Behavioral Health Services Revenue Maximization Plan

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Better Health Care for All Floridians
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Legislatively Mandated Report

- 2016 Legislature passed Senate Bill 12 (s. 394.761(5), F.S.)

*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.*

Required Elements of Report

1. Amount of GR funding available to be used as state match for revenue maximization/ draw down of federal funds
2. Evaluate alternative uses of increased Medicaid funding including:
   - Seeking Medicaid eligibility for the severely and persistently mentally ill or persons with substance use disorders
   - Inclusion of targeted case management for individuals with substance use disorders as a Medicaid-funded services
   - Adjustments to the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders
   - Increased reimbursement rates for behavioral health services
   - Supplemental payments to mental health and substance abuse service providers through a designated state health program or other mechanisms
   - Innovative programs to provide incentives for improved outcomes for behavioral health conditions

Florida's System of Care for Behavioral Health Services

<table>
<tr><th></th><th>Agency for Health Care Administration: Medicaid Program</th><th>Department of Children and Families: Substance Abuse and Mental Health Program</th></tr>
<tr><td>Populations Covered</td><td>Parents and caretaker relatives of children under age 18
Children (including newborns) up to 21 years of age
Pregnant women
Former foster care individuals
Children in Foster care and Special need adoption children
Non-citizens with medical emergencies
The aged, blind and disabled</td><td>Children and adults who are otherwise unable to obtain mental health and substance abuse treatment services, including:
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.</td></tr>
<tr><td>Delivery System</td><td>Most people enrolled in Florida Medicaid are required to enroll in a health plan under the Managed Medical Assistance (MMA) component of the Statewide Medicaid Managed Care Program to receive Medicaid covered services.
MMA plans contract with local services providers for the provision of behavioral health services.</td><td>Participants receive services from providers contracted with seven Managing Entities (MEs).
DCF contract with these MEs for the administration and management of regional behavioral health systems of care throughout the state.
MEs contract with local service providers for the provision of prevention, treatment, and recovery support services.</td></tr>
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Behavioral Health Services for Adults: Medicaid vs. DCF

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

Behavioral Health Services (Available for Adults)	Medicaid	DCF
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

Florida's System of Care for Behavioral Health Services

	Agency for Health Care Administration: Medicaid Program	Department of Children and Families: Substance Abuse and Mental Health Program
Financing	• Jointly financed with state and local dollars • The amount of federal funding received is based on the state FMAP (Federal Matching Assistance Percentage). • The federal government pays 60% of every dollar spent on Medicaid services to Medicaid eligible individuals. • General revenue or other funding (intergovernmental transfers, certified public expenditures, etc.) must be allocated to fund the state share of Medicaid expenditures (40% of spend)	• Financed with state general revenue, federal discretionary grants, county matching funds, and federal block grant funding. • General revenue funding must be maintained for activities of the block grants; this is the "maintenance of effort" requirement.
Behavioral Health Population SFY 15-16	• 352,517 Medicaid recipients received Medicaid funded behavioral health services during state fiscal year 2015-2016.	• 303,769 SAMH client received DCF funded behavioral health services during state fiscal year 2015-2016.
Behavioral Health Expenditures SFY 15-16	• $396,464,409	• $562,589,890

General Revenue Funds Available

- A key component of revenue maximization plans is identifying the amount of funding available to draw down additional federal funds.
- DCF has identified **$412.4 million** in general revenue funding appropriated during fiscal year 2016-2017 for mental health and substance abuse services that may be eligible.
- Of this, $190.8 million is tied to federal Maintenance of Effort (MOE) requirements for DCF's federal grants.
  – Note: State general revenue funds that must be maintained for MOE purposes can also be used as the state match to receive federal Medicaid funding for covered services provided to Medicaid recipients.

Evaluation of Revenue Maximization Options

Revenue Maximization Options Explored

- Four types of options were explored with nine individual options:
- 1. Options that “free up” general revenue through program changes that allow state to draw down federal Medicaid match for services previously funded only by general revenue
  - Seeking Medicaid eligibility for people with severe mental illness (SMI) and/or substance use disorder (SUD)
  - Covering additional services through Medicaid for people with SUD

Revenue Maximization Options Explored (continued . . .)

- 2. Options that re-direct “freed- up” general revenue to provider payment and/or incentive programs
  - Adjusting the capitation rate for Medicaid enrollees with chronic mental illness and substance use disorders
  - Increasing reimbursement rates for Medicaid behavioral health treatment services
  - Increasing reimbursement rates to providers through incentive payments

Revenue Maximization Options Explored (continued . . .)

- 3. Options that use existing general revenue expenditures to draw down federal funds to be used for system transformations
  - Making supplemental payments to providers using Designated State Health Program model
  - Implementing innovative programs to provide incentives for improved outcomes for behavioral health conditions through a Delivery System Reform Incentive Payment (DSRIP) model

Revenue Maximization Options Explored (continued . . .)

- 4. Options that bring new funding into the system
  - Making supplemental payments to providers using Intergovernmental Transfers (IGTs) or Certified Public Expenditures (CPEs)

Option 1. Seeking Medicaid Eligibility for People with SMI and/or SUD

- Seek federal approval to extend Medicaid eligibility for people with SMI or SUD who currently are served through DCF's system of care and do not otherwise qualify for Medicaid or subsidized coverage.
- Options could include:
  - Full Medicaid benefits for people with SMI or SUD who are ages 21 – 65.
  - Medicaid behavioral health benefits only for adults with SMI or SUD who are age 21 – 65.
  - Full Medicaid benefits for mothers of substance exposed newborns, for a period of three years after the birth.
  - Full Medicaid benefits for parents and caretakers of children involved in the state's child welfare system who have substance use disorders and co-occurring mental illness.

Option 1: Seeking Medicaid Eligibility for the SMI and/or SUD Population

Option 1 Parameters:	
Federal Authority Required?	Yes
Type of Authority	1115 or 1915 (c) waiver, depending on population and services covered
Timeline for implementation	12-18 months
Additional Federal Reporting Requirements	CMS may require additional reporting requirements if an 1115 is utilized; yes if new 1915(c) waiver is needed
Utilize Medicaid Delivery System?	Yes if full benefits provided. New recipients would enroll in MMA plans for their health care. HCBS services under a 1915 (c) waiver could also be provided by MMA plans.
Utilize Managing Entities?	HCBS services under a 1915 (c) waiver could be provided by the MEs.
Funding Source	General revenue and federal matching funds. Some of the GR currently spent by DCF on providing services to this population could be used to offset the costs.

Option 2. Covering Targeted Case Management and Other Services as Medicaid-Funded Services for People with SUDs

- Medicaid covers Targeted Case Management (TCM) in limited circumstances:
  - 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.
- Florida Medicaid does not cover TCM for individuals who are only diagnosed with a substance use disorder.
  - The Department of Children and Families covers TCM services for individuals with an SUD.
  - There are approximately 8,000 Medicaid recipients with an SUD receiving TCM through DCF.

Option 2: Covering Targeted Case Management as Medicaid-Funded Services for People with SUDs

Option 2 Parameters:	
Federal Authority Required?	Yes
Type of Authority	Medicaid State Plan Amendment or 1115 amendment (if restricted to certain population)
Timeline for implementation	3-6 months for State Plan Amendment; 6-12 months for 1115 amendment
Additional Federal Reporting Requirements	No
Utilize Medicaid Delivery System?	Services could be added to the MMA benefit package and provided through the MMA plans.
Utilize Managing Entities?	Services could be excluded from the MMA benefits package and provided through the MEs, or MMA plans could be required to contract with MEs for this service.
Funding Source	General revenue and federal matching funds. 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 by DCF. General revenue would need to be appropriated to AHCA.

Option 3: Eliminate current limits on certain Medicaid covered behavioral health services

- Eliminate Medicaid coverage limitations for certain services for people with SMI/ SUD which are funded by DCF once Medicaid limits are reached:
  - Assessment service
  - Case management
  - Day treatment
  - Group therapy
  - Individual therapy
  - Medical services
  - Inpatient detoxification
  - Inpatient hospital services

Option 3: Eliminate current limits on certain Medicaid covered behavioral health services

Option 3 Parameters:	
Federal Authority Required?	Yes
Type of Authority	Medicaid State Plan Amendment or 1115 amendment (if restricted to certain population)
Timeline for implementation	3-6 months for State Plan Amendment; 6-12 months for 1115 amendment
Additional Federal Reporting Requirements	No
Utilize Medicaid Delivery System?	MMA plans already cover these services up to a limit and could cover the additional volume through their network of providers.
Utilize Managing Entities?	No
Funding Source	General revenue and federal matching funds. 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. General revenue would need to be appropriated to AHCA.

Option 4. Add Medicaid coverage of certain services for the SMI/SUD population

- These services are not covered by Florida Medicaid, but are offered by DCF using state general revenue funding.
- Add Medicaid coverage of:
  - Crisis stabilization
  - Incidental expenses
  - Residential services
  - Residential detoxification
  - Room and board with supervision
  - Supportive housing and supportive employment

Option 4: Add Medicaid coverage of certain services for the SMI/SUD population

Option 4 Parameters:	
Federal Authority Required?	Yes
Type of Authority	1115 Waiver Amendment
Timeline for implementation	12-18 months (including federal approval and engaging in transition activities)
Additional Federal Reporting Requirements	No
Utilize Medicaid Delivery System?	Yes. Services can be provided through the MMA plans or the Agency could require the plans to contract with the MEs in the delivery of care for recipients they have in common.
Utilize Managing Entities?	Yes. Services would be carved out of managed care and the Agency would make direct payments to the MEs.
Funding Source	General revenue and federal matching funds. 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. General revenue would need to be appropriated to AHCA.

Option 5. Increase the Capitation Rate for Medicaid Enrollees with Chronic Mental Illness and Substance Use Disorders

- Increase managed care plan capitation rates using a portion of the general revenue savings achieved from implementation of any of the previously discussed options to serve as the match for federal Medicaid funding.
- Options include:
  - Plans provide additional health benefits for the target population
  - Plans implement innovative quality improvement programs (such as the healthy behavior programs required in Part IV of Chapter 409, F.S.)
  - Plans pay providers more based on quality-related outcomes.

Option 5: Increase the Capitation Rate for Medicaid Enrollees with Chronic Mental Illness and Substance Use Disorders

Option 5 Parameters:	
Federal Authority Required?	Unknown, dependent on program specifics
Type of Authority	N/A
Timeline for implementation	Unknown, dependent on program specifics
Additional Federal Reporting Requirements	N/A
Utilize Medicaid Delivery System?	Yes, utilize existing MMA plans
Utilize Managing Entities?	No
Funding Source	General revenue and federal matching funds. Savings from drawing down federal dollars to fund services previously funded by 100% general revenue could be re-allocated to increase reimbursement rates for providers under either system. General revenue would need to be appropriated to AHCA.

Option 6. Increase Reimbursement Rates for Behavioral Health Services

- Adjust provider payment rates using a portion of the general revenue savings achieved from implementation of any of the previously discussed options to serve as the match for federal Medicaid funding.
  - Providers of mental health and substance abuse services are reimbursed either through the Florida Medicaid program or by the Managing Entities under the Department of Children and Families Substance Abuse and Mental Health program.
  - Savings from drawing down federal dollars to fund services previously funded by 100% general revenue could be re-allocated to increase reimbursement rates for providers under either system.
  - The Agency could also require the MMA plans to contract with the managing entities to provide services and develop an incentive payment program utilizing benchmarks for providers to earn incentive payments:

Option 6: Increase Reimbursement Rates for Behavioral Health Services

Option 6 Parameters:	
Federal Authority Required?	Unknown, dependent on program specifics
Type of Authority	N/A
Timeline for implementation	Unknown, dependent on program specifics
Additional Federal Reporting Requirements	N/A
Utilize Medicaid Delivery System?	Yes. MMA plans could be required to pay higher rates to providers directly or through subcontracting arrangements with the MEs.
Utilize Managing Entities?	Yes. MEs could receive incentive payments based on their provider performance.
Funding Source	General revenue and federal matching funds. Savings from drawing down federal dollars to fund services previously funded by 100% general revenue could be re-allocated to fund rate increases or an incentive program. General revenue would need to be appropriated to AHCA.

Option 7. Make Supplemental Payments to Providers using Designated State Health Program

- Use General Revenue to draw down additional federal funds through a federally approved Designated State Health Program
    - DSHP programs are time-limited and must support a goal of health system transformation
    - Federal funds could be used to implement previously discussed options (e.g., implementing innovative programs or services targeted towards individuals with chronic SMI or SUD)

Option 7: Make Supplemental Payments to Providers using Designated State Health Program

Option 7 Parameters:	
Federal Authority Required?	Yes
Type of Authority	1115 Waiver
Timeline for implementation	6-18 months
Additional Federal Reporting Requirements	Yes, associated with new 1115 waiver, and additional financial reporting also required for DSHP.
Utilize Medicaid Delivery System?	No
Utilize Managing Entities?	Yes. DCF would use MEs to manage new services and populations funded through the DSHP.
Funding Source	Existing general revenue and new federal funds. Federal funds would be time-limited.

Option 8. Implement Innovative Programs to Provide Incentives for Improved Outcomes for Behavioral Health Conditions

- Implement a Delivery System Reform Incentive Payment program (DSRIP)
  - Goal: Transformation of Medicaid payment and delivery system to achieve measurable improvements in qualify of care and overall population health
  - Focused on system transformation and improving outcomes
  - Incentive payments linked to performance-based initiatives

Option 8: Implement Innovative Programs to Provide Incentives for Improved Outcomes for Behavioral Health Conditions

Option 8 Parameters:	
Federal Authority Required?	Yes
Type of Authority	1115 Waiver
Timeline for implementation	6-18 months
Additional Federal Reporting Requirements	Yes, associated with new 1115 waiver, and additional financial and extensive data reporting also required for DSRIP
Utilize Medicaid Delivery System?	No
Utilize Managing Entities?	Yes. DCF would use MEs to manage new services and populations funded through the DSHP
Funding Source	Existing general revenue and new federal funds. Federal funds would be time-limited

Option 9. Make Supplemental Payments to Providers using IGTs or CPEs

- Supplemental payment could be funded through:
  - Intergovernmental Transfers (IGTs)
    - IGTs are funds moved from a governmental entity (e.g., counties, local taxing districts, county health departments, publicly funded hospitals) to Medicaid to draw down additional federal match for the Medicaid program.
  - Certified Public Expenditures (CPEs)
    - 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.
    - Certain health care provider organizations can use CPEs to draw down federal funds to fund uncompensated costs for medical care provided to Medicaid recipients.

Option 9: Make Supplemental Payments to Providers using IGTs or CPEs

Option 9 Parameters:	
Federal Authority Required?	Yes
Type of Authority	Unknown, dependent on program specifics
Timeline for implementation	Unknown, dependent on program specifics
Additional Federal Reporting Requirements	Unknown, dependent on program specifics
Utilize Medicaid Delivery System?	IGTs and CPEs could be used to fund increases to provider payments through the MMA program or the fee-for-service program.
Utilize Managing Entities?	IGTs and CPEs could be used to fund increased payments through the MEs.
Funding Source	IGTs and CPEs would serve as the state share of funding to draw down federal matching funds.

Summary of Four Revenue Maximization Options Explored

- 1. "Free up" general revenue through program changes that allow state to draw down federal Medicaid match for services previously funded only by general revenue
- 2. Re-direct "freed- up" general revenue to provider payment and/or incentive programs
- 3. Use existing general revenue expenditures, in place, to draw down federal funds to be used for system transformations
- 4. Bring new funding into the system

Questions?