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HOUSE OF REPRESENTATIVES

COUNCIL FOR HEALTHY COMMUNITIES
ANALYSIS

BILL #: CS/HB 1073

RELATING TO: Behavioral Health Care Service

SPONSOR(S): Committee on Child & Family Security, Representative(s) Murman, Rich, Lynn

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) CHILD & FAMILY SECURITY YEAS 10 NAYS 0
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 11 NAYS 0
(3) COUNCIL FOR HEALTHY COMMUNITIES YEAS 13 NAYS 0
(4)
(5)

I. SUMMARY:

Despite funding for a wide array of mental health and substance abuse treatment services by different state, federal and local agencies, Floridians find it difficult to obtain services they need. The two largest sources of public funding for mental health and substance abuse services are state and federal programs through the Department of Children and Family Services (DCF), and Medicaid through the Agency for Health Care Administration (AHCA). These overlapping funding sources and regulations associated with them make it difficult to address gaps and provide services efficiently in local communities.

CS/HB 1073 creates the Behavioral Health Care Demonstration Models to operate for three years to test two models of integration and management of mental health services and substance abuse treatment services. The bill requires a managing entity and an advisory body for each model. One model permits DCF to contract with a Medicaid prepaid mental health plan. The second model requires DCF and AHCA to competitively procure management services from a single entity for behavioral health services that are funded under the Medicaid program and DCF.

The bill creates an interagency workgroup led by the DCF mental health office to report on strategies to address barriers to integration by January 2002.

The bill requires DCF and AHCA to accept accreditation in lieu of its administration and monitoring requirements, with certain exceptions that provide for additional standards and review.

On April 11, 2001, the Health and Human Services Appropriations Committee adopted four amendments, which provide for demonstration Children's Crisis Stabilization Units that integrate mental health and substance abuse services in Collier, Lee and Sarasota counties using existing funds; require cost reduction strategies that would mitigate the impact on services in the event of Medicaid funding reductions; add requirements for children in the child welfare system; expand the workgroup membership to include providers and consumers; and add a requirement to DCF to establish separate personnel standards for certain child care programs. On April 17, 2001, the Council for Healthy Communities adopted two amendments. One removed provisions of day care amendment. The other amendment conformed the bill to the Senate version to incorporate clarifying changes and remove provisions that conflicted with appropriations proviso language regarding capitated rates.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [X]
2.	Lower Taxes	Yes []	No []	N/A [X]
3.	Individual Freedom	Yes []	No []	N/A [X]
4.	Personal Responsibility	Yes []	No []	N/A [X]
5.	Family Empowerment	Yes []	No []	N/A [X]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Overview

Florida's public mental health and substance abuse (behavioral health) systems are funded primarily through legislative appropriations (general revenue and federal trust funds) to DCF. Local governments provide matching funds for a portion of the budget. The FY 1999-2000 legislative appropriation to DCF for mental health and substance abuse services was approximately $462 million. Medicaid, a federal/state health insurance entitlement program administered by AHCA, provides payment for certain mental health and substance abuse services to approved providers for enrolled eligible children, adolescents, and adults. AHCA reports that Medicaid expenditures for community mental health and substance abuse services for FY 1999-2000 were approximately $230 million.

Community-based mental health and substance abuse services are administered by the Mental Health Program Office, the Substance Abuse Program Office and 15 district offices of DCF. Services are delivered by private, nonprofit, service providers under contract with each district mental health and substance abuse office. DCF contracts with 280 private for-profit and not-for-profit providers (mental health centers, substance abuse treatment and prevention centers, public and private psychiatric hospitals, and private mental health professionals) that deliver a variety of services. DCF currently uses a fee-for-service method of payment to its contract service providers.

Medicaid reimburses for behavioral health services through a variety of mechanisms. Fee-for-service is a process by which providers bill Medicaid for eligible services provided to Medicaid recipients. To bill for community mental health services, providers must either have a contract or rate agreement with the mental health program in DCF's district offices. Medicaid pays a fixed rate for the particular service that is provided. Medicaid has also begun to implement managed care strategies, using prospective payments for behavioral health services.

AHCA obtained a 1915B waiver from the federal Health Care Financing Administration that has allowed them to implement a demonstration capitated financing strategy in Districts 6 and 14. This financing strategy puts managed care entities at risk for the provision of mental health services of Medicaid recipients. In these demonstration sites, Medicaid recipients who select Medicaid's MediPass program for the delivery of their health care services, have their mental health and substance abuse needs provided for through a prepaid mental health plan. Providers within the plan are paid a per-member per-month capitated rate based on the age and eligibility category for

the enrollees assigned to their geographic area. For that fee, providers must provide for all of the enrollee's mental health services, with the exception of medications. Medications are still reimbursed on a fee for service basis. The prepaid plan will soon be operational in District 1 pursuant to chapter 2000-277, Laws of Florida. Substance abuse services are being added to the benefit structure in these capitated plans effective January 1, 2001. The prepaid mental health plan has been evaluated by the Louis de la Parte Florida Mental Health Institute. Based on their May 2000 report, the cost containment objectives of the plan have been met.

Findings of the Florida Commission on Mental Health and Substance Abuse

The Florida Commission on Mental Health and Substance Abuse was created in 1999 pursuant to chapter 99-396, Laws of Florida, to conduct a systematic review of the state's mental health and substance abuse system. The commission was asked to make recommendations in areas including planning, service strategies, funding, accountability, emergency behavioral health services, and the unique needs of older persons. Findings of the commission report include:

- The state of the science in both mental health and substance abuse has improved dramatically during the last 20 years as evidenced by the proven techniques to successfully treat most mental and addictive disorders. However, Florida's practices lag behind in both the treatment of these disorders and in the service system design. The organization, financing, and management structures need to be improved for more efficient and effective services.

- It is estimated that only about 20 percent of all children and adults with the need for mental health and substance abuse services receive treatment from providers under contract with DCF. It is not possible to estimate the percentage of the state's population in need of services who are served by other state agency service providers. The commission's research indicated that within Florida jails and nursing homes, about 1 in 4 persons in need of treatment receives services from at least one non-department provider.

- Persons with severe disorders who are served in the traditional mental health and substance abuse systems often have difficulty obtaining the support and rehabilitative services such as housing and transportation needed to recover. Restrictions include categorical funding and barriers to service access and continuity of care. It is difficult to hold agencies and service providers accountable for client outcomes when there are inadequate resources to meet the complicated needs of persons with significant disability because of mental and addictive disorders.

- Each of the state agencies serving people with mental and addictive disorders has planning, quality assurance and accountability functions. There is no governmental entity responsible for state strategy, policy and leadership across the combined system in mental health as exists in substance abuse through the Office of Drug Control.

- Mental health and substance abuse services are fragmented, uncoordinated and ineffective in many Florida communities across health, human services, educational, and correctional settings.

- The data needed to make important treatment, funding, and other policy decisions are either unavailable or cannot be integrated to the degree necessary to understand the full impact of the current mental health and substance abuse systems.

The commission made several recommendations to improve the mental health and substance abuse systems in Florida. The commission recommends that DCF be provided with the

management and purchasing tools needed to fulfill its statutory missions. DCF should be charged by the Legislature to assure an accountable system of mental health and substance abuse services through the establishment of local management entities and local advisory groups to organize and manage local service delivery systems. The commission also recommends better integration of mental health and substance abuse services among all community-based systems to facilitate the recovery of persons with the disabling illnesses. Better integration should include: dissemination of state of the art approaches to treatment, and devising performance management systems that promote the use of effective treatment, support and rehabilitation within local service contracts.

Licensure and accreditation

While residential and acute care mental health facilities and all substance abuse programs in Florida are licensed by DCF under Chapter 394, F.S., there is no statutory authority for licensure of any other community mental health programs. DCF, as well as community mental health interest groups concerned with quality care, has seriously considered seeking legislation to license community mental health programs. DCF does license substance abuse treatment facilities and services facilities pursuant to rules adopted by DCF's Substance Abuse Program Office under Chapter 397, F.S. In addition, DCF performs administrative monitoring and program monitoring to ascertain compliance with laws, regulations and contracts.

AHCA provides for mental health licensure and certification of Medicaid funded services under Chapter 394, F.S., and Chapters 65E-5 and 65E-12, F.A.C. While Chapter 394, F.S., requires that all Medicaid providers have a contract with DCF for mental health and substance abuse treatment, there is no other requirement for the two separate funding streams to develop a complementary system of care.

Under current law DCF is authorized to accept accreditation reports in lieu of performing licensure inspections for substance abuse facilities under Chapter 397, F.S. DCF is mandated by section 397.403 to accept accreditation in lieu of certain information required in a licensure application for substance abuse facilities. AHCA is authorized to accept accreditation reports in lieu of performing licensure inspections of mental health residential and crisis stabilization units under Chapter 394, F.S.

In addition to licensure and contract standards of DCF and AHCA, many mental health and substance abuse providers pursue accreditation to establish higher standards of care and meet requirements for third party payers such as Medicaid. Two accreditation associations most involved with mental health and substance abuse services are the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and CARF–The Rehabilitation Accreditation Commission.

The accreditation process involves conducting a detailed self-study of standards, procedures and practices. This is followed by an on-site evaluation and structured review by professional peers, their written report of findings of the review, the opportunity for the reviewed organization to respond to the findings, and ongoing, regular cycles of monitoring to ensure adherence to standards.

With almost fifty years experience, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) now accredits nearly 20,000 health care organizations and programs in the United States. These include hospitals, health care networks, home care organizations, long-term care facilities, behavioral health care organizations, ambulatory care providers, and clinical laboratories. The outcome data collected in the accreditation process are housed in JCAHO's database. JCAHO accreditation is currently used by forty-four states for deemed status, including total and partial relief from state compliance requirements for funding and licensure, as well as added incentives to accredited agencies.

CARF–The Rehabilitation Accreditation Commission was established in 1966. At present, close to 25,000 programs and services in more than 3,000 organizations in the U.S., Canada and Europe have earned CARF accreditation in the areas of adult day services, assisted living, behavioral health, employment and community services, and medical rehabilitation. CARF accreditation is mandated, promoted, and endorsed by many governmental and private entities.

Another accrediting agency involved in social services is the Council on Accreditation of Family and Children's Services (COA). This organization accredits approximately 4,000 programs in 1,200 agencies in the U.S. and abroad. To date, twelve state agencies are investigating, undergoing, or have achieved COA accreditation.

C. EFFECT OF PROPOSED CHANGES:

CS/HB 1073 creates the Behavioral Health Care Demonstration Models to test techniques and strategies for coordinating, integrating, and managing mental health services and substance abuse treatment services. One model permits DCF to contract with a Medicaid prepaid mental health plan. The second model requires DCF and AHCA to competitively procure the management services of a single entity for behavioral health services that are funded under the Medicaid program and under DCF.

The bill creates an interagency workgroup led by the DCF mental health office to report by January 2002, on strategies to address barriers to integration.

The bill requires DCF and AHCA to accept accreditation in lieu of its administration and monitoring requirements with certain exceptions that provide for additional standards and review.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 394.66, F.S., adding intent to achieve national accreditation and ensure efficient and effective licensing and monitoring for substance abuse and mental health services.

Section 2. Creates s. 394.741, F.S., to require DCF and AHCA to accept accreditation in lieu of its administration and monitoring requirements, with certain exceptions that provide for additional standards and review. Allows for continued monitoring of contract deliverables. Accrediting agencies include: Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); CARF–The Rehabilitation Accreditation Commission; and the Council on Accreditation of Family and Children's Services (COA).

Requires a report to the Legislature by January 1, 2002, on the viability of mandating contracted mental health and substance abuse programs be accredited and privatization of DCF licensure and monitoring functions.

Section 3. Amends s. 394.90, F.S., relating to inspection of records for licensure, to conform requirements for licensure of mental health facilities to new section 394.741, F.S., regarding use of accreditation in lieu of licensure.

Section 4. Amends s. 397.411, F.S., relating to inspection of records for licensure, to conform requirements for licensure of substance abuse service provider to new section 394.741, F.S., regarding use of accreditation in lieu of licensure.

Section 5. Amends s. 397.403 to make technical correction in the name of CARF, the Rehabilitation Accreditation Commission, that is an accepted accreditation organization.

Section 6. Amends s. 409.1671 to make technical correction in the name of CARF, the Rehabilitation Accreditation Commission, that is an accepted accreditation organization.

Section 7. Behavioral health care service delivery strategies.

The bill establishes the following provisions in chapter law:

- Legislative Findings: Demonstration models and transition period are needed for single point of accountability and flexible funding.
- Service Delivery Strategies: "Behavioral health care" is defined to include both mental health and substance abuse services for children, adolescents, and adults. Intent is to move provision of DCF and Medicaid funded mental health and substance abuse services from fee for service to risk sharing. Creates the Behavioral Health Care Demonstration Models to operate for three years to test two models of integration and management of mental health services and substance abuse treatment services. One model permits DCF to contract with a Medicaid prepaid mental health plan to provide mental health and substance abuse services through a managed care model. The second model requires DCF and AHCA to competitively procure management services from a single entity to serve as an administrative services organization for behavioral health services that are funded under the Medicaid program and DCF. Requires a managing entity and an advisory body for each model.
- Organization and Functions: Establishes two models of managing entities--prepaid managed care and administrative service organization. Provides for flexibility in funding. Specifies that the prepaid model may be in District 6 or District 14 where AHCA already has prepaid mental health. If the model is in area District 6 or District 14, the contract must include the substance abuse provider network already in place. One model must be in the G. Pierce Woods Hospital service area (District 5, District 6, District 8, District 14, District 15).
- Goals: Includes improved accountability, integration, quality, continuity of care, cost control, and testing of models
- Essential Elements: Requirements include defined target populations; local advisory bodies; cooperative agreements with other systems; outcomes; amendments to mental health and substance abuse master plan that describe each model; Medicaid reimbursement for substance abuse services must remain fee for service until prospective payment methodologies are developed and tested; and promotes specialized services to residents of assisted living facilities.
- Monitoring and Evaluation: Requires independent evaluation of each model with reports every 12 months and termination of models after 3 years if the Executive Office of the Governor makes no recommendation to the Legislature to implement the service delivery strategies in other areas.

Section 8. Report on state mental health and substance abuse plan.

Creates an interagency workgroup led by DCF mental health office to report by January, 2002 on strategies to address barriers to integration.

Section 9. Provides the act shall take effect upon becoming law.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

CS/HB 1073 specifies that to operate the managing entity, DCF and AHCA may not expend more than 10 percent of the annual appropriations for mental health and substance abuse services, including all behavioral health Medicaid funds, prorated to the geographic areas.

According to DCF and AHCA, costs for the capitated managed entity contract would be offset by efficiencies achieved by the entity. In the administrative services organization (ASO) model, funding for the contract would have to be shifted from AHCA's Peer Review Organization contract (both prior authorization and historical review) for behavioral health services to the extent that the ASO contract replicates the peer review process.

According to DCF, block grant funds cannot be used to pay for any administrative costs of the administrative services organization if it is a for-profit entity.

DCF also reports that the following resources would be expended to implement the provisions of CS/HB 1073 in FY 2001-2002:

- Professional Consultation to assist in the development of the strategies (examples of work include organizational design of managing entities, historical actuarial analysis for services, document for procurement of services, and implementation of entities). $90,000
- Independent Evaluation of Management Entities. $100,000

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

According to AHCA, there may be some minor impact relating to a local body or group that must be identified by the DCF district administrator to serve in an advisory capacity. Counties providing local funds for behavioral health services may see costs decrease under the alternative service delivery systems.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to AHCA, unaccredited providers will be required to pay for the cost of accreditation. Accreditation costs range from approximately $3,000 to $35,000 depending on the size of the organization and the range of programs provided. Small crisis stabilization units, residential treatment facilities, community mental health centers and case management providers may not be able to achieve accreditation because of higher staffing requirements, physical plant standards or budgetary restrictions.

In addition, implementation of a managed care system would result in reduced funding to providers, which would require that they apply more efficient and effective strategies for service delivery.

D. FISCAL COMMENTS:

HB 1807 (General Appropriations bill) includes a $20.9 million reduction for statewide capitation of Medicaid behavioral health services. Section 7 of CS/HB 1073, as amended, adds a provision to allow flexibility in service delivery strategies, but requires strategies that mitigate the impact on services in the event of Medicaid funding reductions.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to expend funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce revenue-raising authority.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The Committee on Child and Family Security adopted HB 1073 as a committee substitute incorporating a “strike everything” amendment. Provisions of the committee substitute are analyzed in the Section-by-Section Analysis. The provisions of the committee substitute are substantially the same and provide wording changes and policy clarification. In Section 2 of the bill the committee substitute adds COA, The Council on Accreditation of Child and Family Services as an accreditation organization. It also provides for DCF and AHCA to develop additional standards in areas that accreditation standards do not address, and it provides for monitoring whether providers deliver contracted services. Some provisions in Section 7 are reorganized. The committee substitute clarifies where the models may be implemented. In Section 8, the committee substitute replaces a proposed statewide Behavioral Health Policy Integration Council with an interagency workgroup to focus on funding and administrative barriers to service integration.

On April 11, 2001, the Health and Human Services Appropriations Committee adopted four

amendments. The first amendment incorporated HB 1799, which provides for demonstration Children's Crisis Stabilization Units that integrate mental health and substance abuse services in three counties (Collier, Lee and Sarasota) using existing funds. The second amendment replaced section 2 with SB 1258 language: authorizes flexible service delivery strategies , but requires cost reduction strategies that would mitigate the impact on services in the event of Medicaid funding reductions; adds goals to reduce admissions and length of stay for children in residential treatment centers and provide services to abused and neglected children in court-ordered case plans; and adds requirements to the master state plan for mental health and substance abuse to address children in the child welfare system. The third amendment expanded the workgroup membership to include providers and consumers. The fourth and last amendment added a requirement to DCF to establish separate personnel standards for certain child care programs: before and after school, day camp and summer camp.

On April 17, 2001, the Council for Healthy Communities adopted two amendments. One amendment removed the provision of the amendment on child-care licensing standards. The other amendment is a substitute amendment that removes a conflict with appropriations proviso language and HB 1753 to allow use of capitated rates for behavioral healthcare statewide to meet Medicaid cuts.

VII. SIGNATURES:

COMMITTEE ON CHILD AND FAMILY SECURITY:

Prepared by:	Staff Director:
Glenn Mitchell	Bob Barrios

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
Stephanie Massengale	Cynthia Kelly

AS FURTHER REVISED BY THE COUNCIL FOR HEALTHY COMMUNITIES:

Prepared by:	Council Director:
Glenn Mitchell	Mary Pat Moore