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 Appropriations

BILL:	SPB 7068
INTRODUCER:	For consideration by the Appropriations Committee
SUBJECT:	Mental Health and Substance Abuse Services
DATE:	March 24, 2015 REVISED:

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
Brown/Hendon	Kynoch		**Pre-meeting**

I. Summary:

SPB 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 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.

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.

[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.

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 homelessness 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 Department of Children and Families (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 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]

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[2] *Mental Illness: The Invisible Menace; Economic Impact, available at* http://www.mentalmenace.com/economicimpact.php
[3] *Mental Illness: The Invisible Menace: More impacts and facts, available at* http://www.mentalmenace.com/impactsfacts.php
[4] *Id.*
[5] *How does Mental Illness Impact Rates of Homelessness? Available at* http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/
[6] *Id.*
[7] *Id.*
[8] Donna M. White, OPCI, CACP, *Living with Co-Occurring Mental & Substance Abuse Disorders, available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occuring-mental-substance
[9] *Id.*
[10] *Id.*
[11] *See* s. 394.9082, F.S., as created by Chapter 2008-243, Laws of Florida.
[12] Department of Children and Families website, http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities, last visited 3/11/15.

Florida Medicaid

The Medicaid program is a partnership between the federal and state governments to provide medical care to low income 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 & Medicaid Services. The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the Agency for Health Care Administration (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 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.

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

The Managed Medicaid Assistance program is authorized by a Medicaid waiver granted by the federal Centers for Medicare & 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 the Agency for Health Care Administration (AHCA) and the Department of Children and Families (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 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. 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. Requirements for the DCF to contract for a managing

entity are revised to require managing entities to 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 three-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, may be renewed until a performance-based contract can be developed.

Failure by a managing entity to implement a coordinated care organization constitutes a disqualification as a managing entity and the DCF must begin procurement of another managing entity. The new entity must be either a managing entity from another region, a Medicaid managed care organization operating in the same region, or a behavioral health specialty 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 of a coordinated care organization as:
- 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; and

- Medical services necessary for the integration of behavioral health care with primary care.

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.

The bill revises the make-up of a managing entity's governing board effective December 31, 2015. The members must be selected through a transparent process and serve in staggered terms. Members are limited to serving no more than eight years. Under the bill, the board must have the following members from the region:
- Four consumer representatives, or family members of persons receiving behavioral health care, nominated by behavioral health care providers;
- Two local government representatives nominated by local governments;
- Two employer representatives nominated by a chamber of commerce;
- Two service provider representatives serving families in the child welfare system, appointed by the child welfare community-based care agency; and
- Three health care professionals or representatives of health facilities that are not under contract with the managing entity, nominated by local medical societies, hospitals, or other health care organizations.

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 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.

Section 7 amends s. 397.427, F.S., to repeal language relating to medication-assisted treatment, such as treatment for opiate addiction. The repealed language requires the DCF to determine the need for such treatment programs, adopt rules, and select providers of medication-assisted treatment.

Section 8 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 9 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 10 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 11 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 12 repeals s. 394.4985, F.S., relating to placement of children in mental health treatment facilities. The statute currently prohibits a child under the age of 14 who is admitted for mental health treatment to any hospital from being placed in a room or ward with an adult patient. The bill addresses this issue in section 6.

Section 13 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 14 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 15 repeals s. 394.9084, F.S., relating to self-directed care programs. The statute currently allows the DCF, in cooperation with the AHCA, to provide a client-directed and choice-based Florida Self-Directed Care Program in all service districts, in addition to the pilot projects established in District 4 and District 8, to provide mental health treatment and support services to adults who have serious mental illness.

Section 16 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 17 repeals s. 397.333, F.S., creating the Statewide Drug Policy Advisory Council in the Department of Health.

Section 18 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 19 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 20 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 21 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 22 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 section 5 of the bill to specify priority target populations for behavioral health care services.

Section 23 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 24 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 25 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 26 through 30 amend various statutory provisions to correct cross-references to conform to changes made in sections 1 through 25.

Section 31 through 36 reenact various statutory provisions for the purpose of incorporating amendments by reference thereto made in sections 1 through 25.

Section 37 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 SPB 7068, private providers of behavioral health services could experience lower costs through a consolidated licensing process by DCF. Private managing entities would have additional duties in establishing a coordinated care organization. If the bill results in expanded Medicaid services or payment rates, private behavioral health 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, 394.493, 394.875, 394.9082, 397.427, 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: 3964.4674, 394.4985, 394.657, 394.745, 394.9084, 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 Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.