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 Appropriations Committee on Health and Human Services

BILL:	SB 1084
INTRODUCER:	Senator Trumbull
SUBJECT:	Long-term Managed Care Program
DATE:	April 17, 2023
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown	HP	**Favorable**
2.	Gerbrandt	Money	AHS	**Pre-meeting**
3.			FP	

I. Summary:

SB 1084 amends s. 409.981, F.S., to create a Medicaid long-term care managed care pilot program in Miami-Dade County to integrate health care services, long-term care services, and home and community-based services for persons with developmental disabilities. The pilot program will be available, on a volunteer basis, to Medicaid eligible individuals on the iBudget waitlist.

The bill is likely to have a significant negative fiscal impact. The Agency for Health Care Administration (AHCA), which operates the state's Medicaid program, has not submitted an estimate of the bill's potential fiscal impact. See Section V. of this analysis.

The bill takes effect upon becoming a law.

II. Present Situation:

The Florida Medicaid Program

Florida Medicaid is the health care safety net for low-income Floridians. The national Medicaid program is a partnership of federal and state governments established to provide coverage for health services for eligible persons. Florida's program is financed through state and federal funds.[1]

The Agency for Health Care Administration (AHCA) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act (SSA). This authority includes establishing and maintaining a Medicaid state plan approved by the federal Centers for Medicare & Medicaid Services (CMS) and maintaining any

[1] Section 20.42, F.S.

Medicaid waivers needed to operate the Florida Medicaid program as directed by Florida Statute,[2] the General Appropriations Act (GAA), and other legislation accompanying the GAA.

A Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements. State Medicaid programs may request from CMS a formal waiver of the requirements codified in the SSA, which provides states flexibility in providing services not afforded through their Medicaid state plan.

Statewide Medicaid Managed Care

In Florida, a large majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[3] Other recipients who are not eligible for managed care, are not subject to mandatory managed care enrollment, or are not yet enrolled in a plan, are provided services directly from health care practitioners or facilities, and in those cases, providers are paid on a fee-for-service basis.

SMMC has three components:

- Managed Medical Assistance (MMA), under which the AHCA makes payments for primary and acute medical treatments and related services using a managed care model;
- Long-term Care Managed Care (LTCMC), under which the AHCA makes payments for long-term care, including home and community-based services, using a managed care model; and
- The Medicaid Prepaid Dental Health Program (Prepaid Dental), under which the AHCA makes payments for dental services for children and adults using a managed care model.

SMMC benefits are authorized through federal waivers and are specifically required by the Florida Legislature in ss. 409.973 and 409.98, F.S. SMMC benefits cover primary, acute, preventive, behavioral health, prescribed drugs, long-term care, and dental services. Section 409.973, F.S., specifies the minimum services that must be provided by managed care plans:

Managed Care Plan Benefits[4]	
Advanced practice registered nurse services	Medical supplies, equipment, prostheses, and orthoses
Ambulatory surgical treatment center services	Mental health services
Birthing center services	Nursing care
Chiropractic services	Optical services and supplies
Donor human milk bank services	Optometrist services

[2] *See* parts III and IV of ch. 409, F.S.
[3] As of January 31, 2023, Florida Medicaid's total enrollment comprised 5,696,638 persons. Eighty-seven percent were enrolled in a Medicaid managed care plan. *See:* https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_202301.xls (last visited March 9, 2023).
[4] Section 409.973, F.S.

Early periodic screening diagnosis and treatment services for recipients under age 21	Physical, occupational, respiratory, and speech therapy services
Emergency services	Physician services, including physician assistant services
Family planning services and supplies. Pursuant to 42 C.F.R. s. 438.102, plans may elect to not provide these services due to an objection on moral or religious grounds, and must notify the agency of that election when submitting a reply to an invitation to negotiate	Podiatric services
Healthy start services, except as provided in s. 409.975(4)	Prescription drugs
Hearing services	Renal dialysis services
Home health agency services	Respiratory equipment and supplies
Hospice services	Rural health clinic services
Hospital inpatient services	Substance abuse treatment services
Hospital outpatient services	Transportation to access covered services
Laboratory and imaging services	

Florida Medicaid does not cover all low-income Floridians. Current eligibility prioritizes low-income children, disabled persons, and elders, and sets income eligibility by reference to the annual federal poverty level. For some groups, clinical eligibility provisions apply, as well.

The Florida Medicaid program covers:[5]

- More than 5.5 million low-income individuals, including approximately 2.5 million children, or 54 percent of the children in Florida;
- More than 54 percent of the births occurring in Florida in calendar year 2020; and
- More than 60 percent of the nursing home days in Florida.

Types of Comprehensive Medicaid Managed Care Plans

Comprehensive services in SMMC are managed by two types of managed care plans: traditional managed care organizations and provider service networks (PSNs). Traditional managed care organizations are usually health insurers or health maintenance organizations (HMOs). PSNs are managed care plans that are owned or are majority-controlled by health care providers, such as physician groups or hospitals.

All managed care plans in SMMC, including PSNs, are reimbursed as prepaid plans. That is, they are paid capitated rates (prospective, per-member, per-month payments) by the AHCA in advance for any particular month and are expected to provide medically necessary services to their respective members during that month, using the dollars within that month's capitation. Medically necessary services are required to be provided regardless of whether the capitation includes all the dollars necessary to provide those services.[6]

[5] Agency for Health Care Administration, Presentation to the Senate Health Policy Committee, Jan. 23, 2023.
[6] *See* s. 409.968(1) and (2), F.S.

The AHCA contracts with managed care plans on a statewide and regional basis, in sufficient numbers to ensure choice. The cyclical Medicaid procurement process ensures plans offer competitive benefit designs and prices. In addition, plans compete for consumer choice. That is, while Medicaid requires a basic benefit package, and regulates the adequacy of plans' provider networks, plans can add to their benefit packages and offer provider networks attractive to Medicaid recipients when choosing a plan.

The AHCA began the next procurement process in 2022 for implementation in the 2025 plan year and released the re-procurement solicitation documents on April 11, 2023.[7]

Medicaid Long-Term Care

Federal Medicaid law establishes coverage for institutional care, such as nursing home care and residential institutions for people with developmental disabilities, but does not allow federal dollars to be spent on alternatives to such care. Those alternatives include home and community-based services designed to keep people in their homes and communities instead of going into an institution when they need higher levels of care. This federal spending limitation creates a bias toward institutional care, and toward acute care, rather than allowing the non-acute supports that prevent institutionalization.

Florida obtained federal waivers to allow the state Medicaid program to cover other kinds of long-term care services for elders and people with disabilities, to prevent admission into a nursing home. The Medicaid Long-term Care Waiver provides services to eligible individuals age 18 or older who need long-term services and supports, including individuals over the age of 18 with a diagnosis of cystic fibrosis, AIDS, or a traumatic brain or spinal cord injury. The Long-term Care Waiver is designed to delay or prevent institutionalization and allow waiver recipients to maintain stable health while receiving services at home and in the community. Individuals in the program may also be served in a nursing facility setting. The Long-Term Care Waiver is a capitated, managed care program.

Section 409.98, F.S., specifies the non-institutional, often non-acute, long-term care benefits that must be provided by the long-term care managed care program:

[7] Agency for Health Care Administration, Presentation to the Senate Health Policy Committee, Jan. 23, 2023.

SMMC Long-Term Care Mandatory Benefits	
Services provided in an ALF	Physical therapy
Hospice services	Intermittent and skilled nursing
Adult day care	Medication administration
Personal care	Medication management
Home accessibility adaption	Nutritional assessment and risk reduction
Behavior management	Caregiver training
Home-delivered meals	Respite care
Case management	Personal emergency response system
Occupational therapy	Transportation
Speech therapy	Medical equipment and supplies
Respiratory therapy	Nursing Facility Care Services

Medicaid Home and Community-Based Waiver for Persons with Developmental Disabilities

Under federal law, fee-for-service Medicaid provides coverage for health care services to cure or ameliorate diseases. Generally, Medicaid does not cover services that will not cure or mitigate a medical diagnosis. However, people with developmental disabilities, while certainly requiring traditional medical services, need other kinds of services to maintain their independence and avoid institutionalization. Home and community-based services (HCBS) can be provided to assist people with developmental disabilities with activities of daily living which enables them to live in their homes or communities, rather than moving to a facility for care.

To obtain federal Medicaid funding for HCBS, Florida obtained a Medicaid waiver.[8] This allows coverage of non-medical services to avoid institutionalization and allows the state to limit the scope of the program to the number of enrollees deemed affordable by the state. In this way, the HCBS waiver is not an entitlement; it is a first-come, first-served, slot-limited program.

The HCBS waiver, known as iBudget Florida, serves eligible[9] persons with developmental disabilities. Eligible diagnoses include disorders or syndromes attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome. The disorder must manifest before the age of 18, and it must constitute a substantial handicap that can reasonably be expected to continue indefinitely.[10]

The Agency for Persons with Disabilities (APD) administers the iBudget program with the stated purpose of:

- Promoting and maintaining the health and welfare of eligible individuals with developmental disabilities.
- Providing medically necessary supports and services to delay or prevent institutionalization.

[8] Florida Developmental Disabilities Individual Budgeting Waiver (0867.R02.00), March 4, 2011, authorized under s. 1915b of the Social Security Act.
[9] The HCBS waiver retains the Medicaid requirement that enrollees be low-income, but measures only the developmentally disabled person's income; not the income generated by the whole household.
[10] Section 393.063(12), F.S.

- Fostering the principles of self-determination as a foundation for services and supports.[11]

Section 393.066 (3), F.S., specifies that community-based services offered through the iBudget must include the following medically necessary services to prevent institutionalization:

Home and Community-Based Services[12]	
Adult Day Training	Respite Services
Family Care Services	Social Services
Guardian Advocate Referral Services	Physical, Occupational, Respiratory, and Speech Therapy
Medical/Dental Services	Supported Employment
Parent Training	Supported Living
Personal Care Services	Behavioral Services
Recreation	Transportations
Residential Facility Services	Residential Habilitation

Under the broad service categories specified in s. 393.066(3), F.S., the APD offers 26 supports and services delivered by contracted service providers to assist individuals to live in their own homes or the community.[13]

Currently, HCBS services are not integrated with Medicaid acute medical services, as those services are administered for iBudget enrollees by the AHCA, usually through the fee-for service model, not through SMMC. However, every iBudget enrollee receives case management services from a waiver support coordinator. Waiver support coordinators are responsible for identifying, coordinating, and accessing supports and services from all available funding sources for iBudget enrollees, including Medicaid state plan services.

Florida law requires that Medicaid be the payer of last resort for medically necessary supports and services,[14] and that iBudget enrollees use all available services authorized under the Medicaid state plan, school-based services, private insurance and other benefits, prior to using iBudget Waiver funds.[15] Therefore waiver support coordinators must first obtain supports and services from third party payers, other government or community programs, school-based programs, and natural supports.

Historically, despite the utilization management tools authorized by law and the entitlement flexibilities provided by the federal waiver, APD has frequently been unable to manage the

[11] Agency for Health Care Administration, *Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook*, September 2021.
[12] Section 393.006(3), F.S.
[13] *Supra*, note 11.
[14] Section 409.910, F.S.
[15] 393.0662(3), F.S.

iBudget program within the budget appropriated by the legislature, resulting in significant deficits[16] and surpluses.[17]

In 2019, the Legislature directed the APD to implement better monitoring and accounting procedures and to take corrective action when deficits are projected to develop. Additionally, APD was required to develop a plan to redesign the iBudget program if a deficit were to reoccur in the 2018-2019 fiscal year.[18] The APD did generate a deficit that year and submitted a plan to address the budget shortfall that included the following recommendations:

- Include the iBudget Waiver in the Social Services Estimating Conference;
- Implement a behavioral health Intermediate Care Facility service rate;
- Implement individual caps for iBudget clients;
- Implement budget transfers from the Medicaid state plan to the iBudget waiver for clients turning 21;
- Expand the Medicaid Assistive Care Services program to include APD group homes;
- Centralize the significant additional needs process;
- Implement service limitations on Life Skills Development services; and
- Restructure support coordination services.[19]

In 2020, Senate Bill 82 was passed and addressed some of the recommendations from the APD's iBudget waiver redesign plan, specifically the bill:

- Centralized the significant additional needs process at APD headquarters; and
- Restructured support coordination services.[20]

For FY 2022-2023, the Legislature appropriated $1,871,531,214 to APD for the iBudget waiver program, of which $742,997,892 are state funds. [21] Currently, the program serves over 35,300 enrolled people.[22]

iBudget Waiver Waitlist

The APD maintains a waitlist of people who would like to enroll in the iBudget. Currently, the waitlist includes 22,535 people. About 660 of those receive other, limited, services from APD, and over 9,000 people on the waitlist are otherwise eligible for, and receive, Medicaid coverage

[16] For example, the legislature made retroactive general revenue appropriations to address APD deficits that occurred in Fiscal Year's 2017-2018 ($22.0 million), 2018-2019 ($41.2 million), and 2019-2020 ($50.8 million). *See*, the Fiscal Year 2019-2020 General Appropriations Act, section 30 and the Fiscal Year 2020-2021 General Appropriations Act, sections 29 and 30, respectively.
[17] The APD's historical deficits have been offset by more recent general revenue surpluses of $11.3 million, $1.0 million and $39.6 million in Fiscal Year's 2019-2020, 2020-2021, and 2021-2022, respectively. Data was retrieved from the Legislative Budgeting System.
[18] Chapter 2019-116, s. 26, Laws of Fla.
[19] Agency for Persons with Disabilities and Agency for Health Care Administration, 2019 iBudget Waiver Redesign, Sept. 30, 2019.
[20] Chapter 2020-71, Laws of Florida
[21] Chapter 2022-156, Laws of Fla., Specific Appropriation 245.
[22] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2022-2023*, Nov. 15, 2023, available at: https://apd.myflorida.com/publications/reports/docs/FY%202023%20Quarterly%20Report%201st%20Quarter%20report.pdf (last viewed Mar. 24, 2023).

for medical care. About 13,500 people on the waiver waitlist receive no APD or Medicaid services.[23]

As new funding becomes available, APD enrolls people from the waitlist in a statutory order of priority in seven categories:[24]

- Category 1 – Clients deemed to be in crisis.
- Category 2 – Specified children from the child welfare system.[25]
- Category 3 – Includes, but is not limited to, clients:
  - Whose caregiver has a documented condition that is expected to render the caregiver unable to provide care within the next 12 months and for whom a caregiver is required but no alternate caregiver is available;
  - Who are at substantial risk of incarceration or court commitment without supports;
  - Whose documented behaviors or physical needs place them or their caregiver at risk of serious harm and other supports are not currently available to alleviate the situation; or
  - Who are identified as ready for discharge within the next year from a state mental health hospital or skilled nursing facility and who require a caregiver but for whom no caregiver is available.
- Category 4 – Includes, but is not limited to, clients whose caregivers are 70 years of age or older and for whom a caregiver is required but no alternate caregiver is available;
- Category 5 – Includes, but is not limited to, clients who are expected to graduate within the next 12 months from secondary school and need support to obtain or maintain competitive employment, or to pursue an accredited program of postsecondary education to which they have been accepted.
- Category 6 – Clients 21 years of age or older who do not meet the criteria for categories 1-5.
- Category 7 – Clients younger than 21 years of age who do not meet the criteria for categories 1-4.[26]

APD rarely moves beyond Category 1 (individuals experiencing a crisis) in enrolling people off the wait list. In Fiscal Years 2020-2021 and 2021-2022, for example, APD enrolled a total of 2,646 new enrollees in the waiver program. Of those, 1,841 (70%) were Category 1 enrollees.[27]

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[23] Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2022-2023*, Nov. 15, 2023, available at: https://apd.myflorida.com/publications/reports/docs/FY%202023%20Quarterly%20Report%201st%20Quarter%20report.pdf (last viewed Mar. 24, 2023).

[24] Section 393.065(5), F.S.

[25] *See* s. 393.065(5)(b), F.S., for specific criteria.

[26] Section 393.065(5), F.S.

[27] Of the 2,646 new enrollees, 182 were in Category 2 (children aging out of the child welfare system); the remainder were in special categories authorized by the legislature to jump the queue (military dependents, people with Phelan-McDermid Syndrome, and people in ICFs or nursing facilities), *see* s. 393.064(6), (7), F.S. *See*, Agency for Persons with Disabilities, *Quarterly Report on Agency Services to Floridians with Developmental Disabilities and Their Costs: First Quarter Fiscal Year 2022-2023*, Nov. 15, 2023, available at: https://apd.myflorida.com/publications/reports/docs/FY%202023%20Quarterly%20Report%201st%20Quarter%20report.pdf (last viewed Mar. 24, 2023).

Medicaid Coverage for iBudget Enrollees

iBudget waiver benefits include Medicaid coverage for medical services, administered by the AHCA. The vast majority of full-coverage Medicaid recipients receive services through the SMMC managed care model, in which the recipient can choose from different health plans to provide their care. However, under current law, using the managed care model is an option for iBudget enrollees – not a requirement. iBudget participants may opt to use the traditional fee-for-service model of service delivery.[28]

Medical services and HCBS are currently not integrated because they are provided by two different programs in two different state agencies. .

HCBS and Managed Care Models

Some states use managed care models for HCBS for persons with developmental disabilities, in varying forms.

Iowa and Kansas use a long-term care managed care model to provide developmental disability services. These states use a single, risk-bearing, managed care plan to coordinate all services for this population, including primary care, acute care, behavioral health, and long-term care services. Tennessee takes a similar approach, but its managed care plans do not bear risk.[29]

New York obtained a federal waiver to transition the Medicaid developmental disability population into managed care based on a phased-in model, beginning with integrated care coordination under a single, comprehensive plan. In addition, New York operates a service delivery model that fully integrates with Medicare coverage, for persons eligible for both programs, offering primary, acute, long-term care, and habilitation services.[30]

Using managed care for the developmental disability population requires careful adaptation of acute care models to address factors that differentiate this population from a typical long-term care population. These factors include: the longer length of time individuals will require these services, often for a lifetime; the role of community services and supports and the need to integrate them into the model; and the unique developmental disability provider community, composed of smaller organizations exclusively dependent on government funding and inexperienced at navigating a managed care environment; among other differentiating factors.[31]

Florida does not use a risk-based managed care model for HCBS services, and the Medicaid managed care model is rarely used by iBudget enrollees. Medicaid acute care services and HCBS services are not integrated, or coordinated, by any single entity for individual enrollees.

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[28] Section 409.972(1)(e), F.S.
[29] National Association of States United for Aging and Disabilities, MLTSS Institute, "MLTSS for People with Intellectual and Developmental Disabilities: Strategies for Success (2018), available at: http://www.advancingstates.org/sites/nasuad/files/2018%20MLTSS%20for%20People%20with%20IDD-%20Strategies%20for%20Success_0.pdf (last viewed Mar. 24, 2023).
[30] Center for Health Care Strategies, "Enrolling Individuals in Intellectual/Developmental Disabilities in Managed Care: A strategy for Strengthening Long-Term Services and Supports", March 2019, available at: https://www.chcs.org/media/Integration-Strategy-3-Strengthening-LTSS-Toolkit_032019.pdf (last viewed March 24, 2023).
[31] *Id.*

III. Effect of Proposed Changes:

The bill amends the long-term care managed care statutes in s. 409.981, F.S., to create a pilot program in Miami-Dade County that establishes an integrated managed care model for providing medical care, long-term care, and home and community-based services to persons with developmental disabilities.

The bill requires the Agency for Health Care Administration (AHCA) to contract with a long-term care managed care plan in Miami-Dade County to integrate medical services, long-term care services and home and community-based services, under the same managed care coverage umbrella. Integrated services must be provided on an individualized basis and must be updated at least quarterly or as warranted by changes in an individual's circumstances.

The pilot program will be available, on a volunteer basis, to Medicaid eligible individuals on the iBudget waitlist. Participation is limited to the maximum number of enrollees specified in the GAA, if any.

The pilot program must provide the medical care benefits described in s. 409.973, F.S., long-term care benefits described in s. 409.98, F.S., and the home and community-based benefits described in 393.066, F.S.

The AHCA must utilize the "invitation to negotiate" process under s. 287.057(1)(c), F.S., to procure a single managed care plan for the pilot program. The selected long-term care managed care plan must:

- Be a provider service network (PSN) whose owners include health care providers with experience serving iBudget waiver clients;
- Provide all benefits through a single, integrated model of care;
- Document revenues and expenditures related to the pilot program and submit financial reports; and
- Participate in the achieved savings rebate program.[32]

The AHCA must contract for an independent evaluation of the selected PSN's performance based on specific metrics of access to care, care quality, and cost. The AHCA must submit the evaluation to the President of the Senate and the Speaker of the House of Representatives by October 1, 2024.

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[32] The achieved savings rebate program requires plans to share savings with the state, and authorizes plans to retain statutorily-defined portions of savings, some increments of which are tied to achieving AHCA-defined quality measures. Section 409.967(3)(f), F.S.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Persons who enroll in the pilot will experience an increase in home and community-based services and/or traditional Medicaid benefits.

A provider service network (PSN) awarded a contract under the pilot program will benefit financially from the bill's implementation, if that PSN is able to successfully manage services rendered to the program's enrollees. The Agency for Health Care Administration (AHCA) has not provided an analysis of the bill; therefore, the number of PSNs, if any, who currently meet the bill's qualifications, or could potentially be created to meet those qualifications, is unknown.

C. Government Sector Impact:

The bill will have a significant negative fiscal impact on state expenditures. The pilot program limits participation to the maximum number of enrollees specified in the General Appropriations Act.

Currently, House Bill 5001, the House proposed General Appropriations Act for Fiscal Year 2023-2024, provides that AHCA may request budget authority associated with the enrollment of up to 600 individuals who are currently on the iBudget waiting list and who voluntarily choose to participate in the pilot program.

The Agency for Persons with Disabilities estimates the average annual cost for a non-crisis enrollee on the iBudget Waiver is $53,136. Therefore, the estimated cost to provide

home and community-based services to 600 individuals who are on the waitlist, and who are not in crisis, is $31.8 million ($12.9 million GR; $18.9 million TF).[33]

The bill will likely have an indeterminate yet negative fiscal impact on the AHCA due to the bill's provisions that require the AHCA to contract for an independent evaluation of the integrated plan.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill provides that enrollee participation in the Miami-Dade pilot is voluntary and that participants "will be selected" from individuals who are on the waitlist for iBudget waiver services. However, the bill does not specify who will do the selecting.

The bill also provides that participation is limited to the maximum number of enrollees specified in the General Appropriations Act (GAA), if any. In the event that the number of the volunteers exceeds the GAA's maximum number of enrollees, the bill does not provide a process or criteria to determine which individuals will be selected and which will be excluded. The bill also does not grant the Agency for Health Care Administration (AHCA) rulemaking authority to develop selection criteria.

In terms of benefits, it is unclear whether the Provider Service Network (PSN) that wins the contract under the pilot program will be required to provide coverage for dental services. The bill requires coverage to include benefits "described in" s. 409.973, F.S. Statewide Medicaid Managed Care (SMMC) dental services are provided under s. 409.973(5), F.S., but are usually provided under the Prepaid Dental Health Program, separate from other health care services. The bill references s. 409.973, F.S., but is silent on whether the AHCA should include dental services in the pilot's PSN contract.

It is unclear how quickly the pilot program will be operational. It is not unusual for procurements conducted via the invitation to negotiate process to take a significant amount of time to be concluded. For example, as reported earlier in this analysis, the AHCA began the next SMMC procurement process in 2022 for implementation in the 2025 plan year. It is unclear whether the bill's evaluation of the pilot which is required to be submitted by October 1, 2024, will have any meaningful data or results worthy of being evaluated. The bill does not provide for any evaluations to be submitted beyond October 1, 2024, in the event the pilot program endures past that date.

VIII. Statutes Affected:

This bill substantially amends section 409.981 of the Florida Statutes.

[33] This estimate excludes medical costs provided to people with developmental disabilities currently covered by Medicaid.

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.