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Evaluation of Florida's Prepaid Mental Health Plan: Preliminary Findings of the Member Survey Component

Roger A. Boothroyd
University of South Florida, boothroy@usf.edu

David L. Shern

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PRELIMINARY FINDINGS OF THE MEMBER SURVEY COMPONENT

Roger A. Boothroyd, Ph.D.
David L. Shern, Ph.D.

1.0 BACKGROUND AND RATIONALE

Appropriate access to care needs to be a major emphasis in evaluating the effectiveness of managed care arrangement systems involving prospective payment systems, given the incentives inherent in managing costs. As such, barriers to accessing care can result in the under-service to persons who are most in need. Some individuals enrolled in health care plans do not use all the available services. The non-utilization of services is poorly understood and could result in under-service to many individuals. Non-utilization could be the result of several factors, among them may be that the non-utilizers are in good health, they are receiving services from other sources, or their health/mental health has deteriorated to the extent that they are unable to access appropriate care.

Since the majority of *outcomes research* only includes individuals who are being treated in service environments, persons who do not utilize services are excluded from the evaluations. Their service needs, therefore, are unknown.

Given these concerns regarding individual access to health care and the present inadequacy of service recipient data to address these issues, it is important to conduct population-based outcome studies that assess the needs and status of all program enrollees — not only those who have successfully gained entry to the health service system.

In the Member Survey Component of this evaluation we are assessing the physical health and mental health status of a representative sample of Medicaid enrollees across the various health care plans in Florida.

2.0 METHODOLOGY

2.1 Sample

Questionnaires were mailed to 7,456 adult Medicaid enrollees (*i.e.,* ages 21 to 64) who receive Supplemental Security Income (SSI) in the Florida Agency for Health Care (AHCA) Area 6 (Tampa Bay area) and AHCA Area 4 (Jacksonville area). The sample of adult Medicaid enrollees included 2,382 enrollees in the Medicaid Provider Access

System / Prepaid Mental Health Plan (MediPass/PMHP) plan in AHCA Area 6, 2,424

enrollees in the Medicaid Health Maintenance Organizations (HMOs) in AHCA Area 6, and 2,650 enrollees in the MediPass system in AHCA Area 4. Adult Medicaid enrollees receiving SSI were randomly selected from the State's Medicaid eligibility database. Their names and addresses were obtained from this file.

2.2 Survey Design

The content and format of the questionnaire and the cover letter sent to each individual in the survey sample was initially drafted by a work-group of investigators participating in the evaluation of Florida's Prepaid Mental Health Plan (PMHP). The draft questionnaire and cover letter were reviewed and critiqued by 19 volunteer Medicaid enrollees who participated in four focus groups. Each focus group lasted approximately two hours during which general issues concerning the individuals' general responses to mail surveys were discussed. In addition, specific participants' comments and recommendations on the clarity and ease of use of the draft questionnaire and cover letter were elicited from the volunteers. Revisions to the survey and cover letter were made based on the feedback from the volunteers.

The final version of the questionnaire contained 24 questions asking respondents (1) to report their current eligibility status in Medicaid, Medicare, Work and Gain Economic Self Sufficiency (WAGES), and SSI, (2) to specify the health care plan in which they were enrolled, and (3) to report any recent changes of their health care plans. The enrollees were also asked (4) to rate their health status, (5) to report on their need for medical, mental health, dental, and substance abuse services, (6) if they used these services, and (7) about their satisfaction services they used during the previous nine months. (Copies of the questionnaires and cover letters are presented in the Appendix).

The questionnaire was printed as an 8½" by 7" booklet in both English and Spanish. Each questionnaire booklet was personalized to include information specific to the individual. A personalized cover letter was printed on customized letterhead. The contents of the cover letter stressed that the respondents' confidentiality will be protected in order to reduce possible stigma. Even though the cover letter used the University of South Florida logo, the address was for the "Florida Health Services Survey" rather than the "Louis de la Parte Florida Mental Health Institute" in order to further reduce any potential stigma. The individuals were also offered $5.00 in compensation for completing and returning the questionnaire.

The individuals being surveyed were encouraged to call a toll-free telephone number in order to complete the questionnaire by telephone or to get any questions pertaining to the survey answered. Telephone coverage was available weekdays from 8:30 AM until 8:30 PM.

2.3 Mailing Procedures

Mail survey techniques have been used in a variety of settings with varying success. In this evaluation we used a highly systematic and structured approach to survey design and follow-up similar to those recommended by Dillman (1978) and Salant and Dillman (1994). In total, five separate mailings were conducted. The first mailing consisted of a pre-notification postcard informing the designated Medicaid enrollees that we were conducting a study examining their health care services and that they would receive a questionnaire in the mail in about a week. One week later a second mailing was conducted. This mailing included a personalized cover letter and questionnaire and a pre-addressed, stamped return envelope. One week later, a postcard reminder was sent to each person who had not yet responded. This reminder emphasized the importance of the study and again included information on the toll-free telephone number they could call. Two weeks after the postcard reminder was mailed, a fourth mailing containing a cover letter, questionnaire, and return envelope was mailed to each non-respondent. Finally, four weeks later, a fifth mailing was sent via certified mail to individuals who still had not responded. As with the first and fourth mailings, enrollees received a personalized cover letter, questionnaire, and a pre-addressed, stamped return envelope. The mailing schedule and content is summarized in Figure 1.

Figure 1. Mailing Contents and Schedule.

Mailing Contents	Week								
	1	2	3	4	5	6	7	8	9
1st mailing: Pre-notification postcard	X								
2nd mailing: Personalized letter & questionnaire in English & Spanish, preaddressed stamped return envelope		X							
3rd mailing: Postcard reminder			X						
4th mailing: Personalized letter & questionnaire in English & Spanish, preaddressed stamped return envelope					X				
5th mailing: Personalized letter & questionnaire in English & Spanish, preaddressed stamped return envelope – sent certified mail									X

As recommended by Dillman (1978), first class postage was used on both the outgoing and return envelopes of each mailing and address correction was requested from the post office so that mailing lists could be updated. These mailing procedures were based on the findings of a feasibility study conducted to assess the efficacy of using mail survey procedures with a Medicaid population. The findings from this feasibility study are summarized in Boothroyd and Shern (1998).

2.4 Analytic Issues and Decisions

In performing the data analyses a conservative approach was taken in an effort to minimize the probability of finding differences when no difference actually existed (*i.e.,* a Type I error). For example, respondents were classified into one of the three health care plans (*i.e.,* MediPass/PMHP; HMOs in AHCA Area 6; MediPass in AHCA Area 4) only if there was reasonable assurance that the classification was correct. For example, Medicaid recipients who were listed in the AHCA Medicaid eligibility database as enrolled in MediPass in AHCA Area 4 (*i.e.,* fee-for-service plan in Jacksonville) but who reported they were enrolled in a HMO, were excluded from the analysis. In addition, respondents who indicated that they were no longer receiving Medicaid, or did not know whether they were currently receiving Medicaid, were excluded from the analyses.

In the Results section that follows, we present findings related to Medicaid enrollees' "unmet service needs." Unmet services need was conceptualized as follows: Respondents were asked whether they had needed the various services and whether they had actually used these services since April 1, 1997. The unmet service need was then calculated by determining the percentage of respondents who reported a need for a particular service but who did not receive that service.

The analyses summarizing enrollees' satisfaction with the different services were limited to those respondents who reported using those services since April 1, 1997.

2.5 Limitations

Prior to summarizing the findings, it is important to note several limitations of this study.

First, the individuals surveyed to date are limited to a population of adult Medicaid enrollees who are also receiving SSI. As noted earlier, in terms of the total number of covered lives in the different health care plans, adult SSI recipients represent only a small percentage (10%-12%) of the enrolled population. While this subgroup of Medicaid enrollees likely represents individuals who are most in need of services, their experiences, and subsequently their responses to the survey, may differ significantly from other subgroups of enrollees served by these health care plans.

Second, the questionnaire used in this mailing was originally developed as the first stage of a two-stage sampling framework. However, delays in getting an accurate Medicaid eligibility database resulted in a change of strategy. Because of time constraints on a companion study, it was decided to use the existing Medicaid eligibility database and this questionnaire to identify and recruit adult Medicaid enrollees with severe mental illness into our federally-funded, longitudinal, interviewer-administered study, but to delay the full scale Medicaid mailing until an accurate eligibility file was secured. Given that the questionnaire was intended for this first phase of sampling it was not designed to provide an in-depth assessment of Medicaid enrollees health and behavioral health status and service needs. A more comprehensive survey, specifically designed to provide a more detailed assessment of enrollees health, mental health, and substance abuse status and

service needs, has been developed and is currently being mailed to 7,200 adults and children SSI and WAGES recipients. The findings from this aspect of the member survey will offer a much broader and more detailed description of the differences and similarities of enrollees' health care experiences.

Third, many of the analyses summarized below assume that there is one homogeneous HMO plan, similar to the MediPass/PMHP and MediPass plans. A preliminary analysis comparing the responses of enrollees in different HMOs fails to support this assumption. Many significant differences were found among HMOs in terms of enrollees' unmet services needs and level of satisfaction with services.

Given that we did not systematically sample enrollees across the various HMOs and thus, do not know the extent to which the HMO respondents are representative of their particular HMO, we do not summarize these findings in this report. These findings show that not all the HMOs are alike.

Finally, the analyses conducted to date have not been adjusted for between-plan differences in the health or demographics of enrollees. Findings from this survey suggest that some between-health-care-plan differences may exist pertaining to the characteristics of enrollees and/or their health status. These differences should be taken into account when conducting further analyses. As more is learned about the magnitude and direction of these differences, statistical adjustments will be made.

3.0 RESULTS

The results are organized according to the issue addressed. Each general heading is followed by the findings related to that topic. Please refer to the end of the report for the definitions of the statistical notation used in this report.

3.1 Mail survey response rate

Of the 7,456 surveys disseminated, 3,966 were completed and returned for an unadjusted response rate of 53%. When adjusted for survey packages that were undeliverable (750 or 10%) and for individuals who were deceased (51 or 1%), the response rate was 60%. When further adjusted for certified mail returned as unclaimed (747 or 10%), the response rate was 67%. To date, 75% of the surveys mailed can be accounted for. This number will probably increase because we are still receiving completed surveys and unclaimed certified letters. Only 25% of surveys mailed cannot be accounted for. A complete breakdown of the status of the surveys mailed is presented in Table 1.

Table 1. Status of Surveys Mailed.

RETURN STATUS	NUMBER	PERCENTAGE
Mail Return	3,524	47
Telephone Return	442	6
Refused	58	1
Deceased \ Too Ill	60	1
Undeliverable	750	10
Unclaimed Certified Mail	744	10
Unaccounted	1,875	25
TOTAL	**7,456**	**100**

3.2 Characteristics of the respondents

The demographic data were extracted from the Medicaid eligibility database provided by AHCA to us. These data were used to describe the characteristics of survey respondents and to compare them demographically to individuals who did not return the questionnaire. Overall, 64% of the respondents were female and 36% male. A large percentage of respondents were white (47%), 33% were Black/African American, 1% were classified as Hispanic, while 19% were reported as "Other". Given that nearly 6% of the questionnaires returned were completed in Spanish, it is assumed that many of the respondents classified as "Other" in the Medicaid eligibility database are actually of Hispanic origin. A comparison of demographics of respondents, non-respondents, and the overall sample is presented in Table 2.

Table 2. Characteristics of Respondents, Non-respondents, and the Overall Sample.

CHARACTERISTIC	RESPONDENTS (*n*=3,967)	NON-RESPONDENTS (*n*=3,489)	SAMPLE (*N*=7,456)
GENDER			
Male	39%	40%	39%
Female	61%	60%	61%
RACE			
White	42%	45%	43%
Black	39%	34%	37%
Hispanic	0%	1%	1%
Other	19%	20%	19%
AGE	45 years old	44 years old	44 years old
HEALTH PLAN	(*n*=2,979)		
MediPass/PMHP	38%	N/A	32%
HMO (Area 6)	32%	N/A	32%
MediPass	30%	N/A	35%

The gender distribution of respondents closely approximated the distribution in the overall sample (Table 2). The racial/ethnic distribution of the respondents also closely mirrors the complete sample. Similarly, the average age of respondents closely

corresponds to the average age of the sample. These findings indicate that the demographic composition of the respondents is representative of the overall sample.

The characteristics of respondents and non-respondents were analyzed to determine whether there were any systematic demographic differences. No significant difference was found between respondents and non-respondents with respect to gender ($\chi^2 = .76$; $df = 1$; p = NS). With respect to racial/ethnicity, however, respondents differed significantly from non-respondents ($\chi^2 = 24.46$; $df = 3$; $p < .001$). Blacks were somewhat over-represented (39% versus 34%) and white were somewhat under-represented (42% versus 45%) among respondents compared to non-respondents. There was no significant difference in the average age of respondents and non-respondents ($t = .73$; $df = 7454$; p = NS).

Only the questionnaires of respondents who could be classified in one of the three health care plans were used to determine whether the distribution of respondents across health care plans differed. The following categories of responses were eliminated from the analysis: (1) respondents who were no longer on Medicaid or did not know whether they were currently on Medicaid, (2) individuals who knew they were on Medicaid but did not know the health care plan in which they were enrolled, or (3) those who did not answer these questions.

Findings from this analysis indicate that MediPass enrollees were somewhat under-represented (30% versus 35%, respectively) while MediPass/PMHP enrollees were somewhat over-represented (38% versus 32%, respectively).

3.3 Characteristics of respondents by health care plan

A comparison of the characteristics of respondents by health care plan is presented in Table 3. Significant gender differences were noted among respondents in the three health care plans ($\chi^2 = 30.42$; $df = 2$; $p < .001$). HMO respondents (in AHCA Area 6) were significantly more likely to be women (72%) compared to MediPass/PMHP respondents (66%), who were in turn, more likely to be women compared to MediPass enrollees (59%). The racial/ethnic distribution of respondents also differed across health care plans ($\chi^2 = 84.13$; $df = 6$; $p < .001$). HMO and MediPass respondents were more likely to be Black (36% and 36%, respectively) compared to MediPass/PMHP respondents (22%). MediPass/PMHP enrollees were more likely to be White (53%) compared to HMO and MediPass enrollees (44% and 46%, respectively). Additionally, MediPass/PMHP respondents were more likely "Other races/ethnicities" (24%) compared to HMO (20%) or MediPass (15%) respondents. A significant difference in respondents' age was also found across health care plans ($F = 11.83$; $df = 2,976$; $p < .001$) with HMO respondents being significantly younger (0 = 42.9 years old, $SD = 11.85$) than both MediPass/PMHP (0 = 44.9 years old, $SD = 12.11$) and MediPass respondents (0 = 45.4 years old, $SD = 11.96$).

Table 3. Characteristics of Respondents by Health Care Plan.

CHARACTERISTIC	MediPass/PMHP (*n*=1,008)	HMOs (*n*=818)	MediPass (*n*=774)
GENDER			
Male	34%	28%	41%
Female	66%	72%	59%
RACE			
White	53%	44%	46%
Black	22%	36%	38%
Hispanic	1%	0%	0%
Other	24%	20%	15%
AGE	44.9 years old	42.9 years old	45.4 years old

3.4 Overall health status

On average, respondents reported their current health status as "Fair" (0 = 2.04, $SD = 0.73$) on a three-point scale ranging from 1 = "Poor" to 3 = "Good".

A significant difference was found among respondents enrolled in different health care plans ($F = 3.80$; $df = 2,296$; $p = .023$). Respondents in the MediPass/PMHP plan reported significantly poorer health (0 = 2.00, $SD = 0.73$) compared to respondents in MediPass (0 = 2.04, $SD = 0.75$) or those enrolled in HMOs (0 = 2.08, $SD = 0.70$). Further examination revealed, however, that the magnitude of the difference in health status between MediPass/PMHP enrollees and enrollees in other health care plans was small.

3.5 Unmet medical needs

Overall, 2.3% of 2,432 respondents who indicated needing medical services since April 1, 1997, did not use them. There was a significant difference in the level of respondents' unmet medical needs across health carc plans ($\chi^2 = 21.67$; $df = 2$; $p < 001$). Respondents enrolled in HMOs had greater unmet medical needs (4.4%) compared to respondents in the MediPass/PMHP (1.2%) or MediPass (1.5%) plans.

3.6 Satisfaction with medical services

Respondents who used medical services were generally "Moderately" satisfied with the medical services they received. On average, respondents' level of satisfaction averaged 1.82 ($SD = 0.92$) on a four-point scale ranging from 1 = "Very Satisfied" to 4 = "Not at All Satisfied".

A significant difference was found in respondents' level of satisfaction with medical services across health care plans ($F = 10.48$; $df = 2,2437$; $p < .001$). Respondents

enrolled in HMOs were significantly less satisfied with the medical services they received (0 = 1.95, $SD = 0.97$) compared to respondents in the MediPass/PMHP (0 = 1.77, $SD = 0.91$) or MediPass (0 = 1.76, $SD = 0.85$) plans. Additional analysis, however, indicated that while this difference was statistically significant, the magnitude of the difference was small.

3.7 Unmet mental health needs

Overall, 11.3% of the 1,108 respondents who reported needing mental health services since April 1, 1997, did not use them. A significant difference was found in the unmet mental health needs of respondents' enrolled in the different health care plans ($\chi^2 = 13.07$; $df = 2$; $p = .001$). Respondents enrolled in HMOs had significantly greater unmet mental health needs (15.7%) compared to enrollees in either the MediPass/PMHP (10.6%) or MediPass (6.7%) plans.

3.8 Difficulties getting mental health services

One quarter of the respondents needing mental health services experienced problems getting the services they wanted. Significant differences were found across all three health care plans in the percentage of respondents experiencing difficulties accessing mental health services ($\chi^2 = 18.16$; $df = 2$; $p = .001$). A significantly smaller percentage of MediPass respondents (18%) experienced difficulties getting mental health services compared to the 24% in the MediPass/PMHP plan; 32% of the enrollees in HMOs experienced difficulties which was significantly higher than the percentage in both the MediPass and MediPass/PMHP.

3.9 Types of difficulties encountered

Respondents who experienced difficulties getting mental health services were also asked to indicate the types of problems they encountered. These are summarized in Table 4. Of the respondents experiencing difficulties, the most frequently cited issue (35%) was that the enrollees' preferred doctor would not accept Medicaid enrollees. Needed services not covered by Medicaid, was the second most frequent (29%) difficulty. These were followed closely by lacking transportation to services (28%), being placed on long waiting lists (26%), problems with changes in Medicaid rules (25%), difficulties getting a doctor's referral (24%), limits on benefits (23%), and problems getting appointments (21%).

Table 4. Types of Difficulties Experienced Getting Mental Health Services.

TYPE OF DIFFICULTY	PERCENT REPORTING DIFFICULTY[1]
Preferred doctor won't take Medicaid	35
Services needed not covered by Medicaid	29
No transportation	28
Long waiting lists	26
Changes in Medicaid rule	25
Getting doctor's referral	24
Limits on benefits	23
Can not get an appointment	21
Doctor won't listen to me	17
Services provided not helpful	16
Can't afford co-payment	14
Need child care	3
Need interpreter	3

[1] Percentages exceed 100% because respondents cited multiple difficulties.

3.10 Difficulties getting mental health services by health care plan

Table 5 (on the following page) summarizes the difficulties respondents experienced getting mental health services by health care plan. A significantly greater percentage of MediPass/PMHP and MediPass respondents (45% and 37%, respectively) indicated that their preferred doctor does not accept Medicaid compared to HMO enrollees (24%) (χ^2 = 20.35; df = 2; p < 001). A significantly smaller percentage of HMO enrollees (24%) indicated that the services they wanted were not covered compared to MediPass (35%) and MediPass/PMHP (31%) respondents (χ^2 = 8.13; df = 2; p < 05). There were no other statistically significant between-plan differences for any of the remaining problems listed in Table 5.

3.11 Respondents' satisfaction with mental health services

Respondents who used mental health services reported moderate levels of satisfaction with the services they used. Respondents' satisfaction with mental health services averaged 1.81 (SD = 0.92) on a four-point scale ranging from 1 = "Very Satisfied" to 4 = "Not at All Satisfied". No significant differences were found in the respondents' level of satisfaction with mental health services across health care plans (F = 1.90; df = 2,832; p = NS). MediPass enrollees' level of satisfaction with mental health services was (0 = 1.76, SD = 0.89, HMO respondents' level of satisfaction was (0 = 1.79, SD = 0.92, while the satisfaction with mental health services of among MediPass/PMHP enrollees averaged (0 = 1.86, SD = 0.93.

Table 5. Difficulties Getting Mental Health Services By Health Care Plan.

DIFFICULTY	PERCENTAGE OF MENTAL HEALTH USERS REPORTING DIFFICULTY [1]		
	MediPass/PMHP (*n*=106)	HMO (*n*=49)	MediPass (*n*=110)
Preferred doctor won't take Medicaid [2]	45	24	37
Services needed not covered by Medicaid [2]	31	24	35
No transportation	25	32	26
Long waiting lists	26	31	14
Changes in Medicaid rule	31	24	14
Getting doctor's referral	21	26	31
Limits on benefits	20	26	26
Can not get an appointment	20	24	16
Doctor won't listen to me	16	19	14
Services provided not helpful	16	14	16
Can't afford co-payment	15	13	16
Need child care	3	4	2
Need interpreter	1	2	1

[1] Percentages exceed 100% because respondents could cite multiple difficulties.

[2] Denotes a statistically significant difference among health care plans.

3.12 Respondents' unmet dental needs

Overall, 50.8% of 1,141 respondents needing dental services since April 1, 1997, did not use them. A significant difference was found in the unmet dental needs of respondents' enrolled in the different health care plans ($\chi^2 = 29.87$; $df = 2$; $p < 0.01$). Respondents enrolled in HMOs had significantly fewer unmet dental needs (29.1%) compared to respondents enrolled in either the MediPass/PMHP (56.8%) or MediPass (57.3%) plans.

3.13 Respondents' satisfaction with dental services

Respondents who used dental services reported a "Moderate" level of satisfaction with the services they received. Respondents' satisfaction with dental services averaged 2.07 ($SD = 1.11$) on a four-point scale ranging from 1 = "Very Satisfied" to 4 = "Not at All Satisfied". No significant differences were found in respondents' level of satisfaction with dental services across the three health care plans ($F = 1.75$; $df = 2,543$; p = NS). HMO respondents' level of satisfaction with dental services averaged 2.15 ($SD = 1.11$), MediPass/PMHP averaged 2.05 ($SD = 1.14$), while MediPass respondents averaged 1.93 ($SD = 1.05$).

3.14 Respondents' unmet substance abuse needs

Overall, 16% of 109 respondents who reported a need for substance abuse services since April 1, 1997 did not receive them. No significant differences were found in the unmet substance abuse needs of respondents' across health care plans ($\chi^2 = .99$; $df = 2$; p = NS).

It is important to note, however, that the number of individuals reporting a need for substance abuse services is so small that there is little statistical power to detect between health-care-plan differences.

3.15 Respondents' satisfaction with substance abuse services

The 91 respondents who used substance abuse services were moderately satisfied with the services they received. Respondents' satisfaction with substance abuse services averaged 1.97 (*SD* = 1.05) on a four-point scale ranging from 1 = "Very Satisfied" to 4 = "Not at All Satisfied". No significant differences were found in respondents' level of satisfaction with substance abuse services across the health care plans ($F = .33$; $df = 2,102$; p = NS). As noted above, the small number of individuals who reported using substance abuse services provides little statistical power to examine between health-care-plan differences.

4.0 SUMMARY AND IMPLICATIONS

A summary of each finding is listed below, followed by a brief statement of the potential implications. It is important to remember that these findings pertain only to adult Medicaid enrollees receiving SSI.

Overall health status. While respondents were generally in "fair" health, MediPass/PMHP enrollees were in significantly poorer health compared to individuals enrolled in either MediPass or HMOs.

> The between-health-care plan differences found in respondents' overall health status provides some evidence for the need for case-mix adjusted analyses. While the difference is small, it is nevertheless puzzling why the MediPass/PMHP enrollees differed from the HMO and MediPass plans. One would think that if "differential selection" of enrollees was operating, that the health status of enrollees in the two MediPass plans would differ from that of HMO enrollees.

Unmet medical needs. Of respondents needing medical services, a significantly higher percentage of HMO enrollees did not receive them (4.4%) compared to enrollees in either MediPass/PMHP (1.2%) or MediPass (1.5%).

> This finding suggests that the MediPass enrollees had better access to the medical services they wanted. This finding is logical given that the process for accessing medical services in both the MediPass/PMHP and MediPass plans is a Primary Care Case Management model (PCCM), so one would not anticipate differences. In contrast, the process for accessing medical services in most HMOs does not use a PCCM process.

Satisfaction with medical services. Respondents who used medical services were moderately satisfied with the services they received, although those enrolled in HMOs

were significantly less satisfied with their medical services compared to enrollees in the MediPass/PMHP or MediPass plans.

> This finding suggests that even among enrollees who access medical services, their perceived quality of these services differs systematically by health care plan. MediPass/PMHP and MediPass enrollees were more satisfied with the medical services they received than were HMO enrollees.

Unmet mental health needs. Of the individuals reporting a need for mental health services, a significantly higher percentage of HMO enrollees did not receive these services (15.7%) compared to those enrolled in either the MediPass/PMHP (10.6%) or MediPass (6.7%) plans.

> In each of the health care plans, procedures for accessing mental health services differ. In the MediPass plan, where the unmet service needs was the smallest (6.7%), mental health services are provided on a fee-for-service basis. In the MediPass/PMHP, where mental health services are provided by the Community Mental Health Centers (CMHCs) and who receive a capitated payment rate, the unmet mental health service needs were somewhat higher (10.6%). In HMOs, where pre-authorization is required for mental health services, unmet service needs were the highest (15.7%).

Satisfaction with mental health services. Respondents who used mental health services were moderately satisfied with the services they received and no significant difference was found in respondents' level of satisfaction across health care plans.

> The "no difference" finding regarding satisfaction among mental health service users is not surprising. Given that in AHCA Area 6 (Tampa Bay area), the majority of the mental health services are provided by the CMHCs, it is likely that HMO and MediPass/PMHP enrollees receive their mental health services from the same service providers. We do not currently have sufficient information to determine who provides the majority of the mental health services to the MediPass enrollees in AHCA Area 4 (Jacksonville).

Accessing mental health services. Of the respondents needing mental health services, 32% of HMO enrollees experienced difficulties getting services compared to 24% of MediPass/PMHP enrollees and 18% of the MediPass enrollees.

> This finding parallels the access finding discussed above. The difficulties experienced by enrollees seeking mental health services has the same pattern as their unmet physical health service needs: MediPass enrollees experienced the fewest difficulties (18%), MediPass/PMHP enrollees the second most (24%), and HMO enrollees the most (32%).

Unmet dental needs. Of individuals needing dental services, HMO enrollees had significantly fewer unmet dental needs (29.1%) compared to respondents in either the MediPass/PMHP (56.8%) or MediPass (57.3%) plans.

Given that MediPass benefits for dental services are very limited, it is not surprising that unmet dental needs were quite high and similar among enrollees in the two MediPass plans. The significantly lower unmet dental need among HMO enrollees is the result of the dental coverage provided by most HMOs. Dental services are optional requirements for most HMOs, meaning that HMOs are not obligated to provide them. However, a review of the various HMOs' benefit plans indicated that most HMOs do offer dental care services that are not available through MediPass.

Satisfaction with dental services. Enrollees who used dental services were moderately satisfied with the services they received. There was no significant difference found in respondents' level of satisfaction with dental services across the health care plans.

The "no difference" finding regarding satisfaction with dental services is difficult to discuss given how little is known about the actual dental service providers. Presumably, MediPass/PMHP and MediPass enrollees are receiving most of their dental services out-of-plan while HMO enrollees are receiving these services as part of their coverage.

Unmet substance abuse needs and satisfaction. There was no significant difference across health care plans in enrollees' unmet service needs or with users' level of satisfaction with substance abuse services. However, the number of individuals reporting substance abuse service needs and use was too small make a definitive statement.

Despite the small number of respondents reporting substance abuse service needs and use, finding no difference in either unmet needs or satisfaction with services used is not surprising given that in each of the three health care plans, substance abuse services are paid for on a fee-for-service basis.

5.0 NEXT STEPS

A more comprehensive survey to a sample of Medicaid enrollees is being mailed. A sample of an additional 7,200 Medicaid enrollees has been drawn from the AHCA Medicaid eligibility database. The sampling procedure used to select the recipients ensured that an equal numbers of children (ages 5-20) and adults (ages 21 to 65), and AFDC and SSI recipients enrolled in the MediPass/PMHP (AHCA Area 6), HMO (AHCA Area 6), and MediPass (AHCA Area 4) plans were included.

The contents of the survey package have been reviewed by the research staff and comments by volunteer consumers attending a focus group have been incorporated into the survey instruments. This survey contains health, mental health, and substance abuse status measures, an expanded number of questions concerning service needs and utilization, questions about changes in medications, satisfaction with services, quality of life, as well as more detailed demographic information about respondents. Preliminary findings from the expanded survey should be available beginning in April 1998.

6.0 REFERENCES

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DEFINITION OF STATISTICAL NOTATIONS

0 = Average score or mean score.

SD = Standard deviation, a measure of dispersion in a distribution of scores.

N = The number of individuals in the sample.

n = The number of individuals in a subgroup of the sample.

t = "Student's t", a statistical test for comparing the means between two samples.

F = Analysis of variance *F* statistic, a statistical test for comparing the means between two or more groups.

χ^2 = Chi square, a statistical test for determining the independence among groups.

df = Degrees of freedom, the freedom of scores to vary which is needed to interpret *t*, *F* and χ^2.

p = The probability of being correct.

NS = Not significant.