



ANALYSIS OF FLORIDA'S BEHAVIORAL HEALTH MANAGING ENTITY MODEL

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Dear Fellow Taxpayer:

We are honored to present this research analysis of Florida's Behavioral Health Managing Entity (BHME) system. The BHME is the management system through which the state delivers behavioral health services to uninsured Floridians. Behavioral health services, including community-based substance abuse and mental health treatment, are vital to many of the most vulnerable Floridians, and ensuring the efficient and effective delivery of these services is of great value to taxpayers statewide. Organizations that make up Florida's BHME system administer millions of dollars worth of services to Floridians in need in every community throughout the state.

Ensuring that the delivery of government services is efficient and effective is a core function of Florida TaxWatch. Along with promoting and protecting budget integrity, improving taxpayer value and government accountability, and educating citizens on the activity of their government, analyzing government service delivery models is the mission of Florida TaxWatch as a nonpartisan, nonprofit public policy research institute.

This analysis finds that the BHME model is generally a good model for delivery of these services, but that barriers limiting the success of the system remain. The report makes recommendations to improve the system, remove the barriers to full access, and enhance taxpayer value.

Respectfully,

Dominic M. Calabro
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President & CEO

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EXECUTIVE SUMMARY

Florida delivers substance abuse and mental health services to the indigent and uninsured through a regional model managed by Behavioral Health Managing Entities (BHMEs). This report finds that this BHME model is a good behavioral healthcare system that provides a framework for future success. TaxWatch recommendations to build upon the current model hope to expedite that success through:

- Data driven funding for BHMEs and their service providers;
- Greater funding flexibility;
- Continued/transitional treatment for young adults who aged out of youth services and are ineligible for adult services; and
- Improved data reporting systems and outcome measures that will assist future analyses.

INTRODUCTION

Florida administers the delivery of behavioral health services to the indigent and uninsured through what is referred to nationally as a regional model. In Florida, this regional model is managed by a group of nonprofit organizations called Behavioral Health Managing Entities (BHMEs). This model was designed to promote access to care and service continuity, be more efficient and effective, and streamline the administrative process to create cost efficiencies and provide flexibility to better match services to needs.

Florida's behavioral health system has gone through several transformations to address the changing needs of the communities it serves. During this process, the system has faced challenges as well as seen significant improvements.

This paper analyzes the BHME model by exploring the history of Florida's BHME model, BHME models in other states, and the benefits and limitations of the model. The analysis concludes with several recommendations for the continued improvement of Florida's BHME model.

HISTORY

The history of behavioral health systems across the United States show that the creation of an ideal substance abuse and mental health delivery model is a process of evolution. In the early stages of behavioral health systems, Florida and the rest of the nation consisted primarily of individual providers funded by local governments or charitable donations and no organized system of publicly funded mental health programs existed. This changed in 1968, when the Florida Constitution was revised to assign health and social services to the Department of Health and Rehabilitative Services (DHRS). This became one of the first attempts in the nation to integrate health and human services, and was meant to address the increasingly complex health and social needs that were neglected through a disjointed and inadequate system of care.¹

¹ "Constructing a Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Treatment System: Strategies for Planning, Leadership, Financing, and Service Development." (2007). Florida Supreme Court.

Florida began the first of many attempts to restructure and improve DHRS in 1975. Eleven service districts within the state were outlined to better implement services at the local level. The old structure was abandoned and the Alcohol and Drug Abuse and Mental Health (ADM) program offices were created. Over time, ADM offices took over the roles of mental health boards, eventually completely replacing them.²

In 1996, the Legislature made adjustments to address growing needs. It expanded the eleven districts into fifteen and reorganized the health and rehabilitative system once again, dividing DHRS into two separate entities: the Department of Health, and the Department of Children and Families (DCF),³ the latter of which became the agency central to the development of Florida's regional BHME model.

WHAT IS A BEHAVIORAL HEALTH MANAGING ENTITY?

A BHME or managing entity is a nonprofit organization that manages a network of behavioral healthcare providers in a specific region on behalf of the state. In Florida, the DCF contracts with managing entities in order to better identify and meet the varying Substance Abuse and Mental Health (SAMH) needs of individual communities statewide.

The regional BHME system is built upon a tiered organizational structure, with DCF at the top as the authoritative body. DCF then contracts with non-profit organizations that serve as BHMEs and, in turn, bring their own established and contracted networks of community mental health and substance abuse providers.⁴ BHMEs offer a vehicle for coordinating the full range of needs for adults and children with complex behavioral health issues as well as provide oversight for the quality and consistency of providers, making the providers subject to review by community BHME boards if found noncompliant with DCF standards of care.

BHMEs also perform several of the administrative functions undertaken by DCF staff pre-reform, such as negotiating, managing, and paying for contracts with local providers. In addition, BHMEs have taken on many essential tasks not previously executed by DCF, such as credentialing providers, creating provider networks, and performing provider reviews to assess the quality of the services provided.

² *Ibid.*

³ *Ibid.*

⁴ "Care Management Entities: A Primer." Center for Health Care Strategies, Inc. (2011).

This model enables DCF staff to focus their attentions on matters like statewide planning for SAMH services and DCF's collaboration with other state agencies to improve mental health and substance abuse services.⁵

The BHME structure took almost a decade to develop. The process began in 2000 with a Center for Substance Abuse Treatment report on networks and care management.⁶ The results of this research provided the basis for the two pilot programs launched soon after, but the first conclusive steps toward conversion did not come until 2008, when the Legislature amended subsection 394.9082, Florida Statutes, and authorized BHMEs as a collaborative effort of DCF, the Florida Council for Community Mental Health, and the Florida Alcohol and Drug Abuse Association. The decision to switch to the BHME model was solidified in 2010 when DCF began the procurement process to select managing entities for each of seven regions and contracted Central Florida Behavioral Health Network to cover the SunCoast region.⁷

In the following years, DCF procured more managing entities. The first BHMEs contracted were Central Florida Behavioral Health Network and South Florida Behavioral Health Network in 2010. Four more BHMEs were awarded contracts in 2012, and the BHME model reached completion in 2013, after Big Bend Community Based Care was established as the managing entity for the Northwest region. The completed structure consists of the seven BHMEs that now cover the state of Florida (See Fig. 1; numbers indicate BHMEs in the following order):⁸

Early Implementation: 2010⁹

Central Florida Behavioral Health Network, Inc. - Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk and Sarasota counties;

South Florida Behavioral Health Network, Inc. - Miami-Dade and Monroe counties;

5 "Centralizing DCF Substance Abuse and Mental Health Programs Produced Benefits." (Feb. 2006). Office of Program Policy Analysis and Government Accountability (OPPAGA).

6 "DCF Behavioral Health Contracting and Reimbursement: Current State Policy, Impact in Communities." (April 2006). Florida Alcohol and Drug Abuse Association (FADAA). Available at: http://www.fadaa.org/provider_networks.php

7 "Managing Entities: Presentation to the Senate Children Families and Elder Affairs Committee," Florida Council for Community Mental Health (FCCMH).

8 "Managing Entities." DCF. <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities>

9 Sign-on dates collected from individual BHME contracts, available at: <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities/contracts>

Mid-Implementation: 2012

Broward Behavioral Health Coalition - Broward County;

Central Florida Cares Health System - Serving Brevard, Orange, Osceola and Seminole counties;

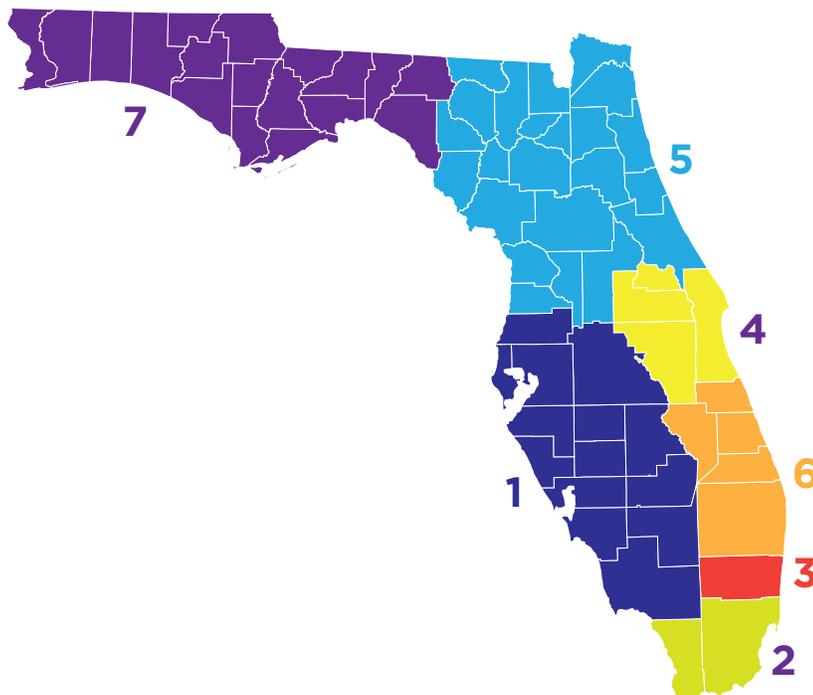
Lutheran Services Florida - Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union and Volusia counties;

Southeast Florida Behavioral Health Network - Indian River, Martin, Okeechobee, Palm Beach and St. Lucie counties; and

Final Implementation: 2013

Big Bend Community Based Care - Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington counties.

FIGURE 1: REGIONAL COVERAGE OF BHMES



Source: "Managing Entities." DCF. Available at: <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities>

BEHAVIORAL HEALTH ACROSS THE NATION

Many states have switched their mental health and substance abuse service delivery structures to regional systems similar to Florida's BHME model, including: North Carolina,¹⁰ Georgia,¹¹ Arizona,¹² Arkansas,¹³ and others. A thorough examination of available information on these states shows that the general reason for implementing this type of model is to tailor services to community needs at a lower cost to the state.

Regional models are gaining popularity across the nation, but even the most effective regional models faced initial challenges. Their methods of identifying and addressing these issues could help prevent similar problems from manifesting within Florida's BHME model. Of the issues identified two common complications were frequently cited in states that have switched to regional models: insufficient financial supports and lack of well-established framework.¹⁴

Among the states most similar to Florida, Texas provides a quality example of these issues and their solutions. As of the most recent (2010) ranking of all fifty states and D.C., Texas was one of only two states ranked below Florida for per capita mental health expenditures, with the states ranked 50th (\$38.99 per capita) and 49th (\$39.55 per capita), respectively.¹⁵ This lack of funding made it difficult to implement best practices, programs, and services that reduce reliance on hospital emergency departments for behavioral healthcare. Additionally, the lack of funding acted as a disincentive to behavioral healthcare professionals, who instead

10 North Carolina BHME equivalents are Local Management Entities (LMEs): <http://www.ncdhhs.gov/mhddsas/lmeonblue.htm>

11 Georgia BHME equivalents are Care Management Entities (CMEs) for the coordination of mental health services for children and adolescents: [http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/2013%20C%26A%20Consumer%20Survey%20Report%20-%20Final%20\(2014.04.01\).pdf](http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/document/2013%20C%26A%20Consumer%20Survey%20Report%20-%20Final%20(2014.04.01).pdf)

12 Arizona BHME equivalents are Tribal/Regional Behavioral Health Authorities (T/RBHAs): <http://www.azdhs.gov/bhs/documents/news/az-behavioral-health-system-intro-2013.pdf>

13 Arkansas BHME equivalents are Community Mental Health Centers: <http://humanservices.arkansas.gov/dbhs/Documents/Community%20Mental%20Health%20Center%20Directory.pdf>

14 "The Implementation of Local Management Entities in North Carolina." (2007). Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Department of Health and Human Services.

15 "State Mental Health Agency (SMHA), Per Capita Mental Health Services Expenditures." (2010). The Henry J. Kaiser Family Foundation. Available at: <http://kff.org/other/state-indicator/smha-expenditures-per-capita/#table>

sought employment in the private sector or in states with more funding. This, in turn, created weaknesses and gaps in the framework of the model.

Nearly 300,000 children in Texas live with a serious mental health condition. Yet the majority of the state's counties are designated as mental health profession shortage areas, with 70 percent of Texas' counties reporting they have no practicing psychiatrists.¹⁶ Overall, there are less than seven child psychiatrists per 100,000 youth in the state, which is more than 50 percent lower than the nationally accepted recommendation of 14.38 per 100,000.¹⁷

Funding and infrastructure are linked within a causal model that can lead to a regional model's success or failure. With insufficient funding there is insufficient staff; without adequate staff, providers cannot provide services; and without proper services, BHMEs (referred to in Texas as Local Mental Health Authorities/LMHAs) are left with gaps in their networks that ensure many individuals will be denied the services they need. Recognizing this, Texas took several steps during its 2014 Legislative Session to address these problems; including the appropriation of an additional \$259 million in General Revenue and \$298 million in All Funds for the expansion of LMHAs, the implementation of additional services, and the elimination of client waiting lists.¹⁸ Increases in behavioral healthcare funding like those seen in Texas were generally consistent across the nation between FY2014 and FY2015, and marks one area where Florida does not align with other states.

National mental health funding declined by almost \$4.4 billion from FY2009 to FY2012, leaving public behavioral health systems struggling to meet rising community needs with limited resources.¹⁹ As the 2013 Legislative sessions began and economic prospects began to turn upward,²⁰ thirty-six states named behavioral health services a priority, taking the opportunity to increase state mental health funding for FY2014.

16 Texas Hospital Association: Scope of the Problem. Accessed Feb. 2015: <http://www.tha.org/HealthCareProviders/Issues/BehavioralMentalHea096F/FacingBehavioralHea094D/ScopeoftheProblem/index.asp>

17 "The Continuing Shortage of Child and Adolescent Psychiatrists." (2006). C.R. Thomas and C.E. Holzer. *Journal of the American Academy of Child and Adolescent Psychiatry*. DOI: <http://dx.doi.org/10.1097/01.chi.0000225353.16831.5d>

18 Texas Hospital Association: Behavioral/Mental Health Funding. Accessed Feb. 2015: <http://www.tha.org/HealthCareProviders/Issues/BehavioralMentalHea096F/BehavioralMentalHea0965.asp>

19 "The Waterfall Effect: Transforming the Cascading Impact of Medicaid Expansion on States" (2012). National Association of State Mental Health Program Directors.

20 "2013 Presents a Dichotomy for State Budgets." (2013). NCSL News.

GOALS OF BHMEs

Based on the review of other states and government process improvement, it becomes clear that the process of developing a successful behavioral health model is a gradual one. Florida's BHME model is still in its infancy; however, at this early stage, Florida can determine whether BHMEs are taking steps to meet the promised goals of regional models through initiatives targeting provider accountability, the assessment of community needs, and the use of state dollars.

PROVIDER ACCOUNTABILITY

To ensure access and service quality of their providers, BHMEs work with DCF to enforce a number of checks and balances, including a review of providers' monthly data submissions and the creation of any necessary corrective action plans.

DCF and BHMEs require the submission of monthly data to ensure that providers are meeting service needs with high quality-treatment. One essential requirement is that providers collect and report consumer survey data on the services they have provided to their respective BHMEs. The BHMEs then compile this information and submit it to DCF. This data assesses consumers' perceptions of care through targeted questions about: (1) general satisfaction with care; (2) access to care; (3) appropriateness and quality of care; (4) outcomes of care; (5) involvement in treatment; (6) social connectedness; and (7) functional satisfaction.²⁴

Depending on the results or timeliness of this data, as well as the general operational data submitted to BHMEs each month, a provider may be found noncompliant with the standards set by DCF. In this case, BHMEs do not immediately terminate contracts, but instead seek to correct deficiencies by providing technical assistance and training. If those methods are insufficient, BHMEs develop corrective action plans to help providers improve.²⁵ Following consistent issues of noncompliance, a BHME can work with Community Boards to remove a provider from their network.²⁶ As an example, one BHME recently made the decision to cease funding for a provider that had been in existence for almost 40 years. The levels of transparency and communication fostered by

24 "Chapter 13: SAMH Community Consumer Satisfaction Survey (SCCSS). DCF. Available at: <http://www.dcf.state.fl.us/programs/samh/publications/c13v10.pdf>

25 Interviews with BHME experts

26 "Legislative Status Report: Attachment 2 - Managing Entity Corrective Action Plans." (2014). DCF.

BHMEs allowed attempts to provide assistance to be well documented at all levels of oversight, resulting in the decision being presented in a much less speculative light than it would have been pre-reform.²⁷

ASSESSMENT OF COMMUNITY NEEDS

BHMEs target and identify community needs by actively engaging with community members through public meetings and open communication with providers.

In addition to “town hall” meetings to discuss their operations with the public, most BHMEs have monthly meetings with their Community Boards, which consist of local stakeholders and some provider leadership, to discuss the needs of their districts. Complete lists of who each BHME meets with, for what purpose, and how frequently are all a matter of public record and can be easily located in individual managing entity profiles on DCF’s website.²⁸

Many members of provider leadership are also on community boards for BHMEs. This allows BHMEs to voice their issues directly as well as enables providers’ to express their concerns and those of the clients they serve.

USE OF STATE DOLLARS

Fiscal responsibility is of huge importance to Florida and its residents. BHMEs protect taxpayer dollars by ensuring that state money is only used as a last resort, using payment sorting and data driven reimbursement.

Clients can be placed into one of four buckets of payment: direct (out of pocket), health insurance, Medicaid, or the “safety net.” Provided through BHMEs, the safety net refers to the last possible option: state funded services for clients who are ineligible for federal/state joint-funded programs like Medicaid.

27 Interviews with BHME experts

28 “ME Profiles.” DCF. Available at: <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities>

Ultimately, BHMEs use their resources to try and see if clients are eligible or capable of being sorted into non-safety-net buckets, like Medicaid, in order to reserve state dollars.

Many BHMEs utilize their own information systems to provide a more intuitive, user-friendly data input process for providers. Through these systems, BHMEs link provided services and their associated costs to the records and names of clients that have been served through those treatments. This data is then transferred to the state's database, the Substance Abuse and Mental Health Information System (SAMHIS). Together these data collection and analysis systems allow only error-free reporting to be reimbursed and reinforce the importance of responsible spending.

All of these initiatives paint a picture of behavioral health that is community- and quality-focused as well as indicate a road leading in the right direction for the improvement of SAMH services in Florida. In addition to the steps outlined above, several direct benefits of BHMEs can be seen through more intensive analysis.

ANALYSES

Research shows that SAMH funding across the nation was on the decline until 2013, but while most states have begun to reverse this trend, Florida has lagged behind. Despite this fact, Florida's utilization of SAMH dollars continues to meet or exceed standards of efficiency from pre-reform years.

BUDGET & PERSONS SERVED

In FY2010, prior to procuring the first BHME, DCF was appropriated \$985.9 million for publicly funded community and state SAMH programs across the state that served 348,640 indigent clients in need.^{29,30} Using inflation, this sum rises to \$1.1 billion in 2013 dollars, for a rate of \$3,070 per client served.³¹ This is 13 percent more in overall funding and 6 percent higher per client served than the budget for post-reform behavioral health. In FY2014, DCF received \$931.5 million and served 322,173 uninsured patients at a per client rate of \$2,890.^{32,33} It is important to note that these numbers are unduplicated estimates. In reality, BHMEs alone connected clients to services over 340,000 times in FY2014³⁴ for 63.5 percent of the state SAMH budget (\$592.3 million),³⁵ indicating a true BHME per client rate of approximately \$1,740 for each client served.

The inflation-adjusted \$140 million decrease in overall DCF SAMH expenditures is largely due to budget cuts at the Legislative level and the fact that appropriations for services are not keeping pace with inflation, but can also be attributed to BHME efforts to minimize administrative costs.³⁶

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- 29 "Department of Children and Families Substance Abuse and Mental Health Program Annual Data Snapshot as of May, 2010." (2010). DCF.
- 30 State Unduplicated Data Numbers of Clients Receiving Substance Abuse and Mental Health Services: FY0910. Retrieved February 2015: <http://www.myflfamilies.com/service-programs/substance-abuse/reports/statewide>
- 31 Calculated using the Bureau of Labor Statistics Consumer Price Index. Available at: <http://www.bls.gov/cpi/data.htm>
- 32 "Substance Abuse and Mental Health Services Plan 2014 Annual Plan Update." (2013). DCF.
- 33 State Unduplicated Data Numbers of Clients Receiving Substance Abuse and Mental Health Services: FY1314. Retrieved February 2015: <http://www.myflfamilies.com/service-programs/substance-abuse/reports/statewide>
- 34 Estimates taken from FY2014 managing entity profiles in February of 2015. Retrieved from: <http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities/profiles>
- 35 "Fiscal Year 14-15 Department of Children and Families Behavioral Health Planning Tool." (2014). DCF.
- 36 Interviews with BHME leadership.

BHMEs decreased the share of the budget devoted to the operation of SAMH programs throughout the state to approximately 4 percent³⁷ in the new model, substantially lower than the industry standard of 15-20 percent for insurance companies.³⁸ Efficient administrative practices, in combination with client payment sorting practices that reserve state dollars for the last resort, helped limit the drop in clients served between FY2010 and FY2014 to 8 percent, despite a drop in SAMH funding of about 13 percent. Using the same budget proportions as FY2014, restoring overall DCF funding to be equitable with the FY2010 inflation adjusted level would allow BHMEs to provide services for over 50,000 additional individuals in need each year.³⁹ Overall, these numbers show that BHMEs help the state leverage more services for less money.

COSTS AVERTED

BHMEs in Florida have voiced a dedication to continuous program improvement and effective services. In FY2013-2014, Florida BHMEs met or exceeded 83 percent of the performance outcome targets for SAMH programs; every one of the annual targets for substance abuse were met, as were eight out of eleven targets for mental health services.⁴⁰ These types of improvements provide significant cost avoidances for Florida by ensuring those with mental health and substance abuse issues receive the treatment they need to lead stable, productive lives and avoid cycling through more costly and deleterious alternatives, like criminal justice and emergency medical systems.

The resources and time required to continuously incarcerate the mentally ill are substantial. Individuals with mental health issues often have concurrent substance abuse problems, require medication, and are five times more likely to end up in jail

37 Recent interviews with BHME leadership show only one BHME with administrative costs slightly over 4 percent. An earlier report cites four BHMEs with administrative costs at 4 percent and three BHMEs at 5 percent. Source: "Fiscal Year 14-15 Department of Children and Families Behavioral Health Planning Tool." (2014). DCF.

38 Interviews with industry experts.

39 Inflation adjusted FY2010 budget (\$1.07 billion) times the percentage of state SAMH budget appropriated to BHMEs in FY2014 (63.5%) leaves a \$679.5 million BHME budget. Divided by the FY2014 per capita rate for BHMEs (\$1,740), this results in funded services for 390,489 clients. This total is about 50,000 higher than current FY2014 service estimates (340,000).

40 "Fiscal Year 2013-2014 Legislative Status Report." (November 1, 2014). DCF Office of Substance Abuse and Mental Health. Available at: http://www.dcf.state.fl.us/programs/samh/pubs_reports.shtml

or prison than in a state mental facility in Florida.⁴¹ These people are also arrested frequently and repetitively, with 44 percent of mentally ill inmates being back behind bars within three months after being released.⁴² One individual in Orange County has been in and out of the county jail over 100 times in the past twenty years.⁴³

When the frequency of incarceration is combined with the cost of incarcerating an offender with behavioral health issues, potential expenses become overwhelming. Mentally ill inmates cost a little more than one and a half times as much as an inmate without a behavioral disorder.⁴⁴ For every person with a mental illness or concurrent disorder whose SAMH treatment prevented them from being incarcerated at least once, the state saves a minimum of around \$23,000⁴⁵ to \$72,300⁴⁶ in corrections costs.

In FY2013-14 substance abuse treatment services provided through BHMEs for clients with substance abuse and concurrent disorders resulted in outcomes that exceeded targets, with a 58 percent decrease in “percent change in the number of adults arrested 30 days prior to admission versus 30 days prior to discharge,” and in “percent change in the number of children arrested 30 days prior to admission versus 30 days prior to discharge.”⁴⁷

Decreases in hospitalizations are also essential to driving down state behavioral health costs. In 2007, one of eight emergency room visits and one of four hospital stays in Florida involved a behavioral health condition or disorder and publicly funded treatments in hospitals are much more expensive than treatment from provider treatment programs.⁴⁸

41 “Examining the Efficacy of Florida’s Publically Funded Mental Health Services.” FCCMH.

42 *Ibid.*

43 *Ibid.*

44 Mentally ill inmates cost 1.6 times as much to house as inmates without behavioral health issues. Source: “Mentally Ill Individuals and Jails: Fact Sheet.” (2010) FCCMH.

45 Assumes a 6 month jail sentence. A non-mentally ill inmate cost per diem for jails is ~\$80.00. $(\$80 \times 1.6)(6 \times 30 \text{ days}) = \$23,040$ per sentence.)

46 Assumes a 2.5 year prison sentence. The average inmate cost per diem for prisons is ~\$49.50. $(\$49.50 \times 1.6 \times 365 \times 2.5) = \$72,270$ per sentence.

47 “Fiscal Year 2013-2014 Legislative Status Report.” (November 1, 2014). DCF Office of Substance Abuse and Mental Health. Available at: http://www.dcf.state.fl.us/programs/samh/pubs_reports.shtml

48 *Ibid.*

The stabilization of adults with severe mental illness, like those targeted through Crisis Stabilization, can also help reduce suicides, which killed more people in Florida than homicides and HIV combined in 2009.⁴⁹ For example, in the year following the establishment of the final BHME in 2013, the suicide rate in Florida dropped by about 4 percent.⁵⁰

While preventing and treating suicide and mental illness promotes the happiness and well-being of Florida's citizens, it also has lesser acknowledged economic impacts. In 2011, Florida's economy lost \$26.1 billion in earnings due to mental illness, with \$21.8 billion in lost productivity, and \$4.3 billion in estimated mortality costs.⁵¹

A lack of comparable pre-reform data and the recency of the BHME model's statewide implementation make conclusions regarding these savings premature. Despite this, all of the benefits mentioned above indicate that the value of Florida BHMEs is not limited to up-front cost savings. It is clear that continuing to improve outcomes and avoid costly alternatives will create a positive return on investment for the state as well as a positive impact on quality of life for individuals receiving publicly funded services.

49 "Examining the Efficacy of Florida's Publically Funded Mental Health Services." FCCMH. Available at: http://www.fccmh.org/news/summit_docs/FloridasPublicallyFundedMental.pdf

50 "Recorded deaths by year by recorded county: 50 leading rankable causes of death = Suicide." Florida Charts. Custom tables available at: <http://www.floridacharts.com/FLQuery/Death/DeathRate.aspx>

51 "Examining the Efficacy of Florida's Publically Funded Mental Health Services." FCCMH. Available at: http://www.fccmh.org/news/summit_docs/FloridasPublicallyFundedMental.pdf

ISSUES WITH FLORIDA BHMEs⁵²

There are several areas in the current model that warrant attention, most notably: funding, measures and data collection, and transitional eligibility issues.

FUNDING

Florida is currently ranked 49th in the nation for mental health funding.⁵³ When the Florida DCF began the process of localizing behavioral healthcare, SAMH services lost annual increases that helped account for inflation. Now, when or if any additional money is appropriated, most of it goes to specific, tightly defined, and legislatively earmarked services instead of overall provisions to address needs. In the FY2014-15 General Appropriations Act there were more than \$23 million in special projects awarded directly to providers. Appropriations like this mean that some providers' financial needs are met while others gradually receive less and less compensation for providing the same services. So while it is encouraging to see a decrease in overall SAMH expenditures, it becomes substantially less rewarding when it is largely a result of budget cuts that could affect services.

Despite being ranked 49th for funding, Florida is still ranked 26th in the country for mental health prevalence and access.⁵⁴ Overall, the state serves only 8 percent fewer clients than Florida's pre-reform behavioral health system despite a 13 percent decrease in funding since pre-reform years. But the 8 percent decrease in clients served could be indicative of an emerging downward trend in patient access or, conversely, a reduction of quality in exchange for the maintenance of access.

Data indicate the downward trend in access as a more likely possibility. Funding for SAMH providers is at an all time low. Restoring current DCF funding to the FY2001 level, adjusted for inflation, would require a state investment of approximately \$130 million (See Figure 3), which would only just cover the \$126 million in unfunded services claimed by providers.⁵⁵

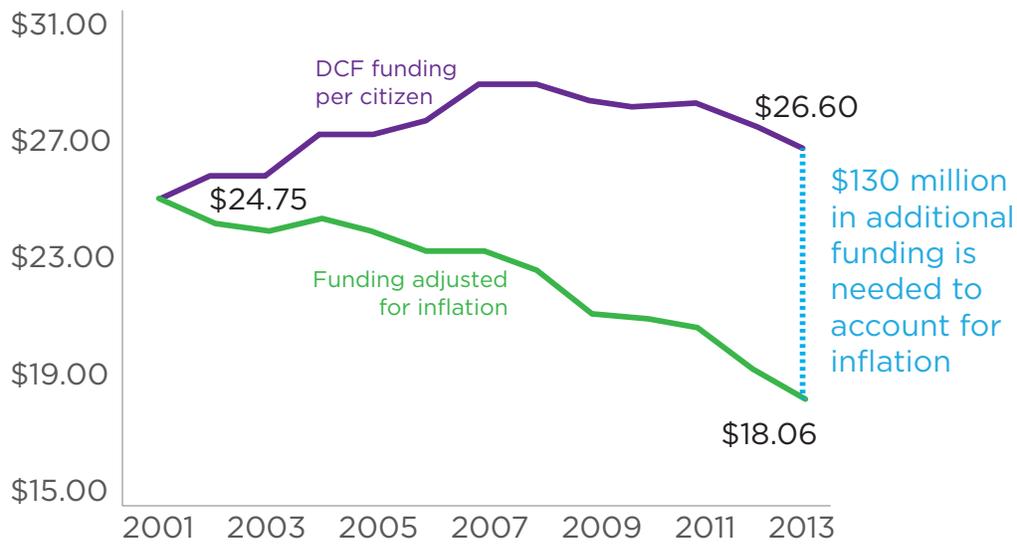
52 In addition to extensive research, TaxWatch conducted interviews with BHME leadership.

53 "State Mental Health Agency (SMHA), Per Capita Mental Health Services Expenditures." (2010). The Henry J. Kaiser Family Foundation. Available at: <http://kff.org/other/state-indicator/smha-expenditures-per-capita/#table>

54 "Parity or Disparity: The State of Mental Health in America 2015." (2015). Mental Health America.

55 "Mental health, substance abuse providers in Florida make case for more state dollars." (Nov. 28, 2014). The Florida Times Union.

FIGURE 3: DCF FUNDING FOR SAMH (2001-2013)



Source: DCF appropriations for SAMH (2001-2013), EDR population estimates for Florida: (2001-2013)

Monetary issues for BHMEs and their providers also involve four restrictive funding silos: adult mental health, children’s mental health, adult substance abuse, and children’s substance abuse. These silos represent tightly defined funding streams that can only be applied to specific groups of clients and cannot be shifted around to fill gaps in areas with higher need without state processes that can take months to be cleared.

The inflexible structure of funding silos makes shifting money around particularly problematic for clients with concurrent substance abuse and mental health disorders. Such clients are common, but the funding structure for BHMEs and providers does not allow for a service to be reported or funded simultaneously by substance abuse and mental health dollars, making it difficult to finance treatment as well complicated to record the services provided. But, most importantly, these silos might dictate treatment. BHMEs show concern that providers may deliver services according to what money is available as opposed to what services are most required. This means that treatment is occasionally insufficient at worst and not tailored to individual needs at best; a problem only exacerbated by limited funding.

TRANSITIONAL ELIGIBILITY

The DCF definitions for who is eligible for adult versus child SAMH programs through BHMEs vary greatly. To be eligible for mental health treatment through BHME networks as an adult, DCF requires that the patient must suffer from “serious or persistent” mental illness, whereas their eligibility criteria for children require as little as “at-risk of becoming emotionally disturbed.”⁵⁶ As a result, many children age out of child SAMH programming and do not meet the severity requirements for adult SAMH programs; therefore the patient loses eligibility/coverage at eighteen. This is cited as an issue because these kids frequently get worse once they lose access to services, and return to the system as adults with significantly worse problems that consistent, preventative treatment could have addressed.

MEASURES AND DATA COLLECTION

DCF’s data reporting system, SAMHIS, seems to fall short of provider and BHME needs. The majority of issues cited by BHMEs and providers revolve around selective accountability enforcement, frequent reporting errors, and poor outcome measures both of which culminate in inconsistent report interpretation.

With regards to accountability, BHMEs work with DCF to enforce the checks and balances required by the state to ensure quality, access, and efficiency of services. However, it is important to note that there are exceptions to these monthly and annual requirements. Section 402.7306 of the Florida Statutes mandates that SAMH providers who receive accreditation from an organization with requirements comparable to those used by the state may only be subject to administrative monitoring by BHMEs once every 3 years. This means that eligible providers are not monitored by BHMEs with sufficient regularity with regards to service compensation and state compliance.

⁵⁶ “Substance Abuse and Mental Health Services Plan 2014-2016.” (2014). DCF.

Of particular concern regarding data collection are “orphan records.” This term refers to a common error that results in SAMHIS’ inability to link financial information to a specific client’s SSN and the service they were provided. Ultimately, this leads to gaps in patient histories that are critical to the coordination and tailoring of appropriate services to meet individual needs.⁵⁷ For this reason and reasons of user un-friendliness, the SAMHIS system is universally acknowledged by BHMEs as being in need of reexamination or replacement.

The data and outcomes being collected and reported are also too general, and tell more about the type of person being served than the outcome of the treatment provided. Measures like “percent of children at risk of emotional disturbance who live in stable housing environment” can tell BHMEs a lot about the children served by mental health programs but not whether or not the treatment altered their path in any significant way.⁵⁸

57 Interviews with BHME leadership.

58 “Fiscal Year 2013-2014 Legislative Status Report.” (November 1, 2014). DCF Office of Substance Abuse and Mental Health. http://www.dcf.state.fl.us/programs/samh/pubs_reports.shtml

CONCLUSIONS

The state's BHME model is one step further in the evolutionary process, and shows efficiencies that provide a solid framework upon which the state can build. The majority of benefits of the BHME model identified revolve around cost savings/avoidances attained through:

- Ensured provider accountability: BHMEs work with DCF to ensure providers' services are up to standard, and maintain efficient and strictly defined protocols to improve noncompliant providers or remove them from their regional provider networks;
- Improved assessment of community needs: Public meetings and Community Boards made up of local stakeholders and providers promote transparency and foster collaborative efforts to identify and address community needs; and
- Responsible use of state dollars: BHMEs ensure data-driven reimbursement and serve as a payment sorting mechanism to optimize and protect state dollars. Additionally, BHMEs provide cost efficiencies through decreased administrative costs and their unique ability to work with providers and communities to leverage more services for less money.⁵⁹

Despite the promises made and the steps being taken, there are still several barriers that hinder the potential of this model:

- Funding: Inflexible and limited funding restrict not only how many people can be treated but also what services a client may be given, as many providers have limited resources.
- Transitional Eligibility: Issues regarding transitional services for youth that age out of children's SAMH programs and are ineligible for adult programs limit SAMH treatments' ability to serve as effective preventative or intervention tools.
- Measures and Data Collection: Issues with reporting and insufficient outcome measures lead to inefficient records maintenance and a lack of knowledge regarding the most successful treatments.

59 Decreased administrative costs as a percentage of total costs.

It is essential, however, to avoid potentially derailing circumstances seen in the implementation of other states' BHME models. Increased funding allocation and flexibility, as well as improved data reporting and outcome measures will help Florida's BHME model avoid these potential setbacks and ensure the improved outcomes and success of Florida's mentally ill and substance abusers.

RECOMMENDATIONS

Use Data to Inform BHME Funding Decisions

Limited funding leads to issues in access and quality of services provided that account for much of the 8 percent drop in clients served by Florida BHME providers. The majority of states agree that greater state investment in treatment services for citizens with mental health and substance abuse issues could provide even greater savings in the future, while also increasing public safety and improving the lives of the indigent and uninsured proportion of the estimated 3 million people in Florida that have behavioral health disorders.⁶⁰ Tying BHME funding to calculations regarding inflation, and predicted need/caseloads would allow for SAMH providers to receive compensation for services at a rate that takes into account the yearly adjusted value of services.

Allow for Funding Flexibility Where Possible

Giving BHMEs the responsibility of running and maintaining a provider network without the authority to independently cater to the needs of their communities limits BHMEs' capacity to effectively manage their regions. Maintaining direct agency oversight of state dollars is essential, but allowing for funding flexibility across silos and eliminating direct contracting (special projects appropriations) between DCF and providers will enable BHMEs to better tailor services to their communities in real time; targeting provider and client needs, improving outcomes, and increasing access to service for those who need them most.

Allow for Transitional SAMH Services for Young Adults Aging Out of Child Funding Eligibility

Denying young adults access to the services they need before they are properly equipped to go without them only ensures that they will return with more serious issues later; issues that may have been prevented with adequate front-end care. Raising the age criterion for publicly funded youth behavioral health or creating a separate, transitional funding category that includes college-aged clients would ensure continuity of care by providing a transitional period.

⁶⁰ Calculated using estimates from 2010 and adjusting for general population increase.

This period could either better prepare young adults for adulthood post-treatment or establish them as being reliant enough on SAMH services to warrant acceptance into state-funded adult care; ensuring that services are always available to those in need.

Improve Data Reporting Systems and Measures to Assist Future Analyses

Poor outcome measures and methods of data reporting make any framework for future success an unstable one. SAMHIS has several deficiencies that impede BHMEs and providers from reporting their data effectively. It needs to be reevaluated or replaced and input from BHMEs and providers should play a key factor in DCF's decision on the subject. Additionally, current outcome measures do not provide details necessary to determine efficacy. The state needs to develop outcome measures that show the individual successes of specific treatments. Together, these improvements will improve efficiency, establish the best methods of care, and increase the availability of data necessary for future cost and implementation analyses.

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