SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/CS/SB 1706

SPONSOR: Appropriations Committee; Health, Aging, and Long-Term Care Committee, Children and Families Committee, and Senator Wise

SUBJECT: Specialty Behavioral Health Care Providers

DATE: April 13, 2004 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Collins	Whiddon	CF	Fav/CS
2.	Parham	Wilson	HC	Fav/CS
3.	Peters	Belcher	AHS	Fav/CS
4.			AP	Withdrawn: Fav/CS
5.				
6.				

I. Summary:

This bill requires the Department of Children and Family Services (DCF) to establish a demonstration project in District 4 for the purpose of determining the benefits of having a specialty behavioral health care provider deliver behavioral health services to individuals residing in an assisted living facility (ALF) with a limited mental health license.

The bill further directs DCF to establish an advisory committee and specifies the membership of the committee. The committee is directed to make recommendations to DCF and the Agency for Health Care Administration (AHCA) on the development of the demonstration project.

The bill requires AHCA and DCF to ensure that providers participating in the demonstration project develop and implement a plan to provide specific services, and that any services provided as a part of the demonstration project must be reimbursed on a fee-for-service basis, as well as cost neutral for AHCA and DCF. A "request for information" process is to be used to procure specialty behavioral health providers under the demonstration project.

The bill requires AHCA to authorize the selected behavioral health care provider to negotiate a capitated payment for the demonstration project's behavioral health care services if a managed care system is implemented in District 4 as part of the statewide expansion. This bill further specifies that the capitation rate must be based on 90 percent of the historical utilization of Medicaid funding by this population and that the services provided must include all outpatient state-funded behavioral health care services and inpatient psychiatric services. DCF is further directed to calculate a rate for the non-Medicaid residents served in the demonstration area in order to ensure that the capitation rate does not result in the displacement of residents.

The bill provides an implementation deadline and requires the project to operate for at least three years following implementation.

The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct an evaluation and a subsequent review of the demonstration project and submit a report to the Legislature.

The bill amends s. 394.4574, Florida Statutes.

II. Present Situation:

Assisted Living Facilities

ALFs provide housing, meals, and personal assistance to frail elders and persons with physical and mental disabilities who need support to live in the community but do not require institutionalization (chapter 400, part III, F.S.). Facility staff provide supervision to residents, including oversight of their diet, activities, general whereabouts, and activities of daily living. These facilities are licensed by AHCA.

Limited Mental Health Services in ALFs

In 1995, the Legislature established limited mental health specialty licensure for ALFs that serve residents with mental illness. Any ALF that serves three or more mental health residents is required under s. 400.4075, F.S., to obtain a limited mental health license. Residents with mental illness receive personal services from the facilities and mental health services from local community mental health centers. Cooperative arrangements are made between ALF staff and local mental health treatment providers to provide mental health residents with emergency and after-hours services when they are needed. DCF staff at the district level are responsible for ensuring mechanisms are in place to provide appropriate services to ALF residents with mental health problems.

By definition, mental health residents are persons with severe and persistent mental illnesses, who may have been recently released from a state mental health treatment facility or an acute care intensive treatment setting. These residents are typically aged 40-60 and have severe and chronic disorders such as schizophrenia, other psychosis, or bipolar disorder that need a supervised living environment. These residents are in need of sufficient services and supports to allow them to live in the community. Because many of these individuals have very limited financial resources and may need assistance with their activities of daily living, ALFs are often the only living arrangement available to them. If they receive either SSDI or SSI, and are eligible for Medicaid, these residents are eligible for and have access to the same array of services that all other Medicaid recipients may access in the community. Requirements for ALFs with the limited mental health license include: additional training for direct care staff, coordination with the residents' mental health provider, and participation in planning for resident needs.

There are currently more than 75,000 ALF beds statewide in 2,250 facilities. There are 675 ALF providers in the state holding a limited mental health license; approximately 8,500 individuals with mental illness live in these facilities. In District 4 (Duval, Clay, Volusia, Nassau and Flagler

counties), there are 37 ALFs with limited mental health licenses and approximately 480 residents reside in these facilities.[1]

Since 1996, at least two reports to the Florida Legislature have raised concerns about the provision of behavioral health (mental health and substance abuse) services for residents living in ALFs.[2] Specific concerns have been raised regarding the adequacy of available placement resources for mental health clients and the adequacy of services available to support community placement options for individuals with severe mental illnesses. The availability of after-hours mental health coverage is also a problem that is frequently cited by ALF administrators.

Services Provided by the Department of Children and Family Services

DCF is required by s. 394.4574, F.S., to provide certain services to residents in ALFs. Those services include:

- Assessment prior to ALF placement by a mental health professional or person supervised by one;
- Cooperative agreement with the ALF to ensure coordination of services, as well as procedures for responding to emergent conditions;
- Assignment of a case manager to each mental health resident; and
- Development of a community living support plan, specifying services to be provided in the ALF residence.

The statute further requires that each DCF district administrator develop detailed plans that describe how the district will ensure that state-funded substance abuse and mental health services are provided to residents of ALFs with a limited mental health license. The plans must address how case management services, access to consumer-operated drop-in centers, access to services during evenings, weekends and holidays, supervision of clinical needs, and access to emergency psychiatric care will be provided to residents who may need those services. Services must be provided within existing resources available in the district.

Section 394.4574, F.S., further requires that the administrator of an ALF with a limited mental health license have a cooperative agreement with the mental health care provider that is providing services to residents. This section stipulates that in cases when a resident of an ALF providing limited mental health services is also a Medicaid recipient in a prepaid health plan, the entity that is providing the prepaid plan must ensure coordination of health care with the ALF. If the entity is also at risk for Medicaid targeted case management and behavioral health services, they must ensure that the ALF administrator has been made aware of procedures to follow to obtain mental health services for a resident in an emergency.

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[1] Based upon information obtained from the Agency for Health Care Administration.
[2] Review of Assisted Living Facilities Serving Residents with Severe Mental Illness, 1997, OPPAGA Report No. 96-57 and Follow-Up Report on Assisted Living Facilities Serving Residents with Severe Mental Illnesses, 1998, OPPAGA Report No. 98-27.

Medicaid Behavioral Health Care Services

Under AHCA's Medicaid State Plan, ALFs receive a Medicaid payment of $9.28 per Medicaid resident per day for assistive care services.[3] This fee does not include behavioral health services. Medicaid behavioral health care services are provided on a fee-for-service basis by local and community behavioral health care providers. Residents of ALFs that are Medicaid recipients are eligible and have access to the same array of services that all other Medicaid recipients have access to in the community.

Behavioral Health Services Integration Workgroup

Efforts have been made to address concerns relating to the provision of mental health and substance abuse services to residents of ALFs. The interface between the publicly funded mental health and substance abuse system and ALFs was one area focused on by the Behavioral Health Services Integration Workgroup, which was established by the 2001 Legislature. As a result of recommendations by this workgroup, further study was conducted by the Louis de la Parte Florida Mental Health Institute (FMHI) resulting in the report *Behavioral Health Services Integration: Assisted Living Facility Study,* 2003. Some of the findings from this report indicate the following:

- There are mixed opinions concerning whether ALF residents receive the mental health services they need. Most residents, case managers and direct care staff are satisfied with the availability of mental health services. However, the majority of administrators are not satisfied with the availability of these services.
- Administrators, case managers, and direct care staff are not satisfied with the availability of substance abuse services.
- Most residents would like to receive substance abuse services such as Alcoholics Anonymous, group therapy, or counseling.

Despite the information contained in this report, the extent of difficulty that is encountered in obtaining mental health services for persons with mental illness who reside in an ALF remains unclear, largely due to the lack of available data. Unfortunately, there is no single standard assessment system or data base maintained for ALFs. Information pertaining to ALFs is maintained separately by DCF and AHCA, which has made it difficult to obtain cohesive, critical information since at least 1996.[4]

Medicaid Cost Containment

Over the last 25 years, Medicaid program enrollment and expenditures have grown well beyond original expectations when the program was established. Although expanding coverage to needy groups was a dominant goal of the program, expenditure growth and the pressure it has placed on state budgets has made cost containment a central objective for states. States have adopted

[3] Assistive care services are similar to services typically provided in residential care facilities to residents who require an integrated set of services on a 24-hour basis. They include assistance with activities of daily living, medication assistance, assistance with instrumental activities of daily living, and health support.
[4] Review of Assisted Living Facilities Serving Residents with Severe Mental Illness, 1997, OPPAGA Report No. 96-57.

Medicaid managed care both to contain costs as well as to improve access to care. There are two broad kinds of managed care: primary care case management (PCCM) programs and capitated health maintenance organizations (HMOs). In general, PCCMs pay primary care physicians a fixed fee, usually $3 to $6 per member per month in addition to regular fee-for-service payments for care. Primary care physicians are expected to influence but are not held financially responsible for use of specialists and inpatient stays. Unlike PCCMs, capitated HMOs assume financial risk for inpatient and outpatient services and often for prescription drugs, dental care, and other services. Plans receive a fixed dollar amount per month per beneficiary for a specified benefit package. Both PCCMs and HMOs have had similar effects: inappropriate emergency room use has declined, access to office-based primary care has improved, and expenditures have fallen 5 to 15 percent below fee-for-service levels.[5]

Over time, states have migrated toward capitated HMO alternatives as the preferred strategy to not only improve access and accountability and reduce costs, but also to achieve budget predictability. Furthermore, many states chose to build upon voluntary managed care programs by enrolling beneficiaries on a mandatory basis into capitated managed care programs under 1915(b) freedom of choice or Section 1115 of the Social Security Act managed care demonstration waivers.[6]

Medicaid managed behavioral health care is delivered through three vehicles in Florida: a statewide primary care case management plan, a statewide voluntary HMO program and a mental health stand alone program in Districts 1 and 6. Statewide, all Medicaid recipients may choose between the HMO program and the primary care case management plan for physical health services. Other than in Districts 1 and 6, community mental health and substance abuse services are excluded from these plans and provided on a fee-for-service basis. In Districts 1 and 6, however, recipients who choose the primary care case management plan are referred to a mental health stand alone program, known as the Florida Prepaid Mental Health Plan. Recipients who choose the HMO receive all of their services, including mental health and substance abuse treatment, from the HMO. However, HMOs in Districts 1 and 6 subcontract with the carve-out subcontracted providers.

Three other managed care programs are operating in Florida: a child welfare initiative that includes behavioral health services; a capitation program for all social services including substance abuse; and a Medicaid utilization management program for all inpatient psychiatric visits.

Medicaid Prepaid Mental Health

The 1991 Florida Legislature created s. 409.905(34), F.S., which directed the State of Florida to apply for a waiver from the Centers for Medicare and Medicaid Services (CMS) to provide mental health services to Area 6 Medicaid beneficiaries in the most cost effective setting possible. It stipulated that the waiver incorporate competitive bidding for services, prepaid

[5] U.S. General Accounting Office. 1993. *Medicaid: States Turn to Managed Care to Improve Access and Control Costs*. GAO/HRD 93-46. March. Washington, DC: GAO.

[6] Holahan, J., Wiener, J.M., and Lutzky, A.W. 2002. "Health Policy for Low Income People: State Responses to new Challenges." *Health Affairs* web exclusive http://healthaffairs.org/WebExclusives/Holahan_Web_Excl_052202.htm.

capitated arrangements, and that the waiver proposed no additional aggregate cost to the state. A two-year waiver was approved effective July 1, 1993. This waiver was renewed by CMS in January 1996, July 1999, and July 2001.

In 2000, the Legislature amended s. 409.912, F.S. to authorize expansion of Medicaid managed mental health care services into Medicaid Areas 1, 5, 8, and Alachua County by December 31, 2001. It additionally required that AHCA add substance abuse services to the Area 6 contract by January 1, 2001.

The July 2001 waiver renewal amended the waiver to add fourteen counties specified in the 2000 Florida legislation for expansion of the carve-out program. The additional fourteen counties are pending expansion currently for various reasons including provider resistance to the capitated system, inability to calculate feasible capitation rates due to lack of inpatient psychiatric facilities in certain regions, and inability to isolate one county out of an entire Medicaid Area into the prepaid system of care. Round table discussions and education for providers has been offered to encourage response to the RFP, and alternative methods to calculate capitation rates have been sought.

The Medicaid Prepaid Mental Health Plan (PMHP) is currently operating in nine counties – Hillsborough, Hardee, Highlands, Manatee, Polk, Escambia, Santa Rosa, Okaloosa, and Walton. These counties make up two geographic areas within the state – Medicaid Area 1 and Area 6. The Area 6 PMHP has been in place since March 1, 1996 with Florida Health Partners as the PMHP provider. The Area 1 PMHP was implemented November 1, 2001 with Access Behavioral Health as the PMHP provider. A local Medicaid Managed Mental Health Care Advisory Group, that includes representation from all stakeholders within the area, is a requirement of the PMHP contracts. The advisory groups meet on a quarterly basis and minutes from each meeting are developed.

Beneficiaries in TANF, foster care, SOBRA, and SSI categories of eligibility who are not eligible for Medicare are enrolled in the program. When Medicaid beneficiaries in one of these counties choose or are assigned to MediPass for their physical health care, they are automatically assigned to the PMHP for their mental health services. MediPass provides primary care case management and authorizes physical health services and the PMHP manages and provides mental health services. Currently, the Medicaid HMOs in these counties also manage and provide both physical and mental health care. Services for substance use and chemical dependency diagnoses remain covered under the Medicaid fee-for-service program for beneficiaries enrolled in both plans.

Medicaid pays the PMHP a per member per month rate based on eligibility category and age groups. This payment is currently 91 percent of Medicaid's anticipated cost of providing mandatory covered mental health services to eligible persons residing in each area. The rate is calculated in accordance with a CMS approved actuarial methodology. Mandatory services covered by the PMHP are detailed in the contracts and include mental health related inpatient, outpatient, and physician services, community mental health and mental health targeted case management services. The PMHP also provides, to qualifying members as a downward substitution, several additional services not reimbursable by fee-for-service Medicaid. These services currently include crisis stabilization, drop-in/self help centers, preventive services,

residential care for adults, respite care, sheltered and supported employment, supported housing, partial hospitalization, and transportation.

AHCA's Bureau of Medicaid Services manages and monitors the contracts. On-site contract compliance monitoring for current contracts is completed on an annual basis for each PMHP contract and desk reviews of mandatory reports from the contractors are conducted each month. These monitoring visits are coordinated with the local Substance Abuse and Mental Health Program Offices. Results are shared with the local Managed Care Advisory Group to obtain input and direction for quality improvement activities.

AHCA continues to contract with the Florida Mental Health Institute (FMHI) at the University of South Florida to complete an independent evaluation of the PMHP (carve-out) as part of the requirement for a 1915 (b) waiver.

In the 2003 regular Legislative Session, Senate Bill 2404, a bill relating to Florida's mental health and substance abuse programs, directed AHCA to contract with a single managed care entity in each AHCA area through capitated prepaid arrangements for enrolled MediPass recipients by July 1, 2006. Under this new legislation, Medicaid substance abuse services will also be included with mental health services. This legislation will expand managed care for comprehensive behavioral health services statewide.

Subsequent to the passage of SB 2404, differing interpretations arose regarding the phrase, "single managed care entity." The Attorney General's office has opined that it would be appropriate for the Legislature to issue clarification regarding the intent of this legislation. Outside of the demonstration areas, comprehensive mental health services for Medicaid recipients are reimbursed through a fee-for-service mechanism in which the state is at risk for mental health service utilization. With the exception of mental health services provided by the PMHPs and the HMOs in Areas 1 and 6, prior authorizations for inpatient admissions are managed statewide by First Health, a utilization management firm. This utilization management system was initiated in January 1997. Also, as of April 1, 2002, Medicaid has required prior authorization for three additional services: day treatment, intensive therapeutic onsite services, and rehabilitation day treatment.

III. Effect of Proposed Changes:

Section 1. Amends s. 394.4574, F.S., relating to DCF responsibilities for an individual with mental health needs who resides in an ALF that holds a limited mental health license, to create new subsections (4)-(9).

This section directs DCF to establish a demonstration project in District 4 for the purpose of determining the benefits of having specialty behavioral health care providers deliver behavioral health services to residents of an assisted living facility with a limited mental health license. The purpose of this demonstration project is to develop evidence-based practices in the delivery of state-funded behavioral health care services to persons who reside in an ALF with a limited mental health license. Participation in the program of fee-for-service options is voluntary for ALF residents eligible for Medicaid and recipients of state-funded services.

This section requires DCF to create an advisory committee to make recommendations to AHCA and the department pertaining to the demonstration project. DCF is further directed to develop the demonstration project in consultation with AHCA. The committee is directed to solicit input from a variety of sources relative to the standards, criteria, and array of services that will be included in the demonstration project. The membership of the advisory committee is to consist of local community partners including residents, advocates, private and publicly funded health care providers, and representatives from AHCA, DCF, and local government facility administrators. This bill provides that membership from the private sector for the proposed workgroup may include a representative of: the Florida Psychiatric Society, the Florida Council for Behavioral Health, the National Alliance for the Mentally Ill, the Florida Assisted Living Affiliation, and the local advocacy council. The members of the committee are to serve at their own expense

For the purposes of this bill, the term "specialty behavioral health provider" means a public or private behavioral health care entity, provider, or organization or coalition of providers that holds a contract with DCF and can offer a full array of state-funded behavioral health care services to residents living in ALFs holding a limited mental health license in district 4. The bill specifies that services are to be provided directly by the specialty behavioral health provider on a fee-for-service basis. DCF is directed to allow private providers an opportunity to seek a contract and compete to provide state-funded behavioral health services. Residents living in ALFs currently receive mental health services on a fee-for-service basis.

This section requires that AHCA and DCF ensure that providers participating in the demonstration project develop and implement a plan to provide certain services, including intensive case management services, on-call case managers, and vocational support. This section further specifies that any services provided as a part of the demonstration project must be fee-for-service, as well as cost neutral for AHCA and DCF. The department, in consultation with AHCA, is directed to use a "request for information" process to procure specialty behavioral health providers under the demonstration project.

This section provides that DCF and AHCA, for the purposes of this demonstration project, must allow any behavioral health care provider meeting the requirements of the demonstration project to become a specialty behavioral health care provider for Medicaid-eligible ALF residents who are enrolled in the MediPass program. Each eligible behavioral health provider must be permitted to seek and develop cooperative agreements with administrators of ALFs that hold limited mental health licenses for a minimum of one year. These agreements are to be focused on improving the coordination of services and communication, developing protocols to assist with supervision of the residents' clinical needs, and meeting all other provisions currently required under existing statute.

This section requires AHCA to seek federal waivers to implement an alternative prepaid behavioral health care plan for residents in District 4 who live in an ALF with a limited mental health license, if a prepaid behavioral health plan is introduced in District 4 in accordance with SB 2404. This section further specifies that the capitation rate must be based on 90 percent of the historical utilization of Medicaid funding by this population and that the services provided must include all outpatient state-funded behavioral health care services and inpatient psychiatric **s**ervices. Medications are exempt from these provisions. DCF is directed to calculate a rate for

the non-Medicaid residents served in the demonstration area in order to ensure that the capitation rate does not result in the displacement of residents.

This section requires the demonstration project to be implemented no later than January 1, 2005, and that the project be continued for no less than three years following implementation. The advisory committee is required to complete its work by the end of the 3-year period.

This section requires OPPAGA to conduct an evaluation of the demonstration project after the first year of operation. The evaluation must assess the recidivism of residents from the ALF to the inpatient hospital setting, improvement in behavioral health care outcomes, patient satisfaction with care, improvements in program competencies and linkages, increased tenure of case management relationships with residents, and implementation of meaningful plans of recovery. OPPAGA is required to review the project after the 3rd year of the operation. After the evaluation and review are completed, OPPAGA is required to submit the evaluation and the review to the President of the Senate and the Speaker of the House of Representatives in a timely manner.

Section 2. Provides that this bill shall take effect July 1, 2004.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, s. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill requires membership from the private sector for the proposed advisory committee: one person from the Florida Psychiatric Society, one person from the Florida Council for Behavioral Health, a member of the National Alliance for the Mentally Ill, a

member of the Florida Assisted Living Affiliation, and a member from the local advocacy council. Members of the committee are to serve at their own expense.

The bill increases an individual's choice of providers if a prepaid behavioral health program is implemented in District 4 since ALF residents will have a choice of service providers who participate in the demonstration project.

C. Government Sector Impact:

Agency for Health Care Administration

There will be a fiscal impact to AHCA of $26,000 annually for actuarial services needed to certify the validity of capitated rates. Federal regulations require that rates must be re-certified annually.

Although the bill calls for a capitated rate in Area 4 for mental health services for recipients residing in assisted living facilities, clarification is required to estimate the fiscal impact. The bill states the capitation rate should be based on no more than 90 percent utilization of the fee-for-service base; however, Medicaid typically capitates at a percentage of the fee-for-service base, not a percentage of a component of the base.

Department of Children and Family Services

DCF reports that it does not have the authority to develop a demonstration project utilizing AHCA funding.

DCF indicates there will be administrative costs to the department to organize and staff the workgroup, develop the bid specifications, and monitor the implementation of the demonstration project.

VI. Technical Deficiencies:

None.

VII. Related Issues:

DCF indicates that estimates of utilization have found that persons with mental illness who reside in ALFs may already receive as many as four times the units of service as persons receiving state funded behavioral health services in other settings.

The term "behavioral health services" generally includes both mental health and substance abuse services. At this time, AHCA is capitating only mental health services.

Facilities that are larger than 16 beds which are primarily engaged in the care or treatment of persons diagnosed with mental illness are defined under federal Medicaid law as "institutions for mental disease" (IMD). Persons who reside in IMDs have their Medicaid benefits suspended. Providing a large volume of mental health services within an ALF may increase the likelihood

that the facility may be defined as an IMD. However, this requirement does not prevent persons from receiving mental health services in other settings.

District 4 is currently the pilot site for two other projects (an In Depth Technical Assistance Grant to help improve substance abuse services for families involved in the child welfare system, and a pilot to "develop a project for a single managing entity to provide substance abuse services to families in the child protection system" that is directed by the Legislature). The creation of an additional pilot in this area that requires coordination and oversight by DCF staff may exceed current departmental capacity.

DCF and AHCA are directed to calculate a rate for the non-Medicaid residents served in the demonstration area in order to ensure that the capitation rate does not result in the displacement of residents. The direction to carve out certain areas or populations for a capitated payment system is contrary to previous direction provided by the 2003 Legislature requiring the implementation of a single managing entity to deliver behavioral healthcare services (chapter 2003-279, L.O.F.). Further, there is no precedent for developing a capitated rate for any particular subgroup.

The bill carves out a subpopulation of individuals with mental illness; those living in ALFs with a limited mental health license. Carving out small groups under a managed care arrangement puts plans at higher risk of not being able to cover costs because of their inability to spread risk across many plan enrollees. Furthermore, as less than 700 recipients receive mental health benefits from assisted living providers in Area 4 currently, it is unclear how many of that number would participate in such a pilot project and if such pilot could attract sufficient enrollees to reach a critical mass to provide effective services at the capitated rate.

VIII. Amendments:

None.