HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1535 CS Specialty Behavioral Health Care Providers
SPONSOR(S): Smith
TIED BILLS: **IDEN./SIM. BILLS:** SB 1852

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee	6 Y, 0 N, w/CS	Walsh	Liem
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

Committee Substitute for HB 1535 provides requirements for the provision of mental health services to residents of an assisted living facility having a limited mental health license (ALF-LMHL).

The CS also requires the Agency for Health Care Administration (AHCA) to establish a workgroup to examine strategies and make recommendations prior to implementation of any managed care plan that would include behavioral health care services in Nassau, Baker, Clay, Duval and St. Johns counties.

The effective date is July 1, 2005.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government --- CS for HB 1535 establishes a workgroup consisting of members of private sector organizations, county government, state agencies, and consumers.

B. EFFECT OF PROPOSED CHANGES:

Background

Assisted Living Facilities. ALF 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 ALF. In 1995, the Legislature established limited mental health specialty licensure for ALF 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. Department of Children and Families (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 and 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, ALF 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 ALF 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.

Currently, there are more than 74,000 ALF beds statewide in 2,250 facilities, and 764 of these facilities hold a limited mental health license. There are 663 ALF facilities with limited mental health licenses in the counties specified in HB 1535. Of the 663 facilities, 467 are located in Dade County. There are no ALFs with a limited mental health license located in Charlotte, Collier, or Lee counties.

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 ALF.[1] 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

[1] *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.

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 ALF. 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 ALF 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. However, due to reorganization, functional responsibility is now in the Substance Abuse and Mental Health Program Office rather than with the District Administrators.

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, it must ensure that the ALF administrator has been made aware of procedures to obtain mental health services for a resident in an emergency.

Medicaid Behavioral Health Care Services. Under AHCA's Medicaid State Plan, ALF receive a Medicaid payment of $9.28 per Medicaid resident per day for assistive care services.[2] 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 ALF who 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 ALF. The interface between the publicly funded mental health and substance abuse system and ALF was one area examined by the Behavioral Health Services Integration Workgroup, 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

[2] 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.

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 ALF. Information pertaining to ALF is maintained separately by DCF and AHCA, which has made it difficult to obtain cohesive, critical information since at least 1996.[3]

Medicaid Cost Containment. Over the last 25 years, Medicaid program enrollment and expenditures have grown well beyond original expectations when the program was established. States have adopted 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.[4]

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.[5]

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. 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.

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[3] *Review of Assisted Living Facilities Serving Residents with Severe Mental Illness, 1997*, OPPAGA Report No. 96-57.
[4] 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.
[5] 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.

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 and prepaid 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 14 counties specified in the 2000 Florida legislation for expansion of the carve-out program. The additional 14 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. Roundtable discussions and education for providers have 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.

Section 409.9129(4)(b), F.S., directs AHCA and DCF to contract, by July 1, 2006, with managed care entities in each AHCA area to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans.

Proposed Changes

CS for HB 1535 amends s. 409.912(6), F.S., to provide requirements for the provision of mental health services to residents of an assisted living facility having a limited mental health license. The CS provides that an entity may provide prepaid health care services to Medicaid recipients, either directly or through arrangements with other entities, if the entity:

- Ensures that each resident of an ALF-LMHL receives access to an adequate and appropriate array of state-funded mental health services
- Ensures that state-funded mental health services promote recovery by implementing best practices through cooperate agreements between mental health providers and ALF-LMHL, by implementing community support plans, and by complying with s. 394.4574, F.S.[6]
- Ensures that a resident may not be displaced from an assisted living facility as a result of the implementation of any specialty behavioral health care managed care plan
- In providing state-funded mental health services to a resident of an ALF-LMHL, develops and implements a plan complying with s. 394.4574, F.S., for providing state-funded mental health services; ensures that each resident of an ALF-LMHL has access to medications including atypical psychotropics, as directed by his or her physician; and ensures that each resident of an ALF-LMHL has access to state-funded primary care and mental health services covered by Medicaid.

The CS requires that AHCA establish a workgroup that, prior to implementation of any managed care plan that would include behavioral health care services in Nassau, Baker, Clay, Duval and St. Johns counties, will:

- examine strategies that would allow minority-access and county-based administrative service organizations the ability to seek a capitation rate to improve access to behavioral health care services; in rural areas and areas identified as in need of minority access providers; and
- make recommendations to AHCA for consideration in their RFP process.

The membership of the workgroup shall consist of local minority access providers, a representative of the North Florida Behavioral Health Center, a member of a local chapter of the National Alliance for the Mentally Ill, consumer representatives, a representative of a local county government, a representative from AHCA, and a representative from the Local Advocacy Council.

The provisions of the CS are effective July 1, 2005.

C. SECTION DIRECTORY:

[6] DCF responsibilities for a mental health resident who resides in an ALF-LMHL

Section 1: Amends s. 409.912(6), F.S.; adds new subparagraphs (c) through (f); provides requirements for the provision of mental health services to residents of an assisted living facility having a limited mental health license.

Section 2: Requires AHCA to establish a workgroup to examine strategies and make recommendations prior to implementation of any managed care plan that would include behavioral health care services in Nassau, Baker, Clay, Duval and St. Johns counties.

Section 3: Provides an effective date of July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See "Fiscal Comments" below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill requires membership from the private sector for the proposed workgroup: local minority access providers, a representative of the North Florida Behavioral Health Center, a member of a local chapter of the National Alliance for the Mentally Ill, consumer representatives, a representative of a local county government, a representative from AHCA, and a representative from the Local Advocacy Council.

D. FISCAL COMMENTS:

The CS requires AHCA to establish a workgroup but does not provide funding.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not apply to counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Lines 127-132: The term "behavioral health services" generally includes both mental health and substance abuse services. At this time, AHCA is capitating only mental health services.

In addition, the CS requires the workgroup to examine strategies that would "allow minority access administrative services organizations and county-based administrative service organizations" the ability to seek a capitation rate. The terms "minority access administrative service organizations," "county-based administrative service organizations," and "minority access providers" are undefined.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

At its April 13, 2005, meeting, the Committee on Elder & Long-Term Care adopted one strike everything amendment to HB 1535. The amendment provides requirements for the provision of mental health services to residents of an assisted living facility having a limited mental health license. The amendment also requires AHCA to establish a workgroup to examine strategies and make recommendations prior to implementation of any managed care plan that would include behavioral health care services in Nassau, Baker, Clay, Duval and St. Johns counties.

The Committee favorably reported a Committee Substitute for the bill.

This analysis is drawn to the Committee Substitute.