

Assisted Living Facility Work Group

MENTAL HEALTH RECOMMENDATIONS	STATUS
<p>1. Improve case management services and advocacy for residents by offering residents choice of case managers and living arrangements.</p>	<p><u>DCF</u> DCF supports choice. Individuals receiving or seeking case management services who have Medicaid or another means of payment can obtain those services from any provider who offers those services. Most individuals in ALFs have, or are eligible for, Medicaid. Those who have no third-party payer must get services from a mental health provider who has a contract with DCF (or its Managing Entity). Sometimes choice of providers is limited in rural geographic areas. Whenever possible (contingent upon resources), individuals are offered choice of living environments, such as supportive housing settings, independent living, family, residential treatment facilities, and Adult Family Care facilities.</p> <p><u>AHCA</u> Medicaid’s managed care contracts currently require recipient choice in direct care provider for behavior health services. Enrollee handbooks inform enrollees of their right to choose their providers.</p> <p>According to the Medicaid Provider General Handbook: Per Title 42 of the Federal Code of Regulations Part 431.51, recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.</p> <p>AHCA has developed an ALF Behavioral Health Subgroup of the Statewide Behavioral Health Workgroup. The Workgroup identified the need to address behavioral health services to ALF residents. The purpose of the ALF Behavioral Health Subgroup is to provide an opportunity for the managed care organizations behavioral health providers, ALF representatives, and other interested parties to discuss any concerns related to the provision of behavioral health services to residents of ALFs.</p> <p>Proposed in 2012 LEGISLATION</p>

ALF WORKGROUP OCTOBER 2012

<p>2. Require DCF/Managing Entity verify that each mental health resident is assigned a case management and that face-to-face contact has been documented as required by law and rule.</p> <p><i>Originally Recommendation 12 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u> DCF concurs with this recommendation and has already incorporated contract language that directs the ME to provide services to residents in ALFs, to follow provisions of the law, and to review samples of case management record to assure services are offered.</p> <p><u>DOEA</u> ALF Negotiated Rulemaking Committee Rule Change: Edit Rule 58A-5.029 FAC to state that every facility with a LMH license is required to ensure that mental health residents are referred for case management and other mental health services. Residents may be referred to public or private agencies for assistance. In the event that a resident refuses such services the refusal must be documented by the facility and the facility must request that the refusal be submitted in writing.</p> <p>Proposed in 2012 LEGISLATION</p>
<p>3. Maintain the Mental Health Targeted Case Management service in the community mental health centers to provide the extensive psychiatric oversight and linkage only available in a clinical setting; and retain role of the designated mental health providers to manage mental health clinical issues and do not shift this role of the ALF. While close working relationships between the ALF and the mental health providers are essential, it is equally essential that no inducements or other devices limit the choice of residents as to where or from whom they receive their mental health services.</p> <p><i>Originally Recommendation 6,7,and 8 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u> DCF concurs with the recommendation.</p> <p><u>AHCA</u> If the ALF were to provide these mental health services, they would effectively be creating an institution for mental diseases (IMD). An IMD is a facility of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with behavioral diseases (Title 42 CFR Part 441.13 and 435.1008). According to the <i>Medicaid Behavioral Health Community Behavioral Health Services Coverage and Limitations Handbook</i>, services rendered to residents of institutions for mental diseases are not covered under the Medicaid community behavioral health services.</p> <p>The community living support plan must clearly address the resident’s behavioral health concerns and needs. Ultimately, there has to be a collaborative relationship between the ALF staff and mental health providers.</p> <p>AHCA has language in our contracts with managed care organizations ensuring that recipients have choice in their behavior health provider. The Medicaid managed care core contract language has been revised to strengthen the responsibility of the managed care organizations to ensure the community living support plan is developed and implemented by the ALF and the designated behavior health care provider for recipients residing in long term care facilities.</p>

ALF WORKGROUP OCTOBER 2012

<p>4. Retain continuity of care for ALF residents by prohibiting DCF from contracting with specialized community mental health centers to provide case management and other mental health services which could limit choice.</p> <p><i>Originally Recommendation 9 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u></p> <p>It is not clear what is meant by “specialized community mental health centers.” DCF is directed by s. 394.4573 F.S. to provide a continuity of care management system which includes case management. This system is funded through contracts with DCF Managing Entities based upon available funding. Generally, there are multiple providers within each region and a person receiving services can choose their service provider if that is the case.</p>
<p>5. Increase the monitoring of case managers and increase services for mental health residents in assisted living facilities.</p> <p><i>Originally Recommendation 4 and 13 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u></p> <p>DCF concurs with this recommendation and has contract language that directs the ME to provide services to residents in ALFs, to follow provisions of the law, and to review samples of case management record to assure services are offered.</p> <p><u>AHCA</u></p> <p>AHCA monitors case management services provided to mental health residents in ALFs who participate in the behavioral health managed care program. We are working to improve and expand this process.</p> <p>Currently the policies and procedures of each managed care plan related to the provision of case management services to mental health recipient’s in ALFs are reviewed during monitoring. As a part of managed care organizations (MCO) compliance audits the following is reviewed:</p> <ol style="list-style-type: none">1. A sample of clinical and TCM records of residents who live in an ALF2. A copy of the cooperative agreement between the MCO and the ALF Administrator3. A Copy of the resident’s community living support plan, and procedures for the ALF to follow should an emergent condition arise with an enrollee that resides at the ALF <p>Proposed in 2012 LEGISLATION</p>

ALF WORKGROUP OCTOBER 2012

<p>6. Require DCF/Managing Entity evaluate the cooperative agreement and community living support plans in place to ensure that they are sufficient to meet the mental health needs of ALF/LMH facility residents.</p> <p><i>Originally Recommendation 11 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u> The role of DCF/ME is to monitor the contracted public community mental health providers. The DCF offices and MEs have been given templates. Language included in ME contracts. Representative sample reviewed. Template provided in packet.</p> <p><u>AHCA</u> In addition to DCF/ME activities, Medicaid has taken steps to improve its oversight of Medicaid managed care plans in meeting their recently modified contractual responsibilities of ensuring that the community living support plan is implemented as written.</p>
<p>7. Cooperative agreements should adequately address: case management services, access to consumer-operated drop-in centers, access to services during evenings, weekends, and holidays, access to emergency psychiatric care and, supervision of the clinical needs of residents.</p> <p><i>Originally Recommendation 10 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u> Representative sample is reviewed. Template provided in packet.</p> <p><u>AHCA</u> Per Florida Statute 429.02(8), Medicaid has revised the Medicaid managed care contracts to require cooperative agreements between the mental health care providers and the ALFs. Managed care plans will ensure the cooperative agreements are in place and are implemented. AHCA will oversee the managed care organizations in meeting this requirement.</p>
<p>8. Clarify oversight responsibilities of private case management and mental health treatment providers as it relates to community living support plans and cooperative agreements. Not all individuals in ALFs are served by DCF funded mental health providers, making DCF oversight of those providers difficult.</p> <p><i>Originally Recommendation 5 under “Mental Health ” for Phase II</i></p>	<p><u>DOEA</u> ALF Negotiated Rulemaking Committee Recommendation for Statutory Change: Change to Rule 58A-5.029 FAC to assure that every LMH ALF assure that mental health residents have the documentation from either a case manager or other mental health provider that they are a resident with a severe and persistent mental illness and that they are referred for mental health services to either a public or private provider. Furthermore, if the mental health resident refuses services, the ALF must document the refusal and request a signature from the resident.</p>

ALF WORKGROUP OCTOBER 2012

<p>9. Conduct a study to explore the methods of enhancing care for persons with severe and persistent mental illness in assisted living facilities.</p> <p><i>Originally Recommendation 16 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u> DCF will assist as needed.</p> <p><u>AHCA</u> AHCA will explore ideas for research projects through our contract with Florida Mental Health Institute for next year.</p>
<p>10. Require facilities to utilize a best practice tool governing behavior management /aggression control and involuntary Baker Act guidelines.</p> <p><i>Originally Recommendation 14 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u> The Florida Health Care Association published a document called Best Practice Tool for Behavior Management, Aggression Control, and Baker Act Guidelines found at: http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/2011BakerActRevFINAL.pdf</p> <p><u>DOEA</u> ALF Negotiated Rulemaking Committee Rule Change: Change to Rule 58A-5.029(3) to require a facility that initiates an involuntary mental health examination pursuant to the Florida Mental Health Act, the facility must document all actions taken to avoid the involuntary mental health examination.</p>
<p>11. Require LMH facility administrators to have a two year degree and two years of experience or a four year degree with coursework in a mental health related field.</p> <p><i>Originally Recommendation 1 under “Mental Health” for Phase II</i></p>	<p>Proposed in 2012 LEGISLATION</p>
<p>12. Recognize the shift of placements for persons discharged from state hospitals, currently residing in ALFs.</p> <p><i>Originally Recommendation 2 under “Mental Health” for Phase II</i></p>	<p><u>DCF</u> Data is not available to show a trend, but DCF recognizes that ALFs have filled a housing choice gap for individuals being discharged from state hospitals for many years. Currently, there are 20 DCF-contracted providers serving over 1600 people in Permanent Supportive Housing programs (wrap around services and rental subsidies). This is not enough to meet the need. People with serious mental illnesses are disproportionately poor and cannot afford even modestly priced rental housing without government housing assistance. Federal housing subsidies are extremely scarce, and housing waiting lists can be five-ten years long.</p>