Health Innovation Subcommittee

Wednesday, January 13, 2016
1:00 PM – 3:00 PM
306 HOB

Steve Crisafulli
Speaker

Kenneth Roberson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Wednesday, January 13, 2016 01:00 pm
End Date and Time:	Wednesday, January 13, 2016 03:00 pm
Location:	306 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 89 Florida Kidcare Program by Diaz, J., Santiago
HB 363 Health Insurance For Opioids by Nuñez
HB 421 Reimbursement of Medicaid Providers by Trumbull
HB 471 Responsibilities of Health Care Providers by Burton
HB 819 Sunset Review of Medicaid Dental Services by Diaz, J.

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Tuesday, January 12, 2016.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, January 12, 2016.

NOTICE FINALIZED on 01/11/2016 10:24AM by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 89 Florida Kidcare Program
SPONSOR(S): Diaz
TIED BILLS: **IDEN./SIM. BILLS:** SB 248

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Poche
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Florida Kidcare Program (Kidcare) was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997, later known more simply as the Children's Health Insurance Program (CHIP). CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for Kidcare is found in part II of ch. 409, F.S.

Kidcare consists of Medicaid, MediKids, the Children's Medical Services Network, and Florida Healthy Kids. Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act. Families also contribute to the cost of the coverage under the Title XXI-funded components of Kidcare based on their household size, income, and other eligibility factors. For families with incomes above the income limits for premium assistance or who do not otherwise qualify for assistance, Kidcare also offers an option under the Healthy Kids component and the Medikids component for the family to obtain coverage for their children by paying the full premium.

Federal law restricted the eligibility of documented immigrants, including children and pregnant women, for social service benefits and programs such as Medicaid and CHIP. Documented immigrants were ineligible to apply for and received these benefits for 5 years, beginning with the date of their arrival in the United States. In 2009, the Children's Health Insurance Program Reauthorization Act permitted states to remove the 5 year waiting period and allow certain children immediate eligibility for Medicaid and CHIP coverage.

HB 89 removes the 5-year waiting period for lawfully present children in Florida, which makes those children immediately eligible for health care coverage through Kidcare and for payment of optional medical assistance and related services under Medicaid. The bill clearly states that eligibility is not being extended to undocumented immigrants.

The bill has a significant fiscal impact of $32,350,065, of which $1,336,538 is General Revenue. However, the fiscal impact on General Revenue may be reduced or eliminated by a reduction in expenditures on Emergency Medical Assistance for Noncitizens for children who are eligible for health care coverage through Kidcare. See fiscal comments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Kidcare Program

The Florida Kidcare Program (Kidcare or Program) was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997, later known more simply as the Children's Health Insurance Program (CHIP). The federal authority for the CHIP is located in Title XXI of the Social Security Act. Initially authorized for 10 years and then recently re-authorized through 2019, with federal funding through 2015 by the Patient Protection and Affordable Care Act[1] and additional funding through 2017 by the Medicare Access and CHIP Reauthorization Act,[2] the CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for the Program is found in part II of ch. 409, F.S.

Kidcare encompasses four programs:

- Medicaid for children;
- The Medikids program;
- The Children's Medical Services Network; and
- The Florida Healthy Kids program.

Kidcare coverage is funded by state and federal funds through Title XIX (Medicaid) and Title XXI (CHIP) of the federal Social Security Act. Families also contribute to the cost of the coverage under the Title XXI-funded components of Kidcare based on their household size, income, and other eligibility factors. For families with incomes above the income limits for premium assistance or who do not otherwise qualify for assistance, Kidcare also offers an option under the Healthy Kids component and the Medikids component for the family to obtain coverage for their children by paying the full premium. Eligibility for the Program components that are funded by Title XXI is determined in part by age and household income as follows:

- Medicaid for Children: Title XXI funding is available from birth until age 1 for family incomes between 185 percent and 200 percent of the Federal Poverty Level (FPL).
- Medikids: Title XXI funding is available from age 1 until age 5 for family incomes between 133 percent and 200 percent of the FPL.
- Healthy Kids: Title XXI funding is available from age 5 until age 6 for family incomes between 133 percent and 200 percent of the FPL. For age 6 until age 19, Title XXI funding is available for family incomes between 100 percent and 200 percent of the FPL.
- Children's Medical Services Network: Title XXI and Title XIX funds are available from birth until age 19 for family incomes up to 200 percent of the FPL for children with special health care needs. The Department of Health assesses whether children meet the program's clinical requirements.

Kidcare is administered jointly by the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the Department of Health (DOH), and the Florida Healthy Kids Corporation (FHKC). Each entity has specific duties and responsibilities under Kidcare as detailed in part II of ch. 409, F.S. The DCF determines eligibility for Medicaid, and the FHKC processes all Kidcare

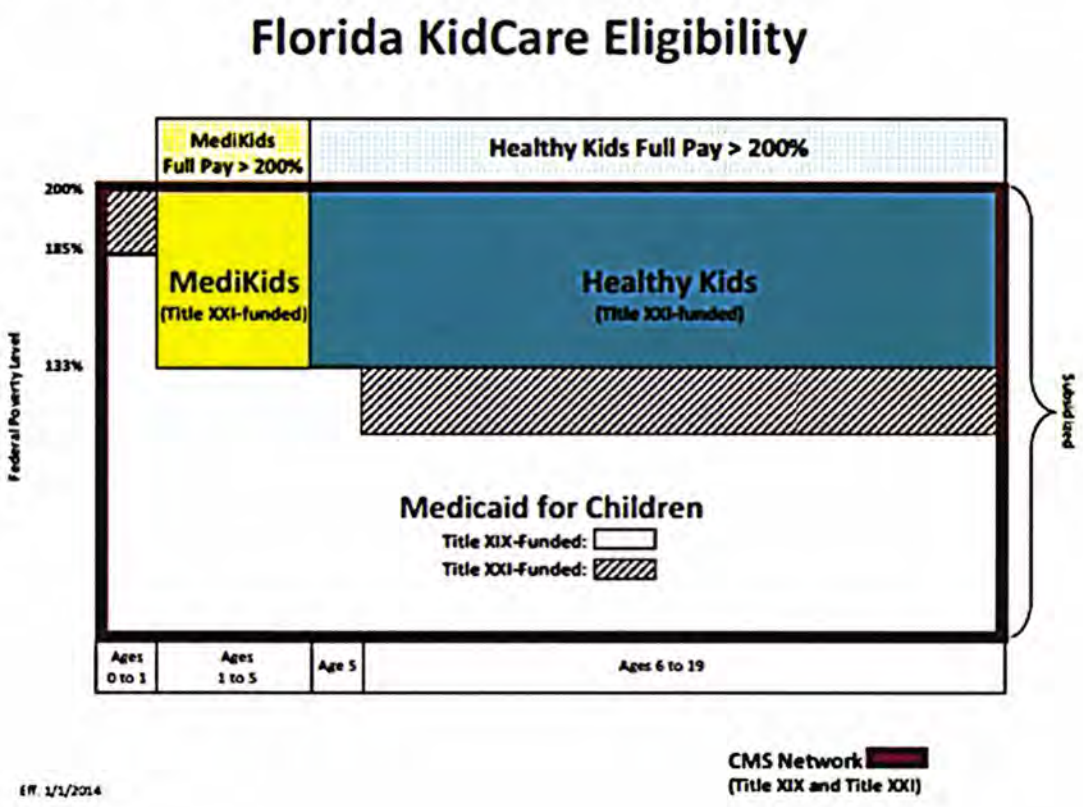
[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, s. 10203.
[2] Pub. L. No. 114-10, s. 301.

applications and determines eligibility for the CHIP, which includes a Medicaid screening and referral process to the DCF, as appropriate.

To enroll in Kidcare, families utilize a form that is both a Medicaid and CHIP application. Families may apply using the paper application or an online application. Both formats are available in English, Spanish, and Creole. Income eligibility is determined through electronic data matches with available databases or, in cases where income cannot be verified electronically, through submission of current pay stubs, tax returns, or W-2 forms. Children are then determined to be eligible for the appropriate Program component based on the applicable income standards or they are determined to be ineligible for the Program based on applicable income standards.

Currently, FHKC receives all KidCare applications and screens for Medicaid eligibility. Families can apply for Medicaid for children or the Title XXI programs using the KidCare application. Families may also apply for Medicaid using the DCF form, Request for Assistance. The DCF Request for Assistance form cannot be used to apply for the Title XXI programs. Families can apply for both programs online. KidCare applications for children potentially eligible for Medicaid are electronically sent to the DCF for a complete Medicaid eligibility determination. If the child is not eligible for Medicaid, FHKC is notified to continue the Title XXI eligibility determination. FHKC determines eligibility for all of the Title XXI programs.

The following chart summarizes eligibility and funding for Kidcare.[3]



[3] Florida KidCare Coordinating Council, *2014 Annual Report and Recommendations*, page 4, available at http://www.floridakidcare.org/council/wp-content/uploads/2014/08/2014_Annual_Report.pdf (last viewed on January 11, 2016).

The 2015-2016 General Appropriations Act appropriated $417,791,567 for the Title XXI (CHIP) Program.[4] As of December 2015, a total of 2,377,312 children are enrolled in Kidcare.[5] The following chart details the enrollment totals for each component of Kidcare:[6]

PROGRAM	ENROLLMENT
Medicaid- Title XIX	2,061,412
Healthy Kids- Title XXI	155,242
CMS Network- Title XXI	9,877
MediKids- Title XXI	27,690
(full pay enrollees)	(5,777)
Funded Medicaid[7]	123,091
TOTAL	**2,377,312**

The Social Services Estimating Conference met on December 8, 2015, to adopt a caseload and expenditure forecast for the Program through fiscal year 2019-20. Caseload projections under the new forecast for fiscal year 2015-16 for Healthy Kids are slightly higher than the caseload for fiscal year 2014-15, with an approximate 5 percent increase in enrollees. As of the date of this analysis, the expenditure forecast from the December SSEC is not yet available.

Eligibility of Alien Children for Medicaid and CHIP

The Immigration and Nationality Act (INA)[8] was created in 1952 to consolidate statutes governing immigration law. The INA defines the term "alien" as "any person not a citizen or national of the United States."[9] Generally, under the INA, an alien is not eligible for any State or local public benefit, including health benefits, unless the alien is:

- A qualified alien,
- A nonimmigrant alien under the INA, or
- An alien who is paroled into the United States under the INA.[10]

The INA permits a state to provide an alien, who is not lawfully present in the United States, eligibility for any state or local public benefit for which the alien would otherwise be ineligible, but only through the enactment of a state law which affirmatively provides for such eligibility.[11]

The enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("Reconciliation Act)[12] placed limitations on federal funding for health coverage of immigrant families. The law imposed a 5-year waiting period on certain groups of qualified aliens, including most children and pregnant women who were otherwise eligible for Medicaid.[13] Medicaid coverage for individuals subject to the 5-year waiting period and for those who do not meet the definition of qualified alien was

[4] Email correspondence from Health Care Appropriations Subcommittee staff, January 7, 2016 (on file with Health Innovation subcommittee staff).
[5] Agency for Health Care Administration, *Florida KidCare Enrollment Report-December 2015* (on file with Health Innovation subcommittee staff).
[6] MediKids and Medicaid enrollment numbers reflect retrospective data as reported by the Agency for Health Care Administration, Program Analysis. Healthy Kids enrollment is reported by Florida Healthy Kids Corporation and CMS Network enrollment is reported by the Department of Health.
[7] Includes new eligibles and Medicaid children who would have previously been referred to CHIP due to income between 112 percent and 133 percent FPL.
[8] Pub. L. No. 82-414
[9] Id. at s. 101(3)
[10] 8 U.S.C. §1621(a)(1)-(3)
[11] 8 U.S.C. §1621(d)
[12] Pub. L. No. 104-193
[13] Id. at s. 403(a)

limited to treatment of an emergency medical condition. The 5-year waiting period also applies to children and pregnant women under the CHIP.

Children's Health Insurance Program Reauthorization Act of 2009

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)[14] permits states to cover certain children and pregnant women who are "lawfully residing in the United States" in both Medicaid and the CHIP, notwithstanding certain provisions in the Reconciliation Act. States may elect to cover these groups under Medicaid only or under both Medicaid and the CHIP. The law does not permit states to cover these new groups only in the CHIP, without also extending the option to Medicaid.

On July 1, 2010, the Centers for Medicare and Medicaid Services sent a letter to state health officials regarding Medicaid and CHIP coverage for lawfully residing children and pregnant women. The letter states that children and pregnant women who fall into one of the following categories will be considered lawfully present. These individuals are eligible for Medicaid and CHIP coverage, if the state elects the new option under CHIPRA, and the child or pregnant woman meets the state residency requirements and other Medicaid or CHIP eligibility requirements.

- A qualified alien as defined in section 431 of Reconciliation Act (8 U.S.C. §1641).
- An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission.
- An alien who has been paroled into the U.S. pursuant to section 212(d)(5) of the INA (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings.
- An alien who belongs to one of the following classes:
    - Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
    - Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
    - Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
    - Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
    - Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
    - Aliens currently in deferred action status; or
    - Aliens whose visa petition has been approved and who have a pending application for adjustment of status.
- A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. §1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. §1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days.
- An alien who has been granted withholding of removal under the Convention Against Torture.
- A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J)).
- An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. §1806(e).
- An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

[14] Pub. L. No. 111-3

Effect of Proposed Changes

The bill adds the definition of "lawfully residing child" to the Florida Kidcare Act.[15] To meet the definition, a child must be lawfully present in the United States and meet state residency requirements for CHIP or Medicaid, and may be eligible for assistance under CHIPRA.

The bill makes a lawfully residing child immediately eligible for health benefits coverage under Kidcare, and eligible for payment of optional Medicaid assistance and related services, thereby removing the 5-year waiting period imposed under the Reconciliation Act and exercising the state's option to do so as provided under CHIPRA.

The bill clearly states that Kidcare eligibility is not being extended to an undocumented immigrant by the changes to s. 409.814, F.S. The bill also clearly states that Kidcare eligibility for optional Medicaid payments or other services is not being extended to an undocumented immigrant through the changes to s. 409.904, F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.811, F.S., relating to definitions relating to Florida Kidcare Act.
Section 2: Amends s. 409.814, F.S., relating to eligibility.
Section 3: Amends s. 409.904, F.S., relating to optional payments for eligible persons.
Section 4: Amends s. 624.91, F.S., relating to the Florida Health Kids Corporation Act.
Section 5: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   THIS NEEDS UPDATING FROM AHCA ANALYSIS

   The Agency for Health Care Administration provides the following fiscal impact analysis of the bill on both CHIP and Medicaid programs (emphasis added):[16]

   Title XXI (CHIP)

   As federal funds are available for these expenditures, the state would incur its share of this additional cost. For SFY 2016-17, the state will pay 3.90% of the qualified expenditures and the federal government under Title XXI covers the remaining 96.10%. This analysis assumes that funding will continue for the Title XXI KidCare eligible children. **2,077** additional children will be covered a month for the first 12 months and this number will be recurring.

   Total Additional Costs $4,672,735

[15] SS. 409.810, F.S., through 409.821, F.S.
[16] Agency for Health Care Administration, *2016 Agency Legislative Bill Analysis- HB 89*, December 4, 2015, pg. 6 (on file with Health Innovation subcommittee staff).

Less: Federal Funds under Title XXI (89.70%)	$4,191,532
Less: Grants & Donation Trust Fund (6.39%)	$298,811
State Funds required (3.90%) General Revenue	**$182,393**

Funds from the Grants and Donation Trust Fund, derived from family payment of premiums, are applied to reduce state and federal share.

Medicaid Services funded by Title XXI funds

This analysis assumes that Medicaid services provided would be funded by Title XXI FMAP per section 214 of the federal CHIPRA legislation. **15,097** additional children will be covered a month for the first 12 months and this number will be recurring.

Total Additional Cost with no Family Premiums	$27,677,330
Less: Federal Funds under Title XIX (71.37%)	$26,523,185
Less: Grants & Donation Trust Fund	$0
State Funds required (28.63%) General Revenue	**$1,154,145**

Potential Medicaid EMA cost offset

Total Additional Cost with no Family Premiums	($3,398,263)
Less: Federal Funds under Title XIX (60.67%)	($2,061,726)
Less: Grants & Donations Trust Fund	$0
State Funds required (39.33%) General Revenue	($1,336,537)

The total fiscal impact on the Agency for both CHIP and Medicaid funded under Title XIX and XXI in SFY 2016-17 for the provisions in this bill, including the potential Medicaid EMA cost offset, will be $28,951,802 with $0.00 being the General Revenue impact.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care providers may see an increase in patients who receive health insurance coverage through the Program sooner than under current law. Children who are lawfully present in the state will be eligibility for health insurance coverage, potentially increasing the frequency of access to medical care.

D. FISCAL COMMENTS:

The fiscal impact from increased enrollment in the Title XIX and Title XXI program could be offset by a reduction in expenditures under the Emergency Medical Assistance for Noncitizens (EMA) program.[17] Medicaid may already be paying for emergency services for part of the population of children who will be newly eligible for coverage under the bill.

During fiscal year 2014-15, a total of 3,192 children received EMA coverage, totaling $7,970,967 in expenditures.[18] In its' analysis, AHCA assumed that 50 percent of these EMA expenditures were for children who were in the 5-year waiting period and would have qualified for and enrolled in CHIP or Medicaid coverage under the provisions of the bill. Using this assumption, the net fiscal impact of the bill would be a $230,953 reduction in General Revenue expenditures. Alternatively, if it is assumed that 25 percent of these expenditures were for children who were in the waiting period, the net fiscal impact of the bill would be a $552,792 increase in General Revenue expenditures.

AHCA's fiscal analysis included in Section II(A.)2., above, assumes 42.63% of the EMA expenditures from fiscal year 2014-15 were for children who were in the waiting period and would have qualified for and enrolled in CHIP or Medicaid coverage. In that case, the net fiscal impact of the bill would be a $0.00 impact in General Revenue expenditures.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The DOH, the DCF, and the AHCA have appropriate rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

AHCA will need to submit to the federal Centers for Medicare and Medicaid Services (CMS) an amendment to the Medicaid and CHIP State Plans for approval to implement the changes proposed in the bill. It is unknown how long it will take CMS to approve the amendments, which may delay implementation of the changes made by the bill.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[17] Noncitizens, who are Medicaid eligible except for citizenship, may be eligible for Medicaid to cover a serious medical emergency. If so, Medicaid will cover necessary treatment until the medical emergency has abated. Before Medicaid may be authorized, applicants must provide proof from a medical professional stating the treatment was due to an emergency condition. The proof also must include the date or dates of the emergency.

[18] Supra, FN 16 at page 4.

A bill to be entitled

An act relating to the Florida Kidcare program; amending s. 409.811, F.S.; defining the term "lawfully residing child"; deleting the definition of the term "qualified alien"; conforming provisions to changes made by the act; amending s. 409.814, F.S.; revising eligibility for the program to conform to changes made by the act; clarifying that undocumented immigrants are excluded from eligibility; amending s. 409.904, F.S.; providing eligibility for optional payments for medical assistance and related services for certain lawfully residing children; clarifying that undocumented immigrants are excluded from eligibility for optional Medicaid payments or related services; amending s. 624.91, F.S.; conforming provisions to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsections (17) through (22) of section 409.811, Florida Statutes, are renumbered as subsections (18) through (23), respectively, a new subsection (17) is added to that section, and present subsections (23) and (24) of that section are amended, to read:

409.811 Definitions relating to Florida Kidcare Act.—As used in ss. 409.810-409.821, the term:

(17) "Lawfully residing child" means a child who is lawfully present in the United States, meets Medicaid or Children's Health Insurance Program (CHIP) residency requirements, and may be eligible for medical assistance with federal financial participation as provided under s. 214 of the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, and related federal regulations.

~~(23) "Qualified alien" means an alien as defined in s. 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, Pub. L. No. 104-193.~~

(24) "Resident" means a United States citizen~~,~~ or lawfully residing child ~~qualified alien,~~ who is domiciled in this state.

Section 2. Paragraph (c) of subsection (4) of section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component.

(4) The following children are not eligible to receive Title XXI-funded premium assistance for health benefits coverage under the Florida Kidcare program, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(c) A child who is an alien~~,~~ but who does not meet the definition of a lawfully residing child ~~qualified alien, in the United States~~. This paragraph does not extend eligibility for the Florida Kidcare program to an undocumented immigrant.

Section 3. Subsections (8) and (9) of section 409.904, Florida Statutes, are renumbered as subsections (9) and (10), respectively, and a new subsection (8) is added to that section to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(8) A child who has not attained the age of 19 who, notwithstanding s. 414.095(3), would be eligible for Medicaid under s. 409.903, except that the child is a lawfully residing child as defined in s. 409.811. This subsection does not extend eligibility for optional Medicaid payments or related services to an undocumented immigrant.

Section 4. Paragraph (b) of subsection (3) of section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.—

(3) ELIGIBILITY FOR STATE-FUNDED ASSISTANCE.—Only the

following individuals are eligible for state-funded assistance in paying Florida Healthy Kids premiums:

(b) Notwithstanding s. 409.814, a legal alien ~~aliens~~ who is ~~are~~ enrolled in the Florida Healthy Kids program as of January 31, 2004, who does ~~do~~ not qualify for Title XXI federal funds because he or she is ~~they are~~ not a lawfully residing child ~~qualified aliens~~ as defined in s. 409.811.

Section 5. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 363 Health Insurance Coverage For Opioids
SPONSOR(S): Nuñez
TIED BILLS: **IDEN./SIM. BILLS:** SB 422

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		McElroy	Poche
2) Insurance & Banking Subcommittee			
3) Appropriations Committee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

Deaths from drug overdose have steadily increased over the past few decades and are the leading cause of accidental deaths in the United States. Every day in the United States,120 people die as a result of drug overdose, and another 6,748 are treated in emergency departments for the misuse or abuse of drugs. The vast majority of these deaths and emergency department visits involve an overdose related to opioid analgesics drug products (opioids), which are narcotic pain relievers derived from the opium poppy, or its synthetic analogues.

Opioids can be abused in numerous ways including being swallowed, snorted, smoked, or injected. These delivery methods create a more rapid onset of the effects of the opioid than intended by the manufacturer and a greater euphoria. Abuse-deterrent opioids are formulated to deter abuse by making product alteration more difficult (crush resistant) or by making the altered product less attractive or rewarding (crushing renders the drug essentially ineffective).

HB 363 allows a health insurance policy which provides coverage for opioids to impose a prior authorization requirement for an abuse-deterrent opioid only if the policy requires prior authorization for opioids without an abuse-deterrence labeling claim. The bill also prohibits a policy from requiring the use of an opioid without an abuse-deterrent labeling claim before providing coverage for an abuse-deterrent opioid.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of January 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Opioids

The drug overdose death rate has more than doubled from 1999 through 2013 and has now become the leading cause of accidental deaths in the United States.[1] In 2013, there were 43,982 drug overdose deaths in the United States, of which 22,767, or 51.8 percent, were related to pharmaceuticals.[2] The majority of the pharmaceutical related deaths, 16,235, or 71.3 percent, involved opioid analgesic drug products (opioids).[3]

Opioids also play a prominent role in drug overdose deaths in Florida. In 2014, there were 8,587 drug-related deaths in the state.[4] Opioids were listed as the cause of death in 2,922 cases and were present in an additional 3,098 cases.[5] The four most harmful drugs, found in more than 50 percent of the deaths in which these drugs were present, were all opioids.[6]

Opioids are psychoactive substances derived from the opium poppy or their synthetic analogues.[7] They are commonly used as pain relievers to treat acute and chronic pain. An individual experiences pain as a result of a series of electrical and chemical exchanges among his or her peripheral nerves, spinal cord and brain.[8] Opioid receptors occur naturally and are distributed widely throughout the central nervous system and in peripheral sensory and autonomic nerves.[9] When an individual experiences pain the body releases hormones, such as endorphins, which bind with targeted opioid receptors.[10] This disrupts the transmission of pain signals through the central nervous system and reduces the perception of pain.[11] Opioids function in the same way by binding to specific opioid receptors in the brain, spinal cord and gastrointestinal tract, thereby reducing the perception of pain.[12] Opioids include:[13]

- Buprenorphine (Subutex, Suboxone)
- Codeine
- Fentanyl (Duragesic, Fentora)
- Heroin
- Hydrocodone (Vicodin, Lortab, Norco)

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[1] More deaths occur each year due to drug overdose than deaths caused by motor vehicle crashes. *Prescription Drug Overdose Data*, Centers for Disease Control and Prevention. http://www.cdc.gov/drugoverdose/data/overdose.html (last viewed January 4, 2016).
[2] *Prescription Drug Overdose Data*, Centers for Disease Control and Prevention. http://www.cdc.gov/drugoverdose/data/overdose.html (last viewed January 4, 2016).
[3] Id.
[4] *Drugs Identified in Deceased Persons by Florida Medical Examiners 2014 Annual Report*, Florida Department of Law Enforcement, September 2015. https://www.fdle.state.fl.us/Content/Medical-Examiners-Commission/Drugs-in-Deceased-Persons-Reports.aspx (last viewed January 4, 2016).
[5] Id. A decedent may have more than one drug listed as the cause of death.
[6] Id. Heroin (91.3%), Fentanyl (73.8%), Methadone (63.2%), Morphine (59.1%).
[7] *Information Sheet on Opioid Overdose*, World Health Organization, November 2014. http://www.who.int/substance_abuse/information-sheet/en/ (last viewed January 4, 2016).
[8] Mayo Clinic Health Library, http://www.riversideonline.com/health_reference/Nervous-System/PN00017.cfm (last viewed January 4, 2016).
[9] *Imaging of Opioid Receptors in the Central Nervous System*, Gjermund Henriksen, Frode Willoch; Brain (2008) 131 (5): 1171-1196.
[10] Id.
[11] Id.
[12] *SAMHSA Opioid Overdose Toolkit: Facts for Community Members*, Department of Health and Human Services- Substance Abuse and Mental Health Services Administration. http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742 (last viewed January 4, 2016).
[13] *Supra* at footnote 4.

- Hydromorphone (Dilaudid, Exalgo)
- Meperidine
- Methadone
- Morphine
- Oxycodone (OxyContin, Percodan, Percocet)
- Oxymorphone
- Tramadol

Opioid formulations are classified as either short-acting opioids (SAOs) or long-acting opioids (LAOs), which relate to the onset and duration of the effects of the drug in the body. SAOs are typically prescribed for transient pain types, such as acute, breakthrough or chronic intermittent pain and include immediate release (IR) formulation of various opioids.[14] The effects of an IR opioid begin shortly after ingestion and generally lasts between three to four hours. LAOs are typically prescribed for chronic pain and are designed to gradually release the drug in the blood stream and include the extended release (ER) formulation of various opioids.[15] The effects of an ER opioid generally last between eight to twelve hours with some formulations of LAOs having effect for up to seventy-two hours.[16]

Opioid Abuse and Misuse

The abuse and misuse of opioids is a serious and growing public health concern. In the United States:

- Approximately 4.5 million individuals use prescription pain medications for nonmedical purposes.[17]
- In 2011, approximately 1.4 million emergency departments (ED) visits involved nonmedical use of pharmaceuticals.[18]
- Every day 114 people die as a result of drug overdose, and approximately 6,748 are treated in ED for the misuse or abuse of drugs.[19]
- Nearly 9 out of 10 poisoning deaths are caused by drugs.[20]
- Prescription opioid abuse costs were about $55.7 billion in 2007.[21]

Opioids can be abused and misused in a variety of ways. For example, an abuser may swallow a greater quantity of the unaltered drug than what is prescribed. This typically occurs with ER opioids. Also, abusers may crush ER opioids and ingest the drug in a number of ways, including:[22]

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[14] *A Comparison of Long and Short-Acting Opioids for the Treatment of Chronic Noncancer Pain: Tailoring Therapy to Meet the Patient Need*, Charles E. Argoff and Daniel I. Silverstein, Mayo Clin Proc. Jul; 84(7): 602-621. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704132/ (last viewed January 4, 2016).

[15] Id.

[16] Id.

[17] *The NSDUH Report: Substance and Use and Mental Health Estimates from the 2013 National Survey on Drug Use and health: Overview of Findings*, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, September 4, 2014. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fstore.samhsa.gov%2Fshin%2Fcontent%2FNSDUH14-0904%2FNSDUH14-0904.pdf&ei=WwQDVY2ZMsuXNobrgNAH&usg=AFQjCNEFZtjCu4cxzFBucykETY7MMsY2Fg (last viewed January 4, 2016).

[18] *Prescription Drug Overdose in the United States: Factsheet*, Centers for Disease Control. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&ved=0CDYQFjAGahUKEwjWueOGz_fIAhVImx4KHdz1CtY&url=http%3A%2F%2Fwww.mayorsinnovation.org%2Fimages%2Fuploads%2Fpdf%2F1_-_Prescription_Drug_Overdose_in_the_United_States.pdf&usg=AFQjCNG4txIr2GiqmkMxlcpalgqZ6MguNA (last viewed January 4, 2016).

[19] Id.

[20] Id.

[21] Id. Of this amount, 46% was attributable to workplace costs (e.g., lost productivity), 45% to healthcare costs (e.g., abuse treatment), and 9% to criminal justice costs.

[22] *Draft Guidance for Industry: Abuse-Deterrent Opioids-Evaluation and Labeling*, U.S. Food and Drug Administration, April 2015. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fwww.fda.gov%2Fdownloads%2Fdrugs%2Fguidancecomplianceregulatoryinformation%2Fguidances%2Fucm334743.pdf&ei=HykDVaWHDpLRggTIgoT4Cg&usg=AFQjCNHvX1Wg3qdmw6C3Jz97t3ulJ5-bxw&bvm=bv.88198703,d.eXY (last viewed January 4, 2016).

- Swallowing;
- Snorting;
- Smoking; and
- Dissolving and injecting.

Opioids are commonly abused due to the euphoric effect created by their use.[23] ER opioids hold a greater attraction for abusers than IR opioids because of their higher concentrations of the drug.[24] When ER opioids are altered, the higher concentrations of the drug are immediately absorbed in the bloodstream rather than the gradual release and absorption of the drug as originally designed. This creates a more rapid onset of the effects of the opioids than the manufacturer intended and a greater euphoria.[25] This is the effect the abusers seek; however, this commonly can lead to overdose and death.

Continued use or abuse of opioids can lead to the development of tolerance and psychological and physical dependence.[26] This dependence is characterized by a strong desire to take opioids, impaired control over opioid use, persistent opioid use despite harmful consequences, a higher priority given to opioid use than to other activities and obligations, and a physical withdrawal reaction when opioids are discontinued.[27] This issue is widespread as an estimated 15 million people worldwide suffer from opioid dependence.[28]

Abuse-Deterrent Opioids

Abuse-deterrent opioids are formulated to deter abuse and misuse of the drug.[29] The goal of abuse-deterrent opioids is to limit access or attractiveness of the highly desired active ingredient for abusers while assuring the safe and effective release of the medication for patients.[30]

In 2013, the Food and Drug Administration (FDA) released draft guidance to assist the pharmaceutical industry in developing new formulations of opioid drugs with abuse-deterrent properties. The document provides guidance on the studies that should be conducted to demonstrate that a given formulation has abuse-deterrent properties, how the studies will be evaluated, and what labeling clams may be approved based on the results of the studies.[31]

The FDA guidance provides that abuse-deterrent formulations are categorized in one of the following groups:[32]

- **Physical/Chemical barriers** – Physical barriers can prevent chewing, crushing, cutting, grating, or grinding. Chemical barriers can resist extraction of the opioid using common solvents like water, alcohol, or other organic solvents. Physical and chemical barriers can change the physical form of an oral drug rendering it less amenable to abuse;

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[23] Opioids affect the regions of the brain involved with pleasure and reward and can thereby create a euphoric effect. *How Do Opioids Affect the Brain and Body?,* National Institute on Drug Abuse. http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/how-do-opioids-affect-brain-body (last viewed January 4, 2016).
[24] *A Review of Abuse-Deterrent Opioids for Chronic Nonmalignant Pain,* Robin Moorman-Li, Carol Motycka, et al., P.T. 2012 Jul; 37(7): 412-418. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411218/ (last viewed January 4, 2016).
[25] Id.
[26] *Supra* at footnote 9.
[27] *Supra* at footnote 7.
[28] Id.
[29] The National Addictions Vigilance Intervention and Prevention Program (NAVIPPRO) database was created to track drugs of abuse, their current popularity and their preferred method of use by abusers. Pharmaceutical companies can review this database to determine the drugs of abuse the most concern and to identify the routes of delivery that new formulations should specifically strive to deter. *Supra* at footnote 24.
[30] Id.
[31] *Supra* at footnote 22.
[32] Id.

- **Agonist/Antagonist combinations** – An opioid antagonist can be added to interfere with, reduce, or defeat the euphoria associated with abuse. The antagonist can be sequestered and released only upon manipulation of the product. For example, a drug product may be formulated such that the substance that acts as an antagonist is not clinically active when the product is swallowed but becomes active if the product is crushed and injected or snorted;
- **Aversion** – Substances can be combined to produce an unpleasant effect if the dosage form is manipulated prior to ingestion or a higher dosage than directed is used;
- **Delivery System**– Certain drug release designs or the method of drug delivery can offer resistance to abuse. For example, a sustained-release depot injectable formulation that is administered intramuscularly or a subcutaneous implant can be more difficult to manipulate;
- **Prodrug** – A prodrug that lacks opioid activity until transformed in the gastrointestinal tract can be unattractive for intravenous injection or intranasal routes of abuse;
- **Combination** – Two or more of the above methods can be combined to deter abuse; and
- **Novel approaches** – This category encompasses novel approaches or technologies that are not captured in the previous categories.

Abuse Deterrence Studies and Labeling

The FDA recommends premarket and post-market studies which evaluate the known routes of abuse of opioids and anticipate new routes which could develop due to the development of abuse-deterrent opioids. These studies fall into four categories:[33]

- **Category 1- Laboratory-based in vitro manipulation and extraction studies**- The goal of laboratory-based studies is to evaluate the ease with which the potentially abuse-deterrent properties of a formulation can be defeated or compromised. This information should be used when designing Category 2 and Category 3 studies;
- **Category 2- Pharmacokinetic studies**- The goal of the clinical pharmacokinetic studies is to understand the in vivo properties of the formulation by comparing the pharmacokinetic profiles of the manipulated formulation with the intact formulation and with manipulated and intact formulations of the comparator drugs through one or more routes of administration.
- **Category 3- Clinical abuse potential studies**- The goal of clinical studies of abuse potential is to assess the impact of potentially abuse-deterrent properties.
- **Category 4- Post-market**- The goal of post-market studies is to determine whether the marketing of a product with abuse-deterrent properties results in meaningful reductions in abuse, misuse, and related adverse clinical outcomes, including addiction, overdose, and death in the post-approval setting.

Abuse-deterrent labeling is important to inform health care professionals, the patient community, and the public about a product's abuse potential.[34] The FDA encourages labeling that sets forth the results of in vitro, pharmacokinetic, clinical abuse potential and formal post-market studies and appropriately characterizes the abuse-deterrent properties of a product.[35] Category 1 studies should be described in general terms to avoid creating a road map for defeating the product's abuse-deterrent properties.[36] However, the design, conduct, and results of Category 2 and 3 studies should be described in sufficient detail to support clear labeling regarding a product's abuse-deterrent properties.[37]

Health Insurer Prior Authorization

Insurers use cost containment strategies to manage medical and drug spending and utilization. For example, plans may place utilization management requirements on the use of certain drugs on their

[33] Id.
[34] Id.
[35] Id
[36] Id.
[37] Id.

formulary, such as requiring enrollees to obtain prior authorization from their plan before being able to fill a prescription, requiring enrollees to first try a preferred drug to treat a medical condition before being able to obtain an alternate drug for that condition, or limiting the quantity of drugs that they cover over a certain period of time.[38]

Under prior authorization, a health care provider is required to seek approval from an insurer before a patient may receive a specified diagnostic or therapeutic treatment or specified prescription drugs under the plan.[39] A preferred drug list (PDL) is an established list of one or more prescription drugs within a therapeutic class deemed clinically equivalent and cost effective.[40] In order to obtain another drug within the therapeutic class, not part of the PDL, prior authorization is required.[41]

Health insurers are increasingly turning to step therapy (or "fail first") policies in pharmacy benefit design.[42] This designation requires an insured to try one drug first to treat his or her medical condition before the insurer will cover another drug for that condition.[43] For example, if Drug A and Drug B both treat a medical condition, a plan may require doctors to prescribe Drug A first. If Drug A does not work for a beneficiary, then the plan will cover Drug B.

Effect of the Proposed Changes

HB 363 allows a health insurance policy which provides coverage for opioids to impose a prior authorization requirement for an abuse-deterrent opioid only if the policy imposes the same prior authorization requirement for opioids without an abuse-deterrence labeling claim. The bill defines "abuse-deterrent opioid analgesic drug product" as a brand or generic opioid analgesic drug product approved by the U.S. Food and Drug Administration with an abuse-deterrence labeling claim that indicates the drug product is expected to deter abuse. The bill defines "opioid analgesic drug product" is a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions in immediate-release, extended release, or long-acting form regardless of whether or not combined with other drug substances to form a single drug product or dosage form.

The bill prohibits a policy from requiring the use of an opioid without an abuse-deterrent labeling claim before providing coverage for an abuse-deterrent opioid. As a result, a physician may prescribe an abuse-deterrent opioid for a patient as an initial treatment, rather than waiting for a patient to fail in the use of a non-abuse deterrent opioid.

The bill provides an effective date of January 1, 2017.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.64194, F.S., relating to requirements for opioid coverage.
Section 2: Provides an effective date of January 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

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[38] *Prescription for Prior Authorizations: A Better Way*, Leah Krieger, Policy Matters Journal, Fall 2014- Special Edition. http://www.policymattersjournal.org/krieger.html (last viewed January 4, 2016).
[39] *Administrative Simplification and Fair Contracting*, American Medical Association, http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/admin-simp-fair-contracting.page (last viewed January 4, 2016).
[40] *Health Cost Containment and Efficiencies, NCSL Briefs for State Legislators*, National Conference of State Legislatures, No.9, June 2010. http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf (last viewed January 4, 2016).
[41] Id.
[42] *The Ethics Of 'Fail First': Guidelines And Practical Scenarios For Step Therapy Coverage Policies*, Rahul K. Nayak and Steven D. Pearson, Health Aff October 2014, vol. 33, no. 10, 1779-1785.
[43] Id.

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Insurers may pay higher costs for abuse-deterrent opioids prescribed by a physician as an initial treatment, rather than paying for lower cost opioids without an abuse deterrence claim.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health insurance coverage for opioids; creating s. 627.64194, F.S.; defining terms; providing that a health insurance policy that covers opioid analgesic drug products may impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the insurer imposes the same requirement for each opioid analgesic drug product without an abuse-deterrence labeling claim; prohibiting such health insurance policy from requiring use of an opioid analgesic drug product without an abuse-deterrence labeling claim before providing coverage for an abuse-deterrent opioid analgesic drug product; providing an effective date.

WHEREAS, the Legislature finds that the abuse of opioids is a serious problem that affects the health, social, and economic welfare of this state, and

WHEREAS, the Legislature finds that an estimated 2.1 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers in 2012, and

WHEREAS, the Legislature finds that the number of unintentional overdose deaths from prescription pain relievers has more than quadrupled since 1999, and

WHEREAS, the Legislature is convinced that it is imperative

for people suffering from pain to obtain the relief they need while minimizing the potential for negative consequences, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.64194, Florida Statutes, is created to read:

627.64194 Requirements for opioid coverage.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the United States Food and Drug Administration with an abuse-deterrence labeling claim that indicates the drug product is expected to deter abuse.

(b) "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions in immediate-release, extended-release, or long-acting form regardless of whether or not combined with other drug substances to form a single drug product or dosage form.

(2) COVERAGE REQUIREMENTS.—A health insurance policy that provides coverage for opioid analgesic drug products:

(a) May impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the policy imposes the same prior authorization requirement for each opioid

analgesic drug product without an abuse-deterrence labeling claim which is covered by the policy.

(b) May not require use of an opioid analgesic drug product without an abuse-deterrence labeling claim before providing coverage for an abuse-deterrent opioid analgesic drug product.

Section 2. This act shall take effect January 1, 2017.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 421 Reimbursement of Medicaid Providers
SPONSOR(S): Trumbull
TIED BILLS: **IDEN./SIM. BILLS:** SB 526

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		McElroy	Poche
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In the Medicaid program, to determine the appropriate reimbursement to a provider for services rendered to a recipient, the Agency for Health Care Administration (AHCA) pays the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by AHCA, whichever amount is less. AHCA is required to make timely payment for services or goods to a provider upon receipt of a claim form from the provider. Among other requirements, the claim form certifies that the services or goods were completely furnished to the recipient and that the amount billed does not exceed the provider's usual and customary charge for the same services or goods.

"Usual and customary" is a common payment methodology utilized in various sections of Florida law, including the Medicaid statutes. However, despite its prevalent use, the term is not defined in law. This potentially creates uncertainty of interpretation of the term and, as least in the Medicaid program, has resulted in litigation.

HB 421 amends s. 409.901, F.S., to define "usual and customary", for the purposes of the Medicaid program, as the amount routinely billed by a provider or supplier to an uninsured consumer for services or goods before application of any discount, rebate, or supplemental plan. The term does not include free or discounted charges for services or goods based upon a person's insured or financial status. The bill expressly states that the definition is remedial in nature and, based on existing case law, demonstrates the intent for retroactive application of the definition.

The bill does not appear to have a fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds. Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states: some populations are entitled to enroll in the program and enrollees are entitled to certain benefits.

The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[1] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, dental services, and dialysis.[2]

Statewide Medicaid Managed Care[3]

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC program is an integrated managed care program which provides all mandatory and optional Medicaid benefits to enrollees. Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services, including dental services.[4] In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.[5]

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.[6] AHCA selected 19 managed care plans and executed 5-year contracts in February 2014. The MMA program was fully implemented statewide as of August 1, 2014.

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[1] S. 409.905, F.S.
[2] S. 409.906, F.S.
[3] The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority.
[4] The other component of the SMMC program is the Long-Term Care Managed Care Program.
[5] This comprehensive coordinated system of care was successfully implemented in the 5-county Medicaid reform pilot program, 2006-2014.
[6] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Addendum 2*, Solicitations Number: AHCA ITN 017-12/13; dated February 26, 2013 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm (last visited on January 4, 2016); AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitation Number: AHCA ITN 017-12/13; dated December 28, 2012 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm (last visited on January 4, 2016).

Medicaid Provider Reimbursement- Usual and Customary

AHCA is required to reimburse Medicaid providers in accordance with state and federal law.[7] Requirements for reimbursement are established according to methodologies set forth in AHCA's administrative rules and in policy manuals and handbooks incorporated by reference.[8]

Medicaid reimbursement methodologies differ based upon what type of services or goods are being provided; however, these methodologies often include a prohibition against reimbursement in excess of the provider's usual and customary rate for the service or good. In fact, with some exceptions, for each allowable service or good furnished in accordance with applicable law, the reimbursement is the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee, whichever is less.[9] Further, in order to be eligible to receive payment from AHCA, a provider must certify that the service or good has been completely furnished to the Medicaid recipient and that the amount billed does not exceed the provider's usual and customary charge.[10] However, despite its prevalent use, the term is not defined in Florida law.[11]

Reimbursement for Laboratory Services- Qui Tam Action against Certain Providers[12]

"Qui tam" is a Latin abbreviation for "he who sues in this matter for the king as well as for himself".[13] Qui tam actions are commonly referred to as whistle blower lawsuits and involve a private citizen suing a person or corporation on behalf of the federal or state government. The private citizen plaintiff is authorized to prosecute the lawsuit from start to finish; however, the government may intervene and assume primary responsibility for the lawsuit. The private citizen plaintiff is entitled to a percentage of any amount recovered for the government.

In 2007, Hunter Labs and Chris Riedel filed a qui tam action under the Florida False Claims Act in the circuit court in Leon County, alleging that LabCorp and Quest Diagnostics (LabCorp/Quest) defrauded the state by overcharging the Medicaid program for laboratory services provided to recipients. In 2013, the Attorney General (AG) intervened in the above lawsuit alleging that LabCorp/Quest defrauded the state by failing to charge the Medicaid program its lowest charge to any other third party payer for providing laboratory services.[14]

LabCorp/Quest filed an administrative petition with the Division of Administrative Hearings (DOAH) against AHCA challenging the validity of the "lowest charge" rule.[15] Ultimately, AHCA agreed that the rule was invalid and a Consent Order was entered in March 2014, formally striking down the rule. This litigation, although related to the circuit court case, was separate and distinct from the qui tam action.

In light of the Consent Order entered into in the DOAH hearing, the AG is pursuing an alternative legal theory against LabCorp/Quest in the qui tam action. The AG alleges that LabCorp/Quest defrauded the state by charging more than their usual and customary charge. For purposes of the litigation, it is the

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[7] S. 409.908, F.S. Reimbursement is subject to specific appropriations.
[8] Id.
[9] Id; see also s. 409.912(8)(a), F.S.; s. 409.9128(5), F.S.; s. 409.967, F.S.; 42 C.F.R. 447.512; Florida Medicaid Provider General Handbook, as promulgated in Rule 59G-5.020, F.A.C.; and Florida Medicaid Prescribed Drug Services Handbook, as promulgated in Rule 59G-4.250, F.A.C.,
[10] S. 409.907(5)(a), F.S.
[11] Usual and customary is identified as a payment methodology in chapters 394, 400, 409, 440, 627, 641, and 817; however, the term is not defined.
[12] State of Florida ex rel. Hunter Laboratories, LLC and Chris Riedel v. Quest Diagnostics, Incorporated, et al, in the Circuit Court for the Second Judicial Circuit in and for Leon County, case number 2007-CA-003549.
[13] Qui Tam: An Abbreviated Look at the False Claims Act and Related Federal Statutes, Congressional Research Service, Charles Doyle, August 6, 2009, available at: http://webcache.googleusercontent.com/search?q=cache:INZp35Nhq5EJ:https://www.fas.org/sgp/crs/misc/R40786.pdf+&cd=5&hl=en&ct=clnk&gl=us (last viewed January 7, 2016).
[14] Rule 59G-5.110(2), F.A.C.
[15] The petition was filed against AHCA because AHCA developed and adopted the rule.

AG's position that the term "usual and customary" is defined as any amount accepted by LabCorp/Quest as payment from any other third-party payer.

In August 2014, AHCA proposed a rule that would have codified the AG's interpretation of usual and customary charge. Medicaid providers objected to the rule and the interpretation, arguing that the proposed definition was contrary to the long understood meaning of the term, and the term had never been interpreted in that manner. LabCorp/Quest filed an administrative petition with DOAH, challenging the proposed rule as an invalid exercise of delegated legislative authority. This litigation, although related the circuit court case, was separate and distinct from the qui tam action. AHCA subsequently withdrew the proposed rule and stipulated that it had never previously interpreted "usual and customary charge" according to the "accepted payment" standard in the proposed rule and that it would not rely on that interpretation moving forward.

Although litigation of the administrative petitions with DOAH has resolved, the qui tam action against LabCorp/Quest is currently ongoing.

Retroactive and Remedial Application of Law

Newly enacted legislation is presumed to apply prospectively absent clear legislative intent to the contrary.[16] However, the intent for retrospective application of enacted legislation can be established through the express language of the statute or by analyzing the practical effect of the statute. If the intent for retrospective application is established, then it must be determined whether such application of the statute is constitutionally permissible.[17] Retroactive application is unconstitutional, and thereby prohibited, if:[18]

- Vested rights are adversely affected or destroyed;[19]
- A new obligation or duty is created or imposed; or
- An additional disability is established.

The Florida Supreme Court previously ruled that retroactive application of a remedial statute is constitutionally permissible and should occur to achieve the intended purpose of the statute.[20] Remedial statutes operate to further a remedy or confirm existing rights and do not create new obligations or adversely affect vested rights.[21] Further, when an amendment to a statute is enacted soon after controversies as to the interpretation of the original statute arise, a court may consider that amendment as legislative interpretation of the original law and not a substantive change of the law.[22]

Effect of Proposed Changes

The term "usual and customary" is not defined for purposes of determining reimbursement of Medicaid providers in Florida. HB 421 amends s. 409.901, F.S., and defines "usual and customary" as the amount routinely billed by a provider or supplier to an uninsured consumer for services or goods before application of any discount, rebate, or supplemental plan. The term does not include free or discounted charges for services or goods based upon a person's insured or financial status. The definition applies to the entire Medicaid program, through sections 409.901 through 409.920, F.S., unless expressly stated otherwise. The bill expressly states that the definition is remedial in nature and, based upon existing case law, demonstrates intent for retrospective application of the definition.

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[16] See Metropolitan Dade County v. Chase Federal Housing Corp., 737 So.2d 494 (Fla. 1999).
[17] Id.
[18] Id.
[19] For example, a law which retroactively criminalizes a vested legal right, such as the right to marriage, would be considered unconstitutional. Similarly, a zoning law which retroactively prohibits the use of real property is unconstitutional if the right to that particular use had previously vested in the owner.
[20] See City of Lakeland v. Cantinella, 129 So.2d 133 (Fla. 1961); see also Smiley v. State, 966 So.2d 330 (Fla. 2007); City of Orlando v. Desjardins, 493 So.2d 1027 (Fla. 1986).
[21] Id.
[22] See Lowry v. Parole and Probation Commission, 473 So.2d 1248 (Fla. 1985).

B. SECTION DIRECTORY:

Section 1: Amends s. 409.901, F.S., relating to definitions; ss. 409.901-409.920.
Section 2: Creates an unnumbered section of law stating that changes made by the act to s. 409.901, F.S., are intended to clarify existing law and are remedial in nature.
Section 3: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If a provider has a system in place to calculate the usual and customary charge for Medicaid billing which applies a definition of "usual and customary" which is different from the definition in the bill, then the provider may need to change the way they calculate billing rates.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill contains an unnumbered section of law which states, "The changes made by this act to s. 409.901, Florida Statutes, are intended to clarify existing law and are remedial in nature." It is unclear whether a statement of remedial intent in an unnumbered section of law in pending legislation has the

same impact as a statement of remedial intent contained within a statute. Existing statutes that expressly intend for remedial application of the law include such statements within the statute itself.[23] Thus, it is recommended that the statement of remedial intent contained within the bill be placed within s. 409.901, F.S.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[23] For example, the remedial statement is contained within the statute itself in ss. 553.73 (14), 655.851 and 222.21(2)(c), F.S.

A bill to be entitled

An act relating to reimbursement of Medicaid providers; amending s. 409.901, F.S.; defining the term "usual and customary charge" for purposes of Medicaid billing; providing applicability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (29) is added to section 409.901, Florida Statutes, to read:

409.901 Definitions; ss. 409.901-409.920.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(29) "Usual and customary charge" means the amount routinely billed by a provider or supplier to an uninsured consumer for services or goods before application of any discount, rebate, or supplemental plan. The term does not include free or discounted charges for services or goods based upon a person's uninsured or indigent status or other financial hardship.

Section 2. The changes made by this act to s. 409.901, Florida Statutes, are intended to clarify existing law and are remedial in nature.

Section 3. This act shall take effect July 1, 2016.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health Innovation Subcommittee

Representative Trumbull offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (11) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or

goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(11) A provider of independent laboratory services shall be reimbursed on the basis of competitive bidding or for the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the agency. For purposes of ss. 409.901-409.9201 and with respect to a provider of independent laboratory services, "usual and customary charge" means the amount routinely billed by the provider to an uninsured consumer for services or goods before the application of any discount,

rebate, or supplemental plan. Free or discounted charges for services or goods based on a person's uninsured or indigent status or other financial hardship are not usual and customary charges. This subsection is intended to be remedial in nature and to clarify existing law, and shall apply retroactively.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to Medicaid providers of independent laboratory services; amending s. 409.908, F.S.; providing a definition of "usual and customary charge" for providers of independent laboratory services; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 471 Responsibilities of Health Care Providers
SPONSOR(S): Burton
TIED BILLS: **IDEN./SIM. BILLS:** SB 586

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Guzzo	Poche
2) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 471 requires a hospital to notify each obstetrical physician with privileges at the hospital at least 120 days before closing the obstetrical department or ceasing to provide obstetrical services.

The bill also repeals s. 383.336, F.S., which requires the state Surgeon General to establish practice parameters for a physician performing cesarean section procedures at a provider hospital, defined as a hospital where at least 30 cesarean section procedures are performed and paid for, at least in part, by state funds or federal funds distributed by the state. Each provider hospital is also required to establish a peer review board to examine cesarean section procedures. These provisions are no longer implemented by the Department of Health.

The bill does not appear to have a fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Obstetrical Services

Licensure Requirements

A hospital is required to report the emergency services it will provide on its license application form to the Agency for Health Care Administration (AHCA).[1] Obstetrics is included as one of the reportable emergency services. These services are then listed on the hospital's license,[2] which must be conspicuously displayed in the facility.[3] The list of services is also used for the inventory of hospital emergency services maintained by AHCA.[4]

Hospitals and other facilities regulated by AHCA are required to submit a request to amend a license 60 to 120 days in advance of the requested effective date. However, the deadline does not apply to a request to amend hospital emergency services.[5]

There are currently 144 hospitals in Florida that are licensed to offer emergency obstetrical services.[6]

Cesarean Births at Provider Hospitals

A cesarean section is a surgical procedure performed when a mother is not able to safely deliver a fetus vaginally. Instead, the fetus is delivered through an incision in the mother's abdomen and uterus.

Section 383.336(2), F.S., requires the Department of Health (DOH) to adopt rules to implement practice parameters for a physician performing a caesarean section delivery in a provider hospital. A provider hospital has at least 30 births per year that are paid, in part or in full, by state funds or federal funds administered by the state.

Section 383.336(3), F.S., requires a provider hospital to establish a peer review board consisting of obstetric physicians and other credentialed individuals performing cesarean sections within the hospital. The board is required to review, on a monthly basis, all cesarean sections performed within the hospital that were paid, in part or in full, by state funds or federal funds administered by the state. Further, the board is required to conduct its review pursuant to the parameters specified in rules adopted by DOH.

In 1992, the former Department of Health and Rehabilitative Services (HRS) adopted rules to implement the provisions of s. 383.336, F.S.[7] In 1996, responsibility for all public health matters was moved from HRS to DOH[8]; however, the rules adopted by HRS were never amended or readopted. In

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[1] Agency for Health Care Administration, *Health Care Licensing Application: Hospitals*, at 12, available at http://ahca.myflorida.com/mchq/Health_Facility_Regulation/Hospital_Outpatient/Hospitals/SupportingForms.shtml#licap (last visited December 1, 2015).
[2] Section 408.806(4)(b), F.S.
[3] Section 408.804(2), F.S.
[4] Section 395.1041(2), F.S.
[5] Rule 59A-35.040(2)(c), F.A.C.
[6] Agency for Health Care Administration, *Facility/Provider Locator*, available at http://www.floridahealthfinder.gov/facilitylocator/Facility_Search.aspx (report generated December 1, 2015).
[7] Chapter 10D-116, F.A.C.
[8] Ch. 96-403, s. 6, Laws of Fla.

2012, the Legislature directed DOH to initiate rulemaking to readopt or amend the rules by July 1, 2013, to avoid nullification of the rules.[9] Instead, the rules were repealed on July 1, 2013.

Effect of Proposed Changes

The bill creates s. 395.0192, F.S., to require a hospital to notify each obstetrical physician with privileges at the hospital at least 120 days before closing the obstetrical department or ceasing to provide obstetrical services. Penalties for failure to comply with the notification requirement are not specified in the bill. However, AHCA has the authority to fine a health care facility up to $500 for an unclassified violation.[10]

The bill also repeals s. 383.336, F.S., which requires DOH to establish practice parameters for physicians performing cesarean section procedures in provider hospitals and requires each provider hospital to create a peer review board to examine such procedures. The provisions of this section are not being implemented and the rules adopted under the authority provided in this section were repealed in 2013.

B. SECTION DIRECTORY:

Section 1: Repeals s. 383.336, F.S., relating to provider hospitals; practice parameters; peer review board.
Section 2: Creates s. 395.0192, F.S., relating to duty to notify physicians.
Section 3: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Hospitals may experience an increase in administrative fines imposed for failure to comply with the notification requirement.

[9] Ch. 2012-31, ss. 9-10, Laws of Fla.
[10] S. 408.813(3), F.S., authorizes AHCA to impose an administrative fine for a violation that is not designated as a class I, class II, class III, or class IV violation. Unless otherwise specified by law, the amount of the fine may not exceed $500 for each violation. Unclassified violations include: Violating any term or condition of a license; Violating any provision of part II of ch. 408, F.S., authorizing statutes, or applicable rules; Exceeding licensed capacity; Providing services beyond the scope of the license; or violating a moratorium imposed pursuant to s. 408.814.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to responsibilities of health care providers; repealing s. 383.336, F.S., relating to practice parameters for physicians performing caesarean section deliveries in provider hospitals; creating s. 395.0192, F.S.; requiring a hospital to notify certain obstetrical physicians within a specified timeframe before the hospital closes its obstetrical department or ceases to provide obstetrical services; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 383.336, Florida Statutes, is repealed.

Section 2. Section 395.0192, Florida Statutes, is created to read:

395.0192 Duty to notify physicians.—A hospital shall notify each obstetrical physician who has privileges at the hospital at least 120 days before the hospital closes its obstetrical department or ceases to provide obstetrical services.

Section 3. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 819 Sunset Review of Medicaid Dental Services
SPONSOR(S): Diaz
TIED BILLS: **IDEN./SIM. BILLS:** SB 994

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Langston	Poche
2) Health & Human Services Committee			

SUMMARY ANALYSIS

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program. The SMMC program requires the Agency for Health Care Administration (AHCA) to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care, including dental services, through a Managed Medical Assistance (MMA) program. In February 2014, AHCA executed 5-year contracts for the MMA program, and began implementation, which was completed August 1, 2014. As of December 2015, over 3.89 million Medicaid recipients enrolled in the MMA program receive services, including dental health benefits, through MMA plans.

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

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

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

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

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

Except as otherwise provided, the bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

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

Statewide Medicaid Managed Care

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

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

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.[5] AHCA selected 19 managed care plans (MMA plans) and executed 5-year contracts in February 2014. The MMA program was fully implemented statewide by of August 1, 2014.[6] As of December 2015, approximately 3.89 million Medicaid recipients are enrolled in the MMA program.[7]

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

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

[3] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000, available at http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf (last visited January 8, 2016).

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

[5] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Addendum 2, Solicitations Number: AHCA ITN 017-12/13*; dated February 26, 2013 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm; AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Solicitation Number: AHCA ITN 017-12/13*; dated December 28, 2012 http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm (last visited January 8, 2016).

[6] Agency for Health Care Administration, Agency Analysis of 2016 House Bill 819, p. 3, January 6, 2105 (on file with the Health Innovation Subcommittee).

[7] Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Report: December 2015*, available at http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_December_2015.xls (last visited January 8, 2016).

AHCA expects to competitively procure the next round of contracts in May 2017, and make awards to plans in May 2018.[8] AHCA further expects those MMA plans to begin providing services in September 2019.[9]

Waivers for Medicaid Managed Care

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

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

Dental Care in the MMA Program

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

All MMA plans provide full dental services, not currently covered under the Medicaid state plan, to adult enrollees. Through these dental benefits, adult Medicaid recipients have access to expanded dental services, including preventive services.[13] Examples of these additional benefits include twice-yearly exams and cleanings, fluoride treatments, fillings, and yearly x-rays.[14] Not only do these benefits exceed what is required by law, AHCA negotiated their inclusion within the MMA plans at no cost to the state.[15] AHCA estimates the value of the additional benefits at $100 million over five years.[16]

Dental Service Accountability and Performance in the MMA Program

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

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[8] *Supra*, note 6 at 6.
[9] Id.
[10] 42 U.S.C. § 1396a(72).
[11] S. 409.906(1), (6), F.S. Adults must be provided dentures and medically necessary, emergency dental procedures to alleviate pain or infection.
[12] A Medicaid PDHP is a risk-bearing entity paid a prospective per-member, per-month payment by AHCA to provide dental services to enrollees.
[13] *Supra*, note 6 at 3-4.
[14] Information provided by AHCA and on file with the Health Innovation Subcommittee.
[15] Agency for Health Care Administration, *Agency Analysis of 2014 House Bill 27*, November 25, 2013 (on file with the Health Innovation Subcommittee)
[16] Id.

First, there are specific requirements for network adequacy for all MMA plans, to ensure a sufficient number of primary and specialty dental care providers are available to meet the needs of plan enrollees.[17] Each plan must have at least one full time primary dental provider in each service area and at least one full time primary dental provider for every 1500 enrollees.[18] Since July 2014, 213,819 adult enrollees have received dental benefits under the MMA program.[19] Dentist participation in Medicaid has increased over 26 percent since the implementation of the MMA program. As of October 2015, there were 2,378 dentists participating in the MMA program as either fee-for-service (FFS) dental providers in the Medicaid program or non-FFS providers in the Medicaid program, who registered for encounter data purposes.[20]

Provider Type[21]	*November 2013*	*October 2015*	*Total % Change*
FFS Fully Enrolled Dentists	1,414	1,575	11.39%
Registered Dentists	470	803	70.85%
Total Participating Dentists	1,884	2,378	26.22%

Second, MMA plans must maintain an annual medical loss ratio (MLR) of a minimum of 85 percent for the first full year of MMA program operation.[22] The MLR measures the amount of money spent on providing services to enrollees against the amount of money spent on administrative functions; an MLR of 85 percent requires 85 percent of the capitation paid to the MMA plan to be expended on dental care services. The MLR must also take into account, as required in the terms and conditions of the 1115 waiver, any payments of the achieved savings rebate, which requires:

- 100 percent of income up to, and including, five percent of revenue to be retained by the plan;
- 50 percent of income above five percent and up to ten percent to be retained by the plan, with the other 50 percent returned to the state; and
- 100 percent of income above ten percent of revenue to be returned to the state.[23]

In addition, under the terms and conditions of the 1115 waiver, AHCA must work with MMA plans on an oral health quality improvement initiative. The MMA program contracts[24] have specific performance goals for pediatric dental services and penalties for not reaching these goals. Each MMA plan is required to provide a Child Health Check-Up (CHCUP) to every enrollee. The CHCUP includes dental screenings and referrals starting at age three, or earlier if indicated.[25] The MMA plans must achieve a CHCUP rate of at least 80 percent for children enrolled for eight continuous months.[26] A plan that fails to meet this goal is subject to a corrective action plan[27] and liquidated damages of $50,000 per occurrence and $10,000 for each percentage point less than the target.[28]

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[17] *MMA Model Agreement, Attachment II, Exhibit II A*, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, February, 2014, available at http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-A-Managed_Medical_Assistance_MMA_Program_2015-11-01.pdf (last visited January 8, 2016).

[18] Id. at 103.

[19] Email correspondence with Agency for Health Care Administration Staff on HB 819, December, 28, 2015 (on file with Health Innovation Subcommittee staff).

[20] Id.

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

[22] *Supra*, note 17.

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

[24] Agency for Health Care Administration, *SMMC Plans: Model Contract*, available at: http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml (last visited January 8, 2016).

[25] *Supra*, note 17 at 22.

[26] Id. at 22, 109.

[27] The Corrective Action Plan details the actions to be taken by the MMA Plan to reach the rate.

[28] *Supra*, note 17 at 22, 109.

The MMA plans are also required to achieve a preventive dental services rate of at least 28 percent for children enrolled for 90 continuous days.[29] A plan that fails to meet this goal is subject to a corrective action plan and liquidated damages of $50,000 per occurrence and $10,000 for each percentage point less than the target.[30] For both the CHCUP and preventive dental services, the MMA plan must provide transportation to and from the child's dental appointments, if needed.

Lastly, the MMA plans are required to have Healthcare Effectiveness Data and Information Set (HEDIS)[31] scores above 50 percent for pediatric dental services or face liquidated damages. This requires a significant improvement over the PDHPs and reform county pilot plans. The liquidated damages for failure to meet the HEDIS scores will be calculated based on the number of members enrolled in the MMA plan.

Dental Care Prior to the SMMC Program

Prior to the implementation of the SMMC program, dental services were provided to Medicaid recipients in a number of ways. Children and adults enrolled in Medicaid health plans in the five reform pilot counties received their dental care through comprehensive managed care health plans.[32] Children outside of the reform pilot counties were required to access their dental services through PDHPs under contract with AHCA to provide children's dental services.[33] Adults enrolled in the Medicaid program, outside of the reform pilot counties, received their dental services either through the fee-for-service system or through health plans that chose to include Medicaid adult dental services in the benefit package.[34] The adult dental services were limited to dentures and medically necessary, emergency dental procedures to alleviate pain or infection.[35]

Prepaid Dental Health Plans (PDHPs)

In 2001, Florida began using a PDHP to deliver dental services to children as a pilot program in Miami-Dade County.[36] In 2003, the Legislature expanded the PDHP initiative beyond Miami-Dade County by authorizing AHCA to contract with PDHPs in other areas[37] and permitted AHCA to include the Medicaid reform pilot counties.[38] In 2011, the Legislature made PDHP contracting mandatory, not discretionary, outside the reform pilot counties and Miami-Dade County.[39] However, the Legislature limited the use of PHDPs for fiscal year 2012-2013, by requiring that AHCA not limit dental services to PDHPs and allow dental services to be provided on a fee-for-service basis, as well.[40]

AHCA issued a competitive procurement for the statewide PDHP program in 2011 and awarded contracts to two PDHPs to provide dental services to Medicaid recipients in all Florida counties with the exceptions noted above.[41] The contracts with PDHP providers expired on September 30, 2014.[42] On

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[29] Id. at 22, 110.
[30] Id.
[31] HEDIS measures are developed by the National Committee for Quality Assurance (NCQA), and allow for comparison of otherwise dissimilar health plans.
[32] *Supra*, note 6 at 4.
[33] Id.
[34] Id.
[35] S. 409.906(1), F.S.
[36] Proviso language in the 2001 General Appropriations Act (GAA) authorized AHCA to initiate a PDHP pilot program in Miami-Dade County. Similar statutory authority was provided in 2003.
[37] Ch. 2003-405 s. 18, Laws of Fla. (codified as. 409.912(42), F.S.).
[38] In 2005, the Legislature enacted laws to reform the delivery and payment of services through the Medicaid program and directed AHCA to seek a federal waiver for a Medicaid managed care pilot program over five years. The program began in Broward and Duval counties in 2006 and later expanded to Baker, Clay and Nassau counties in 2007, as authorized in statute. The five-year waiver was set to expire June 30, 2011, but was renewed through June 30, 2014.
[39] Ch. 2011-135 s. 17, Laws of Fla. (codified as s. 409.912(41), F.S.). This subsection expired October 1, 2014.
[40] Ch. 2012-119 s. 9, Laws of Fla. (codified as s. 409.912(41)(b), F.S.). This paragraph expired July 1, 2013.
[41] During 2012, AHCA implemented the statewide PDHP program in Medicaid Area 9 on January 1; Areas 5, 6, and 7 on October 1; and Areas 1, 2, 3, 4, 8, and 11 (Monroe County only) on December 1, 2012.

October 1, 2014, the statutory authority for AHCA to contract with PDHPs expired, as the program transitioned to the comprehensive managed care contracts in the new MMA program.

PDHP Accountability and Performance

Like the MMA program contracts, PDHP contracts imposed specific requirements for network adequacy;[43] required plans to meet an MLR of 85 percent;[44] and required plans to provide CHCUP to enrollees[45] and achieve an annual screening and participation CHCUP rate of 80 percent.[46] Unlike the MMA plans, which must have HEDIS scores over 50 percent, the PDHPs were only required to have an "acceptable HEDIS score" or potentially be subject to unspecified monetary damages.[47]

Performance of the PDHPs and MMA Plans, Compared

AHCA measures the performance of the MMA plans, and measured the performance of PDHPs, based on HEDIS scores. To ensure the validity of HEDIS results, the data is reviewed by certified auditors using a process designed by the NCQA.[48]

AHCA conducted an independent analysis to determine the percentage of MMA enrollees ages 2 – 21 years who received at least one dental service during the first year of MMA implementation, from August 1, 2014 through July 31, 2015.[49] AHCA used the same parameters used to calculate the HEDIS scores for children's dental care annual dental visits, with two variations:

- HEDIS uses a calendar year; AHCA used an August through July time period; and
- HEDIS requires that individuals be enrolled in the plan on December 31 of the measurement year; AHCA's analysis required that they be enrolled on July 31 of the measurement year.[50]

Using these parameters, AHCA determined that 43 percent of the children who qualified to be counted in this measure received dental services during this time period.[51] This score is higher than the HEDIS score achieved in 2013 by Medicaid reform plans of 42 percent which, until MMA, was the highest score ever recorded for this measure in Florida.

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[42] The original procurement period was December 1, 2011 through September 30, 2013. The program was renewed once, which extended the contracts through September 30, 2014.
[43] Agency for Health Care Administration, *Medicaid Prepaid Dental Health Plan Contract, Attachment II, January, 2012*, p. 60 (on file with the Health Innovation Subcommittee).
[44] In calendar year 2013, both PDHPs failed to meet the required MLR and were required to repay AHCA an estimated $20 million. Agency for Health Care Administration, *Agency Analysis of 2015 House Bill 601*, January 28, 2015 (on file with the Health Innovation Subcommittee).
[45] *Supra*, note 43 at 53-54.
[46] Id.
[47] Id. at 83. "Acceptable HEDIS score" was not defined in the PDHP contracts.
[48] National Committee for Quality Assurance, *HEDIS and Quality Measurement: What is HEDIS?*, available at: http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx (last visited January 8, 2016).
[49] *Supra*, notes 19; 52.
[50] Id.
[51] Id.

HEDIS Annual Dental Visit Scores[52]

	MMA	*Reform Pilot Plans*[53]	*Dentaquest Miami-Dade*	*Dentaquest Statewide*	*MCNA Miami-Dade*	*MCNA Statewide*
CY 2007 (Reported in 2008)	N/A	15.2%	N/A[54]	N/A	N/A	N/A
CY 2008 (Reported in 2009)	N/A	28.5%	N/A[54]	N/A	N/A	N/A
CY 2009 (Reported in 2010)	N/A	33.4%	N/A[54]	N/A	N/A	N/A
CY 2010 (Reported in 2011)	N/A	34.0%	N/A[54]	N/A	N/A[55]	N/A
CY 2011 (Reported in 2012)	N/A	35.3%	N/A[54]	N/A	N/A[55]	N/A
CY 2012[56] (Reported in 2013)	N/A	40.4%	41.4%	47.3%	36.8%	39.3%
CY 2013 (Reported in 2014)	N/A	42.3%	43.3%	37.2%	39.9%	34.3%
MMA Year 1 (08/2014 – 07/2015)	43.1%	N/A	N/A	N/A	N/A	N/A

The chart does not reflect HEDIS annual dental visit scores for either the MMA plans or pre-MMA plans calendar year 2014 because 2014 was the MMA transition year, so the data is not representative of performance.[57]

Effect of the Proposed Changes

Dental Services Carve-Out

Removal of Dental Services from MMA Plan Coverage

HB 819 amends s. 409.973(1), F.S., to remove "dental services" as a minimum benefit that must be included in future MMA plans. Presently all MMA plans are required to provide dental services, as medically necessary, to their enrollees.[58] Absent Legislative action before July 1, 2017, MMA plans would no longer provide child or adult dental services; instead, dental services would be provided through a statewide Medicaid PDHP, starting March 1, 2019.

The carve-out of dental services from the MMA program would represent a departure from the system of care that was created through Medicaid reform. As a result of the carve-out, Medicaid patients

[52] *Supra*, note 14; Justin M. Senior, Florida Medicaid Director, Agency for Health Care Administration, *Florida Medicaid: Statewide Medicaid Managed Care*, PowerPoint Presentation to the House Health and Human Services Committee, January 2016. (Presentation on file with Health Innovation Subcommittee Staff).

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

[54] DentaQuest self-reported unaudited HEDIS scores for its Miami-Dade County PDHP Pilot from 2005 to 2011 showing an increase from 20 percent in 2005 to 39.1 percent in 2011. (Information on file with Health Innovation Subcommittee staff).

[55] MCNA self-reported unaudited HEDIS scores for its Miami-Dade County PDHP Pilot from 2010 to 2011 showing 34.8 and 35 percent, respectively. (Information on file with Health Innovation Subcommittee staff).

[56] 2012 was the first year the PDHPs submitted performance measures that were audited by an NCQA-certified HEDIS auditor.

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

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

would no longer receive integrated, coordinated care. Additionally, adult Medicaid recipients would lose the expanded dental benefits they receive through the MMA plans.

Creation of a Statewide Medicaid PDHP Program

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

The bill requires PDHP contracts to include an MLR provision consistent with the current statutory MLR calculation requirement for MMA plans.[59] Currently, the MLR calculation must use uniform financial data collected from all plans and must be computed for each plan on a statewide basis. AHCA anticipates that it would need actuarial analysis services to create capitation rates for the new dental managed care plans selected and to separate dental services from the MMA program.[60]

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

The bill authorizes AHCA to seek a state plan amendment or a federal waiver to begin enrollment into the prepaid dental program no later than March 1, 2019. AHCA anticipates that it would need to seek a new 1115 or 1915(b) waiver to enable it to implement the statewide Mediaid PDHP program.[61]

Comprehensive Report on Provision of Dental Services under the SMMC Program

The bill creates subsection (5) of s. 409.973, F.S., which requires AHCA to complete a comprehensive report[62] on the provision of dental services under the SMMC program. The report must examine the effectiveness of MMA plans in:

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

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

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

[59] S. 409.967(4), F.S.
[60] *Supra*, note 6 at 7.
[61] Id.
[62] The bill grants AHCA the authority to contract with an independent third party to assist in the preparation of the report.

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

The bill appears to give AHCA discretion to determine the specific metrics used to evaluate the MMA plans, and to determine how to weigh and reports on the topics included in the report. Nothing in the bill expressly precludes AHCA from considering additional elements when evaluating the MMA plans, provided those elements touch on at least one of the topics that must be addressed in the report.

The report is due by December 1, 2016 and must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Legislative Use of the Comprehensive Report

The bill states that the Legislature may use the findings of the report to establish the minimum benefits under the MMA program for future procurements of managed care plans. Specifically, the bill authorizes Legislature to consider the findings from the report when deciding whether to continue to include dental services as a minimum benefit under the MMA program or to provide dental services separately. If the bill is enacted, and the Legislature later wishes to keep dental services as a minimum benefit that plans must provide under the MMA program, the 2016 chapter law section reflecting the proposed removal of dental services from the list of minimum benefits must be repealed before July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.973, relating to benefits, effective March 1, 2019.
Section 2: Amends s. 409.973, relating to benefits.
Section 3: Provides an effective date of July 1, 2016, except as otherwise expressly provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA estimates a contract with an independent entity to assist in preparing the comprehensive report will cost $250,000.[63]

   Additionally, if AHCA implements a statewide PDHP program, it estimates that it would need an additional $200,000 per year for the current contracted actuarial firm to perform analysis services necessary to amend the current plan capitation rates to remove dental services and to create capitation rates for the selected plans.[64] AHCA also anticipates using outside counsel for the defense of competitive procurement specifications and bid awards for the statewide PDHP program, at a cost of $100,000.[65]

   AHCA also anticipates the need for five FTE positions to implement the bill: one grade 26 FTE to manage waiver oversight, one grade 26 FTE for financial monitoring, and three grade 25 FTEs as contract managers.[66] According to AHCA, each FTE would need to be hired at 8 percent above

[63] Id. at 9.
[64] Id.
[65] Id.
[66] Id. at 7.

minimum to recruit and retain quality staff.[67] To fund these additional positions, AHCA would require recurring General Revenue funds as follows:

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

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Adult Medicaid recipients may see increased dental care costs. Without the requirement to provide a dental benefit under the MMA program, it may no longer be cost effective for plans to maintain a full dental network, which may impact the plans' ability and willingness to continue to offer expanded dental benefits to adults.[68]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Due to the potential for overlap and conflict between AHCA's anticipated procurement schedule for the MMA program and the timeline specified in the bill for the PDHP program, AHCA recommends that any benefit changes be postponed from March 1, 2019 to October 1, 2019.[69]

AHCA previously noted that creating a carve-out for any single service would set a bad precedent for the future of the new, reformed SMMC program.[70] AHCA expressed concern that removing dental

[67] Id. at 9.
[68] Id. at 5.
[69] Id. 4-7.
[70] *Supra*, note 15.

services from the MMA plans could incentivize other service providers to seek carve-outs from the Legislature in the future.[71] Additional providers seeking carve-outs would undermine the unified, coordinated care provided to enrollees in the SMMC program. AHCA has also noted that there is no data or evidence to suggest that the current approach to providing dental services through the MMA program is flawed in design, network adequacy, quality, or implementation, or in need of change.[72]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[71] Id.
[72] Agency for Health Care Administration, *Agency Analysis of 2015 House Bill 601*, January 28, 2015 (on file with the Health Innovation Subcommittee).

A bill to be entitled

An act relating to the sunset review of Medicaid Dental Services; amending s. 409.973, F.S.; providing for the future removal of dental services as a minimum benefit of managed care plans; requiring the Agency for Health Care Administration to provide a report to the Governor and the Legislature; specifying requirements for the report; providing for the use of the report's findings; requiring the agency to implement a statewide Medicaid prepaid dental health program upon the occurrence of certain conditions; specifying requirements for the program and the selection of providers; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Effective March 1, 2019, subsection (1) of section 409.973, Florida Statutes, is amended to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(a) Advanced registered nurse practitioner services.

(b) Ambulatory surgical treatment center services.

(c) Birthing center services.

(d) Chiropractic services.

~~(e) Dental services.~~

(e)~~(f)~~ Early periodic screening diagnosis and treatment services for recipients under age 21.

(f)~~(g)~~ Emergency services.

(g)~~(h)~~ 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.

(h)~~(i)~~ Healthy start services, except as provided in s. 409.975(4).

(i)~~(j)~~ Hearing services.

(j)~~(k)~~ Home health agency services.

(k)~~(l)~~ Hospice services.

(l)~~(m)~~ Hospital inpatient services.

(m)~~(n)~~ Hospital outpatient services.

(n)~~(o)~~ Laboratory and imaging services.

(o)~~(p)~~ Medical supplies, equipment, prostheses, and orthoses.

(p)~~(q)~~ Mental health services.

(q)~~(r)~~ Nursing care.

(r)~~(s)~~ Optical services and supplies.

(s)~~(t)~~ Optometrist services.

(t)~~(u)~~ Physical, occupational, respiratory, and speech therapy services.

(u)~~(v)~~ Physician services, including physician assistant services.

(v) ~~(w)~~ Podiatric services.

(w) ~~(x)~~ Prescription drugs.

(x) ~~(y)~~ Renal dialysis services.

(y) ~~(z)~~ Respiratory equipment and supplies.

(z) ~~(aa)~~ Rural health clinic services.

(aa) ~~(bb)~~ Substance abuse treatment services.

(bb) ~~(cc)~~ Transportation to access covered services.

Section 2. Subsection (5) is added to section 409.973, Florida Statutes, to read:

409.973 Benefits.—

(5) PROVISION OF DENTAL SERVICES.—

(a) The agency shall provide a comprehensive report on the provision of dental services under this part to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2016. The agency is authorized to contract with an independent third party to assist in the preparation of the report required by this paragraph.

1. The report must examine the effectiveness of medical managed care plans in increasing patient access to dental care, improving dental health, achieving satisfactory outcomes for Medicaid recipients and the dental provider community, providing outreach to Medicaid recipients, and delivering value and transparency to the state's taxpayers regarding the dollars intended for, and spent on, actual dental services. Additionally, the report must examine, by plan and in the aggregate, the historical trends of rates paid to dental

providers and to dental plan subcontractors, dental provider participation in plan networks, and provider willingness to treat Medicaid recipients. The report must also compare current and historical efforts and trends and the experiences of other states in delivering dental services, increasing patient access to dental care, and improving dental health.

2. The Legislature may use the findings of this report in setting the scope of minimum benefits set forth in this section for future procurements of eligible plans as described in s. 409.966. Specifically, the decision to include dental services as a minimum benefit under this section, or to provide Medicaid recipients with dental benefits separate from the Medicaid managed medical assistance program described in this part, may take into consideration the data and findings of the report.

(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under subparagraph (a)2., the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act and who meet all agency standards and requirements. The contracts for program providers shall be awarded through a competitive procurement process. The contracts must be for 5 years and may not be renewed; however, the agency may extend the

term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(4). The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019.

Section 3. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2016.