The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 7068
INTRODUCER:	Children, Families, and Elder Affairs and Appropriations Committee
SUBJECT:	Mental Health and Substance Abuse Services
DATE:	March 30, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Brown	Kynoch		**AP Submitted as Committee Bill**
1.	Hendon	Hendon	CF	**Fav/CS**
2.				
3.				

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 7068 reforms the delivery and funding of mental health and substance abuse services, referred to as behavioral health services. The bill requires the Agency for Health Care Administration (AHCA) and the Department of Children and Families (DCF) to develop a plan by November 1, 2015, to apply for and obtain federal approval to increase Medicaid funding for behavioral health care.

To prepare for such approval, the bill reorganizes behavioral health managing entities.[1] The bill requires managing entities that contract for publically-funded mental health and substance abuse services to create a coordinated care organization in each region of the state. The coordinated care organization will be a network of behavioral health care providers offering a comprehensive range of services and capable of integrating behavioral health care and primary care. The structure of the governing boards of the managing entities are revised. The bill revises criteria for priority populations to be observed when the demand for publically-funded behavioral health services exceeds resources.

[1] *See* s. 394.9082, F.S. A managing entity is a not-for-profit corporation organized in Florida which is under contract with the DCF on a regional basis to manage the day-to-day operational delivery of behavioral health services through an organized system of care and a network of providers who are contracted with the managing entity to provide a comprehensive array of emergency, acute care, residential, outpatient, recovery support, and consumer support services related to behavioral health.

The bill requires the DCF to modify licensure rules to create a consolidated license for a behavioral health care provider that offers multiple mental health and substance abuse services. The bill repeals obsolete statutes relating to behavioral health care. The bill may result in a positive fiscal impact by increasing resources for behavioral health care if federal approval is obtained to increase Medicaid funding.

The bill has an effective date of July 1, 2015.

II. Present Situation:

Mental Health and Substance Abuse

Mental illness creates enormous social and economic costs.[2] Unemployment rates for persons with mental disorders are high relative to the overall population.[3] People with severe mental illness have exceptionally high rates of unemployment, between 60 percent and 100 percent.[4] Mental illness increases a person's risk of homelessness in America threefold.[5] Studies show that approximately 33 percent of our nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are not receiving treatment.[6] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future re-offenses.[7]

According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse.[8] NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.[9] When mental health disorders are left untreated, substance abuse is likely to increase. When substance abuse increases, mental health symptoms often increase as well or new symptoms may be triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[10]

Behavioral Health Managing Entities

In 2008, the Legislature required the DCF to implement a system of behavioral health managing entities that would serve as regional agencies to manage and pay for mental health and substance abuse services.[11] Prior to this time, the DCF, through its regional offices, contracted directly with behavioral health service providers. The Legislature found that a management structure that

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[2] Mental Illness: The Invisible Menace, *Economic Impact* http://www.mentalmenace.com/economicimpact.php
[3] Mental Illness: The Invisible Menace, *More impacts and facts* http://www.mentalmenace.com/impactsfacts.php
[4] *Id.*
[5] Family Guidance Center, *How does Mental Illness Impact Rates of Homelessness?* (February 4, 2014) *available at* http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/
[6] *Id.*
[7] *Id.*
[8] Donna M. White, LPCI, CACP, Psych Central.com, *Living with Co-Occurring Mental & Substance Abuse Disorders*, (October 2, 2013) *available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occurring-mental-substance-abuse-disorders/
[9] *Id.*
[10] *Id.*
[11] *See* s. 394.9082, F.S., as created by Chapter 2008-243, Laws of Fla.

places the responsibility for publicly-financed behavioral health treatment and prevention services within a single private, nonprofit entity at the local level, would promote improved access to care, promote service continuity, and provide for more efficient and effective delivery of substance abuse and mental health services. There are currently seven managing entities across the state.[12]

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income pregnant women, children and disabled persons. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare and Medicaid Services. The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The DCF determines eligibility for the Medicaid program and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program.[13]

Over 3.7 million Floridians are currently enrolled in Medicaid[14] and the program's estimated expenditures for the 2014-2015 fiscal year are $23.4 billion.[15] The federal government currently pays 59.56 percent of the costs of Medicaid services with the state paying 40.44 percent. Florida has the fourth largest Medicaid program in the country.[16]

Medicaid currently covers:
- 20 percent of Florida's population;
- 27 percent of Florida's children;
- 62.2 percent of Florida's births; and
- 69 percent of Florida's nursing homes days.[17]

The structure for each state's Medicaid program varies and the percentage of costs paid by each state is largely determined by the federal government. Federal law and regulation sets the minimum amount, scope, and duration of services offered in the program, among other requirements. Eligibility for the Medicaid program is based on a number of factors, including age, household or individual income, and assets. State Medicaid benefits are provided in statute

[12] Department of Children and Families website, http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities, (last visited Mar. 11, 2015).
[13] *See* s. 409.963, F.S.
[14] Agency for Health Care Administration, *Report of Medicaid Eligibles - January 31, 2015*, http://ahca.myflorida.com/medicaid/about/pdf/age_assistance_category_2015-01-31.pdf (last visited Mar. 9, 2015).
[15] Office of Economic and Demographic Research, *Social Services Estimating Conference Medicaid Expenditures* (December 12, 2014) http://edr.state.fl.us/Content/conferences/medicaid/medhistory.pdf (last visited Mar. 6, 2015).
[16] Agency for Health Care Administration, Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - An Overview* (Jan. 22, 2015), slide 9, http://www.flsenate.gov/PublishedContent/Committees/2014-2016/AHS/MeetingRecords/MeetingPacket_2759.pdf (last visited Mar. 6, 2015).
[17] Id at 10.

under s. 409.903, F.S. (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

In 2011, the Legislature established the Statewide Medicaid Managed Care Program.[18] The managed care program has two components: the Long Term Care Managed Care program and the Managed Medical Assistance program. The Statewide Medicaid Managed Care Program is an integrated managed care program for Medicaid enrollees that incorporates all of the covered services, for the delivery of primary and acute care in 11 regions.

The Managed Medicaid Assistance program is authorized by a Medicaid waiver granted by the federal Centers for Medicare and Medicaid Services. Behavioral health care is covered by Medicaid managed care plans and by Medicaid's system for providing services under fee-for-service payments.

III. Effect of Proposed Changes:

Section 1 amends s. 394.455, F.S., to revise the definition of "mental illness" to exclude dementia and traumatic brain injuries.

Section 2 amends s. 394.492, F.S., to revise the definition of "adolescent" to a person under 21 years of age.

Section 3 creates s. 394.761, F.S., to require AHCA and DCF to obtain federal approval to increase Medicaid funding for behavioral health care. The bill states that the goal of this federal approval is to implement a coordinated care organization (defined later in the bill) and to improve the integration of behavioral and primary health care services. A plan to obtain this approval must be submitted to the Legislature by November 1, 2015. The plan must identify:

- State funding that could be used as matching funds for the Medicaid program;
- How increased Medicaid funding could be used for expanded eligibility;
- How increased Medicaid funding could increase reimbursement rates and capitation rates for behavioral health services;
- How increased Medicaid funding could make supplemental payments to behavioral health service providers;
- Innovative programs for providing incentives for improved client outcomes;
- The advantages and disadvantages for each alternative;
- The types of federal approvals needed; and
- A timeline for implementing these changes.

Section 4 amends s. 394.875, F.S., to require the DCF to work with AHCA to modify licensure rules to create a consolidated license for a behavioral health care provider that offers multiple mental health and substance abuse services under ch. 394, F.S., (mental health) and ch. 397, F.S., (substance abuse) by January 1, 2016.

Section 5 amends s. 394.9082, F.S., effective upon the bill becoming law, relating to the Legislature's intent to establish behavioral health managing entities. Intent language is added

[18] *See* Chapter Laws, 2011-134 and 2011-135.

suggesting the integration of primary health care with behavioral health care. The bill strikes reference to behavioral health managing entities being single, private, nonprofit, local entities. The bill deletes the definition of "decision-making model" and redefines the geographic areas for managing entities as areas used by AHCA to implement Medicaid managed care. The bill revises the definition of "managing entity" to delete reference to nonprofit status and defines such entities as those under contract with the DCF as of July 1, 2015.

The bill defines "coordinated care organizations" and requires managing entities to create a coordinated, regional network of behavioral health care providers. Such coordinated care organizations must provide access to a comprehensive range of services for persons with a mental illness or substance abuse disorder. DCF must designate a coordinated care organization based on established relationships between service providers, written agreements between providers, common intake and assessment, joint operations, and integrated case management. Requirements for the DCF to contract for a managing entity are revised so that managing entities develop a regional coordinated care organization. Outdated language relating to the implementation of the managing entities is repealed.

The bill requires DCF contracts with managing entities to be performance-based with specific performance standards, and consequences for failure to establish a coordinated care organization. In creating a coordinated care organization, a managing entity must consider public input, a needs assessment, and include evidence-based and best practice models. Under the bill, the DCF must establish 3-year contracts with managing entities on the next date of contract renewal after the bill becomes law. All managing entities; however, must be under performance-based contracts by July 1, 2017. Those managing entities with contracts providing for a renewal on July 1, 2015, but must comply with the law by July 1, 2017.

Failure by a managing entity to implement a coordinated care organization, failure to meet performance standards, or failure to meet financial standards constitutes a disqualification as a managing entity. DCF must then begin procurement of another managing entity. The new entity must be either a managing entity from another region, a behavioral health organization under contract with a Medicaid managed care plan, a Medicaid managed care organization operating in the same region, or a behavioral health specialty Medicaid managed care plan. When selecting a new managing entity, the DCF must consider input from behavioral health care providers, the experience of the proposed managing entity in providing behavioral health care, the extent to which the proposed managing entity has community partnerships with behavioral health care providers, the demonstrated ability to manage a network, and the ability to integrate behavioral health care with primary health care.

The bill establishes goals for the coordinated care organization as follows:

- Improved outcomes of persons receiving behavioral health care;
- Accountability and transparency for behavioral health care;
- Continuity of care for all children, adolescents and adults for behavioral health care;
- Value-based purchasing of behavioral health care to maximize the return on the investments of public resources;
- Early diagnosis and treatment to prevent unnecessary hospitalization;
- Regional service delivery systems that are responsive to local needs;

- Quality care by using evidence-based services and best practices; and
- Integration of behavioral health services with other assistance programs.

The bill defines the essential elements that a coordinated care organization must provide or arrange for the provision of:

- A centralized receiving facility or coordinated receiving system for persons needing emergency assistance with behavioral health care through the Baker Act or the Marchman Act;
- Crisis services including mobile response teams and crisis stabilization units;
- Case management;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- After-care and post-discharge services;
- Recovery support, such as housing assistance, employment support, education assistance, independent living skill services, family support and education, and wellness services;
- Medical services necessary for the integration of behavioral health care with primary care;
- Prevention and outreach services;
- Medicaid assisted treatment; and
- Detoxification services.

The bill establishes that the provider network must include all mental health and substance abuse providers currently receiving public funds for such services. Provider participation in the network would be based on credentialing and other performance standards. Managing entities must continue to provide financial management; allocate funds; monitor providers; collect, report, and analyze data; collaborate with community stakeholders, coordinate consumer care, continuously improve the quality of services; manage and maximize resources, including third-party payments; be a liaison with consumers; conduct community needs assessments; and secure local matching funds.

The managing entity must strive to serve all persons in need and will prioritize services when resources are limited. The bill establishes priority populations as:

- Individuals in crisis stabilization units awaiting placement in a state treatment facility;
- Individuals in state treatment facility awaiting community services;
- Parents or caretakers with involvement in the child welfare system;
- Individuals with multiple arrests and incarceration due to their behavioral health; and
- Individuals with conditions similar to those in the community that use a disproportionate amount of behavioral health care.

In order to better coordinate care of persons receiving behavioral health care services, the bill requires DCF to establish a unique identifier to be used by the managing entities and their contracted providers.

The bill provides additional direction for the composition of a managing entity's governing board and requires DCF to verify that changes have been made to the boards by December 31, 2015. The bill requires the boards to be broadly representative of the community. It must include

consumers and family members, community organizations that are not under contract with the managing entity, local governments, local law enforcement agencies, business leaders, local child welfare providers, health care professionals, and representatives of health care facilities. The managing entities must also establish a technical advisory panel made up of providers of mental health and substance abuse services. The managing entity shall select one member of the advisory panel to serve on the board as an ex officio member.

The bill deletes outdated language relating to the implementation of statutes relating to managing entities.

Section 6 creates s. 397.402, F.S., to establish a consolidated license for behavioral health care providers. Currently, the DCF licenses substance abuse providers. The standards are set out in law and rule and require an application, license fee, and inspections. Mental health providers, such as psychiatric hospitals, crisis stabilization units, and residential facilities, are licensed by the AHCA. For these AHCA-licensed facilities, the DCF develops or contributes to the rules. When a hospital is accredited, the accreditation can be substituted for state licensing. Individual providers who offer substance abuse and mental health services (psychiatrists, psychologists, social workers, counselors, etc.) are licensed by their respective professional boards.

Under the bill, the DCF, in consultation with AHCA, will develop the option for providers to have a single, consolidated license by January 1, 2016. Providers must operate under a single corporate entity to be eligible for the consolidated license. When such providers serve both children and adults, they must meet DCF standards for providing separate facilities and other arrangements to ensure the safety of children. The bill also requires these two agencies to recommend changes to the Florida Statutes to further implement the intent of this section.

Section 7 amends s. 409.967, F.S., relating to Medicaid managed care plans. The bill requires managed care plans to provide or contract for care coordination of behavioral health care. The aim of such care coordination is to provide services in the least restrictive environment. The bill requires behavioral health care services delivered by Medicaid managed care plans to be integrated with primary care. Plans are to meet specific outcome standards developed in consultation with the DCF.

Section 8 amends s. 409.973, F.S., relating to benefits under Medicaid managed care plans. The bill establishes a new initiative for integrated behavioral health and requires each plan to work with behavioral health managing entities.

Section 9 amends s. 409.975, F.S., relating to managed care plan accountability. The bill adds publically-funded behavioral health care providers to the list of essential Medicaid providers with which Medicaid managed care plans are required to contract.

Section 10 repeals s. 394.4674, F.S., relating to deinstitutionalization. The statute currently directs the DCF to develop a plan for the deinstitutionalization of patients in a treatment facility who are over age 55 and do not meet the criteria for involuntary placement.

Section 11 repeals s. 394.4985, F.S., relating to information and referral services that requires DCF to establish a districtwide comprehensive child and adolescent mental health information and referral network.

Section 12 repeals s. 394.657, F.S., relating to county planning for behavioral health. The statute currently requires each county have an entity to make a formal recommendation to the board of county commissioners regarding how the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program may best be implemented within a community.

Section 13 repeals s. 394.745, F.S., relating to annual reports on behavioral health. The statute currently requires the DCF to submit an annual report to the President of the Senate and the Speaker of the House of Representatives, which describes the compliance of providers that provide substance abuse treatment programs and mental health services under contract with the DCF. This provision of current law is obsolete because responsibility for managing such providers has been turned over to the managing entities.

Section 14 repeals s. 397.331, F.S., relating to legislative intent and definitions for substance abuse treatment. The statute currently calls for a state drug control strategy to be developed and implemented.

Section 15 repeals s. 397.333, F.S., creating the Statewide Drug Policy Advisory Council in the Department of Health.

Section 16 repeals s. 397.801, F.S., relating to substance abuse impairment coordination. The statute currently requires the DCF, the Department of Education, the Department of Corrections, and the Department of Law Enforcement to each appoint a policy-level staff person to serve as the agency substance abuse impairment coordinator.

Section 17 repeals s. 397.811, F.S., relating to juvenile substance abuse. The statute currently provides intent language that a substance abuse impairment crisis is destroying the state's youth. The statute further provides legislative intent that funds be invested in prevention and early intervention programs.

Section 18 repeals s. 397.821, F.S., establishing juvenile substance abuse impairment prevention and early intervention councils. The purpose of the councils is to identify community needs in the area of juvenile substance abuse impairment prevention and early intervention and to make recommendations to the DCF.

Section 19 repeals s. 397.901, F.S., which authorizes prototype juvenile addictions receiving facilities to provide substance abuse impairment treatment services and community-based detoxification, stabilization, and short-term treatment and medical care to juveniles found to be impaired and in need of emergency treatment as a consequence of being impaired.

Section 20 repeals s. 397.93, F.S., which specifies that the target populations for children's substance abuse services are children at risk for substance abuse and children with substance abuse problems. This provision of current law is superseded by language in the bill to specify priority target populations for behavioral health care services.

Section 21 repeals s. 397.94, F.S., relating to planning information and referral networks for child substance abuse services. These requirements are made obsolete by the bill's provisions for coordinated care organizations.

Section 22 repeals s. 397.951, F.S., relating to treatment and sanctions for children in substance abuse treatment. The statute currently calls for the integration of treatment and sanctions to increase the effectiveness of substance abuse treatment.

Section 23 repeals s. 397.97, F.S., relating to Children's Network of Care Demonstration Models. The purpose of such models is to create an effective interagency strategy for delivering substance abuse services to the target populations through a local network of service providers, which is duplicative of the requirements of the bill to establish coordinated care organizations.

Sections 24 through 28 amend various statutory provisions to correct cross-references to conform to changes made in sections 1 through 25.

Section 29 through 34 reenact various statutory provisions for the purpose of incorporating amendments by reference thereto made in sections 1 through 25.

Section 35 provides an effective date of July 1, 2015, except for section 5, which takes effect upon the bill becoming law

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under the bill, private providers of behavioral health services could experience lower costs through a consolidated licensing process by DCF. The duties of private managing entities would be revised under the bill such as establishing a coordinated care

organization. If the bill results in expanded Medicaid services or payment rates, private behavioral health care providers could experience increased revenues.

C. Government Sector Impact:

The bill could have a positive, indeterminate fiscal impact on the state to the extent that efforts by the Agency for Health Care Administration and Department of Children and Families to obtain federal approval to increase Medicaid funding for behavioral health care, are successful.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.455, 394.492, 394.875, 394.9082, 397.321, 397.98, 409.966, 409.967, 409.973, 409.975, 943.031, and 943.042.

This bill creates the following sections of the Florida Statutes: 394.761 and 397.402.

This bill repeals the following sections of the Florida Statutes: 394.4674, 394.4985, 394.657, 394.745, 397.331, 397.333, 397.801, 397.811, 397.821, 397.901, 397.93, 397.94, 397.951, and 397.97.

This bill reenacts the following sections of the Florida Statutes: 39.407, 394.67, 394.674, 394.676, 409.1676, and 409.1677.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on April 2, 2015:
The CS requires DCF to work with AHCA to implement a consolidated license for mental health and substance abuse providers and recommend any needed law changes.

The CS clarified that contracts for managing entities could be terminated for not meeting performance or financial standards.

The CS states that a coordinated care organization shall provide or arrange for the provision of certain services. Additional services such as prevention and outreach, medication assisted treatment, and detoxification services to the list of essential elements of a coordinated care organization.

The CS restores language regulating medication assisted treatment programs and the self-directed care pilot programs for mental health services.

The CS requires DCF to establish a unique identifier for persons receiving behavioral health care and requires managing entities and their contracted providers to use the identifier to better coordinate services.

The CS revises language changing the composition of the managing entity board of directors to provide more flexibility.

B. Amendments:

None.