The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/SB 1950
INTRODUCER:	Health Policy Committee and Senator Brodeur
SUBJECT:	Statewide Medicaid Managed Care Program
DATE:	February 25, 2022 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.	McKnight	Money	AHS	**Recommend: Fav/CS**
3.	McKnight	Sadberry	AP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1950 makes changes to the Statewide Medicaid Managed Care (SMMC) program in anticipation of the next competitive procurement for the 2025 plan year. The bill:

- Requires provider service networks (PSNs) to be reimbursed on a prepaid basis.
- Authorizes the Agency for Health Care Administration (AHCA) to select eligible managed care plans to provide services through a single statewide procurement and deletes the requirement that the AHCA conduct separate and simultaneous procurements for each Medicaid region.
- Authorizes the AHCA to award contracts to managed care plans on a regional or statewide basis.
- Outlines a new regional structure for plan selection under the SMMC program's Managed Medical Assistance (MMA) and Long-Term Care (LTC) programs with a minimum and maximum number of plans designated for each region. The bill provides for eight regions named by letters (Regions A-H), rather than the 11 regions named by numbers (Regions 1-11) in current law.
- Requires the AHCA to award a contract to at least one PSN in each of the eight regions under the MMA program and under the LTC program.
- Amends the Achieved Savings Rebate (ASR) structure to change thresholds relating to profit-sharing for managed care plans.
- Requires managed care plans to include Florida cancer hospitals that meet specified federal criteria in their networks as essential providers.

- Revises MMA plan healthy behaviors program requirements to include tobacco cessation programs, rather than smoking cessation programs, and to clarify that substance abuse programs must include opioid abuse recovery.
- Authorizes an MMA Child Welfare Specialty Plan to serve a child in a permanent guardianship situation whose parents receive payments through the Guardianship Assistance Program.
- Deletes obsolete language.

The bill has a significant negative fiscal impact to the Florida Medicaid program. *See* Section V of this analysis.

The bill takes effect on July 1, 2022.

II. Present Situation:

Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[1] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the Agency for Health Care Administration (AHCA) and financed through state and federal funds.[2]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

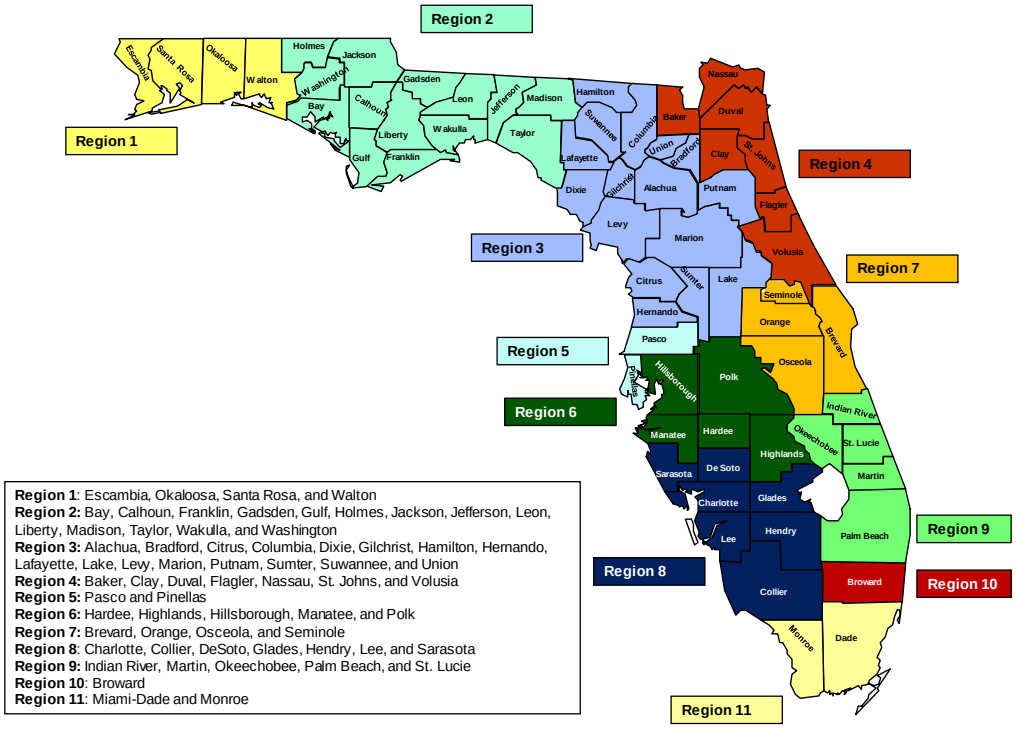
In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[3]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service or managed care. Under fee-for-service, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the state contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

[1] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Jan. 23, 2022).
[2] Section 20.42, F.S.
[3] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Jan. 23, 2022).

Statewide Medicaid Managed Care (SMMC) Program

In 2011, the Legislature established the Medicaid program as a statewide, integrated managed care program for all covered services, and directed the AHCA to create the Statewide Medicaid Managed Care (SMMC) program and contract with managed care plans on a regional basis to provide services to eligible recipients.[4] The SMMC minimum benefits are authorized by federal authority and are specifically required in s. 409.973, F.S., for Managed Medical Assistance (MMA) plans and s. 409.98, F.S., for Long-Term Care (LTC) plans.



Today, the majority of Florida Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the SMMC program. The SMMC program has three components:

- MMA: provides Medicaid covered medical services like doctor visits, hospital care, prescribed drugs, mental health care, and transportation to these services.[5]
- LTC: provides Medicaid LTC services like care in a nursing facility, assisted living, or at home. To get LTC you must be at least 18 years old and meet nursing home level of care (or meet hospital level of care if you have Cystic Fibrosis).[6]
- Dental: provides all Medicaid dental services for children and adults. All individuals on Medicaid must enroll in a dental plan.[7]

[4] Chapter 2011-134, Laws of Fla.
[5] Agency for Health Care Administration, *Statewide Medicaid Managed Care, Health Plans and Programs, available at* https://www.flmedicaidmanagedcare.com/health/comparehealthplans (last visited Feb. 9, 2022).
[6] *Id.*
[7] *Id.*

Eligible Plan Selection

The SMMC program was fully implemented in August 2014. During the initial SMMC procurement, the AHCA awarded contracts to 18 plans, including seven provider service networks (PSNs). By the end of the first contract period, due to various mergers, acquisitions, and conversions to HMO status, only one PSN remained.[8]

During the second procurement, beginning December 2018 and ending in December 2023, the AHCA awarded contracts to 16 plans, including five PSNs, but only three of the PSNs currently remain in the program due to mergers and acquisitions with a total of 10 health plans.[9] In 2020, the Legislature extended the allowable term of the SMMC contracts from five to six years.[10] As a result, the AHCA's current contracts will end in December 2024. The AHCA will conduct its next procurement in Fiscal Year 2022-2023 for implementation in the 2025 plan year.

Various mergers and acquisitions have occurred during the lifecycle of each SMMC contract, resulting in a situation where a majority of enrollees are receiving services from statewide plans that operate in all 11 regions. As of October 1, 2021, 40 percent of the SMMC population, including those enrolled in a specialty plan, were enrolled in a plan operating statewide and 79 percent were enrolled in a plan that operates in at least eight of the 11 regions. The chart below reflects the current operational SMMC plans in their designated regions as of October 1, 2021:[11]

SMMC Health Plans by Region (2018-2024)											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
MMA Health Plans											
AmeriHealth									✓		✓
Community Care Plan										✓	
Simply Healthcare	✓	✓							✓		
Vivida Health								✓			
Comprehensive Plans (MMA & LTC Combined)											
Aetna Better Health						✓	✓				✓
Humana Medical Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Molina Healthcare								✓			✓
Simply Healthcare					✓	✓	✓			✓	✓
Sunshine Health	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
United Healthcare			✓	✓		✓					✓
Specialty Plans											
CMS Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clear Health Alliance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Molina SMI Specialty				✓	✓		✓				
Sunshine SMI Specialty	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sunshine Child Welfare	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

[8] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).
[9] *Id.*
[10] Chapter 2020-156, s. 44, Laws of Fla.
[11] Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/SMMC_Plans_by_Region.pdf (last visited Feb. 9, 2022).

Provider Service Networks (PSNs)

A PSN in the Medicaid program is a managed care plan established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions.[12] The health care providers must have a controlling interest in the governing body of the PSN. The AHCA is authorized to contract with PSNs under s. 409.912(1), F.S., and may currently reimburse PSNs on a fee-for-service basis with a shared savings settlement or on a prepaid basis with per-member, per-month payments. A PSN may be reimbursed on a fee-for-service basis for only the first two years of the plan's operation.[13]

Specialty Plans[14]

An MMA managed care plan can participate in the MMA program as a standard plan or as a specialty plan. A specialty plan is a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.[15] Under federal Medicaid law and the SMMC waiver, each recipient has a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient.[16] If a specialty plan is available to accommodate a specific condition or diagnosis of a Medicaid recipient, the AHCA must automatically enroll the recipient in that plan unless the recipient chooses a different plan.[17] MMA specialty plans cover the same health care services as the standard MMA plans, and in addition, they must maintain a care coordination program tailored to the special needs of the plan's enrollees.

When a recipient is eligible for more than one MMA specialty plan, the AHCA uses a ranking to determine which MMA specialty plan to assign. Unless the recipient chooses to enroll in another MMA specialty plan for which he or she is eligible, or in a standard MMA plan offered in his or her region, the recipient is automatically assigned to the specialty plan listed highest on the ranking. The AHCA has awarded specialty plan contracts to serve enrollees with specialty conditions including severe mental illness, HIV/AIDS, as well as children with special health care needs, and those involved with Florida's child welfare system.

Achieved Savings Rebate (ASR)

The AHCA is responsible for verifying the achieved savings rebate (ASR) for all Medicaid prepaid plans. Prepaid plans are required to provide the AHCA with unaudited quarterly and annual reports that detail managed care plan financial operations and performance for the applicable reporting period. If a plan reports that its profits exceed a certain percent of revenue

[12] Section 409.912(1)(b), F.S.
[13] *Id.*
[14] Agency for Health Care Administration, *Medicaid Managed Medical Assistance Specialty Plans available at* https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Specialty_Plans_110316.pdf (last visited Jan. 23, 2022).
[15] Section 409.962(18), F.S.
[16] Section 409.969(1), F.S.
[17] Section 409.977(1), F.S.

(thereby achieving savings for the overall program), the plan must return a portion of the profits (a rebate) to the state.[18]

The ASR is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

- All profit up to five percent of revenue is retained by the plan. Half of the profit above five percent and up to 10 percent of revenue is retained by the plan and the other half refunded to the state. All profit above 10 percent of revenue is refunded to the state.[19]
- Plans may retain an additional one percent of revenue if they meet or exceed quality measures defined by the AHCA, including plan performance for managing complex, chronic conditions that are associated with an elevated likelihood of recurring high-cost medical treatments.[20]

The following chart reflects the total amount of rebates the plans were required to pay to the AHCA and the number of plans who made a payment, by year:[21]

ASR Year	Total Rebate	Number of plans
MMA/LTC Plans		
2015	$2,373,946	2
2016	$30,440,542	4
2017/2018	$13,140,788	1
2019	$127,889,844	1
2020	$218,431,920	8
Dental		
2019	$1,409,012	1
2020	$55,796,119	3

III. Effect of Proposed Changes:

Section 1 amends s. 409.912(1), F.S., to eliminate fee-for-service (FFS) reimbursement of provider service networks (PSNs) in conjunction with changes made to s. 409.968(2), F.S., in section 6 of the bill. Under these changes, PSNs must be reimbursed on a prepaid basis, receiving a per-member, per-month payment. This section of the bill prohibits the Agency for Health Care Administration (AHCA) from contracting with a PSN outside of the procurement process in s. 409.966, F.S., as amended by section 4 of the bill.

Changes to this subsection relocate, but do not substantively change, language exempting PSNs from parts I and III of ch. 643, F.S.

Section 2 repeals obsolete language in s. 409.9124, F.S., relating to managed care plan reimbursement.

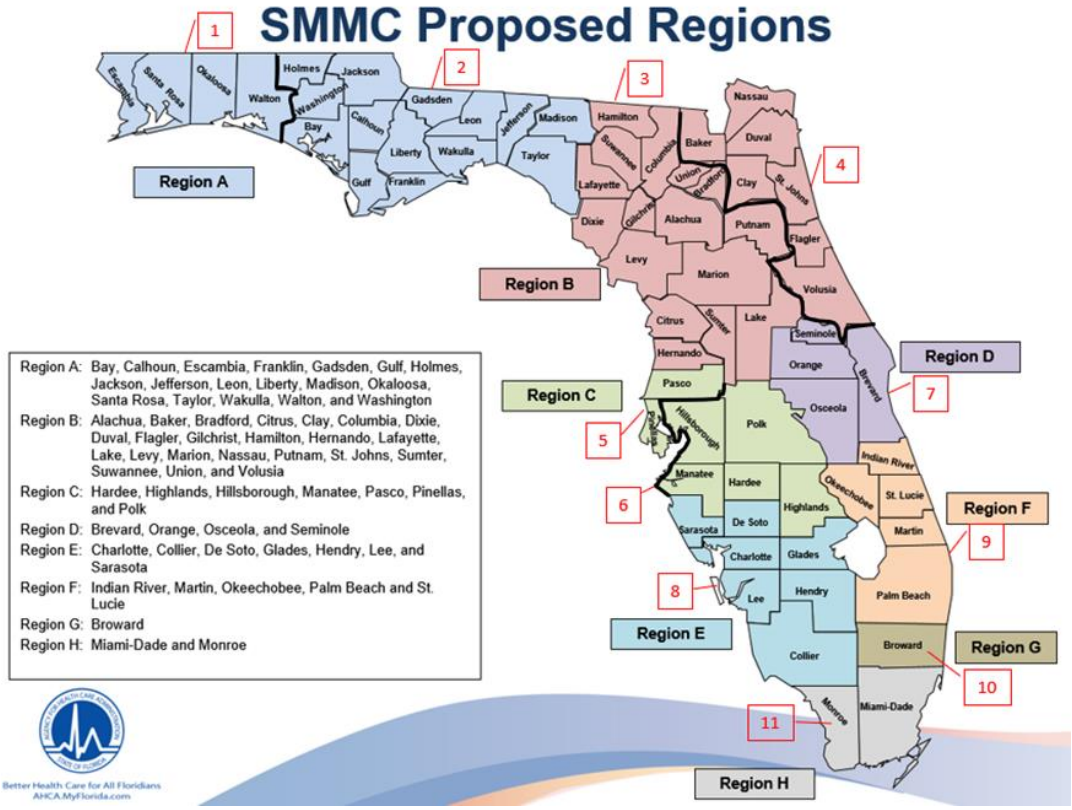
[18] Section 409.967(3), F.S.
[19] Section 409.967(3)(f), F.S.
[20] Section 409.967(3)(g), F.S.
[21] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).

Section 3 amends s. 409.964, F.S., to eliminate an obsolete requirement that the AHCA provide public notice and the opportunity for public comment before seeking a waiver to implement the Statewide Medicaid Managed Care (SMMC) program. This language is obsolete as the public notice and public meeting requirements were met prior to the AHCA seeking federal authority to implement the SMMC program in 2011 and 2012.

Section 4 amends s. 409.966(2), F.S., to require the AHCA's databook consisting of Medicaid utilization and spending data (which must be published 90 days before issuing an invitation to negotiate) to include at least the 24 most recent months of data from the Medicaid Encounter Data System. This removes the requirement that the databook consist of data for the three most recent contract years, include historic fee-for-service claims, and delineate utilization by age, gender, eligibility group, geographic area, and aggregate clinical risk score.

This section of the bill deletes the requirement for the AHCA to conduct separate and simultaneous procurements for each Medicaid region and outlines a new structure for regional awards. The new structure includes eight regions named by letters (Regions A-H), rather than the 11 regions named by numbers (Regions 1-11) included in the original statute.

The following map and chart outline the eight regions proposed in the bill:[22]



[22] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).

Current	Counties	Proposed
Region 1	Escambia, Okaloosa, Santa Rosa, and Walton	**Region A**
Region 2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington	
Region 3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union	**Region B**
Region 4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia	
Region 5	Pasco and Pinellas	**Region C**
Region 6	Hardee, Highlands, Hillsborough, Manatee, and Polk	
Region 7	Brevard, Orange, Osceola, and Seminole	**Region D**
Region 8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	**Region E**
Region 9	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie	**Region F**
Region 10	Broward	**Region G**
Region 11	Miami-Dade and Monroe	**Region H**

This section of the bill also deletes obsolete language in s. 409.966(3)(d), F.S., that required the AHCA to negotiate capitation rates for the first year of the first contract term and in s. 409.966(3)(e), F.S., that awarded additional contracts to plans who are awarded contracts in Regions 1 and 2. The AHCA indicates that due to the merger of Regions 1 and 2 into a single Region A, and because the bill provides for the award of statewide contracts, this provision is no longer needed.[23]

Section 5 amends s. 409.967, F.S., to delete obsolete language relating to plans contracting with hospital facilities that became licensed and operational before January 1, 2013. This section of the bill also deletes obsolete language requiring the AHCA to issue a request for information to determine whether cost savings could be achieved through oversight and management by the end of the fourth year of the first contract term.

This section also amends the achieved savings rebate (ASR) structure to change the thresholds relating to profit sharing with the plans. The bill changes the threshold at which profit-sharing begins from five percent to three percent of revenue. The bill authorizes the plans to retain up to an additional two percent of revenue, rather than the additional one percent. The bill specifies that the AHCA's quality measures must include two tiers. A plan meeting tier one quality or performance targets would retain all profit up to four percent of revenue. A plan meeting tier two quality or performance targets would retain all profit up to five percent of revenue. Half of the profit above such final threshold, up to 10 percent of revenue, would be retained by the plan and the other half refunded to the state. All profit above 10 percent of revenue would continue to be refunded to the state.

[23] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).

	3%	4%	5%	6%	7%	8%	9%	10%	11%
Current Statute									
Profit retained without meeting agency-defined quality measures	100%	100%	100%	50%	50%	50%	50%	50%	0%
Profit retained meeting agency-defined quality measures	100%	100%	100%	100%	50%	50%	50%	50%	0%
Proposed Bill									
Profit retained without meeting any quality benchmarks	100%	50%	50%	50%	50%	50%	50%	50%	0%
Profit retained once new tier one benchmarks are met	100%	100%	50%	50%	50%	50%	50%	50%	0%
Profit retained once new tier two benchmarks are met	100%	100%	100%	50%	50%	50%	50%	50%	0%

Section 6 amends s. 409.968(2), F.S., to delete language allowing PSNs to receive fee-for-service rates with a shared savings settlement. In conjunction with changes made to s. 409.912. F.S., in section 1 of this bill, the bill requires all PSNs to be prepaid plans, receiving a per-member, per-month payment, and be negotiated pursuant to the procurement process in s. 409.966, F.S.

Section 7 amends s. 409.973, F.S., to revise language related to Healthy Behaviors programs which Managed Medical Assistance (MMA) plans are required to establish to encourage and reward healthy behaviors. The bill requires each plan to establish a "tobacco cessation program" rather than a "smoking cessation program" to ensure that each program also includes smokeless tobacco products. It also requires an MMA plan's substance abuse recovery program to include opioid abuse recovery.

This section of the bill also deletes obsolete language in 409.97(4)(b), F.S., relating to the Primary Care Initiative, which requires the plans to schedule an appointment with a primary care provider for enrollees who became eligible for Medicaid between January 1, 2014 and December 31, 2015, within 6 months of enrollment in the plan.

Section 8 amends s. 409.974(1), F.S., to outline the structure for plan selection under the MMA program. This section authorizes the AHCA to select eligible plans to provide services through a single statewide procurement and to award contracts to plans on a regional or statewide basis. It requires the AHCA to award a contract to at least one PSN in each of the 8 regions and to procure:

- 3-4 plans for Region A
- 3-6 plans for Region B
- 5-10 plans for Region C
- 3-6 plans for Region D

- 3-4 plans for Region E
- 3-5 plans for Region F
- 3-5 plans for Region G
- 5-10 plans for Region H

This section of the bill also amends s. 409.974(2), F.S., to eliminate the requirement that the AHCA exercise a preference for plans with a provider network in which over 10 percent of the providers use electronic health records. It is estimated that 80 percent of providers currently use electronic health records.[24]

Section 9 amends s. 409.975(1)(b), F.S., to expand the list of statewide essential providers to include Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v). Currently, Moffitt Cancer Center in Tampa and Sylvester Comprehensive Cancer Center in Miami meet this criteria. Under the bill, managed care plans would be required to include these cancer hospitals in their networks as essential providers.

Section 10 amends s. 409.977, F.S., to revise and relocate the requirement for the AHCA to maintain a recipient's enrollment in a plan if a recipient was enrolled in a plan immediately before the recipient's choice period and that plan is still available in the region, unless an applicable specialty plan is available from subsection (1) to subsection (2).

This section of the bill deletes the obsolete requirement in s. 409.977(4), F.S., for the AHCA to seek federal approval to develop and implement a process to enable a Medicaid recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage. The AHCA has already obtained federal approval for what has come to be known as their Health Insurance Premium Payment (HIPP) program[25] and continues to implement this program.[26] As of August 2021, 53 recipients were participating in the HIPP program.[27]

This section of the bill also amends s. 409.977(5), F.S., to authorize a child welfare specialty managed care plan under contract with the MMA program to serve a child in a permanent guardianship situation.[28] Specifically, such a child must continue to be eligible for Medicaid and must receive guardianship assistance payments under the Guardianship Assistance Program.

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[24] Email from Legislative Affairs Director, Agency for Health Care Administration, to Senate Committee on Health Policy Staff (Jan. 24, 2022) (on file with the Senate Committee on Health Policy).
[25] *See* Rule 59G-7.007, F.A.C.
[26] The Agency for Health Care Administration reports that for the 2020 calendar year, $95,388.79 was spent on premium reimbursements through the HIPP program. From January to August of 2021, $912,363.87 was spent on premium reimbursements through the program. Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).
[27] Email from Legislative Affairs Director, Agency for Health Care Administration, to Senate Committee on Health Policy Staff (Jan. 24, 2022) (on file with the Senate Committee on Health Policy).
[28] For more information on the Sunshine Health Child Welfare Specialty Plan and the Guardianship Assistance Program, *see* Florida Senate Bill Analysis and Fiscal Impact Statement for CS/SB 1080, Jan. 19, 2022 *available* at https://www.flsenate.gov/Session/Bill/2022/1080/Analyses/2022s01080.hp.PDF (last visited Jan. 23, 2022). The provisions of CS/SB 1080 are identical to the changes made to s. 409.977(5), F.S., in this bill.

Currently, only children in foster care, extended foster care, or subsidized adoption are eligible for the child welfare specialty plan.

Section 11 amends s. 409.981, F.S., to outline the structure for plan selection under the Long-Term Care program. Tracking the structure for MMA plan selection above in section 8 of this bill, except as noted, this section authorizes the AHCA to select eligible plans to provide services through a single statewide procurement and to award contracts to plans on a regional or statewide basis. It requires the AHCA to award a contract to at least one PSN in each of the eight regions and to procure:

- 3-4 plans for Region A
- 3-6 plans for Region B
- 5-10 plans for Region C
- 3-6 plans for Region D
- 3-4 plans for Region E
- 3-5 plans for Region F
- 3-4 plans for Region G[29]
- 5-10 plans for region H

Section 12 amends s. 409.8132, F.S., to conform a cross-reference to changes made in bill section 2 which repeals s. 409.9124, F.S.

Section 13 reenacts s. 409.962, F.S., to incorporate changes made by this act to s. 409.912, F.S., in bill section 1.

Section 14 reenacts s. 641.19, F.S., to incorporate changes made by this act to s. 409.912, F.S., in bill section 1.

Section 15 reenacts s. 430.2053, F.S., to incorporate changes made by this act to s. 409.981, F.S., in bill section 11.

Section 16 provides an effective date of July 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[29] Note that the Agency for Health Care Administration must award 3-5 MMA plans for Region G under bill section 8.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Changes made by CS/SB 1950 to the achieved savings rebate structure could result in cost savings. The bill tasks the Agency for Health Care Administration (AHCA) with specifying two tiers of quality measures for which profit-sharing would be based. Without additional information as to what those quality measures are, it is impossible to estimate whether the AHCA would receive revenue (and at what percent) from the plans, and at this time, the fiscal impact is indeterminate.

The capitation rate for children in the Child Welfare Specialty Plan is higher than the rates for most children in other plans. If children become eligible and receive services through the Child Welfare Specialty Plan as authorized in the bill, the bill will have a significant negative fiscal impact to the Florida Medicaid program. The AHCA estimates a maximum recurring fiscal impact of $12.2 million ($4.7 million General Revenue) based on a rate year 2020-2021 estimate of 4,120 children who currently would be eligible for the change in plans.[30]

The precise fiscal impact of children becoming newly eligible for the Child Welfare Specialty Plans cannot be calculated without knowing the Medicaid region in which an eligible child resides and the capitation rate category in which the child is currently categorized. This is because Medicaid capitation rates vary by region and children could be in different rate cells based on age, gender, Medicaid eligibility category, and other characteristics.

VI. Technical Deficiencies:

None.

[30] Agency for Health Care Administration, 2022 Agency Legislative Bill Analysis for SB 1950, Jan. 19, 2022 (on file with the Senate Committee on Health Policy).

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.912, 409.964, 409.966, 409.967, 409.968, 409.973, 409.974, 409.975, 409.977, 409.981, and 409.8132.

This bill repeals section 409.9124 of the Florida Statutes.

This bill reenacts the following sections of the Florida Statutes: 409.962, 641.19, and 430.2053.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 26, 2022:
The CS corrects a drafting error in the underlying bill that would have inadvertently deleted the AHCA's existing authority to implement the HIPP program. The amendment keeps the HIPP program intact and removes obsolete language from statute regarding already-obtained federal approval to implement the program.

B. Amendments:

None.