HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 43 Medicaid Behavioral Health Provider Performance
SPONSOR(S): Select Committee on Health Innovation, Silvers and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	15 Y, 0 N, As CS	Lloyd	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida has experienced a significant increase in psychiatric crisis hospitalizations of children and teens in recent years, and an increase in those children being repeatedly hospitalized in the same year. The Florida Medicaid program has a significant role in behavioral health care because it insures a disproportionate share of the children repeatedly hospitalized for behavioral health problems.

Medicaid managed care plans must meet standards set by the Agency for Health Care Administration (AHCA) for provider network adequacy; that is, for a sufficient number, type, and location of health care providers to meet the needs of a plan's enrollees. However, AHCA does not establish network adequacy standard for inpatient psychiatric care. Current law requires AHCA to test managed care plan networks for network adequacy, but does not specify how AHCA must do so. While current law requires AHCA to ensure access, current network standards and testing methods do not adequately ensure access to care.

CS/HB 43 establishes a more specific framework Medicaid managed care network adequacy for behavioral health care services. The bill modifies the quality selection criteria for provider networks to ensure that Medicaid enrollee access to behavioral health care providers is included in future procurement processes.

For ongoing managed care plan performance, the bill requires AHCA to establish network adequacy standards for each type of behavioral health provider, including facilities, and to establish maximum wait times for appointments or admissions by each provider type. These network standards must exceed federal minimum standards. The bill also requires AHCA to be more rigorous in testing plan provider networks, by requiring AHCA to contract with an independent vendor to do this work, and to publish quarterly and annual reports on the results of network testing by plan and region.

The bill also requires AHCA to establish and enforce plan-specific, year-over-year, clinical performance goals in behavioral health. AHCA must use each plan's federal behavioral health HEDIS score in the first full year of the contract as the baseline for improvement. Similarly, the bill requires AHCA to establish behavioral health-specific metrics for plans to qualify for an achieved savings rebate.

Finally, the bill requires AHCA to report to the legislature annually, beginning October 1, 2024, on Medicaid-enrolled children who are high-utilizers of crisis stabilization services and on plan network testing and performance data based on the measures established by AHCA under the bill. This expands and recodifies a similar report previously required by law, which ended in 2022.

AHCA must to amend managed care plan contracts by January 1, 2025, to implement the bill's requirements.

The bill has an indeterminate, negative fiscal impact on AHCA, and none on local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, adult dental services, and dialysis.[3]

States have some flexibility in the provision of Medicaid services. Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services (HHS) to waive requirements to the extent that he or she "finds it to be cost-effective and efficient and not inconsistent with the purposes of this title." Section 1115 of the Social Security Act allows states to implement demonstrations of innovative service delivery systems that improve care, increase efficiency, and reduce costs. These laws allow HHS to waive federal requirements to expand populations or services, or to try new ways of service delivery.

Florida operates under a Section 1115 waiver to use a comprehensive managed care delivery model for primary and acute care services, the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.[4] Florida also has a waiver under Sections 1915(b) and (c) of the Social Security Act to operate the SMMC Long-Term Care (LTC) program.[5]

The Florida Medicaid program covers almost 5 million low-income individuals, including approximately 2.3 million children, or almost half of the children in Florida.[6]

Medicaid Behavioral Health Services

Medicaid provides coverage for behavioral health services, including both services in the community and inpatient hospitalization. Community services include crisis stabilization, transitional day services, therapeutic behavioral on-site services, psychosocial rehabilitation, medication and medication management, behavioral health overlay services, and community supports for independent living, among other services.

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] S. 409.905, F.S.
[3] S. 409.906, F.S.
[4] S. 409.964, F.S.
[5] Id.
[6] Agency for Health Care Administration, *Medicaid Eligibles Report (December 31, 2023)* available at https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-eligibles-reports (last viewed January 19, 2024).

For a child to obtain covered behavioral health services, a practitioner must formally assess the child's mental health status, substance use concerns, functional capacity, strengths, and service needs, to develop a plan of care.[7]

Federal law requires state Medicaid programs to provide all medically necessary services needed by a child, under the "Early and Periodic Screening, Diagnosis and Treatment" standard established by the federal Social Security Act.[8] This applies even to services not formally covered, and to services needed beyond the scope or duration of coverage.[9]

Behavioral Health Crisis Stabilization

Crisis Stabilization Units (CSUs) are specialized public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[10] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[11]

The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.

Crisis stabilization services are covered by commercial health insurance, by Medicaid, and by the behavioral health safety net program for people without other coverage administered by the Department of Children and Families (Department)[12].

Child Baker Act Data

Recent years have seen a significant increase in the number of people requiring mental health crisis stabilization – particularly children and teenagers – as indicated by the table below. The table shows indicates the significant annual increase in involuntary examination of minors between 2001 and 2017, which rose from 14,997 in 2001 to 36,078 in 2017. The rate of child examinations also rose at a much higher rate than that in the general population: a 140% increase in that time period.

[7] Agency for Health Care Administration, Community Behavioral Health Services Coverage and Limitations Handbook, March 2014, p. 2-3.
[8] Title 42 U.S.C. 1396(d).
[9] See, e.g., Agency for Health Care Administration, Behavioral Health Therapy Services Coverage Policy, Nov. 2019, p. 3.
[10] S. 394.875(1)(a), F.S. Involuntary admissions are governed by the Florida "Baker Act". For involuntary patients the receiving facility must examine the patient within 72 hours of arrival. During that 72 hours, an involuntary patient must be examined by a physician or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met. If the patient is a minor, the examination must be initiated within 12 hours. By the end of that 72-hour examination period, one of the following must happen:

- The patient must be released;
- The patient must be released for voluntary outpatient treatment;
- The patient must consent to voluntary inpatient admission; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

[11] Id.
[12] See, ch. 394 and ch. 397, F.S. DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

Fiscal Year	All Ages			Minors (< 18)		
	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000	Involuntary Exams	% Increase to FY17/18	Rate Per 100,000
2017-2018	205,781	N/A	1,005	36,078	N/A	1,186
2016-2017	199,944	2.92%	992	32,763	10.12%	1,092
2015-2016	194,354	5.88%	981	32,475	11.09%	1,097
2014-2015	187,999	9.46%	964	32,650	10.50%	1,102
2013-2014	177,006	16.26%	919	30,355	18.85%	1,030
2012-2013	163,850	25.59%	859	26,808	34.58%	914
2011-2012	154,655	33.06%	818	24,836	45.26%	848
2010-2011	145,290	41.63%	773	21,752	65.86%	743
2009-2010	141,284	45.65%	754	21,128	70.76%	702
2008-2009	133,644	53.98%	711	20,258	78.09%	664
2007-2008	127,983	60.79%	685	19,705	83.09%	643
2006-2007	120,082	71.37%	661	19,238	87.54%	652
2005-2006	118,722	73.33%	668	19,019	89.69%	651
2004-2005	114,700	79.41%	660	19,065	89.24%	664
2003-2004	107,705	91.06%	634	18,286	97.30%	648
2002-2003	103,079	99.63%	620	16,845	114.18%	606
2001-2002	95,574	115.31%	586	14,997	140.57%	547

2017 DCF Task Force

In 2017, the Legislature created a task force within DCF[13] to address the issue of involuntary examination of minors age 17 years or younger, specifically by:[14]

- Analyzing data on the initiation of involuntary examinations of minors;
- Researching the root causes of and trends in such involuntary examinations;
- Identifying and evaluating options for expediting the examination process; and
- Identifying recommendations for encouraging alternatives to or eliminating inappropriate initiations of such examinations.

The task force found that specific causes of increases in involuntary examinations of children are unknown. Possible factors cited in the task force report include an increase in mental health concerns, social stressors, and a lack of availability of mental health services.[15]

[13] Ch. 2017-151, Laws of Florida.
[14] Florida Department of Children and Families, *Task Force Report on Involuntary Examination of Minors,* (Nov. 2017), https://www.myflfamilies.com/service-programs/samh/publications/docs/S17-005766-TASK%20FORCE%20ON%20INVOLUNTARY%20EXAMINATION%20OF%20MINORS.pdf (last viewed January 19, 2024).
[15] Id.

As a follow up to the 2017 task force report, in 2019, the Legislature instructed DCF to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit it by November 1 of each odd numbered year.[16]

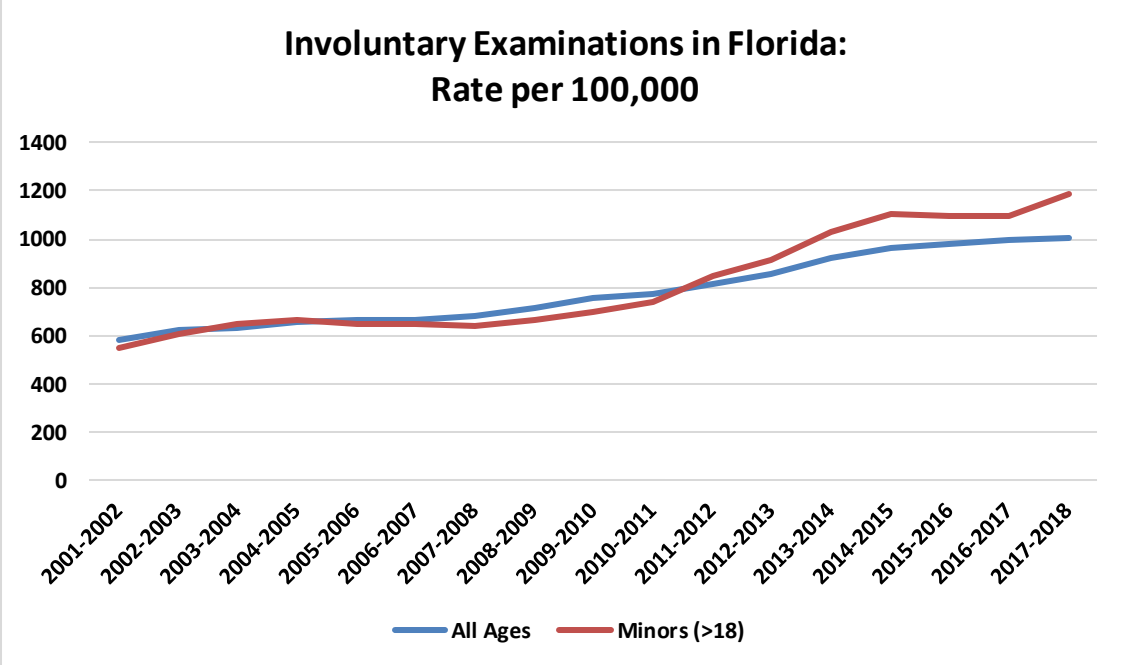
2019-2021 DCF Reporting

The 2019 report, revealed that some crisis stabilization units are not meeting the needs of children and adolescents with significant behavioral health needs, contributing to multiple exams.

The 2019 report found there were 205,781 involuntary examinations in FY 2017-2018, 36,078 of which were of minors.[17] From FY 2013-2014 to FY 2017-2018, statewide involuntary examinations increased 18.85% for children. Children had a larger increase in examinations compared to young adults ages 18-24 (14.04%) and adults (12.49%). Additionally, 22.61% of minors had multiple involuntary examinations in FY 2017-2018: up to 19 involuntary examinations in a single year. DCF identified 21 minors who had more than ten involuntary examinations in FY 2017-2018, with a combined total of 285 examinations. DCF's review of medical records found:

- Most initiations were a result of minors harming themselves and were predominately initiated by law enforcement (88%);
- Many minors were involved in the child welfare system and most experienced significant family dysfunction;
- Most experienced multiple traumas such as abuse, bullying, exposure to violence, parental incarceration, and parental substance abuse and mental health issues;
- Most had behavioral disorders of childhood, such as ADHD or Oppositional Defiant Disorder, followed by mood disorders, followed by anxiety disorders;
- Most involuntary examinations were initiated at home or at a behavioral health provider; and
- Discharge planning and care coordination by the receiving facilities was not adequate enough to meet the child's needs.

The 2019 report documented the significant increase in the rate of involuntary examinations of children, from a rate (per 100,000 population) of 547 in 2001 to a rate of 1,186 in 2018.



[16] Ch. 2019-134, Laws of Florida.
[17] Florida Department of Children and Families, *Report on Involuntary Examination of Minors, 2019,* (Nov. 2019), p. 25, https://www.usf.edu/cbcs/baker-act/documents/dcfoddyearreport2019.pdf (last visited January 19, 2024).

The 2021 report made similar findings, and updated the data.[18]

Table 1: Minors with Repeated Involuntary Exams				
# of Involuntary Exams	**Count of People**	**% of People**	**Count of Exams**	**% Exams**
1	18,378	76.03%	18,378	51.06%
2	3,393	14.04%	6,786	18.85%
3	1,143	4.73%	3,429	9.53%
4	498	2.06%	1,992	5.53%
5	271	1.12%	1,355	3.76%
6-10	409	1.69%	2,943	8.18%
11+	**79**	**0.33%**	**1,113**	**3.09%**
Counts of exams for children with 11 or more involuntary exams during the year are grouped together to redact for cell sizes lower than 10.				

The 2021 report noted that the vast majority of children with multiple crisis examinations in a year have Medicaid coverage, which should have provided greater access to community care that would help the children avoid the need for crisis care.[19]

Child Baker Act High Utilizer Project

Following up on this work, the Legislature in 2020 required DCF and AHCA to identify children and adolescents who are the highest users of crisis stabilization and inpatient psychiatric hospitalization services, collaboratively act to meet the behavioral health needs of those children, and submit a joint quarterly report during Fiscal Years 2020-2021 and 2021-2022 to the Legislature.[20] A "high utilizer" was defined by the Department and the Agency as children or adolescents under 18 years of age with three or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days.[21]

This reporting documented the fact that the vast majority of high utilizer children are covered by Medicaid, rather than by the Department safety net program, as indicated by the table below.[22]

Children Identified as High Utilizers Jan 2022 – Jun 2022		
SOURCE	COUNT	% of TOTAL
Medicaid	550	99%
DCF only (non-Medicaid)	7	1%
TOTAL	**557**	100%

[18] Florida Department of Children and Families, *Report on Involuntary Examination of Minors, November 2021,* Report on Involuntary Examination of Minors 2021.pdf (myflfamilies.com) (last viewed January 19, 2024).
[19] Id. at 11.
[20] S. 394.493(4), F.S.; Ch. 2020-107, L.O.F.
[21] Department of Children and Families and Agency for Health Care Administration, *Standards of Care in Facilities Providing Crisis Stabilization Services for Children and Adolescents, Findings and Recommendations (November 15, 2020)* available at Standards of Care in Facilities Providing Crisis Stabilization Services for Children and Adolescents (myflfamilies.com) (last viewed January 19, 2024).
[22] Department of Children and Families and Agency for Health Care Administration, Presentation to the House Subcommittee on Children, Families and Seniors, Feb. 8, 2023.

This reporting broke out the repeat child hospitalizations by Medicaid managed care plan, as indicated in the table below. Note that the plans highlighted in yellow are specialty plans, and have disproportionate numbers of children in their enrollment cohort with serious trauma (as with the Sunshine Child Welfare plan) or with serious mental illness (as with the Molina and Sunshine SMI plans). Higher rates of crisis treatment would be expected in those plans.[23]

Children < 19 Yrs. Identified as High Utilizers of CSU/ Inpatient Behavioral Health Services by Health Plan		
MMA Health Plan as of June 2022	Count of Children	High Utilizers Per 1,000 Enrollees
Aetna	2	0.02
Amerihealth	5	0.06
CCP	4	0.10
CMS Plan	49	0.57
FFS Provider	4	0.05
Humana	36	0.09
Molina	5	0.07
Molina - Serious Mental Illness*	15	3.42
Simply	34	0.08
Sunshine	142	0.14
Sunshine - Child Welfare*	129	3.33
Sunshine - Serious Mental Illness*	99	3.62
United	25	0.13
Vivida	1	0.06
Grand Total	550	0.21

AHCA reported on efforts made by the plans to improve care, including requiring managed care plans to assign the children a case manager and reaching out to parents to offer more services. According to AHCA, more than one-third of the parents contacted could not be reached or did not respond. In some instances, parents declined case management or specific service offer.[24] This may point to a need to address whole-family problems in order to assist the child.

Medicaid Provider Networks

Current law requires AHCA to establish network adequacy requirements for the managed care plans to meet when contracting with providers. Specifically, AHCA must establish standards for how many providers, the type of providers, and the regional distribution of providers are necessary for each plan to ensure access to care for the Medicaid recipients in their enrollment cohort. Each plan must establish a database of contracted providers and information about them, and publish the database online that allows Medicaid enrollees to compare provider availability to the network adequacy standards.[25]

Prior to 2020, Florida law did not expressly require the Medicaid program to test the provider networks, to confirm accuracy and compliance with the network standards.

Provider Network Testing

In 2020, the legislature required the Medicaid program to conduct (or contract for) systematic and continuous testing of the provider network databases to confirm accuracy. In addition, the legislature required more intensive network adequacy testing for the network of behavioral health providers.

[23] Id.
[24] Id.
[25] S. 490.967(2)(c)1., F.S.

Section 409.967(2)(c), F.S., requires AHCA to systematically and continuously test the behavioral health network to confirm:

1. That Medicaid behavioral health providers are accepting Medicaid patients; and
2. That Medicaid enrollees have access to behavioral health services.

AHCA implemented this requirement by conducting this testing in-house, as a desk review of the provider databases, or by requiring the plans to test themselves. In addition, AHCA performs periodic "secret shopper" testing by calling the provider offices and confirming[26]:

- Whether the provider's phone number and address listed in the database are correct;
- Whether the provider is available to see patients at the location listed;
- Whether the provider's staff is aware that the provider is in the plan's network; and
- Whether the provider is accepting new patients.

AHCA tests the network of behavioral health care *practitioners*; it does not test the network of inpatient or residential providers. AHCA does not establish network adequacy requirements for inpatient pediatric psychiatric beds or facilities, or assess the supply and demand for such services to determine whether there are access gaps.

This testing succeeds in identifying errors in the database and provider office confusion about participation in the plan. For example, one test of Humana practitioners in 2021 identified several providers with incorrect contact information, or which were no longer providing care at a listed location, or were no longer accepting Humana patients, or could not be reached at all.[27] A similar 2021 exercise across all plans for behavioral health practitioners identified several over 30 similar problems: provider not found, provider not at the listed location, provider does not accept new patients, and address and phone number problems.[28]

AHCA does not test how long it would take for a Medicaid enrollee to get an appointment with the practitioner, or use other methods of measuring the level of access to care. AHCA does not compile or publish reports on in its current testing results, or on trends.

Federal Network Adequacy Standards

Federal Medicaid rules require state Medicaid programs that use managed care models to develop specific quantitative standards for network adequacy, and monitor plan compliance with those standards. The federal Centers for Medicare and Medicaid Services (CMS) does not establish the specific standards for network adequacy; rather, it allows each state to develop its own guidelines and methods of measurement. However, the standards must ensure that beneficiaries have access to care,[29] and the plans must document to the state their ability to serve the anticipated enrollment before the contract begins and on an annual basis.[30]

The federal regulation does establish maximum wait times for routine appointments for primary care, obstetrics and gynecology, and outpatient mental health and substance use disorder care. Additionally, plan monitoring must include annual enrollee experience surveys for each Medicaid managed care plan, independent contractor calls to providers to verify access to appointments, and improvement plans when networks do not meet required levels.[31]

Medicaid Achieved Savings Rebates

[26] Agency for Health Care Administration, Agency Prescribed Secret Shopper Template, on file with staff of the House Subcommittee on Healthcare Regulation.
[27] Agency for Health Care Administration, Agency Prescribed Secret Shopper July 2021, on file with staff of the House Subcommittee on Healthcare Regulation.
[28] Agency for Health Care Administration, Agency Prescribed Secret Shopper, Q3 2021 Behavioral Health LDs, on file with staff of the House Subcommittee on Healthcare Regulation
[29] 42 CFR 438.68.
[30] 42 CFR 438.66.
[31] 42 CFR Part 438.

Current law requires Medicaid managed care plans to revert any achieved savings to the state, over a certain level. However, current law establishes an achieved savings rebate whereby a plan may retain a limited amount of savings for meeting certain quality performance measures established by AHCA. Specifically, plans may retain an additional one percent of revenue if they exceed any AHCA-defined quality measure related to preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments .[32]

AHCA's current quality metrics for obtaining an achieved savings rebate do not specifically address behavioral health outcomes.

Effect of the Bill

CS/HB 43 enhances the statutory and contractual requirements for Medicaid managed care plans related to behavioral health care quality performance and provider network adequacy.

Medicaid Behavioral Health Provider Networks

The bill requires AHCA to establish network standards for each type of behavioral health care provider serving Medicaid enrollees, and specifically include both community-based and residential providers, by October 1, 2024. Currently, AHCA does not establish adequacy standards for residential providers, pointing to a gap which the bill addresses. At a minimum, the standards must ensure timely access to care and exceed any federal requirements for behavioral health networks. For each behavioral health care provider type, AHCA must establish standards for:

- Patient to provider ratios.
- Maximum waiting times for appointments and admissions.
- Availability of innovative health care service delivery methods, such as telehealth, mobile response services, and certified community behavioral health clinics.

AHCA must amend current plan contracts by January 1, 2025, to reflect these changes.

In addition, the bill requires AHCA to contract with an independent vendor to perform systematic and continuous testing of the managed care plan network rather than only reviewing plans through desk audits, concurring with the plan attestations of provider and facility network sufficiency or accepting information as submitted through provider directories. The bill requires the vendor to produce, and AHCA to publish online, quarterly and annual reports on network performance, beginning April 1, 2025 and July 1, 2026, respectively. All reporting must be by plan and by region.

Medicaid Behavioral Health Performance Measures

The bill requires AHCA to establish specific, outcome-based, performance measures for Medicaid managed care plans.

AHCA must identify the individual HEDIS score earned by each Medicaid managed care plan during its first full contract year for each measure in the Core Set of Child and Adult Behavioral Health Indicators and notify each plan of that score. These first year HEDIS scores will serve as the plan's performance baseline. AHCA must then establish annual, plan-specific, regional performance goals, working collaboratively with the managed care plans. The performance goals must include, but are not limited to, reductions in the use of crisis stabilization services by children and adolescents, and include plan-specific targets for year-over-year improvements in outcomes for that population. In setting those performance goals, AHCA must consider each plan's population, enrollment, patient mix and clinical risk, and other factors established by AHCA.

[32] S. 409.967(3), F.S.

Under the bill, managed care plans that do not meet the performance measures established by AHCA will be subject to quality improvement plans, automatic assignment suspension, and administrative and contractual sanctions determined by AHCA.

CS/HB 43 also amends the achieved savings rebate in current law to add a performance category for plans to obtain a savings rebate. AHCA must establish metrics for plans to meet in behavioral health performance, including:

- A reduction in the incidence of crisis stabilization services for children and adolescents.
- Improvements in follow up visit rates for children and adolescents after a behavioral health related hospitalization.
- Reduction in behavioral health care related emergency room visits for children or adults.

Medicaid Behavioral Health Performance Data Reporting

The bill requires AHCA to annually report to the legislature data on children and adolescents identified as high utilizers of crisis stabilization services, the bill requires AHCA to report to the legislature annually on those numbers, and to establish specific performance goals which establish plan-specific, year-over-year improvement targets to reduce repeated use of such services and to create better outcomes for children and adolescents.

The report must also include an analysis of managed care plan contract mechanisms for enforcing or incentivizing compliance with the requirements of the bill, and data on the use of those or other mechanisms by the agency, and any other actions taken by the agency to improve behavioral health outcomes for children in Medicaid.

This provision extends and expands the high-utilizer reporting established by the legislature in 2020, which ended in 2022. The first annual report is due October 1, 2024.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.966, F.S., related to eligible plans; selection.
Section 2: Amends s. 409.967, F.S, related to managed care plan accountability.
Section 3: Creates an unnumbered section of law, related to Medicaid contract amendments.
Section 4: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requirement for AHCA to contract for network adequacy testing has an unknown, but insignificant, cost. Current contracted services allocations are sufficient to fund the requirements of the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Medicaid managed care plans may reallocate their Medicaid capitated payments or establish other initiatives to improve performance in behavioral health. Plans that improve performance will experience cost-avoidance savings due to fewer repeat hospitalizations of children.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to affect county or municipal governments

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 22, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Provides greater specificity for the bill's requirement for AHCA to establish network adequacy standards for behavioral health care providers by requiring AHCA to address provider/patient ratios, maximum wait times, and availability of innovated service delivery systems.
- Requires AHCA to contract with an independent vendor to validate managed health care plan compliance with AHCA network adequacy and access standards, and publish quarterly and annual reports on findings from the independent vendor beginning April 1, 2025 and July 1, 2026, respectively.
- Requires AHCA to establish quality measure baseline scores for each managed care plan, and set annual clinical performance goals cooperatively with each managed care plan.
- Requires the performance goals to be plan-specific, show year-over-year improvements, and provides mechanisms for administrative and contractual sanctions when not achieved.
- Retains the bill's requirement for AHCA to amend managed care contracts prior to January 1, 2025 to comply with the bill.
- Retains the bill's requirement for AHCA to submit an annual report on Medicaid-enrolled children who are high utilizers of crisis stabilization.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.