Behavioral Health Services Revenue Maximization Plan

Report to the Florida Legislature

Pursuant to Section 394.761(5), Florida Statutes

December 31, 2016

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Executive Summary

The Agency for Health Care Administration (Agency) serves as the single state agency responsible for administering the Florida Medicaid program, while the Department of Children and Families (DCF) serves as the single state agency for the provision of mental health and substance abuse services. Collectively, these entities are responsible for operating a system of care responsible for the medical and behavioral health care of approximately 680,041 individuals living with chronic health conditions such as serious mental illness (SMI) or substance use disorder (SUD). The services provided to this population are primarily funded through the use of federal dollars and state general revenue.

During the 2016 legislative session, the Agency and DCF were directed in Senate Bill 12 to develop a written plan to evaluate alternative uses of increased Medicaid funding, in order to advance the goal of improved integration of behavioral health services and primary care services for individuals eligible for Medicaid through the development and effective implementation of the behavioral health system of care. Information contained in the report solely focuses on adults, because children (recipients under the age of 21) can receive all medically necessary services through Florida Medicaid regardless of any service limitations that may be specified in policy. Additionally, this report explores how maximizing federal Medicaid funding can assist DCF in redirecting some state general revenue to meet the needs of other vulnerable populations who, as a result of their mental illness and/or substance abuse disorder, require a more intensive level of community-based services and supports.

As required by Senate Bill 12 (codified in section 394.761(2), F.S.), DCF has identified $412,411,814 in general revenue funding appropriated during fiscal year 2016-2017 for mental health and substance abuse services that may be eligible to be used as state match to receive additional federal Medicaid funding depending upon the delivery system enhancements that are implemented.

The Agency and DCF examined ways in which the State could seek federal approval to extend Medicaid eligibility for individuals contending with SMI or SUD (approximately 132,940 individuals) who currently are served through DCF's system of care and who do not meet the criteria for any of the eligibility categories currently covered under Medicaid. This extension of eligibility would be through an 1115 Research and Demonstration Waiver or a 1915 (c) or 1915(i) Home and Community-Based Services Waiver.

The Agency and DCF evaluated alternative uses of increased Medicaid funding to cover targeted case management as a Medicaid-funded service for the SUD population. Implementation of this option could be achieved in one of the following ways:

- The Agency could contract with the Statewide Medicaid Managed Care Managed Medical Assistance (MMA) plans to provide this service (to the extent the recipient is mandatory for enrollment in a health plan).
- The Agency could enter into contracts with the managing entities to provide TCM for recipients with a SUD.

- The Agency could require the MMA plans to subcontract with the managing entities to provide the service.

As a part of this report, the Agency and DCF also examined alternative uses of increased federal Medicaid funding to cover other services provided to the target population through the managing entities that are not available through the Medicaid program (e.g., residential detox services, mobile crisis support services, etc.).

If the Agency is directed to expand eligibility for the SMI and/or SUD population or to cover additional services and those services were provided through the MMA plans, the capitation rates paid to the health plans would need to be adjusted. The report also highlights some value based purchasing opportunities that can be achieved through the MMA program and/or through the managing entities in which behavioral health providers could be eligible for enhanced payments that are tied to specific quality indicators/performance.

Three supplemental payment opportunities were explored in the analysis – many of the options resulting in enhanced payments for providers. The most complex opportunity examined was the use of Designated State Health Programs (DSHP) to receive federal Medicaid match funding. The DSHP option may present an opportunity to address state needs and undertake a reform/transformational approach to the needs of persons with SMI and SUD who are currently residing in or at risk for hospitalization. The final component of the report is a review of Delivery System Reform Incentive Payment (DSRIP) programs (including how DSHP helps to finance DSRIP strategies) and the use of health homes as innovative programs to provide incentives for improved outcomes for behavioral health conditions.

The six alternative funding options identified in the report each might improve Florida's behavioral health system of care while maximizing existing state funding. If directed to implement any of the options described, the Agency could receive approximately 60 cents in federal matching funding for every 40 cents the state spends of its own resources on mental health and SUD services.

Section I. Background

A. Purpose of the Report

This report fulfills the requirements of section 394.761 (1-2), Florida Statutes. The 2016 Legislature passed Senate Bill 12, which amended section 394.761, Florida Statutes to do the following:

(1) *The agency and the department shall develop a plan to obtain federal approval for increasing the availability of federal Medicaid funding for behavioral health care. Increased funding shall be used to advance the goal of improved integration of behavioral health services and primary care services for individuals eligible for Medicaid through the development and effective implementation of the behavioral health system of care as described in s. 394.4573.*

(2) *The agency and the department shall identify in the plan the amount of general revenue funding appropriated for mental health and substance abuse services eligible to be used as state Medicaid match. The agency and the department shall evaluate alternative uses of increased Medicaid funding, including seeking Medicaid eligibility for the severely and persistently mentally ill or persons with substance use disorders, increased reimbursement rates for behavioral health services, adjustments to the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders, targeted case management for individuals with substance use disorders as a Medicaid-funded service, supplemental payments to mental health and substance abuse service providers through a designated state health program or other mechanisms, and innovative programs to provide incentives for improved outcomes for behavioral health conditions. The agency and the department shall identify in the plan the advantages and disadvantages of each alternative and assess each alternative's potential for achieving improved integration of services. The agency and the department shall identify in the plan the types of federal approvals necessary to implement each alternative and project a timeline for implementation.*

(5) *The agency and the department shall submit the written plan and report required in this section to the President of the Senate and the Speaker of the House of Representatives by December 31, 2016.*

As directed by the Florida Legislature, the Agency for Health Care Administration, in collaboration with the Department of Children and Families, has explored potential uses of increased Medicaid funding within Florida's existing behavioral health system of care for individuals diagnosed with a serious mental illness or substance use disorder. Because children can receive all medically necessary services through Florida Medicaid regardless of any service limitations that may be specified in policy, the focus of this revenue maximization exercise is on adults (individuals ages 21 and older).

B. Serious Mental Illness and Substance Use Disorder Populations

Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder (excluding development and substance use disorders) among those currently diagnosed or within the past year, is of sufficient duration to meet diagnostic criteria specified within the DSM-V, and results in serious functional impairment, which substantially interferes with or limits one or more major life activities.[1] The general description normally involves one or a combination of the following conditions: Psychotic disorders, bipolar disorders major depression, schizoaffective disorder, delusional disorder, or obsessive-compulsive disorder.

The prevalence of SMI among adults ages 18-64 was 5.2% in Florida (6.0% nationally) in 2012.[2] Many individuals with SMI lack insight into the illness and, as a result, may be resistant to psychiatric treatment (including medication adherence). These individuals may suffer from overt psychotic symptoms such as hallucinations and delusional thinking, severe depression, problems with substance use, social impairment, co-morbid medical conditions such as hypertension and diabetes, and incidences of criminal justice involvement. For this group, recovery from the illness can be difficult. Additional areas of consideration identified in research literature and by national quality organizations include: low quality medical care, underuse or overuse of services, lack of medication adherence, and lack of housing and transitional services.

Substance Use Disorders (SUD) are defined as the use, abuse, or dependence of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[3] The level of severity can be indicated as mild, moderate, or severe. The prevalence of SUD among uninsured adults ages 18-64 in Florida is 13.7% (14.6% nationally) in 2012.[4]

Individuals with SUDs encounter various academic, health-related, relational, and legal challenges. These issues bring cost and consequences to families, communities, and society. There is a high incidence of substance abuse among individuals diagnosed with a serious mental illness; this is commonly referred to as having co-occurring disorders. As compared to a person with either a mental illness or SUD alone, those with co-occurring disorders often have significantly more impairment in functioning, more severe symptoms,

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[1] National Institute of Mental Health (2016). Serious mental illness (SMI) among U.S. adults. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml

[2] SAMHSA (March 2012). Enrollment under the Medicaid expansion and health insurance exchanges: A focus on those with behavioral health conditions in Florida. Retrieved from http://store.samhsa.gov/shin/content//PEP13-BHPREV-ACA/NSDUH_state_profile_Florida_508_final_exam.pdf

[3] http://www.samhsa.gov/disorders/substance-use

[4] SAMHSA (March 2012). Enrollment under the Medicaid expansion and health insurance exchanges: A focus on those with behavioral health conditions in Florida. Retrieved from http://store.samhsa.gov/shin/content/PEP13-BHPREV-ACA/NSDUH_state_profile_Florida_508_final_exam.pdf

and are at an increased risk of health problems, hospitalization, incarceration, and suicide, amongst other negative consequences.[5]

[5] Weatherford, J.A. (2012). Co-occurring mental health and substance use disorders: A review of issues and clinical approaches for dual diagnosis. *Research Papers,* Paper 209.

Section II. Florida's System of Care Overview

A. The Agency for Health Care Administration, Florida Medicaid Program

Medicaid is an entitlement program that provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, in accordance with federal requirements codified in the Social Security Act. The Agency for Health Care Administration is the single state Medicaid agency responsible for administering the Florida Medicaid program. Each state operating a Medicaid program has a state plan, which serves as an agreement between the state and the federal government describing how that state administers its Medicaid program. States can also request approval from the federal Centers for Medicare and Medicaid Services (CMS) for a waiver of certain requirements found in 1902(a) of the Social Security Act. Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid. There are three primary types of waivers and demonstration projects:

- Section 1115 Research & Demonstration Waivers
- Section 1915(b) Selective Contracting/Managed Care Waivers
- Sections 1915(c) Home and Community-Based Services Waivers

The Agency administers numerous waivers under the Florida Medicaid program. See Attachment I for a detailed description of each waiver.

Medicaid is jointly funded by states and the federal government. For every dollar that a state government spends on Medicaid, the federal government pays an average of 57 cents (and between 90 and 100 cents of every dollar for those who are newly eligible under the Affordable Care Act Medicaid expansion provision). As of December 2015, it is estimated that over 72 million people are covered by Medicaid nationwide and the program costs accounted for over $532 billion in spending in the federal and state budgets. In state fiscal year 2016-2017, Florida's Medicaid program is estimated to cost $25.8 billion and is projected to serve approximately 4.0 million Floridians.

The Florida Medicaid program provides a comprehensive benefit package for eligible recipients. Recipients under the age of 21 years are entitled to a comprehensive array of prevention, diagnostic, and treatment services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible.

The behavioral health services that are covered under the Medicaid state plan for adults and children include:

- Psychiatric physician services

- Individual, group, and family therapy services
- Assessment services
- Support/rehabilitative services
- Mental health targeted case management
- Inpatient hospital services (psychiatric and medical detoxification services)
- Substance abuse county match services

In addition to the services listed above, recipients under the age of 21 years are also eligible to receive the following:

- Therapeutic group care services
- Specialized therapeutic foster care services
- Statewide Inpatient Psychiatric Program services
- Therapeutic behavioral on-site services

See Attachment II for a more detailed description of the services covered under the Florida Medicaid program, including the associated rates listed on the fee schedule.

Statewide Medicaid Managed Care – Managed Medical Assistance Program

Florida has transitioned to a delivery model wherein the majority of fully Medicaid eligible recipients receive their services through a health plan. The Statewide Medicaid Managed Care (SMMC) program was fully implemented in August 2014 and has two components: the Managed Medicaid Assistance (MMA) program and the Long-term Care program [see Part IV of Chapter 409, Florida Statutes]. The Agency received approval from CMS to operate the MMA program through an 1115 Research and Demonstration waiver.

The MMA program covers most medical and acute care services for health plan enrollees, including substance use and mental health treatment services. The objectives of the SMMC program are to improve health outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. These objectives are achieved by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and a high rate of customer satisfaction. Florida Medicaid actively encourages all stakeholders to report any potential issue, concern, or complaint regarding the SMMC program to the SMMC Complaint Operations Center. This is one mechanism that enables the Agency to remain aware of performance of the SMMC program.

The goals of the SMMC program are depicted below in Figure 1.

Figure 1: SMMC Goals

Most Medicaid recipients who are eligible for the full array of Medicaid benefits are enrolled in a health plan. In addition to providing coverage for an array of substance use and mental health treatment services, health plans are required to coordinate all aspects of care for their enrollees including the coordination of services that are not covered by the plan. Through care coordination efforts, health plans are responsible for assessing enrollees and identifying factors that may impact their ability to manage health care needs, such as homelessness and comorbid conditions. Specifically, health plans are responsible for:

- Developing a process that plans, implements, coordinates, evaluates, and monitors the options and services required to meet an enrollee's health needs using available resources to promote quality outcomes.
- Providing proper care coordination/case management across the continuum of care and making appropriate referrals to ensure needs are met.
- Providing outreach to enrollees experiencing homelessness or who are at risk for involvement with the court system.
- Maintaining written protocols for identifying, assessing and implementing interventions for enrollees with complex medical issues, high service utilization, intensive health care needs, or who consistently access services at the highest level of care.
- Conducting comprehensive assessments that identify enrollee needs across multiple domains (e.g., current medical/behavioral health needs, caregiver support availability, transportation barriers, medication management, and treatment preferences).
- Developing a comprehensive treatment plan that contains goals that are outcomes based and measureable and include the interventions and services to be provided to obtain goals. Interventions should include community service linkage, improving support services and lifestyle management as appropriate based on the enrollee's identified issues.
- Identifying enrollees with co-morbid mental health and substance abuse disorders, including through a depression screening, and addressing those disorders.

Medicaid health plans can provide additional behavioral health services that are not covered under the state plan, called "in lieu of" services. In lieu of services are offered as an alternative to services covered under the State Plan when the health plan has determined that the alternative service is a medically appropriate and cost effective substitute. Some health plans have received approval from the Agency to cover in lieu of services including: peer support, ambulatory detoxification, community-based wrap around, and mobile crisis services. In addition, health plans have the option to provide expanded benefits, which are offered to all enrollees in specific population groups, for which the plan receives no direct payment from the Agency. Examples of expanded benefits include, but are not limited to: adult dental services, adult hearing services, newborn circumcision, etc.

Health plans can participate in the MMA program as a standard plan or a specialty plan. A specialty plan is a type of MMA plan for Medicaid recipients who have a chronic medical condition or a specific diagnosis, or who are in a certain age range. The MMA specialty plans cover the same health care services as the standard MMA plans. Specialty plans are required to have enhanced care coordination and provider network standards and may offer expanded benefits that are more targeted to the population that they serve. The Agency contracts with Magellan Complete Care as a specialty plan to

serve recipients diagnosed with a serious mental illness. Currently, Magellan Complete Care has over 58,000 enrollees and provides services in most areas of the state.

Medicaid Expenditures on Behavioral Health Services

The table below demonstrates the Medicaid program expenditures for behavioral health services provided to 352,517 Medicaid recipients during state fiscal year 2015-2016. Total expenditures, including those made through the fee-for-service program and the SMMC program, were $614,252,990.

Table 1: Medicaid Total Expenditures

Total Medicaid Expenditures for Substance Abuse and Mental Health Treatment Services		
Service	**FFS Amount**	**Encounter Health Plan Payment***
Substance Abuse Services	$ 982,335	$ N/A
Mental Health Services	$ 216,806,246	$ N/A
Behavioral Health Services (Total)	$ 217,788,581	$396,464,409

These numbers represent the amount that health plans paid to their providers. Data Source: SQL Server FY1516 Claim and Encounter Table as of 9/26/2016

B. The Department of Children and Families, Substance Abuse and Mental Health

The Department of Children and Families (DCF) Office of Substance Abuse and Mental Health (SAMH) serves as the single state authority for mental health and substance abuse services and is comprised of four major areas:

- Community Substance Abuse and Mental Health
- State Mental Health Treatment Facilities
- The Sexually Violent Predator Program
- Quality Assurance

The Office of Substance Abuse and Mental Health administers a statewide system of safety-net services for substance abuse and mental health prevention, treatment, and recovery services. This system serves children and adults who are otherwise unable to obtain mental health and substance abuse treatment services. This group includes individuals who are eligible for Medicaid, Medicaid enrolled individuals who require services not covered under Florida Medicaid, and those who are not financially able to cover medical expenses independently.

Florida law requires DCF to implement a system of care to provide substance abuse treatment and mental health services as follows:

Substance Abuse Services

The Department of Children and Families is authorized to provide substance abuse services to the following priority populations:

- Adults who have substance abuse disorders and a history of intravenous drug use
- Individuals diagnosed as having co-occurring substance abuse and mental health disorders
- Parents whose substance abuse disorder put their children at risk for involvement in the dependency system
- Individuals who have a substance abuse disorder and have been ordered by the court to receive treatment
- Children at risk for initiating drug use
- Children under state supervision
- Children who have a substance abuse disorder but who are not under the supervision of a court or in the custody of a state agency
- Individuals identified as being part of a priority population as a condition for receiving services funded through federal Substance Abuse Treatment and Prevention Block Grants

The Department of Children and Families' system of care is required to prevent and remediate the consequences of substance abuse for persons with substance abuse problems through the provision of a comprehensive continuum of accessible and quality substance abuse prevention, intervention, and treatment services in the least restrictive environment of optimum care (see section 394.67, F.S.). The system of care is comprised of the following broad categories of substance abuse services:

- Prevention services
- Assessment services
- Intervention services
- Rehabilitation services
- Ancillary services, including:
  - Self-help and other support groups and activities
  - Aftercare provided in a structured, therapeutic environment
  - Supported housing
  - Supported employment
  - Vocational services
  - Educational services

Mental Health Services

The Department of Children and Families is authorized to provide mental health services to the following priority populations:

- Adults who have severe and persistent mental illness, including:
  - Older adults in crisis

    - Older adults who are at risk of being placed in a more restrictive environment because of their mental illness
    - Individuals deemed incompetent to proceed or not guilty by reason of insanity under chapter 916, F.S.
    - Other persons involved in the criminal justice system
    - Individuals diagnosed as having co-occurring mental illness and substance abuse disorders
    - Individuals who are experiencing an acute mental or emotional crisis
- Children who are at risk of emotional disturbance
- Children who have an emotional disturbance
- Children who have a serious emotional disturbance
- Children diagnosed as having a co-occurring substance abuse and emotional disturbance or serious emotional disturbance

The Department of Children and Families' system of care related to mental health services is designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders (see section 394.67, F.S.). The system of care is comprised of the following broad categories of mental health services:

- Treatment services
- Rehabilitative services, including:
    - Assessment of personal goals and strengths
    - Readiness preparation
    - Specific skill training
    - Designing of environments that enable individuals to maximize functioning and community participation
- Support services, including:
    - Income supports
    - Housing supports
    - Vocational supports
- Case management services

The majority of individuals within this population receive services in the community; individuals who require a more restrictive clinical setting are served in state funded mental health treatment facilities.

Managing Entities

In the past, the Office of SAMH contracted directly with behavioral health providers to implement services. The Florida Legislature found that a managing structure that places responsibility for publicly-funded behavioral health services in local entities would promote access to care and continuity, be more efficient and effective, and streamline administrative processes to create cost efficiencies and provide flexibility to better match services to need. As a result, the Office of SAMH now contracts with seven managing entities for the

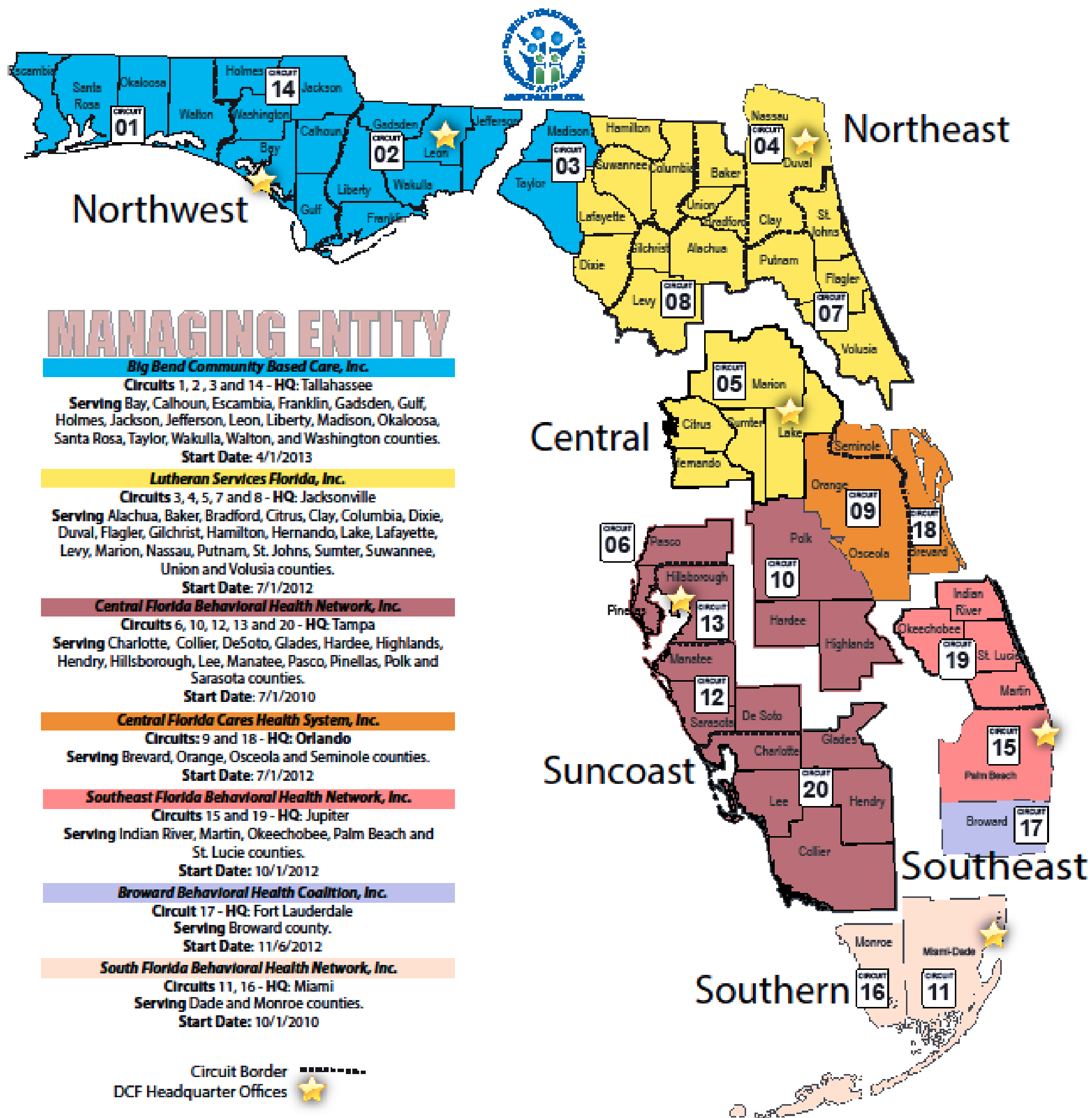
administration and management of regional behavioral health systems of care throughout the state.

The managing entities are private, non-profit organizations responsible for planning, implementation, administration, monitoring, and data collection, reporting, and analysis for behavioral health care in their regions. Managing entities do not provide services, but contract with local service providers for the provision of prevention, treatment, and recovery support services. Procurement of the contracts with the managing entities is governed by both Chapter 287, F.S., which applies generally to all state contracts, and section 402.7305, F.S., which applies specifically to DCF contracts. In accordance with both Florida and federal law, the contracts were competitively procured. The contracts with each managing entity are based upon a fixed-payment methodology, where the managing entity receives the equivalent of a two-month advance payment, and equal monthly payments thereafter. The managing entity is also permitted to carry up to 8% of state general revenue from fiscal year to fiscal year, for the life of the contract.

In state fiscal year 2015-2016, there were 303,768 clients served through DCF's system of care (238,286 adults and 66,995 children).

The Department of Children and Families contracts with the following managing entities listed in Figure 2.

Figure 2: DCF Managing Entities by Counties Served



General Revenue and Block Grant Funding

The services provided through DCF's system of care are funded through state general revenue, federal discretionary grants, county matching funds, and federal block grant funding. A block grant is a noncompetitive, formula grant mandated by the U.S. Congress. Eligible entities must submit an annual application to demonstrate statutory and regulatory compliance in order to receive the formula-based funding. The Department of Children and Families is currently approved on an annual basis for the following federal block grants related to substance abuse and mental health: the Substance Abuse Prevention and Treatment Block Grant (SAPT) and the Community Mental Health Block Grant (MH).

States are required to maintain non-federal funding (i.e., state general revenue) for activities described in the block grant application at a level which is not less than the average eligible expenditures reported for such activities during the two fiscal years prior to receiving the grant – this is called maintenance of effort (MOE). In addition to MOE requirements, states are also required to meet threshold spending amounts for specific target populations. These thresholds are based on the reported expenditures for a particular fiscal year specified in federal statute. The underlying principle of this provision is to ensure that federal grantees (and cooperative agreement awardees) are committed to maintaining the same level of services already being provided after receipt of a federal grant award. More specifically, the federal government wants grantees to rely on state and local funds as much as possible in order to maximize those resources thus ensuring that federal funds supplement rather than supplant normal activities.

The SAPT and MH block grants received by DCF have MOE and threshold requirements. According to DCF, state general revenue funds that must be maintained for MOE purposes can also serve a dual purpose and be used as the state match to receive federal Medicaid funding for covered services provided to Medicaid recipients. The expenditures must be reported to the Substance Abuse and Mental Health Services Administration (SAMHSA) and meet all applicable service level information. In addition, the use of this funding for federal Medicaid match obligates DCF to meet Title XIX CMS 64 reporting requirements as well. The table below demonstrates managing entities' budget for behavioral health services during SFY 15-16.

Table 2: Managing Entity Budget SFY 2015-2016

Total Managing Entity Budget for Adult and Children Substance Abuse and Mental Health Services	
Service	Managing Entity
Substance Abuse Services	$224,719,253
Mental Health Services	$337,870,637
Behavioral Health Services (Total)	$562,589,890*

* The listed figure does not include the cost of operational expenditures.

C. Collaboration and Integration Efforts

Collectively, Florida Medicaid and DCF cover a comprehensive array of behavioral health services. The table below compares the services available through both Florida Medicaid and the managing entities.

Table 3: Services Covered by Medicaid and DCF for Adults

Behavioral Health Services (Available for Adults)	Medicaid	DCF
Assessment/Treatment Plan Development and Modifications		
Assessment	X	X

Treatment Plan Development	X	X
Treatment Plan Review	X	X
Therapy Services		
Group Therapy	X	X
Individual Therapy	X	X
Family Therapy	X	X
Psychosocial Rehabilitation		
Outpatient Detoxification		X
Day Treatment	X	X
Supportive Housing*	X	X
Supportive Employment		X
Recovery Support (Individual/Group)**	X	X
Mental Health Clubhouse Services	X	X
Medication-assisted treatment services	X	X
Medical Services	X	X
Residential Services		
Residential Treatment		X
Room and Board w/Supervision		X
Case Management Services		
Case Management	X	X
Intensive Team Case Management		X
Crisis Management		
Crisis Stabilization***	X	X
Crisis Support		X
Substance Abuse Inpatient Detoxification	X	X
Inpatient Hospital Services	X	X
Other Support Services		
Day Care Services		X
Drop-in Center/Self Help		X
Respite		X
Intervention (Individual/ Group)		X
Treatment Alternative for Safer Communities (TASC)		X
Incidental Expenses		X
Aftercare/Follow-up		X
Outreach		X
Florida Assertive Community Treatment (FACT)		X
Prevention		X
Comprehensive Community Service Team		X

*The Agency is seeking approval for a pilot to provide housing support services under the Medicaid MMA program.
**These services can be received through the Medicaid's therapy benefit.
***Florida Medicaid's health plans have the flexibility to offer this service as an in lieu of service when medically appropriate.

DCF and the Agency's behavioral health services are intended to complement each other, establishing a comprehensive system of care. Florida Medicaid provides medically necessary behavioral health services up to specified limits. DCF funds rehabilitative and community support services, essential to the successful recovery of a person, including services not covered by Medicaid. As an example, DCF can cover services in an institution for mental disease, provide housing financial support (i.e., room and board), and provide services to incarcerated individuals, which are not generally allowable under Medicaid programs. DCF offers community-based services as well,

such as individual therapy, intended to serve uninsured individuals or Medicaid recipients whose service needs exceed the limit established by Medicaid or are deemed not medically necessary.

Collaboration among the Agency and DCF is essential to aid in the continual integration of services under Florida's behavioral health system of care which will serve to avoid duplication of services and eliminate undue confusion for individuals seeking care. Both agencies continually seek ways to further improve upon this framework to provide the best quality services to the SMI and SUD population. Most recently, the Agency and DCF implemented an initiative to enroll all managing entities as Medicaid providers to afford managing entities greater access to Medicaid eligibility and health plan enrollment information. In August 2016, the SMMC contract was amended to require health plans to coordinate with DCF's managing entities to establish specific organizational supports and protocols that enhance the integration and coordination of primary care and behavioral health services. The Agency and DCF are actively working to operationalize these new contract requirements.

Section III. Evaluation of Revenue Maximization Options

A. Eligible General Revenue Funding

As required by Senate Bill 12 (codified in section 394.761(2), F.S.), DCF has identified $412,411,814[6] in general revenue funding appropriated during fiscal year 2016-2017 for mental health and substance abuse services that may be eligible to be used as state match to receive additional federal Medicaid funding depending upon the delivery system enhancements that are implemented. The entirety of this funding is allocated within DCF's substance abuse and mental health budget, as appropriated by the Florida Legislature. Of the $412.4 million identified, $190.8 million is tied to MOE requirements for the SAPT and MH grants currently awarded to DCF.

The following chart provides the budget by fund source type allocated to the Managing Entities for State Fiscal Year 2016-17. This table breaks out both the Federal and State sources including MOE.

Table 4: Managing Entities Funding Sources

	Funding Source	Description	Total Budget
1	Federal	Mental Health Block Grant	33,026,605
2	Federal	Substance Abuse and Mental Health Services Federal Project Grants	8,415,679
3	Federal	Substance Abuse Prevention and Treatment Block Grant	122,422,116
4	Federal	Temporary Assistance for Needy Families	13,529,978
5	Federal	Title XIX Medicaid Administration	8,972,330
6	Federal	Title XXI Children's Health Insurance Program	5,481,296
7	**Total Federal Sources**		**191,848,004**
8	State	MOE Mental Health Block Grant	87,640,612
9	State	MOE Substance Abuse Block Grant (Must Remain in Cognizant Program Budget)	103,145,590
10	State	Match Title XIX Medicaid Administration	8,972,330
11	State	MOE Temporary Assistance for Needy Families	14,319
12	State	State General Revenue - Non MOE *(includes $795K Fee Funding)*	180,157336
13	State	State General Revenue - Non MOE Special Projects	41,453,957
14	**Total State Sources**		**421,384,144**
15	**Total Managing Entity Budget By Source SFY 2016-17**		**613,232,148**

[6] This number was derived by adding lines 8, 9, 11, 12, and 13 in Table 4.

The Legislature further directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding, including the following:

1. Seeking Medicaid eligibility for the severely and persistently mentally ill or persons with substance use disorders who are not currently Medicaid eligible
2. Covering targeted case management for individuals with substance use disorders as a Medicaid-funded service
3. Adjusting the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders
4. Increasing Medicaid reimbursement rates for behavioral health services
5. Making supplemental payments to mental health and substance abuse service providers who serve Medicaid recipients through a designated state health program or other mechanisms
6. Implementing innovative programs to provide incentives for improved outcomes for behavioral health conditions

This section of the report evaluates ways in which the above referenced objectives could be accomplished. Because children can receive all medically necessary services through Florida Medicaid regardless of any service limitations that may be specified in policy, the focus of this revenue maximization exercise is on adults (recipients ages 21 and older). In addition, this report explores how maximizing federal Medicaid funding can assist DCF in redirecting some state general revenue to meet the needs of other vulnerable populations who, as a result of their mental illness and/or substance abuse disorder, require a more intensive level of community-based services and supports. Without these services, this population experiences multiple admissions/readmissions to emergency rooms, inpatient settings, and short-term acute care settings; and has high rates of homelessness and arrest. These individuals include:

- Individuals with mental health or substance abuse disorders enrolled in Medicaid Managed Medical Assistance plans that represent the highest 15-20% of plan expenditures
- Individuals with a mental illness awaiting discharge from state treatment facilities
- Individuals with multiple admissions to community acute care settings including: psychiatric inpatient units, crisis stabilization units, addiction receiving or detoxification facilities
- Individuals with criminal justice involvement, with a mental illness or substance use disorder requiring services as a result of their release from jail, Department of Corrections, or court ordered treatment
- Parents and caretakers with substance abuse and/or mental health issues who have children involved in the state's child welfare system
- Mothers with substance use disorders

Although these individuals represent a small number of individuals as compared to the overall Medicaid or SAMH caseload, they represent an inordinate level of demand on

services and are very high cost to multiple health care, rehabilitative, social services and community providers.

B. Federal Authorities

In order to implement one or more of the alternative options, the Agency would likely need to seek authority from CMS through a Medicaid waiver. Though use of a Medicaid State Plan amendment is the most common means of seeking authority, it does not afford much flexibility to achieve the intent of the bill language. A brief description of each waiver option is presented below in order to facilitate the discussion throughout the report.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

There are general criteria CMS uses to determine whether Medicaid program objectives are met. These criteria include whether the demonstration will:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- Improve health outcomes for Medicaid and other low-income populations in the state; or
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Demonstrations must also be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending would have been without the demonstration[7].

An 1115 Research and Demonstration Waiver is the broadest and most flexible authority in which the State can implement strategies to achieve many of the funding alternative options described in Senate Bill 12 for the target population.

Section 1915 Home and Community-Based Services Waivers

Home and community-based services (HCBS) provide opportunities for Medicaid recipients to receive services in their own home or community rather than institutions or other isolated

[7] https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html

settings. These programs serve a variety of targeted population groups, such as people with intellectual or developmental disabilities, physical disabilities, and mental illnesses or co-occurring mental illness and substance use disorders. Below is a brief overview of the two HCBS options that appear most viable in achieving the objectives set forth in the SB 12.

Table 5: Overview of 1915(c) and 1915(i) Home and Community-Based Services Waivers

SECTION 1915 (c) and (i) WAIVERS		
	Home and Community-Based Services 1915(c)	**Home and Community-Based Services 1915(i)**
Authority Type	Waiver	State Plan Option
Requirements Waived	• Comparability • Community income rules • Statewideness	• Comparability • Community income rules
Purpose	Provides home and community-based services to individuals who met institutional level of care, however prefer to receive long-term care services and supports in their home or community	Provides home and community-based services to individuals who require less than institutional level of care and who would therefore not be eligible for a §1915(c) HCBS waiver. Also allows states to provide services to individuals who meet institutional level of care.
Services	States can offer services that are not covered in the State Plan (like homemaker services, adult day health services, programs can also offer medical services and assistive technology) and long-term/home and community-based services (like respite, case management, supported employment and environmental modifications). States cannot cover room and board costs or educational services covered under the Individuals with Disabilities Education Act (IDEA).	States can offer a combination of acute-care medical services (like dental services, skilled nursing services) and long-term/home and community-based services (like respite, case management, supported employment and environmental modifications). States cannot cover room and board costs or educational services covered under the Individuals with Disabilities Education Act (IDEA). Must provide services statewide to all eligible target groups.
Clinical Eligibility	States can make waiver services available only to people with specific needs and risk factors or choose to target services on the basis of disease or condition. Allows states to target benefits to one or more target populations.	States can make waiver services available only to people with specific needs and risk factors or choose to target services on the basis of disease or condition. Allows states to target benefits to one or more target populations.

SECTION 1915 (c) and (i) WAIVERS		
	Home and Community-Based Services 1915(c)	**Home and Community-Based Services 1915(i)**
Financial Eligibility	Institutional financial eligibility criteria, which, expands income eligibility criteria to 300 percent of the Federal SSI benefit which is approximately 222% of the Federal Poverty Level; applies spousal impoverishment rules; does not deem parental income for dependent children; and allows exclusions from countable income when determining financial eligibility for services.	Individuals eligible for Medicaid under the state plan up to 150% of the Federal Poverty Level. May include special income group for individuals meeting an institutional level of care criteria (with incomes up to 300% of the SSI FBR).
Limits on the number of people served	Allowed	Not allowed
Waiting Lists	Allowed	Not allowed
Approval Duration	Initially three years and renewed in five-year increments.	One-time approval except when states choose to target the benefit to a specific population(s). If a state is targeting the benefit to certain populations, renewal is required every 5 years. Changes must be submitted to CMS and approved.
Self-Direction	Allowed	Allowed
Geographic Limitations	Allowed	Not allowed

C. Seeking Medicaid Eligibility for the SMI and/or SUD Population

Background

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to seek Medicaid eligibility for the severely and persistently mentally ill or persons with substance use disorders. This section of the report evaluates how this objective can be accomplished.

Medicaid eligibility in Florida is determined either by the DCF or the Social Security Administration (for individuals with Supplemental Security Income (SSI)). The Department of Children and Families determines Medicaid eligibility for:

- Parents and caretaker relatives of children under age 18
- Children (including newborns) up to 21 years of age
- Pregnant women
- Former foster care individuals

- Child in care:
  - Foster care
  - Special need adoption children
- Non-citizens with medical emergencies
- Aged or disabled individuals not currently receiving SSI
- Other populations including presumptively eligible newborn and pregnant women, family planning and women in the breast and cervical cancer program, which may be determined by qualified designated providers or with assistance from other state agencies providing screening and clinical eligibility criteria.

The Social Security Administration's eligibility determination for individuals with SSI includes the aged, blind, and disabled. In Florida, SSI recipients are automatically eligible for Medicaid. In order to qualify for Medicaid, individuals must meet categorical and financial (income/asset) requirements. In addition, the individual must meet citizenship and Florida residency requirements. Financial requirements are as follows:

Family-related Group	**Income Limit**
Children Under age 1	200% Federal Poverty Level
Children age 1 through 18 years	133% Federal Poverty Level
Pregnant Women	185% Federal Poverty Level
Parents, Caretakers, Children ages 19 – 20 years.	Approximately 18% Federal Poverty Level

Options

(1) The Agency could seek federal approval through an 1115 waiver to extend Medicaid eligibility for individuals contending with SMI or SUD who currently are served through DCF's system of care and who do not meet the criteria for any of the eligibility categories listed above. The individual would have to meet the basic minimum requirements specified below, in additional to any other technical requirements specified by DCF.

- Be 21 years or age or older and under age 65 years
- Not pregnant
- Not entitled to or enrolled in Medicare benefits under part A or B
- Not otherwise eligible for and enrolled in mandatory coverage under Florida Medicaid
- Have a household income that is at or below 100 percent of the federal poverty level (FP) for the applicable family size. Note: One hundred percent of the FPL is the minimum amount of income an individual can have and qualify for financial

assistance provided under the Affordable Care Act (ACA) when purchasing coverage through health insurance Marketplaces (also called exchange plans).

The Agency selected the criteria referenced above to address gaps in coverage for childless adults not currently eligible for Medicaid and who are also not eligible for coverage through an exchange plan or other plan purchased in the individual market.

There are approximately 132,940 individuals currently being served by DCF who meet the eligibility criteria specified above. The DCF is currently spending general revenue funding on this population to provide both Medicaid covered services and non-Medicaid covered services. If directed to extend Medicaid eligibility for individuals contending with SMI or SUD as described above, the receipt of federal matching funds for services provided to this population will free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services through DCF. This general revenue may be needed to fund expenditures as described below.

If the Agency sought authority for the population to gain full Medicaid benefits, they would be eligible for the array of medical, behavioral, and dental benefits currently available for adults under the Medicaid state plan. This may result in additional expenditures on medical/dental care that is not provided by DCF for this population, and the savings derived from the receipt of federal match for services provided to this population would likely need to be used to offset the costs associated with the medical and dental care not currently furnished by DCF; otherwise, the Legislature would have to appropriate additional general revenue to cover these costs.

a. Alternatively, the Agency could seek through the 1115 more limited eligibility options as listed below:
   - Limited Medicaid benefits (behavioral health services currently covered by DCF as described in Table 3 on page 18 of this report) for all adult individuals contending with SMI or SUD who currently are served through DCF's system of care and who do not meet the criteria for any of the eligibility categories listed on page 24.
   - Full Medicaid benefits for mothers of substance exposed newborns, for a period of three years after the birth. According to DCF, Florida is experiencing an increase in the rates of substance exposed newborns. Typically, the mother will lose her Medicaid eligibility three months after the birth of the child. Extending eligibility for mothers of substance exposed newborns would enable the mother to receive critical services that may aid in recovery. The number of potential individuals meeting this criterion is indeterminate, but is estimated to be substantially less than the larger target population described earlier.
   - Full Medicaid benefits for parents and caretakers of children involved in the state's child welfare system who are contending with substance use disorders

and co-occurring mental illness. When these children are removed from the home, many parents lose their Medicaid eligibility and cannot access medical, behavioral health, and rehabilitative services that are essential to restore the parents and caretaker's capacity to effectively care for their children. There are approximately 27,000 individuals who meet this criterion and are receiving services through DCF.

Unless otherwise exempted in state law, these newly eligible individuals would receive the majority of their medical care through an MMA plan, which would provide an opportunity for better integration and coordination of both medical and behavioral health care through an MMA health plan.

(2) Through other waiver authorities, such as the HCBS 1915(i) or 1915(c) waivers, the Agency could offer a limited array of services needed by the most vulnerable and at-risk individuals within the target population (i.e., individuals with multiple psychiatric admissions within a year, etc.), while also enabling these individuals, who would not otherwise qualify for Medicaid, to become eligible. The Agency could model the waiver program after states like Connecticut and Montana who have sought and received federal approval to serve this target population through 1915 HCBS waivers. An example of the eligibility criteria that could be utilized to serve the SMI and/or SUD population in Florida under a 1915(i) or 1915(c) waiver include:

- Be 21 years old or older
- Meet the following clinical eligibility criteria (e.g., be diagnosed with an SMI or SUD; have two or more inpatient psychiatric admissions or residential treatment admissions in two years or have a single inpatient psychiatric admission exceeding a 30-day length of stay; be unable to work full time; require supervision and support; be homeless or at risk of homelessness; be at greater risk for having an acute episode; etc.)
- Meet financial (income and asset) eligibility criteria

Through a 1915(i) waiver, the Agency would not be able to cap enrollment/participation levels. However, through a 1915(c) waiver, the state could limit participation as directed by the Legislature, thereby better controlling costs and forecasting expenditures in the long-term. A state must include in its waiver application request, the list of home and community-based services that will be available to recipients enrolled in the 1915(c) or 1915(i) waiver. Services that may be beneficial for this population include peer support, crisis support, and supported employment. These services are not currently available through the Medicaid state plan, but are covered by DCF. In addition, waiver participants would receive case management services to assist with their recovery and/or stabilization.

Again, unless otherwise exempted in state law, these newly eligible individuals enrolled in the 1915(c) or 1915(i) waiver would receive the majority of their medical care through

an MMA plan. The State would have to decide how recipients will receive the covered home and community-based services (e.g., fee-for-service, managed care, etc.). Options are provided below for consideration:

- The Agency could enter into contracts with the managing entities to provide the home and community-based services through a capitated or fee-for service payment arrangement. The managing entities are already providing the types of services that would likely be included in the HCBS waiver application; this option also leverages the existing systems (e.g., provider network) that are in place to serve this population.
- The Agency could contract with the MMA plans to provide the home and community-based services through a capitated payment arrangement. This option provides an opportunity for the majority of the recipient's behavioral health care to be provided through a single entity – the MMA plan.

Regardless of the waiver authority sought (e.g., 1115 or 1915 HCBS waiver), the Agency will likely need to engage in extensive negotiations and discussions with CMS prior to receiving federal approval to implement any of these options. In addition, once approved, administration and maintenance of these waivers generally come with increased federal reporting and oversight requirements to ensure funding is being expended as stated in the approved waiver application. It would likely take the Agency and DCF approximately 12 – 18 months to fully implement any of these options (this includes obtaining federal approval and engaging in transition activities).

D. Covering Targeted Case Management and Other Services as Medicaid-Funded Services for the SUD Population

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to cover targeted case management as a Medicaid-funded service for the SUD population. This section of the report evaluates how this objective can be accomplished and also explores additional services currently not covered by Medicaid.

Targeted Case Management

Targeted case management (TCM) are services that assist eligible individuals to gain access to needed medical, social, educational, and other services and are provided only to specific classes of individuals, or to individuals who reside in specified areas of the state (or both). Currently, under Florida Medicaid, TCM is a covered service for children and adults with a mental health diagnosis; children at-risk of abuse or neglect; children at risk of a developmental delay (birth up to age 3); and children receiving medical foster care services. Medicaid recipients who meet the eligibility criteria for mental health TCM with a co-occurring mental health and substance use disorder could receive TCM services through Florida Medicaid. However, individuals who are only diagnosed with a substance use disorder are not eligible to receive TCM through Florida Medicaid because TCM for the SUD population is not available through the Medicaid State Plan.

The Department of Children and Families currently covers TCM services for individuals with a SUD. There are approximately 8,051 Medicaid recipients with a SUD receiving TCM services through the managing entities using general revenue funding. If the Agency is directed to cover TCM for individuals with SUD under Florida Medicaid, the receipt of federal matching funds for TCM services for individuals with SUD will free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services under DCF.
Implementation of this option is most easily implemented through a state plan amendment. It generally takes the Agency 3 – 6 months to obtain CMS approval for state plan amendments; it can also be implemented through amendment of the existing 1115 MMA waiver. Approval of an 1115 waiver amendment request by CMS has no specific deadlines and typically takes 6 – 12 months.

The State would have to decide how recipients will receive this newly covered service. Options are provided below for consideration:

- The Agency could contract with the MMA plans to provide this TCM service (to the extent the recipient is mandatory for enrollment in a health plan). The MMA plans are responsible for coordinating all aspects of their enrollee's care. Requiring the MMA plans to provide this service reduces the opportunity for duplication of services, particularly for recipients with a co-occurring SMI and SUD who may be eligible for both mental health TCM services and this newly covered TCM for recipients with a SUD.
- The Agency could enter into contracts with the managing entities to provide TCM for recipients with a SUD; in this scenario, the service would be carved out of managed care for those recipients receiving services through a health plan. The managing entities are currently providing this service through its network of providers; this option avoids any disruption in care for recipients.
- The Agency could require the MMA plans to subcontract with the managing entities to provide the service. This option ensures continuity of care, facilitates greater collaboration among the MMA plan and the managing entities, and reduces opportunities for duplication. This, however, limits the health plans' flexibility to manage their network of providers.

Any option that requires the managing entities to contract directly with the Agency or the MMA plans in order to receive Medicaid reimbursement for services (i.e., the federal Medicaid match) would take time and careful planning. The managing entities are not required to reimburse for services using standard medical claims forms (i.e., UB-04 or CMS 1500) or standard transactions that are federally required to protect a patient's privacy and are needed for federal reporting purposes if the services are covered by Medicaid;

managing entities would likely need several months to adapt their systems to such a change.

Other DCF Funded Services

The Department of Children offers certain services, through its system of care, above the service level provided under Florida Medicaid. The services that are covered under Florida Medicaid that have specific coverage limitations that may be exceeded through DCF's system of care, include:

- Assessment services
- Group therapy
- Individual therapy
- Day treatment
- Medical services
- Case management
- Substance abuse inpatient detoxification
- Inpatient hospital services

The Department of Children and Families is currently spending general revenue funding on these services for individuals with SMI and SUD. One potential opportunity is to eliminate the service limitations that are in place under Florida Medicaid for these eight services that the Agency and DCF cover in common, eliminating the need for Medicaid recipients to access these services through the managing entities. If directed to cover these services in this manner, the receipt of federal matching funds would free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services provided through the managing entities.

Since these services are already covered under Florida Medicaid, it would be fairly seamless to require the MMA health plans to provide the services through their networks of providers. This option provides administrative simplification for providers, eliminating the need for providers to have to seek payment from two different payment sources for the same service provided to Medicaid recipients. As stated previously, it also affords greater coordination/integration of care as a single entity is responsible for providing like services.

Implementation of this option is most easily implemented through a state plan amendment. It generally takes the Agency 3 – 6 months to obtain CMS approval for state plan amendments; it can also be implemented through an 1115 waiver if the desire is to place certain restrictions in place that are not permitted for services covered through the state plan. Approval of an 1115 waiver amendment request by CMS typically takes 6 – 12 months.

The Department of Children and Families also offers (using state general revenue funding) certain services that are not covered at all under Florida Medicaid. The most heavily utilized

services by Medicaid recipients that are paid for by the managing entities are: residential services, room and board with supervision, incidental expenses, crisis stabilization, residential detoxification, supportive housing and supportive employment. If directed to cover these types of services in order to maximize federal Medicaid funding, the Agency could pursue authority through an 1115 waiver to provide these non-covered services (through the managing entities) to Medicaid recipients contending with an SMI and/or SUD.

In this model, the Agency would make direct payments to the managing entities for services provided – the services would be carved out of managed care. This framework permits all providers currently contracted with the managing entities to continue providing care with minimum impact to the recipients. This leverages the managing entities' knowledge, history, and relationships with non-traditional Medicaid providers and offers stability in the transition to a new payment source. It is recommended that the managing entities and the health plans be required to collaborate in the delivery of care to the recipients they have in common in order to further the goals of integration and improve care coordination for the population. It would likely take the Agency and DCF 12–18 months to fully implement this option (this includes obtaining federal approval and engaging in transition activities).

For reference purposes, Attachment III is a breakdown of services and units of service provided through the managing entities for non-covered Medicaid services.

E. Adjusting the Capitation Rate for Medicaid Enrollees with Chronic Mental Illness and Substance Use Disorders

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to adjust the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders. This section of the report evaluates how this objective can be accomplished.

Under the SMMC program, the State has contractual agreements with health plans to provide comprehensive health care services and coordinate all care delivered to Medicaid recipients. The Agency reimburses health plans with a monthly capitation payment. A capitation rate is a per-member, per-month amount, including any adjustments, that is paid by the Agency to a health care plan for each Medicaid recipient enrolled in the plan for the provision of Medicaid services during a payment period. The Agency calculates capitation rates annually.

Capitation rates for the MMA health plans are developed in accordance with 42 CFR 438.6. The Agency develops actuarially sound, risk-adjusted premiums by assessing historical Florida Medicaid expenditures and encounter data. Health-based risk adjusters use individuals' historical diagnoses to predict expected future expenditures more effectively than age and gender. The health-based risk adjustment provides a risk score for each

individual to reflect predicted health care needs. The scores of all of the recipients enrolled in each MMA plan determine the collective risk score, and the resulting capitation rates for that MMA plan. This approach provides an incentive for MMA plans to take all necessary steps to identify enrollees who have undiagnosed chronic conditions. The MMA plan may receive a higher premium only if an enrollee is diagnosed with a condition that merits the additional premium. Once an MMA plan identifies an enrollee with a chronic condition, it is in the plan's financial interest to properly manage the enrollee's condition to avoid the need for higher cost services typical of untreated chronic conditions.

If the Agency is directed to expand coverage for the SMI/SUD population or to cover additional services, as discussed thus far, the capitation rates paid to the health plans would need to be adjusted. One high-risk population group mutually served by the health plans and the managing entities are individuals with mental health or substance abuse disorders enrolled in MMA plans that represent the highest 15-20% of plan expenditures. By identifying general revenue dollars spent on this population that could serve as the match for federal Medicaid funding, the Agency could fund changes in the health plan contracts (reflected in the resulting capitation rates) that require the plans to provide additional health benefits for the target population, implement innovative quality improvement programs (such as the healthy behavior programs required by the Legislature in Part IV of Chapter 409, F.S.), or to pay providers more based on certain quality outcomes. This can also be accomplished if a portion of the general revenue savings achieved from implementation of any of the previously discussed options (in Sections III.C. and III.D. of this report) are used for this purpose. All of these initiatives would have an impact on the capitation rates to ensure they remain actuarially sound. If directed to implement such changes by the Legislature, it is recommended that the MMA plans partner with the managing entities (through formal or informal agreements) to effectuate the best outcomes. The idea of requiring plans to pay providers an increased rate based upon quality outcomes is explored in the next section of the report.

If the Agency adjusted the capitation rates for the MMA plans, the Agency would need to seek federal approval of these changes by submitting the SMMC contract amendment that contained the changes. The process to obtain CMS approval of the capitation rate changes can, at times, take several months.

F. Increasing Reimbursement Rates for Behavioral Health Services

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to increase reimbursement rates for behavioral health services. This section of the report evaluates how this objective can be accomplished.

Providers of mental health and substance abuse treatment services can be reimbursed for services in two ways. If the individual is enrolled in Medicaid, the provider can either submit claims directly to the Agency's fiscal agent if the recipient is receiving services through the

fee-for-service system or submit the claim directly to the appropriate MMA health plan if the recipient is enrolled in managed care. The Agency maintains a fee schedule that lists covered services and the fee-for-service rates paid by Medicaid for those services. They are promulgated in Florida Administrative Code, in accordance with Chapter 120, F.S. requirements. The rates listed on the fee schedule are established based on appropriations made by the Florida Legislature and are not modified unless the Legislature appropriates additional funding. Health plans have the flexibility to negotiate mutually agreed upon rates with their networks of providers, unless otherwise specified in Florida law. Fee schedules dictate payment under the fee-for-service system and health plans are not bound by the rates established on the Agency's fee schedules.

Managing entities pay their providers through availability or utilization based contracts. They have the flexibility to negotiate rates with their network of providers and are not bound by the rates that DCF previously paid providers when DCF contracted directly with the providers to render services. If an individual is not enrolled in Medicaid or any other health plan, mental health and substance abuse treatment providers may seek reimbursement for services through a managing entity.

In the context of revenue maximization, one of the ways that is feasible to increase rates for behavioral health services would be to reinvest any savings achieved through implementation of the other system reforms described thus far in this report in increased rates for providers. Given the heavy focus for both state agencies on ensuring the quality of care received, any rate increases for providers should be tied to performance. To the extent that the options that have been presented thus far generate additional funding, one option is to use the additional funding to enhance capitation rates paid to MMA plans or the amounts paid to the managing entities, requiring them to pay better performing providers higher reimbursement rates for services provided. For services provided in the fee-for-service delivery system, the Legislature could reinvest any savings achieved through appropriations to increase reimbursement rates for behavioral health services directly paid to providers.

G. Increasing Reimbursement Rates to Providers Through Incentive Payments

Another option is to require the MMA plans to contract with the managing entities to provide services and require that the plan establish certain benchmarks for the managing entities, that when met, entitles the managing entity to increased reimbursement for providing services.

One method of increasing awareness and focus on improved outcomes is through the development of an incentive payment program. Incentive payments are a mechanism that can be replicated within the MMA program and applied across a number of service areas including services for individuals contending with SMI and SUD. This strategy moves away from the traditional model of purchasing services based on quantity and toward value based purchasing focused on improving quality. In the incentive based model, providers are not

simply paid more for doing the same thing; they must achieve certain identified goals or improvements to earn the incentive payment.

For example, the Agency has designed a Managed Medical Assistance Physician Incentive Program that requires the health plans to furnish higher reimbursement to physicians out of the managed care savings they achieved from efficiencies through care coordination, as specified by section 409.967(2) (a), F.S. The intent of the program is to incentivize access and quality through select measures; qualified providers who meet the specific criteria are eligible for enhanced payments that are equivalent to Medicare rates.

Each health plan was granted the opportunity to either adopt an Agency defined Managed Medical Assistance Physician Incentive program or develop their own. The Agency had the ability to reject health plan proposals. A key component of this program is that all qualified providers must have a reasonable opportunity to earn the incentive payment. This incentive program is an example of one tool that could be used to enrich the quality of services provided to eligible Medicaid recipients by behavioral health providers contracted with Medicaid health plans.

If the Agency or DCF established a similar program for behavioral health services, there could be a focus on the following performance outcomes, as examples:

- Reduce the time of individuals' wait for discharge to less restrictive services
- Provide enhanced access to the most appropriate, least restrictive settings for care
- Reduce readmissions to most expensive community settings such as crisis stabilization units, inpatient detox
- Increase tenure in the community through stable housing, assertive community treatment, care coordination
- Reduce recidivism and increase successful community tenure for persons with high rates of arrest/incarceration
- Reduce costs associated with readmissions and recidivism to residential treatment

H. Making Supplemental Payments to Providers

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to make supplemental payments to mental health and substance abuse service providers through a designated state health program or other mechanisms. This section of the report evaluates how this objective can be accomplished through several different types of supplemental payment options, including:

- Intergovernmental transfers
- Certified public expenditures, and
- Designated State Health Program

Supplemental payments have historically been established to provide funding for services in specific facility settings such as hospitals, nursing facilities, intermediate care facilities for

individuals with intellectual disabilities, and clinics. In unique instances, supplemental payments have been approved by CMS for medical school faculty group physicians. Medicaid supplemental payment programs for mental health and substance abuse treatment providers are atypical, but that does not mean that the State could not seek and receive federal approval to implement such a program. The federal government would have full discretion to accept or reject the state's proposal. An 1115 demonstration waiver would be needed in order for these supplemental payments to be made to providers for services provided through a Medicaid health plan or for more complicated supplemental payment options such as Delivery System Reform Incentive Payment programs. For services provided through the Medicaid fee-for-service delivery system, most supplemental payment options can be implemented through a state plan amendment.

Intergovernmental Transfers

The primary source of funding for the non-federal share (the state share) for the Medicaid program comes from state general revenue fund appropriations. States can also fund the non-federal share of Medicaid with other state funds which may include funding from local governments or revenue collected from provider taxes and fees. Intergovernmental transfers (IGTs) are transfers of funds from another governmental entity (e.g., counties, local taxing districts, county health departments, publicly funded hospitals, and in some cases other state agencies) to the Medicaid agency which are used to draw down additional federal match for the Medicaid program. If IGTs were contributed for the purpose of funding behavioral health and substance abuse services, the increased funding generated through the use of IGTs could result in increased payments to safety-net providers, such as crisis stabilization units, community behavioral health centers, etc.

In recent years, there has been increased scrutiny at the federal level over states' use of IGTs and other types of supplemental payment funding. One disadvantage to this option is the potential for increased federal oversight and reporting requirements to ensure the funding is being used appropriately. More specifically, IGTs cannot be used as a funding source to:

- Raise the federal share of total Medicaid funding far above their nominal statutory federal matching rate
- Make federal matching funds available for purposes other than purchasing covered services for Medicaid recipients
- Inflate the overall Medicaid spending growth rates without commensurate increase in spending for services for Medicaid recipients
- Create incentive for states to reduce the use of public funding

The Agency and DCF would need to engage in further discussions with providers and local county governments to better determine the availability of IGTs that could be used for enhanced funding to behavioral health and substance abuse providers. The Florida legislature would also have to authorize the Agency to seek federal approval to implement the use of IGTs.

Certified Public Expenditures

Certified public expenditures (CPEs) can be implemented in the same fashion as the IGTs to provide increased payments to eligible providers such as publicly funded crisis stabilization units. CPEs are expenditures made by a governmental entity, including a provider operated by a state or local government, for health care services provided to Medicaid recipients. Federal rules allow certain health care provider organizations to utilize certified public expenditures to draw down federal funds to account for uncompensated costs for medical care provided to Medicaid recipients.

There are two primary requirements in order to receive federal match under a CPE methodology. First, providers are required to expend local funds in lieu of state funds. Second, providers cannot be reimbursed for more than the cost of providing the service. Under a CPE arrangement, no additional state general revenue is expended. This funding tool can also be used to offset payment differences to providers for Medicaid compensable services that DCF provides as well. Reducing the amount of uncompensated care experienced by providers may lead to an increase in access to services. In the state of Florida, CPEs account for 5.4 percent of the state's federal matching funds arrangements.[8]

The Agency and DCF would need to engage in further discussions with providers to better determine the availability of CPEs that can be used for enhanced funding to behavioral health and substance abuse providers. The Florida legislature must authorize the Agency to seek federal approval to implement CPEs.

Designated State Health Programs

Designated State Health Programs (DSHP) are health care programs that are funded only with state general revenue dollars that can be eligible to receive federal Medicaid funding, on a time limited basis, if they meet certain federal requirements.

DSHPs provide safety-net health care services for low-income or uninsured individuals (e.g., adult day care, outpatient substance abuse treatment, etc.). Federal funding for DSHPs generally support the goals of a health system transformation.

While CMS has not published any regulations or technical assistance on how to access DSHP funding, states that have received approval did so through an 1115 waiver. The National Governors Association published a toolkit called the *Future of Medicaid Transformation: A Practical Guide for States* that contains useful information about the design and implementation steps of DSHPs. To seek DHSP funding, states are required to clearly identify how funds will support Medicaid transformation and due to the time limited nature of the funding, how the efforts will be sustained once federal funding is no longer

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[8] United States Government Accountability Office (July 2014). Medicaid financing: States' increase reliance on funds from health care providers and local governments' warrants improved CMS data collection (GAO-14-627). Retrieved from: http://www.gao.gov/assets/670/665077.pdf

available. When requesting DSHP funding, states must provide CMS with detailed information on how the programs are currently funded, who is served, and how the program will be maintained once federal funding is no longer available. Approvals are made on a case-by-case basis through negotiations with CMS.

Documentation of each DSHP's expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS. In order to assure CMS that Medicaid funds are used for allowable expenditures, the state may be required to document DSHP payment requests through a specific accounting system. Sources of non-federal funding must be compliant with section 1903(w) of the Social Security Act and applicable regulations. Finally, states are required to report all expenditures on their CMS-64 reports (this report reflects expenditures for all services for which federal matching funds are sought).

Historically, federal matching funds have not been allowed for state expenditures associated with prison health care, institutions for mental disease, housing, school-based services, programs that serve undocumented persons, individuals who would be eligible for Medicaid through Medicaid expansion, and non-health care related state spending. This seems to hold true for states seeking approval for DSHP funding. This appears to limit the scope of how the State can utilize the DSHP in the behavioral health system of care. For example, providers who qualify as an institution for mental disease would not be eligible to participate and some services that DCF provides that Medicaid does not, such as housing, may not be allowable.

CMS has approved federal matching payments for designated state health programs in several states (e.g., California, Massachusetts, New York, New Hampshire, and Oregon). Oregon and New Hampshire have received approval of DSHP funding related to their substance abuse and mental health programs. State general revenue funds dedicated to the following programs operated by DCF could be included in the initial application request:

- Community Substance Abuse and Mental Health
- State Mental Health Treatment Facilities

It is recommended that, if directed to implement a DSHP, the eight services (listed on page in Section III.D. of this report) that are covered under both Medicaid and the managing entity delivery systems be consolidated under the responsibility of the Agency through Medicaid and the additional federal funding received through the DSHP be utilized to cover services and populations currently provided by the managing entities that are not eligible for Medicaid funding.

The DSHP model could be used to target one or more of the elements specified in the revenue maximization component of Senate Bill 12 (e.g., increasing rates for behavioral health services, implementing innovative programs targeted towards individuals with chronic SMI or SUD, etc.). In order to preserve and leverage the infrastructure established by the managing entities, it is recommended that any increased federal funding be directly paid to

the managing entities for the delivery of services through their networks of providers. Given the level of increased documentation of expenditures that would be required by CMS, it is recommended that the Agency have an agreement with the managing entities in addition to DCF to ensure all federal Medicaid reporting requirements are met and to ensure the Agency has the necessary authority in place to provide oversight of the DSHP expenditures.

Here is a brief overview of the DSHP components:

Goals and Objectives: In collaboration with DCF, the following goals and objectives were identified if this financing strategy were pursued:

- Reduce hospitalizations
- Reduce admissions to crisis stabilization units/residential detox services, emergency rooms, and arrest rates
- Increase community tenure through stable housing
- Improve the coordination of care across health care, behavioral health care, and community support providers
- Improve access to health and behavioral health
- Improve patient/client and family outcomes

Eligible Populations: As described earlier in the report, DCF has identified certain priority populations that require more intensive level of community-based services and supports, including care coordination, access to primary health care, and behavioral health treatment services. These populations include:

- Individuals with a mental illness awaiting discharge from state treatment facilities
- Individuals with multiple admissions to community acute care settings including; psychiatric inpatient units, crisis stabilization units, addictions receiving or detoxification facilities
- Individuals with criminal justice involvement, with a mental illness or substance use disorder requiring services as a result of their release from jail, Department of Corrections, or court ordered treatment

Eligible Services: To be successful, a full range of community health, rehabilitative and support services need to be in place. The DSHP appears to offer the opportunity to build the community systems of care needed to reduce demand for most restrictive state hospital placements. Community-based services that would be viewed as essential to this effort include:

- Assertive Community Teams
- Mobile Crisis Response
- Assessment services,
- Care coordination
- Targeted case management
- Housing and housing support services
- Short-term residential treatment

- Community support services
- Peer support
- Intensive outpatient/Day treatment
- Outpatient primary care services
- Inpatient mental health and detoxification services.

If directed, the Agency would likely request authority for DSHP federal funding by amending its existing 1115 MMA waiver. The length of time to receive federal approval is indeterminate at this time, as there are no prescribed timeframes for CMS to address 1115 waiver amendment requests. Typically, it takes six to twelve months to negotiate approval of an 1115 waiver amendment request with CMS – more complex waiver amendment requests such as a DSHP typically take a significantly longer period of time. It should also be noted that states who received approval from CMS did so in conjunction with Delivery System Reform Incentive Payment programs.

In general, use of supplemental payment methods have the benefit of increasing funding for providers and local delivery systems that enable them to addresses uncompensated care costs or maximize the available funding to address underserved populations (both Medicaid and non-Medicaid). However, federal funding under a DSHP program is time-limited, with states expected to transform their system to support the DSHP without federal funding in the long-term. The state will have to be cognizant of additional federal regulatory and administrative requirements that are associated with these supplemental payment funding opportunities and in some cases, the limited duration in which the funding may be available. DSHP has auditing and reporting standards that may require additional staff which may be a disadvantage in terms of State resources available to design, implement, and maintain a DSHP. This places an increased burden on states to use the funding to achieve sustainable systemic reforms that are not reliant upon the federal funding in the long-term to maintain successes. For a DSHP program, states must be aware that approvals are made on a case-by-case basis through negotiations with CMS, which could be lengthy.

I. Implementing Innovative Programs to Provide Incentives for Improved Outcomes for Behavioral Health Conditions

Senate Bill 12 directs the Agency and DCF to evaluate alternative uses of increased Medicaid funding to implement innovative programs to provide incentives for improved outcomes for behavioral health conditions. This section of the report evaluates how this objective can be accomplished through a Delivery System Reform Incentive Payment (DSRIP) program and health homes. Delivery System Reform Incentive Payments are another form of supplemental payment, but because it is exclusively focused on system transformation and improving outcomes, the DSRIP option is discussed in this section of the report.

Delivery System Reform Incentive Payment

Prompted by an interest in improving the health of the population and enhancing the experience and outcome of the patient, more states are seeking ways to implement innovative programs. Delivery System Reform Incentive Payment programs are one of the ways that states can achieve such reforms.

Delivery System Reform Incentive Payment programs allow states to make incentive payments that are linked to performance-based incentive initiatives, or projects aimed at improving health care processes, clinical outcomes, and that otherwise positively transform health service delivery. The overall goal of state DSRIP initiatives must be transformation of the Medicaid payment and delivery system in an effort to achieve measurable improvements in quality of care and overall population health.

Normally, progress on these projects is tracked and payments are adjusted based on providers' successes in meeting agreed-upon milestones. DSRIP demonstrations require states to work closely with CMS throughout the duration of the program given the complexity of designing broad system transformations specific to each state and the need for accountability for investments of billions of dollars. Significant time spent by providers, states, and CMS are needed to launch DSRIP programs and most require substantial resources dedicated to implementation and eventual administration. Most states report the need for increased staff/consulting capacity and expertise in clinical quality and performance improvement. To undertake this option, the Agency will need to enter into discussion with CMS and DCF regarding options available and the best way to proceed in designing a program. Examples from other state programs sourced though DSRIP are complicated, and the State must fully understand how best to incentivize the changes sought and determine how to measure that change in an efficient and effective way.

Seven states have acquired federal authority to employ DSRIP as an umbrella for systemic payment reform. For the state of Florida, a DSRIP could be used to incentivize providers and health plans to improve behavioral health performance outcomes.

CMS has approved seven states' DSRIP programs as part of 1115 waivers to advance payment and delivery system reform. Other states are applying or are negotiating. See Attachment IV for more information on states that have been approved to use this model. Delivery System Reform Incentive Payment initiatives provide states with significant funding that can be used to support providers in changing how they provide care to Medicaid recipients. Approval of a DSRIP program is dependent upon the following:

- **Goals and Objectives:** The State must evaluate its existing Medicaid programs and identify specific goals and measureable outcomes that reduce costs, increase efficiency and improve quality of care. CMS and the state use these goals and metrics to assess whether providers meet, exceed or fall short of the necessary milestones. Providers only receive enhanced DSRIP funding if they meet the measures approved in the DSRIP project plan.

- In collaboration with DCF, the following goals and objectives were identified if this financing strategy could be pursued:
  - Reduce the time of individuals' wait for discharge to less restrictive services
  - Enhance access to the most appropriate, least restrictive settings of care
  - Reduce readmissions to most expensive community settings such as crisis stabilization units and inpatient detox
  - Increase community tenure through stable housing, assertive community treatment, care coordination
  - Improve functioning and overall wellness
  - Reduce recidivism and increase successful community tenure for persons with high rates of arrest/incarceration
  - Reduce cost associated with readmissions and recidivism to residential treatment
  - Improve the coordination of care across health care, behavioral health care, and community support providers
  - Improve coordination of benefits across multiple payors of services
  - Reduce denials of services as a result of improved care coordination
  - Improve access to health and behavioral health care services
  - Improve patient/client and family outcomes

- **Eligible Providers:** The State must determine which providers are eligible to receive DSRIP funds. In some states, only public hospitals are eligible entities, while in others "safety net providers" (including nonpublic hospitals and other categories of providers) are eligible through a collaborative provider network or through affiliation with an anchor public hospital.

  - The primary focus of DCF's goals and objectives is on reducing the use of crisis stabilization and residential treatment services for vulnerable populations by creating greater capacity and availability of outpatient services. As such, the providers eligible for the incentive payments could be those who provide community-based/outpatient services through the managing entities and Medicaid health plans to the target populations.

- **Funding Sources:** The State must identify the source of funding for the program. Other states have used IGTs from public entities, provider taxes, state general revenue, and DSHP. Many states struggle with how to finance the state share to contribute to the DSRIP program. While IGT's have become the most common source of funding used by states, it can be a challenge for the entity providing the IGT to meet the high level of funding required.

  - It is recommended to utilize a combination of IGT's, state general revenue funding, and a DSHP as funding sources if this option is selected by the Legislature.

- **Funding Allocation:** The State must describe the methodology for allocating the DSRIP funding. State waivers including DSRIP programs have prioritized certain types of

projects (e.g., integrated healthcare delivery, expanded primary care capacity, and/or population-focused improvements), as well as certain provider types (e.g., those with the largest percentages of Medicaid and uninsured individuals).

- It is recommended that any increased federal funding be directly paid to the managing entities or Medicaid health plans for the delivery of services through their networks of providers.

- **Data Collection and Evaluation:** Providers have varying data collection and reporting systems which may present a challenge for project evaluation. The data infrastructure needed by a provider to participate in DSRIP is a potential disadvantage of this option. A large hospital provider in one state reported the need for a complete overhaul of their data infrastructure and often the ability to share data amongst participating providers is important. This is an area of concern for behavioral health providers who are generally smaller and less sophisticated in terms of information technology.

  The State must establish data collection and reporting requirements that adequately measure provider performance against approved process and outcome metrics to determine whether participating providers have achieved the necessary milestones to receive DSRIP funds.

  - As part of systemic reform, the Agency and DCF can identify new performance measures that can be used to evaluate health plan performance toward improving the delivery of behavioral health services and integration of care. Performance measures can be designed to target a known system weakness or gap to focus improvements to that specific issue. For example, an additional behavioral health performance measure can be designed to measure reductions in the number of recipients who experience repeated Baker Act and Marchman Act admissions. Health plans can be required to report the frequency of care management contacts following an inpatient episode to demonstrate intensive effort to connect these recipients with community-based services and supports and improve compliance with discharge recommendations and prescribed medications. This strategy can also be used to assist health plans in improving scores on existing behavioral health performance measures, such as follow-up after hospitalization for mental illness.

Health Homes

The use of health homes is an innovative mechanism for increasing access to federal funding. The significance of this model must be considered when examining payment reform.

The health home provision authorized by the Affordable Care Act provides an opportunity to build a person-centered system of care designed to achieve improved outcomes for Medicaid enrollees with chronic conditions and ensure care and value for state Medicaid programs. This provision supports CMS's primary objective of improving health care while

achieving three goals: improving the experience of care; improving the health of populations; and reducing per-capita costs of health care.[9]

The health home provision offers States flexibility in designing their payment methodologies and a significant financial incentive by providing an eight-quarter enhanced federal match for health home services received by eligible Medicaid enrollees. The federal government pays 90 percent of the cost for the specific health home services for a total of eight quarters for one enrollee.

Under the health home state plan benefit, a health home provider delivers a comprehensive system of care by integrating and coordinating all primary, acute, behavioral health (including mental health and substance use) and long term services and supports for individuals with chronic conditions to treat the "whole-person." The main goals for the health home are to improve health outcomes that will result in lower rates of emergency room use, reduction in hospital admissions and readmissions, reduction in health care costs, create less reliance on long-term care facilities and improve experience of care for Medicaid individuals with chronic conditions.

The Secretary of Health and Human Services has the authority to approve entities or providers as a health home.[10] CMS outlines three distinct types of health home providers that can provide health home services: designated providers; a team of health care professionals; and a health team.

- A designated provider may be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider.
- A team of health professionals may include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center.
- A health team must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractic, and licensed complementary and alternative practitioners.

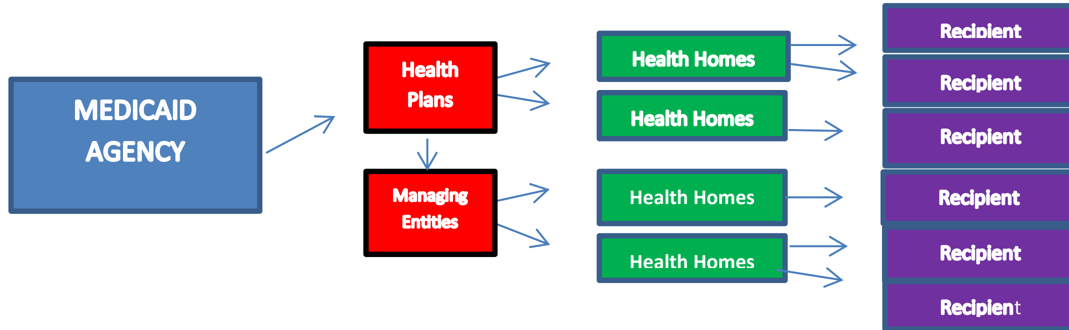
The Medicaid health plans and managing entities could work collaboratively to implement this initiative as depicted below.

Figure 3: Health Home Option

Health plan + third party contracts with health homes

[9] Centers for Medicare and Medicaid Services (2010, November 16). Health homes for enrollees with chronic conditions. *Medicaid Directors Letter* (SMDL# 10-024, ACA# 12). Retrieved from: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

[10] Centers for Medicare and Medicaid Services (February 2012). Health homes consideration for a Medicaid managed care delivery system: Avoiding duplication of services and payments. *Technical Assistance Tool.* Retrieved from http://www.chcs.org/media/hh-managed-care-options-matrix_020312.pdf



The Medicaid health plans could contract with the managing entities for additional care coordination activities provided to their enrollees. To the extent that the managing entities are contracting with providers meeting the qualifications of a health home, the additional federal funding generated could flow through to both the managing entity and the providers.

CMS envisions payment of a health home model of service delivery with either a fee-for-service or capitated payment structure, although they would consider other methods or strategies utilizing additional payment models. States may structure a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the "capabilities" of the designated provider, the team of health care professionals operating with the designated provider, or the health team.

This option would require submission of waiver request to CMS; likely an 1115 waiver.

Section IV. Summary

This report contains a comprehensive overview of mechanisms to increase federal funding for behavioral health services. If directed to implement certain options described, the receipt of federal matching funds for services provided to individuals with SMI and/or SUD will free up general revenue. The Agency would receive approximately 60% of the cost of services provided from the federal government, which would replace prior general revenue expenditures on those services through DCF. A more formal fiscal analysis can be conducted on any of the options discussed in the report, upon request of the Agency and DCF by the Florida Legislature.

The report also explores the federal authority vehicles for increasing access to federal funding including research and demonstration and home and community-based waiver programs. While there are various options available for the state to choose, the 1115 Research and Demonstration Waiver provides the state with the greatest flexibility to achieve one or all of the potential alternative uses of enhanced federal matching funding.

Attachment I: Florida Medicaid Waivers

Section 1115 Research & Demonstration Waivers	
Family Planning Waiver	Provides family planning and family planning-related services to all women of child bearing ages (14-55) losing Medicaid coverage, who have a family income at or below 185 percent of the federal poverty level and who are not otherwise eligible for Medicaid, Children's Health Insurance Program, or other health insurance coverage providing family planning services.
Managed Medical Assistance Waiver	Provides primary care, acute medical care, dental care, and behavioral health care for Florida Medicaid recipients through contracts with managed care plans.
MEDS AD Waiver	Provides Medicaid eligibility for people with disabilities who are 65 years of age or older, disabled, and who have resources below $5,000 for an individual and $6,000 for a couple and whose income is less than 88 percent of the federal poverty level.
Sections 1915(b) Selective Contracting/Managed Care Waivers	
Non–emergency Transportation Waiver	Provides non-emergency services eligible Medicaid recipients who are not enrolled in a health plan.
Long-term Care (LTC) Waiver* **The LTC Program operates under a combination 1915(b)/1915(c) waiver authority*	Provides LTC services and supports to eligible disabled individuals age 18-59 years and elderly individuals age 65 years or older.
Sections 1915(c) Home and Community-Based Services Waivers	
Adult Cystic Fibrosis Waiver	Provides home and community-based services to recipients over 18 years of age who have been diagnosed with cystic fibrosis.
Developmental Disabilities Individual Budgeting Waiver	Provides home and community-based services to recipients three years of age or older who have been diagnosed with a developmental disability.
Familial Dysautonomia Waiver	Provides home and community-based services to recipients 3 through 64 years of age who have been diagnosed with familial dysautonomia.
Model Waiver	Provides home and community-based services to children under 21 years of age who are complex/medically fragile or diagnosed with degenerative spinocerebellar disease.
Project AIDS Care Waiver	Provides home and community-based services to individuals diagnosed with AIDS.
Traumatic Brain Injury and Spinal Cord Injury Waiver	Provides home and community-based services to recipients 18 years of age or older who have been diagnosed with traumatic brain injury or spinal cord injury.

Attachment II: Medicaid Behavioral Health Services and Fees

<table>
<tr><td colspan="6"></td></tr>
<tr><th>Description of Service</th><th>Procedure Code</th><th>Modifier 1</th><th>Modifier 2</th><th>Maximum Fee</th><th>Service Limitations</th></tr>
<tr><td colspan="6">Assessments/Evaluations</td></tr>
<tr><td colspan="6">Psychiatric evaluation: A comprehensive evaluation that investigates the recipient’s clinical status. The purpose of a psychiatric evaluation is to establish a therapeutic doctor–patient relationship, gather accurate data in order to formulate a diagnosis, and initiate an effective treatment plan.</td></tr>
<tr><td>Psychiatric evaluation by physician</td><td>H2000</td><td>HP</td><td></td><td>$210.00 per evaluation</td><td rowspan="3">Max of 2 per state fiscal year (SFY)</td></tr>
<tr><td>Psychiatric evaluation by physician—telemedicine</td><td>H2000</td><td>HP</td><td>GT</td><td>$210.00 per evaluation</td></tr>
<tr><td>Psychiatric evaluation by non-physician</td><td>H2000</td><td>HO</td><td></td><td>$150.00 per evaluation</td></tr>
<tr><td colspan="6">Brief behavioral health status exam: A brief clinical, psychiatric, diagnostic, or evaluative interview to assess behavioral stability or treatment status. A brief behavioral health status examination must be completed prior to the development of the recipient’s individualized treatment plan.</td></tr>
<tr><td>Brief behavioral health status exam</td><td>H2010</td><td>HO</td><td></td><td>$14.66 per quarter hour</td><td>Max. daily limit of 2 15-minute units</td></tr>
<tr><td>Brief behavioral health status exam—telemedicine</td><td>H2010</td><td>HO</td><td>GT</td><td>$14.66 per quarter hour</td><td>Max. 10 15-minute units per SFY</td></tr>
<tr><td colspan="6">Psychiatric review of records: A review of a recipient records, psychiatric reports, psychometric or projective tests, and clinical and psychological evaluation data for diagnostic use in evaluating and planning for recipient care. A written report must be done by the individual rendering the service and must be included in the recipient’s clinical record.</td></tr>
<tr><td>Psychiatric review of records</td><td>H2000</td><td></td><td></td><td>$26.00 per review</td><td>Max 2 reviews per SFY</td></tr>
<tr><td colspan="6">In-depth assessment: A diagnostic tool for gathering information to establish or support a diagnosis, to provide the basis for the development of or modification to the treatment plan, and to develop the discharge criteria.</td></tr>
<tr><td>In-depth assessment, new patient, mental health</td><td>H0031</td><td>HO</td><td></td><td>$125.00 per assessment</td><td rowspan="8">Max 1 per SFY

Not reimbursable on same day as a bio-psychosocial</td></tr>
<tr><td>In-depth assessment, new patient, mental health-telemedicine</td><td>H0031</td><td>HO</td><td>GT</td><td>$125.00 per assessment</td></tr>
<tr><td>In-depth assessment, established patient, mental health</td><td>H0031</td><td>TS</td><td></td><td>$100.00 per assessment</td></tr>
<tr><td>In-depth assessment, established patient, mental health-telemedicine</td><td>H0031</td><td>TS</td><td>GT</td><td>$100.00 per assessment</td></tr>
<tr><td>In-depth assessment, new patient, substance abuse</td><td>H0001</td><td>HO</td><td></td><td>$125.00 per assessment</td></tr>
<tr><td>In-depth assessment, new patient, substance abuse-telemedicine</td><td>H0001</td><td>HO</td><td>GT</td><td>$125.00 per assessment</td></tr>
<tr><td>In-depth assessment, established patient, substance abuse</td><td>H0001</td><td>TS</td><td></td><td>$100.00 per assessment</td></tr>
<tr><td>In-depth assessment,</td><td>H0001</td><td>TS</td><td>GT</td><td>$100.00 per</td></tr>
</table>

established patient, substance abuse-telemedicine				assessment	
Bio-psychosocial evaluation: An evaluation to describe the biological, psychological, and social factors that may have contributed to the recipient's need for services. The evaluation includes a brief mental status exam and preliminary service recommendations.					
Bio-psychosocial evaluation, mental health	H0031	HN		$48.00 per assessment	Max 1 per SFY Not reimbursable after in-depth assessment unless documented changed in status and additional information is needed to modify treatment plan.
Bio-psychosocial evaluation, mental health - telemedicine	H0031	HN	GT	$48.00 per assessment	
Bio-psychosocial evaluation, substance abuse	H0001	HN		$48.00 per assessment	
Bio-psychosocial evaluation, substance abuse - telemedicine	H0001	HN	GT	$48.00 per assessment	
Psychological testing: The assessment, evaluation, and diagnosis of the recipient's mental status or psychological condition through the use of standardized testing methodologies.					
Psychological testing	H2019			$15.00 per quarter hour	Max 40 15-min units per state fiscal year
Limited functional assessment: Administration of the Functional Assessment Rating Scale (FARS), and the Children's Functional Assessment Rating Scale (C-FARS), the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R), or any other functional assessment required by the DCF.					
Limited functional assessment, mental health	H0031			$15.00 per assessment	Max 3 assessments per SFY
Limited functional assessment, mental health - telemedicine	H0031	GT		$15.00 per assessment	
Limited functional assessment, substance abuse	H0001			$15.00 per assessment	
Limited functional assessment, substance abuse - telemedicine	H0001	GT		$15.00 per assessment	
Treatment Plan Development and Modification					
Treatment planning services is an individualized, structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level.					
Treatment plan development, new and established patient, mental health	H0032			$97.00 per event	Max 1 per SFY Authorized by treating practitioner
Treatment plan development, new and established patient, substance abuse	T1007			$97.00 per event	
Treatment plan review, mental health	H0032	TS		$48.50 per event	Max 4 per SFY authorized by treating practitioner
Treatment plan review, substance abuse	T1007	TS		$48.50 per event	
Medical and Psychiatric Services					
Medical and Psychiatric services include evaluation of the need for medication; evaluation of clinical effectiveness					

and side effects of medication; prescribing, dispensing, and administering of psychiatric medications; medication education and facilitating informed consent (including discussing side effects, risks, benefits, and alternatives with the recipient or other responsible persons); planning related to service delivery; and evaluating the status of the recipient's community functioning.					
Medication management	T1015			$60.00 per event	As medically necessary. Not reimbursable on same day as brief group medical therapy or brief individual medical therapy
Medication management - telemedicine	T1015	GT		$60.00 per event	
Brief individual medical psychotherapy, mental health	H2010	HE		$15.00 per quarter hour	Max daily limit of 2 15-minute units Max limit of 16 quarter hour units per SFY Not reimbursable on same day as brief group medical therapy or med management
Brief individual medical psychotherapy, mental health—telemedicine	H2010	HE	GT	$15.00 per quarter hour	
Brief individual medical psychotherapy, substance abuse	H2010	HF		$15.00 per quarter hour	
Brief individual medical psychotherapy, substance abuse—telemedicine	H2010	HF	GT	$15.00 per quarter hour	
Brief group medical therapy	H2010	HQ		$8.65 per quarter hour	Max daily limit of 2 15-minute units. Max limit of 18 quarter hour units per SFY Not reimbursable on same day as brief individual medical therapy or med management
Behavioral health medical screening, mental health	T1023	HE		$43.62	Max 2 per SFY Not reimbursable on same day as BH related medical services: verbal interaction or med management
Behavioral health medical screening, substance abuse	T1023	HF		$43.62	
Behavioral health—related medical services: verbal interaction, mental health	H0046			$15.00 per event	Max 52 per SFY Not reimbursable on same day as behavioral health screening services
Behavioral health-related medical services: verbal interaction, mental health—telemedicine	H0046	GT		$15.00 per event	
Behavioral health-related medical services: verbal interaction, substance abuse	H0047			$15.00 per event	
Behavioral health-related medical services: verbal interaction, substance abuse—telemedicine	H0047	GT		$15.00 per event	
Behavioral health-related medical services: medical	T1015	HE		$10.00 per event	

procedures, mental health					Max 52 times per SFY
Behavioral health-related medical services: medical procedures, substance abuse	T1015	HF		$10.00 per event	
Behavioral health-related medical services: alcohol and other drug screening specimen collection	H0048			$10.00 per event	Max 52 times per SFY
Medication-assisted treatment services	H0020			$67.48, weekly rate	Max 52 times per SFY (once per seven days) Not reimbursable with any other procedure code
Behavioral Health Therapy Services					
Behavioral health therapy services are the provision of insight-oriented, cognitive behavioral or supportive therapy interventions to an individual recipient or a recipient's family. Individual and family therapy may involve the recipient, the recipient's family without the recipient present, or a combination of therapy with the recipient and the recipient's family.					
Individual and family therapy	H2019	HR		$18.33 per quarter hour	Max 104 quarter hour units per SFY Max per day= 4 quarter hour units
Individual and family therapy - telemedicine	H2019	HR	GT	$18.33 per quarter hour	
Group therapy	H2019	HQ		$6.67 per quarter hour	Max 156 quarter hour units per SFY
Behavioral health day services, mental health	H2012			$12.50 per hour	Max 190 hour units per SFY Not reimbursable on same day as PSR
Behavioral health day services, substance abuse	H2012	HF		$12.50 per hour	
Community Support and Rehabilitative Services					
Community support and rehabilitative services encompass rehabilitation-focused, community-based psychosocial services. Community support and rehabilitative services are designed to assist recipients in strengthening or regaining interpersonal skills and in developing environmental supports necessary to function in their community.					
Psychosocial rehabilitation services	H2017			$9.00 per quarter hour	Max 1,920 units per SFY
Clubhouse services	H2030			$5.00 per quarter hour	Max 1920 units SFY
Therapeutic Behavioral On-Site Services for Recipient Under the Age of 21 Years					
Therapeutic behavioral on-site services are intended to prevent recipients who have complex needs from requiring placement in a more intensive, restrictive behavioral health setting. These services are coordinated through individualized treatment teams and are designed to assist recipients and their families.					
Therapeutic behavioral on-site services, therapy	H2019	HO		$16.00 per quarter hour	Max 36 quarter hour units per month
Therapeutic behavioral on-site services, behavior management	H2019	HN		$10.00 per quarter hour	Max 36 quarter hour units per month
Therapeutic behavioral on-site services, therapeutic support	H2019	HM		$4.00 per quarter hour	Max 128 quarter hour units per month
Mental Health Targeted Case Management					
Mental health targeted case management services assist adults with a serious mental illness and children with a serious emotional disturbance gain access to needed medical, social, educational, and other necessary services as					

they relate to the recipient's mental health.					
Targeted Case Management for Children (birth through 17)	T1017	HA		$12.00 per quarter unit	344 per month
Targeted Case Management for Children (18 and older)	T1017			$12.00 per quarter unit	344 per month
Intensive Team Targeted Case Management	T1017	HK		$12.00 per quarter unit	48 per day
Specialized Therapeutic Services					
Specialized therapeutic services contributes to the maximum reduction of the recipient's disability and restoration to the best possible functional level, and include comprehensive behavioral health assessments, specialized therapeutic foster care, and therapeutic group home services provided to recipients under the age of 21 years with mental health, substance use, and co-occurring mental health and substance use disorders.					
Comprehensive Behavioral Health Assessment	H0031	HA		$12.12 per quarter hour	Max 1 per SFY, and limited to a total of 20 hours per SFY Not reimbursable for Juvenile Justice recipients
Specialized Therapeutic Foster Care, Level I	S5145			$87.30 per day	
Specialized Therapeutic Foster Care, Level II	S5145	HE		$135.80 per day	
Specialized Therapeutic Foster Care, Crisis Intervention	S5145	HK		$135.80 per day	
Therapeutic Group Care Services	H0019			$180.00 per day	Not reimbursable if the provider has been paid for the provision of the same service or type of service by another purchasing entity.
Behavioral Health Overlay Services					
Behavioral health overlay services contributes to the maximum reduction of the recipient's disability and restoration to the best possible functional level in order to avoid a more intensive level of care by providing mental health, substance abuse and supportive services designed to meet the behavioral health treatment needs of recipients in the care of Medicaid enrolled, certified agencies under contract with the Department of Children and Families, Child Welfare and Community-Based Care organization.					
Behavioral health overlay services	H2020	HA		$32.75 per day	Not reimbursable if the provider has been paid for the provision of the same service or type of service by another purchasing entity or for Juvenile Justice recipients

Attachment III: Behavioral Health Services Covered by DCF but Not Covered by Medicaid

Services Not-Covered by Medicaid				
	FY1415		FY1516	
	Clients	Units	Clients	Units
Day Care Services	80	2,360.00	106	4,394.58
Intervention	51,564	204,751.19	52,471	190,700.64
Substance Abuse Detoxification	20,159	102,502.00	18,270	87,857.00
TASC	12,962	49,813.05	10,662	46,989.49
Incidental Expenses	15,992	210,365.58	15,180	236,638.18
Aftercare/Follow-up	1,580	11,865.34	929	8,530.31
FACT Team	3,370	50,184.39	2,443	36,379.96
Room & Board w/Supervision, Level 1	218	20,953.00	96	18,160.00
Room & Board w/Supervision, Level 2	1,222	144,134.00	1,379	149,429.00
Room & Board w/Supervision, Level 3	1,131	76,669.00	1,009	85,825.00
Intervention - Group	12,509	70,848.57	8,410	103,289.71
Aftercare - Group	878	12,850.38	634	8,871.57
MH Comprehensive - Individual	8,942	40,478.35	4,510	40,704.89
MH Comprehensive - Group	92	3,753.95	34	1,000.24
Indicated Prevention	0	0	25	15,695.00

This table reflects clients served by the Department by program, who were identified as Medicaid recipients as indicated by a weekly data feed from AHCA, and the current clients estimated to be Medicaid eligible based on:

1. *with a household income at or below 133 % of the federal poverty level (for the applicable family size),*
2. *over 21 and under 65,*
3. *not pregnant.*

Attachment IV: States DSRIP Summaries

States with DSRIP programs as part of 1115 waivers to advance payment and delivery system reform are California, Kansas, Massachusetts, New Jersey, New York, and Texas. Each state falls within a common framework, but varies in program specifics and funding sources, and has been approved as a component of a larger Medicaid Section 1115 demonstration waiver.

California

California was the first state approved to implement DSRIP and has entered into a five-year renewal of its DSRIP program using the Hospital System Transformation model. The State was looking for a way to stabilize reductions in public hospital funding and providing comparable funding levels to replace its supplemental payment program. The California DSRIP was considered as part of a bridge to reform as the safety net was transitioning and transforming into a coordinated system. Over the course of the DSRIP, California's public hospitals assigned more than 500,000 individuals to a medical home or a primary care provider and entered over one million individuals into disease registries for care management purposes. Fifteen counties have a DSRIP plan, which cover all 21 eligible public hospitals (Designated Public Hospitals). Each DSRIP plan sets its own measures within a set of categories.

Kansas

The Kansas DSRIP pool was created through the approval of the Section 1115 demonstration waiver for the KanCare program, which allows special payments to certain hospitals that participated in reforms that benefit the health care delivery system widely. These hospitals must plan and implement significant system reform projects over five years that are consistent with the three-part aim CMS has for improving health care: better individual care, better population health, and lower cost through improvement. Currently, two hospitals are eligible to participate in the project. They are eligible due to their status as a large public teaching or border city children's hospital. Payments to the hospital will be funded by state funds, IGT's and federal funds.

Massachusetts

The Massachusetts DSRIP initiative, referred to as the "Delivery System Transformation Initiative" or "DSTI" within the state – has its origins in an 1115 Medicaid waiver originally approved by the federal government in the mid-1990s. The original waiver established a safety net care pool that enabled Massachusetts to dramatically expand coverage and continue supporting safety net hospitals that were significantly impacted by the growth in Medicaid membership. In more recent years, some of the funding available for safety net institutions has been incorporated into a DSRIP-type incentive payment program for selected providers implementing projects and meeting performance metrics. In order to be potentially eligible for DSRIP payments, hospitals must have both a high share of Medicaid patients and a low share of commercially-insured patients. As a result, seven hospitals within the state are eligible for DSRIP payments. In order to secure funding, they must develop projects, largely of their own choosing, and meet metrics established by internal work groups.

New Jersey

In New Jersey, the 49 DSRIP-participating hospitals focus on improving care management for common chronic conditions: asthma; behavioral health and substance use disorder; cardiac care; diabetes; HIV/AIDS; obesity; or pneumonia. Hospitals must meet requirements over four stages to receive funds. The project activities funded by the DSRIP Program will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with this DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. Hospitals qualify to receive incentive payments (DSRIP payments) for fully meeting performance and outcome metrics (as specified in this Planning Protocol, as well as the Funding and Mechanics Protocol), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care. The stages are spread out over four years and one of the eight listed conditions must be the focus.

New York

New York's DSRIP seeks to change how care is paid for and provided in the state by developing a number of Performing Provider Systems (PPSs), which are generally multi-county in size. The program was created to incentivize provider collaboration at the community level to improve care for Medicaid recipients while lowering costs and improving health. By 2020, 90 percent of managed care organization payments to providers must be value-based and emergency department visits must be reduced by 25 percent. CMS took the uncommon step of approving a 5.5-year waiver in 2014. The projects are all regional in nature and both population health and statewide measure will be used; there are no options for addressing hospital-specific operations as cross provider collaboration is required in every case. The primary goal of the waiver is to prepare providers for capitation payment, and reduce unnecessary utilization of emergency departments by 25 percent over 5 years.

Texas

Texas' waiver allows for managed care expansion to additional areas of the state and split incentive payment across 20 Regional Healthcare Partnerships (RHPs), which are generally multi-county in size. DSRIP payments to these regional provider groups are based on various outcome measures, such as the average inpatient length of stay. The five-year waiver was approved in 2011 with a strong focus on population health. Much negotiation was driven by CMS, including the focus on a regional approach and the inclusion of both public and private providers. The primary goal of the Texas waiver was to prepare hospital providers for carving inpatient care into managed care, which had historically been left out for state financing reasons. The state has relied on IGTs and state behavioral health funding as the source of the non-federal share. There have been some ongoing financing issues, with CMS recently issuing a deferral on some of the state's IGTs. DSRIP has helped alleviate the initial distrust between public and private providers in Texas by helping both provider classes realize that all providers are needed to make the safety net work.

Attachment V: Department of Children and Families Substance Abuse and Mental Health Program Office: Behavioral Healthcare Rate Comparison between the Department and Medicaid Fee-For-Service

Behavioral Healthcare Rate Comparison between the Department and Medicaid Fee-For-Service

Department of Children and Families
Substance Abuse and Mental Health Program Office

January 1, 2017

Mike Carroll
Secretary

Rick Scott
Governor

Pursuant to s. 394.761(3) and (4) F.S., the Florida Department of Children and Families submits the following analysis of rates between Department covered behavioral healthcare services and Florida Medicaid Fee-for-Service.

Analysis of DCF Services Cost Compared with Medicaid Fee-for-Service:

The Department presently has 51 covered services defined in 65E-14.021, F.A.C. A majority of these services represent direct to consumer activities such as outpatient treatment or case management, however others are related to prevention activities such as universal indirect prevention. The Department's covered services are related, but not equivalent, to services funded by other sources such as Medicaid. The principle difference in services funded by the Department and those funded by other payors is the unit of measure for each service (see Table 1).

Table 1 Department Covered Services and Units of Measure as Defined in 65E-14.021, F.A.C.

Unit of Measure	Department Covered Services
Direct Staff Hour	Aftercare Assessment Case Management Comprehensive Community Service Team Crisis Support/Emergency Day Care Day Treatment Information and Referral In-Home and On-Site Intensive Case Management Intervention Medical Services Mental Health Clubhouse Services Outpatient Prevention – Indicated Recovery Support Respite Services Substance Abuse Outpatient Detoxification Supported Employment Supportive Housing/Living Treatment Alternatives for Safer Communities
Non-Direct Staff Hour	Drop-in/Self-Help Centers Outreach Prevention – Selective Prevention – Universal Direct Prevention – Universal Indirect
Day	Crisis Stabilization Inpatient Residential Level I to IV Room and Board with Supervision Level I to III Short-term Residential Treatment Substance Abuse Inpatient Detoxification
Dollars	Incidental Expenses
Dosage	Medication-Assisted Treatment
Enrollment	Florida Assertive Community Treatment Team

Unit of measure is important because many of the Department funded services do not directly relate to a Florida Medicaid service. For example, the Department and Florida Medicaid each

pay for assessment services. However, the Department only has a single code while Florida Medicaid has 23 codes. Florida Medicaid uses the Healthcare Common Procedure Coding System (HCPCS) for tracking service events and for billing purposes. HCPCS represent is a set of standardized health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT). CPT codes describe medical, surgical, and diagnostic services. All healthcare providers that receive funding through the Centers for Medicare and Medicaid Services utilize HCPCS and CPT.

Differences between how the Department tracks and pays for services with the larger healthcare community create challenges for comparing costs and tracking service utilization in the context of treatment outcomes. For example, Florida Medicaid reimburses a maximum of two psychiatric evaluations per recipient per state fiscal year. The duration for each evaluation is not a factor in reimbursement. The Department pays for assessments based on duration. Comparing Florida Medicaid psychiatric evaluations with Department funded assessments is likely to result in an inaccurate accounting of cost and units delivered because the unit of measure between each organization are so widely different. Of the 51 covered services offered by the Department, eight services are closely related to services paid for by the Florida Medicaid Fee-for-Service schedule (see Table 2 below).

Table 2. Covered Services and Medicaid Equivalents with Service Limits[11]

COVEREDSERVICE	MEDICAID LIMITS	PROCEDURE CODE
Assessment	Two psychiatric evaluations per year	H2000HP; H2000HP GT; H2000HO
	2.5 hours of brief MSE per year	H2010HO; H2010HO GT
	Two record reviews per year	H2000
	One in-depth assessment per year	H0031HO; H0031HO GT; H0031TS; H0031TS GT; H0001HO; H0001HO GT; H0001TS; H0001TS GT
	One bio-psychosocial per year	H0031HN; H0031HN GT; H001HN; H0001HN GT
	10 hours testing per year	H2019
	Three limited functional assessments per year	H0031; H0031GT; H0001; H0001GT
Day / Night	47.5 hours or 11.9 half-days per recipient per year	H2012; H2012HF
In-Home and On-Site Services Overlay	9 hours per year	H2019HO; H2019HN
	32 hours on-site per year	H2019HM
Medical Services	4 brief individual medical psychotherapy per year	H2010HE; H2010HE GT; H2010HF; H2010HF GT
	4.5 hours of group medical therapy per year	H2010HQ
	Two medical screenings per year	T1023HE; T1023HF
	52 behavioral health services per year	H0046; H0046GT; H0047; H0047GT
	52 alcohol and drug screening specimen collections	T1015HE; T1015HF
Methadone Maintenance	52 medication-assisted treatment per year	H0020
Outpatient-Individual	26 hours of individual or family therapy per year	H2019HR; H2019HR GT
Supported Housing/Living	480 hours or 20 days per year	H2017
Outpatient-Group	39 hours of group per year	H2019HQ
Mental Health Clubhouse Service	480 hours or 20 days per year	H2030

Other services such as Crisis Stabilization or Inpatient Detoxification are covered, in limited quantity, through Managed Medical Assistance programs.

11 https://www.flrules.org/gateway/readRefFile.asp?refId=3749&filename=Community%20Behavioral%20Health%20Services%20Coverage%20and%20Limitations%20Handbook_Adoption.pdf pages A1 to A10

The Department presently does not have restrictions on the number of services provided to each person served. The relevance of the Medicaid Fee-for-Service restrictions is that persons that continue to require specialized services may exhaust their Medicaid funded services and then have their services continued under a contract with a Managing Entity.

Comparison of Department Funded Services and Florida Medicaid Services

The Department received Fee-for-Service data from the Agency for Health Care Administration for State Fiscal Year 2015-16. The Florida Medicaid unit rate was taken from the Community Behavioral Health Services Coverage and Limitations Handbook. DCF unit rate was determined by taking the average Managing Entity contracted rate for State Fiscal Year 2015-16. Table 3 shows the relative difference in fees based on the nature of the service.

Table 3. Comparison of Florida Medicaid Fee-for-Service Rate and Average Managing Entity Rate for Comparable Services.

DCF Covered Service	Procedure Code and Modifiers	Service Description	Medicaid Unit Rate	DCF Unit Rate	Difference DCF (-) Medicaid
Assessment	H0001	Limited Functional Assessment, substance abuse per quarter hour	$ 15.00	$ 19.17	$ 4.17
Assessment	H0001HN	Bio-psychosocial Evaluation, substance abuse per assessment	$ 48.00	$ 76.67	$ 28.67
Assessment	H0001HO	In-Depth Assessment, new patient, substance abuse per assessment	$ 125.00	$ 76.67	$ (48.33)
Assessment	H0001TS	In-Depth Assessment, established patient, substance abuse per assessment	$ 100.00	$ 76.67	$ (23.33)
Assessment	H0031	Limited Functional Assessment, mental health	$ 15.00	$ 76.67	$ 61.67
Assessment	H0031HN	Bio-psychosocial Evaluation, mental health per assessment	$ 48.00	$ 76.67	$ 28.67
Assessment	H0031HO	In-Depth Assessment, new patient, mental health per assessment	$ 125.00	$ 76.67	$ (48.33)
Assessment	H0031TS	In-Depth Assessment, established patient, mental health per assessment	$ 100.00	$ 76.67	$ (23.33)
Assessment	H2000	Psychiatric Review of Records per review	$ 26.00	$ 76.67	$ 50.67
Assessment	H2000HO	Psychiatric Evaluation by a Non-Physician per assessment	$ 150.00	$ 76.67	$ (73.33)
Assessment	H2000HP	Psychiatric Evaluation by a Physician per assessment	$ 210.00	$ 76.67	$ (133.33)
Assessment	H2000HPGT	Psychiatric Evaluation by a Physician - Telemedicine per evaluation	$ 210.00	$ 76.67	$ (133.33)
Assessment	H2010HO	Brief Behavioral Health Status Exam per quarter hour	$ 14.66	$ 19.17	$ 4.51
Assessment	H2010HOGT	Brief Behavioral Health Status Exam - Telemedicine per quarter hour	$ 14.66	$ 19.17	$ 4.51
Assessment	H2010HQ	Brief Group Medical Therapy per quarter hour	$ 8.65	$ 19.17	$ 10.52
Assessment	H2019	Psychological Testing per quarter hour	$ 15.00	$ 19.17	$ 4.17
Day Treatment	H2012	Behavioral Health Day Services, mental health per quarter hour	$ 12.50	$ 11.12	$ (1.38)
Medical Services	H2010HE	Brief Individual Medical Psychotherapy, mental health per quarter hour	$ 15.00	$ 83.92	$ 68.92
Medical Services	H2010HF	Brief Individual Medical Psychotherapy, substance abuse per quarter hour	$ 15.00	$ 83.92	$ 68.92
Medical Services	T1015	Medication Management per event	$ 60.00	$ 335.68	$ 275.68
Medical Services	T1015GT	Medication Management - Telemedicine per event	$ 60.00	$ 335.68	$ 275.68
Medical Services	T1015HE	Behavioral Health related services: medical procedures, mental health per event	$ 10.00	$ 335.68	$ 325.68
Medical Services	T1015HF	Behavioral Health related services: medical procedures, substance abuse per event	$ 10.00	$ 335.68	$ 325.68
Medical Services	T1023HE	Behavioral Health Medical Screening, mental health per event	$ 42.62	$ 335.68	$ 293.06
Medical Services	T1023HF	Behavioral Health Medical Screening, substance abuse per event	$ 43.62	$ 335.68	$ 292.06
Medication Assisted Treatment	H0020	Medication-assisted Treatment Services Weekly Rate	$ 67.48	$ 11.69	$ (55.79)
Mental Health Clubhouse Services	H2030	Clubhouse Services per quarter hour	$ 5.00	$ 2.68	$ (2.32)
Outpatient	H2019HQ	Group Therapy per quarter hour	$ 6.67	$ 3.83	$ (2.84)
Outpatient	H2019HR	Individual and Family Therapy per quarter hour	$ 18.33	$ 15.31	$ (3.02)
Supportive Housing	H2017	Psychosocial Rehabilitation Services per quarter hour	$ 9.00	$ 14.48	$ 5.48

*NOTE: All recipients served by Florida Medicaid though Fee-for-Service providers in SFY15/16. Claims submitted and adjudicated as of 10/21/2016

Items in blue in Table 3 represent services where there is no direct equivalency in the unit of measure. For example, Florida Medicaid pays $125.00 per In-Depth Assessment, new patient, substance abuse regardless of how long the assessment takes. The Department pays based on time at an average rate of $76.17 per hour. Likewise, Florida Medicaid pays $60.00 for each Medication Management service. The Department pays $335.00 per hour for medical services which covers medication management.

Items in beige in Table 3 represent services where equivalency was established. The average Managing Entity rate is based on an hour of service. The hourly average Managing Entity rate was divided into quarter hours to compare with Florida Medicaid units of measure. For example, Florida Medicaid pays $14.66 per quarter hour of a Brief Behavioral Health Status Exam. The average Managing Entity rate of $76.67 was divided by 4 to arrive at a quarter-hour rate of $19.17.

A comprehensive review of fees payable by Florida Medicaid and the Department can be completed but will not yield accurate results at this time. Differences in units of measure complicate the analyses such that Florida Medicaid services paid for as a distinct event are not directly comparable to Department funded services paid for by duration. It is unlikely that a Medication Management event at the rate of $60.00 per event, as paid by Florida Medicaid, would cost the Department $335.68, as shown in Table 3. The Department in unable to accurately account for how many Medical Services are equivalent to T1015 Medication Management per event, and the Department is unable to determine the average length of time it takes to complete a Medication Management review. If it takes 20 minutes, then the Department rate would be $83.92 ($335.68 divided by 4). In such a scenario, the Department would pay $23.92 more than the Florida Medicaid rate. However, if it takes 10 minutes, the Department rate would be $55.95 or $4.05 less than the Florida Medicaid rate.

The comparison between the Department and Florida Medicaid rates illustrates the problem of having different units of measure. In order for the Department to better compare fee schedules with Florida Medicaid, the Department would need to adopt HCPCS codes. Adoption of such codes would require changes to 65E-14.021, F.A.C., and 394.74, F.S. In addition to allowing for true rate comparisons, the adoption of HCPCS codes will also eliminate an administrative burden on providers as they would not have to maintain one set of service codes for Department funded services and another, standardized set of codes, for all other healthcare services.