COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

1 Committee/Subcommittee hearing bill: Select Committee on Health
2 Innovation
3 Representative Silvers offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Paragraph (a) of subsection (3) of section 409.966,
8 Florida Statutes, is amended to read:
9 409.966 Eligible plans; selection.—
10 (3) QUALITY SELECTION CRITERIA.—
11 (a) The invitation to negotiate must specify the criteria
12 and the relative weight of the criteria that will be used for
13 determining the acceptability of the reply and guiding the
14 selection of the organizations with which the agency negotiates.
15 In addition to criteria established by the agency, the agency

16 shall consider the following factors in the selection of
17 eligible plans:
18 1. Accreditation by the National Committee for Quality
19 Assurance, the Joint Commission, or another nationally
20 recognized accrediting body.
21 2. Experience serving similar populations, including the
22 organization's record in achieving specific quality standards
23 with similar populations.
24 3. Availability and accessibility of primary care,
25 behavioral health care, and specialty physicians in the provider
26 network.
27 4. Establishment of community partnerships with providers
28 that create opportunities for reinvestment in community-based
29 services.
30 5. Organization commitment to quality improvement and
31 documentation of achievements in specific quality improvement
32 projects, including active involvement by organization
33 leadership.
34 6. Provision of additional benefits, particularly dental
35 care and disease management, and other initiatives that improve
36 health outcomes.
37 7. Evidence that an eligible plan has obtained signed
38 contracts or written agreements or has made substantial progress
39 in establishing relationships with providers before the plan
40 submits a response.

41 8. Comments submitted in writing by any enrolled Medicaid
42 provider relating to a specifically identified plan
43 participating in the procurement in the same region as the
44 submitting provider.
45 9. Documentation of policies and procedures for preventing
46 fraud and abuse.
47 10. The business relationship an eligible plan has with
48 any other eligible plan that responds to the invitation to
49 negotiate.
50 Section 2. Paragraphs (c), (d), (e), and (f) of subsection (2)
51 and paragraphs (g), (h), (I), and (j) of subsection (3) of
52 section 409.967, Florida Statutes, are amended to read:
53 409.967 Managed care plan accountability.—
54 (2) The agency shall establish such contract requirements
55 as are necessary for the operation of the statewide managed care
56 program. In addition to any other provisions the agency may deem
57 necessary, the contract must require:
58 (c) Access.—
59 1. The agency shall establish specific standards for the
60 number, type, and regional distribution of providers in managed
61 care plan networks to ensure access to care for both adults and
62 children. Each plan must maintain a regionwide network of
63 providers in sufficient numbers to meet the access standards for
64 specific medical services for all recipients enrolled in the
65 plan. The exclusive use of mail-order pharmacies may not be

66 sufficient to meet network access standards. Consistent with the
67 standards established by the agency, provider networks may
68 include providers located outside the region. Each plan shall
69 establish and maintain an accurate and complete electronic
70 database of contracted providers, including information about
71 licensure or registration, locations and hours of operation,
72 specialty credentials and other certifications, specific
73 performance indicators, and such other information as the agency
74 deems necessary. The database must be available online to both
75 the agency and the public and have the capability to compare the
76 availability of providers to network adequacy standards and to
77 accept and display feedback from each provider's patients. Each
78 plan shall submit quarterly reports to the agency identifying
79 the number of enrollees assigned to each primary care provider.
80 2. By October 1, 2024, the agency shall specifically and
81 expressly establish network standards for each type of
82 behavioral health care provider, including, but not limited to,
83 community-based residential providers. The standards shall
84 ensure timely access to care and exceed any federal behavioral
85 health network requirements. At a minimum, the agency shall, for
86 each provider type, establish standards for:
87 a. Patient to provider ratios.
88 b. Maximum waiting times for appointments and admissions.

89 c. Availability of innovative health care service delivery
90 methods, such as telehealth, mobile response services, and
91 certified community behavioral health clinics.
92 3. The agency shall ~~conduct, or~~ contract with an
93 independent vendor for~~,~~ systematic and continuous testing of the
94 plan provider networks ~~databases maintained by each plan~~ to
95 confirm accuracy, confirm that ~~behavioral health~~ providers are
96 accepting enrollees, and confirm that enrollees have timely
97 access to ~~behavioral health~~ services. Related to behavioral
98 health providers, the vendor shall, at a minimum, test
99 performance under the standards established by the agency under
100 subparagraph 2. The vendor shall produce and the agency shall
101 publish online quarterly and annual reports on plan network
102 performance related to behavioral health, by plan and region,
103 beginning April 1, 2025 and July 1, 2026, respectively.
104 4.~~2.~~ Each managed care plan must publish any prescribed
105 drug formulary or preferred drug list on the plan's website in a
106 manner that is accessible to and searchable by enrollees and
107 providers. The plan must update the list within 24 hours after
108 making a change. Each plan must ensure that the prior
109 authorization process for prescribed drugs is readily accessible
110 to health care providers, including posting appropriate contact
111 information on its website and providing timely responses to
112 providers. For Medicaid recipients diagnosed with hemophilia who
113 have been prescribed anti-hemophilic-factor replacement

114 products, the agency shall provide for those products and
115 hemophilia overlay services through the agency's hemophilia
116 disease management program.
117 5.~~3.~~ Managed care plans, and their fiscal agents or
118 intermediaries, must accept prior authorization requests for any
119 service electronically.
120 6.~~4.~~ Managed care plans serving children in the care and
121 custody of the Department of Children and Families must maintain
122 complete medical, dental, and behavioral health encounter
123 information and participate in making such information available
124 to the department or the applicable contracted community-based
125 care lead agency for use in providing comprehensive and
126 coordinated case management. The agency and the department shall
127 establish an interagency agreement to provide guidance for the
128 format, confidentiality, recipient, scope, and method of
129 information to be made available and the deadlines for
130 submission of the data. The scope of information available to
131 the department shall be the data that managed care plans are
132 required to submit to the agency. The agency shall determine the
133 plan's compliance with standards for access to medical, dental,
134 and behavioral health services; the use of medications; and
135 followup on all medically necessary services recommended as a
136 result of early and periodic screening, diagnosis, and
137 treatment.

138 (d) Quality care.—Managed care plans shall provide, or contract
139 for the provision of, care coordination to facilitate the
140 appropriate delivery of behavioral health care services in the
141 least restrictive setting with treatment and recovery
142 capabilities that address the needs of the patient. Services
143 shall be provided in a manner that integrates behavioral health
144 services and primary care. Plans shall be required to achieve
145 specific behavioral health outcome standards, established by the
146 agency in consultation with the department.
147 (e) Encounter data.—The agency shall maintain and operate
148 a Medicaid Encounter Data System to collect, process, store, and
149 report on covered services provided to all Medicaid recipients
150 enrolled in prepaid plans.
151 1. Each prepaid plan must comply with the agency's
152 reporting requirements for the Medicaid Encounter Data System.
153 Prepaid plans must submit encounter data electronically in a
154 format that complies with the Health Insurance Portability and
155 Accountability Act provisions for electronic claims and in
156 accordance with deadlines established by the agency. Prepaid
157 plans must certify that the data reported is accurate and
158 complete.
159 2. The agency is responsible for validating the data
160 submitted by the plans. The agency shall develop methods and
161 protocols for ongoing analysis of the encounter data that
162 adjusts for differences in characteristics of prepaid plan

163 enrollees to allow comparison of service utilization among plans
164 and against expected levels of use. The analysis shall be used
165 to identify possible cases of systemic underutilization or
166 denials of claims and inappropriate service utilization such as
167 higher-than-expected emergency department encounters. The
168 analysis shall provide periodic feedback to the plans and enable
169 the agency to establish corrective action plans when necessary.
170 One of the focus areas for the analysis shall be the use of
171 prescription drugs.
172 3. The agency shall make encounter data available to those
173 plans accepting enrollees who are assigned to them from other
174 plans leaving a region.
175 (f) Continuous improvement.—The agency shall establish
176 specific performance standards and expected milestones or
177 timelines for improving performance over the term of the
178 contract.
179 1. Each managed care plan shall establish an internal
180 health care quality improvement system, including enrollee
181 satisfaction and disenrollment surveys. The quality improvement
182 system must include incentives and disincentives for network
183 providers.
184 2. Each managed care plan must collect and report the
185 Healthcare Effectiveness Data and Information Set (HEDIS)
186 measures, the federal Core Set of Children's Health Care Quality
187 measures, and the federal Core Set of Adult Health Care Quality

188 Measures, as specified by the agency. Each plan must collect and
189 report the Adult Core Set behavioral health measures beginning
190 with data reports for the 2025 calendar year. Each plan must
191 stratify reported measures by age, sex, race, ethnicity, primary
192 language, and whether the enrollee received a Social Security
193 Administration determination of disability for purposes of
194 Supplemental Security Income beginning with data reports for the
195 2026 calendar year. A plan's performance on these measures must
196 be published on the plan's website in a manner that allows
197 recipients to reliably compare the performance of plans. The
198 agency shall use the measures as a tool to monitor plan
199 performance.
200 a. The agency shall identify each individual HEDIS score
201 earned by each managed care plan during the first full contract
202 year for each measure in the Core Set of Children's and Adult
203 behavioral health measures, and establish those scores as
204 baseline indicators for each plan. The agency shall notify each
205 plan of their baseline for each HEDIS score annually. The
206 agency, in consultation with each plan, shall establish regional
207 clinical outcome performance goals for each contract year for
208 each plan. In establishing the performance goals, the agency
209 shall take into account the plan's HEDIS baseline, population,
210 enrollment, patient mix and clinical risk, and other factors
211 established by the agency.

212 b. The agency shall establish specific outcome performance
213 goals to reduce the incidence of crisis stabilization services
214 for children and adolescents who are high users of such
215 services. Performance goals must at, at a minimum, establish
216 plan-specific, year-over-year improvement targets to reduce
217 repeated use and ensure better behavioral health outcomes for
218 children and adolescents.
219 c. A managed care plan that does not meet the behavioral
220 health agency performance goals established under this paragraph
221 may be subject to quality improvement projects, automatic
222 assignment suspension, and administrative and contractual
223 sanctions as determined by the agency.
224 3. Each managed care plan must be accredited by the
225 National Committee for Quality Assurance, the Joint Commission,
226 or another nationally recognized accrediting body, or have
227 initiated the accreditation process, within 1 year after the
228 contract is executed. For any plan not accredited within 18
229 months after executing the contract, the agency shall suspend
230 automatic assignment under ss. 409.977 and 409.984.
231 (4)~~(3)~~ ACHIEVED SAVINGS REBATE.—
232 (g) A plan that exceeds agency-defined quality measures in
233 the reporting period may retain an additional 1 percent of
234 revenue. For the purpose of this paragraph, the quality measures
235 must include:

236 1. ~~p~~Plan performance in~~for~~ preventing or managing complex,
237 chronic conditions that are associated with an elevated
238 likelihood of requiring high-cost medical treatments.
239 2. Plan performance in behavioral health, including
240 reduction in the incidence of crisis stabilization services for
241 children and adolescents; improvement in follow-up visit rates
242 after behavioral health related hospitalization for children and
243 adolescents; and reduction in behavioral health related
244 emergency room visits for children or adults.
245 (h) The following may not be included as allowable
246 expenses in calculating income for determining the achieved
247 savings rebate:
248 1. Payment of achieved savings rebates.
249 2. Any financial incentive payments made to the plan
250 outside of the capitation rate.
251 3. Any financial disincentive payments levied by the state
252 or federal government.
253 4. Expenses associated with any lobbying or political
254 activities.
255 5. The cash value or equivalent cash value of bonuses of
256 any type paid or awarded to the plan's executive staff, other
257 than base salary.
258 6. Reserves and reserve accounts.
259 7. Administrative costs, including, but not limited to,
260 reinsurance expenses, interest payments, depreciation expenses,

261 bad debt expenses, and outstanding claims expenses in excess of
262 actuarially sound maximum amounts set by the agency.
263
264 The agency shall consider these and other factors in developing
265 contracts that establish shared savings arrangements.
266 (i) Prepaid plans that incur a loss in the first contract
267 year may apply the full amount of the loss as an offset to
268 income in the second contract year.
269 (j) If, after an audit, the agency determines that a
270 prepaid plan owes an additional rebate, the plan has 30 days
271 after notification to make the payment. Upon failure to timely
272 pay the rebate, the agency shall withhold future payments to the
273 plan until the entire amount is recouped. If the agency
274 determines that a prepaid plan has made an overpayment, the
275 agency shall return the overpayment within 30 days.
276 Section 3. The Agency for Health Care Administration shall
277 amend existing contracts with managed care plans to execute the
278 requirements of this act. Such contract amendments must be
279 effective before January 1, 2025.
280 Section 4. Beginning on October 1, 2024, and annually
281 thereafter, the Agency for Health Care Administration shall
282 submit to the Legislature an annual report on Medicaid-enrolled
283 children and adolescents who are the highest users of crisis
284 stabilization services. The report must include demographic and
285 geographic information; plan-specific performance data based on

286 the performance measures in s. 409.967(2)(f), Florida Statutes;
287 plan-specific provider network testing data generated pursuant
288 to s. 409.967(2)(c), Florida Statutes, including, but not
289 limited to, an assessment of access timeliness; and trends on
290 reported data points beginning from fiscal year 2021-2022. The
291 report must include an analysis of relevant managed care plan
292 contract terms and the contract enforcement mechanisms available
293 to the agency to ensure compliance. The report must include data
294 on enforcement or incentive actions taken by the agency to
295 ensure compliance with network standards and progress in
296 performance improvement, including, but not limited to, the use
297 of the achieved savings rebate program as provided under s.
298 409.967, Florida Statutes. The report must include a listing of
299 other actions taken by the agency to better serve such children
300 and adolescents.
301 Section 5. This act shall take effect July 1, 2024.
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303 ---
304 **T I T L E A M E N D M E N T**
305 Remove everything before the enacting clause and insert:
306 An act relating to Medicaid behavioral health provider
307 performance; amending s. 409.966, F.S.; revising quality
308 selection criteria to specify inclusion of behavioral health
309 care providers in the Medicaid program; amending s. 409.967,
310 F.S.; revising provider network requirements for behavioral

311 health providers in the Medicaid program; specifying network
312 testing requirements; requiring the Agency for Health Care
313 Administration to establish certain performance measures related
314 to behavioral health; requiring the agency to establish provider
315 network standards; requiring managed care plan contract
316 amendments by a specified date; requiring the agency to submit
317 an annual report to the Legislature; providing an effective
318 date.