

**HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS**

BILL #: HB 819

FINAL HOUSE FLOOR ACTION:

SPONSOR(S): Diaz, J. and others

100 Y's

15 N's

**COMPANION
BILLS:** SB 994

GOVERNOR'S ACTION: Approved

SUMMARY ANALYSIS

HB 819 passed the House on February 24, 2016, and subsequently passed the Senate on March 7, 2016.

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program. The SMMC program requires the Agency for Health Care Administration (AHCA) to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care, including dental services, through the Managed Medical Assistance (MMA) program. As of February 2016, over 3.91 million Medicaid recipients receive services, including dental health benefits, through MMA plans.

A Medicaid prepaid dental health plan (PDHP) is a risk-bearing entity paid a prospective per-member, per-month payment by AHCA to provide dental services. Prior to implementing the MMA program, Florida used PDHPs to deliver dental services to Medicaid recipients.

HB 819 removes dental services from the list of minimum benefits that MMA plans must provide, effective March 1, 2019. Effective July 1, 2017, AHCA must implement a statewide PDHP program for children and adults and begin enrollment by March 1, 2019. AHCA must contract with at least two licensed dental managed care providers, licensed as either prepaid limited health services organizations or health maintenance organizations, through a competitive procurement process to provide dental benefits. AHCA is authorized to seek any necessary state plan amendment or federal waiver to implement the statewide PDHP program.

The bill creates s. 409.973(5), F.S., which requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to prepare a report on Medicaid dental services. The report must examine the effectiveness of the managed care plans in providing dental care, improving access to dental care and dental health, and achieving satisfactory outcomes for recipients and providers. The report must also track the historical trends of rate payments to providers and plan subcontractors, provider participation in dental networks, and provider willingness to treat recipients. Finally, the report must compare Florida's experience in providing dental services to Medicaid recipients with the experiences of other states in delivering the same services, increasing access to care, and overall dental health. OPPAGA may contract with an independent third party, if necessary, to assist in the preparation of the report.

The bill authorizes the Legislature to use the findings of the report to establish the scope of minimum benefits under the MMA program for future procurements of eligible plans; specifically, the Legislature may use the findings of the report to determine whether dental benefits should be benefits under the MMA program or be provided separately. If the Legislature determines dental services should be provided by the MMA plans, it must repeal the changes made in this bill before July 1, 2017.

The bill may have a significant negative fiscal impact on the Medicaid program, and a significant negative fiscal impact to AHCA.

The bill was approved by the Governor on March 24, 2016, ch. 2016-109, L.O.F., and will become effective on July 1, 2016.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

STORAGE NAME: h0819z1.HIS

DATE: March 25, 2016

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

Medicaid

Medicaid is a joint federal- and state-funded program that provides health care for low-income Floridians, administered by the Agency for Health Care Administration (AHCA) under ch. 409, F.S. Federal law establishes the mandatory services to be covered in order to receive federal matching funds. Benefit requirements can vary by eligibility category. Florida's mandatory and optional benefits are prescribed in state law under ss. 409.905, and 409.906, F.S., respectively.

Statewide Medicaid Managed Care

In 2010, the Florida House of Representatives contracted with a consultant to analyze Florida's Medicaid program and identify problems and possible solutions; the consultant concluded that Florida Medicaid's fragmented, complex system made it difficult to improve value for patients and taxpayers.¹ As a result, in 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S.

The SMMC program is an integrated managed care program for Medicaid enrollees to provide all mandatory and optional Medicaid benefits. A unified, coordinated system of care is a primary characteristic of the SMMC program, in part because it solves the problem of complexity with which Florida's Medicaid program was plagued by for decades. In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.² Such coordinated care is particularly important in the area of oral health, which is connected to overall health outcomes.³ Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services to enrollees, including dental services.⁴

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.⁵ AHCA selected 19 managed care plans (MMA plans) and executed 5-year contracts in February 2014. The MMA program was fully implemented statewide by of August 1, 2014.⁶ As of February 2016, approximately 3.91 million Medicaid recipients are enrolled in the MMA program.⁷

¹ Medicaid Managed Care Study, Pacific Health Policy Group, p. 73, March 2010.

² This comprehensive coordinated system of care was first successfully implemented in the 5-county Medicaid reform pilot program from 2006-2014.

³ U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, available at: <http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf> (last visited March 14, 2016).

⁴ The other component of the SMMC program is the Long-Term Care Managed Care Program.

⁵ AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Addendum 2, Solicitations Number: AHCA ITN 017-12/13*; dated February 26, 2013, <http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm>; AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Solicitation Number: AHCA ITN 017-12/13*; dated December 28, 2012, <http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm> (last visited March 14, 2016).

⁶ Agency for Health Care Administration, *Agency Analysis of 2016 House Bill 819*, p. 3, January 6, 2105 (on file with Health and Human Services Committee staff).

⁷ Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Report: February 2016*, available at: http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_February_2016.xls (last visited March 14, 2016).

AHCA expects to competitively procure the next round of contracts in May 2017, and make awards to plans in May 2018.⁸ AHCA further expects those MMA plans to begin providing services in September 2019.⁹

Waivers for Medicaid Managed Care

The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). Section 1915(b) of the Social Security Act provides authority for the Secretary of the U.S. Department of Health and Human Services to waive requirements to the extent he or she “finds it to be cost-effective and efficient and not inconsistent with the purposes of this title.” Also, section 1115 of the Social Security Act allows states to use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Florida operated its previous Medicaid dental program under a 1915(b) waiver, which expired on January 31, 2014. AHCA did not seek renewal of the waiver; instead, the federal government agreed to give a series of temporary extensions while AHCA implemented the Statewide Medicaid Managed Care (SMMC) program. The temporary extensions of the 1915(b) waiver allowed dental services to be gradually folded into the SMMC program. To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority, which provides authority to include dental services in the SMMC program.

Dental Care in the MMA Program

Under federal law, dental services are an optional Medicaid benefit.¹⁰ Florida provides full dental services for children and limited dental services for adults.¹¹ Currently, Medicaid recipients must enroll in an MMA plan to receive covered services, including dental services. The MMA plans participating in the SMMC have developed their dental networks by both subcontracting with prepaid dental health plan (PDHPs)¹² and directly contracting with dentists.

All MMA plans provide full dental services, not currently covered under the Medicaid state plan, to adult enrollees. Through these dental benefits, adult Medicaid recipients have access to expanded dental services, including preventive services.¹³ Examples of these additional benefits include twice-yearly exams and cleanings, fluoride treatments, fillings, and yearly x-rays.¹⁴ Not only do these benefits exceed what is required by law, AHCA negotiated their inclusion within the MMA plans at no cost to the state.¹⁵ AHCA initially estimated the value of the additional benefits at \$100 million over five years;¹⁶ however, the value may end up being in excess of that. From May 1, 2014, to January 25, 2016, the MMA plans spent \$84,600,000 on expanded dental benefits to adults.¹⁷

⁸ Supra, note 6 at pg. 6.

⁹ Id.

¹⁰ 42 U.S.C. § 1396a(72).

¹¹ S. 409.906(1), (6), F.S. Adults must be provided dentures and medically necessary, emergency dental procedures to alleviate pain or infection.

¹² A Medicaid PDHP is a risk-bearing entity paid a prospective per-member, per-month payment by AHCA to provide dental services to enrollees.

¹³ Supra, note 6 at pgs. 3-4.

¹⁴ Information provided by AHCA and on file with the Health Human Services Committee.

¹⁵ Agency for Health Care Administration, *Agency Analysis of 2014 House Bill 27*, November 25, 2013 (on file with Health and Human Services Committee).

¹⁶ Id.

¹⁷ Email from Orlando Pryor, Deputy Director of Legislative Affairs, Agency for Health Care Administration Staff, Questions, February 1, 2016, (on file with Health and Human Services Committee). The amount was calculated based on the approved expanded adult dental procedures codes for encounters for dental claims and procedures for recipients over the age of 18.

Dental Service Accountability and Performance in the MMA Program

MMA program contracts impose various accountability provisions and performance measures on the MMA plans, specific to dental services.

First, there are specific requirements for network adequacy for all MMA plans, to ensure a sufficient number of primary and specialty dental care providers are available to meet the needs of plan enrollees.¹⁸ Each plan must have at least one full time primary dental provider in each service area and at least one full time primary dental provider for every 1500 enrollees.¹⁹ Since July 2014, 213,819 adult enrollees have received dental benefits under the MMA program.²⁰ Dentist participation in Medicaid has increased over 26 percent since the implementation of the MMA program. As of October 2015, there were 2,378 dentists participating in the MMA program.²¹

<i>Provider Type</i> ²²	<i>November 2013</i>	<i>October 2015</i>	<i>Total % Change</i>
FFS Fully Enrolled Dentists	1,414	1,575	11.39%
Registered Dentists	470	803	70.85%
Total Participating Dentists	1,884	2,378	26.22%

Second, MMA plans must maintain an annual medical loss ratio (MLR) of a minimum of 85 percent for the first full year of MMA program operation.²³ The MLR measures the amount of money spent on providing services to enrollees against the amount of money spent on administrative functions;²⁴ an MLR of 85 percent requires 85 percent of the capitation paid to the MMA plan to be expended on health care services, including dental services. The MLR must also take into account, as required in the terms and conditions of the 1115 waiver, any payments of the achieved savings rebate, which requires:

- 100 percent of income up to, and including, five percent of revenue to be retained by the plan;
- 50 percent of income above five percent and up to ten percent to be retained by the plan, with the other 50 percent returned to the state; and
- 100 percent of income above ten percent of revenue to be returned to the state.²⁵

Third, under the terms and conditions of the 1115 waiver, AHCA must work with MMA plans on an oral health quality improvement initiative. The MMA program contracts²⁶ have specific performance goals for pediatric dental services and penalties for not reaching these goals. Each MMA plan is required to provide a Child Health Check-Up (CHCUP) to every enrollee. The CHCUP includes dental screenings and referrals starting at age three, or earlier if indicated.²⁷ The MMA plans must achieve a CHCUP rate of at least 80 percent for children enrolled for eight continuous months.²⁸ A plan that fails to meet this

¹⁸ *MMA Model Agreement, Attachment II, Exhibit II A*, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, February, 2014, available at: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-A-Managed_Medical_Assistance_MMA_Program_2015-11-01.pdf (last visited March 14, 2016).

¹⁹ *Id.* at pg. 103.

²⁰ Email correspondence with Agency for Health Care Administration Staff on HB 819, December, 28, 2015 (on file with Health and Human Services Committee).

²¹ *Id.*

²² Participating Providers are providers that have submitted a paid claim within twelve months of the report's run date.

²³ *Supra*, note 18.

²⁴ U.S. Centers for Medicare and Medicaid Services, *Medical Loss Ratio (MLR)*, <https://www.healthcare.gov/glossary/medical-loss-ratio-mlr/> (last visited March 14, 2016).

²⁵ S. 409.967(3), F.S.; AHCA established a uniform method for the plans to use for annually reporting premium revenue, medical and administrative costs, and income or losses. Using the reporting method, the plans calculate whether they have achieved a savings for the reporting year and whether they must pay a rebate to the state.

²⁶ Agency for Health Care Administration, *SMMC Plans: Model Contract*, available at: http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml (last visited March 14, 2016).

²⁷ *Supra*, note 18 at pg. 22.

²⁸ *Id.* at pgs. 22, 109.

goal is subject to a corrective action plan²⁹ and liquidated damages of \$50,000 per occurrence and \$10,000 for each percentage point less than the target.³⁰

Fourth, the MMA plans are also required to achieve a preventive dental services rate of at least 28 percent for children enrolled for 90 continuous days.³¹ A plan that fails to meet this goal is subject to a corrective action plan and liquidated damages of \$50,000 per occurrence and \$10,000 for each percentage point less than the target.³² For both the CHCUP and preventive dental services, the MMA plan must provide transportation to and from the child's dental appointments, if needed.

Lastly, the MMA plans are required to have Healthcare Effectiveness Data and Information Set (HEDIS)³³ scores above 50 percent for pediatric dental services or face liquidated damages. This requires a significant improvement over the PDHPs and reform county pilot plans. The liquidated damages for failure to meet the HEDIS scores will be calculated based on the number of members enrolled in the MMA plan.³⁴

Dental Care Prior to the SMMC Program

Prior to the implementation of the SMMC program, dental services were provided to Medicaid recipients in a number of ways. Children and adults enrolled in Medicaid health plans in the five reform pilot counties received their dental care through comprehensive managed care health plans.³⁵ Children outside of the reform pilot counties were required to access their dental services through PDHPs under contract with AHCA to provide children's dental services.³⁶ Adults enrolled in the Medicaid program, outside of the reform pilot counties, received their dental services either through the fee-for-service system or through health plans that chose to include Medicaid adult dental services in the benefit package.³⁷ The adult dental services were limited to dentures and medically necessary, emergency dental procedures to alleviate pain or infection.³⁸

Prepaid Dental Health Plans (PDHPs)

In 2001, Florida began using a PDHP to deliver dental services to children as a pilot program in Miami-Dade County.³⁹ In 2003, the Legislature expanded the PDHP initiative beyond Miami-Dade County by authorizing AHCA to contract with PDHPs in other areas⁴⁰ and permitted AHCA to include the Medicaid reform pilot counties.⁴¹ In 2011, the Legislature made PDHP contracting mandatory, not discretionary, outside the reform pilot counties and Miami-Dade County.⁴² However, the Legislature limited the use of

²⁹ The Corrective Action Plan details the actions to be taken by the MMA Plan to reach the rate.

³⁰ Supra, note 18 at pgs. 22, 109.

³¹ Id. at pgs. 22, 110.

³² Id.

³³ HEDIS measures are developed by the National Committee for Quality Assurance (NCQA), and allow for comparison of otherwise dissimilar health plans.

³⁴ Supra, note 18 at pg. 109.

³⁵ Supra, note 6 at pg. 4.

³⁶ Id.

³⁷ Id.

³⁸ S. 409.906(1), F.S.

³⁹ Proviso language in the 2001 General Appropriations Act (GAA) authorized AHCA to initiate a PDHP pilot program in Miami-Dade County. Similar statutory authority was provided in 2003.

⁴⁰ Ch. 2003-405 s. 18, Laws of Fla. (codified as. 409.912(42), F.S.).

⁴¹ In 2005, the Legislature enacted laws to reform the delivery and payment of services through the Medicaid program and directed AHCA to seek a federal waiver for a Medicaid managed care pilot program over five years. The program began in Broward and Duval counties in 2006 and later expanded to Baker, Clay and Nassau counties in 2007, as authorized in statute. The five-year waiver was set to expire June 30, 2011, but was renewed through June 30, 2014.

⁴² Ch. 2011-135, s. 17, Laws of Fla. (codified as s. 409.912(41), F.S.). This subsection expired October 1, 2014.

PDHPs for Fiscal Year 2012-2013, by requiring AHCA to allow dental services to be provided on a fee-for-service basis, as well.⁴³

AHCA issued a competitive procurement for the statewide PDHP program in 2011 and awarded contracts to two PDHPs to provide dental services to Medicaid recipients in all Florida counties with the exceptions noted above.⁴⁴ The contracts with PDHP providers expired on September 30, 2014.⁴⁵ On October 1, 2014, the statutory authority for AHCA to contract with PDHPs expired, as the program transitioned to the comprehensive managed care contracts in the new MMA program.

PDHP Accountability and Performance

Like the MMA program contracts, PDHP contracts imposed specific requirements for network adequacy,⁴⁶ required plans to meet an MLR of 85 percent (although this MLR was dental-specific);⁴⁷ and required plans to provide CHCUP to enrollees⁴⁸ and achieve an annual screening and participation CHCUP rate of 80 percent.⁴⁹ However, in calendar year 2013, both PDHPs, MCNA and DentaQuest, failed to meet their contractually required MLRs and, as a result, were required to repay AHCA an estimated \$20 million.⁵⁰

Unlike the MMA plans, which must have HEDIS scores over 50 percent, the PDHPs were only required to have an “acceptable HEDIS score” or potentially be subject to unspecified monetary damages.⁵¹

Performance of the PDHPs and MMA Plans, Compared

AHCA measures the performance of the MMA plans, and measured the performance of PDHPs, based on HEDIS scores. To ensure the validity of HEDIS results, the data is reviewed by certified auditors using a process designed by the NCQA.⁵²

AHCA conducted an independent analysis to determine the percentage of MMA enrollees ages 2 – 21 years who received at least one dental service during the first year of MMA implementation, from August 1, 2014 through July 31, 2015.⁵³ AHCA used the same parameters used to calculate the HEDIS scores for children’s dental care annual dental visits, with two variations:

- HEDIS uses a calendar year; AHCA used an August through July time period; and
- HEDIS requires that individuals be enrolled in the plan on December 31 of the measurement year; AHCA’s analysis required that they be enrolled on July 31 of the measurement year.⁵⁴

⁴³ Ch. 2012-119, s. 9, Laws of Fla. (codified as s. 409.912(41)(b), F.S.). This paragraph expired July 1, 2013.

⁴⁴ During 2012, AHCA implemented the statewide PDHP program in Medicaid Area 9 on January 1; Areas 5, 6, and 7 on October 1; and Areas 1, 2, 3, 4, 8, and 11 (Monroe County only) on December 1, 2012.

⁴⁵ The original procurement period was December 1, 2011 through September 30, 2013. The program was renewed once, which extended the contracts through September 30, 2014.

⁴⁶ Agency for Health Care Administration, *Medicaid Prepaid Dental Health Plan Contract, Attachment II, January, 2012*, p. 60 (on file with Health and Human Services Committee).

⁴⁷ Agency for Health Care Administration, *Agency Analysis of 2015 House Bill 601*, January 28, 2015 (on file with Health and Human Services Committee).

⁴⁸ *Supra*, note 46 at pgs. 53-54.

⁴⁹ *Id.*

⁵⁰ *Supra*, note 47.

⁵¹ *Id.* at pg. 83. “Acceptable HEDIS score” was not defined in the PDHP contracts.

⁵² National Committee for Quality Assurance, *HEDIS and Quality Measurement: What is HEDIS?*, <http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx> (last visited March 14, 2016).

⁵³ *Supra*, note 20; *infra*, note 56.

⁵⁴ *Id.*

Using these parameters, AHCA determined that 43 percent of the children who qualified to be counted in this measure received dental services during this time period.⁵⁵ The score of 43.1 percent in MMA Year 1 is higher than prior PDHP HEDIS scores, and is higher than the HEDIS score achieved in 2013 by Medicaid reform plans of 42 percent which, until MMA, was the highest score ever recorded for this measure in Florida.

HEDIS Annual Dental Visit Scores for Children Ages 2-21 Years⁵⁶

Time Period	MMA Plans	Reform Pilot Plans ⁵⁷	PDHPs (MCNA ⁵⁸ and DentaQuest ⁵⁹)
CY 2007 (Reported in 2008)	N/A	15.2%	N/A
CY 2008 (Reported in 2009)	N/A	28.5%	N/A
CY 2009 (Reported in 2010)	N/A	33.4%	N/A
CY 2010 (Reported in 2011)	N/A	34.0%	N/A
CY 2011 (Reported in 2012)	N/A	35.3%	N/A
CY 2012 (Reported in 2013)	N/A	40.40%	40.92%
CY 2013 (Reported in 2014)	N/A	42.3%	37.04%
MMA Year 1	43.1%	N/A	N/A

The chart does not reflect HEDIS annual dental visit scores for either the MMA plans or pre-MMA plans calendar year 2014 because 2014 was the MMA transition year, so the data is not representative of performance.⁶⁰

⁵⁵ Id.

⁵⁶ Justin M. Senior, Florida Medicaid Director, Agency for Health Care Administration, *Florida Medicaid: Statewide Medicaid Managed Care*, PowerPoint Presentation to the House Health and Human Services Committee, January 2016. (Presentation on file with Health and Human Services Committee).

⁵⁷ The data for the Reform Pilot Plans indicate an initial improvement from 2007 to 2009, followed by relatively static numbers over the next few years from 2009 to 2011, followed by another improvement from 2011 to 2013.

⁵⁸ MCNA self-reported *unaudited* HEDIS scores for its Miami-Dade County PDHP Pilot from 2010 to 2011 showing 34.8 and 35 percent, respectively. (Information on file with Health and Human Services Committee).

⁵⁹ DentaQuest self-reported *unaudited* HEDIS scores for its Miami-Dade County PDHP Pilot from 2005 to 2011 showing an increase from 20 percent in 2005 to 39.1 percent in 2011. (Information on file with Health and Human Services Committee).

⁶⁰ For enrollees to be counted, for the purpose of the HEDIS score, they must have been in a single plan for at least 11 out of 12 months and must have been enrolled in that plan as of December 31, 2014. Neither the PDHP nor reform pilot plans remained in effect as of December 31, 2014. Additionally, data for the MMA plans 2014 calendar year is not accurate because the number of enrollees counted in the scores are artificially low. Due to the transition to MMA program throughout 2014, there were very few enrollees who had been in an MMA plan for the required time that could then be counted for the 2014 HEDIS score.

HEDIS Annual Dental Visit Scores for Children Ages 2-21 Years by MMA Plan, MMA Year 1⁶¹

Eligible Population	Dental Visits	Percentage of Population Receiving Dental Care by MMA Plan
7,431	5,699	Sunshine CW, 77%
46,670	22,309	Molina, 48%
25,556	12,055	Simply, 47%
166,816	77,721	Amerigroup, 47%
42,993	19,293	CMSN, 45%
115,755	50,997	Humana, 44%
334,650	144,769	Staywell, 43%
44,204	18,816	Better Health, 43%
22,826	9,665	SFCCN, 42%
130,171	54,631	Prestige, 42%
20,793	8,536	Coventry, 41%
178,285	72,443	Sunshine, 41%
41,935	17,018	Integral, 41%
100,141	39,898	United, 40%
10,520	2,990	Preferred, 28%
5,437	1,349	Magellan, 25%
101	24	Clear Health, 24%
12	1	Positive, 8%

Effect of the Proposed Changes

Dental Services Carve-Out

Removal of Dental Services from MMA Plan Coverage

HB 819 amends s. 409.973(1), F.S., to remove dental services as a minimum benefit that must be covered by MMA plans, effective March 1, 2019. Presently all MMA plans are required to provide dental services, as medically necessary, to their enrollees.⁶² Absent Legislative action before July 1, 2017, MMA plans would no longer provide child or adult dental services; instead, dental services would be provided through a statewide Medicaid PDHP, starting March 1, 2019.

The carve-out of dental services from the MMA program would represent a departure from the system of care that was created by Medicaid reform. As a result of the carve-out, Medicaid patients would no longer receive integrated, coordinated care.

Additionally, adult Medicaid recipients would lose the expanded dental benefits they receive through the MMA plans.

Current law requires MMA plans to provide transportation for “covered services.” Because dental services are no longer “covered services” for MMA plans, it appears that MMA plans are no longer obligated to provide transportation to dental services now covered by PDHPs. The bill is silent on which

⁶¹ Agency for Health Care Administration, *Florida Medicaid: Data Visualization Series*, https://bi.ahca.myflorida.com/t/FLMedicaid/views/DentalProfileMMAYear1/DENTALSERVICES-MMA?embed=y&toolbar=no&display_count=no (last visited March 14, 2016).

⁶² The removal of dental services from the list of minimum benefits that MMA plans must provide will require AHCA to amend the current 1115 waiver authorizing the SMMC program to cover dental services separately, or apply for a 1915(b) waiver, which would allow AHCA to competitively procure prepaid dental plans and operate them as capitated managed care plans. Additionally, the removal of dental services would require AHCA to amend the SMMC plan contracts to exclude dental services as a covered service and modify existing capitation rates. *Supra*, note 6 at 4-7.

entity must provide transportation. A lack of integrated transportation may make it more difficult for children to go to the dentist.

Creation of a Statewide Medicaid PDHP Program

Effective July 1, 2017, AHCA must implement a statewide PDHP program for children and adults and begin enrollment by March 1, 2019. To establish the program, the bill requires AHCA contract with at least two licensed dental managed care providers through a competitive procurement process. The providers must be licensed as a prepaid limited health services organization under ch. 636, F.S., or a health maintenance organization under ch. 641, F.S. The providers must have substantial experience in providing dental care to Medicaid enrollees and children eligible for assistance under the Children's Health Insurance Program and meet all AHCA standards and requirements. Provider contracts will be for five years and may not be renewed; however, contracts may be extended to cover delays during a transition to a new provider.

The bill requires PDHP contracts to include an MLR provision consistent with the current statutory MLR calculation requirement for MMA plans.⁶³ Currently, the MLR calculation must use uniform financial data collected from all plans and must be computed for each plan on a statewide basis. AHCA anticipates that it would need actuarial analysis services to create capitation rates for the new dental managed care plans selected and to separate dental services from the MMA program.⁶⁴

The bill does not specify the level of adult dental services required in the statewide Medicaid PDHP program. The scope of adult dental services provided by the MMA plans exceeds the statutory requirements at no additional cost. The bill does not require the statewide Medicaid PDHP program to provide the same level of adult dental services that are currently offered in the MMA program. The bill appears to limit dental services to those required by s. 409.906(1),(6), F.S.; that is, full benefits for children and limited benefits (dentures and emergency procedures) for adults.

The bill authorizes AHCA to seek a state plan amendment or a federal waiver to begin enrollment into the prepaid dental program no later than March 1, 2019. AHCA anticipates that it would need to seek a new section 1115 or section 1915(b) waiver to enable it to implement the statewide Medicaid PDHP program.⁶⁵

Comprehensive Report on Provision of Dental Services under the SMMC Program

The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to complete a comprehensive report⁶⁶ on the provision of dental services under the SMMC program. OPPAGA's report must examine the effectiveness of MMA plans in:

- Increasing patient access to dental care;
- Improving dental health;
- Achieving satisfactory outcomes for Medicaid recipients and dental providers;
- Providing outreach to Medicaid recipients; and
- Delivering value and transparency regarding funds intended for, and spent on, actual dental services.

⁶³ S. 409.967(4), F.S.

⁶⁴ Supra, note 6 at pg. 7.

⁶⁵ Id.

⁶⁶ The bill grants OPPAGA the authority to contract with an independent third party to assist in the preparation of the report.

The report must also examine, by MMA plan and in total:

- Historical trends of rates paid to providers and dental plan subcontractors;
- Provider participation in plan networks; and
- Provider willingness to treat Medicaid recipients.

Finally, the report must compare Florida's experience in providing dental care to Medicaid recipients with other states in delivering dental services, increasing access to dental care, and improving dental health.

OPPAGA must submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2016.

Legislative Use of the Comprehensive Report

The bill states that the Legislature may use the findings of the report to establish the minimum benefits under the MMA program for future procurements of managed care plans. Specifically, the bill authorizes the Legislature to consider the findings from the report when deciding whether to continue to include dental services as a minimum benefit under the MMA program or to provide dental services separately.

If the Legislature wishes to keep dental services as a minimum benefit that plans must provide under the MMA program, the 2016 chapter law section reflecting the proposed removal of dental services from the list of minimum benefits must be repealed before July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

1. Expenditures:

A contract with an independent entity to assist in preparing the comprehensive report is estimated to cost \$250,000.⁶⁷

If AHCA implements a statewide PDHP program, it estimates that it would need an additional \$200,000 per year for the current contracted actuarial firm to perform analysis services necessary to amend the current plan capitation rates to remove dental services and to create capitation rates for the selected plans.⁶⁸ AHCA also anticipates using outside counsel for the defense of competitive procurement specifications and bid awards for the statewide PDHP program, at a cost of \$100,000.⁶⁹

Additionally, AHCA anticipates the need for five FTE positions to implement the bill: one grade 26 FTE to manage waiver oversight, one grade 26 FTE for financial monitoring, and three grade 25

⁶⁷ Supra, note 6 at pg. 9.

⁶⁸ Id.

⁶⁹ Id.

FTEs as contract managers.⁷⁰ To fund these additional positions, AHCA would require recurring General Revenue funds as follows:

State Fiscal Year	State General Revenue	Medicaid Care Trust Fund	Total
2016-17	\$225,000	\$225,000	\$450,000
2017-18	\$261,428	\$261,428	\$522,856
2018-19	\$235,720	\$235,720	\$471,440

Neither the bill, nor the GAA, appropriated funds to AHCA for these purposes.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Adult Medicaid recipients may see increased dental care costs. Without the requirement to provide a dental benefit under the MMA program, it may no longer be cost effective for plans to maintain a full dental network, which may affect the plans' ability and willingness to continue to offer expanded dental benefits to adults.⁷¹

D. FISCAL COMMENTS:

None.

⁷⁰ Id. at pg. 7.

⁷¹ Id. at pg. 5.