HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1457 Medicaid Behavioral Health Provider Performance
SPONSOR(S): Silvers
TIED BILLS: **IDEN./SIM. BILLS:** SB 1652

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	14 Y, 0 N	Calamas	McElroy
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. Current law requires AHCA to test managed care plan networks, but does not specify that AHCA must establish standards for all types of behavioral health providers. While current law requires AHCA to ensure access, current network testing methods do not address access.

HB 1457 increases Medicaid requirements for managed care plan behavioral health performance for children.

The bill requires AHCA to establish network requirements for each type of behavioral health provider serving Medicaid enrollees, and improve its testing of behavioral health provider networks by including provider-specific data on access timelines.

The bill requires AHCA to establish specific, outcome-based, performance measures for Medicaid managed care plans to reduce high-utilization of crisis stabilization services by children and teenagers. The bill requires the measures, at a minimum, to require plan-specific measures for year-over-year improvement.

Finally, the bill requires AHCA to report to the legislature annually, beginning October 1, 2023, on Medicaid-enrolled children who are high-utilizers of crisis stabilization services. The report must include demographic and geographic data, plan network testing data, and plan performance data based on the outcome performance measures established by AHCA under the bill. The report must also include an analysis of AHCA contract mechanisms for enforcing or incentivizing plan 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.

The bill requires AHCA to amend managed care plan contracts by January 1, 2024, to reflect these changes.

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

The bill provides an effective date of July 1, 2023.

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 over 5.5 million low-income individuals, including approximately 2.5 million children, or 54%, 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, Presentation to the House Healthcare Regulation Subcommittee, Jan. 18, 2023.

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]

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 the behavioral health safety net program administered by the Department of Children and Families (for people without other coverage)[12], and by Medicaid.

High Utilizer Project

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.

[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. Involutary 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 give express and informed consent to a placement as a voluntary patient and admitted as a voluntary patient; 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

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 visited March 26, 2023).
[15] Id.

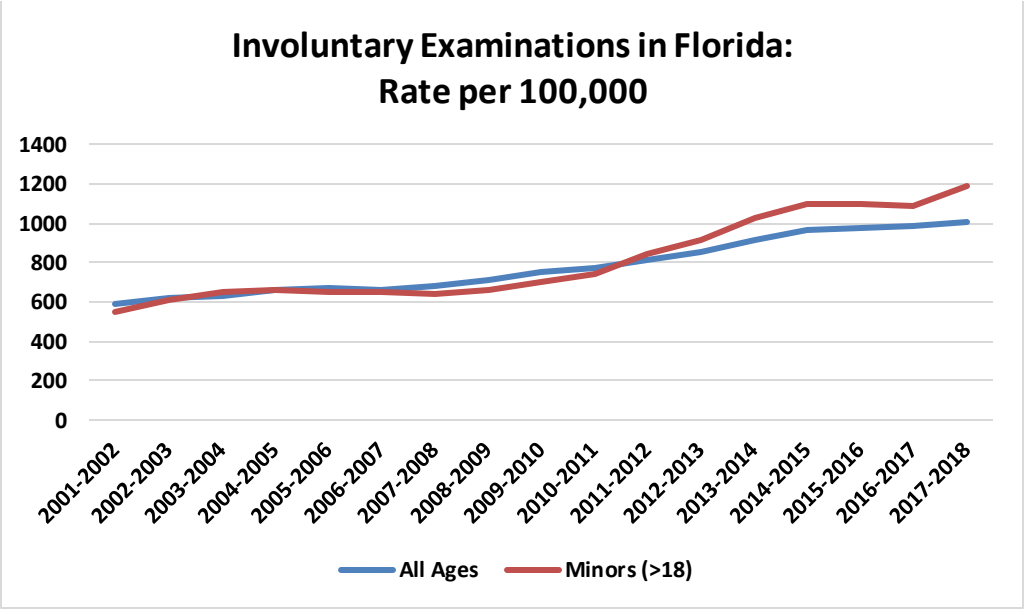
As a follow up to the 2017 task force report, in 2019, the Legislature instructed DCF to prepare a report on the initiation of involuntary examinations of minors age 17 years and younger and submit it by November 1 of each odd numbered year.[16]

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.



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

[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 March 26, 2023).
[18] Florida Department of Children and Families, *Report on Involuntary Examination of Minors, November 2021,* https://www.usf.edu/cbcs/baker-act/documents/dcf_oddyearreport_2021.pdf (last viewed March 26, 2023).

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]

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 take action 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]

This reporting further documented the Medicaid share of the problem, as noted in the table below:[21]

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%

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, 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), so higher rates would be expected in those plans.[22]

[19] Id. at 11.
[20] Ch. 2020-107, L.O.F.
[21] Department of Children and Families and Agency for Health Care Administration, Presentation to the House Subcommittee on Children, Families and Seniors, Feb. 8, 2023.
[22] Id.

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 assigning 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 [23] 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.[24]

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. 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[25]:

- 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

[23] Id.
[24] S. 490.967(2)(c)1., F.S.
[25] Agency for Health Care Administration, Agency Prescribed Secret Shopper Template, on file with staff of the House Subcommittee on Healthcare Regulation.

- Whether the provider is accepting new patients.

The agency tests the network of behavioral health care practitioners; it does not test the network of inpatient psychiatric providers. It is unclear whether AHCA assesses need for inpatient services or establishes network adequacy requirements for inpatient pediatric psychiatric beds or facilities.

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.[26] 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.[27]

The agency 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. The agency does not compile or publish reports on in its current testing results, or on trends.

Effect of the Bill

HB 1457 increases Medicaid requirements for managed care plan provider network adequacy, related to behavioral health providers.

Medicaid Provider Networks

Specifically, the bill requires AHCA to establish network requirements for each type of behavioral health provider serving Medicaid enrollees, and specifically include both community-based and residential providers. AHCA must amend current contracts by January 1, 2024, to reflect these changes.

In addition, the bill requires AHCA to improve testing of behavioral health provider networks by including provider-specific data on access timelines.

The bill requires AHCA to contract to perform all network testing functions, rather than conduct it in-house or rely on the managed care plans to test their provider directories, and provides that testing should be conducted on the actual network, not merely the provider database or directory.

Medicaid Behavioral Health Performance Measures

The bill requires AHCA to establish specific, outcome-based, performance measures for Medicaid managed care plans to reduce high-utilization of crisis stabilization services by children and teenagers. The bill requires the measures, at a minimum, to require plan-specific measures for year-over-year improvement.

AHCA must amend current managed care plan contracts by January 1, 2024, to reflect these changes.

Medicaid Performance Data

Finally, the bill requires AHCA to report to the legislature annually on Medicaid-enrolled children who are high-utilizers of crisis stabilization services. The report must include demographic and geographic data, and include plan performance data related to the outcome performance measures established by

[26] Agency for Health Care Administration, Agency Prescribed Secret Shopper July 2021, on file with staff of the House Subcommittee on Healthcare Regulation.

[27] 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

AHCA under the bill. In addition, the report must provide plan network testing data, including, at a minimum, an assessment of access timelines and data trends.

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.

The first annual report is due October 1, 2023.

The bill provides an effective date of July 1, 2023.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.967, F.S, related to managed care plan accountability.
Section 2: In an unnumbered section of law, requires certain contract amendments.
Section 3: In an unnumbered section of law, requires a certain report.
Section 4: Provides that the bill takes effect July 1, 2023.

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 the Medicaid capitated payment 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:

Not Applicable. 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