**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 Health Policy

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| BILL: | SB 994 |
| INTRODUCER: | Senator Negron and others |
| SUBJECT: | Sunset Review of Medicaid Dental Services |
| DATE: | January 8, 2016 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Lloyd | Stovall | HP | **Pre-meeting** |
| 2. | | | AHS | |
| 3. | | | AP | |

## I. Summary:

SB 994 removes dental services as a required benefit from the Medicaid Managed Assistance (MMA) program 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 the Medicaid managed care plans 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 statewide.

The Legislature may use this report to determine the scope of dental benefits in the Medicaid program in future procurements and whether to provide the benefit 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. The contract must be for 5 years, be non-renewable, and include a medical loss provision consistent with the requirement for health plans in the SMMC program.

The bill is effective July 1, 2016.

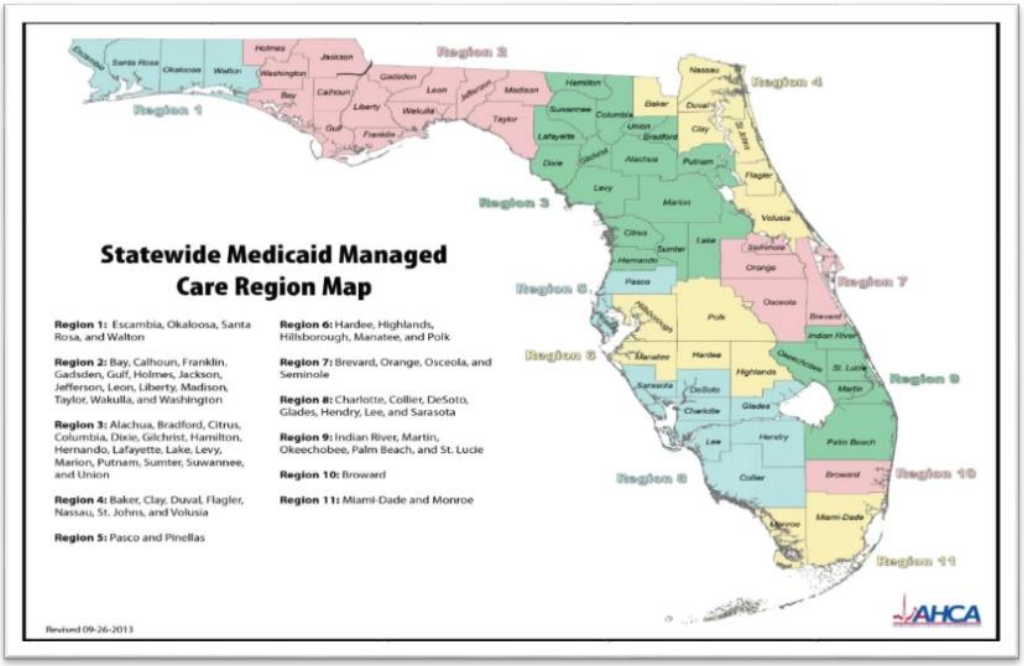
## II. Present Situation:

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 and 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: the Long Term Care Managed Care (LTC) program and the Managed Medical Assistance (MMA) program. The SMMC is an integrated, comprehensive, managed care program for Medicaid enrollees that manages the delivery of primary and acute care in 11 regions.




To implement the two components and receive federal Medicaid funding, the AHCA received federal authorization through two different Medicaid waivers from the CMS. The first component authorized was the LTC's 1915(b) and (c) waivers on February 1, 2013. The waivers for the LTC program are effective July 1, 2013, through June 30, 2016, and operate concurrently.[3]

The MMA program is authorized by a section 1115 demonstration waiver by federal CMS. It was approved in 2005 as a managed care pilot program and operates statewide as an expansion

[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).

of the managed care pilot program. The MMS program was renewed on July 31, 2014, for a second 3-year period through June 30, 2017.[4]

The SMMC contracts for LTC and MMA include a provision requiring the managed care plans to report quarterly and annually on their respective plans' 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 federal regulation, large group 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 spent at least 85 percent of the premiums received on health care services and activities to improve health care quality.[6]

***Managed Medical Assistance Program (MMA)***

For the MMA component, 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, such as the Children's Medical Services Network for children with special health care needs, or those in the child welfare system. Medicaid recipients with HIV/AIDS, serious mental illness, dual enrollment with Medicare, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease may also select from specialized plans.

Statewide implementation of the MMA plans started May 1, 2014, and was completed by August 1, 2014. MMA contracts were executed for a 5-year period; 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 the MMA plans. A comparison of those mandatory minimum benefits are shown in the table below.

| **Comparison of Mandatory Medicaid Benefits** | |
|---|---|
| **Federal Mandatory Benefits[7]** | **State Minimum Benefits 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 |

[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).
[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]** | **State Minimum Benefits s. 409.973, F.S.** |
| Physician services | Physician services, including physician assistant services |
| Rural health clinic services | Rural health clinic services |
| Federally qualified health center services | Covered 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 |
| | 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 must provide all state minimum benefits for an enrollee when medically necessary. Many MMA plans supplemented the state required minimum benefits and offered 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 a separate statute, 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 only required to provide adult dental coverage which provides medically 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 authorizes AHCA to initiate PDHP pilot in Miami-Dade County. |
| 2003-2004 SFY | Legislature authorizes AHCA to contract on competitive basis using PDHPs; AHCA executes first PDHP contract in 2004 in Miami Dade for children. |
| 2010-2011 SFY | Legislature authorizes time limited statewide PDHP competitive procurement, excluding Miami-Dade and Medicaid Reform counties. |

[8] Section 409.972, F.S.
[9] 42 U.S.C. 1396d(a)(i)
[10] *See* Section 409.906(6), F.S.
[11] *See* Section 409.906(1), F.S.
[12] *See* Specific Proviso 135A, General Appropriations Act 2001-2002 (Conference Report on CS/SB 2C).

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| 2012-2013 SFY | Legislature provides that Medicaid dental services should not be limited to PDHPs and also authorizes fee-for-service; Statewide PDHP program implemented in December 2012 for children. |
| July 1, 2013 | Fee for service dental care option ends. |
| May 1, 2014 | MMA Roll-out begins; PDHP contracts terminate as regions are 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 2 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]

For the 2012 -2013 GAA, 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 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 only Medicaid recipients under age 21. Dental care through Medicaid fee for service providers ended July 1, 2013.

The Invitation to Negotiate (ITN) limited renewal for these contracts to no more than a 3-year period; however, with the final implementation of SMMC and the integration of dental coverage within the Medicaid managed care plans, these PDHP contracts were non-renewed as each region under SMMC was implemented.[18] SMMC began its regional roll-out on May 1, 2014, and completed the final regions on August 1, 2014.

[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).
[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.

While the SMMC 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 agency's health care information website, www.floridahealthfinder.gov, does 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 -** Effective March 1, 2019, the bill amends s. 409.973, F.S., to remove dental services from the list of minimum benefits that managed care plans must cover under the SMMC MMA program.

**Section 2 -** A new subsection (5) is added 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 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. It must examine:

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

Findings of the report may be used by the Legislature to set future minimum benefits for s. 409.973, F.S., and for future dental procurements of eligible plans, including whether to include dental services as a minimum benefit under the managed care plans or to provide as a separate benefit.

If the Legislature takes no action before July 1, 2017, with regard to the report's findings, the bill directs the AHCA to 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 (CHIP) and who meet all agency standards and requirements.

[19] *See* Agency for Health Care Administration, *FloridaHealthFinder.gov*, http://www.floridahealthfinder.gov/HealthPlans/Default.aspx (last visited Jan. 4, 2016).

The bill further requires that contracts be awarded through a competitive procurement process for a 5-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 contracts must also include a medical loss ratio provision consistent with s. 409.967(4), F.S., which is applicable to health plans in SMMC.

The AHCA is granted authority to seek any necessary state plan amendments or federal waivers in order to begin enrollment no later than March 1, 2019.

**Section 3 -** The effective date of the bill is 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 at a dental provider's office.

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 benefits should remain as a minimum benefit in the MMA program and be procured separately, the dental plans that have contracts now may or may not retain those

[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).

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 and at least two statewide vendors must be selected. Additionally, the MMA and LTC 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:

SB 994 will have both an operational and a fiscal impact on the AHCA. According to the AHCA, the bill requires budget authority of $450,000 in state fiscal year (SFY) 2016-2017; $522,856 in SFY 2017-18, and 522,856 in SFY 18-19.[22]

The AHCA must complete the report by December 1, 2016, using existing resources, but also has authority to seek a third party's assistance with the report. The AHCA indicates it generally costs about $250,000 to contract with an entity to conduct such an evaluation.[23] The bill does not provide the AHCA with any additional funds for third party support.

Included in the AHCA's fiscal note is a request for an additional 5 FTEs to implement the bill and funds for the agency's current actuarial firm. The AHCA also contemplates the need for additional resources for outside counsel for challenges to the competitive dental procurement bid awards.[24]

Operationally, the AHCA notes it would need to seek a new 1115 waiver or 1915(b) waiver from the Centers for Medicare and Medicaid Services before the pre-paid dental program could be implemented.[25] Approval for such waivers can take 6 to 9 months to obtain.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 409.973 of the Florida Statutes.

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

## 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.