*e.g.*, increase in therapeutic foster care service use), it occurred across other comparison groups as well.

Table 3.1 . Patterns of service from 3/94–2/97 by Area, financing condition and age group.

Area	Financing Condition	Age	Overall Trends	Service trends over time
4	MP	Child	Fairly flat across time	↑ in therapeutic foster care
		Adult	Fairly flat across time	↓ in general health and more consistent high use of day tx
	GE	Child	Fairly flat across time	↑ in foster care, and slight ↑ in day treatment
		Adult	Fairly flat across time	slight ↓ in general health and ↑ in targeted case management
6	MP	Child	Fairly flat across time	↑ in day Tx and general health overall, and ↑ in therapeutic foster care for non-PMHP disenrollees only
		Adult	Fairly flat across time	↑ in general health (particularly the year before demonstration)
	GE	Child	Fairly flat across time	↑ in therapeutic foster care
		Adult	Fairly flat across time	↑ in rehabilitative services and ↓ in general health

3.2.2 (Q4): What are the patterns of inpatient care?

The patterns of inpatient care are outlined in Table 3.2⁴. It is clear inpatient service use remained stable or decreased (length of stay) in all groups except in the Area 4 MediPass group. In the Area 4 MediPass group, children showed wide fluctuations from month to month and adults showed an increasing trend (greater length of stays).

Table 3.2. Patterns of inpatient service by Area, financing condition and age group.

Area	Financing condition	Age	Inpatient Trends
4	MP	Child	sawtooth pattern over time with high variability (no clear trends)
		Adult	↑ trend
	GE	Child	↓ trend
		Adult	↓ trend
6	MP	Child	even to ↓ trend
		Adult	even trend
	GE	Child	↓ trend
		Adult	↓ trend

3.2.3 (Q5): What is the level of use of less intensive services?

There did not appear to be a general indication in first implementation year of increased use of less intensive billable (formal) services attributable exclusively to the PMHP implementation. However, FHP has developed its own codes to track less intensive services (e.g., drop in centers). These data are not interpretable at this time because we have no baseline or comparison data for other conditions. We will watch the trends in these special categories over the second implementation year. We will conduct a cohort analysis for the next report, which might better address changes in types of services used by specific individuals.

3.2.4 (Q6): What are the linkages between inpatient care and community mental health after discharge?

Our initial evaluation plan called for an analysis of the linkages between inpatient care and community mental health services. That is, when a recipient is discharged from a psychiatric hospitalization, how smooth is the transition to community mental health care? How quickly is the recipient engaged into the community mental health system? We anticipated an analysis using a cohort design to essentially *follow* recipients who received inpatient services into the community. However, because of the tight time frame for analyses caused by delays in receiving data, the problems with the HMO encounter data, and the fact

⁴ Note that the rates plotted and examined for trends really reflect an average length of stay (that is the aggregate number of days per admission were divided by the number of admissions/persons to obtain the number of persons-days per user).

that we do not yet have the requested hospital discharge data set,⁵ we are postponing the analysis that will address this question until the second year report that will be submitted in Fall 1998.

3.2.5 Summary of Findings from Questions 2, 3, 4, 5, and 6

Overall non-inpatient service trends did not change over time, except for services such as therapeutic foster care and day treatment. Inpatient trends showed a general decrease over time for all conditions except for enrollees in Area 4 MediPass. Finally, there does not appear to be any general changes in the use of less intensive services in the first year of implementation with these data. However, special codes created by FHP may help us better assess this question in the second year analyses.

3.3 Access to Services

3.3.1 (Q7): What is the rate of penetration across financing conditions and age categories?

Simple annual penetration rates for mental health service use (number of eligible persons using mental health services divided by the total number of eligible persons) were calculated across the MediPass and General Eligibility financing conditions and age groups in both geographic areas. As recipients could change financing condition every thirty days, they were only included in the penetration calculations if they were enrolled at least 6 months in the financing condition in which they were categorized. Results for General Eligibility and MediPass recipients are presented in Tables 3.3 and 3.4.

Please note: Results for the General Eligibility group in Table 3.3 may be misleading because of the definition of persons who are included in that category for this penetration analysis. Recipients had to be generally eligible for at least 6 months, *without* receiving service in through either MediPass or HMOs. Thus recipients in that group for this penetration analysis may primarily be more disabled dual eligible recipients, or individuals residing in nursing homes or Institutions for the Mentally Disabled (IMDs).

⁵ This linkages analysis should be greatly enhanced (and somewhat simplified) when we receive the hospital discharge data set.

Table 3.3 Mental Health Penetration for General Eligibility

AHCA Area	Age Group	Intensity of MH Use ⁶	Penetration (% who used MH services)		
			3/1/94–2/28/95	3/1/95–2/28/96	3/1/96–2/28/97 Implementation
Area 4	Child	Specialty MH	15.6%	18.1%	10.1%
		All MH	30.1%	31.2%	19.1%
	Adult	Specialty MH	17.6%	20.5%	20.1%
		All MH	37.2%	42.0%	43.8%
Area 6	Child	Specialty MH	14.2%	15.2%	9.3%
		All MH	33.7%	30.6%	20.4%
	Adult	Specialty MH	16.8%	17.6%	17.3%
		All MH	36.6%	39.8%	42.3%

Table 3.4. Mental Health Penetration for MediPass Group

AHCA Area	Age Group	Intensity of ⁷ MH Use	Penetration (% who used MH services)		
			3/1/94–2/28/95	3/1/95–2/28/96	3/1/96–2/28/97 Implementation
Area 4	Child	Specialty MH	8.8%	8.5%	10.1%
		All MH	24.9%	22.2%	26.2%
	Adult	Specialty MH	8.6%	6.6%	7.1%
		All MH	27.7%	26.1%	27.6%
Area 6	Child	Specialty MH	6.5%	7.5%	7.5%
		All MH	25.3%	21.4%	25.6%
	Adult	Specialty MH	10.1%	9.1%	8.1%
		All MH	26.3%	24.8%	26.1%

⁶ “All MH” = use of any mental health service (as defined in Appendix B) during the year.

“Specialty MH” = use of any service from a specialty provider (non-primary care) excluding drug claims.

⁷ “All MH” = use of any mental health service (as defined in Appendix B) during the year.

“Specialty MH” = use of any service from a specialty provider (non-primary care) excluding drug claims.

In Tables 3.3 and 3.4, the patterns of mental health penetration appear to be fairly consistent across the two geographic areas. For both generally eligible recipients and MediPass recipients, the penetration rates are similar in both Area 4 and Area 6. For MediPass recipients about one-quarter of recipients (both adults and children) received some mental health service, and 6–10% received services from a specialty mental health provider. Thus, at this point, the demonstration intervention in Area 6 (MediPass/PMHP) appears to have substantially maintained penetration rates as compared to the two years prior to the intervention and compared to rates for MediPass in Area 4.

For the General Eligible group, both Areas are again consistent, but there are some differences in penetration by age group. Around 40% of general eligible adults received some mental health service over the three evaluation years, and 17–20% of adults received services from a specialty MH provider. In contrast, slightly over 30% of general eligible children received any MH service and 14–18% received services from specialty MH provider *in the first two years of the evaluation time frame*; however, in last year (3/96–2/97), the penetration rates for generally eligible children dropped to about 20% receiving any MH service and around 10% receiving service from a specialty provider (more similar to the consistent findings for the MediPass group). At this point, it is not clear what is causing this somewhat precipitous drop in Area 4 penetration rates for generally eligible children.

3.3.2 Summary of Question 7 Findings

Penetration rates appear to be fairly consistent over time across Areas and age groups (with the exception of Area 4 general eligible children). At this point, the Demonstration in Area 6 (MediPass/PMHP) appears to have substantially maintained penetration rates as compared to the two years prior to the intervention and compared to rates for MediPass in Area 4.

3.3.3 (Q8): What are the patterns of financing condition switching among MediPass, HMO and General Eligibility (FFS)?

Medicaid recipients are allowed to change service provision financing conditions (*e.g.*, MediPass, HMO, etc.) every thirty days. With such a short time frame allowed for changing (switching) financing conditions, it was hypothesized that if recipients were unhappy with a financing condition, they would “vote with their feet”, and overall we would see trends over time showing recipients switching to other financing conditions. Similarly, if recipients were happy with a financing condition, they may tend to not switch from that financing condition and overtime more recipients would gravitate towards that perceived **better** financing condition.

Switching was determined by comparing the financing condition that every recipient was enrolled in for two consecutive months. If the first month’s financing condition differed from the second month’s financing condition for a particular recipient, that was counted as a **switch**. Switches are recorded on the charts in the column for the first month. For example, if recipient John Doe is in financing condition A in March 1995, and in financing condition B in April 1995, it is recorded as a switch in March 1995. The following sections and figures describe overall financing condition switching, the direction of financing condition switching (*e.g.*, MediPass to HMO, HMO to general eligibility, etc.), and finally, **non-switching** or those who stayed in the same financing condition over time.

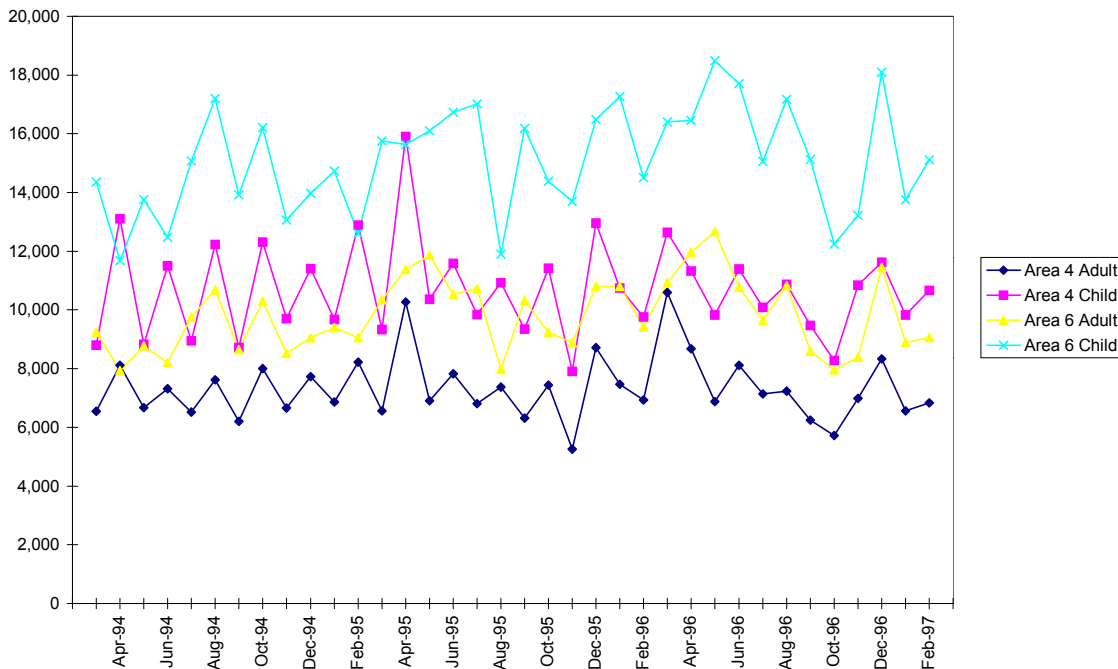
3.3.3.1 Overall Financing condition Switching

In Figure 8a, overall in Area 4, there were 15,000–25,000 recipients switching financing conditions each month (including new enrollees and those recipients leaving Medicaid⁸). This means that with an average total Medicaid enrollment in Area 4 of around 100,000 recipients, typically about 20% of enrollees were

⁸ New enrollees and those leaving Medicaid represent about one-half to two-thirds of the plan switches.

switching financing conditions (or joining/leaving Medicaid) each month. This pattern appears to hold for both children and adults. There appears to be a cycle to Area 4 switching, as there is a *saw tooth* pattern over time. This could simply be due to a cycle of when requests for changing financing conditions are processed or reported by the Medicaid Office in Area 4.

Figure 8a: Number of Plan Switches



Overall in Area 6, there were 20,000–30,000 recipients switching financing conditions each month (again including new enrollees and those recipients leaving Medicaid). This means that with a typical total Medicaid enrollment in Area 6 of about 130,000 recipients, approximately 20% of enrollees are switching financing conditions (or joining/leaving Medicaid) each month — similar to Area 4. Also as with Area 4, children and adults seem to have similar patterns of overall switching. There does not appear to be any significant changes in the pattern of switches over time, suggesting that the implementation of the demonstration in Area 6 on March 1, 1996, did not have a great impact on overall switching enrollment patterns in the first year.

3.3.3.2 Directional patterns of financing condition switching

The directional patterns of financing condition switches were fairly similar among adults and children in both Areas and as Figures 8b and 8c illustrate, the patterns are similar across Areas (although the *saw-tooth* pattern is still quite evident in Area 4 and not in Area 6). In both Areas in 1996 there was a substantial increase of switches from General Eligibility to MediPass; likely the result of mandatory assignment to MediPass at that time. The switching into MediPass declines at the beginning of 1997 as assignment to HMOs increases, again likely reflecting the mandatory assignment policy change that added HMOs to the mandatory assignment pool.

Figure 8b: Number of Plan Switches Among Adults in Area 4

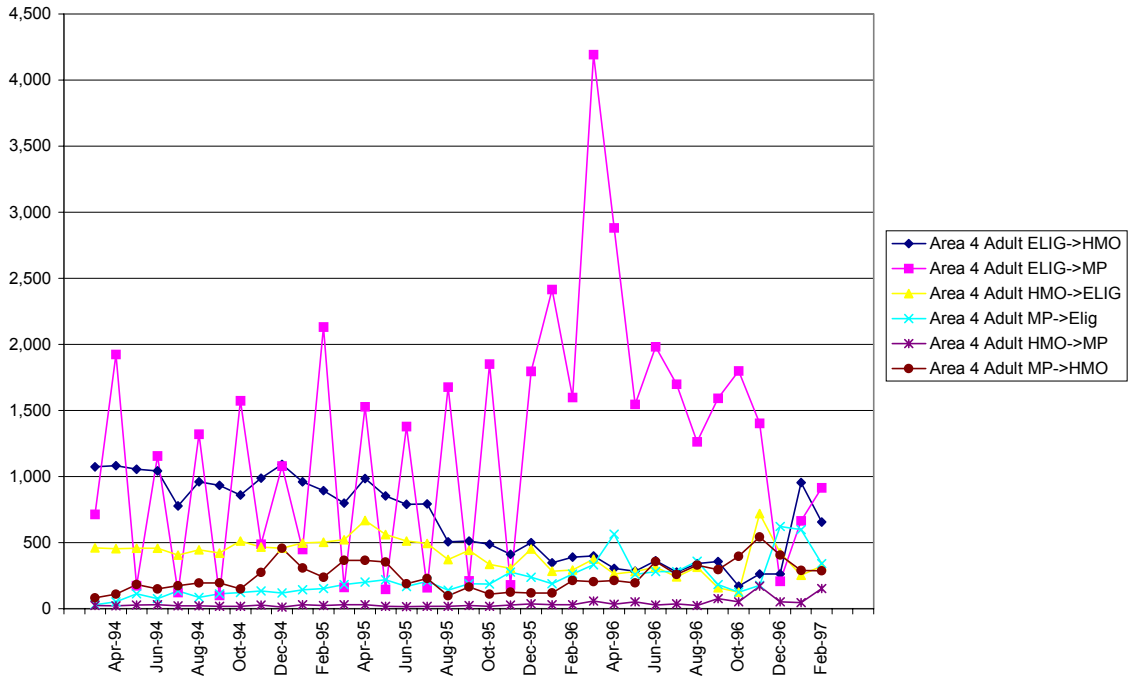
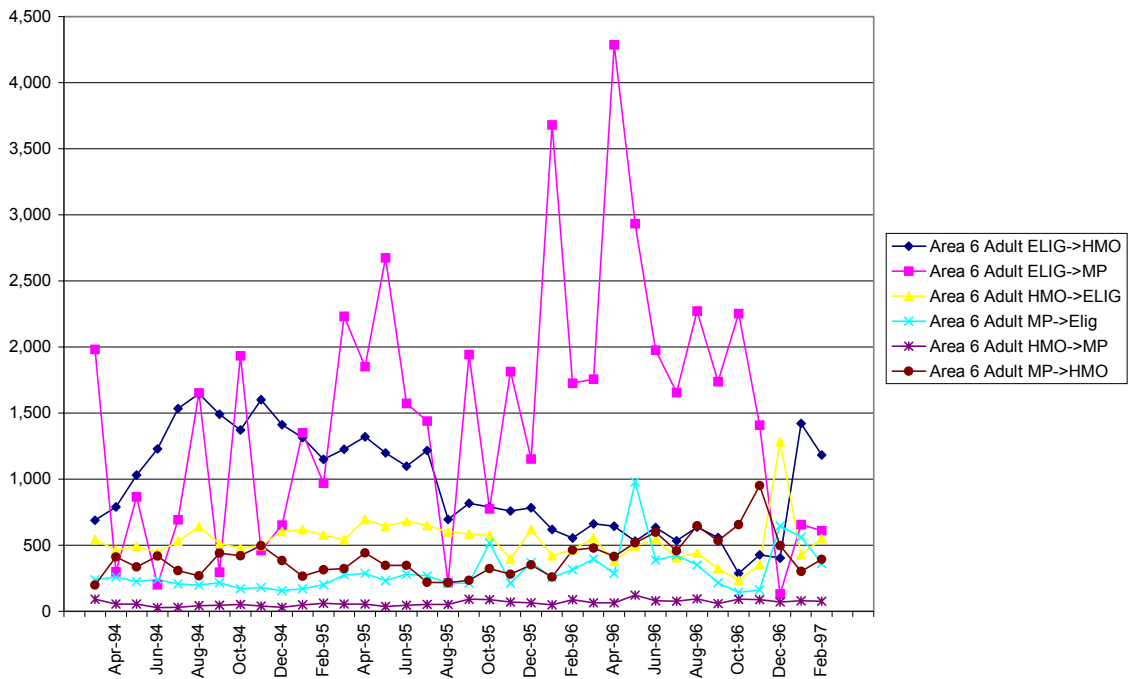


Figure 8c: Plan Switches Among Adults in Area 6



Switches of recipients between HMOs and MediPass show an interesting pattern. Recipients choosing to move from HMOs to MediPass are consistently low in number, averaging about 50 recipients per month in both Areas over the entire three year period. Conversely, switches of recipients from MediPass to HMOs average around 200–400 in both Area through 1994 and 1995, and then begin to rise in 1996. They peak in November 1996 at about 550 in Area 4, and about 950 in Area 6. After November, they taper off back down to around 250 in each Area. As the increase occurred in both Areas, it is unlikely that it is due to the implementation of the Area 6 demonstration, however, the greater magnitude of the increase could be related to the implementation. Analysis of the second year implementation data this coming Fall may be more revealing. Regardless of the cause of the increase in switches from MediPass to HMOs, it is clear that recipients tend to switch much more from MediPass to HMOs than vice versa in both Areas.

Finally, focusing on switches from either MediPass or HMOs to the general eligibility category (*i.e.*, **deselecting** MediPass or HMO). It appears that in both Areas, in 1994 and 1995, HMO recipients consistently **deselect** more than MediPass recipients. That pattern converges, however, in 1996 in both Areas. The convergence could be the result of mandatory assignment to MediPass in 1996 (that is, those recipients assigned to MediPass, who did not want that financing condition, deselected MediPass causing a higher rate in 1996).

3.3.3.3 Non-Switching

The patterns of **non-switchers** (that is, those recipients who remained in the same financing condition from month to month) are summarized in Figures 8d and 8e. Figure 8d shows the numbers of adult recipients in Area 6 (Area 4 was similar) who stayed in the same financing condition from month to month. The pattern is similar to the overall eligibility patterns over time with recipients in HMOs staying fairly constant while general eligibility (ELIG) declines and MediPass (MP) increases so that all three converge during 1996. The pattern of Area 6 child **non-switchers** presented in Figure 8e shows a slightly different pattern with the numbers staying in HMOs increasing precipitously at the end of 1994 before leveling off, and the numbers in MediPass gradually increasing to the same level as HMOs in 1995 and 1996. As with adults, those in General Eligibility decrease consistently over time. Area 4 has a similar pattern, although the HMO increase in 1994 is not as pronounced.

Figure 8d: Number of Adults in Area 6 Remaining in Same Plan Over Time

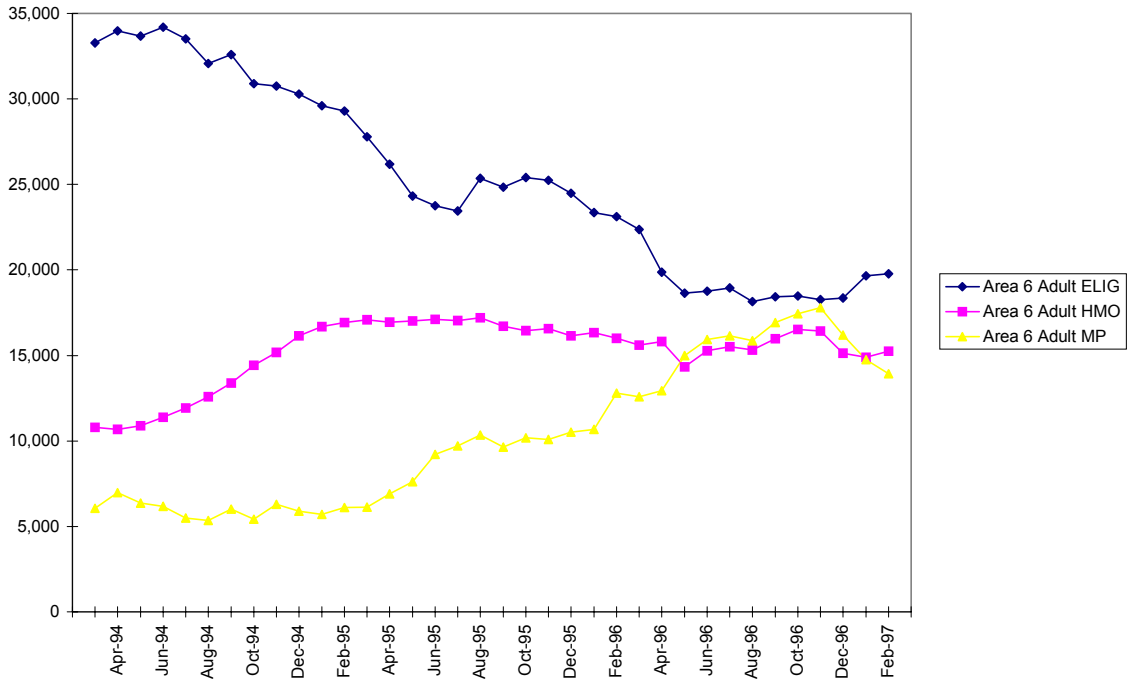
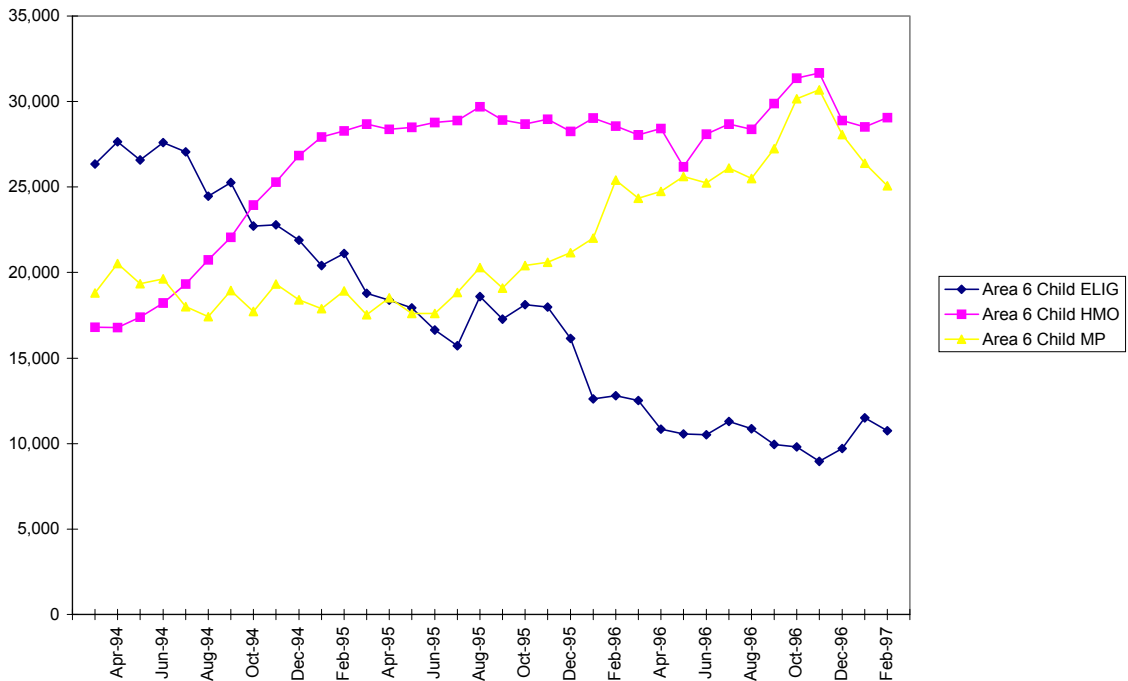


Figure 8e: Number of Children in Area 6 Remaining in Same Plan Over Time



3.3.3.4 Summary of Question 8 Findings

Several switching patterns are evident over the course of the three year study period. However, the patterns seem to be affected more by mandatory assignment policies than recipients' satisfaction with the financing condition in which they were enrolled. If recipients did indeed "vote with their feet", it is not clearly distinguishable in the first year data. The consistently higher number of recipients switching from MediPass to HMOs than from HMOs to MediPass is interesting. It is not known the reasons for the switches at this time. These trends could be a result of a number of factors, including mandatory assignment. Analysis of the second year implementation data this coming Fall may shed more light on this finding.

3.4 Cost of Services

3.4.1 (Q9) What is the cost of services over time across financing conditions and Areas?

The overall cost of services were calculated for the General Eligibility and MediPass groups in both Areas by adding payment amounts for each Medicaid claim. The cost of services for FHP is captured by the PMHP capitation payments included in the claims files. As all claim payments are just summed, adjustments to claims amounts are thus added or subtracted, resulting in an actual paid amount per claim. It is hoped that a more sophisticated method of cost estimation (*e.g.*, using service utilization to estimate cost using Medicaid rate tables) will be possible when more complete service data are available next year. The following sections and figures describe aggregated cost estimates in both Areas for the general eligibility group (combined general and mental health costs), MediPass general health costs, and MediPass mental health costs.

3.4.1.1 General Eligibility Group Costs

Similar patterns of costs were revealed for persons in the General Eligibility Group in both Area 4 and Area 6. Therefore, data is presented here only for the General Eligibility Group in Area 6. Figures 9a and 9b show the costs per eligible recipient over time for the two age categories (dollar amounts represent monthly aggregates per eligible recipient). The substantial dip in costs around November 1995 is caused by relatively fewer claims in the data set around that time and thus likely do not reflect actual cost decreases. The PMHP cap cost amounts that appear in March 1996 are likely an artifact of financing condition switching and the "float" period that occurs as papers are processed.⁹ This artifact decreases over time to almost zero by March 1997.

⁹ The artifact is a result of a recipient not being indicated as having switched to MediPass (and hence PMHP) in the eligibility file, but having a PMHP cap cost paid claim in the claims file in a particular month. This means that we label the recipient as still in the general eligibility group for that month, even though they may have recently switched to MediPass. This may cause the estimates of PMHP cost (see Figures 9d and 9e) to be lower than their actual cost.

Figure 9a: Cost per Enrollee for Area 6 Adults in General Eligibility Group

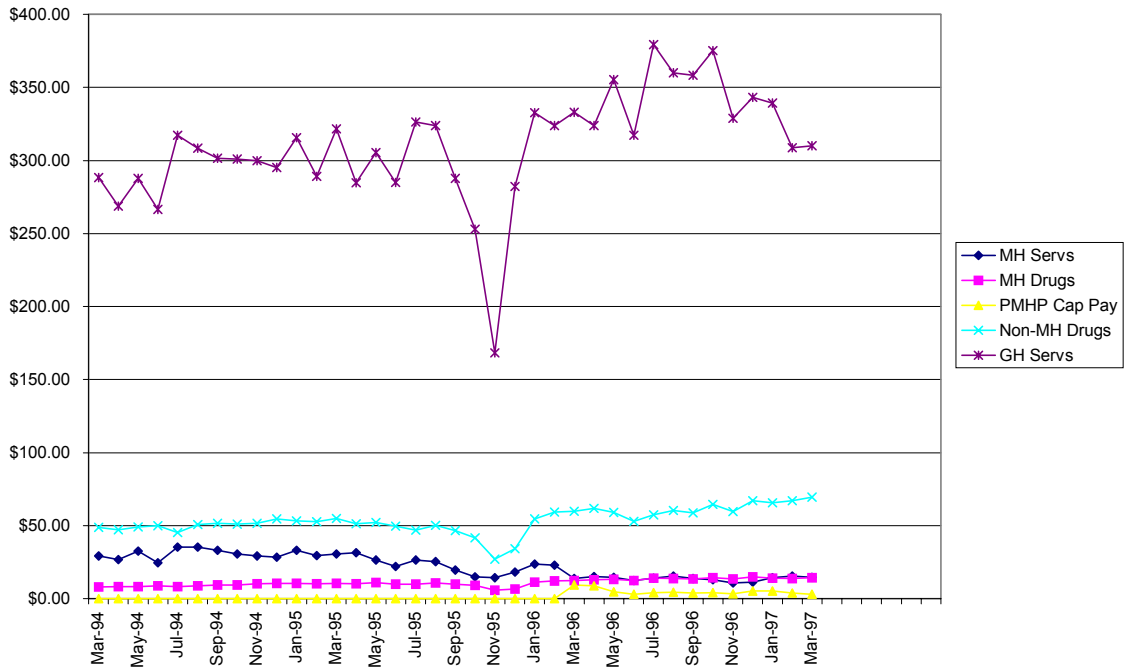
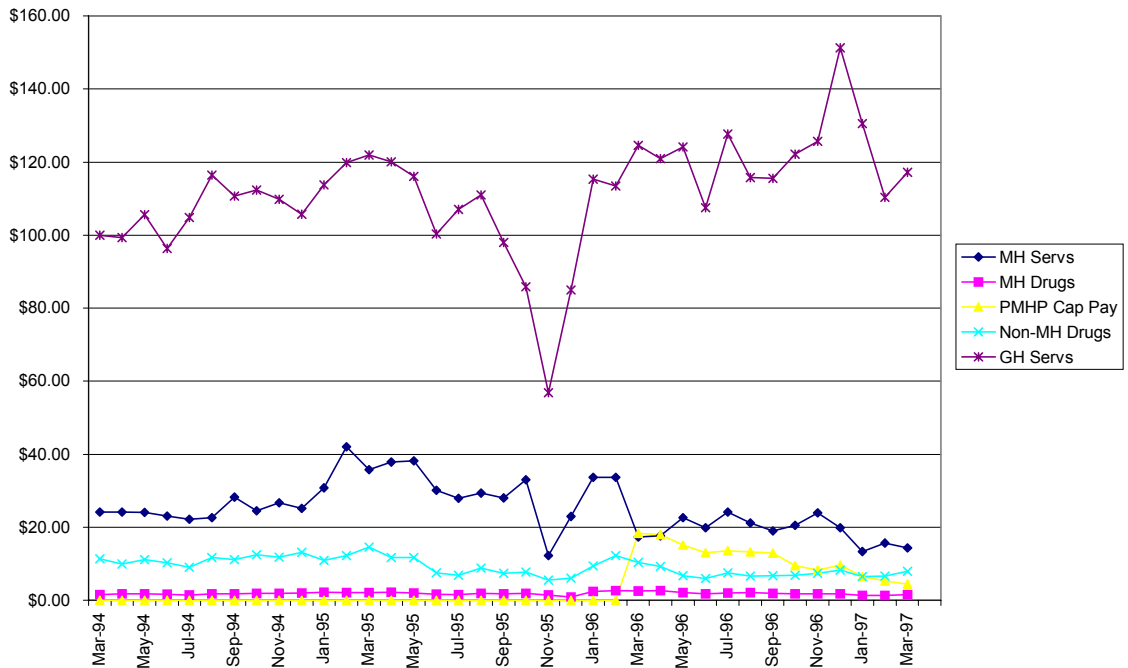


Figure 9b: Costs per Enrollee for Area 6 Children in General Eligibility Group



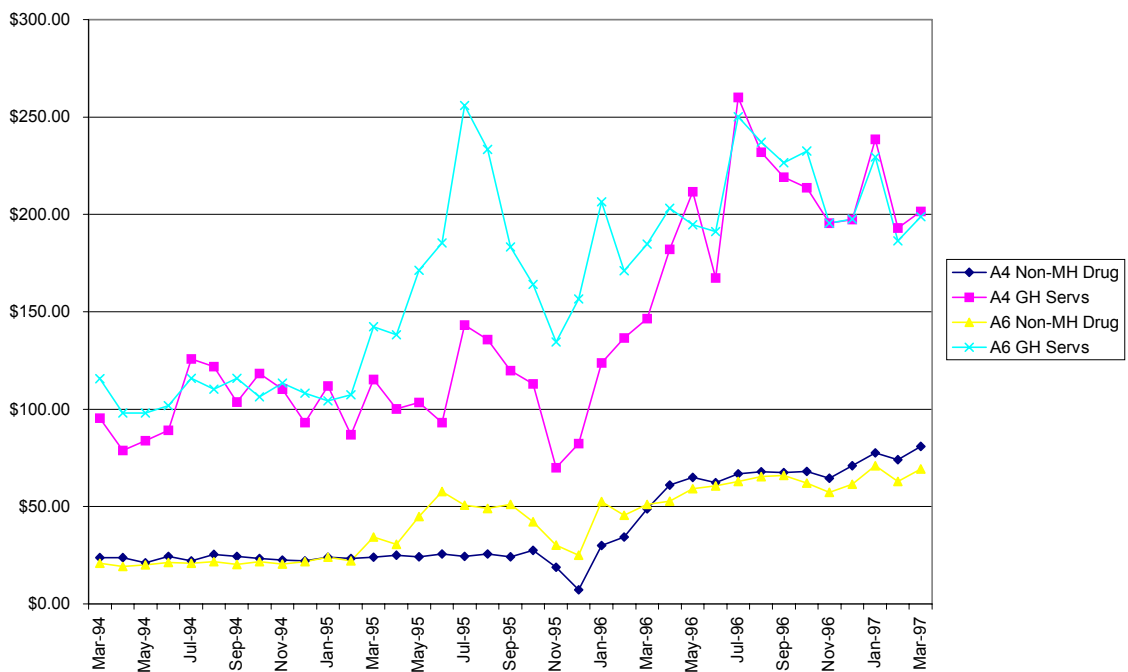
Adults in the general eligibility group consistently have higher general health costs over time (around \$250–400 per month per recipient for services and \$50–70/month per recipient for drugs/medications) than children (\$100–150/month per recipient for services and \$10–15/month per recipient for drugs/medications). General health costs for both age groups appear to be increasing over time.

Although the amount of general health costs is very different, adults and children in the general eligibility group appear to have similar mental health costs. Both age groups have about \$20–50/month per recipient in mental health service costs and under \$10/month per recipient in mental health drug/medication costs. Mental health costs also seem to be decreasing slightly over time (compared to general health costs increasing). This could be a result of cost controls and utilization management of mental health services recently implemented by AHCA.

3.4.1.2 MediPass General Health Costs

In examining MediPass general health costs, Figure 9c shows that Areas 4 & 6 have similar patterns of general health costs (including the November 1995 dip. See Section 2.4.2 for a discussion of this). The pattern of costs was also similar for the two age groups: gradually increasing over time, except that costs for adults, as with the general eligibility group, were higher (\$80–250/month per recipient for services and \$20–75/month per recipient for drugs/medications) than costs for children’s general health care (\$40–80/month per recipient for services and \$5–18/month per recipient for drugs/medications).

Figure 9c: General health Costs per Enrollee for Adults in MediPass Group



General health care costs were lower overall per recipient for the MediPass group compared to the general eligibility group (services and medications in all both Areas and age categories). This may seem to suggest that the MediPass program is working to reduce costs of care; however, because the general eligibility group is contains a diverse population (including dual eligible Medicare/Medicaid recipients), there may be more severely physically disabled recipients in the general eligibility group. Perhaps a closer examination of the types of general health care services next year will shed more light on this finding.

3.4.1.3 MediPass Mental Health Costs

Overall MediPass mental health costs are tracked over time for the two age groups in Figures 9d and 9e. For MediPass adults in Area 6 (Figure 9d), costs peaked in mid to late 1995, before the implementation of the PMHP, followed by a drop to about \$5/month per recipient for services not covered in the demonstration after March 1996. Examining the non-aggregated data, the services that are responsible for the peak in 1995 are inpatient care and day treatment. Drug/medication costs increased to about \$12/month per recipient the year before PMHP implementation and continued at that level during the first PMHP implementation year. The PMHP capitation appropriately begins in March 1996 and remains fairly consistent at \$25–28/month per recipient cost. Note that this PMHP capitation cost may be low because of the switching issue described in the above discussion of general eligibility group costs (Section 3.4.1.1).

Figure 9d: Mental Health Cost per Enrollee for Adults in MediPass Group

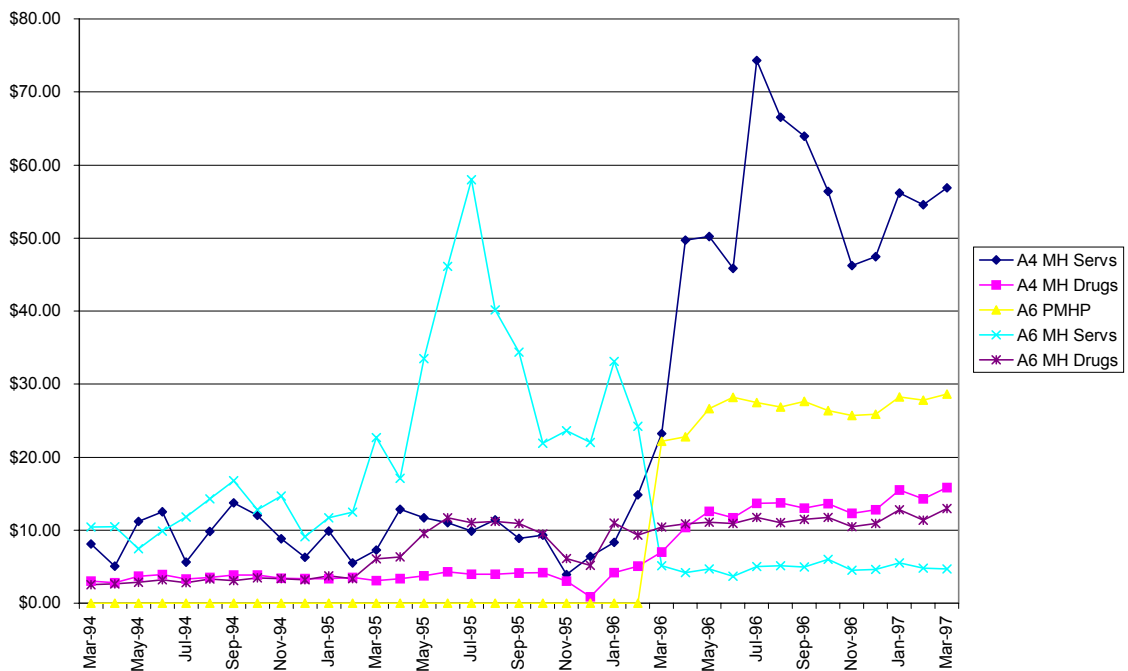
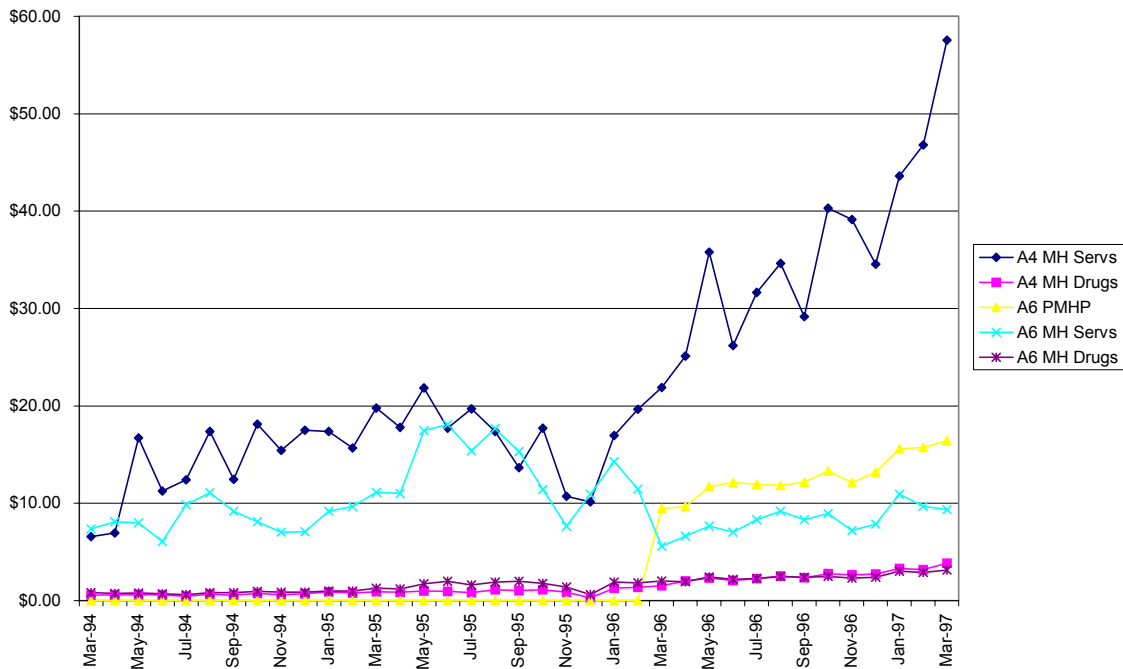


Figure 9e: Mental Health Cost per Enrollee for Children in MediPass Group



Area 4 MediPass adults (Figure 9d) show a slightly different cost pattern over time. Area 4 costs paralleled Area 6 costs in 1994, remain constant in 1995 as Area 6 costs peaked, and then as Area 6 costs decreased and leveled off in 1996 during the PMHP implementation, mental health service costs for Area 4 adults increased precipitously. Mental health drug/medication costs in Area 4 also increased in 1996 to slightly higher than the level in Area 6. Examining the non-aggregated data, services responsible for the increased adult mental health costs included inpatient care, day treatment, and case management. We intend to examine this phenomenon more closely, including possibly tracking costs to the provider level, for the second year analysis next Fall.

MediPass children’s overall mental health costs over time are presented in Figure 9e. For MediPass children in Area 6, costs did not peak in 1995 as the adult mental health costs did. As the PMHP implementation began in March 1996, the capitation payments appropriately begin and other mental health costs (which include costs for children disenrolled from the PMHP because placement in a residential facility)¹⁰ decrease to around \$8–10/month per recipient. This *non-demonstration* service cost is higher than that for adults in Area 6, but mental health costs overall in Area 6 during the PMHP implementation (that is, adding the PMHP capitation payments and other mental health service costs) appear slightly lower for children than for adults. Note again that PMHP capitation costs may be low because of the switching issue described in the discussion of general eligibility group costs (Section 3.4.1.1).

Figure 9e also shows a precipitous increase in mental health costs in 1996 for Area 4 MediPass children, similar to the adult MediPass recipients. Examining the non-aggregated data, services responsible for the increased adult mental health costs include case management, inpatient care, children’s behavioral health services (intensive therapeutic on site services, and home and community based rehabilitative services), and therapeutic foster care. As with the adults, we intend to examine this phenomenon closer for the second year analysis, possibly tracking costs to the provider level.

¹⁰ We are in the process of obtaining from AHCA a list identifying these disenrolled children so that we might more accurately depict PMHP costs in the second year analyses.

3.4.1.4 Summary of Question 9 Findings

Using aggregated cost data generated by adding up the amounts paid in the claims file, we tracked overall costs over time in both Areas and age groups for MediPass and general eligibility recipients. General (non-mental health) health care costs per recipient gradually increased over time for all groups with adults consistently responsible for more of the costs than children. Mental health costs per recipient were predictably much lower than general health costs for all groups, but did not seem to be increasing over time. Adult MediPass recipients were responsible for a peak in mental health costs in 1995 (prior to the PMHP implementation) in Area 6 that was not reflected in Area 4 (nor by children). Service costs for Area 4 MediPass recipients (both adults and children) increased precipitously in 1996. As indicated in the Executive Summary (Shern, 1998), costs appear to have stabilized in Area 6, but continued to increase in Area 4. This finding is suggestive that the PMHP has contained costs, although it is too early to determine this empirically at this time. Closer examination of the data this coming year may address the differences in costs between the two areas, as well as why costs increased so rapidly.

How much of these differences in costs over time can be explained by changes in payment arrangements is still not clear. It is hoped that with increased participation by HMOs this coming year, and with more time to analyze the data sets, we can use more sophisticated methods to estimate costs and perhaps provide a better understanding of the role of payment arrangements on overall cost of services.

4. Summary of Findings

This study reflected an examination of changes in access, cost and utilization of services for Medicaid enrollees as a result of a Prepaid Mental Health Demonstration in AHCA Area 6. Two service areas were examined: Area 6 (Medicaid Demonstration) Area 4 (comparison site, non-Demonstration). Two types of managed care entities (MediPass and HMOs) were compared with the General Eligibility fee-for-service system. The time period included two years prior to implementation of the Medicaid Demonstration (March 1994 to February 1996) and the first year of the demonstration (March 1996 to February 1997).

Several issues emerged from this study, some of which will be examined further in subsequent analyses. First, there was a marked difference in enrollment trends between MediPass and HMOs. The MediPass levels increased significantly over time, whereas the HMO enrollment levels remained constant. This is most likely a result of mandatory assignment to MediPass. Will be examining whether this trend continues in the second year of implementation or if enrollment levels become more stable in both conditions as HMOs enter into the mandatory assignment pool.

Second, there were no noteworthy differences between Areas 4 and 6 in relation to system access and service utilization, other than inpatient service trends, attributable to financing condition or Area. Penetration rates remained fairly stable over time in both areas, as did the use of outpatient services. There were, however, differences in inpatient service trends in the MediPass financing condition across the areas. For children, inpatient use increased slightly in Area 4, while it decreased in Area 6. For adults, inpatient use increased in Area 4 yet remained stable in Area 6. These findings suggest that the Medicaid Demonstration may be impacting inpatient use, although it is still too early to tell. Further it is not known if these trends are similar in the HMO condition. Using these findings to draw conclusions about the effects of managed care strategies on Medicaid mental health systems would be premature.

Third, differences in the overall annual cost of MediPass mental health services were noted between the Areas (HMOs were not included in the cost analysis). Prior to the Demonstration in Area 6 (March 1996) costs increased in both Areas for children and adults, although the sharpness of the increase differed by age. After implementation of the Demonstration, costs continued to rise in Area 4, but flattened out in Area 6, suggesting that at a minimum, the PMHP stabilized costs. There remains a caveat to this finding at this time. The continued increase in costs in Area 4 is comprised primarily of inpatient and day treatment services. It is not known if these services were billed by a few providers or many. It is possible that there are a few "heavy" billers, which would skew the results. Further analyses are needed to address these questions.

Fourth, there was a consistently higher number of enrollees switching from MediPass to HMOs than from HMOs to MediPass. Nevertheless, enrollment trends were significantly different between the two conditions. It is still unclear the reason for this difference.

Given the unavailability of HMO data, combined with new information on service definitions, we were unable to provide specific information about cost and service utilization trends to examine some of the critical questions that surround such issues as the use of less intense services and linkages to community care. As this information becomes available and integrated we will be able to examine the effectiveness of managed care structures and payment arrangements on the provision of health care to Medicaid enrollees.

5. Recommendations and Future Analyses

In order to provide useful information to the State, it is imperative that several changes be made. First, all agencies represented in the analysis must provide data that are 1) complete (contain all necessary records and variables), 2) submitted in a timely fashion (by a reasonable deadline), 3) representative of all agencies (i.e., all HMOs, FHP, and Medicaid). As indicated earlier, we did not receive data from all of the HMOs, and of those data received, less than 10% of the HMO market was represented. Consequently, none of the HMO data were used to examine services or cost. The delays in obtaining data not only limited the types of analyses possible, but placed heavy burdens on our resources to provide effective analyses in a timely fashion.

Future analyses will require the following step: First, secure accurate and complete data from all the HMOs participating in the evaluation. Second, refine our algorithms for different service categories to reflect changes in the Medicaid system. Third, incorporate a fourth year of data to examine year two of the implementation. Fourth, conduct further fidelity checks on the data (due to delays in obtaining data, our fidelity checks were limited). Fifth, conduct a cohort analysis to follow individual persons and examine their access and service utilization patterns over the four years. This analysis, however, will require the full array of complete data sets. And finally, identify the children who were disenrolled from the PMHP or HMOs to enter residential treatment. Once identified and separated from the primary population of analysis, subsequent analyses will be more representative of those persons receiving mental health services in the MediPass and HMO financing conditions. Additionally, we may be able to identify more accurately specific populations within the General Eligibility group, which would aide us in interpreting findings. We anticipate the second year of implementation analyses to provide valuable information for State agencies and policy makers.

Appendix A
Service Category Definitions

Algorithm for Designating Mental Health Claim (for purposes of categorizing recipient groups)	
Medicaid Claims Variable	Values Indicating Mental Health Claim
Primary and Secondary Diagnostic codes (“prim” and “sec”)	290-316
Procedure codes (“procode”)	90801-90899, 96100, 96105, 96115, 96117, W1023, W1027, W1044, W1046, W1058-W1061, W1063-W1087, W9654, W9695, W9881, W9890, W9891, W9892, W9899, G0071-G0094, J1320, J1630, J1631, J1800, J2060, J2330, J2680, J3230, J3270, J3310, J3360
Appropriations codes (“appcode”)	10355600, 10031101, 10061600, 10355600, 10031101, 10061600
Provider codes (“provtype”)	4, 5, 7, 32, 87, 91
Pharmacy Codes	Any code indicating a drug categorized as psychotherapeutic by the 1997 Physicians Desk Reference

Algorithms to assign a claim to a particular service category	
NOTE: All algorithms are generated from data dictionaries provided by the Florida AHCA. “mhselect”= mental health claim as defined in above table.	
Service Category	Algorithm
Adult MH Inpatient Care	(appcode=10158200 and provtype=01) or ((procode >='99217' and procode <='99223') or (procode='99231' or (procode='99232') or (procode='99233') or (procode='99238') or (procode='99239')) and (((mhselect=1) or appcode=10355600) and age >=19)
Adult MH, possibly inpatient care	((procode >='99251' and procode <='99255') or (procode >='99261' and procode <='99263') and mhselect=1) or (procode >='G0071' and procode <='G0094') and (mhselect=1 and age >=19)
Child Inpatient Care	(((((appcode=10158200 and provtype=01) or ((procode >='99217' and procode <='99223') or (procode='99231' or (procode='99232') or (procode='99233') or (procode='99238') or (procode='99239')) and (((mhselect=1) or appcode=10355600) and age <19)
Child MH, possibly inpatient care	((procode >='99251' and procode <='99255') or (procode >='99261' and procode <='99263') and mhselect=1) or (procode >='G0071' and procode <='G0094') and (mhselect=1 and age <19)
Inpatient Substance Abuse Tx	(((((appcode=10158200 and provtype=1) or ((procode >='99217' and procode <='99223') or (procode='99231' or (procode='99232') or (procode='99233') or (procode='99238') or (procode='99239')) and mhselect=1) or appcode=10355600) and ((prim >='291' and prim <'293') or (prim >='303' and prim <'306') or (sec >='291' and sec <'293') or (sec >='303' and sec <'306'))))
Substance Abuse, possibly inpatient	((procode >='99251' and procode <='99255') or (procode >='99261' and procode <='99263') and mhselect=1) or (procode >='G0071' and procode <='G0094') and mhselect=1 and ((prim >='291' and prim <'293') or (prim >='303' and prim <'306') or (sec >='291' and sec <'293') or (sec >='303' and sec <'306'))
Outpatient Hospital/Emer MH Tx	(appcode=10159600 or appcode=10159603 or provsp = 7 or procode='W1061' or (procode >='99281' and procode <='99285')) and mhselect=1
CMH: Physician services	((procode='99203' or procode='99214' or (procode >='99241' and procode <='99245') or (procode >='99271' and procode <='99275') or (procode >='99361' and procode <='99373') or procode='W9840') and mhselect=1) or procode='90862' or procode='W1070'
CMH: Treatment planning and review	procode='W1065' or procode='W1066' or procode='W1067' or procode='W1068' or procode='W1069'

CMH: Evaluation and Testing Services	prococode='W1027' or prococode='90801' or prococode='90825' or prococode='W1073'
CMH: Coun, ther & tx serv- psychiatrist	prococode='90843' or prococode='90844' or (prococode>='G0071' and prococode<='G0076') or prococode='90853' or prococode='90887'
CMH: Coun, ther & tX serv- beh health	prococode='W1074' or prococode='W1075'
CMH: Rehabilitative services	prococode='W1044' or prococode='W1046'
CMH: Childrens behav health serv	prococode='W1071' or prococode='W1072'
CMH: Day treatment services	prococode='W1064' or prococode='W1023'
Targeted Case Management	prococode='W9891' or prococode='W9892' or prococode='W9899'
Physician MH Services- not listed above	(provtype=25 or provtype=26) and mhselect=1 [and not captured above]
Other Assessment	prococode='W1059' or prococode='95882'
Therapeutic Foster Care I & II	prococode='W1058' or prococode='W1060'
EPSDT Screening	prococode='W9881'
MH Drug	drug_typ>=1 or procdiag=9 [psychotherapeutic drugs indicated in 1997 PDR]
MH Capitation Payment	prococode='W1078'
Other MH	mhselect=1 [and not captured above]
Non-MH Drugs	drug>" [all drugs not captured above]
Non-MH Capitation Payment	prococode='W9600' or prococode='W9893'
Non-MH Services	All other services not captured above or in FHP codes below.
FHP Additional Services	Special FHP codes indicating: specialized case management, supported housing, supported employment, sheltered employment, drop in center, case management support, adult overlay/community outpatient.