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.)

Prepared By: Children and Families Committee

BILL: SB 1852

SPONSOR: Senator Wise

SUBJECT: Specialty Behavioral Health Care Providers

DATE: March 16, 2005 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Collins	Whiddon	CF	**Favorable**
2.			HE	
3.			HA	
4.				
5.				
6.				

I. Summary:

This bill authorizes the Agency for Health Care Administration (AHCA) to establish a demonstration project in certain counties for the purpose of determining the benefits of having a specialty behavioral health care provider deliver behavioral health services to individuals residing in an assisted living facility with a limited mental health license (ALF-LMHL).The bill also authorizes AHCA to seek an amendment to current waivers that would provide a mechanism for residents of ALFs-LMHL under the age of 65 who have significant medical needs to remain in the ALF through the provision of additional services.

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

Upon approval, this act will become effective July 1, 2005.

The bill amends s. 394.4574, Florida Statutes.

II. Present Situation:

Assisted Living Facilities

ALFs provide housing, meals, and personal assistance to frail elders and persons with physical and mental disabilities who need support to live in the community but do not require institutionalization (chapter 400, part III, F.S.). Facility staff provide supervision to residents,

including oversight of their diet, activities, general whereabouts, and activities of daily living. These facilities are licensed by AHCA.

Limited Mental Health Services in ALFs

In 1995, the Legislature established limited mental health specialty licensure for ALFs that serve residents with mental illness. Any ALF that serves three or more mental health residents is required under s. 400.4075, F.S., to obtain a limited mental health license. Residents with mental illness receive personal services from the facilities and mental health services from local community mental health centers. Cooperative arrangements are made between ALF staff and local mental health treatment providers to provide mental health residents with emergency and after-hours services when they are needed. The Department of Children and Families 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, ALFs are often the only living arrangement available to them. If they receive either SSDI or SSI and are eligible for Medicaid, these residents are eligible for and have access to the same array of services that all other Medicaid recipients may access in the community. Requirements for ALFs with the limited mental health license include: additional training for direct care staff, coordination with the residents' mental health provider, and participation in planning for resident needs.

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 SB 1852. 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 ALFs.[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 with severe mental illnesses. The availability of after-hours mental health coverage is also a problem that is frequently cited by ALF administrators.

[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.

Services Provided by the Department of Children and Family Services

The Department of Children and Families is required by s. 394.4574, F.S., to provide certain services to residents in ALFs. Those services include:

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

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

Medicaid Behavioral Health Care Services

Under AHCA's Medicaid State Plan, ALFs receive a Medicaid payment of $9.28 per Medicaid resident per day for assistive care services.[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 ALFs 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.

[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.

Behavioral Health Services Integration Workgroup

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

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

Despite the information contained in this report, the extent of difficulty that is encountered in obtaining mental health services for persons with mental illness who reside in an ALF remains unclear, largely due to the lack of available data. Unfortunately, there is no single standard assessment system or data base maintained for ALFs. Information pertaining to ALFs is maintained separately by DCF and AHCA, which has made it difficult to obtain cohesive, critical information since at least 1996.[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. Although expanding coverage to needy groups was a dominant goal of the program, expenditure growth and the pressure it has placed on state budgets has made cost containment a central objective for states. States have adopted 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

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

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.

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 fourteen counties specified in the 2000 Florida legislation for expansion of the carve-out program. The additional fourteen counties are pending expansion currently for various reasons including provider resistance to the capitated

[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.

system, inability to calculate feasible capitation rates due to lack of inpatient psychiatric facilities in certain regions, and inability to isolate one county out of an entire Medicaid Area into the prepaid system of care. Round table discussions and education for providers 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.

III. Effect of Proposed Changes:

Section 1. Amends s. 394.4574, F.S., to create new subsections (4)-(10) authorizing AHCA, in consultation with the Department of Children and Families, to establish a demonstration waiver in certain counties and to seek amendment to any current waiver programs being conducted in those counties.

This section authorizes AHCA to establish a demonstration project in Duval, Nassau, Pasco, Pinellas, Lee, Volusia, Putnam, Charlotte, Hillsborough, Dade, Sarasota, Broward, Brevard, Orange, Santa Rosa, Collier, and Palm Beach counties for the purpose of determining the benefits of having specialty behavioral health care providers deliver behavioral health services to residents of an assisted living facility with a limited mental health license. The purpose of this demonstration project is to develop evidence-based practices in the delivery of state-funded behavioral health care services to persons who reside in an ALF with a limited mental health license. Participation in the program of fee-for-service options is voluntary for ALF residents eligible for Medicaid and recipients of state-funded services.

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

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

behavioral health services. Residents living in ALFs currently receive mental health services on a fee-for-service basis.

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

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

This section authorizes AHCA to seek federal waivers to implement an alternative prepaid behavioral health care plan for residents in specified counties who live in an ALF with a limited mental health license, if a prepaid behavioral health plan is introduced. This section further specifies that the capitation rate must be based on 90 percent of the historical utilization of Medicaid funding by this population and that the services provided must include all outpatient state-funded behavioral health care services and inpatient psychiatric **s**ervices. Medications are exempt from these provisions. The Department of Children and Families is directed to calculate a rate for the non-Medicaid residents served in the demonstration area in order to ensure that the capitation rate does not result in the displacement of residents.

This section authorizes AHCA, at the direction of its Secretary, to implement the demonstration project. If the implementation of the demonstration project is authorized, the project must be continued for no less than three years following implementation. The advisory committee is required to complete its work by the end of the three year period.

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

Subsection (10) of SB 1852 authorizes AHCA to seek the necessary federal waivers or approval to amend a current waiver for the purpose of addressing the needs of individuals who reside in an assisted living facility that holds a limited mental health license. The agency is directed to establish a workgroup to assist in the preparation and development of the amendment to the waiver and to provide input and information relevant to the completion and successful submission of an amendment. The amendment is required to address the needs of certain individuals who reside in a state-licensed assisted-living facility that holds a limited mental health license. The amendment must provide for a mechanism by which those individuals having increased medical needs who are under the age of 65 and meet certain criteria would be eligible based on the availability of funding for additional services that would enable these individuals to remain as residents in an assisted living facility that holds a limited mental health license.

OPPAGA is required to conduct an evaluation of the waiver amendment after the first year of implementation. The evaluation shall assess whether the amendment to the waiver and the services provided have reduced, delayed, or otherwise improved the ability of the assisted living facility to "retrain" individuals who otherwise would have been homeless or placed in an institutional setting. The agency is also directed to implement the waiver and serve 400 individuals who meet the criteria and reside in an assisted living facility that holds a limited mental health license in the counties of Duval, Nassau, Pasco, Sarasota, Putnam, Volusia, Dade, Charlotte, Palm Beach or Lee. The agency shall implement the waiver amendment upon approval from appropriate federal agencies and access to available funding. The waiver amendment may not increase costs to the Medicaid program and must demonstrate savings.

Section 2. Provides that this bill shall take effect July 1, 2005.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill requires membership from the private sector for the proposed advisory committee: one person from the Florida Psychiatric Society, one person from the Florida Council for Behavioral Health, a member of the National Alliance for the Mentally Ill, a member of the Florida Assisted Living Affiliation, and a member from the local advocacy council. Members of the committee are to serve at their own expense.

C. Government Sector Impact:

Agency for Health Care Administration

If ACHA proceeds with a demonstration project, there will be a $25,000 fiscal impact to AHCA for actuarial services needed to certify the validity of capitated rates. Federal regulations require that rates must be re-certified annually.

AHCA reports that one medical/healthcare analyst position will be needed at the agency headquarters to develop and manage the demonstration project, if the project is implemented.

If implemented, the demonstration project proposed by this bill will result in the provision of additional services to residents with increased medical needs, and is an expansion in Medicaid services and would be accompanied by a fiscal impact on the agency.

The agency reports that an independent evaluation is required for all demonstration projects operating under a federal waiver. The evaluation by OPPAGA which is specified in this bill does not meet the criteria for an independent evaluation. Additional funding of $100,000 will be needed for an evaluation, if the project is implemented.

Department of Children and Family Services

The Department of Children and Families indicates that administrative costs to the department to organize and staff the workgroup, develop the bid specifications, and monitor the implementation of the demonstration project will be contingent upon whether AHCA elects to carry out a demonstration project or to seek amendment to any current waiver programs.

VI. Technical Deficiencies:

This bill amends s. 394.4574, F.S., which describes the department's responsibilities to residents of ALFs with a limited mental health license. However, the bill relates to AHCA and the development of specialty behavioral health care providers through federal waivers for Medicaid demonstration projects. This language may be more appropriate for ch. 409, F.S.

In subsection (10) it is not clear that the mandates to establish a workgroup and other subsequent actions are contingent upon AHCA seeking federal waivers or approval to amend a current waiver.

The word “retrain” is used on page nine, line seven of this bill. Given the context of the sentence, the word should be “retain.”

VII. Related Issues:

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

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

Facilities that are larger than 16 beds which are primarily engaged in the care or treatment of persons diagnosed with mental illness are defined under federal Medicaid law as “institutions for mental disease” (IMD). Persons who reside in IMDs have their Medicaid benefits suspended. Providing a large volume of mental health services within an ALF may increase the likelihood that the facility may be defined as an IMD. However, this requirement does not prevent persons from receiving mental health services in other settings.

All Medipass recipients will be capitated to comprehensive prepaid plans by March of 2006. The waiver authorized by this bill would allow for “carve out” of ALF-LMHL residents from prepaid mental health plans, resulting in a “carve out” of a “carve out.”

The bill carves out a subpopulation of individuals with mental illness; those living in ALFs with a limited mental health license. Carving out small groups under a managed care arrangement puts plans at higher risk of not being able to cover costs because of their inability to spread risk across many plan enrollees. It is unclear how many of the ALFs-LMHL would participate in such a pilot project and if such pilot could attract sufficient enrollees to reach a critical mass to provide effective services at the capitated rate.

The counties specified by this bill for the demonstration project are not organized by either AHCA Medicaid area or DCF district. This may create some difficulty in managing a demonstration project. Further, there are no ALF-LMHL facilities in Collier, Lee, or Charlotte counties.

The Florida Assisted Living Affiliation, the ALF trade organization, has indicated that this bill is not part of their legislative agenda and, given that, they will probably not support the bill.

VIII. Summary of Amendments:

None.