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/SB 700

SPONSOR: Children and Families Committee and Senator Lynn

SUBJECT: Department of Children and Family Services

DATE: April 11, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Collins	Whiddon	CF	Fav/CS
2.	Fabricant	Belcher	AHS	Fav/CS
3.			AP	Withdrawn: Fav/CS
4.			RC	
5.				
6.				

I. Summary:

Committee Substitute for Committee Substitute for Senate Bill 700 creates a not-for-profit corporation to be known as The Florida Substance Abuse and Mental Health Board, Inc. The Board is given the authority to set direction and policy for the substance abuse and mental health programs with the intent of providing coordinated and consistent mental health and substance abuse services throughout the state. This bill provides direction regarding board membership and process for appointment.

A contract is to be developed between the Board and the Department requiring the department to implement the policies of the Board. The contract is also to address how the department is to respond to requests made by the Board and additionally directs the Secretary to provide information requested by the Board in a timely manner.

This bill directs the Secretary to appoint an Assistant Secretary for the substance abuse and mental health programs from a list of recommendations made by the Board. The Secretary is to appoint a Director for each program area who is to have line of authority over district level staff. The Program Directors are to have direct control of budgets and contracts. Staff that are needed to manage these functions are to be placed under the supervision of the Program Director.

The bill also requires annual financial and program evaluation reports by the Board to both the Legislature and the Governor reporting on the status of the state's publicly funded mental health and substance abuse systems. The report must also address whether the department and the Board are complying with the terms of the contract.

The Executive Office of the Governor is to obtain an independent evaluation of the effectiveness of the mental health and substance abuse programs which must include the operation of the

Board, the programs' organization within the department, and the contractual agreement between parties to determine the effectiveness of these changes. A report with recommendations relating to the continuation of the Board and organization of the department must be submitted to the Executive Office of the Governor, to the President of the Senate, and to the Speaker of the House of Representatives by January 1, 2006. The statutory section created by this legislation expires on October 6, 2006 unless it is reviewed and re-enacted by the Legislature prior to that date.

The bill includes a $250,000 appropriation for staff and travel.

This bill amends s. 394.74, F.S., authorizing DCF to adopt rules for fee-for-service, prepaid case rate or prepaid capitation contracts for purchasing mental health or substance abuse services. DCF may not change the ration of state to local matching funds and may not increase the required local funds. Authorizes the establishment of a single managing entity for the delivery of substance abuse services to child protective services recipients.

This bill amends s. 394.741 the accreditation requirements for behavioral health care services directing the Department of Children and Family Services and the Agency for Health Care Administration to adopt rules in order to conduct monitoring of accredited service providers. It also requires the department to follow only properly adopted and applicable federal and state statutes and rules when monitoring service providers and specifies that the department may also monitor an organization to ensure that services billed to the department were provided.

The bill requires DCF to file a State Project Compliance Supplement for behavioral health services. Desk reviews of audit reports will be performed if problems have been identified by the audit or other sources of information.

The bill amends s. 394.9082, F.S., modifying the current language to reflect that the managing entity is accountable for behavioral health care services that are specified and funded by the department and the Agency for Health Care Administration (ACHA or the agency). The bill also creates new language regarding the data systems and reporting requirements of the strategy areas, creating reporting flexibility that is needed in the strategy areas.

The bill directs the expansion of the "managing entity" concept into Districts 4 and 12 specifically for substance abuse services and restricts service expansion in those districts to the area of substance abuse. In these districts, a managing entity is to be accountable for the provision of substance abuse services to the recipients of child protective services. After the managing entity is established and meets the requirements the Department may enter into a noncompetitive contract with the entity. The department is directed to work with stakeholders to develop a phase-in of services, provide technical assistance to assure district and provider readiness, and enter into a contract with a managing entity.

The department is directed to implement this project and provide status reports to the appropriate substantive committees of the Senate and the House of Representatives no later than February 29, 2004 and February 28, 2005. The integration of all services agreed upon by the managing entity and authorized by the department must be completed within 2 years after project initiation.

The bill provides additional direction for the study currently required to be conducted by the Florida Mental Health Institute (FMHI), as a part of the ongoing evaluation of the strategies. The state must address the strategies implemented in Districts 1, 8, 4 and 12, and, based upon this study, the department and AHCA must provide a report no later than December 31, 2006, to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must contain recommendations for the statewide implementation of successful strategies, including any modifications to the strategies currently in use and target dates for statewide implementation.

The bill amends s. 409. 912 requiring ACHA to seek federal approval to contract with a single entity to provide comprehensive behavioral health care services to all Medicaid recipients in an AHCA area. Each entity must offer a sufficient choice of providers. DCF and ACHA will collaborate on all policy, budgets, contracts and monitoring plans. DCF and AHCA shall contract to provide comprehensive mental health and substance abuse services though capitated pre-paid arrangements. Requires a plan to be submitted to the EOG, Senate and House. Allows for capitation rates to be changed if insufficient and allows general revenue to be used to meet additional match but prohibits over obligations of existing funds on an annualized basis. Requires the development of a plan to implement new Medicaid procedure codes for emergency and crisis care, residential services and other services. The plan may not be implemented in any part until approved by the Legislative Budget Commission by December 31, 2003. If the plan is not approved by the LBC, the plan shall be submitted for consideration by the 2004 Legislature.

ACHA will not implement the prepaid mental health managed care program until a plan is approved by the Legislative Budget Commission. The plan must be submitted to the Commission by January 1, 2004.

This bill creates section 394.655 of the Florida Statutes and amends sections 20.19, 394.74, 394.741, 394.9082, and 409.912, of the Florida Statutes.

II. Present Situation:

The Department of Children and Family Services

The mental health and substance abuse programs currently reside with the Department of Children and Family Services (department or DCF). The department's mission is to work in partnership with local communities to help people be self sufficient and live in stable families and communities and to deliver or provide for the delivery of all family services.

The Department of Children and Family Services is responsible for the delivery of diverse programs throughout the State of Florida. Program service areas include Adult Services; Child Care Services; Developmental Disabilities; Economic Self-Sufficiency Services; Family Safety; Mental Health; Refugee Services; and Substance Abuse. These programs are directed by the Secretary at the headquarters level and administered in 14 separate districts or regions that are managed by a District Administrator.

The Family Safety program has been a specific area of ongoing public concern, especially regarding the effectiveness of the child welfare system. Given the intensity of problems associated with the child welfare program, it has been suggested that other programs, particularly the mental health and substance abuse programs, do not receive adequate attention from the Secretary and District Administrators.

While some concerns regarding departmental management stem from recent adverse events, it has also been noted that the department has experienced management difficulties since its inception. A number of reasons have been cited for these problems some of which include:

- The separation of administrative services from program management allows administrative services to operate without careful consideration of the impact their decisions have on the mission of the organization. Routine transactions may take longer than necessary and needed actions may not get done.
- Districts operate independently and frequently like mini departments. Contracting mechanisms, standards, and monitoring are very different across the 14 districts.
- The program components representing services the department delivers are buried in the organizational structure. This structure compounds the difficulty in getting things done as program initiatives must be approved at several levels of the organization before reaching the Secretary for approval.
- There is no direct line relationship between the program offices and the district staff.

New Organizational Structure

A new Secretary and Assistant Secretary were appointed to provide leadership for the department in September 2002. One of the first tasks of the new leadership team was to determine the most appropriate organizational and service delivery structure that aligned with the department's mission, in order to build a more accountable and responsive department focused on excellence and family safety and stability. A report "Re-forming the Social Service Business Partnership: Setting out the Vision and Strategies for Reform" was provided to the Legislature in February, 2003.

The Secretary's Plan for Reforming the Social Service Business Partnership identified needs of the substance abuse and mental health programs to:

- Increase the visibility of and focus on needs of persons with mental illness and substance abuse problems;
- Support advocacy for mental health/substance abuse funding and other resources;
- Provide a consistent policy framework oriented to community-based, client and family centered services;
- Support standardized and streamlined administration of mental health and substance abuse throughout the state;
- Maximize the critical role of Medicaid funding in behavioral health services; and
- Focus on the importance of mental health and substance abuse services in strengthening families.

In an effort to address these needs, based upon the authority designated in s. 20.19, F.S., the Secretary rearranged the organizational structure of the mental health and substance abuse

program offices. Effective March 16, 2003, a new structure was initiated that resulted in the mental health and substance abuse programs becoming directly responsible for budgeting, contracting, and policy development, and established a direct line of supervision for all field staff and institutions.

Critical components of this new structure include the delegation of authority to the Director of the Mental Health Program and the Director of the Substance Abuse Program over control of staff and fiscal resources, program policy direction and performance expectations, contracting for services, interacting with interested parties, as well authority over a number of other specific areas.

The department is authorized by s. 394.74, F.S., to contract with local providers for the establishment and operation of local substance abuse and mental health programs. Notwithstanding s. 394.76(3) (a) and (c), F.S., the department may use a unit cost method of payment in contracts for substance abuse and mental health services. The section specifies how fees are paid on behalf of a specific client and how all fees collected and used by the provider are accounted for in order to determine the amount of services funded by the department, preventing duplicative payments for the same services. This section also allows the department to reimburse actual expenditures for start up contracts.

Section 394.741, F.S., addresses accreditation requirements for providers of behavioral health care services. "Behavioral health care services" is defined as mental health and substance abuse treatment services.

Section 394.741, F.S., requires the agency and the department to accept accreditation in lieu of their on-site review requirements and the department accept accreditation as a substitute for its administrative and program monitoring requirements when:

- An organization from which the department purchases behavioral health care services is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Council on Accreditation for Children and Family Services, or has those services being purchased by the department accredited by CARF—the Rehabilitation Accreditation Commission.
- A mental health facility licensed by the agency or any substance abuse component licensed by the department accredited by the Joint Commission on Accreditation of Healthcare Organizations, CARF—the Rehabilitation Accreditation Commission, or the Council on Accreditation for Children and Family Services.
- A network of providers from which the department or the agency purchases behavioral health care services accredited by the Joint Commission on Accreditation of Healthcare Organizations, CARF—the Rehabilitation Accreditation Commission, Council on Accreditation for Children and Family Services, or the National Committee for Quality Assurance.

Language added by the 2001 Legislature permits but does not require the department and the agency to adopt administrative rules that establish:

- Additional standards for licensing or monitoring accredited programs and facilities that the department and agency have determined are not specifically and distinctly covered by the accreditation standards and processes.
- An on-site monitoring process between 24 months and 36 months after accreditation for non-residential facilities to assure compliance with critical standards.
- An on-site monitoring process between 12 months and 24 months after accreditation for residential facilities to assure compliance with critical standards.

The department has not revised the administrative rules governing Crisis Stabilization Units (CSUs), Short Term Residential Treatment Facilities (SRTs), and Residential Treatment Facilities (RTFs), as permitted by s. 394.741, F.S. In the absence of revised rules for monitoring visits of accredited facilities, the agency implemented its procedures for surveying accredited facilities on September 6, 2001. Because the administrative rules have not been revised to address what should be covered in a monitoring visit of an accredited organization, the agency's procedures direct local field offices to continue to conduct a full re-licensing survey to fulfill the monitoring requirement. These surveys are completed in the 12 to 24 months following the beginning of the facility's accreditation period.

As of early February, there were a total of 189 licensed CSUs, SRTs, and RTFs. Of this number, 163 facilities (86 percent) are accredited by JCAHO or CARF. Between September 1, 2001 and November 30, 2002, the agency conducted 98 CSU, SRT, or RTF surveys. Of these, 80 surveys were of accredited facilities. The other accredited facilities were not required by section 394.741, F.S., to receive a full re-licensing survey during this time period.

The Department pf Children and Family Services has reviewed and compared the accreditation standards of JCAHO, CARF, and COA to the administrative rules covering CSUs, SRTs, and RTFs. It was determined that 55.1 percent of the accreditation standards were not comparable to the licensing standards adopted in these rules.

For substance abuse services, the department is required to conduct full licensure inspections every three years and develop criteria in rule that justify more frequent inspections.

The department and the agency are to be given access to all accreditation reports, corrective action plans, and performance data submitted by the provider to the accrediting organization. The department and the agency may perform follow-up monitoring or inspections when deficiencies are identified through the accreditation process. This is true of contract monitoring, as well; the department or agency may perform monitoring at any time to ensure that deliverables are provided in accordance with contracts.

Section 394.741, F.S., requires the department to submit reports to the Legislature by January 1, 2003. These reports must address the viability of mandating that all organizations under contract with the department or licensed by the agency to provide behavioral health services be accredited and the viability of privatizing all licensure and monitoring functions through an accrediting organization. The legislature received the reports in January, 2003.

When evaluating the viability of mandating accreditation of all organizations under contract with the department some key findings of the reports included:

- Accreditation is beneficial because it provides a basic set of expectations;
- Accreditation may offer minimum staffing requirements for professional staff;
- Accreditation already exists in more than half of Florida's mental health organizations and in nearly half of the substance abuse providers;
- Accreditation is costly but valuable;
- Accreditation may be cost prohibitive for small providers; and
- Accreditation does not specifically address compliance with existing state administrative rule and licensing requirements.

When examining the viability of privatizing licensing and monitoring through an accrediting organization, some key findings included:

- State standards used for licensing provide a more substantial framework for protecting the safety of clients and requires that licensed providers adhere to specific standards that relate directly to the health and safety of the clients, whereas accreditation is a voluntary process that allows a high degree of flexibility in achieving standards and may not fully address the safety needs of clients;
- Accounting of expenditures of state and federal public money is required of single state authorities by the Federal Government and current Federal regulations make it difficult to fully substitute accreditation standards for current contract monitoring standards;
- Accreditation is more costly than licensing;
- Standards used for accreditation are different than departmental standards;
- There is a clear conflict of interest in having an accrediting organization conduct licensing and monitoring because these bodies derive their income from agencies seeking accreditation; and
- Service providers who are not accredited have no more difficulty complying with state requirements than accredited providers.

Currently, the department monitors organizations against some standards that are not specifically authorized by federal or state law. For example, the department's licensing protocol currently includes monitoring of compliance with applicable federal and state statutes and rules but also may include reviews of compliance with contract requirements and departmental rules and policies. Additionally, the department directly monitors the financial operations of its contractors rather than relying upon required Certified Public Accountant audits.

The department reports that workgroups have been established and progress has been made during the past year in modifying monitoring instruments in the areas of administrative and contract services. The department maintains that these efforts should help to streamline and reduce any duplication in monitoring.

The department is also engaged in reorganization efforts that will realign staff in the substance abuse and mental health programs, giving line authority from these program offices to the district level programs. This realignment will provide the mental health and substance abuse program staff with the authority to implement revisions to monitoring practices in a standardized manner. These changes are to become effective March 17, 2003.

Accounting for the expenditure of state and federal public money is required of single state authorities by the Federal Government. The regulation requirements provided in the Office of Management and Budget (OMB) Circular A-133 requires state agencies to monitor the activities of service providers. The monitoring addresses program objectives, procedures, and compliance requirements associated with the program.

In 1998, the Florida Single Audit Act was enacted and codified in s. 215.97, F.S., to establish state audit and accountability requirements for state financial assistance provided to non-state entities. The Legislature found that while federal financial assistance passing through the state to non-state entities was subject to mandatory federal audit requirements, significant amounts of state financial assistance was being provided to non-state entities that was not subject to audit requirements.

The Department of Children and Family Services and the Agency for Health Care Administration are directed in s. 394.9082, F.S., to develop service delivery strategies that will improve the coordination, integration, and management of the delivery of mental health and substance abuse treatment services to persons with emotional, mental, or addictive disorders. These strategies were intended by the Legislature to promote movement towards a well managed and integrated service delivery system that increases consumer access to services and improves the coordination and continuity services for vulnerable and high risk populations. The strategies also assist in re-directing service dollars from out-of-date service models to more community-based models as well as to reward the development of more efficient care patterns.

The Medicaid, mental health, and substance abuse treatment programs are three unique systems with unique eligibility criteria and service payment systems. These eligibility criteria and payment methodologies can make it difficult for a client to obtain the continuum of services that are needed for recovery. The service delivery strategies specified in s. 394.9082, F.S., are intended to be the first phase of transferring the provision and management of mental health and substance abuse services provided by the Department of Children and Families and the Medicaid program from a traditional fee-for-service and unit-cost contracting methods to risk sharing arrangements.

The law authorizes the department and the agency to contract with a managing entity in at least two geographic areas, but both the department and the agency are required to contract with the same managing entity in any distinct geographic area where the strategy is implemented. The managing entity is required to be accountable for the delivery of behavioral health care services specified by the department and the agency. The term “behavioral health services” means mental health and substance abuse treatment services that are provided with state and federal funds. Districts 1 and 8 were selected as the demonstration sites to test new models for managing, integrating, and delivering behavioral health strategies that are directed by s. 394.9082, F.S.

The statute provides for the implementation of two types of strategies. Both of these strategies allow the department and the agency to:

- Establish benefit packages based on the level of severity of illness and level of client functioning;

- Align and integrate procedure codes, standards, or other requirements if it is jointly determined that these actions will simplify or improve client services or efficiencies in service delivery;
- Use prepaid per capita and prepaid aggregate fixed-sum payment methodologies; and
- Modify their current procedure codes to increase clinical flexibility, encourage the use of the most effective interventions, and support rehabilitative activities.

Since the implementation of these strategies in District 1 and District 8, an initial evaluation has been conducted by the Florida Mental Health Institute and a report provided to the department, the Legislature and the Executive Office of the Governor on December 30, 2002. This study indicates that upon initial evaluation, the use of these strategies appears to be promising and have positive effects. District 1 is at a more mature phase of strategy implementation and appears to have experienced more success than the strategy implemented in District 8. A more comprehensive study that will include a more detailed financial audit is scheduled to be completed by June 2003 and will provide additional information to better evaluate the success of these strategies**.**

ACHA contracts with two prepaid mental health plans for Medicaid recipients. One operates in district one of the Department, and the other in Hillsborough, Polk, Highlands and Hardee counties. In these two plans the Agency contracts with a prepaid mental health plan to provide these services to their members. Therefore the Agency pays capitation rates to the entities based on historical expenditures less 8% for Agency savings.

III. Effect of Proposed Changes:

Creates the Florida Substance Abuse and Mental Health Board, Inc. This board is created with the intent of providing mental health and substance abuse services which are coordinated and consistent throughout the state, which reflect the current state of knowledge regarding quality and effectiveness and that are responsive to service recipients and the needs of Florida's communities.

The Board is to be organized as a not-for-profit corporation in compliance with ch. 617, F.S., and is not a unit or entity of state government. While the Board is to be administratively housed within the department, it is not subject to the supervision or control of the department or any other executive agency. The Board and any committees formed by it are subject to the provisions of ch. 119, F.S., relating to public records as well as ch. 286, F.S., pertaining to public meetings. Establishing the board as a not-for-profit corporation enables the board to function autonomously and establishes a distinct separation from the executive branch.

The bill directs that a contract is to be developed between the board and the department requiring the department to implement the policies of the board. This contract is to address how the department is to respond to requests made by the Board. The Secretary of the department is directed to provide information requested by the Board in a timely manner

Purpose of the Proposed Board

This bill establishes the Board as an entity that is subject to and consistent with the direction set by the Legislature. The Board is directed to exercise certain responsibilities that include requiring the collection and analysis of needs assessment data and to monitor the status of the publicly funded mental health and substance abuse systems. The Board is responsible for establishing policy that is designed to improve the coordination and effectiveness of services and to provide mechanisms for stakeholders to provide input regarding system management. The Board is to recommend priorities for service expansion to the department and the Agency for Health Care Administration and make recommendations to the Secretary concerning strategies for improving the performance of the system. It is also a responsibility of the Board to monitor and forecast manpower needs and to work with the department and the educational system to establish policies that will ensure the state has the personnel it needs to continuously implement and improve its services.

The Board is also to develop memoranda of understanding between substance abuse and mental health program offices and any other departments, and performance measures and standards. The Board is also directed to coordinate with other agencies and entities that provide, purchase, or fund substance abuse and mental health programs and services in order to work toward fully developed, integrated when appropriate mental health and substance abuse services.

Appointments and Membership

The Board is to consist of 15 members. Five members are to be appointed each by the President of the Senate, the Speaker of the House of Representatives, and the Governor. The chair of the committee is to be a member designated by the Governor, and the Secretary of the Department of Children and Family Services or his designee and a representative of local government designated by the Florida Association of Counties shall serve as an ex-officio members of the Board. The Board must be composed of:

- Experts in the fields of mental health and substance abuse;
- Former clients or family members of former clients served by the mental health and substance abuse programs;
- A representative of the state's senior population;
- Community or business leaders who have experience and interest in the areas of substance abuse and mental health;
- A representative of the criminal justice system; and
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A majority of the members would be community or business leaders. Although Board members are frequently appointed by the Governor and approved by the Senate, the appointment process specified in the bill for this Board is designed to create a shared sense of ownership by the Governor and the Legislature. This process will also help to ensure that the Board membership is representative of diverse sectors of the state which will contribute to establishing linkages with customers and stakeholder groups that will help the Board set direction and policy in a manner that is consistent with customer needs.

Membership Requirements

Persons who derive their income from either DCF or the Agency for Health Care Administration are excluded from Board membership but may serve on advisory committees. Members of the

Board may be removed for cause by the appointing party or automatically upon three consecutive absences.

The Board is directed to develop by-laws and to meet at least quarterly and at other times upon the call of the chairman. The majority of the membership constitutes a quorum, and the board may only meet and take action with a quorum present. Within the resources appropriated by the Legislature and other available funds, the chairman of the Board may appoint advisory committees to address and advise the board on particular issues.

Members of the Board are required to file financial disclosures which will reduce the possibility of any conflicts of interest. Board and committee members are to provide services without compensation. However, they may be reimbursed for travel and per diem pursuant to s. 112.061, F.S., which is similar to the practices of other boards.

Staff and Funding

The Board is authorized to appoint four staff persons, one of whom is to be designated staff supervisor, including a program analyst, a budget analyst, a contract manager and an administrative assistant. These employees serve at the pleasure of the Board and are considered employees of the corporation, not of the state. Other staff support is to be provided by the department as negotiated in contract.

The bill requires the Board to develop and submit a budget request for its operation to the Governor through the Secretary and to provide for an annual financial audit of its records by an independent certified public accountant. The financial report must include a management letter in accordance with s. 11.45, F.S., as well as a detailed schedule of expenditures from each expenditure category. The audit report must be submitted to the Governor, the department, and the Auditor General for review.

There is a $250,000 appropriation in the bill for staff and travel.

Evaluation

The Board is also directed to annually evaluate and report to both the Legislature and the Governor regarding the status of the state's publicly funded mental health and substance abuse systems with the first report due in December, 2004. Public sector agencies which deliver or contract for substance abuse or mental health services are directed to cooperate with the development of the annual report. As a part of the annual report, the Board and the department must report whether or not both parties are complying with the terms of the contract in a manner that is consistent with the goals and purposes of the Board and is in the best interest of the state.

The provision of annual reports will address one of the core functions of boards, which is to keep the public informed of activities and to protect the public interests. The development and provision of these reports will also help to identify and address the key issues faced by the substance abuse and mental health programs.

Organizational Structure of the Substance Abuse and Mental Health Programs

The committee substitute amends s. 20.19, F.S., and directs the Secretary for DCF to appoint an Assistant Secretary for Substance Abuse and Mental Health from a list of three recommendations made by the Board. The Assistant Secretary is to serve at the pleasure of the Secretary and with the concurrence of the Board. The Assistant Secretary is required to have expertise in both the areas of substance abuse and mental health.

The bill further directs the Secretary of the department to appoint Program Directors for the substance abuse and mental health programs. The Program Directors must have the requisite expertise in these areas and will have line authority over all district substance abuse and mental health program management staff.

The organizational structure proposed by this committee substitute is already substantially in place as a result of the departmental reorganization that was effective March 16, 2003. However, this bill codifies departmental changes that address many of the long-standing concerns regarding departmental management.

Expiration

The Executive Office of the Governor is directed to obtain an independent evaluation of the effectiveness of the mental health and substance abuse programs that must address the operation of the Board, the programs' organization within the department, and the contractual agreement between parties to determine the effectiveness of these changes. A report with recommendations relating to the continuation of the Board and departmental organization must be submitted by the Executive Office of the Governor to the President of the Senate and the Speaker of the House of Representatives by January 1, 2006.

Section 394.655, F.S., expires on October 6, 2006 unless it is reviewed and re-enacted by the Legislature prior to that date.

This bill amends s. 394.74, F.S., authorizing DCF to adopt rules for fee-for-service, prepaid case rate or prepaid capitation contracts for purchasing mental health or substance abuse services. DCF may not change the ration of state to local matching funds and may not increase the required local funds. Authorizes the establishment of a single managing entity for the delivery of substance abuse services to child protective services recipients

This bill amends s. 394.741, F.S., directing that the department and agency must adopt rules before an accredited organizations may receive mental health monitoring by the department in addition to that performed by the accrediting body. There are six administrative rules that would require revision based upon this bill. These rules include chapter 65E-4, 5, 10, 12, 14, and 1, F.A.C. The agency would be unable to conduct monitoring during the time rules are being revised or developed. The licenses held by accredited organizations could expire during the interim unless rules were developed that specifically addressed the renewal of licenses during the rule development process. Additionally, if no monitoring is conducted, there is a greater likelihood that organizations will become non-compliant with state standards that are not addressed as a part of the accreditation process.

The standards requirements used by accrediting agencies are different from the department's standards. An analysis conducted by the department indicated that over half of the accreditation standards are not comparable to state licensing requirements. Accrediting organizations tend to look at a broader array of organizational functions, with an emphasis on quality improvement activities related to the provision of client services. Departmental requirements tend to be more prescriptive, requiring providers to address specific minimum standards of performance. These discrepancies in expectations may have contributed to past difficulties the department has experienced with accredited programs that have failed to meet minimum state standards associated with client care and treatment.

The Department must file a State Projects Compliance Supplement pursuant to s. 215.97, F.S., for behavioral healthcare services. It further specifies that in monitoring the financial operations of its contractors, the department must perform offsite desk reviews of the most recent independent audit by a Certified Public Accountant and restricts onsite monitoring to only when problems have been identified by these audits or other sources.

The area of fiscal monitoring is frequently difficult for agencies to address. While there are benefits to having a Certified Public Accountant with specialized training conduct financial audits, the current standard practice of the provider agency retaining its own auditor may introduce a bias. There have also been cases when the agency "passes" the audit, but there were indications of programmatic issues that needed to be resolved. Further review substantiated significant programmatic problems as well as an inaccurate audit which would not have been identified under the conditions outlined in this bill.

The bill amends s. 394.9082, F.S., modifying the current language to reflect that the managing entity is accountable for behavioral health care services that are specified and funded by the department and the Agency for Health Care Administration (ACHA or the agency). The bill also creates new language regarding the data systems and reporting requirements of the strategy areas, creating reporting flexibility that is needed in the strategy areas.

The bill directs the expansion of the "managing entity" concept into Districts 4 and 12 specifically for substance abuse services and restricts service expansion in those districts to the area of substance abuse. In these districts, a managing entity is to be accountable for the provision of substance abuse services to the recipients of child protective services. After the managing entity is established and meets the requirements the Department may enter into a noncompetitive contract with the entity. The department is directed to work with stakeholders to develop a phase-in of services, provide technical assistance to assure district and provider readiness, and enter into a contract with a managing entity.

The department is directed to implement this project and provide status reports to the appropriate substantive committees of the Senate and the House of Representatives no later than February 29, 2004 and February 28, 2005. The integration of all services agreed upon by the managing entity and authorized by the department must be completed within 2 years after project initiation.

The bill provides additional direction for the study currently required to be conducted by the Florida Mental Health Institute (FMHI), as a part of the ongoing evaluation of the strategies. The

state must address the strategies implemented in Districts 1, 8, 4 and 12, and, based upon this study, the department and AHCA must provide a report no later than December 31, 2006, to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must contain recommendations for the statewide implementation of successful strategies, including any modifications to the strategies currently in use and target dates for statewide implementation.

The CS makes these changes related to Medicaid's cost-effective purchasing of health care:

- AHCA and DCF must develop a written agreement that requires collaboration and joint development of all policies, budgets, procurement documents, contracts, and monitoring plans;
- AHCA is required to seek federal approval to contract with a single behavioral health pre-paid plan to provide services to all Medicaid recipients in a county combination of regions:
    - these entities are required to provide "sufficient choice of providers to ensure recipient access and satisfaction."
    - the managed care entity is expected to provide comprehensive inpatient and outpatient mental health and substance abuse services through pre-paid capitated arrangements to all Medicaid recipients as allowable under federal law and regulation.
    - the agency is to consider the impact of an inadequate service system and lack of access to care in creating capitation rates.

To maximize federal financial participation (Medicaid matching dollars) AHCA is develop a plan to implement new Medicaid procedure codes to allow Medicaid reimbursement of emergency and crisis care, supportive residential services, and other services designed to maximize the use of Medicaid funding. The plan may not be implemented in any part until approved by the Legislative Budget Commission by December 31, 2003. If the plan is not approved by the LBC, the plan shall be submitted for consideration by the 2004 Legislature.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

The Board and any committees it forms are subject to the provisions of ch. 119, F.S., relating to public records and the provisions of ch. 286, F.S., relating to public meetings.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None

B. Private Sector Impact:

This bill will provide additional flexibility in developing contract and payment methodologies that will better meet client needs.

This bill will help to reduce duplicative contract, budget, and data related activities for the strategy areas.

Changes in the billing process will require training for the provider staff regarding changes to software and accounting practices.

C. Government Sector Impact:

There is a $250,000 appropriation in the bill to fund the Board. The estimated funding necessary to support this board is $250,000 annually.

These expenses include:

- $223, 000 annually for staff salaries. This figure includes administrative overhead such as office rental.
- $24,000 for travel expenses. This estimate is based upon travel expenses for quarterly one-day meetings and includes motel, airfare and per diem at an estimated $400 per trip.

Although the contract required for the department to carry out directives of the Board should have no fiscal impact, it is not known whether the expectations of the Board will result in the need for the department to request additional revenues from the Legislature.

Changes in the billing methods will result in a need to provide training for district/region staff. Significant changes will be required in the software system to collect information required by the Mental Health and Substance Abuse programs.

The department anticipates a statewide impact on staff who will be required to process status reports to the House and Senate for delivery in February 2004 and 2005. The department indicates that the expansion project in District 4 and 12 will result in increased workloads for state and district level staff. The implementation plan for this project will need to be developed and will require coordination and consultation with stakeholder staff.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.