The Florida Senate

Interim Report 2012-109 *September 2011*

Budget Subcommittee on Health and Human Services Appropriations

CRISIS STABILIZATION UNITS

Issue Description

For this interim project, the Budget Subcommittee on Health and Human Services Appropriations reviewed the following issues regarding emergency mental health stabilization services:
Revenue streams supporting these services;
Service delivery and accountability mechanisms; and
Alternative funding models that could be developed.

For Fiscal Year 2011-2012, the Florida Legislature appropriated $111.9 million ($105.6 million or 94 percent from general revenue) to support emergency mental health stabilization services provided through Crisis Stabilization Units ("CSUs") for adults and children statewide. Involuntary commitment services or Baker Act services, to individuals account for 69 percent ($76.8 million) of funds supporting emergency stabilization services, with the remaining funds ($35.1 million) supporting voluntary services to individuals. The majority of the Baker Act funding (80%) provides services to adults. By statute, crisis stabilization services require a 25 percent match from local governments or other sources.[1]

For Fiscal Year 2010-2011, the Department of Children and Families ("the Department") there were 65 licensed CSUs with 1,131 beds statewide. Forty-five CSUs with 929 beds served adults. Twenty CSUs with 202 beds served children. CSUs provided services to 41,060 individuals (36,429 adults and 4,631children), which was a six percent decrease from the previous year.[2] The Department funded the majority of these beds (61%) in Fiscal Year 2010-2011. Additional funding sources for CSUs include Medicaid, Medicare, and private insurance.

Background

Individuals experiencing severe emotional or behavioral problems often require emergency treatment to stabilize their situations before referral for outpatient services or inpatient services can occur. Emergency mental health stabilization services may be provided to voluntary or involuntary patients. Involuntary patients must be taken to one of the state's designated receiving facilities. Receiving facilities are defined by the Florida Mental Health Act (ss. 394.451-394.4789, F.S.) and are referred to as Baker Act Receiving Facilities.[3,4] The purpose of receiving facilities is to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. Law enforcement officers usually transport individuals requiring involuntary Baker Act examinations to the nearest receiving facility. The facility must accept individuals brought by a law enforcement officer for involuntary examination, regardless of bed availability.[5]

The Department designates facilities as a Baker Act Receiving Facility prior to licensure by the Agency for Health Care Administration (AHCA). While receiving facilities may be either public or private facilities, only

[1] s.394.67(13), *F.S.*
[2] Information provided by the Department of Children and Families
[3] s. 394.455(25)(26), *F.S.*
[4] According to the Department of Children and Families, the Florida Legislature enacted the Florida Mental Health Act in 1971 to revise the state's mental health commitment laws. The Act substantially strengthened the due process and civil rights of persons in mental health facilities and those alleged to be in need of emergency evaluation and treatment. A major intent of the Act was to increase community care of persons with mental illnesses. Since the Baker Act became effective in 1972, the Legislature enacted a number of amendments to enhance the protection for civil and due process rights of persons in mental health facilities. Some of the most substantial reforms occurred in 1996, including: extending greater protections for persons seeking voluntary admission and specifying the circumstances under which receiving and treatment facilities designations may be suspended or withdrawn. The most recent revision to the Act became effective in January 2005 with the addition of the Involuntary Outpatient Placement provision of the Act.
[5] s. 394.462, *F.S.*

facilities with a contract with the Department to provide mental health services to all persons, regardless of their ability to pay, and receiving state funds for this purpose are considered public receiving facilities. Section 394.4685, Florida Statutes, permits the transfer of individuals between public facilities, between public and private facilities, and private and public receiving facilities. For example, public receiving facilities may transfer an individual, at the request of a patient with the ability to pay for private treatment, to a private receiving facility. Funds appropriated for Baker Act services may only pay for services to diagnostically and financially-eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay. Designation as a private receiving facility by the Department does not entitle the facility to receive any funding appropriated for Baker Act services.

Crisis Stabilization Units (CSUs) are public receiving facilities, receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalizations for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit for short-term services persons brought to the unit under the Baker Act as well as those who present themselves for services.[6] CSUs provide services 24 hours a day, 7 days a week through a team of mental health professionals. The purpose of CSUs is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs. Individuals often enter the public mental health system through CSUs. For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.[7]

The most recent report of Baker Act data from AHCA indicates that there were 136,120 involuntary examinations initiated in 2009. Eighty-five percent of individuals experiencing involuntary exams were adults; the average age of these persons was 37. More men had involuntary exams initiated (55%) than did women (44%). Law enforcement officials initiated almost half (49%) of the involuntary examinations, with 49 percent initiated by mental health professionals. Judges initiated the remaining two percent through ex-parte orders.[8]

Findings and/or Conclusions

Available Receiving Facility Beds Statewide

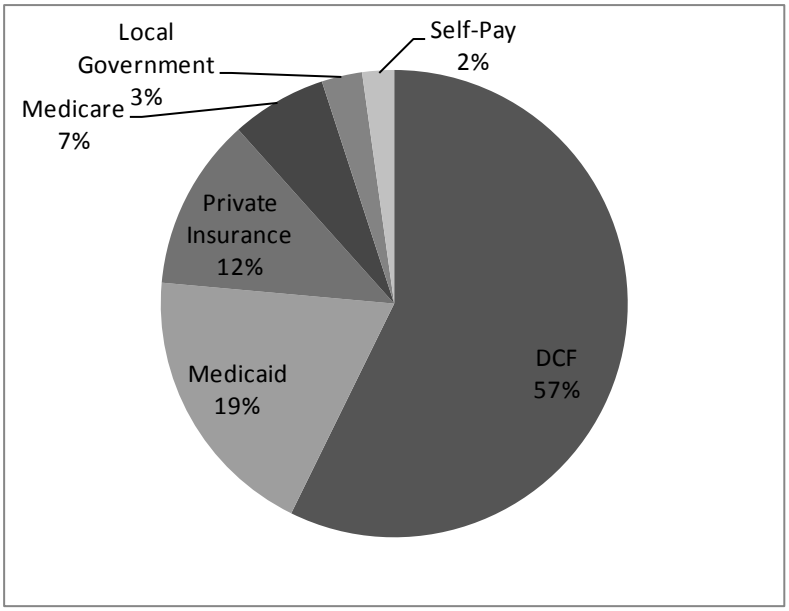
As of August 2011, the Department of Children and Families reported there were 6,224 Baker Act Receiving Facility beds statewide: 2,600 in private hospitals, 1,131 in CSUs, and 1,024 in public hospitals. State funding through the Department supports 690 (61%) of the 1,131 CSU beds in the state.

Revenue Sources and Costs for Crisis Stabilization Services

Revenue sources for CSUs include the Department, Medicaid, Medicare, local governments, and private insurance. In Fiscal Year 2009-2010, the last fiscal year for which comprehensive information on CSUs is available, 57.4 percent of revenues supporting CSUs came from DCF (see Exhibit 1).[9]

[6] s. 394.875, *F.S.*
[7] ss. 394.65-394.9085, *F.S.*
[8] *Report of Baker Act Data: Summary of Data from 2009*, Prepared of the Agency for Health Care Administration, Louis de la Parte Florida Mental Health Institute, University of South Florida, December 2010.
[9] *Bed Use in Public Receiving Facilities and Treatment Facilities Fiscal Year 2009-2010 Annual Report*, Department of Children and Families, July 2011.

Exhibit 1
Crisis Stabilization Units Receive Revenues From Various Sources



Source: *Bed Use in Public Receiving Facilities and Treatment Facilities Annual Report, Fiscal Year 2009-2010,* Department of Children and Families, July 25, 2011

The Department funded 44.6 percent of the 92,840 admissions to CSUs and 66 percent of the bed days used in Fiscal Year 2009-2010. The statewide average per diem cost regardless of payer was $406 for all payer classes. The per diem cost for children was $418 and the per diem cost for adults was $394. The Department paid the lowest per diem with a statewide average of $309. The Department also had the lowest cost per person of $1,542. For payers other than the Department, the average per diem was $503 and the average cost per person was $2,432.[10]

Utilization Rates for Crisis Stabilization Services

Regardless of payer source, the average statewide utilization rate for CSU beds was 86.8 percent. The utilization rate for adults (91.0%) was significantly higher than for children (65.6%). For adults, there was little variation in the utilization rate between Department beds (90.2%) and other beds (92.8%). However, for children, the variation between utilization of Department beds and other beds was significant: 38.2 percent of Department beds were used compared to over 100 percent of other beds. Utilization rates for Department beds for adults and children vary greatly across regions of the state from 100 percent in the southeast to 72 percent in the northeast. The utilization rate for Department adult CSU beds range from 76 percent to 101 percent and for children from four percent to over 100 percent.[11]

Payment Methodology for CSUs

The Department is the only payer class that purchases a specific number of licensed beds in CSUs. Non-Department payers do not purchase a predetermined number of contract days, but pay for bed days only when used. The Department contracts with CSUs for the availability of beds whether these beds are actually used or not, to ensure that beds are available to place individuals requiring involuntary examination.[12]

Limitations on Data Available on Receiving Facilities

Statutory limitations on data submitted to the Department by receiving facilities makes comparisons between public and private receiving facilities difficult. The Department currently does not receive complete or accurate information from and on receiving facilities, since only public receiving facilities are required to submit data to

[10] Ibid.
[11] Ibid.
[12] Interview with DEPARTMENT central office mental health administrators, June 17, 2011.

the Department and only if the data is not submitted to Agency for Health Care Administration ("AHCA"). In addition, the data submitted by facilities to AHCA does not have the content or format needed by the Department to meet the current requirements of s. 394.461(4)(a)-(d) Florida Statutes. Finally, AHCA does not make data submitted by receiving facilities to the agency available to the Department.

Accountability Mechanisms for Crisis Stabilization Services

Some private receiving facilities have raised concerns to the legislature that public receiving facilities are placing individuals with public or private insurance coverage in beds designated for indigent clients and funded by the Department. The Department requested and received examples of these occurrences and is researching these cases so it can take appropriate action. However, the Department believes there are ample mechanisms in place to ensure that CSU providers are not placing third-party funded patients in state-funded beds.[13] The mechanisms in place through statute and rule to ensure that public funding is used for the intended services and priority client groups include:

- Chapter 394, Florida Statutes, and Chapter 65E-14, F.A.C. provide comprehensive financial rules governing community mental health and substance abuse services.
- Providers must attest that all applicable federal laws, state statutes, and associated administrative rules will be followed by signing a contract with the Department.
- Providers are required to determine and document clients' income eligibility and insurance status to ensure that the state is the payer of last resort.
- Providers furnish supporting and source documentation of service units billed to the Department to a contract manager for review prior to approving invoices for payment.
- Department contract managers monitor providers at least annually and compare a sample of client records against billings submitted by the provider.
- Department contract monitors conduct annual administrative, fiscal, and programmatic monitoring of providers, unless the provider is accredited by a nationally recognized accrediting organization.
- Department staff conduct re-designation reviews of receiving facilities every three years.
- Department contract managers and internal auditors receive and review provider's annual Financial and Compliance Audit conducted by a Certified Public Accountant.

In addition, CSUs are licensed and reviewed by the Agency for Health Care Administration.[14]

Changes in the Administration and Oversight of Community Mental Health and Substance Abuse Services

Pursuant to s. 394.9082, Florida Statutes, the Department is in the process of contracting with behavioral health managing entities to administer and oversee the state's community mental health and substance abuse services. Managing entities will assume the responsibility for purchasing, managing, and monitoring behavioral health services in the state that are now the responsibility of the Department. Section 394.9082(4)(c), Florida Statutes, requires that the Department's contracts with managing entities provide payment methods that promote flexibility, efficiency, and accountability. In addition to improved accountability for local systems of behavioral health care services, another stated goal for managing entities is to preserve the "safety net" of publically funded behavioral health services and providers, using flexible strategies for financing behavior health services to enhance treatment and provide cost-effective care. The statute requires governance of managing entities by a community board of directors that includes consumers, community stakeholders and organization, and providers of mental health and substance abuse providers. The board of directors must also include a representative from a private receiving facility as an ex-officio member. Because/Since managing entities must follow current statutes and rules,

[13] Interview with Stephenie Colston, Director of Substance Abuse and Mental Health Program Office, Department of Children and Families (June 17, 2011).

[14] Facilities may choose to be accredited and may ask the Agency to accept their accreditation, in lieu of receiving routine on-site licensure surveys, by submitting the required documentation from an approved accreditation organization. All facilities must submit to an on-site licensure survey at initial licensure. The following accreditation organizations are recognized by AHCA for mental health facilities: The Joint Commission; Council on Accreditation (COA); and Commission on Accreditation of Rehabilitation Facilities (CARF). In addition to accreditation, AHCA reviews compliance with applicable Department of State registration and filing requirements, professional liability coverage, sanitation inspection reports, fire safety inspection reports, AIDS/HIV training, background screening, and compliance with local zoning requirements.

managing entities must pay CSU providers for bed availability rather than utilization and do not have the flexibility to explore other payment methods for CSUs.

Three managing entities already are operating (Lakeview Center, Central Florida Behavioral Health Network, and South Florida Behavioral Health Network), and the remaining three managing entities are scheduled to be operating by July 1, 2012. When the transition is complete, the Department will have 6 contracts rather than nearly 400 contracts with 137 community mental health and substance abuse providers.

Options and/or Recommendations

Reduce the Number of Baker Act Funded CSU Beds for Children

Since utilization rates for children's crisis stabilization beds are low in various regions of the state, the Department should reduce the number of beds in the region where use of those beds is low. If children's' beds were reduced from 202 to 100, some or all of the funds ($7 million) currently supporting these beds could be reallocated to adult Baker Act services in those regions with high CSU utilization rates for the remainder of the fiscal year. These funds could be made available for rate agreement contracts between the Department or managing entities and private receiving facilities willing to accept the average bed rate for CSUs beds in that region and able to document the 25 percent match requirement.

Conduct a Detailed Analysis of Utilization Rates for Adults by Provider

Since utilization for adult crisis stabilization beds vary across regions, the Department should conduct a detailed analysis of bed utilization by provider. For providers with bed utilization rates below 95% for adults, the Department should reduce these providers' contracts accordingly, or work with managing entities to do so. The Department could reallocate these funds to the Department regions with the highest bed utilization rates for adults, and make those funds available for rate agreement contracts with private receiving facilities willing to accept the average bed rate for CSUs in that region and able to document the 25 percent match requirement.

Develop Alternative Payment Methods for CSUs.

The Legislature could consider directing the Department to develop alternative payment methods for CSUs. For example, the Department could consider different payment methods based upon utilization rates while ensuring Baker Act bed availability for:

- Providers with a consistently high bed utilization rates, pay for the availability of beds;
- Providers with lower than average utilization rates, pay on a two-tiered system, i.e., one rate to have state-funded beds available, and a higher rate when these bed are occupied; and
- Providers with consistently low utilization rates, pay only for bed occupancy.

Amend s. 394.9082(7)(a), Florida Statutes, Regarding the Governance of Managing Entities.

Since managing entities are responsible for contracting with and overseeing mental health and substance abuse providers in their regions, representatives of these providers should not have a role in the governance of managing entities. The Legislature should consider amending s. 394.9082(7), Florida Statutes, to require representatives of community mental health providers to be ex-officio members of the managing entity board of directors, rather than be voting members, to avoid the possibility or appearance of conflicts of interest. The potential for conflicts of interest has been addressed with governance bodies created to manage and oversee outsourced state functions. For example, when Community-Based Care Lead Agencies were created, the statute did not address the composition of the board of directors. As a result, these boards sometimes did not reflect the community and had out-of-state and contracted provider agencies as board members.[15] Also, potential conflicts of interest currently are being investigated with some of the state's Regional Workforce Boards.[16]

[15] s. 409.1671(1)(e) 9, F.S.
[16] "U.S. Labor Department probes Florida workforce contracts" Orlando Sentinel, July 15, 2011.

Amend s. 394.461(4)(a), Florida Statutes, Regarding Data Submission by Public Receiving Facilities.

Section 394.461(4)(a), Florida Statutes, requires public receiving facilities to report information to the Agency for Health Care Administration such as the number of beds, contract days, admissions, length of stay and revenues by payer class. To ensure that the Department receives this information on CSU beds from the public receiving facilities with which it contracts, s. 394.461(4)(a), Florida Statutes, should be amended to ensure all public receiving facilities submit the data to both the Agency for Health Care Administration and the Department of Children and Families. In addition, the Department should include this information in its report to the Governor and the legislature required by s. 394.461(4)(d), Florida Statutes. The amended language should read:

> "A facility designated as a public receiving or treatment facility under this section shall report the following data to the department unless such data are currently being submitted into the Department of Children and Family Services' Substance Abuse and Mental Health Information System (SAMHIS). Public receiving facilities and treatment facilities that do not submit data into SAMHIS, shall report these data quarterly, even if such data are currently being submitted to the Agency for Health Care Administration."