HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCC 07-08 Self-Directed Care and Mental Health System Improvements
SPONSOR(S): Healthcare Council and Bean
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Healthcare Council	16 Y, 0 N	Mitchell	Gormley
1)			
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

Self-directed care is a consumer-centered model for mental health services in which participants control the money available for their care. Participants decide their desired goals, what services to purchase, and who provides the services. The program increases consumer choice and supports recovery and independence.

PCB HCC 07-08 requires the Department of Children and Families to make the Florida Self-Directed Care Program available in all areas of the state using existing resources. It removes provisions for a pilot program and its 2008 expiration date.

The bill removes children with emotional disturbances from program eligibility. It provides for applicants with different levels of functioning to be considered for enrollment.

The bill removes Vocational Rehabilitation and the Social Security Administration as funding sources for the program, as they are not under department authority. The bill requires an independent financial agent to pay for services. It removes authorization to spend $100,000 for the required evaluation.

The bill provides for specialty, mental health provider service networks to participate in Medicaid managed care. It authorizes the Agency for Healthy Care Administration to contract with Medicaid provider service networks that exclusively serve recipients with psychiatric disabilities. It makes these specialty provider networks part of the Medicaid Managed Care Pilot Program.

The effective date of the bill is July 1, 2007

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Empower Families
Self-directed care is a mental health service delivery system in which participants control the money available for their care. Participants decide their desired goals, what services to purchase, and who provides the services. The program increases consumer choice and supports recovery and independence.

B. EFFECT OF PROPOSED CHANGES:

PCB HCC 07-08 requires the Department of Children and Families to make the Florida Self-Directed Care Program available in all areas of the state, using existing resources. It removes provisions for a pilot program and its 2008 expiration date.

The bill removes children with emotional disturbances from program eligibility. It provides for applicants with different levels of functioning to be considered for enrollment.

The bill removes Vocational Rehabilitation and the Social Security Administration, which are not under department authority, as funding sources for the program. The bill requires an independent financial agent to pay for services. It removes authorization to spend $100,000 for the required evaluation.

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CURRENT SITUATION

Self-directed care is a consumer-centered model for mental health services established in s. 394.9084, F.S., that is currently offered in Department of Children and Families Districts 4 and 8. Administrative costs are included in program contracts. Other districts have expressed interest in implementing Self-Directed Care programs. To accommodate such expansion, the department is developing the use of one independent financial agent for all areas. Mental health managed care programs are working to incorporate Self-Directed Care program services within their benefit packages. The department recently completed the annual evaluation for this program.

In self-directed care participants control the money available for their care. Participants decide their desired goals, what services to purchase, and determine who provides the services. Section 394.9084, F.S., authorizes the Department of Children and Families to establish self-directed care programs in District 4, and up to three other districts. Self-directed care is implemented in District 4 where it serves 180 participants and in District 8 where it serves 90 participants. Participation in the program is voluntary.

Self-directed care in mental health is an example of consumer-directed models that have been established in different types of social services. The key components of client-directed care include care coordination, client involvement in treatment goals and plans, individualized services, and a strong provider network.

The Agency for Health Care Administration provides behavioral health services for Medicaid recipients via capitated prepaid or managed care programs statewide. Florida began mental health care for Medicaid enrollees under a 1915(b) waiver, as a mental health carve-out demonstration in March 1996, and has since expanded both prepaid and HMO coverage of Medicaid mental health services

statewide. Initially these plans were reimbursed through a fee-for-service (FFS) mechanism in which the state was at risk for mental health service utilization. In 2005, with federal approval, Florida expanded mental health coverage under capitated Medicaid managed care plans throughout the state. Currently, all prepaid and managed care coverage of Medicaid behavioral health statewide is reimbursed through a capitated arrangement.

BACKGROUND INFORMATION

In 2003, the President's New Freedom Commission on Mental Health recommended the mental health system should be consumer and family-centered and designed to give individuals real and meaningful choices about their plan of care. The commission found Self Directed Care is available in five states (Florida, Michigan, Iowa, Oregon, and Vermont), with Florida serving the largest number of participants of any state.

Self Directed Care in Florida started in the Jacksonville area in 1998, at the initiative of the Nassau County chapter of the National Alliance for the Mentally Ill (NAMI). The chapter identified self directed care as a way to improve service delivery and ensure adequate funding of services through client choice and having funding follow the client.

In 2001, the Florida Commission on Mental Health and Substance Abuse recommended the department increase consumer choice and test the self-directed care model in a pilot project.

In 2001, the Legislature passed HB 421 (ch. 2001-152, L.O.F.), to establish the mental health, self-directed care pilot in DCF District 4 centered on Jacksonville. The project allowed the client to control the public mental health funds allotted for their treatment and directly purchase the services from their choice of vendor. The Legislature required an independent evaluation to assess key provisions of the project. The pilot expired in 2004.

In 2004, the Legislature passed SB 2894 (ch. 2004-380, L.O.F.) to expand the client-directed and choice-based pilot project in District 4, and renamed the pilot project "Florida Self-Directed Care." The bill required DCF to contract for administration of the program, and for DCF to prepare an annual report containing a detailed strategic plan for statewide implementation of the program to include children with serious emotional disturbances.

Community Mental Health in Florida
Florida's public community mental health system is funded through a variety of sources that include federal block grants, state general revenue, Medicaid Title XIX, Title XXI, county government funds, and client fees. Section 394.74, F.S., authorizes the department to contract with any hospital, clinic, laboratory, institution, or other appropriate mental health service provider to provide services with available funds. Persons who need publicly funded mental health services may choose a service provider that is under contract with the department or an approved Medicaid provider. Persons must meet certain requirements for services under Medicaid Title XIX, Title XXI, or requirements specified in s. 394.674, F.S.

Program Design
There are a number of differences between the traditional mental health service delivery system and a self-directed care model. Service providers in the SDC model may or may not be members of the publicly-funded mental health provider system. Allowable services that may be paid for with state funding include services that contribute to the individual meeting a recovery goal that may not have been payable under the traditional system. Under the SDC model, the individual has explicit control of the service dollars that have been allocated for his or her care. Residential and crisis stabilization services are delivered by existing community mental health providers through the traditional delivery system.

Program Costs
According to the department, one problem facing areas that want to participate in the expansion of Self Directed Care is the increased administrative cost of handling individualized billing for services for each participant. The original program had a grant of $470,000 to cover additional costs of a program director, service counselors, billing, and an advisory council.

Currently each person has an account of approximately $4,000 to spend for self-directed care. In District 4 the program serves 180 participants through a $933,812 contract with the Mental Health Resource Center that includes $821,295 (88%) for direct services and $112,517 (12%) for administration. The average cost per participant, including direct services and administrative costs, is $5,188 per participant.

In District 8, the program serves 90 participants through a $470,000 contract with NAMI of Collier County, Inc. that includes $405,000 (86%) for services and $65,000 (14%) for administration. The average cost per participant is $5,222, including direct services and administration.

In addition to administrative costs, both programs have dedicated one fiscal staff member to conduct the fiscal intermediary billing for individual services. The department is working on establishing a statewide independent financial agent to support the expansion of this program with reduced administrative costs.

Program Effectiveness
An evaluation issued by the department in January 2007, (Effectiveness of the Self-Directed Care, Community Mental Health Treatment Program) found positive outcomes for self-directed care participants in terms of community integration and residential stability, which are strong indicators of recovery. Self-directed care participants use less crisis stabilization services and more services such as assessments, psychiatry, outpatient individual psychotherapy, and supported employment. The department found the programs are adhering to program requirements of person-centered planning, individual budgets, availability of independently brokered services, and access to the program by all eligible to enroll.

The evaluation cautions that the use of less intensive services and other outcomes of self-directed care may be due to self selection of the program by higher functioning persons. Self-directed care participants are more likely to be educated, female, and non-minority, than the larger mental health population. (Seventy-one percent of self-directed care participants are female compared to 42 percent of non-self-directed care participants. Only 34 percent of non-self-directed care participants finished high school compared to 86 percent of program participants, and 50 percent are minorities, compared to 24 percent of the self-directed care group.)

According to the department, some mental health consumers and providers view the program as only suitable for persons at higher stages of recovery. The department recommends improved outreach to underserved persons, including persons who are less educated, minority, and male through community advocacy groups and program participants. The department recommends the program target individuals who would especially benefit from the self-directed nature of the program, such as persons leaving crisis stabilization units or short-term residential treatment facilities, and children who are transitioning from the children's to the adult mental health system.

Agency for Health Care Administration

Managed Behavioral Health Care in Florida
The Agency for Health Care Administration provides behavioral health services for Medicaid recipients statewide using capitated prepaid and managed care programs.

Florida began addressing mental health care for Medicaid enrollees under a 1915(b) waiver, as a mental health carve-out demonstration project in March 1996 in the Tampa Bay area. The carve-out

demonstration succeeded in creating a fully integrated mental health delivery system with financial and administrative mechanisms that support a shared clinical model.

Following the success of the demonstration project, Florida has continued to expand managed care strategies to establish comprehensive mental health services for Medicaid beneficiaries. Initially these were reimbursed through a fee-for-service (FFS) mechanism in which the state was at risk for mental health service utilization. For beneficiaries enrolled in the Medipass plan, both physical health and pharmacy benefits were paid for on a FFS basis. For beneficiaries enrolled in an HMO, physical health and pharmacy benefits were paid for through a capitated arrangement with the HMOs.

Mental Health Plan services include:

- Inpatient psychiatric services.
- Outpatient hospital services for covered diagnosis.
- Community mental health services.
- Mental health targeted case management.
- Psychiatrist physician services.

In 2005, with federal approval, Florida expanded mental health coverage under capitated Medicaid managed care plans throughout the state.

Currently, all prepaid and managed care coverage of Medicaid behavioral health statewide is reimbursed through a capitated arrangement.

C. SECTION DIRECTORY:

Section 1. Amends s. 394.9084, F.S., regarding expansion of the Florida Self-Directed Care program.

Section 2. Amends s. 409.912, F.S., regarding cost-effective purchasing of health care to include specialty, mental health, provider service networks in Medicaid managed care.

Section 3. Amends s. 409.91211, F.S., regarding the Medicaid managed care pilot program to include mental health.

Section 4. Provides an enacting date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The department would manage the Self-Directed Care program within existing resources. Administrative fees for third party administration of the program will come from funds for services provided to participants.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Agency for Health Care Administration has privatized behavioral health services for Medicaid recipients throughout the state through a prepaid program or Medicaid Reform. This public/private initiative is not currently required to offer self-directed care. Their contracts do not specify self-directed care as a form of service delivery. Contract amendments and/or coordination may be required for existing contracts.

D. STATEMENT OF THE SPONSOR

None provided.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On April 17, 2007, the Healthcare Council adopted a strike-all amendment by the bill sponsor and an amendment to the strike-all and voted the bill favorably as a council substitute as amended.

The amendment to the strike-all provides for specialty provider service networks to provide Medicaid mental health services as part of Medicaid managed care and Medicaid reform.

The bill analysis is drafted to the bill as amended.