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:	SB 994
INTRODUCER:	Senator Negron and others
SUBJECT:	Sunset Review of Medicaid Dental Services
DATE:	February 17, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.	Brown	Pigott	AHS	**Recommend: Favorable**
3.	Brown	Kynoch	AP	**Pre-meeting**

I. Summary:

SB 994 removes dental services as a required benefit from the Medicaid Managed Assistance (MMA) component of the Statewide Medicaid Managed Care (SMMC) program, effective March 1, 2019. The bill requires the Agency for Health Care Administration (AHCA) to provide the Governor, President of the Senate, and Speaker of the House of Representatives by December 1, 2016, a comprehensive report that examines how effective managed care plans within MMA have been in improving access, satisfaction, delivery, and value in dental services. The report must also examine historical trends in costs, utilization, and rates by plan and in the aggregate.

The Legislature may use the report to determine the scope of dental benefits in the Medicaid program in future managed care procurements and whether to provide dental benefits separate from medical benefits. If the Legislature takes no action before July 1, 2017, the AHCA is directed to implement a statewide competitive procurement for a separate dental program for children and adults with a choice of at least two vendors. Such dental care contracts must be for five years, be non-renewable, and include a medical loss ratio provision consistent with the requirement for health plans in the SMMC program.

The AHCA estimates the bill has a negative fiscal impact in general revenue of $225,000 in Fiscal Year 2016-2017, $261,428 in Fiscal Year 2017-2018, and $235,720 in Fiscal Year 2018-2019.

The bill is effective July 1, 2016.

II. Present Situation:

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan that must be approved by the federal

Centers for Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the AHCA and financed with federal and state funds. Over 3.7 million Floridians are currently enrolled in Medicaid, and the program's estimated expenditures for the 2015-2016 fiscal year are over $23.4 billion.[1]

Statewide Medicaid Managed Care

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S.[2] The SMMC has two components: Long Term Care Managed Care (LTCMC) and Managed Medical Assistance (MMA). SMMC is an integrated, comprehensive, managed care program that provides for the delivery of primary and acute care in 11 regions through recipient enrollment in managed care plans.

To implement the two components and receive federal Medicaid funding, the AHCA received federal authorization through Medicaid waivers from CMS. The LTCMC waiver authority was approved on February 1, 2013, and is effective through June 30, 2016.[3]

The MMA component operates as a statewide expansion of the Medicaid Reform demonstration waiver that was originally approved in 2005 as a managed care pilot program in five counties. Waiver authority for MMA is effective through June 30, 2017.[4]

Managed care plan contracts for LTCMC and MMA include a provision requiring the managed care plans to report quarterly and annually on their respective medical loss ratios for the time period.[5] The medical loss ratio is based on data collected from all plans on a statewide basis and then classified consistent with 45 C.F.R., part 158. Under the applicable federal regulations, plans must achieve a medical loss ratio of 85 percent or provide a rebate to the state. Achieving an 85 percent medical loss ratio means that a managed care plan must spend at least 85 percent of the premiums received on health care services and activities to improve health care quality.[6]

Managed Medical Assistance (MMA)

For the MMA component of SMMC, health care services were bid competitively using the 11 specified regions. Thirteen non-specialty managed care plans contract with AHCA across the different regions. Specialty plans are also available to serve distinct populations or conditions, such as children with special health care needs, children in the child welfare system, HIV/AIDS,

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[1] Office of Economic and Demographic Research, *Social Services Estimating Conference of August 4, 2015,* http://edr.state.fl.us/Content/conferences/medicaid/medltexp.pdf (last visited Dec. 11, 2015).
[2] *See* Chapter Laws, 2011-134 and 2011-135.
[3] Department of Health and Human Services, Disabled & Elderly Health Programs Group, *Approval Letter to Agency for Health Care Administration* (February 1, 2013), http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Signed_approval_FL0962_new_1915c_02-01-2013.pdf (last visited Dec. 17, 2015).
[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Medicaid 1115 Demonstration Fact Sheet* (July 31, 2014), *http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-fs.pdf* (last visited Dec. 21, 2015).
[5] *See* s. 409.967(4), F.S.
[6] 45 C.F.R. §158.251 (2012).

serious mental illness, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease.

Statewide implementation of MMA started May 1, 2014, and was completed by August 1, 2014. MMA contracts were executed for a five-year period, and the current contracts are valid through August 31, 2019.

States determine the level of benefits offered in their own Medicaid program, provided that certain mandatory federal benefits are covered. Florida details its minimum benefits under s. 409.973, F.S., for those enrollees in MMA plans. A comparison of those mandatory minimum benefits are shown in the table below.

Comparison of Mandatory Medicaid Benefits	
Federal Mandatory Benefits[7]	**Florida Managed Medical Assistance (s. 409.973, F.S.)**
Inpatient hospital services	Inpatient hospital services
Outpatient hospital services	Outpatient hospital services
Early and periodic screening, diagnostic and treatment services (EPSDT)	Early and periodic screening, diagnostic and treatment services (EPSDT)
Nursing facility services	Nursing care
Home health services	Home health agency services
Physician services	Physician services, including physician assistant services
Rural health clinic services	Rural health clinic services
Federally qualified health center services	Federally qualified health center services, to the extent required under s. 409.975, F.S.
Laboratory and X-ray services	Laboratory and X-ray services
Family planning services	Family planning services
Nurse midwife services	Healthy start services
Certified pediatric and family nurse practitioner services	Advanced registered nurse practitioner services
Freestanding birth center services (when licensed or otherwise recognized)	Birthing center services
Transportation to medical care	Transportation to access covered services
Tobacco cessation counseling for pregnant women	Substance abuse treatment services
	Chiropractic services
	Ambulatory surgical treatment centers
	Dental services
	Emergency services
	Hospice services
	Medical supplies, equipment, prostheses, orthoses

[7] Medicaid.gov, *Benefits*, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html (last visited Dec. 17, 2015).

Comparison of Mandatory Medicaid Benefits	
Federal Mandatory Benefits[7]	**Florida Managed Medical Assistance (s. 409.973, F.S.)**
	Mental health services
	Optical services and supplies
	Optometrist services
	Physical, occupational, respiratory, and speech therapy services
	Podiatric services
	Prescription drugs
	Renal dialysis services
	Respiratory equipment and supplies

A contracted MMA health plan, including specialty plans, must provide all state minimum benefits for an enrollee when medically necessary. Many MMA plans chose to supplement the state required minimum benefits by offering enhanced options, such as expanded adult dental, hearing and vision coverage, outpatient hospital coverage, and physician services.

Most Medicaid recipients must be enrolled in the MMA program. Those individuals who are not required to enroll, but may choose to do so, are:
- Recipients who have other creditable coverage, excluding Medicare;
- Recipients who reside in residential commitment facilities through the Department of Juvenile Justice or mental health treatment facilities under s. 394.455(32), F.S.;
- Persons eligible for refugee assistance;
- Residents of a developmental disability center;
- Enrollees in the developmental disabilities home and community based waiver or those waiting for waiver services; and
- Children in a prescribed pediatric extended care center.[8]

Other Medicaid enrollees are exempt from the MMA program and receive Medicaid services on a fee-for-service basis. Exempt enrollees are:
- Women who are eligible for family planning services only;
- Women who are eligible only for breast and cervical cancer services; and
- Persons eligible for emergency Medicaid for aliens.

Non-MMA enrollees receiving services through fee-for-service have the same mandatory minimum benefits. These benefits are described under s. 409.905, F.S.

History of Prepaid Dental Plans

Comprehensive dental benefits are required for children at both the federal and state level, and coverage includes diagnostic, preventive, or corrective procedures, including orthodontia.[9,10] MMA plans are required to provide adult dental coverage to the extent of covering medically

[8] Section 409.972, F.S.
[9] 42 U.S.C. 1396d(a)(i)
[10] *See* Section 409.906(6), F.S.

necessary emergency procedures to eliminate pain or infection. Adult dental care may be restricted to emergency oral examinations, necessary radiographs, extractions, and incisions and drainage of abscesses. Full or partial dentures may also be provided under certain circumstances.[11]

Prior to SMMC, dental coverage was delivered either through pre-paid dental health plans (PDHP) or individual providers using fee-for-service arrangements. PDHPs were first initiated in the Medicaid program in the 2001-2002 state fiscal year when proviso language in the 2001-2002 General Appropriations Act (GAA) authorized the AHCA to initiate a PDHP pilot program in Miami-Dade County.[12] The following chart provides a brief overview of the history of Medicaid prepaid dental health. Further elaboration is provided in subsequent paragraphs.

Brief Overview of Medicaid Prepaid Dental Plan History	
Year	**Dental Delivery Systems**
2001-2002 SFY	Legislature authorized AHCA to initiate PDHP pilot in Miami-Dade County.
2003-2004 SFY	Legislature authorized AHCA to contract on competitive basis using PDHPs; AHCA executed the first PDHP contract in 2004 in Miami-Dade for children.
2010-2011 SFY	Legislature authorized time-limited statewide PDHP competitive procurement, excluding the existing service programs in Miami-Dade and Medicaid Reform counties.
2012-2013 SFY	Legislature provided that Medicaid dental services should not be limited to PDHPs and also authorized fee-for-service dental services as well; Statewide PDHP program implemented in December 2012 for children.
July 1, 2013	Fee-for-service dental care option ended.
May 1, 2014	MMA roll-out began; PDHP contracts were terminated by region as MMA was implemented.
August 1, 2014	Completion of MMA roll-out; end of PDHP contracts.

The 2003 Legislature again authorized the AHCA to contract on a prepaid or fixed sum basis for dental services for Medicaid-eligible recipients specifically using PDHPs.[13] Through a competitive bid process, the AHCA executed its first PDHP contract in 2004 to serve children under age 21 in Miami-Dade County.[14]

The Legislature added proviso in the 2010-2011 GAA authorizing the AHCA to contract by competitive procurement with one or more prepaid dental plans on a regional or statewide basis for a period not to exceed two years, in all counties except those participating in Miami-Dade County and Medicaid Reform, under a fee-for-service or managed care delivery system.[15]

[11] *See* Section 409.906(1), F.S.
[12] *See* Specific Proviso 135A, General Appropriations Act 2001-2002 (Conference Report on CS/SB 2C).
[13] Chapter 2003-405, Laws of Fla.
[14] Agency for Health Care Administration, *House Bill 27 Analysis*, p. 2, (Nov. 11, 2013) (on file with the Senate Committee on Health Policy).
[15] *See* Specific Proviso 204, General Appropriations Act 2010-2011 (Conference Report on HB 5001).

The Legislature included proviso in the 2012-2013 GAA requiring that for all counties other than Miami-Dade, the AHCA could not limit Medicaid dental services to prepaid plans and must allow qualified dental providers to provide services on a fee-for-service basis.[16] Similar language was also passed in the 2012-2013 appropriations implementing bill, which included additional directives to the AHCA to terminate existing contracts, as needed. The 2012-2013 implementing bill provisions became obsolete on July 1, 2013.

Two vendors were selected for a statewide program starting in 2012-2013 and contracts were implemented effective December 1, 2012.[17] Under the program, Medicaid recipients selected one of the two PDHPs in their county for dental services. The existing dental plan contracts covered Medicaid recipients under age 21. Dental care through Medicaid fee-for-service providers ended July 1, 2013.

The Invitation to Negotiate (ITN) for PDHP limited renewal for the contracts to no more than a three-year period; however, with the final implementation of SMMC and the integration of dental coverage within MMA managed care plans, these PDHP contracts were non-renewed as each region under MMA was implemented.[18] MMA began its regional roll-out on May 1, 2014, and completed the final regions on August 1, 2014.

While the MMA plans are required to collect data, including data related to access to care and quality, no formalized data is available yet which compares the different dental care delivery systems. However, the AHCA's health care information website, www.floridahealthfinder.gov, includes member satisfaction in Medicaid and quality of care indicators for health plans. The most recent member satisfaction surveys are from 2015.[19]

III. Effect of Proposed Changes:

Section 1 amends s. 409.973, F.S., to remove dental services from the list of minimum benefits that managed care plans must cover under MMA, effective March 1, 2019.

Section 2 amends s. 409.973, F.S., to require the AHCA to provide the Governor, the President of the Senate, and Speaker of the House of Representatives, a report on the provision of dental services in MMA by December 1, 2016. The AHCA may contract with an independent third party to assist with the report. The bill requires several components that must be included in the report:

- The effectiveness of the managed care plans in:
  - Increasing access to dental care;
  - Improving dental health;
  - Achieving satisfactory outcomes for recipients and providers; and

[16] *See* Specific Proviso 186, General Appropriations Act 2012-2013 (Conference Report on HB 5001).
[17] Six counties were excluded from the statewide roll-out. Miami-Dade was excluded because of the prepaid dental program that has been in existence since 2004. Baker, Broward, Clay, Duval and Nassau counties were excluded because they were part of the Medicaid Reform Pilot Project, which requires most Medicaid recipients to enroll in managed care plans that provide dental care as a covered service.
[18] Agency for Health Care Administration, *supra* note 8 at 5.
[19] *See* Agency for Health Care Administration, *FloridaHealthFinder.gov*, http://www.floridahealthfinder.gov/HealthPlans/Default.aspx (last visited Jan. 4, 2016).

- Delivering value and transparency to the state's taxpayers;
- The historical trends of rates paid to dental providers and dental plan subcontractors;
- Participation rates in plan networks; and
- Provider willingness to treat Medicaid recipients.

The bill also requires the report to review rate and participation trends by plan and in the aggregate. A comparison of current and historical efforts and trends and the experiences of other states in delivering dental services, increasing patient access, and improving dental care, must also be included.

The bill provides that findings of the report may be used:
- By the Legislature to set future minimum benefits for MMA; and
- For future procurement of dental services, including whether to include dental services as a minimum benefit via comprehensive MMA plans or to provide dental services as a separate benefit.

Under the bill, if the Legislature takes no action before July 1, 2017, with regard to the report's findings:
- The AHCA must implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who have substantial experience in providing care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act and who meet all AHCA standards and requirements;
- Prepaid dental contracts must be awarded through a competitive procurement for a five-year period and may not be renewed; however, the AHCA may extend the term of a plan contract to cover any transition delays to a new plan provider;
- All prepaid dental contracts must include a medical loss ratio provision consistent with s. 409.967(4), F.S., which is applicable to comprehensive health plans in SMMC; and
- The AHCA is granted authority to seek any necessary state plan amendments or federal waivers in order to begin enrollment in prepaid dental plans no later than March 1, 2019.

Section 3 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Today, most of the Medicaid managed care plans subcontract with private sector dental managed care plans or prepaid dental health plans to deliver dental services to Medicaid enrollees. All MMA plans currently include some form of enhanced adult dental services.[20] A smaller portion of Medicaid dental services are also still delivered directly via fee-for-service.

Between the managed care plans and other private providers, the private vendors serve almost 4 million enrollees through the Medicaid program.[21] If the Legislature determines that dental services should remain a minimum benefit in the MMA program but be procured separately, the dental plans that have contracts now may or may not retain those contracts through the competitive procurement process. The bill does not provide the incumbent providers any preference in the procurement process.

A new procurement process may also mean additional economic opportunities for other companies to provide services. Additionally, the MMA and LTCMC contracts are scheduled for rebid with implementation by 2019; therefore, if a decision is made to keep dental benefits as a minimum benefit, the managed care plans would seek dental care partners as part of that procurement process.

C. Government Sector Impact:

According to the AHCA, SB 994 requires budget authority of $450,000 in state fiscal year (SFY) 2016-2017; $522,856 in SFY 2017-18, and $471,440 in SFY 18-19. General revenue would be required for 50 percent while the remainder would be paid by federal funds.[22] The costs are detailed below:

- The AHCA must complete the report by December 1, 2016, and has authority under the bill to seek a third party's assistance with the report. The AHCA indicates that if the resources and expertise to perform the study do not exist internally, the agency will need approximately $250,000 to contract with a third-party consultant to conduct such an evaluation.[23]

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[20] Agency for Health Care Administration, *A Snapshot of the Florida Medicaid Managed Assistance Program* (December 2015), http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SMMC_MMA_Snapshot.pdf (last visited Dec. 22, 2015).
[21] Agency for Health Care Administration, *Eligibles Report As of 10/31/2015*, http://ahca.myflorida.com/medicaid/Finance/data_analytics/eligibles_report/docs/age_assistance_category_2015-10-31.pdf (last visited Dec. 22, 2015).
[22] Agency for Health Care Administration, *Senate Bill 994 Analysis*, p. 10 (Jan. 6, 2016) (on file with the Senate Committee on Health Policy).
[23] Id at. 2.

- Included in the AHCA's fiscal note is a request for five full-time-equivalent (FTE) positions to implement the bill, hired over two fiscal years, plus funding for the agency's current actuarial firm. The AHCA also contemplates the need for additional resources for outside legal counsel for challenges to the competitive dental procurement awards.[24]

Fiscal Impact Estimated by the AHCA			
	FY 2016-2017	**FY 2017-2018**	**FY 2018-2019**
General Revenue			
Consultant for report	$125,000		
Actuarial services	$100,000	$100,000	$100,000
Legal services		$50,000	
New agency FTE		$111,428 ($6,791 NR*)	$135,720 ($4,527 NR*)
Total General Revenue	**$225,000**	**$261,428**	**$235,720**
Federal matching funds	$225,000	$261,428	$235,720
Total Fiscal Impact	**$450,000**	**$522,856**	**$471,440**

* Non-recurring funds

VI. Technical Deficiencies:

None.

VII. Related Issues:

Operationally, the AHCA notes it would need to seek waiver authority from the Centers for Medicare & Medicaid Services before the pre-paid dental program could be implemented and that waiver approval can take six to nine months to obtain.[25]

VIII. Statutes Affected:

This bill substantially amends section 409.973 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None

[24] Id at 3.
[25] Id.