A bill to be entitled

An act relating to Medicaid behavioral health provider performance; amending s. 409.966, F.S.; revising the Agency for Health Care Administration's quality selection criteria for Medicaid program provider service networks to include behavioral health providers; amending s. 409.967, F.S.; requiring the agency to establish provider network standards for behavioral health providers in the Medicaid program; revising network testing requirements; providing reporting requirements; requiring the agency to identify specified managed care plans' scores, to establish such scores as baseline indicators for the plans, and to notify the plans of their baselines for such scores; requiring the agency to establish outcome performance goals related to behavioral health care; providing that plans that do not meet specified outcome performance goals may be subject to certain sanctions; requiring the agency to submit an annual report to the Legislature; providing requirements for such reports; revising requirements for quality measures for managed care plans; requiring managed care plan contract amendments before a specified date; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (3) of section 409.966, Florida Statutes, is amended to read:

409.966 Eligible plans; selection.—

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care, behavioral health care, and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that an eligible plan has obtained signed contracts or written agreements or has made substantial progress in establishing relationships with providers before the plan submits a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

Section 2. Paragraphs (c) and (f) of subsection (2) and paragraph (g) of subsection (3) of section 409.967, Florida Statutes, are amended, and paragraph (p) is added to subsection (2) of that section, to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying

the number of enrollees assigned to each primary care provider.

2. By October 1, 2024, the agency shall specifically and expressly establish network standards for each type of behavioral health provider, including, but not limited to, community-based residential providers. The standards must ensure timely access to care and exceed any federal behavioral health network requirements. At a minimum, the agency shall, for each provider type, establish standards for:

a. Patient-to-provider ratios.

b. Maximum waiting times for appointments and admissions.

c. Availability of innovative health care service delivery methods, such as telehealth, mobile response services, and certified community behavioral health clinics.

3. The agency shall ~~conduct, or~~ contract with an independent vendor for~~,~~ systematic and continuous testing of the plan provider networks ~~network databases maintained by each plan~~ to confirm accuracy, confirm that ~~behavioral health~~ providers are accepting enrollees, and confirm that enrollees have timely access to ~~behavioral health~~ services. The vendor shall, at a minimum, also test the performance of behavioral health providers under the standards established by the agency under subparagraph 2. The vendor shall produce, and the agency shall publish, online quarterly and annual reports on plan provider network performance related to behavioral health, by plan and region, beginning April 1, 2025, and July 1, 2026, respectively.

4.~~2.~~ Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

5.~~3.~~ Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

6.~~4.~~ Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of

information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(f) Continuous improvement.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

2. Each managed care plan must collect and report the Healthcare Effectiveness Data and Information Set (HEDIS) measures, the federal Core Set of Children's Health Care Quality Measures, and the federal Core Set of Adult Health Care Quality Measures, as specified by the agency. Each plan must collect and report the Adult Core Set behavioral health measures beginning with data reports for the 2025 calendar year. Each plan must

stratify reported measures by age, sex, race, ethnicity, primary language, and whether the enrollee received a Social Security Administration determination of disability for purposes of Supplemental Security Income beginning with data reports for the 2026 calendar year. A plan's performance on these measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the measures as a tool to monitor plan performance.

a. The agency shall identify each individual HEDIS score earned by each managed care plan during the first full contract year for each measure in the Core Set of Children's and Adult behavioral health measures, and establish those scores as baseline indicators for each plan. The agency shall notify annually each plan of the plan's baseline for each HEDIS score. The agency, in consultation with each plan, shall establish regional clinical outcome performance goals for each contract year for each plan. In establishing the performance goals, the agency must take into account the plan's HEDIS baseline, population, enrollment, patient mix, clinical risk, and other factors established by the agency.

b. The agency shall establish specific outcome performance goals to reduce the incidence of crisis stabilization services for children and adolescents who are high users of such services. Performance goals must, at a minimum, establish plan-

specific, year-over-year improvement targets to reduce repeated use and ensure better behavioral health outcomes for children and adolescents.

c. A managed care plan that does not meet the behavioral health outcome performance goals established by the agency under this paragraph may be subject to quality improvement projects, automatic assignment suspension, and administrative and contractual sanctions as determined by the agency.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under ss. 409.977 and 409.984.

(p) Annual report.—Beginning on October 1, 2024, and annually thereafter, the agency shall submit to the Legislature an annual report on Medicaid-enrolled children and adolescents who are the highest users of crisis stabilization services. The report must include demographic and geographic information; plan-specific performance data based on the performance measures in paragraph (f); plan-specific provider network testing data generated pursuant to paragraph (c), including, but not limited to, an assessment of access timeliness; and trends on reported data points beginning from the 2021-2022 fiscal year. The report

must include an analysis of relevant managed care plan contract terms and the contract enforcement mechanisms available to the agency to ensure compliance. The report must include data on enforcement or incentive actions taken by the agency to ensure compliance with network standards and progress in performance improvement, including, but not limited to, the use of the achieved savings rebate program as provided under subsection (3). The report must include a listing of other actions taken by the agency to better serve such children and adolescents.

(3) ACHIEVED SAVINGS REBATE.—

(g) A plan that exceeds agency-defined quality measures in the reporting period may retain an additional 1 percent of revenue. For the purpose of this paragraph, the quality measures must include:

1. Plan performance in ~~for~~ preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

2. Plan performance in behavioral health, including reduction in the incidence of crisis stabilization services for children and adolescents, improvement in follow-up visit rates after behavioral health-related hospitalization for children and adolescents, and reduction in behavioral health-related emergency room visits for children or adults.

Section 3. The Agency for Health Care Administration shall amend existing contracts with managed care plans to execute the

requirements of this act. Such contract amendments must be effective before January 1, 2025.

Section 4. This act shall take effect July 1, 2024.