The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Community Affairs

BILL:	CS/SB 340
INTRODUCER:	Community Affairs Committee and Senator Flores and others
SUBJECT:	Prepaid Dental Plans
DATE:	March 19, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.	Stearns	Yeatman	CA	**Fav/CS**
3.			AHS	
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 340 creates a statewide Medicaid prepaid dental health program. The bill provides a statement of legislative findings and intent.

The bill directs the Agency for Health Care Administration (AHCA or agency) to contract with at least two prepaid dental health plans to provide dental services under the Medicaid program to children statewide. The bill directs the agency to seek and implement all necessary federal and state waivers and plan amendments. The bill requires the agency to issue a competitive procurement after the agency has received federal approval for the program. Enrollment in the program shall begin no later than September 1, 2015.

The bill contains provisions requiring gap coverage, notice requirements, submission of encounter data and minimum medical loss ratios. The agency is required to submit a report on the Medicaid prepaid dental health program to the Governor, President of the Senate, and Speaker of the House by January 15 of each year the program is in operation.

The bill amends s. 409.973(1)(3), F.S., to require Medicaid managed care plans to cover only adult dental services.

The bill has an estimated annualized fiscal impact of at least $20 million in lost enhanced adult dental benefits and $138,489 in administrative costs to the AHCA.

II. Present Situation:

Medicaid is a joint federal and state funded program that provides health care for low income Floridians. The program is administered by the AHCA and financed with federal and state funds. Over 3.3 million Floridians are currently enrolled in Medicaid and the program's estimated expenditures for fiscal year 2012-13 were approximately $21 billion.[1] The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Federal law establishes the minimum benefit levels required to receive federal matching funds. Benefit levels can vary by eligibility category. For example, more benefits are required for children than for the adult population. Florida's mandatory and optional benefits are prescribed in statute under ss. 409.905 and 409.906, F.S., respectively. Comprehensive dental benefit coverage is a mandatory Medicaid service only for children in Florida.

Florida Medicaid recipients currently receive their benefits through a number of different delivery systems. Florida has at least 15 different managed care models,[2] including the model being used for the delivery of dental services, licensed, prepaid dental health plans (PDHP). The PDHPs are classified as prepaid ambulatory health plans by 42 CFR Part 438.[3] The PDHPs are paid on a capitated basis for all covered dental services, meaning that the plans receive a single rate per individual member for all dental costs associated with that member. Currently two PDHPs serve more than 1.4 million pediatric Medicaid members.[4, 5]

History of Prepaid Dental Plans

Proviso language in the 2001-2002 General Appropriations Act (GAA) authorized the AHCA to initiate a PDHP pilot program in Miami-Dade County.[6] The 2003 Legislature authorized the AHCA to contract on a prepaid or fixed sum basis for dental services for Medicaid-eligible recipients specifically using PDHPs.[7] Through a competitive bid process, the AHCA executed its first PDHP contract in 2004 to serve children under age 21 in Miami-Dade County.[8]

The Legislature included a proviso in the 2010-11 GAA authorizing the AHCA to contract by competitive procurement with one or more prepaid dental plans on a regional or statewide basis

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[1] Agency for Health Care Administration, *Florida Medicaid*, http://ahca.myflorida.com/Medicaid/index.shtml (last visited March 6, 2014).
[2] Comm. on Health Regulation, Fla. Senate, *Overview of Medicaid Managed Care Programs in Florida,* p.1, (Issue Brief 2011-221) (November 2010).
[3] *See* Agency for Health Care Administration, *Model Statewide Prepaid Dental Health Plan (SPDHP) Contract, Attachment II-Core Contract Provisions*, p. 17, http://ahca.myflorida.com/medicaid/pdhp/docs/120120_Attachment_II_Core.pdf (last visited March 6, 2014).
[4] *See* Agency for Health Care Administration, *Prepaid Dental Health Plans (PDHPs),* http://ahca.myflorida.com/medicaid/pdhp/index.shtml#Home (last visited March 6, 2014).
[5] *See* Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Reports, November 2013*, http://ahca.myflorida.com/mchq/Managed_Health_Care/MHMO/med_data.shtml (last visited March 6, 2014).
[6] *See* Specific Proviso 135A, General Appropriations Act 2001-2002 (Conference Report on CS/SB 2C).
[7] Chapter 2003-405, L.O.F.
[8] Agency for Health Care Administration, *2014 Agency Bill Analysis - HB 27*, p. 2, (Nov. 11, 2013) (on file with the Senate Health Policy Committee).

for a period not to exceed 2 years, in all counties except those participating in Miami-Dade County and Medicaid Reform, under a fee-for-service or managed care delivery system.[9]

In the following year, the Legislature included a proviso in the 2012-13 GAA requiring that, for all counties other than Miami-Dade, the AHCA could not limit Medicaid dental services to prepaid plans and must allow qualified dental providers to provide services on a fee-for-service basis.[10] Similar language was also passed in the 2012-13 appropriations implementing bill, which included additional directives to AHCA to terminate existing contracts, as needed. The 2012-13 implementing bill provisions became obsolete on July 1, 2013.

According to the AHCA website, two vendors were selected for the statewide program and it has been implemented statewide since December 1, 2012.[11] Under the current statewide program, Medicaid recipients may select one of the two PDHPs in their county for dental services. The existing dental plan contracts cover only Medicaid recipients under age 21. Dental care through Medicaid fee-for-service providers ended July 1, 2013.

The current PDHP contracts were procured through a competitive process beginning in 2011, and contracts under that procurement were most recently renewed through September 30, 2014.[12] The Invitation to Negotiate (ITN) for that procurement limited renewal to no more than a three-year period.[13]

Statewide Medicaid Managed Care

In 2011, the Legislature passed HB 7107[14] creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. The SMMC program requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits for the delivery of primary and acute care, including dental services, under the Managed Medical Assistance component (MMA).[15] Instead of being delivered as a separate benefit under a separate contract, dental services are to be incorporated by and be the responsibility of the managed care organization. Medicaid recipients who are enrolled in the MMA program will receive their dental services through fully integrated managed care plans as the program is implemented.[16]

The AHCA released an ITN to competitively procure managed care plans on a statewide basis in December 2012. Plans could supplement the minimum benefits in their bids and offer enhanced

[9] *See* Specific Proviso 204, General Appropriations Act 2010-2011 (Conference Report on HB 5001).
[10] *See* Specific Proviso 186, General Appropriations Act 2012-2013 (Conference Report on HB 5001).
[11] Six counties were excluded from the statewide roll-out. Miami-Dade was excluded because of the prepaid dental program that has been in existence since 2004. Baker, Broward, Clay, Duval and Nassau counties were excluded because the Medicaid Reform Pilot Project has been implemented in those counties, which requires most Medicaid recipients to enroll in managed care plans that provide dental care as a covered service.
[12] Agency for Health Care Administration, *supra* note 8 at 5.
[13] Agency for Health Care Administration, *supra* note 8 at 5.
[14] *See* ch. 2011-134, L.O.F.
[15] Health and Human Services Committee, Fla. House of Representatives, *PCS HHSC 11-01 Staff Analysis*, p.25, (Mar. 25, 2011).
[16] Agency for Health Care Administration *supra* note 8, at 2.

options.[17] Of the 14 general, non-specialty plans selected for contracts, all but one elected to include adult dental benefits as an enhanced benefit.[18]

The AHCA has released a draft MMA implementation schedule by region with the first roll-out scheduled for May 1, 2014, and the final group for August 1, 2014.[19] The enabling legislation required the statewide roll-out to be completed by October 2014. Existing PDHP enrollees will be transitioned to dental coverage through their managed care plan as the enrollee's region is implemented under MMA.

Final approval by the federal government of the 1915(b) Medicaid waiver for the MMA component of the SMMC program was received on June 14, 2013.[20] The AHCA has recently begun the waiver renewal process for the period of July 1, 2014, through June 30, 2017.[21]

III. Effect of Proposed Changes:

Section 1 creates a statewide prepaid dental program for Medicaid recipients. The Legislature finds that the health of children is an overriding concern and the delivery of dental services is considerably different than the delivery of other health care services. The Legislature also finds that it is a paramount interest that continuous and high-quality dental care be provided to Medicaid recipients. Therefore, the bill states that the Legislature intends to establish a Medicaid prepaid dental program that is separate and apart from the Medicaid managed medical assistance program.

The bill directs the agency to implement a statewide prepaid dental program by contracting on a prepaid or fixed-sum basis with at least two appropriately licensed prepaid dental health plans to provide dental services to children statewide.

The bill directs the agency to apply for and implement state plan amendments and waivers of applicable federal laws and regulations necessary to implement the statewide prepaid dental program.

The bill directs the agency to issue a competitive procurement to implement the dental health program after the agency has received the necessary federal approval. All counties are to be included in the competitive procurement. All existing contracts entered into with prepaid dental health plans become null and void upon procurement of the new contracts.

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[17] *See* Correspondence between Agency for Health Care Administration and the Centers for Medicare and Medicaid Services, *Special Terms and Conditions - Customized Benefit Packages,* p.17, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_MMA_STCs_CMS_Approved_06-14-2013.pdf, (last visited March 13, 2014).

[18] *See Correspondence* between Agency for Health Care Administration and Senator Anitere Flores, November 21, 2013 (on file with the Senate Health Policy Committee).

[19] Agency for Health Care Administration, *Implementation Plan - Managed Medical Assistance Program*, p.5, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_1115_MMA_IP_10-30-2013_Final.pdf (last visited March 13, 2014).

[20] *See* Correspondence between Agency for Health Care Administration and the Centers for Medicare and Medicaid Services, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/06-14-2013_Appproval_Letter.pdf (last visited March 13, 2014).

[21] Agency for Health Care Administration, *Managed Medical Assistance - Federal Authorities*, http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA (last visited March 13, 2014).

The bill states that enrollment in the statewide prepaid dental health programs shall not begin until the necessary federal waivers have been received and state plan amendments have been made. However, enrollment is to begin no later than September 1, 2015.

The bill provides that a child who is eligible to receive Medicaid benefits will receive dental care through the Medicaid managed care program until the statewide prepaid dental health program is available.

The bill requires the agency to provide any necessary notice to recipients regarding the transition to the new program before enrollment begins. The agency is authorized to assess any costs related to providing notice to the plans participating in the statewide prepaid dental health programs.

The bill states that the prepaid dental plans will be required by contract to submit encounter data as described in s. 409.967(2)(d), F.S.

The bill directs the agency to require a medical loss ratio of 85 percent for prepaid dental plans participating in the prepaid dental program. Methodology for calculating the ratio is provided.

The agency is required to submit a report by January 15 regarding the statewide prepaid dental program to the Governor, President of the Senate, and Speaker of the House of Representatives.

Section 2 amends s. 409.973,(1)(e), F.S., to require managed care plans to cover only adult dental services as described in s. 409.906(1), F.S., as part of their minimum benefits.

Section 3 states that the bill shall take effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Requiring the AHCA to contract with licensed prepaid dental health plans for Medicaid dental services after October 1, 2014, under this bill could result in a challenge to that law as an unconstitutional impairment of contracts.

Section 409.973, F.S., requires the managed care plans to cover all required benefits which includes dental services. The ITN released for this component of SMMC articulated that managed care plans would be responsible for the full list of minimum benefits, including dental services.[22] The bill's provisions severs the children's dental services from the awarded contracts and directs the AHCA to continue the delivery of these services through separate prepaid dental plans.

The ITN has concluded and 14 standard MMA contracts have been awarded.[23] According to the AHCA, the anticipated contract execution deadline for managed care plans selected under the ITN is January 31, 2014.[24] For 13 of the 14 plans selected, those contracts will include the mandatory benefit of comprehensive dental benefits for children and an expanded dental benefit for adults, a benefit enhancement that was a negotiated item during the ITN.[25] Implementation activities have begun and an implementation plan has been filed for approval, as required, with the federal Centers for Medicare and Medicaid Services (CMS) that includes these provisions.

The United States Constitution and the Florida Constitution prohibit the state from passing any law impairing the obligation of contracts.[26] The courts will subject state actions that impact state-held contracts to an elevated form of scrutiny when the Legislature passes laws that impact such contracts. *Cf. Chiles v. United Faculty of Fla.*, 615 So.2d 671 (Fla. 1993). "[T]he first inquiry must be whether the state law has, in fact, operated as a substantial impairment of a contractual relationship. The severity of the impairment measures the height of the hurdle the state legislation must clear."[27]

The estimated annualized value of the 14 MMA contracts at stake is approximately $70 billion over five years. Extracting just the value of expanded adult dental benefit in those same contracts is estimated at $100 million over the same five-year period.[28] The value of these MMA contracts may be deemed substantial if the AHCA must re-negotiate these contracts or re-procure due to severing pediatric dental benefits from the benefits to be provided.

If a law does impair contracts, the courts will assess whether the law is deemed reasonable and necessary to serve an important public purpose.[29] The court will also consider three factors when balancing the impairment of contracts with the important public purpose:

- Whether the law was enacted to deal with a broad economic or social problem;

[22] Agency for Health Care Administration, ITN 017-12/13, Attachment D, p.87, http://www.myflorida.com/apps/vbs/adoc/F25820_AttachmentD_Region1.pdf (last visited March 13, 2014).
[23] Agency for Health Care Administration, *Florida Medicaid - Managed Medical Assistance*, http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#mmahome (last visited March 13, 2014).
[24] Telephone conversation with Ashley James, Agency for Health Care Administration, December 20, 2013.
[25] Agency for Health Care Administration, *supra* note 18.
[26] U.S. Const. art. I, § 10; art. I, s. 10, Fla. Const.
[27] *Pomponio v. Claridge of Pompano Condominium, Inc.*, 378 So. 2d 774 (Fla. 1980). *See also General Motors Corp. v. Romein*, 503 U.S. 181 (1992).
[28] Agency for Health Care Administration, *supra* note 8 at 4.
[29] *Park Benzinger & Co. v. Southern Wine & Spirits, Inc.*, 391 So. 2d 681 (Fla. 1980); *Yellow Cab C., v. Dade County*, 412 So. 2d 395 (Fla. 3rd DCA 1982). *See also Exxon Corp. v. Eagerton*, 462 U.S. 176 (1983).

- Whether the law operates in an area that was already subject to state regulation at the time the contract was entered into; and,
- Whether the effect on the contractual relationship is temporary; not severe, permanent, immediate, and retroactive.[30]

A law that is deemed to be an impairment of contract will be deemed to be invalid as it applies to any contracts entered into prior to the effective date of the act.

Neither the continued availability nor the full value to taxpayers and enrollees of this expanded adult dental benefit is assured should the MMA contracts be re-negotiated. Adults in the Medicaid program could lose the currently bargained for, and now unavailable adult dental benefits, and the state would lose a valuable customized benefit worth over $20 million annually.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

For the majority of adult Medicaid enrollees, current dental benefits are extremely limited. Under MMA, the AHCA negotiated expanded dental benefits with the managed care organizations. The AHCA estimates the value of these additional benefits at $100 million over five years, at no additional cost to taxpayers.[31] However, if the pediatric enrollees are carved out of the MMA contracts, the AHCA believes that the managed care organizations will lose leverage with the dental providers and existing dental provider networks resulting in the loss of the expanded benefit for the adults.[32] In all likelihood, adult Medicaid enrollees will lose access to expanded dental benefits, dental providers may lose the opportunity for increased patients and revenue, and taxpayers will not have the benefit of a no-cost $100 million negotiated contract term.

The managed care organizations awarded contracts under MMA may incur business costs to re-negotiate rates with the AHCA and with provider networks that must be re-configured due to the loss of pediatric members. Some vendors may elect to discontinue expanded dental benefits if it is no longer cost effective to do so with reduced enrollment.

Because re-procurement is necessary in order to implement the provisions of this bill, the private sector managed care plans will incur the business costs related to participation in re-procurement in addition to the costs of an implementation delay. Private sector managed care plans may also incur business costs for any re-negotiation of rates with their network providers based on delayed implementation.

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[30] *Pomponio v. Cladridge of Pompanio Condo., Inc.*, 378 So. 2d 774 (Fla. 1980).
[31] Agency for Health Care Administration, *supra* note 8 at 4.
[32] Agency for Health Care Administration, *supra* note 8 at 4.

C. Government Sector Impact:

The AHCA has indicated that it is a "logistical impossibility" to implement the bill's provisions prior to MMA implementation, regardless of resources.[33] The impossibility relates to a number of issues, including timing of current SMMC implementation activities, the deadline for requests of federal authority for such actions, the legality of the change in terms, and the programming needed to effectuate the proposed changes.

Secondly, since pediatric dental coverage was a required benefit, all of the contracts include this benefit; therefore, a re-negotiation with all managed care plans will be required to carve this benefit and the associated premium out of their contracts. The CMS will not permit the state to pay twice for the same benefit.

In addition, the AHCA will need to renegotiate rates with those managed care plans that incorporated the expanded adult dental benefit in their rate calculations. It may also become necessary to re-procure statewide without dental benefits. There would be a cost to the AHCA to conduct both of these contract negotiations or a second procurement. While the AHCA has not specifically identified a fiscal impact for an implementation delay, the agency has indicated that a delay results in lost savings to taxpayers for each month that MMA is not implemented.[34]

System change costs to implement the carve-out would also be incurred by the AHCA. The AHCA also requests two additional staff and associated costs for contract monitoring to oversee the PDHP contracts for SFY 2014-15.

Agency for Health Care Administration:

Total Costs for 2 FTEs:	**$131,489**
General Revenue	$65,744.50
Medical Care TF	$65,744.50
Travel Costs for 2 FTEs:	**$7,000**
General Revenue	$3,500
Medical Care TF	$3,500
Total - Agency for Health Care Admin.:	**$138,489**
General Revenue	$69,245
Medical Care TF	$69,245

In addition, as noted above in the Private Sector Impact, the AHCA estimates the value of these additional benefits at $100 million over five years, at no additional cost to taxpayers.[35] However, if the pediatric enrollees are carved out of the current MMA contracts, the AHCA believes that the managed care organizations will lose leverage with

[33] Agency for Health Care Administration, *supra* note 8 at 4.
[34] *See Correspondence* between Agency for Health Care Administration and Senator Anitere Flores, November 21, 2013 (on file with the Senate Health Policy Committee).
[35] Agency for Health Care Administration, *supra* note 8 at 4.

the dental providers and existing dental provider networks resulting in the complete loss of the expanded dental benefit for adults.[36]

The AHCA also loses the anticipated savings from the MMA contracts if implementation is delayed. Based on the projected 5 percent aggregate savings per year contemplated in s. 409.966(3)(d), F.S., and the estimated contract value of $70 billion over five years, the minimum impact for a one year delay is $736 million in lost savings.

An alternative valuation of this benefit by an actuary retained by the Florida Association of Health Plans has estimated the value of the expanded adult dental benefit at full program implementation at $5,765,125 per month or an annualized value of over $69 million.[37] The valuation was based on responses by five of the 13 plans currently participating in Medicaid and awarded contracts under the MMA program component. These plans represent over 58 percent of the November 2013 managed care enrollment.[38]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The AHCA's analysis of the companion House legislation identifies several areas of concern for the implementation of the proposed bill. Carving out the children's dental services component from the MMA program could result in the loss of the expanded dental benefit for adults valued at over $100 million over the life of the five-year contract.[39] Without the inclusion of the pediatric dental benefit, the agency opines that the adult dental network may no longer be cost effective for the managed care plans jeopardizing the benefit for adult enrollees and undermining the overall dental networks.[40]Adult dental benefits that are not currently covered were negotiated and incorporated as an expanded benefit in the majority of the managed care contracts as part of the recently concluded ITN.[41] A separate analysis of the adult dental benefit by the Florida Association of Health Plans placed the value at over $69 million annually, assuming full implementation.[42]

Carving out the pediatric dental benefit will impact the negotiated rates under MMA because the capitated rate covers all services, including the dental. The CMS will not allow double payment for dental services. With the possibility of invalid rates, the AHCA raises the question of whether or not the agency could engage in rate re-negotiation with the existing winning managed care organizations or if a complete re-procurement must be conducted.[43]

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[36] Agency for Health Care Administration, *supra* note 8 at 4.
[37] Wakely Consulting Group, *Valuation of Medicaid Managed Medical Assistance Expanded Adult Dental Benefit,* p. 1, December 10, 2013 (on file with the Senate Health Policy Committee).
[38] Wakely Consulting Group, *supra* note 36 at 1.
[39] Agency for Health Care Administration, *supra* note 8 at 4.
[40] Agency for Health Care Administration, *supra* note 8 at 4.
[41] Agency for Health Care Administration, *supra* note 8 at 3.
[42] Wakely Consulting Group, *supra* note 36 at 1.
[43] Agency for Health Care Administration, *supra* note 8 at 4.

The AHCA's preliminary legal analysis pertaining to re-negotiated rates or re-procurement concern scoring during the bid process since consideration was given for the inclusion of the mandatory pediatric dental benefit as well as the expanded adult benefit. Non-winning vendors who had not included comparable dental benefits might challenge the change in terms and argue a different approach would have been taken if they had known that dental would be carved out later.[44] Similarly, some vendors that chose not to compete due to an inadequate dental network might challenge a re-negotiation. A total re-procurement for the MMA component, seen by the AHCA as the cleanest route, could delay the implementation by more than a year.[45]

The agency states that it cannot logistically carve dental services out prior to implementation.[46] The agency cites the proposed, staggered roll-out schedule for SMMC, the statutory implementation completion date of October 1, 2014, the timeline for choice counseling by mid-February for the first region, and the time needed to re-program enrollment and data systems.[47] Implementation of the carve-out is identified to be a "logistical impossibility" prior to roll-out, regardless of the amount of additional resources.[48]

Carving out this benefit from the MMA program could also set a precedent for other services that have been integrated in the managed medical assistance contracts with the managed care organizations, such as behavioral health care, transportation and pharmacy. If one service is successful in achieving a carve-out, this action could be seen as a slippery slope for other benefits seeking the same consideration.

The AHCA also indicates that federal approval would be required before implementation of the dental carve-out.[49] The current waiver that includes prepaid dental plans expires January 31, 2014, and the existing 1915(b) waiver incorporates dental services into the managed care contracts.[50] There are deadlines for seeking waivers and the deadline for seeking renewal of this particular waiver has passed as the AHCA anticipated the inclusion of these benefits under the managed care contracts.[51] The agency would need to seek a new 1915(b) waiver, or request an amendment to the 1115 waiver that carves dental services out.[52] Under either scenario, the AHCA indicates that there would not be sufficient time to receive approval prior to the rollout of the SMMC.[53]

The bill contains a potential conflict between the conditions precedent to the beginning of enrollment in the program and a deadline beyond which enrollment must begin. In s. 409.91205(2)(c), F.S., (created by the bill), the Legislature declares that enrollment shall not begin before the necessary state plan amendments or waivers of applicable federal laws and regulations are obtained and implemented. The bill then states that enrollment in the program shall begin no later than September 1, 2015. It is unclear how enrollment into the program will

[44] Agency for Health Care Administration, *supra* note 8 at 3-4.
[45] Agency for Health Care Administration, *supra* note 8 at 4.
[46] Agency for Health Care Administration, *supra* note 8 at 4.
[47] Agency for Health Care Administration, *supra* note 8 at 4.
[48] Agency for Health Care Administration, *supra* note 8, at 4.
[49] Agency for Health Care Administration, *supra* note 8 at 4.
[50] Agency for Health Care Administration, *supra* note 8 at 4.
[51] Agency for Health Care Administration, *supra* note 8 at 4.
[52] Agency for Health Care Administration, *supra* note 8 at 4.
[53] Agency for Health Care Administration, *supra* note 8 at 4.

begin if the necessary federal waivers are not obtained or state plan amendments are not completed by September 1, 2015.

VIII. Statutes Affected:

This bill creates section 409.91205 of the Florida Statutes.

IX. Additional Information:

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

CS by Community Affairs on March 19, 2014:

- Directs the agency to implement a statewide prepaid dental program by contracting on a prepaid or fixed-sum basis with at least two appropriately licensed prepaid dental health plans to provide dental services to children statewide.
- Directs the agency to apply for and implement state plan amendments and waivers of applicable federal laws and regulations necessary to implement the statewide prepaid dental program.
- Directs the agency to issue a competitive procurement to implement the dental health program after the agency has received the necessary federal approval. All counties are to be included in the competitive procurement. All existing contracts entered into with prepaid dental health plans become null and void upon procurement of the new contracts.
- States that enrollment in the statewide prepaid dental health programs shall not begin until necessary federal waivers have been received and state plan amendments have been made. However, enrollment is to begin no later than September 1, 2015.
- Provides that a child who is eligible to receive Medicaid benefits will receive dental care through the Medicaid managed care program until the statewide prepaid dental health program is available.
- Requires the agency to provide any necessary notice to recipients regarding the transition to the new program before enrollment begins. Authorizes the agency to assess any costs related to providing notice to the plans participating in the statewide prepaid dental health programs.
- States that the prepaid dental plans will be required by contract to submit encounter data as described in s. 409.967(2)(d), F.S.
- Directs the agency to require a medical loss ratio of 85 percent for prepaid dental plans participating in the prepaid dental program. Provides methodology for calculating the ratio.
- Requires the agency to submit a report by January 15 regarding the statewide prepaid dental program to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

B. Amendments:

None.