1 A bill to be entitled
2 An act relating to coverage of dental services under
3 the Medicaid program; amending s. 409.906, F.S.;
4 removing provisions relating to optional services
5 rendered by providers in mobile units to Medicaid
6 recipients; adjustments in the Medicaid program due to
7 availability of moneys, limitations, and certain
8 directions; and the removal of certain Medicaid
9 service; revising adult dental services that are paid
10 by the Agency for Health Care Administration as
11 optional Medicaid services; requiring the agency to
12 reimburse Medicaid providers at a specified rate for
13 covered adult dental services; requiring the agency to
14 seek federal approval; amending s. 409.973, F.S.;
15 requiring the agency to implement a statewide Medicaid
16 prepaid dental health program for children and adults;
17 providing requirements for the benefits under the
18 program; removing obsolete language; providing an
19 effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 **Section 1. Section 409.906, Florida Statutes, is amended**
24 **to read:**
25 409.906 Optional Medicaid services.—Subject to specific

26 appropriations, the agency may make payments for services which
27 are optional to the state under Title XIX of the Social Security
28 Act and are furnished by Medicaid providers to recipients who
29 are determined to be eligible on the dates on which the services
30 were provided. Any optional service that is provided shall be
31 provided only when medically necessary and in accordance with
32 state and federal law. ~~Optional services rendered by providers~~
33 ~~in mobile units to Medicaid recipients may be restricted or~~
34 ~~prohibited by the agency. Nothing in this section shall be~~
35 ~~construed to prevent or limit the agency from adjusting fees,~~
36 ~~reimbursement rates, lengths of stay, number of visits, or~~
37 ~~number of services, or making any other adjustments necessary to~~
38 ~~comply with the availability of moneys and any limitations or~~
39 ~~directions provided for in the General Appropriations Act or~~
40 ~~chapter 216. If necessary to safeguard the state's systems of~~
41 ~~providing services to elderly and disabled persons and subject~~
42 ~~to the notice and review provisions of s. 216.177, the Governor~~
43 ~~may direct the Agency for Health Care Administration to amend~~
44 ~~the Medicaid state plan to delete the optional Medicaid service~~
45 ~~known as "Intermediate Care Facilities for the Developmentally~~
46 ~~Disabled."~~ Optional services may include:
47 (1) ADULT DENTAL SERVICES.—
48 (a) The agency may pay for services necessary to prevent
49 disease and promote oral health, restore oral structures to
50 health and function, and treat emergency conditions, including

51 routine diagnostic and preventive care, such as dental
52 cleanings, exams, and X rays; basic dental services, such as
53 fillings and extractions; major dental services, such as root
54 canals, crowns, and dentures and other dental prostheses;
55 emergency dental care; and other necessary services related to
56 dental and oral health ~~medically necessary, emergency dental~~
57 ~~procedures to alleviate pain or infection. Emergency dental care~~
58 ~~shall be limited to emergency oral examinations, necessary~~
59 ~~radiographs, extractions, and incision and drainage of abscess~~,
60 for a recipient who is 21 years of age or older.
61 (b) Effective July 1, 2025, the agency shall reimburse
62 providers of Medicaid-covered adult dental services at a rate
63 equivalent to 80 percent of the 50th percentile of the 2024
64 Usual, Customary, and Reasonable fees, as determined by the
65 American Dental Association, or a comparable benchmark approved
66 by the agency. The agency shall seek federal approval through a
67 state plan amendment or Medicaid waiver as necessary to achieve
68 compliance with this paragraph ~~The agency may pay for full or~~
69 ~~partial dentures, the procedures required to seat full or~~
70 ~~partial dentures, and the repair and reline of full or partial~~
71 ~~dentures, provided by or under the direction of a licensed~~
72 ~~dentist, for a recipient who is 21 years of age or older~~.
73 (c) However, Medicaid will not provide reimbursement for
74 dental services provided in a mobile dental unit, except for a
75 mobile dental unit:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

76 1. Owned by, operated by, or having a contractual
77 agreement with the Department of Health and complying with
78 Medicaid's county health department clinic services program
79 specifications as a county health department clinic services
80 provider.
81 2. Owned by, operated by, or having a contractual
82 arrangement with a federally qualified health center and
83 complying with Medicaid's federally qualified health center
84 specifications as a federally qualified health center provider.
85 3. Rendering dental services to Medicaid recipients, 21
86 years of age and older, at nursing facilities.
87 4. Owned by, operated by, or having a contractual
88 agreement with a state-approved dental educational institution.
89 (2) ADULT HEALTH SCREENING SERVICES.—The agency may pay
90 for an annual routine physical examination, conducted by or
91 under the direction of a licensed physician, for a recipient age
92 21 or older, without regard to medical necessity, in order to
93 detect and prevent disease, disability, or other health
94 condition or its progression.
95 (3) AMBULATORY SURGICAL CENTER SERVICES.—The agency may
96 pay for services provided to a recipient in an ambulatory
97 surgical center licensed under part I of chapter 395, by or
98 under the direction of a licensed physician or dentist.
99 (4) BIRTH CENTER SERVICES.—The agency may pay for
100 examinations and delivery, recovery, and newborn assessment, and

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

101 related services, provided in a licensed birth center staffed
102 with licensed physicians, certified nurse midwives, and midwives
103 licensed in accordance with chapter 467, to a recipient expected
104 to experience a low-risk pregnancy and delivery.
105 (5) CASE MANAGEMENT SERVICES.—The agency may pay for
106 primary care case management services rendered to a recipient
107 pursuant to a federally approved waiver, and targeted case
108 management services for specific groups of targeted recipients,
109 for which funding has been provided and which are rendered
110 pursuant to federal guidelines. The agency is authorized to
111 limit reimbursement for targeted case management services in
112 order to comply with any limitations or directions provided for
113 in the General Appropriations Act.
114 (6) CHILDREN'S DENTAL SERVICES.—The agency may pay for
115 diagnostic, preventive, or corrective procedures, including
116 orthodontia in severe cases, provided to a recipient under age
117 21, by or under the supervision of a licensed dentist. The
118 agency may also reimburse a health access setting as defined in
119 s. 466.003 for the remediable tasks that a licensed dental
120 hygienist is authorized to perform under s. 466.024(2). Services
121 provided under this program include treatment of the teeth and
122 associated structures of the oral cavity, as well as treatment
123 of disease, injury, or impairment that may affect the oral or
124 general health of the individual. However, Medicaid will not
125 provide reimbursement for dental services provided in a mobile

126 dental unit, except for a mobile dental unit:
127 (a) Owned by, operated by, or having a contractual
128 agreement with the Department of Health and complying with
129 Medicaid's county health department clinic services program
130 specifications as a county health department clinic services
131 provider.
132 (b) Owned by, operated by, or having a contractual
133 arrangement with a federally qualified health center and
134 complying with Medicaid's federally qualified health center
135 specifications as a federally qualified health center provider.
136 (c) Rendering dental services to Medicaid recipients, 21
137 years of age and older, at nursing facilities.
138 (d) Owned by, operated by, or having a contractual
139 agreement with a state-approved dental educational institution.
140 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual
141 manipulation of the spine and initial services, screening, and X
142 rays provided to a recipient by a licensed chiropractic
143 physician.
144 (8) COMMUNITY MENTAL HEALTH SERVICES.—
145 (a) The agency may pay for rehabilitative services
146 provided to a recipient by a mental health or substance abuse
147 provider under contract with the agency or the Department of
148 Children and Families to provide such services. Those services
149 which are psychiatric in nature shall be rendered or recommended
150 by a psychiatrist, and those services which are medical in

151 nature shall be rendered or recommended by a physician or
152 psychiatrist. The agency must develop a provider enrollment
153 process for community mental health providers which bases
154 provider enrollment on an assessment of service need. The
155 provider enrollment process shall be designed to control costs,
156 prevent fraud and abuse, consider provider expertise and
157 capacity, and assess provider success in managing utilization of
158 care and measuring treatment outcomes. Providers will be
159 selected through a competitive procurement or selective
160 contracting process. In addition to other community mental
161 health providers, the agency shall consider for enrollment
162 mental health programs licensed under chapter 395 and group
163 practices licensed under chapter 458, chapter 459, chapter 490,
164 or chapter 491. The agency is also authorized to continue
165 operation of its behavioral health utilization management
166 program and may develop new services if these actions are
167 necessary to ensure savings from the implementation of the
168 utilization management system. The agency shall coordinate the
169 implementation of this enrollment process with the Department of
170 Children and Families and the Department of Juvenile Justice.
171 The agency is authorized to utilize diagnostic criteria in
172 setting reimbursement rates, to preauthorize certain high-cost
173 or highly utilized services, to limit or eliminate coverage for
174 certain services, or to make any other adjustments necessary to
175 comply with any limitations or directions provided for in the

176 General Appropriations Act.
177 (b) The agency is authorized to implement reimbursement
178 and use management reforms in order to comply with any
179 limitations or directions in the General Appropriations Act,
180 which may include, but are not limited to: prior authorization
181 of treatment and service plans; prior authorization of services;
182 enhanced use review programs for highly used services; and
183 limits on services for those determined to be abusing their
184 benefit coverages.
185 (9) DIALYSIS FACILITY SERVICES.—Subject to specific
186 appropriations being provided for this purpose, the agency may
187 pay a dialysis facility that is approved as a dialysis facility
188 in accordance with Title XVIII of the Social Security Act, for
189 dialysis services that are provided to a Medicaid recipient
190 under the direction of a physician licensed to practice medicine
191 or osteopathic medicine in this state, including dialysis
192 services provided in the recipient's home by a hospital-based or
193 freestanding dialysis facility.
194 (10) DURABLE MEDICAL EQUIPMENT.—The agency may authorize
195 and pay for certain durable medical equipment and supplies
196 provided to a Medicaid recipient as medically necessary.
197 (11) HEALTHY START SERVICES.—The agency may pay for a
198 continuum of risk-appropriate medical and psychosocial services
199 for the Healthy Start program in accordance with a federal
200 waiver. The agency may not implement the federal waiver unless

201 the waiver permits the state to limit enrollment or the amount,
202 duration, and scope of services to ensure that expenditures will
203 not exceed funds appropriated by the Legislature or available
204 from local sources. If the Health Care Financing Administration
205 does not approve a federal waiver for Healthy Start services,
206 the agency, in consultation with the Department of Health and
207 the Florida Association of Healthy Start Coalitions, is
208 authorized to establish a Medicaid certified-match program for
209 Healthy Start services. Participation in the Healthy Start
210 certified-match program shall be voluntary, and reimbursement
211 shall be limited to the federal Medicaid share to Medicaid-
212 enrolled Healthy Start coalitions for services provided to
213 Medicaid recipients. The agency shall take no action to
214 implement a certified-match program without ensuring that the
215 amendment and review requirements of ss. 216.177 and 216.181
216 have been met.
217 (12) HEARING SERVICES.—The agency may pay for hearing and
218 related services, including hearing evaluations, hearing aid
219 devices, dispensing of the hearing aid, and related repairs, if
220 provided to a recipient by a licensed hearing aid specialist,
221 otolaryngologist, otologist, audiologist, or physician.
222 (13) HOME AND COMMUNITY-BASED SERVICES.—
223 (a) The agency may pay for home-based or community-based
224 services that are rendered to a recipient in accordance with a
225 federally approved waiver program. The agency may limit or

226 eliminate coverage for certain services, preauthorize high-cost
227 or highly utilized services, or make any other adjustments
228 necessary to comply with any limitations or directions provided
229 for in the General Appropriations Act.
230 (b) The agency may implement a utilization management
231 program designed to prior-authorize home and community-based
232 service plans and includes, but is not limited to, assessing
233 proposed quantity and duration of services and monitoring
234 ongoing service use by participants in the program. The agency
235 is authorized to competitively procure a qualified organization
236 to provide utilization management of home and community-based
237 services. The agency is authorized to seek any federal waivers
238 to implement this initiative.
239 (c) The agency shall request federal approval to develop a
240 system to require payment of premiums or other cost sharing by
241 the parents of a child who is being served by a waiver under
242 this subsection if the adjusted household income is greater than
243 100 percent of the federal poverty level. The amount of the
244 premium or cost sharing shall be calculated using a sliding
245 scale based on the size of the family, the amount of the
246 parent's adjusted gross income, and the federal poverty
247 guidelines. The premium and cost-sharing system developed by the
248 agency shall not adversely affect federal funding to the state.
249 After the agency receives federal approval, the Department of
250 Children and Families may collect income information from

251 parents of children who will be affected by this paragraph.
252 (d) The agency shall seek federal approval to pay for
253 flexible services for persons with severe mental illness or
254 substance use disorders, including, but not limited to,
255 temporary housing assistance. Payments may be made as enhanced
256 capitation rates or incentive payments to managed care plans
257 that meet the requirements of s. 409.968(4).
258 (14) HOSPICE CARE SERVICES.—The agency may pay for all
259 reasonable and necessary services for the palliation or
260 management of a recipient's terminal illness, if the services
261 are provided by a hospice that is licensed under part IV of
262 chapter 400 and meets Medicare certification requirements.
263 (15) INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY
264 DISABLED SERVICES.—The agency may pay for health-related care
265 and services provided on a 24-hour-a-day basis by a facility
266 licensed and certified as a Medicaid Intermediate Care Facility
267 for the Developmentally Disabled, for a recipient who needs such
268 care because of a developmental disability. Payment shall not
269 include bed-hold days except in facilities with occupancy rates
270 of 95 percent or greater. The agency is authorized to seek any
271 federal waiver approvals to implement this policy. The agency
272 shall seek federal approval to implement a payment rate for
273 Medicaid intermediate care facilities serving individuals with
274 developmental disabilities, severe maladaptive behaviors, severe
275 maladaptive behaviors and co-occurring complex medical

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

276 conditions, or a dual diagnosis of developmental disability and
277 mental illness.
278 (16) INTERMEDIATE CARE SERVICES.—The agency may pay for
279 24-hour-a-day intermediate care nursing and rehabilitation
280 services rendered to a recipient in a nursing facility licensed
281 under part II of chapter 400, if the services are ordered by and
282 provided under the direction of a physician.
283 (17) OPTOMETRIC SERVICES.—The agency may pay for services
284 provided to a recipient, including examination, diagnosis,
285 treatment, and management, related to ocular pathology, if the
286 services are provided by a licensed optometrist or physician.
287 (18) PHYSICIAN ASSISTANT SERVICES.—The agency may pay for
288 all services provided to a recipient by a physician assistant
289 licensed under s. 458.347 or s. 459.022. Reimbursement for such
290 services must be not less than 80 percent of the reimbursement
291 that would be paid to a physician who provided the same
292 services.
293 (19) PODIATRIC SERVICES.—The agency may pay for services,
294 including diagnosis and medical, surgical, palliative, and
295 mechanical treatment, related to ailments of the human foot and
296 lower leg, if provided to a recipient by a podiatric physician
297 licensed under state law.
298 (20) PRESCRIBED DRUG SERVICES.—The agency may pay for
299 medications that are prescribed for a recipient by a physician
300 or other licensed practitioner of the healing arts authorized to

301 prescribe medications and that are dispensed to the recipient by
302 a licensed pharmacist or physician in accordance with applicable
303 state and federal law.
304 (21) REGISTERED NURSE FIRST ASSISTANT SERVICES.—The agency
305 may pay for all services provided to a recipient by a registered
306 nurse first assistant as described in s. 464.027. Reimbursement
307 for such services may not be less than 80 percent of the
308 reimbursement that would be paid to a physician providing the
309 same services.
310 (22) STATE HOSPITAL SERVICES.—The agency may pay for all-
311 inclusive psychiatric inpatient hospital care provided to a
312 recipient age 65 or older in a state mental hospital.
313 (23) VISUAL SERVICES.—The agency may pay for visual
314 examinations, eyeglasses, and eyeglass repairs for a recipient
315 if they are prescribed by a licensed physician specializing in
316 diseases of the eye or by a licensed optometrist. Eyeglass
317 frames for adult recipients shall be limited to one pair per
318 recipient every 2 years, except a second pair may be provided
319 during that period after prior authorization. Eyeglass lenses
320 for adult recipients shall be limited to one pair per year
321 except a second pair may be provided during that period after
322 prior authorization.
323 (24) CHILD-WELFARE-TARGETED CASE MANAGEMENT.—The Agency
324 for Health Care Administration, in consultation with the
325 Department of Children and Families, may establish a targeted

326 case-management project in those counties identified by the
327 Department of Children and Families and for all counties with a
328 community-based child welfare project, as authorized under s.
329 409.987 which have been specifically approved by the department.
330 The covered group of individuals who are eligible to receive
331 targeted case management include children who are eligible for
332 Medicaid; who are between the ages of birth through 21; and who
333 are under protective supervision or postplacement supervision,
334 under foster-care supervision, or in shelter care or foster
335 care. The number of individuals who are eligible to receive
336 targeted case management is limited to the number for whom the
337 Department of Children and Families has matching funds to cover
338 the costs. The general revenue funds required to match the funds
339 for services provided by the community-based child welfare
340 projects are limited to funds available for services described
341 under s. 409.990. The Department of Children and Families may
342 transfer the general revenue matching funds as billed by the
343 Agency for Health Care Administration.
344 (25) ASSISTIVE-CARE SERVICES.—The agency may pay for
345 assistive-care services provided to recipients with functional
346 or cognitive impairments residing in assisted living facilities,
347 adult family-care homes, or residential treatment facilities.
348 These services may include health support, assistance with the
349 activities of daily living and the instrumental acts of daily
350 living, assistance with medication administration, and

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

351 arrangements for health care.
352 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM
353 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency is
354 authorized to seek federal approval through a Medicaid waiver or
355 a state plan amendment for the provision of occupational
356 therapy, speech therapy, physical therapy, behavior analysis,
357 and behavior assistant services to individuals who are 5 years
358 of age and under and have a diagnosed developmental disability
359 as defined in s. 393.063, autism spectrum disorder as defined in
360 s. 627.6686, or Down syndrome, a genetic disorder caused by the
361 presence of extra chromosomal material on chromosome 21. Causes
362 of the syndrome may include Trisomy 21, Mosaicism, Robertsonian
363 Translocation, and other duplications of a portion of chromosome
364 21. Coverage for such services shall be limited to $36,000
365 annually and may not exceed $108,000 in total lifetime benefits.
366 The agency shall submit an annual report on January 1 to the
367 President of the Senate, the Speaker of the House of
368 Representatives, and the relevant committees of the Senate and
369 the House of Representatives regarding progress on obtaining
370 federal approval and recommendations for the implementation of
371 these home and community-based services. The agency may not
372 implement this subsection without prior legislative approval.
373 (27) ANESTHESIOLOGIST ASSISTANT SERVICES.—The agency may
374 pay for all services provided to a recipient by an
375 anesthesiologist assistant licensed under s. 458.3475 or s.

376 459.023. Reimbursement for such services must be not less than
377 80 percent of the reimbursement that would be paid to a
378 physician who provided the same services.
379 (28) DONOR HUMAN MILK BANK SERVICES.—The agency may pay
380 for the provision of donor human milk and human milk products
381 derived therefrom for inpatient use, for which a licensed
382 physician, nurse practitioner, physician assistant, or dietitian
383 has issued an order for an infant who is medically or physically
384 unable to receive maternal breast milk or to breastfeed or whose
385 mother is medically or physically unable to produce maternal
386 breast milk or breastfeed. Such infant must have a documented
387 birth weight of 1,800 grams or less; have a congenital or
388 acquired condition and be at high risk for developing a feeding
389 intolerance, necrotizing enterocolitis, or an infection; or
390 otherwise have a medical indication for a human milk diet. The
391 agency shall adopt rules that include, but are not limited to,
392 eligible providers of donor human milk and donor human milk
393 derivates. The agency may seek federal approval necessary to
394 implement this subsection.
395 (29) BIOMARKER TESTING SERVICES.—
396 (a) The agency may pay for biomarker testing for the
397 purposes of diagnosis, treatment, appropriate management, or
398 ongoing monitoring of a recipient's disease or condition to
399 guide treatment decisions if medical and scientific evidence
400 indicates that the biomarker testing provides clinical utility

401 to the recipient. Such medical and scientific evidence includes,
402 but is not limited to:
403 1. A labeled indication for a test approved or cleared by
404 the United States Food and Drug Administration;
405 2. An indicated test for a drug approved by the United
406 States Food and Drug Administration;
407 3. A national coverage determination made by the Centers
408 for Medicare and Medicaid Services or a local coverage
409 determination made by the Medicare Administrative Contractor; or
410 4. A nationally recognized clinical practice guideline. As
411 used in this subparagraph, the term "nationally recognized
412 clinical practice guideline" means an evidence-based clinical
413 practice guideline developed by independent organizations or
414 medical professional societies using a transparent methodology
415 and reporting structure and with a conflict-of-interest policy.
416 Guidelines developed by such organizations or societies
417 establish standards of care informed by a systematic review of
418 evidence and an assessment of the benefits and costs of
419 alternative care options and include recommendations intended to
420 optimize patient care.
421 (b) As used in this subsection, the term:
422 1. "Biomarker" means a defined characteristic that is
423 measured as an indicator of normal biological processes,
424 pathogenic processes, or responses to an exposure or
425 intervention, including therapeutic interventions. The term

426 includes, but is not limited to, molecular, histologic,
427 radiographic, or physiologic characteristics but does not
428 include an assessment of how a patient feels, functions, or
429 survives.
430 2. "Biomarker testing" means an analysis of a patient's
431 tissue, blood, or other biospecimen for the presence of a
432 biomarker. The term includes, but is not limited to, single
433 analyte tests, multiplex panel tests, protein expression, and
434 whole exome, whole genome, and whole transcriptome sequencing
435 performed at a participating in-network laboratory facility that
436 is certified pursuant to the federal Clinical Laboratory
437 Improvement Amendment (CLIA) or that has obtained a CLIA
438 Certificate of Waiver by the United States Food and Drug
439 Administration for the tests.
440 3. "Clinical utility" means the test result provides
441 information that is used in the formulation of a treatment or
442 monitoring strategy that informs a patient's outcome and impacts
443 the clinical decision.
444 (c) A recipient and participating provider shall have
445 access to a clear and convenient process to request
446 authorization for biomarker testing as provided under this
447 subsection. Such process shall be made readily accessible to all
448 recipients and participating providers online.
449 (d) This subsection does not require coverage of biomarker
450 testing for screening purposes.

451 (e) The agency may seek federal approval necessary to
452 implement this subsection.
453 **Section 2. Subsection (5) of section 409.973, Florida**
454 **Statutes, is amended to read:**
455 409.973 Benefits.—
456 (5) ~~PROVISION OF~~ DENTAL SERVICES.—
457 (a) The agency shall implement a statewide Medicaid
458 prepaid dental health program for children and adults with a
459 choice of at least two licensed dental Medicaid providers who
460 meet agency standards.
461 (b) The minimum benefits provided by the Medicaid prepaid
462 dental health programs to recipients under age 21 must include
463 all dental benefits required under the early and periodic
464 screening, diagnostic, and treatment services in accordance with
465 42 U.S.C. s. 1396d(r)(3) and (5).
466 (c) The minimum benefits provided by the Medicaid prepaid
467 dental health program to recipients aged 21 years or older must
468 cover services necessary to prevent disease and promote oral
469 health, restore oral structures to health and function, and
470 treat emergency conditions, including routine diagnostic and
471 preventive care, such as dental cleanings, exams, and X rays;
472 basic dental services, such as fillings and extractions; major
473 dental services, such as root canals, crowns, and dentures and
474 other dental prostheses; emergency dental care; and other
475 necessary services related to dental and oral health.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

476 ~~(a) The Legislature may use the findings of the Office of~~
477 ~~Program Policy Analysis and Government Accountability's report~~
478 ~~no. 16-07, December 2016, in setting the scope of minimum~~
479 ~~benefits set forth in this section for future procurements of~~
480 ~~eligible plans as described in s. 409.966. Specifically, the~~
481 ~~decision to include dental services as a minimum benefit under~~
482 ~~this section, or to provide Medicaid recipients with dental~~
483 ~~benefits separate from the Medicaid managed medical assistance~~
484 ~~program described in this part, may take into consideration the~~
485 ~~data and findings of the report.~~
486 ~~(b) In the event the Legislature takes no action before~~
487 ~~July 1, 2017, with respect to the report findings required under~~
488 ~~paragraph (a), the agency shall implement a statewide Medicaid~~
489 ~~prepaid dental health program for children and adults with a~~
490 ~~choice of at least two licensed dental managed care providers~~
491 ~~who must have substantial experience in providing dental care to~~
492 ~~Medicaid enrollees and children eligible for medical assistance~~
493 ~~under Title XXI of the Social Security Act and who meet all~~
494 ~~agency standards and requirements. To qualify as a provider~~
495 ~~under the prepaid dental health program, the entity must be~~
496 ~~licensed as a prepaid limited health service organization under~~
497 ~~part I of chapter 636 or as a health maintenance organization~~
498 ~~under part I of chapter 641. The contracts for program providers~~
499 ~~shall be awarded through a competitive procurement process.~~
500 ~~Beginning with the contract procurement process initiated during~~

501 ~~the 2023 calendar year, the contracts must be for 6 years and~~
502 ~~may not be renewed; however, the agency may extend the term of a~~
503 ~~plan contract to cover delays during a transition to a new plan~~
504 ~~provider. The agency shall include in the contracts a medical~~
505 ~~loss ratio provision consistent with s. 409.967(4). The agency~~
506 ~~is authorized to seek any necessary state plan amendment or~~
507 ~~federal waiver to commence enrollment in the Medicaid prepaid~~
508 ~~dental health program no later than March 1, 2019. The agency~~
509 ~~shall extend until December 31, 2024, the term of existing plan~~
510 ~~contracts awarded pursuant to the invitation to negotiate~~
511 ~~published in October 2017.~~
512 **Section 3.** This act shall take effect July 1, 2025.