MANAGING SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES WORKGROUP
October 2006

INTRODUCTION

Executive Summary

The Department of Children and Families' (DCF) Assistant Secretary for Substance Abuse and Mental Health (SAMH) appointed a workgroup to address the plans and business models for substance abuse and mental health services. The group met four times between March 16 and June 22, and group members also discussed a preliminary draft of this document on September 13. The group developed the following recommendations:

I Define DCF's SAMH covered populations for substance abuse and mental health by establishing eligibility criteria.

A. Reserve DCF funding for the medically indigent with medical indigence defined as lack of insurance coverage for needed services and the lack of income to pay for needed services. The workgroup recommends establishing financial eligibility at 250 percent of the poverty guideline.

B. Direct DCF funds to priority populations, most of which are predetermined through federal grant requirements, legislative action, court decisions, and policy decisions.

C. Review eligibility criteria on a periodic basis and revise as needed.

D. Monitor individual exceptions to eligibility guidelines and use the data gathered in this process to inform policy decisions about eligibility.

II. Support an effective and orderly transition to Medicaid reform.

A. Convene stakeholders to help them understand the payment changes and the responsibilities of DCF and HMOs.

B. Work with HMOs to help them identify potential problems and to encourage and support their use of evidence-based practices.

C. Assure that stakeholders, service recipients, and providers are aware that DCF is not the funding body for Medicaid recipients.

D. To ease the transition to Medicaid reform, DCF would continue to fund Medicaid recipients for certain mental health services not in the Medicaid Handbook. This practice would be reconsidered within two years. Likewise, DCF would continue to cover Medicaid recipients for certain substance abuse services while Medicaid-covered substance abuse services remain reimbursed on a fee-for-services basis.

III. Support several approaches to service management and managing entities depending on the characteristics of the districts.

A. The workgroup identified three broad methods of service management, including managing entities responsible for both contract and service management, managing entities responsible for certain service management functions but not contract management, and district staff members providing service management functions directly with the possibility of relying on lead agencies.

B. The workgroup discussed several sources of funding for managing entities: reserving a percentage of revenues for managing entities that manage contracts, directing funds directly to service management functions, and funding managing entities from efficiencies achieved with case rates **and capitation** funding.

IV. Align statutes and state policy in the areas of eligibility, enrollment, case rates, and authorizations of the managing entities.

V. Improve the data management and payment systems so they can support flexible, prospective-payment systems such as case rates and provide the more refined utilization data needed by districts and managed entities.

Workgroup Charge

In March of 2006, Ken DeCerchio established a workgroup charged with the following items:

- Identification of those strategies, goals, objectives, and aspirations that will direct the desired delivery and provision of substance abuse and mental health services over the next 3 to 5 years

- Identification of business models (e.g. managing entities, ASO, lead agency, district), methods, and practices required to meet those goals and objectives

- Development of an operational plan that implements the identified business models, methods, and practices

He also presented the workgroup with a series of assumptions and considerations that served as parameters for the workgroup. (See Attachment I: Assumptions and Considerations)

Workgroup Members

Table 1: Workgroup Members and affiliations

Name	Affiliation
Pamela Baker	District 8 SAMH Program Supervisor
Richard Brown	Chief Operating Officer, ACT's Corporation – Tampa
John N. Bryant	Chief of Operations, SA Program Office
Sheila Collins	Chief of Performance Management, SA Program Office
Susan Dickerson	Senior Management Analyst, SAMH
Carolann Duncan	District 7 SAMH Program Supervisor
Gina Giacomo	Operations Management Consultant, SAMH Contracts Unit
Pat Kramer	District 10 SAMH Program Supervisor
Tom Lucking	Consultant
Lonnie Mann	Governmental Analyst, MH Program Office
Lucia Maxwell	Consultant, FADAA
Aleisa McKinlay	Chief of Operations, MH Program Office
Debbie Spellman	Suncoast Region SAMH Program Supervisor
Silvia Quintana	District 11 SAMH Program Supervisor
Bob Sharpe (Represented by Kate Lyon)	Vice President, Florida Council for Community Mental Health
Dick Warfel	District 4 SAMH Program Supervisor

Workgroup meetings

March 16, 2006 in Orlando
April 18, 2006 in Tampa
May 15, 2006 in Tampa
June 22 2006 in Fort Lauderdale
September 13 teleconference

RECOMMENDATION I
DEFINE DCF'S COVERED POPULATIONS FOR SUBSTANCE ABUSE AND MENTAL HEALTH BY ESTABLISHING ELIGIBILITY CRITERIA.

After much deliberation, the workgroup concluded that the development of strategic directions, recommended models, and operational items hinged on developing **precise** definitions of the populations that DCF SAMH serves. Doing so could help DCF reserve its resources for priority populations with the greatest need for DCF support and set the stage for more accountable service systems. For example, more precise population definitions could help DCF link recipients to outcomes for both individuals and populations.

DCF's limited pools of state and federal funds are the only source of funding for most low-income recipients who lack insurance coverage for substance abuse and mental health services. If DCF were to fund services for persons with other sources of payment, DCF would be reducing access for the large number of people with no other sources of support. This issue is particularly important with Medicaid reform. (See the discussion of this issue under Recommendation II.) Also, clear population definitions can help establish accountability measures for provider organizations and managing entities. For example, holding a provider or managing entity responsible for meeting certain access standards or outcomes within a given population presupposes a clear definition of the population.

Reserve DCF funding for the medically indigent with medical indigence defined as lack of insurance coverage for needed services and the lack of income to pay for needed services. The workgroup recommends establishing financial eligibility at 250 percent of the poverty guideline.

Most states establish medical indigence according to the lack of insurance for needed services and an income level that is expressed as a proportion of the federal poverty guidelines. Most states choose some multiple of the federal guideline, such as 200 or 250 percent of the federal guideline (See Attachment II: January 2006 Federal Poverty Guidelines). Table 2 below presents the distribution of income levels for persons receiving DCF-funded services during the 2005 – 2006 fiscal year.

Table 2	**Mental Health**			**Substance Abuse**		
Poverty Level	**Medicaid**	**Non-Medicaid**	**Total**	**Medicaid**	**Non-Medicaid**	**Total**
100%	88,244	209,153	297,397	8,796	84,272	93,068
200%	6,175	24,736	30,911	1,054	24,522	25,576
250%	731	4,234	4.965	129	6,581	6,710
Other	2,027	8,160	10,187	271	11,752	12,023
Total	97,177	246,283	343,460	10,250	127,127	137,377

Table 2 indicates that most DCF service recipients, regardless of Medicaid eligibility, are within 100 percent of the federal poverty guideline and well over 90 percent are within 250% of the federal poverty guideline.

Direct DCF funds to priority populations

Most priority populations are already determined through federal grant requirements, legislative action, court decisions, and policy decisions (See Attachment III: Priority Populations). Given the state's level of funding, reserving DCF funds to people whose incomes fall below a particular economic threshold, even one as low as 100 percent of the poverty guideline, would probably leave a situation in which the service needs of priority populations would exceed the services that could be purchased by DCF funding.

Review eligibility criteria on a periodic basis and revise as needed

From time to time, the optimal definition of DCF's eligibility criteria will change with changes in population characteristics, state and federal policy directives, available resources, and other factors. DCF will need to review and change its eligibility criteria accordingly.

Monitor exceptions to eligibility guidelines and use the data gathered in this process to inform policy decisions about eligibility.

RECOMMENDATION II
SUPPORT AN EFFECTIVE AND ORDERLY TRANSITION TO MEDICAID REFORM

DCF can take an important role in supporting an effective and orderly transition to Medicaid reform. The workgroup recommends that DCF undertake the following in its role as the authority for mental health and substance abuse:

- Convene stakeholders to help them understand the payment changes and the responsibilities of DCF and HMOs.
- Work constructively with HMOs to help them identify potential problems and to encourage and support their use of evidence-based practices.
- Assure that stakeholders, service recipients, and providers are aware that DCF is not the funding body for Medicaid recipients.
- To ease the transition to Medicaid reform, DCF would continue to fund Medicaid recipients for certain mental health services not in the Medicaid Handbook. This practice would be reconsidered within two years. Likewise, DCF would continue to cover Medicaid recipients for certain substance abuse services while Medicaid-covered substance abuse services remained reimbursed on a fee-for-services basis.

Medicaid-enrolled recipients are not medically indigent by definition because they have access to the full range of services outlined in the Medicaid Handbook and the HMOs could add other services. However, at least for the near term, DCF has two reasons for continuing to fund certain services not in the Medicaid Handbook for Medicaid recipients and possibly others who are not medically indigent. First, establishing financial eligibility and responsibility is not always compatible with a timely response for urgent conditions. Therefore, under certain conditions, DCF will continue to support selected crisis services. Second, up to now, the DCF and Medicaid funded systems have been intertwined as Medicaid eligible providers have been required to be DCF-contracted providers. This brought about a sort of blended system in which providers and stakeholders sometimes treated DCF as a "re-insurer" when Medicaid did not pay for services. In the context of this blended system, DCF absorbed the costs of some services not billed to Medicaid. This is evidenced by DCF's data indicating that Medicaid enrollees have received a substantial amount of DCF-funded services. (See Attachment IV: The Value of Non-Medicaid Billable Services Provided to Medicaid Enrolled Individuals during FY 04-05.) During FT 2004-2005, 51,067 adult service recipients who were Medicaid-enrolled received services valued at $88,544,328.71 that were **not Medicaid billable.** This constituted nearly **75 percent of all Medicaid enrolled adults receiving DCF-funded services.**[1] While Medicaid reform will bring about an end to the blended system, stakeholder expectations for DCF to take lead responsibility may remain and service dislocations may occur. By continuing to pay for certain services not in the Medicaid Handbook, such as housing, DCF could reduce or cushion service dislocations for service recipients.

On the other hand, a DCF commitment to continue funding certain services for Medicaid recipients would need to be revisited after a year or two. Like all insurance plans, Medicaid plans will have a financial incentive to have services provided to their members paid for by other purchasers. In addition, Medicaid managed-care rollouts often result in financial stress for providers, and providers will have an incentive to bill DCF to the extent possible. Consequently, unless DCF establishes clear boundaries, its resources could be redirected from servicing the medically indigent to subsidizing Medicaid HMOs. Also, DCF would need to be cautious about giving insurance plans of all kinds a disincentive to develop adequate coverage because of DCF's willingness cover certain services. Finally, DCF is working to transform its services system, and this transformation will bring about changes in service patterns. For example, systems that are transforming put more reliance on natural community supports and living situations and are therefore less likely to purchase certain residential services. Consequently, DCF will need to consider whether or not non- Handbook services fit within a transforming system.

Nearly all of the workgroup's deliberations about Medicaid centered on mental health services and very little centered on substance abuse services. This is because Medicaid funds a high proportion of publicly-funded mental health services and a low proportion of publicly-funded substance abuse treatment. Also, Medicaid substance abuse services

[1] Just as DCF subsidized some Medicaid services, the Medicaid fee-for-service system generated a volume of care that has helped pay for capacity and thereby subsidize DCF-funded services. This subsidy is ending.

have not been added to managed care contracts anywhere in the State, including the Medicaid reform demonstration projects, because AHCA has judged both the provider network and the funding available to be inadequate. F.S. 409.912(4)(b) authorizes AHCA to decide when resources are adequate for capitation. For this reason, Medicaid reform transition will occur later for substance abuse providers and services. Yet Medicaid funding for substance abuse services is an important source of support to those recipients covered by Medicaid and to the DCF-funded system as a whole. **Consequently, workgroup members associated with FADAA suggested several courses of action specific to Medicaid and substance abuse services. These items are included in Attachment V.**

RECOMMENDATION III
SUPPORT SEVERAL APPROACHES TO SERVICE MANAGEMENT AND MANAGING ENTITIES

Support several approaches to service management

DCF SAMH's broad strategic goals of transformation, the application of evidence-based practices, and the delivery of consumer-centered, integrated care require that services be managed. Trying to accomplish these goals through individual contracts with individual providers can be difficult because doing so reinforces provider-by-provider service delivery. While some providers may cooperate with efforts to coordinate care across systems of care, others may not. In either case, individual provider contracts tend to focus the district's staff members on operational issues, while a single contract with a managing entity can help district staff members focus on systems-integration and strategic issues.

The goals are to approach service planning from both a systems perspective as well as an individual recipient's perspective rather than an agency perspective, and to achieve greater coordination and integration that promotes recipient timely access to the most appropriate services. The workgroup discussed several service management functions, including:

- The development of integrated, consumer-centered systems of care, clinical pathways, and improved care coordination.
- The coordination of the implementation of evidence-based practices, including service design, peer reviews, and shared training resources.
- Adding structures for supporting self-directed care..
- Applying formal quality management activities to the systems level.
- Expanding utilization management, which can include prior and concurrent authorizations and can also be limited to retrospective reviews of pre-established pathways.
- The development of networks and contract management (managing entities with contracting authority may only provide administrative, and not direct services).

- The management of contracts, including data management (monitoring, validation, and planning), claims processing, and vendor technical support.
- Consumer and stakeholder engagement in implementation planning for local systems of care.

Different districts may take different approaches to service management. For example, Florida's current managing entities include one that manages contracts and services for nearly all of the DCF-funded substance abuse and mental health services in a district. Another managing entity manages all of the substance abuse services contracts in a region. Another manages contracts and services for a particular population. Others do not manage subcontracts and instead focus on certain supportive activities, such as quality improvement and utilization management. Some of the factors influencing the type of service management activities include the district's existing capacities for service management, the availability of provider organizations, populations, and the needs of particular districts.

The workgroup discussed several approaches to managing entities:

- Managing entities responsible for contract and service management

  With this model, the managing entity provides service management activities as well as contract management activities. Assigning contract management to the managing entity allows for the broad applications of flexible funding, including case rates and other partial-risk funding mechanisms. Also, it can help districts focus less on direct operations and more on community, systems integration, and strategic issues. On the other hand, contract management is an administrative function, and it draws the most scrutiny.

- Managing entities responsible for service management but not contracting

  With this model, the managing entity takes on a series of contracted service management functions but network development and contract management remain with the districts. This model may be an intermediary stage leading to a model in which the managing entity also manages contracts. However, in some districts, the district office may retain the contract management function indefinitely. The managing entity can be charged with systems integration.

- District provided managing services and reliance on lead agencies

  Rather than contracting for managing entity services, the districts might provide managing services directly. Limitations in district staffing would make this impossible in most situations. This model may work best in rural areas or other areas in which one provider functions as the lead provider for a county or specialty service and coordination is an internal matter for this provider.

Funding of managing entities

The committee discussed several options for funding of managing entities, each of which might be appropriate in different circumstances.

- Paying the managing entity a proportion of dollars it manages. (This model presupposes that the managing entity subcontracts with a provider network.)
- Paying the managing entity directly for the services it provides.
- As with managed care organizations, redirecting a portion of the efficiencies from case raters and other forms of flexible contracting to cover the costs of the managing entities.

The Department currently contracts with managing entities that perform a number of functions and are funded in several different ways. Table 3 below summarizes the location of managing entities, their contract functions, and the methods used to fund their activities.

Table 3: Managing entities: functions and funding

Location	Function	Funding
Districts 4 and 12 Northeast Florida Addictions Network (NEFAN)	Administer the Family Intervention Specialist Program and TANF funded women's services for Districts 4 and 12.	-OPS funds contracted by Districts 4 and 12: $88,000 -Administrative assessment applied to TANF services
Suncoast Region Central Florida Behavioral Health Network	Administration of all publicly funded substance abuse services within the Suncoast Region including contracting, utilization management, quality management, TANF services, and system of care development.	4.5% Administrative cost applied to all public funds contracted through the entity
District 1 Access Behavioral Health (Licensed Health Plan)	Managing entity for mental health and substance abuse treatment and Medicaid funds. All public funded behavioral health services contracted and managed by Access Behavioral.	Rates for administration negotiated annually. Currently established at 3% of total contracted funds.
District 11 South Florida Provider Coalition	Administration of all Departmental substance abuse treatment funds and services for District 11 including contracting, utilization management, performance management, and system of care management.	Rate for administration and management negotiated annually. Currently established at 7% of total contracted funds.

RECOMMENDATION IV
ALIGN STATUTES AND STATE POLICY IN THE AREAS OF ELIGIBILITY, ENROLLMENT, CASE RATES, AND AUTHORIZATION OF THE MANAGING ENTITIES

Accomplishing recommendations I through III will require substantial policy changes and perhaps changes in legislation. In any case, DCF will need to define the role and scope of managing entities and review the need for legislative changes.

RECOMMENDATION V
IMPROVE THE DATA MANAGEMENT AND PAYMENT SYSTEMS

The data management and payment systems need to be improved so that they can support flexible, prospective-payment systems such as case rates and provide the more refined utilization data needed by districts and managed entities.

Fee-for-service contracting can reinforce the delivery of services organized according to cost centers instead of systems of recipient-centered care. Prospective payment systems, such as case rate systems, can better support the flexible delivery of recipient-centered care. However, the development and management of case rate and capitation systems requires reliable encounter data that is gathered recipient-by-recipient, while the current DCF system gathers aggregate encounter data. In addition, optimal flexible financing systems require payment systems capable of great variation. For example, DCF was forced to end a promising case-rate system in the late nineteen-nineties because of the limitations of its data and payment systems.

Attachment I: Assumptions and Considerations

- The Department's Substance Abuse and Mental Health Program Offices are the designated "Single State Authority" (SSA) for the administration and management of federal funds, including Block Grants and other direct grants to the state.

- This role as the SSA is currently viewed by EOG and leadership of the Department as one that holds broad responsibilities for the planning, inter/intra agency coordination, and collaboration.

- The Department will move forward with its Mental Health Transformation and Reform Initiative promoting a person-centered recovery orientation to the design of mental health service delivery models. **Substance Abuse has implemented a client choice model through ATR.**

- The changing approaches by AHCA in methods of providing behavioral health services to Medicaid covered service recipients and the impact these changes have on the mission and obligation of DCF to cover a large number of non-Medicaid clients.

- Coordination and cooperation with Medicaid remains critical, yet DCF needs to take affirmative action and not wait for Medicaid reform to define DCF's role.

- The work and recommendations of the managing entity contracting and data information system work group will be considered as part of the products and recommendations of this workgroup.

- The Department will retain the latitude to apply different methods and strategies (provider networks, managing entities, ASOs, the districts) to achieve the goals and objectives identified as a result of the workgroup.

- Any business model has to advance improvements in the system of care, as defined by improving the experience (processes and outcomes) of customers who utilize these services, including advancing transformation to recovery and resiliency for mental health services.

- There will not be new funding to support administrative infrastructure.

- Models need to minimize duplication of administrative functions between the districts/department and the models being recommended. Ideally, it would create efficiencies at the customer level.

Attachment II: January 2006 Federal Poverty Guidelines

[Federal Register: January 24, 2006 (Volume 71, Number 15)]
[Notices] [Page 3848-3849] From the Federal Register Online via GPO Access
[wais.access.gpo.gov]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of the Secretary, Annual Update of the HHS Poverty Guidelines

2006 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family unit	Poverty guideline
1	$9,800
2	13,200
3	16,600
4	20,000
5	23,400
6	26,800
7	30,200
8	33,600

For family units with more than 8 persons, add $3,400 for each additional person.

Attachment III: Priority Populations

Substance Abuse

The Substance Abuse Program provides prevention, intervention, detoxification, treatment and recovery support services to children, adults, and their families with two primary areas of emphasis: 1) persons who are at-risk for developing substance abuse problems and 2) persons with substance abuse problems. Within these two areas there are several key client groups that services focus on:

Adults

- **Intravenous Drug User** — individuals with substance use disorders with either a history of IV drug use or current drug of choice is administered through injection.
- **Dual Diagnosis** — individuals with Axis I or Axis II mental disorder and a primary or secondary diagnosis of a substance abuse disorder.
- **Parents Putting Children At Risk** — individuals above the age of 17 with substance use disorders who are pregnant or have one or more dependents under the age of 17 for whom they are the custodial parents or the individual or his/her dependent receives services from Family Safety.
- **Persons Involved with Criminal Justice System** — individuals with substance use disorders that have been mandated by the court to receive treatment or are under community supervision of a criminal justice entity.
- **Older Adult** — individuals who are 60 years of age or older who at-risk of substance misuse, abuse or dependence.

Children

- **Children At-Risk** — children who are at risk of initiating drug use or developing substance problems due to individual and environmental risk factors.
- **Children Under State Supervision** — children with substance use disorders who are under supervision of the Department of Juvenile Justice or are recipients of services from Family Safety.
- **Children Not Under State Supervision** — children with substance use disorders who are not under the supervision or custody of a state agency.

Mental Health

Children with or at-Risk for Emotional Disturbances

Children with Serious Emotional Disturbance (SED): This target population, whose services are provided in the community, includes persons under the age of 18, who meet one of the following criteria: (a) have a diagnosis of schizophrenia or other psychotic disorder, major depression, mood disorder, or personality disorder; or (b) are currently classified as a student with serious emotional disturbance by a local school district; or (c) are currently receiving Supplemental Security Income benefits for psychiatric disability; or (d) have an allowable diagnosis other than those listed above and have a Children's Global Assessment Scale (CGAS) score of 50 or below.

Children with Emotional Disturbance (ED): This target population, whose services are provided in the community, includes persons under the age of 18, who meet one of the following criteria: (a) have an allowable diagnosis other than those listed above and Children's Global Assessment Scale (CGAS) score of 51-60, or (b) are currently classified as a student with an emotional handicap by a local school district.
Children at-Risk of Emotional Disturbance: This target population, whose services are provided in the community, includes persons under the age of 18, who have a mental health problem and meet one of the following criteria: (a) do not have a mental health diagnosis but have risk factors associated with an increased likelihood of developing an emotional disturbance (such as homelessness, family history of mental illness, abuse or neglect, domestic violence exposure, substance abuse, chronic physical illness, or multiple out-of-home placements) or (b) have a current referral for placement in an Emotionally Handicapped (EH) program in accordance with the Individuals with Disabilities Education Act (IDEA).

Adults in the Community
Adults with Severe and Persistent Mental Illness (SPMI): This target population, whose services are provided in the community, includes persons above age 17 who have a diagnosis or diagnostic impression of Axis I or Axis II mental disorder and have any of the following characteristics: (a) have documented evidence of long term psychiatric disability; or (b) receive income due to psychiatric disability (e.g., SSI, SSDI, Disabled Veterans income or other type of disability income); or (c) are over the age of 59 and demonstrate inability to perform independently in day-to-day living (e.g., personal hygiene, dressing appropriately, obtaining regular nutrition and housekeeping).
Adults in Mental Health Crisis: There are two sub-groups in this target population: (a) *Adults with Serious and Acute Episodes of Mental Illness*, that is, persons above the age of 17 who have a mental health problem and meet criteria for admission to a mental health facility under Chapter 394, Part I (Baker Act), Florida Statutes; and (b) *Adults with Mental Health Problems*, that is, persons above age 17 who have a presenting mental health problem and meet any of the following criteria: (a) show evidence of a recent severe stressful event and problems with coping; or (b) display symptomatology placing the person at risk of more restrictive intervention if untreated (with short-term intervention —less than one year — the individual's symptomatology can be reduced or eliminated).
Adults with Forensic Involvement: This target population, whose services are provided in the community, includes persons above the age of 17 who meet the following criteria: (a) have an "Incompetent to Proceed" (ITP) Court Order due to mental illness; or (b) have a "Not Guilty by Reason of Insanity" (NGI) Court Order; or (c) are on Conditional Release due to mental illness.

Adults in Facilities (including Sexually Violent Predators)
Adults in Civil Commitment: This target population, whose services are provided in state mental health treatment facilities (hospitals/institutions), includes persons above age 17, who meet the following criteria: (a) committed in accordance with Chapter 394, Florida Statutes, also known as the Baker Act; or (b) admitted on either a voluntary or

involuntary basis; or (c) committed in accordance with Chapter 394, Part V, Florida Statutes, Involuntary Civil Commitment of Sexually Violent Predators.

Adults in Forensic Commitment: This target population, whose services are provided in state mental health treatment facilities (hospitals/institutions), includes persons above the age of 17 or juveniles adjudicated as adults, who meet the following criteria: (a) admitted for evaluation and treatment by court order for commitment under Chapter 916, Florida Statutes, and Rules 3.210-219, Rules of Criminal Procedure; or (b) charged with a criminal offense and classified as incompetent to proceed to trial or not guilty by reason of insanity.

Violent Sexual Predators: Persons committed to the Department of Children and Families pursuant to Chapter 394, F.S. Part V. These persons are either placed in the department's custody pending disposition, or committed to the department for treatment as a violent sexual predator.

ATTACHMENT IV: THE VALUE OF NON-MEDICAID BILLABLE SERVICES PROVIDED TO MEDICAID ENROLLED INDIVIDUALS DURING FY 04-05

AMH SSNs that are Medicaid Enrolled (E) and received Non-Medicaid Billable (NB) services during FY 0405 - by Cost Center

Total Medicaid Enrolled	Unduplicated Total of Medicaid Enrolled (E) Persons Receiving Non-Medicaid Billable (NB) Services	Percent of E Persons Receiving NB Services
68,725	51,067	74.3%

- There are cost centers (CCs) listed below that are usually considered Medicaid Billable (B); however, there are services (procedures) within each CC that are Not Medicaid Billable (NB), so those CCs are included in this list.
- Counts are unduplicated within a CC, but duplicated between CCs.

Cost Center Code	Cost Center Name	Sum of Units	Average State Rate for AMH	"Cost": rate * units	Count of SSN	Units Per Person	Percent of Unduplicated Total SSNs	Percent of Duplicated Total SSNs	Percent of Total Cost/Rate
01	Assessment	402.37	$72.92	$ 29,340.14	707	0.57	1.4%	0.9%	0.0%
02	Case Management	121,063.25	$53.19	$ 6,439,039.50	8215	14.74	16.1%	10.8%	7.3%
03	Crisis Stabilization	48,263.00	$264.35	$ 12,758,188.91	5391	8.95	10.6%	7.1%	14.4%
04	Crisis Support/Emergency	6,899.25	$38.31	$ 264,340.62	4024	1.71	7.9%	5.3%	0.3%
05	Day Care	31.00	$30.30	$ 939.30	22	1.41	0.0%	0.0%	0.0%
06	Day/Night	32,436.00	$52.98	$ 1,718,384.68	1296	25.03	2.5%	1.7%	1.9%
07	Drop In/Self-Help Centers	196.00	$320.00	$ 62,720.57	35	5.60	0.1%	0.0%	0.1%
08	In-Home & On-Site Services	28,022.71	$58.73	$ 1,645,812.99	957	29.28	1.9%	1.3%	1.9%
09	Inpatient	13,110.00	$337.66	$ 4,426,696.38	1279	10.25	2.5%	1.7%	5.0%
Cost Center	Cost Center Name	Sum of Units	Average State	"Cost": rate * units	Count of SSN	Units Per	Percent of Unduplicated	Percent of Duplicated	Percent of Total

Code			Rate for AMH			Person	Total SSNs	Total SSNs	Cost/Rate
10	Intensive Case Management	44,526.06	$59.37	$ 2,643,494.37	871	51.12	1.7%	1.1%	3.0%
11	Intervention	3,804.98	$57.35	$ 218,209.52	1002	3.80	2.0%	1.3%	0.2%
12	Medical Services	43,625.39	$283.42	$ 12,364,225.15	35060	1.24	68.7%	46.0%	14.0%
14	Outpatient	48,260.74	$79.61	$ 3,842,273.99	7109	6.79	13.9%	9.3%	4.3%
15	Outreach	1,566.68	$40.20	$ 62,976.31	207	7.57	0.4%	0.3%	0.1%
16	Prevention	4.25	$36.56	$ 155.39	5	0.85	0.0%	0.0%	0.0%
18	Residential Level 1	16,962.00	$216.95	$ 3,679,863.50	134	126.58	0.3%	0.2%	4.2%
19	Residential Level 2	20,647.00	$144.71	$ 2,987,817.05	265	77.91	0.5%	0.3%	3.4%
20	Residential Level 3	8,870.00	$73.25	$ 649,748.79	96	92.40	0.2%	0.1%	0.7%
21	Residential Level 4	31,128.00	$40.32	$ 1,254,940.88	157	198.27	0.3%	0.2%	1.4%
22	Respite Services	0.84	$12.84	$ 10.79	1	0.84	0.0%	0.0%	0.0%
23	Sheltered Employment	5,677.00	$74.30	$ 421,772.72	187	30.36	0.4%	0.2%	0.5%
24	Substance Abuse Detox	34.00	$182.00	$ 6,188.00	14	2.43	0.0%	0.0%	0.0%
25	Supported Employment	51,661.58	$48.44	$ 2,502,724.58	1383	37.35	2.7%	1.8%	2.8%
26	Supported Housing	150,476.18	$49.23	$ 7,407,340.44	2492	60.38	4.9%	3.3%	8.4%
28	Non-Contractual Services	297.84	$49.94	$ 14,874.93	143	2.08	0.3%	0.2%	0.0%
29	Aftercare	2,818.13	$57.70	$ 162,597.65	353	7.98	0.7%	0.5%	0.2%
Cost Center	Cost Center Name	Sum of Units	Average State	"Cost": rate * units	Count of SSN	Units Per	Percent of Unduplicated	Percent of Duplicated	Percent of Total

Code			Rate for AMH			Person	Total SSNs	Total SSNs	Cost/Rate
30	Information & Referral	353.00	$31.08	$ 10,970.08	4	88.25	0.0%	0.0%	0.0%
34	FACT	104,957.82	$45.46	$ 4,771,004.65	1895	55.39	3.7%	2.5%	5.4%
35	Outpatient Group	41,148.96	$21.97	$ 903,853.37	1599	25.73	3.1%	2.1%	1.0%
36	Room and Board 1	11,417.00	$176.32	$ 2,013,016.90	100	114.17	0.2%	0.1%	2.3%
37	Room and Board 2	62,103.00	$107.62	$ 6,683,692.54	370	167.85	0.7%	0.5%	7.5%
38	Room and Board 3	62,010.00	$73.74	$ 4,572,369.36	308	201.33	0.6%	0.4%	5.2%
39	SRT	16,248.00	$245.73	$ 3,992,690.91	476	34.13	0.9%	0.6%	4.5%
40	Clubhouse	1,025.00	$31.27	$ 32,053.80	78	13.14	0.2%	0.1%	0.0%
			Totals	$ 88,544,328.71	76,235		149.3%	100.0%	100.0%

ATTACHMENT V: MEDICAID/SUBSTANCE ABUSE SERVICES COURSES OF ACTION

As noted in the body of the report, Medicaid substance abuse service issues received less attention from the workgroup because of the immediacy of the changes in Medicaid reform and the higher proportion of mental health recipients and services covered by Medicaid. The workgroup members associated with FADAA suggested the courses of action presented below.

DCF will continue to pay for services not covered by Medicaid. Since substance abuse is not yet capitated anywhere in the state, this would include residential services, services when the recipient has received maximum billable services, and also three services which will not be available in counties which do not participate in the Local Match Certification program – outpatient detoxification, intervention, and aftercare.

DCF should work with AHCA to develop a workable policy for managing Medicaid substance abuse services, including determination of when sufficient resources exist for capitated, pre-paid contracts. Also, evaluate the option of AHCA contracting with DCF to manage capitated Medicaid substance abuse services.