Health & Human Services Committee

Tuesday, January 24, 2017
12:00 PM – 2:00 PM
Morris Hall (17 HOB)

Richard Corcoran
Speaker

W. Travis Cummings
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time:	Tuesday, January 24, 2017 12:00 pm
End Date and Time:	Tuesday, January 24, 2017 02:00 pm
Location:	Morris Hall (17 HOB)
Duration:	2.00 hrs

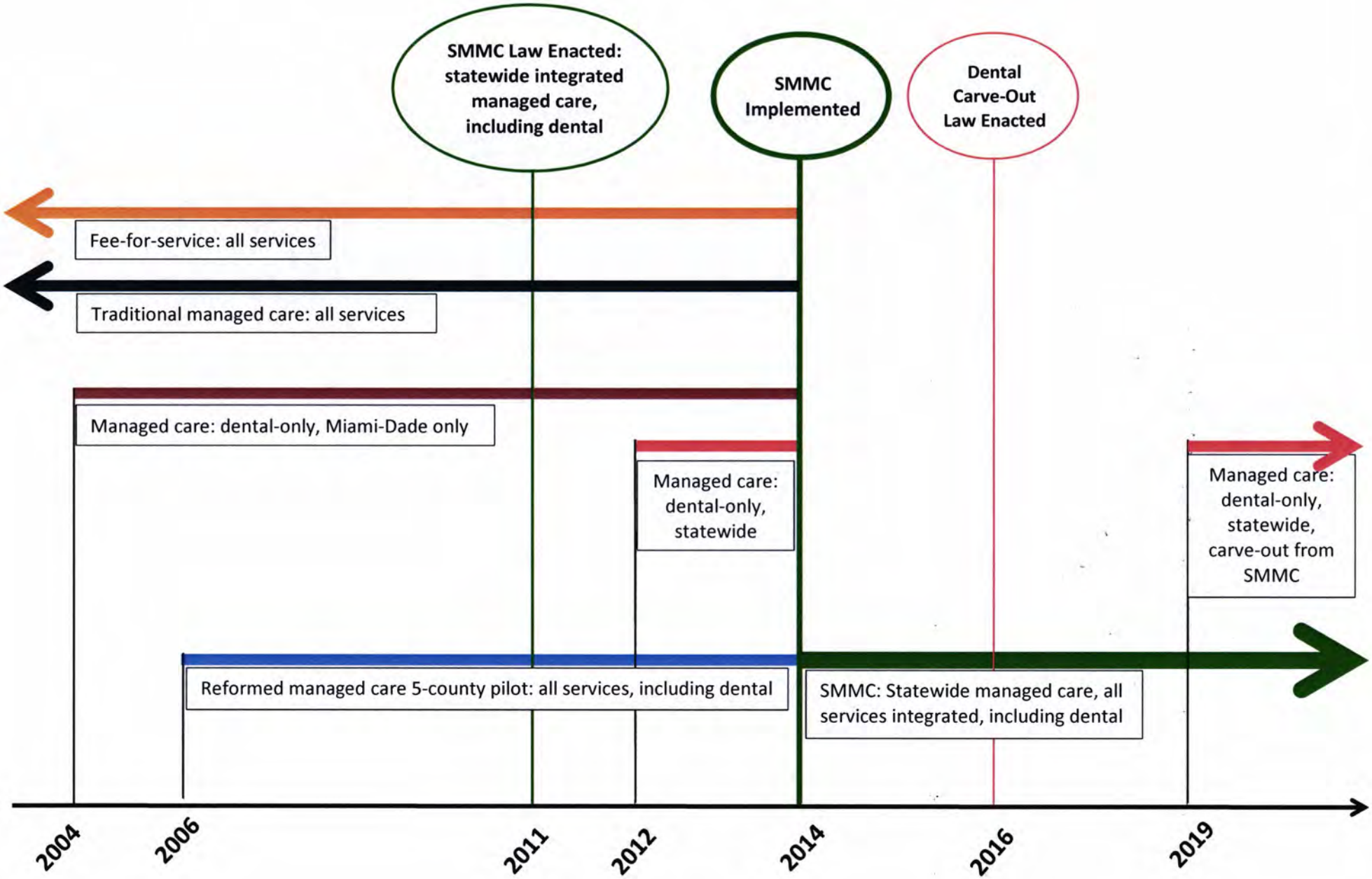
Presentation of OPPAGA Report No. 16-07: Review of Medicaid Dental Services

Briefing on the implementation of Ch. 2016-234, Laws, (CS/CS/HB 1175), Transparency in Health Care, by the Agency for Health Care Administration

NOTICE FINALIZED on 01/17/2017 4:00PM by Iseminger.Bobbye

OPPAGA

Timeline: Florida Medicaid Dental Service Delivery Systems



Review of Medicaid Dental Services

A Presentation to the House Health & Human Services Committee

Mary Alice Nye, Ph.D.
Staff Director
OPPAGA

January 24, 2017

Background

- National focus on better dental services for Medicaid children
- Medicaid requires states to provide preventive health services for children, including dental
- Over the last 5 fiscal years, Florida children eligible for services increased from 2.15 million to 2.55 million (19%)
- Florida children with at least 90 days continuous Medicaid enrollment during year increased by 22%

Chapter 2016-109, *Laws of Florida*

- Effectiveness of managed care plans
  - Access to care and improving dental health,
  - Good outcomes for recipients and providers, and
  - Outreach to Medicaid recipients
- Delivering value and transparency
- Historical rate trends
- Experiences of other states

Florida Medicaid's Managed Care Evolved Over Many Years

- Managed care in Florida dates back to 1982
- The state has tried different forms of medical managed care and dental programs
  - Miami-Dade Prepaid Dental Pilot 2004-2014 (children only)
  - Medicaid Reform 5-County Pilot 2006-2014 (adults/children)
  - Statewide Prepaid Dental 2012-2014 (children only)
- Managed Medical Assistance Program (MMA) 2014 to present (80% of all Medicaid enrollees)

Access and Utilization Measures for Assessing Children's Dental Services

- Comparable statewide programs—2013 and 2015
- Two separate indicators—HEDIS and CMS 416
- CMS 416 and HEDIS data differ
  - Different purposes; individual health plans versus state Medicaid program
  - Reporting periods
  - Eligible populations
  - Population size
  - Slight differences in age calculations

Recent Measures Show Improvement in Providing Medicaid Dental Services to Children

HEDIS Measured during the calendar year for only managed care health plans (For 2015, N=1.4 million)		
	2013	**2015**
Percentage of eligible children who had at least one dental visit	**37%**	**47%**
CMS 416 **Measured during the federal Fiscal Year for all Medicaid programs (For 2015, N=2.4 million)**		
	2013	**2015**
Percentage of eligible children receiving any dental services	**28.6%**	**34.6%**
Percentage of eligible children receiving preventative dental services	23.6%	31.0%
Percentage of eligible children receiving dental treatment services	11.4%	13.7%

Source: Agency for Health Care Administration.

Additional data are needed to attribute increases directly to the current statewide managed care program

Provider Participation and Satisfaction Influenced by Many Factors; Limited Information on Recipient Satisfaction

- Comparable provider participation since transition to MMA
  - 2,700 dentists in Statewide Prepaid Dental (2012-2014); another 1,000 in Medicaid Reform 5-County Pilot (2006-2014)
  - In the MMA program, as many as 4,448 dentists may have participated from January 2014 through June 2016 — 3,500 identified for survey
- Half of Medicaid dentists served fewer than 100 children in a 12-month period
- Issues affecting provider satisfaction
- Few recipient complaints regarding dental services

Program Differences and Reporting Inconsistencies Limit Direct Comparisons

Two ways to view value and transparency—

- Financial
  - Medical Loss Ratio and expenditures
  - Comparison is hindered by program differences, reporting inconsistencies
- Programmatic (program differences)
  - Children only vs. children and adults (standard benefit)
  - Coordination of all services or dental-only focus
  - Expanded adult dental services

Health Plans Provided Adult Expanded Dental Services With an Estimated Value of More Than $234 Million

(August 2013 – September 14, 2016)

Managed Care Plan	Estimated Value of Adult Expanded Dental Services
Humana	$74,917,175.92
Staywell	$43,918,182.40
Sunshine State Health Plan	$26,069,284.10
Prestige Health Choice	$24,676,248.67
United Healthcare Of Florida	$24,334,478.76
Amerigroup	$14,940,140.30
Molina Healthcare of Florida	$11,032,430.87
Magellan Complete Care	$6,058,034.28
Simply	$5,070,283.93
Better Health	$2,094,967.33
Integral Quality Care	$518,071.52
Coventry Health Care	$507,071.88
Community Care Plan	$157,140.01
Preferred Medical Plan	$114,562.77
First Coast Advantage	$70,798.44
Total	**$234,478,871.18**

Source: OPPAGA analysis of Agency for Health Care Administration data on encounter claims files as of September 14, 2016.

Analysis of Medicaid Dental Rates

- Managed care allows flexible financial arrangements with dental providers
- State fee-for-service dental rate schedule influences Medicaid dental reimbursements
- Compared what plans spent to what they would have spent had they paid the state rate
- Examined rates over time for individual procedure codes and for 111 dental procedures

Medicaid Dental Expenditures Compared to the State Medicaid Rate

Compared to fee-for-service rates, health and dental plans paid more for dental services

Year	Percentage Health Plans Paid for Services Above the State Fee-for-Service Rates
2012	5.8%
2013	10.6%
2014	11.3%
2015	9.9%
2016[1]	9.0%

[1] The average rates for 2016 represent only a partial year of data as 2016 was not complete at the time of our review.

Source: OPPAGA analysis.

Rates for Medicaid Dental Procedures Compared to the 2012 Statewide Average

Percentage Difference From 2012 Statewide Average	2013	2014	2015	2016[1]
10% or More Above	1%	**22%**	15%	**10%**
5% to 9.9% Above	63%	30%	28%	**19%**
1% to 4.9% Above	16%	22%	8%	**16%**
Within 1% (+/-)	9%	0%	3%	**10%**
1% to 4.9% Below	1%	11%	30%	13%
5% to 9.9% Below	10%	0%	0%	18%
10% or More Below	0%	14%	15%	14%

[1] The average rates for 2016 represent only a partial year of data as 2016 was not complete at the time of our review.
Source: OPPAGA analysis.

Medicaid Dental Programs in Other States

- Confusion over how states categorized as carved in or carved out
- Of the 28 states like Florida, 14 include dental services in comprehensive managed care; 4 use a prepaid managed dental program; and 10 use a fee-for-service system
- 7 states in transition; no trend apparent
  - 4 carving in; 2 carving out; 1 undecided
- Utilization in Florida improving but lags behind other states; key state differences may affect results

Federal CMS 416 Dental Measures for Selected States

Percentage of Eligible Population Receiving Any Dental Services			
State (Eligible Population 2014-15)	**Federal Fiscal Year** 2012-13	2013-14	2014-15
Texas (3,563,282)	61.9%	59.4%	64.4%
Illinois (1,515,649)	53.5%	52.3%	46.1%
California (5,782,808)	43.2%	44.8%	44.4%
New York (2,463,374)	40.3%	42.4%	41.9%
Florida (2,403,286)	28.6%	29.4%	34.6%
Percentage of Eligible Population Receiving Preventive Dental Services			
Texas	49.8%	49.0%	62.5%
Illinois	50.4%	49.4%	42.9%
New York	38.4%	40.9%	40.2%
California	35.0%	36.3%	35.6%
Florida	23.6%	25.6%	31.0%
Percentage of Eligible Population Receiving Dental Treatment Services			
Texas	28.8%	27.6%	29.6%
California	20.1%	20.1%	19.1%
New York	18.8%	19.5%	18.8%
Illinois	20.5%	19.7%	16.3%
Florida	11.4%	11.4%	13.7%

Source: U.S. Centers for Medicare and Medicaid Services.

Questions?

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THE FLORIDA LEGISLATURE
OPPAGA
OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

December 2016 Report No. 16-07

Review of Medicaid Dental Services

at a glance

From 2013 to 2015, the statewide percentage of Medicaid children who had at least one dental visit increased 10%; additional data are needed to attribute the increase to recent service delivery changes. While dentist participation is stable, it is low, and OPPAGA found little or no change in participation during the transition from the Prepaid Dental program to statewide Managed Medical Assistance (MMA). Recent data show that 51% of Florida Medicaid dentists served fewer than 100 children in a year, while 21% served fewer than 10.

Compared to Medicaid state reimbursement rates, dental and health plans paid more for dental services. Rates reflect provider contractual arrangements, patient enrollment, geographic differences, and market demand.

Medical loss ratio data and expenditure reports provide insight into spending for dental services. However, different populations, reporting periods, and enrollment information hinders comparison of expenditures across the delivery models. Programmatic differences such as care coordination and expanded adult dental benefits as well as reporting inconsistencies further limit a direct comparison of the two delivery models.

Of the 28 states that are like Florida (with at least 50% of Medicaid recipients enrolled in comprehensive, risk-based managed care), 14 include dental services in managed care programs, 4 deliver services through a prepaid dental program, and 10 use a fee-for-service system.

Scope

Chapter 2016-109, *Laws of Florida*, directs OPPAGA to conduct a study of Medicaid dental services. This review answers five questions.

- What do effectiveness and performance measures show regarding access and use of children's Medicaid dental services?
- Do service delivery models influence participation or provider and patient satisfaction?
- What is known about the value and transparency of different Medicaid dental delivery models?
- What factors shape current and historical Medicaid dental services' rates?
- What are the trends regarding Medicaid dental service delivery systems in other states?

Background

Access to and utilization of children's dental services is a national focus

Nationally, tooth decay, known by the profession as dental caries, is the most common childhood disease; experts estimate that 18% of all children and 25% of all children below 100% of the federal poverty level have untreated dental caries.[1] Tooth decay is preventable through a combination of good oral health habits, a healthy diet, and early and regular use of preventive dental services. However, if left

[1] Health, United States, 2015, With Special Feature on Racial and Ethnic Health Disparities. "Untreated dental caries, by selected characteristics: Unites States, selected years 1988-1994 through 2011-2012." U.S. Department of Health and Human Services' Centers for Disease Control and Prevention, National Center for Health Statistics. 2015.

untreated, tooth decay can lead to more serious childhood and adult health issues, highlighting the importance of access to and use of dental services.

During the past several years, there has been a national effort to improve children's access to dental services in Medicaid. For example, in April 2010, the federal Centers for Medicare and Medicaid Services launched the Oral Health Initiative, focusing on children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). The initiatives' two primary goals include

- increasing the rate of children ages 1 to 20 enrolled in Medicaid or CHIP who receive any preventive dental service by 10 percentage points over a five-year period; and
- increasing the rate of children ages six to nine enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar tooth by 10 percentage points over a five-year period.

Medicaid requires states to offer children's dental services. Medicaid, a joint federal and state program, provides health and long-term care services to certain low-income individuals who meet income and assets criteria, including children and families, pregnant women, and aged and disabled individuals. Florida's Agency for Health Care Administration (AHCA) administers the Medicaid Program. Federal law requires state Medicaid programs to offer a minimum set of mandatory services. For children under age 21, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health services, including dental services. At a minimum, Medicaid dental services for children must include relief of pain and infections, restoration of teeth, and maintenance of oral health.

In addition to providing dental services, EPSDT requires states to develop a dental periodicity schedule so that services occur at intervals that meet reasonable standards of dental practice, and every child entitled to EPSDT must be referred to a dentist in accordance with the state's periodicity schedule.

While Medicaid requires the provision of children's dental services, adult dental services are not required and may be offered at the option of states. Florida Medicaid has typically provided eligible adults with emergency dental care and currently provides adult emergency dental care and denture services.

Florida has seen an increase in children enrolled in Medicaid in recent years. From Fiscal Year 2010-11 through Fiscal Year 2014-15 the total number of Florida children eligible for EPSDT services increased by 400,000 (19%) and children with at least 90 days continuous Medicaid enrollment during the year increased by 425,000 (22%).[2] (See Exhibit 1.)

Exhibit 1
The Number of Florida Children Eligible for Medicaid Services Increased 19% From Federal Fiscal Year 2010-11 Through Federal Fiscal Year 2014-15

Federal Fiscal Year	Total Number of Children Eligible for EPSDT	Total Number of Children With 90 Days Continuous Medicaid Enrollment
2010-11	2,151,566	1,978,260
2011-12	2,228,923	2,057,419
2012-13	2,287,667	2,110,488
2013-14	2,430,072	2,258,962
2014-15	2,554,579	2,403,286

Source: Agency for Health Care Administration.

[2] The federal government requires states to use the 90-day continuous enrollment figure when computing the provision of dental services for federal reporting requirements.

The Florida Medicaid Program's use of managed care for medical and dental services has evolved over many years

As early as 1982, state officials began experimenting with different forms of managed care to deliver Medicaid services.[3] Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of services through contracts between the state Medicaid Program and health plans. (See Appendix A for a brief summary of some of the different forms of managed care that Florida has used.) Following a five-county managed care pilot program referred to as the Reform Pilot, the Legislature directed the expansion of managed care statewide in 2011.

Statewide Medicaid Managed Care, an integrated managed care program for all health care services, consists of two component programs: (1) the Long Term Care Program for nursing facility and home and community-based care and (2) the Managed Medical Assistance (MMA) Program for primary and acute health care services. Throughout this report, we use MMA when referring to the current comprehensive, risk-based program that includes medical, dental, and other services.[4]

Following a competitive procurement process, AHCA contracted with 19 health plans, on a capitated payment basis, to manage and deliver services to Florida Medicaid recipients.[5, 6] The program was fully implemented statewide by August 2014, and requires all enrollees to receive dental services from the health plans.[7] While Florida's Medicaid Program provides limited adult dental benefits, all the contracted health plans offer expanded services. Expanded dental services to adults may include preventive services such as cleanings, fluoride treatments, and x-rays.

At the same time that Florida experimented with managed medical services, the state also tried different delivery systems specifically for dental services. Prior to MMA, the state provided dental services through two dental-only programs—the Miami-Dade Prepaid Dental Pilot and the 61-county Prepaid Dental program. (See Exhibit 2.) In the five-county Reform Pilot program, some providers received a capitated payment to provide all services (medical and dental), while other provider arrangements relied on a fee-for-service payment model. (See Appendix B for additional information regarding rates paid by the state and Appendix C for additional information on the Miami-Dade Pilot and the Reform Pilot.)

There are important differences across the populations enrolled in each program. The Miami-Dade Pilot and the Prepaid Dental program provided dental services exclusively to children under the age of 21. In contrast, the Reform Pilot and MMA included services for both children and adults; adult benefits refers to the limited standard dental benefits under the state Medicaid plan.

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[3] The Palm Beach County Public Health Plan operated Florida's first Medicaid managed care plan.

[4] Risk-based means that the health plans accept a fixed monthly prepayment regardless of whether the payment fully covers the cost for all services that need to be provided.

[5] At the time of our review, MMA included 11 standard health plans along with 6 specialty plans serving populations with distinct chronic conditions. The contracted health plans are a mix of health maintenance organizations and provider service networks.

[6] A capitated payment is a fixed, per-member, per-month amount paid by the state to a health plan, designed to cover services needed in the aggregate for any given month in a 12-month period. Capitation is designed to provide the state with less risk and more predictability for Medicaid spending and to encourage the health plans to manage the provision of services in a cost-efficient manner.

[7] Approximately 80% of Florida's Medicaid recipients are enrolled in MMA. The remaining 20%, considered exempt from mandatory managed care enrollment, receive services from Medicaid providers on a fee-for-service basis; however, these recipients may still choose to enroll voluntarily in Medicaid managed care health plans. Exempt recipients include those who have other creditable health care coverage (excluding Medicare); reside in a Department of Juvenile Justice or mental health residential treatment or commitment facility; are eligible for refugee assistance; reside in a developmental disability center; or have enrolled in a home and community-based services waiver or are waiting for waiver services.

Exhibit 2
Florida Medicaid Has Delivered Services Through Several Managed Care Programs

Florida Medicaid Managed Care Program	Timeframe	Location	Description
Miami-Dade Prepaid Dental Health Plan Pilot Program (**Miami-Dade Pilot**)	2004 - 2014[1]	Miami-Dade County	AHCA contracted with two dental health plans, using a risk-based capitated payment system, to provide dental services to Medicaid-eligible children under the age of 21.
Medicaid Reform (**Reform Pilot**)	2006 - 2014	Five counties—Broward and Duval (implemented 2006); Baker, Clay, and Nassau (implemented 2007)	AHCA contracted with both HMOs and PSNs to deliver services in the Reform Pilot counties; HMOs received risk-based capitated payments, PSNs received fee-for-service payments; enrollees received dental services through their health plans.
Statewide Prepaid Dental Health Plans (**Prepaid Dental**)	2012 - 2014	61 counties—excluded Miami-Dade County and the 5 Reform Pilot counties	AHCA contracted with two dental health plans, using a risk-based capitated payment system, to provide dental services to Medicaid-eligible children under the age of 21.
Managed Medical Assistance (**MMA**)[2]	2014 - present	Statewide	AHCA contracts with health plans, using a risk-based capitated payment system, to deliver all health care services to enrollees; enrollees receive dental services from the health plans.

[1] The 2001 Legislature authorized the Miami-Dade Pilot; the first contract was executed in 2004.

[2] Managed Medical Assistance is one part of Florida's Statewide Medicaid Managed Care program that also includes a long-term care component.

Source: OPPAGA analysis of Florida Medicaid information.

Data from two sources are used to measure Medicaid dental program effectiveness and performance

Federal law specifies the minimum services and populations to be covered by state Medicaid programs. However, states may offer services and cover populations in excess of federal requirements. In addition, states may choose how programs are administered and what service delivery and payment models are used.

States may measure Medicaid program effectiveness and performance using data from two sources. (See Exhibit 3.)

- **Federally required Centers for Medicare and Medicaid Services 416 Report.** The Centers for Medicare and Medicaid Services (CMS) requires states to annually submit statewide data on EPSDT Program services across all service delivery systems. The information gathered in the report is used to assess the effectiveness of a state's program in terms of the number of all children under the age of 21 who received health screening services, corrective treatment, and dental services.
- **Healthcare Effectiveness Data and Information Set (HEDIS).** The National Committee for Quality Assurance created the HEDIS measures; all HEDIS data are audited by committee-certified auditors.[8] Health plans use HEDIS to measure a broad range of health issues, including dental services. AHCA requires the MMA health plans to submit HEDIS measures; AHCA also required the Prepaid Dental plans to submit HEDIS measures.

Currently, health outcome data is limited to the data reported in the CMS 416 and HEDIS measures.[9]

[8] The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.

[9] Although health outcome data is limited, some stakeholders suggested that a reduction in pediatric emergency department (ED) use may be evidence of improving dental services. Our review of pediatric ED dental expenditures found $800,000 spent in Fiscal Year 2015-16 compared to $710,000 the prior year. The Fiscal Year 2015-16 expenditures were for approximately 15,000 children with primary diagnoses related to dental services such as abscesses, tooth decay, gingivitis, and dental disorders not otherwise specified or elsewhere classified as well as diagnoses for which someone might not typically visit a dentist, such as various types of mouth sores and diseases of the lips.

Exhibit 3
HEDIS and CMS 416 Measures Differ

Data Description	HEDIS	CMS 416
Purpose	Quality of individual managed care plans	Quality of state Medicaid program
Reporting Period	Calendar Year (January 1 through December 31)	Federal Fiscal Year (October 1 through September 30)
Eligible Population	No more than one gap in enrollment of up to 45 days during the measurement year	At least 90 days continuous enrollment during the year
Children Included	▪ Prior to Calendar Year 2015, children ages 2 to 21 ▪ Beginning in Calendar Year 2015, children ages 2 to 20	Children under age 21
Primary Comparable Measure	Percentage of eligible children who had at least one dental visit during the reporting calendar year	Percentage of eligible children receiving any dental services during the reporting federal Fiscal Year
Calculation	▪ Numerator: eligible children with one or more visits with a dental practitioner ▪ Denominator: total children with no more than one gap in enrollment of up to 45 days during the measurement year	▪ Numerator: unduplicated number of children under age 21 who received at least one dental service by or under the supervision of a dentist ▪ Denominator: total children eligible for EPSDT for 90 continuous days
Number of Children Included in the Most Recent Reporting Year	1.4 million (Calendar Year 2015)	2.4 million (Federal Fiscal Year 2014-15)
Additional Dental Measures	None	▪ Preventive dental services ▪ Dental treatment services ▪ Children ages 6 to 9 or 10 to 14 receiving a sealant ▪ Children receiving oral health services provided by a non-dentist provider
Other Information	Official HEDIS data are subject to audit by National Committee for Quality Assurance-certified auditors	Includes any eligible children receiving Medicaid services including Medicaid fee-for-service

Source: OPPAGA analysis of HEDIS and CMS 416 Report information.

Questions

What do effectiveness and performance measures show regarding access and use of children's Medicaid dental services?

HEDIS and CMS 416 data show increased access and use of children's dental services, although additional data is needed to attribute this improvement to the current managed care program.

Access and utilization measures indicate progress in providing Medicaid dental services for children. From 2013 to 2015, the statewide percentage of Medicaid children who accessed dental services increased. Calendar years 2013 and 2015 represent two years during which Florida provided Medicaid dental services through two different statewide service delivery models. Calendar year 2013 is the first full enrollment year of the Prepaid Dental program; the program was implemented and enrollment was gradually expanded across the state during 2012. Calendar year 2015 represents the first full enrollment year of the state's MMA Program after implementation during 2014.

The calendar year 2015 HEDIS data show a 10% increase in children who had at least one dental visit (for those enrolled with the same managed care plan for at least 11 months).[10] The CMS 416 results show a smaller increase (6%) for Medicaid children receiving any dental services (in federal Fiscal Year 2014-15 who had at least 90 days continuous Medicaid enrollment). (See Exhibit 4.)

[10] The 10% increase shows the calendar year 2015 MMA HEDIS results compared to the calendar year 2013 HEDIS results that included the 61-county Prepaid Dental program and the Miami-Dade Prepaid Dental Pilot.

Exhibit 4
While CMS 416 and HEDIS Measures Differ, Both Show a Higher Percentage of Children Accessing Dental Services in 2015 Than 2013

HEDIS Measured during the calendar year for only managed care health plans (For 2015, N=1.4 million)		
	2013	**2015**
Percentage of eligible children who had at least one dental visit	37%[1]	47%
CMS 416 Measured during the federal Fiscal Year for all Medicaid programs (For 2015, N=2.4 million)		
	2013	**2015**
Percentage of eligible children receiving any dental services	28.6%	34.6%
Percentage of eligible children receiving preventative dental services	23.6%	31.0%
Percentage of eligible children receiving dental treatment services[2]	11.4%	13.7%

[1] The calendar year 2013 HEDIS measure includes the 61-county Prepaid Dental program and the Miami-Dade Prepaid Dental Pilot.

[2] Dental treatment services involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, and adjunctive general services.

Source: Agency for Health Care Administration.

Additional data are needed to attribute the increased use of dental services to the current statewide managed care program. Data are limited given that the Prepaid Dental program lasted just two years, and that due to MMA's implementation schedule, 2015 is the first year with statewide program enrollment. (See Appendix D for further discussion of data limitations related to Medicaid dental services.)

Do service delivery models influence participation or provider and patient satisfaction?

Provider participation is low and relatively stable despite the recent change in delivery models. Provider participation may depend on many factors including one's sense of responsibility to provide for the needy. Provider satisfaction is affected by reimbursement rates, administrative issues, and patient behavior. Research also suggests that many factors can influence patient satisfaction.

Medicaid dentist participation levels appear to have remained the same since the transition from the Prepaid Dental program to MMA. This suggests that service delivery or payment models have little impact on provider willingness to participate.[11] AHCA reported that in June 2013, approximately 2,700 unduplicated dentists participated in the Prepaid Dental program. At the same time, the agency reported that approximately 1,000 dentists participated in the Reform Pilot. The combined 3,700 dentists in both the Prepaid Dental and Reform Pilot programs compares to the 4,136 Medicaid dentists the agency reported as of March 2016 for the MMA program.[12]

To examine provider attitudes, OPPAGA surveyed 3,233 Florida Medicaid dentists about their experiences providing services in the

[11] The agency reported that different models of managed care did contribute to an increase in provider participation when compared to fee-for-service. The Department of Health's 2009-10 workforce survey showed that of the 9,400 active dentists in Florida, 1,500 were enrolled as Medicaid providers.

[12] For the purpose of our review, the agency provided a point-in-time number of participating Medicaid dentists (4,136). Subsequently, OPPAGA analyzed a file containing 4,448 entries of all participating Medicaid dentists for January 1, 2014 through June 30, 2016. The agency acknowledged that, for a variety of reasons, the file might contain some dentists who were no longer participating. A total of 3,508 dentists remained in the file after we eliminated duplicate entries and those dentists who were either not actively practicing in Florida in June of 2016 or had a license status that indicated they were not providing services, e.g., they had relinquished their licenses, were deceased, or had suspended licenses, etc. While some of these dentists may have been actively participating during this 2.5 year period, the net difference suggests little or no change in overall provider participation.

MMA program. Only 12% of dentists responded (379) to the questionnaire and, of those, 32% no longer participate.[13] When asked to select one or more reasons for participating as a Medicaid provider, responding dentists most frequently reported that they were fulfilling a personal responsibility to provide dental care to the needy (64%) or that they believe that dental care should be available for all patients (63%). One stakeholder reported that rather than participate in Medicaid, some dentists fulfill these beliefs by choosing to provide charitable services (e.g., participating in community events where patients are provided dental services at no cost).

Half of Medicaid dentists served fewer than 100 children in a 12-month period. We analyzed Florida's federal Fiscal Year 2014-15 CMS 416 data and found that during that time, approximately 2,823 distinct dentists treated a Medicaid child for any dental service.[14] Of those dentists, 21% treated fewer than 10 children during the year and more than half (51%) treated fewer than 100 children. (See Exhibit 5.)[15]

Exhibit 5
Fifty-One Percent of All Florida Medicaid Dentists Who Treated Medicaid Children During Federal Fiscal Year 2014-15 Treated Fewer Than 100 Children

Number of Children Treated	Percentage of All Medicaid Dentists Treating Children
Fewer than 10	21.0%
10 to 49	19.0%
50 to 99	11.1%
100 to 299	16.9%
300 to 499	7.8%
500 to 999	11.2%
1,000 to 1,499	5.9%
1,500 or more	7.1%

Source: OPPAGA analysis of Florida's Centers for Medicare and Medicaid Services' 416 data.

These results are consistent with national trends. Across the United States, participation by dentists in Medicaid is low. However, limited national data exists to compare Florida to the rest of the nation. The most recent studies indicate little change nationally in Medicaid dental provider participation from 2000 to 2009; however, these studies report participation for all dentists not just Medicaid enrolled dentists.[16]

Research identifies many factors that may limit dentist participation in Medicaid; AHCA contracts require plans to meet provider network standards. Barriers to participation include reimbursement rates, administrative burdens such as cumbersome procedures and paperwork (e.g., claims processing and credentialing), and patient behaviors such as broken appointments and non-compliance with treatment recommendations.[17] Further, one Florida study identified a perceived social stigma related to being a Medicaid provider as a

[13] OPPAGA surveyed 3,233 dentists who AHCA reported as Medicaid dental providers and who had an active, clear license with the Department of Health's Division of Medical Quality Assurance. Of the 3,233 dentists, 3,042 had a valid email address. Of the 3,042 dentists who received the survey, 379 (12%) responded. Of the 379 respondents, 122 (32%) reported that as of August 1, 2016, they did not provide Medicaid dental services. Agency officials said that in the past they have identified a provider education issue that exists in managed care. Some dentists may not realize they are serving Medicaid patients, instead they identify with a particular health plan or dental subcontractor (i.e., being credentialed with a health plan, being paid by a dental subcontractor).

[14] The CMS 416 data does not provide a start or end date for the provider. Therefore, we cannot determine how many providers had only a partial year of Medicaid participation.

[15] Disaggregate level CMS 416 data was not available for prior years.

[16] *Factors Contributing to Low Use of Dental Services by Low-Income Populations.* U.S. Government Accountability Office. September 2000; *Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns.* U.S. Government Accountability Office. November 2010.

[17] Patient compliance may be defined as the extent to which a person's behavior coincides with medical or oral health related advice. It reflects a patient's willingness to comply with preventive or therapeutic strategies as set forth by his or her health care provider. Dahiya, P., Kamal, R., Kumar, M., Bhardwaj, R. *Patient Compliance - Key to Successful Dental Treatment.* Asian Pacific Journal of Health Sciences, 39-41. 2014.

barrier to participation. That is, Medicaid dentists felt that other dentists think less of them because they participate in Medicaid.[18]

In 2009-10, the Florida Department of Health conducted a dental workforce survey. The statewide survey of all dentists found that many in private practice did not participate in Medicaid because of low compensation (53%), too much paperwork (34%), and billing requirements (25%).

AHCA addresses provider participation through network standards. The initial MMA contracts required health plans to provide at least one general dentist per 1,500 enrollees within specified driving distances. This ratio may be increased by 500 enrollees for every licensed dental hygienist affiliated with the dentist; this increase is limited to two licensed dental hygienists per dentist. These network adequacy standards also applied to the Prepaid Dental program.

In October 2016, the agency amended the MMA contract standards in response to a settlement agreement related to Medicaid children's health care. The revised standards require health plans to provide at least one pediatric dentist per 3,000 enrollees. The amended standards also contain specific network adequacy standards for dental specialists, including endodontists, oral surgeons, and orthodontists.[19] Further, the health plans must ensure the availability of other specialty dental providers, at least on a referral basis, in the areas of periodontics and prosthodontics.[20]

Provider satisfaction is affected by reimbursement rates, administrative issues, and patient behavior. Of the dentists responding to the OPPAGA questionnaire who said they were serving Medicaid recipients, 42% reported being satisfied or somewhat satisfied with providing services in the Medicaid program, while 37% were dissatisfied or somewhat dissatisfied. We also asked participating dentists to rank their satisfaction with specific factors regarding their participation in the Florida Medicaid program during the last year. Reimbursement rates (64%) and availability of specialists for referrals (63%) were the most frequently cited factors for which dentists were dissatisfied. (See Exhibit 6.)

Exhibit 6
Several Factors Affect Participating Dentists' Satisfaction

Most Frequent Factors Contributing to Medicaid Dentists' Dissatisfaction According to Survey Respondents	Percentage of Responding Medicaid Dentists Who Were Dissatisfied or Somewhat Dissatisfied
Reimbursement rates	64%
Availability of specialists to whom patients can be referred	63%
Scope of services offered by Medicaid	50%
Patient appointment attendance	48%
Patient compliance with treatment recommendations	43%

Source: OPPAGA survey of Medicaid participating dentists.

Stakeholders reported that one administrative factor that could influence provider satisfaction is provider credentialing requirements. During the Prepaid Dental program, providers had to be credentialed with, at most, two dental plans. Under MMA, providers must be credentialed with every health plan for which they provide services, which could be burdensome in areas with multiple MMA plans. In response to the OPPAGA questionnaire, 31% of respondents were dissatisfied or somewhat dissatisfied by the health plan credentialing process. In comparison, 25% reported that they were satisfied or somewhat satisfied, and 44% said

[18] Henrietta, L., et al. *Barriers to Medicaid Participation Among Florida Dentists.* Journal of Health Care for the Poor and Underserved, 154-167. February 2012.

[19] As a result of a legal settlement with the Florida Pediatric Society, as of October 15, 2016, the MMA contracts require health plans to have one endodontist per 5,000 enrollees; one oral surgeon per 20,600 enrollees; and one orthodontist per 38,500 enrollees.

[20] Periodontics is a dental specialty focusing exclusively on the inflammatory disease that destroys the gums and other supporting structures around the teeth; prosthodontics is a dental specialty focusing on the replacement and restoration of missing teeth.

they were neutral. However, of those respondents who reported that they no longer participate in Medicaid, only 14% reported that their discontinued participation was due to the managed care credentialing process, suggesting that provider credentialing may not be overly burdensome.[21]

Patient satisfaction is affected by numerous factors. Patient satisfaction with access to and use of services encompasses many factors that go beyond scheduling and attending an appointment. For example, access may include ease of scheduling an appointment, the physical location of the provider's office, and timeliness of services.[22] Similarly, satisfaction related to utilization may encompass quality of care that goes beyond the actual dental services provided. Quality of care may also include a dentist's approach or manner with patients (e.g., whether the dentist is friendly and understanding). The patients' overall perception of dentists may affect their willingness to return for continued care.

No data are collected from patients regarding satisfaction with dental services; however, the agency tracks consumer complaints about health plans and providers. AHCA encourages Medicaid recipients to report complaints and issues to the Medicaid Complaint Operations Center; examples of reported complaints include missed or late services, problems receiving care, and dissatisfaction with services. The agency reported only 643 (5.2%) dental-related complaints out of 12,480 total complaints from April 2015 through April 2016. During this period, an average of 49.5 dental complaints were reported each month, or an average of 0.016 complaints per month per 1,000 enrollees.

What is known about the value and transparency of different Medicaid dental delivery models?

The value and transparency of Medicaid dental delivery models may be viewed in two ways—financial and programmatic. However, program differences, along with reporting inconsistencies over time, limit a direct comparison of the value and transparency of the different models.

Medical loss ratio data can provide insight into spending for dental services. One aspect of financial transparency related to dental services, whether provided by MMA or the Prepaid Dental program, is the medical loss ratio (MLR). A contractual MLR requires that a certain percentage of funds be spent on direct services (e.g., at least 85% of funds support direct patient care, while no more than 15% is used for administrative expenses). If a plan does not spend 85% of funding on direct care, the difference must be returned to the state.

The Prepaid Dental program had an 85/15 required MLR. During the Prepaid Dental program, the dental plans returned funds to the state because they did not meet the 85% required direct services threshold. In calendar years 2012, 2013, and 2014, the dental plans returned $7.7 million, $20.6 million, and $6.5 million, respectively.[23]

The current managed care program also has a required MLR of 85/15; however, because MMA is comprehensive managed care, the MLR applies to all services and is not specific to dental services or any other services. A separate MLR within comprehensive managed care for dental or behavioral health or any other service is contrary to the program's goal of providing flexibility within a single payment for all services.

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[21] For 122 survey respondents who reported that they had discontinued their participation in Medicaid, their reasons reflect those identified in the literature—reimbursement rates (61%), administrative complexity (46%), patient broken appointments (37%), limited services covered by Medicaid (34%), and other payment issues (34%).

[22] As required by federal law, the MMA health plans provide transportation to all Medicaid covered services. AHCA reported that the health plans subcontract for transportation services using subcapitated arrangements; as a result, it is difficult to capture the number of unique individuals and costs associated with transportation services for dental visits.

[23] For calendar years 2012, 2013, and 2014, each Prepaid Dental plan received a different capitated payment from AHCA and spent a different percentage of these funds on dental services. One plan received $20.3 million, $75.5 million, and $38.7 million and spent 75.0%, 80.2%, and 85.8% of funds on services, respectively. The second plan received $21.1 million, $76.4 million, and $37.3 million and spent 58.4%, 62.8%, and 67.7% of funds on services, respectively.

Expenditures, also used to measure value, are difficult to compare. AHCA monitors MMA plans' spending across service categories, including dental services. During calendar year 2015, the health plans spent $269 million on both children's and adult standard benefit dental services. (See Exhibit 7.) Since approximately 70% of the MMA population is children who receive full dental benefits while adults receive limited standard dental benefits, it is likely that the bulk of MMA dental expenditures are attributable to children.[24] The five-county Reform Pilot also included adult enrollees and, as a result, Reform Pilot expenditures also include some adult dental expenditures. In contrast, the Miami-Dade Pilot and the Prepaid Dental program only served children.[25] The different populations (adults and/or children), reporting periods (fiscal/calendar year), and enrollment information hinders comparison of the three programs' expenditures. In addition, the annual expenditure data cannot be used to calculate per person expenditures because enrollment data are captured monthly not annually; for comparison, the exhibit presents the highest enrollment month of the year.

Exhibit 7
Dental Services Expenditures Increased From the Prepaid Dental Program to MMA

Program	Year	Enrollment Snapshot for Highest Month of the Year	Total Dental Services Expenditures for Entire Year
Miami-Dade Pilot and Prepaid Dental Program[1] (62 counties)	State Fiscal Year 2012-13	1,410,979[2]	$83,876,625
Reform Pilot (5 counties; capitated HMOs only)	State Fiscal Year 2013-14	168,168[3]	$12,651,059
MMA (67 counties)	Calendar Year 2015	3,097,700[4]	$268,880,562

[1] Implementation of the Prepaid Dental program was not complete until December 2012. The agency was not able to provide expenditures for Fiscal Year 2013-14 because it was a transition year for the MMA program.

[2] Program enrollment represents a point in time—December 2012—the month with the highest enrollment during the fiscal year, while reported expenditures represent the entire fiscal year.

[3] Program enrollment represents a point in time—December 2013—the month with the highest Reform Pilot HMO enrollment during the fiscal year, while reported HMO expenditures represent the entire fiscal year.

[4] Program enrollment represents a point in time—December 2015—the month with the highest MMA enrollment during the calendar year, while reported expenditures represent the entire calendar year.

Source: Agency for Health Care Administration.

Programmatic differences between the two delivery systems emphasize competing goals. When it was created, the Prepaid Dental program only provided services for children; expanded adult dental benefits were not included by design.

Dental prepaid plans are focused only on dental providers, patients, and services; dental plan officials emphasize the value of their ability to understand and work with dentists and suggest that because they are dental-only providers, they are more effective at managing recipients' dental care.

In contrast, comprehensive managed care reflects the 2011 Legislature's direction to provide for a statewide system of care that coordinates all health care services, including dental services. According to health plan officials, the goals of comprehensive managed care include treating the whole person and

[24] Agency officials confirmed that the Medicaid program generally spends more on dental services for children than adults.

[25] The differences in enrollment populations affect available expenditure information. Because the same dental plans provided services in both programs, once the Prepaid Dental program began in 2012, the plans' expenditures for the Miami-Dade Pilot were combined with the Prepaid Dental program for reporting purposes; therefore, the agency could not provide us with expenditures by program. For MMA and the Reform Pilot, reported dental expenditures under these two comprehensive programs include children and the expenditures for the standard adult dental benefits that are covered by the Florida Medicaid program.

providing a single point of contact for all health care needs to help recipients more effectively navigate the health care system. No data is available to assess the health impact of care coordination on dental service delivery.

When committing to provide MMA services, the health plans agreed to provide expanded dental benefits for adults at no additional cost to the state.[26] From 2014, when the MMA Program began, through September 2016, AHCA reported that plans have spent an estimated $234.5 million for adult expanded dental benefits.[27] (See Appendix E.) These expanded benefits represent the plans' efforts to attract recipients who have a choice of health plans. All the MMA health plans provide adult dental benefits beyond the mandatory emergency and denture services required under the state Medicaid plan and do not receive state reimbursement for these services. While the health plans vary on which expanded benefits they offer, examples include cleanings, exams, and x-rays.

The MMA plans also may provide incentives to primary care physicians. According to health plan officials, Medicaid recipients are more likely to see a primary care physician than a dentist, so the plans have developed strategies to encourage plan doctors to promote and encourage dental visits. Plans may also offer alternative payments such as bonuses, pay-for-performance payments, or other incentives for primary care physicians whose patients schedule and keep dental appointments for themselves and their children.

What factors shape current and historical Medicaid dental services' rates?

Many factors have and continue to influence dental services' rates, including the structure of provider networks, health plans' contractual relationships with subcontractors, and the market demand for services. A diverse provider group including Medicaid health plans, private practitioners participating in the Medicaid program, Federally Qualified Health Centers, county health departments, and dental and hygiene school clinics also contributes to the complexity. Compared to Medicaid state rates, dental and health plans pay more for dental services.

Managed care allows for flexible financial arrangements with dental providers. MMA health plans provide dental services either directly through the plan's dental network or through subcontracts with dental organizations. (See Exhibit 8-1.) Provider rates may vary widely based on the nature of contracts. For example, the health plans may subcontract on a capitated, at-risk basis where the subcontractor receives an all-inclusive per-member, per-month (PMPM) payment to cover all recipient services and the company's administrative expenses. Alternatively, plans may use a non-risk-based contract and make an administrative PMPM payment to the subcontractor for administering the dental network and claims processing. The plan would then reimburse the subcontractor for the amount of service claims submitted. As a result of these differences, there is wide variation in the PMPM rates health plans pay to their dental subcontractors. (See Exhibit 8-2.)

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[26] The health plans track and report the value of expanded adult dental benefits separate from plan expenditures for standard child and adult benefits. Expenditures reported in Exhibit 7 for the MMA plans do not include expanded adult dental expenditures.

[27] In the bill analysis for House Bill 819 (2016), AHCA calculated the estimated value for the expanded dental benefits using actual health plan expenditures, a conservative measure of the value of expanded dental benefits. Some health plan information is reported to the agency on an encounter basis. Encounter data are similar to fee-for-service claims data, but encounter data (1) are not tied to per-service payment from the state to the managed care organization because the state is not paying for individual services and (2) do not necessarily include a Medicaid-paid amount. To account for the value of expanded adult dental units of service, the agency calculated the value of these services by using the costs if the state had provided services on the basis of the state Medicaid fee-for-service rates.

Exhibit 8
Medicaid Dental Rates Reflect Market Conditions; No Standard Available for Comparing Rates Across Plans

Exhibit 8-1 Three Types of Contractual Payment Relationships

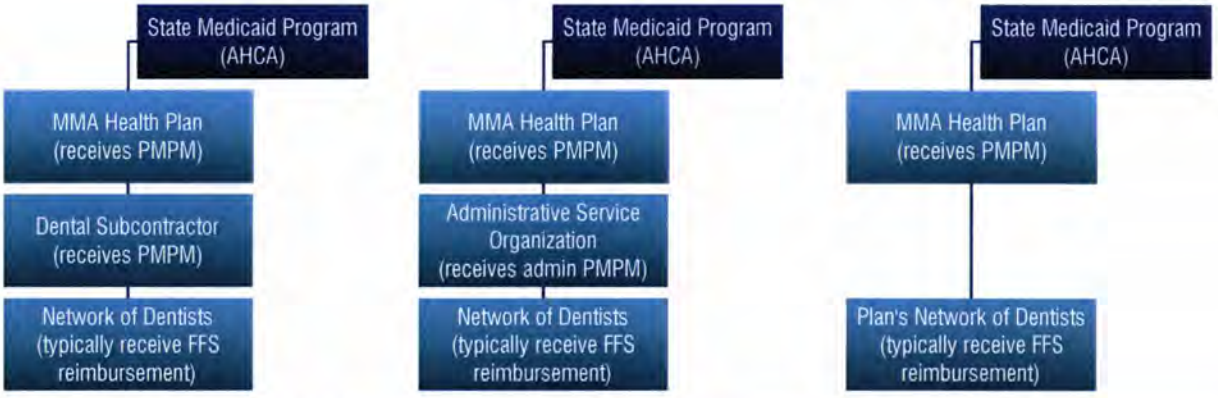


Exhibit 8-2 Per-Member, Per-Month Payments

Factors That May Influence What PMPM Health Plans Pay to Dental Subcontractors

- Health plan's business model, efforts to meet network adequacy standards, or other decisions
- Different program structures (e.g., Prepaid Dental compared to MMA)
- Differences in geographic service areas
- Differences in number of enrollees
- Different eligibility groups (e.g., TANF or SSI)

All-Inclusive, Risk-Based PMPM Payment

- This type of PMPM requires the subcontractor to absorb service costs if they exceed the amount of the health plans' PMPM payment (risk-based).
- PMPMs may change over time and programs, e.g., one provider's PMPM more than doubled from the Reform Pilot to the MMA program, ($4.48 to $11).
- PMPMs may differ by geographic region, e.g., one provider's PMPMs differed by as much as $2 for the same program and timeframe, but in different counties.

Non-Risk-Based Administrative PMPM

- This type of PMPM is intended to cover a provider's administrative cost including claims processing. Claims are paid on a fee schedule and reimbursed separately.
- An administrative PMPM would be much lower than an all-inclusive, risk-based PMPM because no services are included.
- One plan explained that it found that an all-inclusive PMPM was not cost effective and switched to an administrative PMPM (less than $1).

Exhibit 8-3 Fee Schedules and Rate Analysis

The Medicaid fee schedule remains important for understanding dental rates

- Miami-Dade Pilot contracts in 2004 and from 2006 to 2008 required services to be provided at or below the Medicaid fee-for-service rates.
- For the Prepaid Dental program, the Medicaid fee schedule rates were the lowest rates that providers could pay.
- Even though there is no specified floor in MMA for dental rates, some plans still use the Medicaid fee schedule for developing what the plans refer to as standard fee schedules.

Plans describe standard fee schedules; however, exceptions make the rule

- Subcontracted dental organizations typically pay dental service providers (e.g., dentists) using a fee schedule with specified billable amounts for each procedure (e.g., cleaning).
- Individual providers may negotiate exceptions to the standard fee schedule resulting in higher or lower rates for some services.
- Thus, plans may have dozens of different standard fee schedules as well as higher negotiated rates in areas where few dental providers are available to serve Medicaid patients.

Analysis of rate trends requires protecting confidential business information

- Subcontractors' use of dozens of rate schedules complicates analysis.
- No single base or standard rate for comparison aside from Medicaid fee schedule.
- To protect competitive business information, average 2012 rates used as the basis for comparison to analyze rates.

Source: OPPAGA analysis.

In the current marketplace, dental subcontractors are often dental health plans that operate networks of dental providers (e.g., dentists, hygienists, and specialists) and typically pay individual providers for each service based on a fee schedule. Some subcontractors are the same dental health plans that operated the dental networks during the Miami-Dade Pilot and the Prepaid Dental program. In addition to dentists in private practice, the subcontractors may negotiate relationships with other entities including Federally Qualified Health Centers and county health departments.

Florida's fee-for-service rate schedule for dental services continues to influence Medicaid dental reimbursement rates. Prior to the implementation of different forms of managed care, the state paid for Medicaid services on a fee-for-service basis that established allowable services as well as maximum rates and units of service for a specific list of dental procedure codes. The state continues to publish a Medicaid fee schedule for dental services because a portion of Medicaid recipients do not receive services under managed care. Historically, the state Medicaid fee schedule was incorporated in the dental reimbursement rates, i.e., agency contracts for dental services during the Miami-Dade Pilot and Prepaid Dental programs. (See Exhibit 8-3 above for additional information on the dental rate schedules.)

The last increase in the state Medicaid dental fee schedule occurred in 2011; the Legislature established a specific appropriation of $56 million to increase reimbursement rates for dental services provided to children. The 2011 appropriation resulted in a 49% increase in fee-for-service rates; the rate for a comprehensive oral evaluation, for example, increased from $16.00 to $23.78.

Compared to Medicaid state rates, dental and health plans paid more for dental services. To examine overall health plan rates for dental services, we estimated by year what the plans would have paid had they used the state Medicaid fee schedule and compared that to what they did pay. As shown in Exhibit 9, in 2012, plans paid 5.8% above what they would have paid strictly paying the Medicaid state rates. The highest percentage paid above the Medicaid state rates occurred in 2014 (11.3%) after which the percentage paid above the Medicaid state rates declined slightly. Many factors may contribute to this trend, including shifts in enrollment and changes in how frequently services were used.

Exhibit 9
Compared to Fee-for-Service Rates, Health Plans Paid More for Dental Services

Year	Percentage Health Plans Paid for Services Above the State Fee-for-Service Rates
2012	5.8%
2013	10.6%
2014	11.3%
2015	9.9%
2016[1]	9.0%

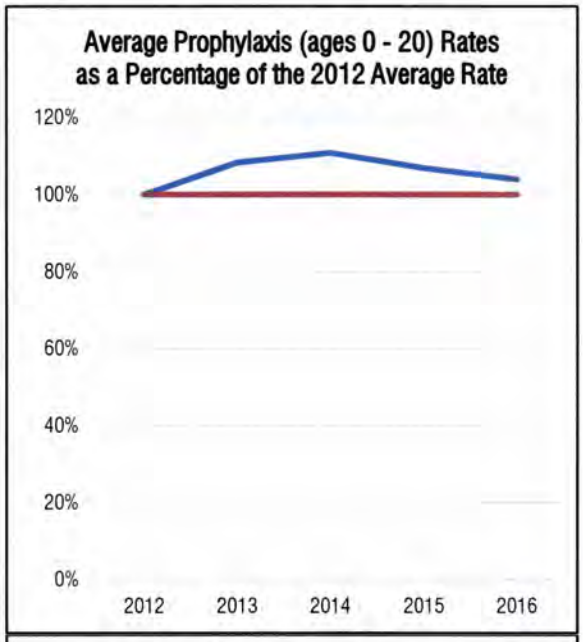
[1] The average rates for 2016 represent only a partial year of data as 2016 was not complete at the time of our review.

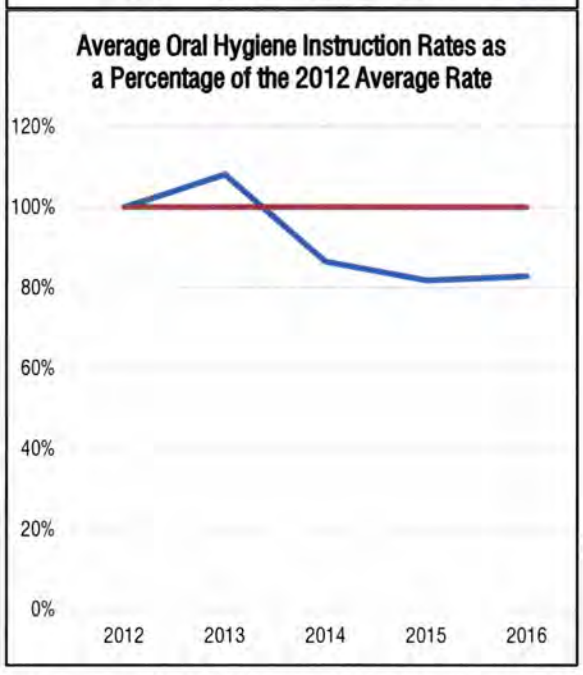
Source: OPPAGA analysis.

Rates paid for specific dental procedures show considerable variation over time. We examined the rates paid for the 10 most frequently provided Medicaid dental services, representing 71% of the dental services provided to children from 2012 to 2016. Exhibit 10 illustrates how average rates paid for 2 of the 10 varied during that period.

Plans reported that they negotiated rates as needed to attract providers where there was a greater need in some specialties or parts of the state. For example, plans may negotiate higher rates in areas where few dental providers are available. Most plans also negotiated separate rates for dental specialists, e.g., oral surgeons. As a result, not all procedures showed the same trend in rates over time. (See Appendix F for information regarding the 10 most frequently provided procedures.)

Exhibit 10
Rates for Individual Dental Procedures Vary Considerably When Compared to 2012 Average Rates[1]





[1] The average rates for 2016 represent only a partial year of data as 2016 was not complete at the time of our review.

Source: OPPAGA analysis.

We found a similar variation when we analyzed average rates associated with the 111 dental procedure codes that were provided by at least one plan in each year from 2012 to 2016.[28] As shown in Exhibit 11, there is no uniform trend when looking at changes in average rates for all procedure codes. For example, the proportion of procedures paid between 5% and 10% above the 2012 statewide average decreased while the proportion paid above 10% increased. The results suggest that plans adjust what they pay for procedures in different ways, presumably in response to market factors.

Exhibit 11
Changes in the Proportion of Dental Procedures Paid at, Above, or Below the 2012 Statewide Average Appear to Reflect How Plans Respond to Market Changes[1, 2]

Percentage Difference From 2012 Statewide Average	2013	2014	2015	2016
10% or more above	1%	22%	15%	10%
5% to 9.9% above	63%	30%	28%	19%
1% to 4.9% above	16%	22%	8%	16%
Within 1% (+/-)	9%	0%	3%	10%
1% to 4.9% below	1%	11%	30%	13%
5% to 9.9% below	10%	0%	0%	18%
10% or more below	0%	14%	15%	14%

[1] The average rates for 2016 represent only a partial year of data as 2016 was not complete at the time of our review

[2] Columns do not all sum to 100% due to rounding.

Source: OPPAGA analysis.

[28] The state Medicaid fee schedule included rates for 148 dental procedures. Procedures excluded from the analysis either were inconsistently provided in the information we obtained from the health plans and dental organizations or were associated with very little spending over time. Average rates were weighted by the units of service to make the analysis more reflective of the impact on providers and children. This analysis is not representative of the less-frequently provided specialty services.

What are the trends regarding Medicaid dental service delivery systems in other states?

States vary widely in the use of comprehensive managed care; many states still rely on limited forms of managed care and fee-for-service delivery of dental services. OPPAGA compared Florida to like states with most recipients in comprehensive managed care. Differences across state Medicaid programs may affect comparisons in access and utilization.

Many states with a high percentage of enrollees in comprehensive, risk-based Medicaid managed care rely on the health plans to provide dental services. States use various forms of managed care and different payment methods for delivering Medicaid medical and dental services. Many times, states with managed care are lumped together regardless of whether they provide comprehensive managed care, like Florida's MMA Program. In Florida, approximately 80% of Medicaid recipients receive all health care services through managed care. For our analysis, we divided the states into those with less than 50% and those with 50% or more of their Medicaid recipients enrolled in comprehensive, risk-based managed care. (See Exhibit 12.)

Exhibit 12
In 29 States, at Least 50% of the Medicaid Recipients are Enrolled in Comprehensive Managed Care[1]

States With at Least 50% of Medicaid recipients Enrolled in Comprehensive Managed Care	States With Less Than 50% of Medicaid Recipients Enrolled in Comprehensive Managed Care
AZ, CA, DE, **FL**, GA, HI, IA[2], IN, KS, KY, MD, MN, NE, NH, NJ, NM, NV, NY, OH, OR, PA, RI, SC, TN, TX, UT, VA, WA, WI **(29)**	AL, AK, AR, CO, CT, ID, IL, LA, MA, ME, MI, MO, MS, MT, NC, ND, OK, SD, VT, WV, WY **(21)**

[1] This information is based on 2014 Centers for Medicare and Medicaid Services' data.

[2] Per a discussion with Iowa officials, as of October 2016, 99% of its Medicaid population is enrolled in comprehensive managed care.

Source: Center for Medicare and Medicaid Services.

Further, with regard to Medicaid dental services, sometimes states are described as "carving in" or "carving out" dental services, but these terms are loosely defined. For example, some states still use primary care case management, a form of limited managed care where a primary care provider receives a fee for coordinating patient care. However, in this type of system, dental care is always separate from medical care. Under this scenario, we do not consider services in these states (and other states that use various forms of limited managed care) to be carved out since there is no comprehensive managed care model to which dental services could be carved in. Of the 28 states that are like Florida, 14 carve dental services into their managed care programs, 4 deliver services through a prepaid dental program, and 10 use a fee-for-service system. (See Exhibit 13.)

Exhibit 13
Many States With at Least 50% of Medicaid Recipients Enrolled in Comprehensive Managed Care Include Dental Services in the Managed Care Program

States With at Least 50% of Their Medicaid Recipients Enrolled in Comprehensive Managed Care (29)			States With Less Than 50% of Their Medicaid Recipients Enrolled in Comprehensive Managed Care (21)		
Dental Services Part of Managed Care (15)	Dental Services Delivered by Prepaid Dental Plans(4)	Dental Services Are Fee-for-Service (10)	Dental Services Part of Managed Care (3)	Dental Services Delivered by Prepaid Dental Plans(2)	Dental Services Are Fee-for-Service (16)
Arizona	California	Delaware	West Virginia	Louisiana	Alabama
Georgia	Rhode Island	Hawaii	Mississippi	Michigan	Colorado (ASO)[4]
Florida	Texas	Iowa[3]	Missouri		Alaska
Indiana	Utah[2]	Maryland (ASO)[4]			Arkansas
Kansas		Nebraska[5]			Connecticut (ASO)[4]
Kentucky		New Hampshire			Idaho (ASO)[4]
Minnesota		South Carolina (ASO)[4]			Illinois
Nevada[1]		Tennessee (ASO)[4]			Maine
New Jersey		Virginia (ASO)[4]			Massachusetts
New Mexico		Washington			Montana
New York					North Carolina
Ohio					North Dakota
Oregon					Oklahoma
Pennsylvania					South Dakota (ASO)[4]
Wisconsin					Vermont
					Wyoming

[1] Nevada issued a request for proposal (RFP) for managed care organizations in August 2016. The RFP stated that dental would no longer be part of the managed care program and that a separate RFP would be issued at a later date for dental benefits administration.

[2] Utah Medicaid recipients who live in Davis, Salt Lake, Utah, and Weber counties receive dental services through Prepaid Dental programs; recipients who live outside these counties receive dental services through Utah Medicaid's fee-for-service network.

[3] Per a discussion with Iowa officials, as of October 2016, 99% of its Medicaid population is enrolled in comprehensive managed care. Iowa's traditional Medicaid population receives fee-for-service dental services; its Medicaid expansion population (adults ages 19 through 64 at 0%-100% and 101%-133% of the federal poverty level) receives services through a prepaid dental plan.

[4] ASO is administrative service organization. These state Medicaid programs contract with a private company to administer the dental program on behalf of the state. Payment to dental providers is on a fee-for-service basis using the state Medicaid fee schedule.

[5] Nebraska issued an RFP for a Medicaid dental benefit program manager in October 2016.

Source: OPPAGA analysis of other states' Medicaid programs.

States continue to reconsider or make changes to the delivery of Medicaid dental services. We identified seven states (Indiana, Iowa, Nebraska, Nevada, New Mexico, New York, and Oregon) that have either changed or are in the process of changing how they deliver Medicaid dental services or are evaluating how they deliver Medicaid dental services. Four of these states have or plan to carve in dental services, two plan to carve out dental services, and one state is still considering its options.

Indiana. Indiana reported that by January 2017, all managed care recipients will be moved from fee-for-service dental to a carved-in model. State officials reported that they gathered and considered information from prepaid dental plans but chose to have the managed care health plans provide dental services. Officials reported that they chose to carve dental services into managed care in an effort to improve dental education to parents, decrease fraud, waste, and abuse, and increase dental provider recruiting efforts.

Iowa. As of October 2016, Iowa officials reported that 99% of the state's Medicaid recipients are enrolled in comprehensive managed care. Adults and children enrolled in Iowa's Medicaid program receive fee-for-service

dental benefits while the state's Medicaid expansion population receives dental services from one of two prepaid dental plans.[29] At the time of our review, Iowa officials reported that they were evaluating the delivery of dental services and considering four options: (1) maintain the current program structures; (2) move adults who are part of the traditional Medicaid population to the prepaid dental plan that serves the expansion population (children would continue to receive fee-for-service dental benefits); (3) move all populations to a fee-for-service delivery system; or (4) carve all dental services into managed care.[30]

Nebraska. In October 2016, Nebraska released a request for proposal (RFP) for a Medicaid dental benefit program manager. Currently, Nebraska delivers dental services through a fee-for-service model. The RFP describes a new Nebraska Medicaid managed care program to be implemented on January 1, 2017. The Nebraska RFP states that Nebraska seeks to transition the delivery of dental services to a prepaid dental plan. The RFP further states that the implementation of a prepaid dental plan will advance the Nebraska Medicaid program's oral health goals.

Nevada. Nevada currently carves in dental services to the managed care program.[31] However, the state plans to release an RFP for a dental benefits administrator in November 2016 and plans to deliver services through a prepaid dental program beginning in July 2017. Nevada officials reported that they chose a prepaid dental program model in an effort to increase the focus on dental services. The change corresponds to Nevada's re-bidding of its managed care contracts.

New Mexico, New York, and Oregon. In January 2014, New Mexico implemented a comprehensive, statewide, capitated, risk-based managed care program and chose to carve in dental services. Beginning in July 2012, New York carved dental services into its managed care program. Prior to that time, managed care plans had the option of providing dental services; all other dental services were fee-for-service. In 2012, Oregon implemented a new managed care program and chose to carve in dental services. Prior to 2012, dental services were offered through a prepaid dental program.

Florida's utilization of dental services is increasing, but still lags behind other large states. Florida has increased the percentage of children receiving dental services for the last three federal fiscal years, as measured in the federal CMS 416 reports. (See Exhibit 14.) Nevertheless, the state ranks below other large states on common measures of children's dental services.

Exhibit 14
Florida Medicaid's CMS 416 Results Indicate Increasing Utilization of Children's Dental Services

State (eligible population 2014-15)	Federal Fiscal Year 2012-13	2013-14	2014-15
Percentage of Eligible Population Receiving Any Dental Services			
Texas (3,563,282)	61.9%	59.4%	64.4%
Illinois (1,515,649)	53.5%	52.3%	46.1%
California (5,782,808)	43.2%	44.8%	44.4%
New York (2,463,374)	40.3%	42.4%	41.9%
Florida (2,403,286)	28.6%	29.4%	34.6%
Percentage of Eligible Population Receiving Preventive Dental Services			
Texas	49.8%	49.0%	62.5%
Illinois	50.4%	49.4%	42.9%
New York	38.4%	40.9%	40.2%
California	35.0%	36.3%	35.6%
Florida	23.6%	25.6%	31.0%
Percentage of Eligible Population Receiving Dental Treatment Services			
Texas	28.8%	27.6%	29.6%
California	20.1%	20.1%	19.1%
New York	18.8%	19.5%	18.8%
Illinois	20.5%	19.7%	16.3%
Florida	11.4%	11.4%	13.7%

Source: U.S. Centers for Medicare and Medicaid Services.

[29] Under the Patient Protection and Affordable Care Act, states may choose to expand Medicaid eligibility to include individuals not traditionally covered—those with incomes up to 133% of the federal poverty level. Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care Education and Reconciliation Act of 2010 (P.L. 111-152).

[30] Iowa officials plan to decide on a dental services delivery plan by July 1, 2017.

[31] Most (72%) of Nevada's Medicaid population, in two urban counties, receive mandatory managed care services.

Key state differences remain important to understanding children's access to and use of dental services. State Medicaid programs have fundamental differences with regard to Medicaid dental services, including historic differences in utilization, program structure and administration, and funding. For example, Florida has historic underutilization of dental services while Texas has historic overutilization. From 2003 to 2010, Texas' Medicaid orthodontic expenditures grew from $6.5 million to $220.5 million. A federal fraud investigation showed that Texas paid millions for unallowable Medicaid orthodontic services. Thus, regardless of similar Medicaid dental delivery systems, historically, Texas' utilization rates were significantly higher than Florida's.

Differences in how states administer Medicaid programs may also influence service utilization, including dental services. These differences complicate efforts to draw conclusions regarding the effect of various delivery models. For example, Illinois has less than 50% of its Medicaid population in comprehensive managed care and provides dental care through a fee-for-service system. States may also administer Medicaid programs at the local level rather than the state level. For example, California administers its Medicaid program at the county level and provides medical services through comprehensive Medicaid managed care and dental services through a Prepaid Dental program. In addition, states may serve all Medicaid recipients through one program or may have separate programs for different populations. For example, Iowa operates two programs—one for its traditional Medicaid population and one for its expansion population.

While Florida's percentages of children accessing dental services have shown improvement over the last three federal fiscal years, this is not the case for all states. In Illinois, the percentage of children receiving any dental services has decreased across the board over the last three federal fiscal years, decreasing from 53.5% to 46.1%. The percentage of children who received any dental services in California shows a very small increase in recent years, less than 1%. In New York, the percentage of children receiving any dental services decreased in federal Fiscal Year 2014-15 after increasing slightly in the prior year.[32]

[32] Another factor that must be considered is the extent to which states capture and measure CMS 416 data in different ways. In 2011, the Medicaid and CHIP Payment and Access Commission reported concerns about the comparability of CMS 416 data across states. In particular, the commission expressed concern that states may require different levels of reporting from managed care plans and certain other providers such as Federally Qualified Health Centers. In March 2016, AHCA completed its work with federal officials to improve how Florida captures and reports CMS 416 data but not all states have taken these steps. Improvements to AHCA's calculation of the CMS 416 measures resulted in an approximately 1% increase in the dental service utilization rate. However, the extent to which improvement in the plans' data submissions affected the CMS 416 measures cannot be determined.

Glossary of Acronyms and Abbreviations

AHCA: The Florida Agency for Health Care Administration

ASO: Administrative Service Organization

CFR: Code of Federal Regulations

CHIP: Federal Children's Health Insurance Program

CMS: Federal Centers for Medicare and Medicaid Services

CMS 416 Report: Federal Centers for Medicare and Medicaid Services required annual submission by states on performance in the Early Periodic Screening, Diagnostic, and Treatment Program (children's Medicaid services)

EPSDT: Early Periodic Screening, Diagnostic, and Treatment Program

FFS: Fee-for-Service

HEDIS: The Healthcare Effectiveness Data and Information Set

HIPPA: The Health Insurance Portability and Accountability Act

HMO: Health Maintenance Organization

Miami-Dade Pilot: Florida's prepaid dental health pilot program, operational 2001 to 2014

MLR: Medical Loss Ratio

MMA: Florida's Managed Medical Assistance Program

PCCM: Primary Care Case Management

PMPM: Per-member, per-month prospective payment use for capitated financial agreements

Prepaid Dental: Florida's 61-county Prepaid Dental Health Program, operational 2012 to 2014

PSN: Provider Service Network

Reform Pilot: Florida's five-county Medicaid Reform Pilot, operational 2006 to 2014

RFP: Request for proposal

SMMC: Florida's Statewide Medicaid Managed Care Program

SSI: Federal Supplemental Security Income Program

TANF: Federal Temporary Assistance for Needy Families Program

Title XXI MediKids: Florida's CHIP Program for children who are ages one through four and between 133% and 200% of the federal poverty level

Appendix A

The Florida Medicaid Program Has Experimented With Various Forms of Managed Care

The Florida Medicaid program began delivering services using a managed care model, on a limited basis, in 1982.[33] Since that time, the program has delivered services through several different managed care models, requiring different levels of care coordination and varying payment processes. Some managed care models (e.g., primary care case management) provided limited care coordination and used a fee-for-service payment system, where services were provided and reimbursed on an individual basis, while other models require coordination of all services through a capitated payment system. A capitated payment system allows the state to contract to make a prepaid, fixed, lump-sum payment per recipient on a monthly basis. This payment, known as a per-member, per-month payment, is designed to cover all services a recipient needs; when a managed care system accepts a capitated payment, it assumes financial risk for delivering all covered services. Exhibit A-1 describes some of the managed care programs that Florida Medicaid has used to deliver services, including the model of managed care used and the payment structure.

Exhibit A-1
Florida Medicaid Has Delivered Services Through Various Managed Care Models and Programs

Florida Medicaid Managed Care Program	Managed Care Model and Description	Payment Structure
MediPass	**Primary Care Case Management** (PCCM)—Health care providers, usually primary care physicians, that provide basic care and coordinate any needed specialty care or other services furnished by other health care providers; Florida's PCCM program was established in 1991.	The primary care physician received a case management PMPM; physician's services were paid on a fee-for-service basis.
Prepaid Health Plans	**Prepaid Limited Health Service Organizations**—Prepaid limited health plans that provide limited or specialized services to certain Medicaid beneficiaries. Florida Medicaid operated a Prepaid Dental Pilot Program in Miami-Dade County from 2004 to 2014 and another Prepaid Dental program in 61 counties from 2012 to 2014. Florida Medicaid has also contracted with prepaid behavioral health plans for certain mental health services: behavioral health targeted case management; community mental health; inpatient psychiatric hospitalization; and outpatient psychiatric hospitalization.	The Prepaid Dental plans provided all Medicaid covered dental services to children under the age of 21 on a capitated basis.
Medicaid Reform	**Health Maintenance Organizations** (HMOs)—Health care plans that allow their recipients to choose a primary care physician from the HMO's network of providers who then refer recipients to network specialists and hospitals when necessary. **Provider Service Networks** (PSNs)—Health care networks that are majority-owned and operated by a health care provider or group of affiliated health care providers, e.g., hospitals and physician groups; recipients choose a primary care physician from the PSN's network of providers. The Reform Pilot was implemented in Broward and Duval counties in 2006 and Baker, Clay, and Nassau counties in 2007.	The **HMOs** provided Medicaid services on a capitated basis, while the **PSNs** provided services on a fee-for-service basis.
Statewide Medicaid Managed Care (SMMC)	AHCA contracts with **HMOs** and **PSNs** as managed care plans. Medicaid recipients enroll in a managed care plan that coordinates all their health care, including dental services. SMMC was fully implemented statewide by August 2014.	All SMMC plans receive a capitated payment to offer and coordinate all Medicaid services.

Source: OPPAGA analysis.

[33] The Palm Beach County Public Health Plan operated Florida's first Medicaid managed care plan.

Appendix B

Medicaid Rates for Dental Services Are Subject to Federal Requirements and Are Not Comparable Across Programs

The Agency for Health Care Administration establishes rates for managed care, fee-for-service, and long-term care, as well as rates for specific providers and programs. Florida contracts with an actuarial firm for rate setting. The current MMA rates must meet the following criteria.

- Approved by the federal Centers for Medicare and Medicaid Services.
- Actuarially sound as required by 42 CFR 438.6(c).[34]
- Certified, with rate changes accompanied by documentation from the actuary.

Capitation rates are the per-member, per-month amount, including any adjustments, that is paid by the agency to a health plan for each Medicaid recipient enrolled under a contract for the provision of Medicaid services during the payment period. Capitation rates reflect historical utilization and spending for covered services projected forward and adjusted to reflect the level of care profile (risk) for enrollees in each health plan.

Exhibit B-1 presents the Fiscal Year 2013-14 capitation rates for both the Miami-Dade Pilot and the Prepaid Dental program. Prepaid Dental rates applied to 61 counties, excluding Miami-Dade County and the Reform pilot counties. Both the Miami-Dade Pilot and the Reform Pilot ended with the implementation of the MMA program. Rates in Exhibit B-1 are dental-only rates that vary by eligibility category, age, and region. Children typically are eligible via criteria for Temporary Assistance for Needy Families (TANF) or under Supplemental Security Income (SSI) due to disability.

Exhibit B-1
Fiscal Year 2013-14 Capitation Rates for the Miami-Dade Pilot and the Prepaid Dental Program

	Miami-Dade Pilot	Prepaid Dental Program (Range of Rates across Regions)[1]	Miami-Dade Pilot	Prepaid Dental Program (Range of Rates across Regions)[1]
	TANF Rates by Age		SSI Rates by Age	
3 to 11 months (Male and Female)	$0.05	$0.01 to $0.06	$0.03	$0.01 to $0.03
1 to 5 Years (Male and Female)	$7.28	$1.44 to $8.84	$7.93	$1.46 to $8.49
6 to 13 Years (Male and Female	$12.24	$2.42 to $14.88	$10.45	$1.92 to $11.19
14 to 20 Years (Male only)	$12.38	$2.45 to $15.05	$9.40	$1.73 to $10.07
14 to 20 Years (Female only)	$11.06	$2.18 to $13.44	$9.40	$1.73 to $10.07

[1] Prepaid Dental rates were lowest in Region 1 (Escambia, Okaloosa, Santa Rosa, and Walton counties) and highest in Region 9 (Indian River, Martin, Palm Beach, Okeechobee, and St. Lucie counties).
Source: Agency for Health Care Administration.

For the Reform Pilot and MMA, dental services are incorporated into rates that also include all other needed services such as primary care, hospitalization, etc. In addition, the age bands for the MMA rates differ from the dental-only rates. The MMA rates are based on age bands as follows: 0 to 2 months, 3 to 11 months, 1 to 13 years, 14 to 54 years, etc. For Fiscal Year 2014-15, the MMA rates for children ages 1 to 13 ranged from $111.70 (Region 1) to $134.27 (Region 11). According to the agency, there is no method for parsing out the dental-only cost from these overall rates; thus, there is no method for comparing across programs.

[34] Actuarial soundness means that rates must be developed by a qualified actuary and provide for all reasonable, appropriate, and attainable costs of providing the required care and administering the contract including benefit costs, administrative expenses, fees and taxes, and cost of capital.

Appendix C

Miami-Dade and Reform Pilot Programs

Appendix C provides information on two Florida Medicaid delivery systems that were implemented prior to the Prepaid Dental program and MMA—the Miami-Dade Prepaid Dental Pilot Program and the Medicaid Reform Pilot Program. The Miami-Dade Pilot provided dental services to children under the age of 21 in Miami-Dade County. The Reform Pilot provided all Medicaid covered services, including dental to both adults and children in five counties. Dental HEDIS measures are presented for both programs; Miami-Dade Pilot HEDIS measures were not audited until the calendar year 2012 submission. Further, because both of these pilot programs served small proportions of the state's entire Medicaid population, these data cannot be used to extrapolate on a statewide basis.

Miami-Dade Prepaid Dental Pilot Program

The 2001 Legislature authorized the agency to implement a Medicaid prepaid dental pilot program in Miami-Dade. The Legislature specified that the Miami-Dade Pilot use a risk-based, capitated payment model in which AHCA would make a prospective per-member, per-month payment to the dental plans. In July 2004, AHCA executed the first Miami-Dade Pilot contract for a prepaid dental plan to deliver services to Miami-Dade County children under the age of 21 who were not already enrolled in a managed care plan that provided its own dental services.[35, 36] (Prior to July 2004, Florida contracted directly with dentists and paid them on a fee-for-service basis.) Beginning in 2010, AHCA contracted with two prepaid dental plans to provide services in the Miami-Dade Pilot. These two plans provided dental care for approximately 248,000 Medicaid children (8% of the total Medicaid population at the time). Both plans received capitated payments for providing all covered dental services.

Under the Miami-Dade Pilot, only dentists could provide covered children's dental services including diagnostic, preventive, therapeutic, palliative care, and the treatment of a particular injury. Like the 61-county Prepaid Dental program and the MMA program, the Miami-Dade Pilot included requirements for new member outreach. From 2004 to 2011, the dental plans were required to contact Medicaid recipients in the pilot area within 60 days of enrolling to educate them on dental services; plans were also required to contact enrollees who were six months behind on their screenings. Outreach requirements changed with the 2012 contract, which required plans to mail new enrollees materials, much earlier, such as within five calendars days of receipt of the enrollment file from Medicaid. It also required plans to contact enrollees within two months after a missed screening.

The Miami-Dade Pilot contracts included accountability requirements and allowed for incentives. Provider network adequacy requirements from 2004 to 2011 included one pediatric dentist per 12,000 enrollees (within specified driving times), as well as two endodontists, two oral surgeons, and two orthodontists for the whole network. The 2012 contract only specified a general dentist ratio, one per 1,500 enrollees throughout the network, and that dental specialists should be available on a referral basis. The Miami-Dade Pilot was allowed to pay the usual, customary, and reasonable fee to non-Medicaid dentists if a client could not find a Medicaid participating dentist. (See Exhibit C-1 for the number of participating dentists by year.) AHCA also required the dental plans to manage provider accountability through comprehensive training programs, claims review processes, and credentialing. In addition, the dental plans were required to evaluate system accountability through at least three mechanisms: (1) quality of care studies or performance improvement projects, (2) utilization

[35] Section 409.912(43), *F.S.* Also eligible were Title XXI MediKids (a subgroup of CHIP) and children with developmental disabilities.

[36] Proviso language in the 2001 General Appropriations Act authorized AHCA to initiate a prepaid dental pilot program in Miami-Dade County. Similar statutory authority was provided in 2003.

management criteria, and (3) by submitting to annual quality reviews or audits. Reporting requirements for the Miami-Dade pilot included

- summary service utilization data;
- payment rates and amounts to Federally Qualified Health Centers;
- submission of encounter data in a HIPAA compliant format;[37]
- financial reporting, no MLR specified; and
- optional sanctions for non-reporting.

Exhibit C-1
From Fiscal Year 2006-07 Through Fiscal Year 2009-10, the Number of Participating Dentists Decreased[1]

	Fiscal Year			
	2006-07	2007-08	2008-09	2009-10
Number of Participating Dentists	318	370	335	292

[1] Counts of dentists for the Miami-Dade Pilot are unavailable prior to Fiscal Year 2006-07 and after Fiscal Year 2009-10.

Source: Agency for Health Care Administration.

Incentives varied across stakeholder groups and over time. Between 2004 and 2011, the Miami-Dade Pilot contracts allowed for dental provider incentives. Specifically, the plans could pass incentive payments on to subcontractor providers (e.g., dentists) who met or exceeded a utilization rate of 60% for preventive care services among enrolled children ages 3 through 20 during each six month reporting period. The 2012 contract discontinued provider incentives, but allowed for the dental plans to give incentives to enrollees for following through on preventive dental visits. It also allowed AHCA to give incentives to high performing dental plans.

AHCA contracts included dental service requirements in addition to the HEDIS annual dental visit measure. The Miami-Dade Pilot contracts required the dental plans to achieve a dental service utilization rate of 60% for the children enrolled continuously for at least six months. However, the 2012 contract specified a screening rate of 60% for children enrolled continuously for eight months. Further, the 2012 contract contained four additional performance measures: the percentage of enrollees with an annual dental visit, a complete oral evaluation, sealants, and the percentage of enrollees contacted by the plan. By 2012, contracts specified dental plans that failed to achieve acceptable HEDIS scores were potentially subject to unspecified monetary damages. The percentage of children who had at least one dental visit during the year increased over the life of the Miami-Dade Pilot (Fiscal Years 2004-05 to 2013-14). Specifically, for one dental plan, the percentage increased from 20% in calendar year 2005 to 43.3% in calendar year 2013. (See Exhibit C-2.) The data suggest that dental services utilization leveled off in 2007 after initial increases and then began increasing in 2010. These increases mirror national trends for the same timeframe.[38] AHCA reported that the Miami-Dade Pilot significantly outperformed fee-for-service dental for federal Fiscal Year 2011-12 (October 1, 2011 to September 30, 2012) with regard to preventive dental services. In December 2012, the implementation of the 61-county Prepaid Dental program began. Miami-Dade and the Reform Pilot counties (Baker, Broward, Clay, Duval, and Nassau) were excluded from the 61-county Prepaid Dental program.

[37] Encounter data are similar to fee-for-service claims data, but encounter data (1) are not tied to per-service payment from the state to the managed care organization, because the state is not paying for individual services, and (2) do not necessarily include a Medicaid-paid amount.

[38] Nationally, for children enrolled continuously in Medicaid for 90 days or longer, the percentage who obtained preventive dental care almost doubled from 23.2% in federal Fiscal Year 2000 to 40.8% in federal Fiscal Year 2010.

Exhibit C-2
The Percentage of Children Who Had at Least One Dental Visit Increased Over Time

	Calendar Year								
	2005	2006	2007	2008	2009	2010	2011	2012	2013
Dental Plan 1	20.0%	25.7%	30.0%	31.5%	32.9%	37.7%	39.1%	41.4%	43.3%
Dental Plan 2						34.8%	35.6%	36.8%	39.9%

Source: Data from calendar years 2005 to 2011 was self-reported by the dental plans to the Agency for Health Care Administration. The first year the dental plans submitted audited performance measures was 2012.

Medicaid Reform Pilot Program

The Reform Pilot program served Medicaid recipients in five counties from 2006 through 2014 when MMA began. In 2005, the federal Centers for Medicare and Medicaid Services approved Florida's request for the Reform Pilot, a five-year Medicaid experimental demonstration pilot project.[39] The Reform Pilot, initially implemented in 2006 in Broward and Duval counties, expanded to Baker, Clay, and Nassau counties in 2007. The Reform Pilot was designed to foster and test a competitive marketplace for healthcare services that allowed the state to become a purchaser of services based on value and quality. The Reform Pilot emphasized choice counseling for recipients to help them select a health plan and allowed participating health plans to compete for enrollees by offering expanded benefits not otherwise available under Medicaid. The agency contracted with health maintenance organizations and provider service networks in the reform counties to deliver all Medicaid covered services to recipients, including dental services. The agency developed capitation rates for the Reform Pilot HMOs based on the health acuity of the population; PSNs provided services on a fee-for-service basis.

As with the MMA program, Reform Pilot health plans were required to offer comprehensive children's dental services. Under the Reform Pilot, covered services for enrollees under age 21 included diagnostic services, preventative treatment, Child Health Check-Up Program dental screenings, restorative treatment, orthodontics, and other dental services as defined in the Medicaid Dental Services Coverage and Limitations handbook. The health plans were required to cover fluoride treatment by a physician or a dentist for children and adolescents; however, if applied in a physician's office, application was limited to children up to three and one-half years of age. Health plans had the option to offer expanded dental benefits to adults; expanded adult dental benefits could include, routine preventative, diagnostic, restorative, and radiology services, as well as discounts on dental services.

The Reform Pilot contracts included health plan outreach requirements and provider network standards; however, they were not specific to dental care. Like the MMA program, the Reform Pilot provided recipients with all their health care needs, so contract provisions were not specific to dental services or dental providers. The Reform Pilot contracts required plans to contact new enrollees twice, if necessary, within the first 90 calendar days of enrollment to offer to schedule an initial appointment with a primary care physician. The health plans also were required to mail new enrollee materials, including the member handbook, provider directory, and identification cards, within five calendar days of enrollment. To further assist enrollees, the health plans were required to operate a toll-free telephone help line. The contract allowed health plans to utilize community outreach representatives who could provide outreach materials at health fairs and other public events.

Provider network standards were only specific to primary care and required one primary care physician per service area and at least one primary care physician per 1,500 enrollees. The health plans could increase this ratio by 750 enrollees for each advanced registered nurse practitioner or physician's

[39] In 2010, the Centers for Medicare and Medicaid Services granted Florida an extension for the Reform Pilot; the pilot was operational until the implementation of MMA in 2014.

assistant affiliated with a primary care physician. (Exhibit C-3 shows the number of dentists that participated in Reform Pilot health plans by year.) The health plans were required to assure that primary care physicians' services and referrals to participating specialists were available on a timely basis. To manage this requirement, the health plans were required to review a statistically valid sample of primary care physicians' offices average appointment wait times.

Exhibit C-3
From Fiscal Year 2007-08 Through Fiscal Year 2013-14, the Number of Reform Pilot Participating Dentists Increased

	Fiscal Year						
	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Number of Participating Dentists	88	203	320	585	1,007	982	1,033

Source: Agency for Health Care Administration.

The Reform Pilot contracts provided for both provider and system accountability requirements as well as recipient and physician incentive programs. The contracts required the health plans to manage provider accountability through several mechanisms, including claims review processes, credentialing, and training programs—both contract compliance training and service-specific training programs. Health plans also had to manage system accountability in various ways. For example, plans were required to maintain a quality improvement committee that was responsible for submitting an annual quality improvement plan and conducting reviews of utilization, grievances, and responses to adverse events. Reform Pilot health plans' reporting requirements were comprehensive; examples of areas of required reporting included

- finance;
- suspected fraud;
- provider network standards; and
- claims inventory.

In addition, the Reform Pilot allowed for both recipient and provider incentives. Health plans could provide incentives to recipients for the completion of a series of preventive services or for other health education activities. The plans also had the option to establish provider incentive programs.

The Reform Pilot health plans were required to gather and report HEDIS measures. The HEDIS measure specifically related to dental services measures the percentage of eligible children who had at least one dental visit during the reporting year. For HEDIS measures, health plans were required to meet the equivalent of the 75th percentile of national Medicaid health plan performance as compiled and reported in the HEDIS national means and percentiles. If AHCA determined a plan's performance was not acceptable, the plan was required to submit a performance measure action plan within 30 days of the unacceptable determination. If the plan failed to provide or failed to adhere to its own action plan, the agency could impose financial sanctions. Exhibit C-4 shows that for the Reform Pilot, the percentage of eligible children receiving at least one dental visit annually increased each year for the life of the pilot.

Exhibit C-4
The Percentage of Eligible Children in the Reform Pilot Receiving at Least One Dental Visit Annually Increased Over Time[1]

	Calendar Year						
	2007	2008	2009	2010	2011	2012	2013
Reform Pilot Plans	15.2%	28.5%	33.4%	34.0%	35.3%	40.4%	42.3%

[1] HEDIS measures reflect the weighted mean across all plans.

Source: Agency for Health Care Administration.

Appendix D

Medicaid Dental Services Data Limitations

Several overarching concerns exist regarding the data available to assess Medicaid dental services. In addition, questions exist regarding the quality of data reported in years prior to 2015.

Existing measures do not assess dental health or quality. The Dental Quality Alliance of the American Dental Association has suggested methods to improve dental measures by developing benchmarks and encompassing quality care. Current CMS 416 and HEDIS measures simply indicate whether children received dental services but do not provide information about the quality of or any improvement in a child's dental health. The alliance suggests measures that incorporate whether children who are at moderate or high risk of tooth decay received services which could help answer questions about improved health for at risk children.

National economic and policy changes may influence changes in dental services. Increases or decreases in dental services over time may be a product of national and state events. For example, the economic downturn beginning in 2008 led to a rise in Medicaid enrollment. Likewise, the federal government's nationwide Oral Health Initiative encouraged states to work toward improvements in children's oral health.[40] In addition, the 2011 Legislature increased funding for dental services which resulted in a significant rate increase. The timeframe of Florida's different Medicaid dental service delivery models also includes the economic recovery that began in 2012.

Only aggregate self-reported plan data are available prior to 2015. Federal Fiscal Year 2015 is the first complete year that individual child-level data is available for analyzing CMS 416 measures of children's dental services.[41] As a result, no check or further analysis of prior years' data can be conducted. While the agency captures individual data for each child who received dental services through fee-for-service, no individual data was collected during the Miami-Dade Pilot, Prepaid Dental, or Reform Pilot programs prior to October 2013. The agency required that health plans provide only aggregate numbers of children receiving any dental services, preventive services, treatment services, etc. For the transition period from October 2013 through September 2014, some individual child data was collected, but agency officials questioned the reliability of the data.

Problems with HEDIS measures for prior forms of managed care. Certain programs, such as the Miami-Dade Pilot, relied largely on self-reported HEDIS data rather than audited data. Further, technical analyses conducted for the agency found that under the Prepaid Dental program, the two dental plans did not ensure appropriate measurement of the dental measures; experts found that only one of three measures (annual dental visits) was reliable.

[40] The agency contractually requires MMA health plans to implement four Performance Improvement Projects; as part of the Oral Health Initiative, one project must focus on preventive dental care for children.

[41] The agency preserved the computer code used to calculate the CMS 416 measures the federal Fiscal Year 2015 report.

Appendix E

Expenditures for Expanded Dental Services for Adults

The MMA health plans provide expanded dental services for adults. States have flexibility to determine what dental benefits are provided to adult Medicaid enrollees. Federal law does not specify minimum requirements for adult dental coverage. Florida Medicaid offers emergency dental services for recipients age 21 years and older to alleviate pain, infection, or both, and procedures essential to prepare the mouth for dentures.[42] In Florida, the MMA health plans also offer expanded dental benefits to recipients age 21 years and older; these expanded benefits include preventive dental services, which adults in the program otherwise cannot access. Such services could include education, annual preventative dental visits, and x-rays. Adults must pay out-of-pocket for any services not covered by their MMA health plan. In general, we found that the type and number of expanded dental benefits offered to eligible adults (any non-emergency and denture-related services), varied by MMA health plan. While most plans offer an exam and an x-ray, fewer offer cleanings, and only some plans (5 of 14) cover fillings; 1 additional plan allows fillings as a service under a spending cap. The total number of covered procedures also varied across plans, ranging from two to six procedures per plan. (See Exhibit E-1.)

Exhibit E-1
Health Plans Differ in the Types of Medicaid Expanded Dental Services Offered to Adults

Managed Care Plan[1]	Expanded Services Covered by MMA Plans								
	Cleaning	Spending cap	Exam	Extractions	Fillings	Fluoride	Periodontal	Restorative	X-ray
Amerigroup	√		√		√	√			√
Better Health	√		√	√					√
Coventry	√		√		√		√		√
Humana	√		√			√	√	√	√
Magellan Complete Care[2]		√	√			√	√		√
Molina Healthcare of Florida	√		√		√	√			
Positive Healthcare Florida[2]		√							
Prestige Health Choice	√		√	√	√				√
Community Care Plan[3]	√		√						√
Simply			√	√					√
Clear Health Alliance	√		√	√					√
Staywell			√						√
Sunshine State Health Plan	√		√						√
United Healthcare of Florida	√		√		√				√
Total number of plans covering the procedure	**10**	**2**	**13**	**4**	**5**	**4**	**3**	**1**	**12**

[1] Data does not consider child-only plans or plans that were no longer providing Medicaid services.

[2] These two plans offer adult recipients reimbursement for select dental services each year, up to a dollar value limit ($1000 - $1500). Services for which both plans provide reimbursement include x-rays and cleanings.

[3] Community Care Plan is formerly South Florida Community Care Network.

Source: OPPAGA analysis of Agency for Healthcare Administration data.

[42] Section 409.906, *F.S.*

Most adults are eligible for Medicaid due to Temporary Assistance for Needy Families (TANF); the most frequent expanded services received are preventive services. From Fiscal Year 2013-14 through Fiscal Year 2015-16, the largest group of Florida adults eligible for expanded dental services were young adults, 21 to 30 years of age (26%) and female (69%). Most adults were eligible based on their TANF receipt (53%). Twenty-one percent of adults eligible for Medicaid expanded dental services were living in Miami-Dade and Monroe counties.

The MMA health plans reported that their dental provider networks made claims for over 6 million units of expanded dental services to eligible adults from Fiscal Year 2013-14 through Fiscal Year 2015-16. Two plans accounted for almost half (49%) of all the units of service provided during that timeframe. Statewide, adult Medicaid dental patients mostly received preventive dental services, including exams, education/instruction, and x-rays. (See Exhibit E-2.)

Exhibit E-2
The 10 Most Commonly Provided Adult Expanded Dental Services Were Mostly Preventive Services

Procedure	Number of Procedures Provided[1]
Comprehensive oral evaluation	1,522,884
Panoramic radiographic image[2]	928,871
Intraoral complete series including 14 bitewing x-rays[3,4]	729,981
Prophylaxis, adult[5]	649,595
Periodic oral evaluation—established patient	260,445
Oral hygiene instructions	232,572
Bitewing x-rays—4 images[4]	219,847
Resin-based composite, one surface, posterior[6]	210,715
Resin-based composite, two surfaces, posterior[6]	190,453
Bitewing x-rays—2 images[4]	178,528

[1] The number of procedures is not individual persons, it is service units. A single beneficiary may receive multiple services or multiple units of one service.

[2] A panoramic radiographic image is a type of x-ray that shows the entire mouth—all teeth on both upper and lower jaws—on a single x-ray.

[3] Intraoral complete series x-rays are the most common type of dental x-rays; they allow dentists to, for example, find cavities and otherwise monitor good tooth health.

[4] Bitewing x-rays highlight the crowns of the back teeth—both upper and lower. These x-rays are called bitewings because the patient bites down on a wing-shaped device that holds the film in place while the x-ray is taken.

[5] Prophylaxis is the cleaning of teeth, including removal of plaque, calculus, and extrinsic stains to prevent and control periodontal disease.

[6] Resin-based composites are materials made of ceramic and plastic compounds used to fill cavities.

Source: OPPAGA analysis of Agency for Health Care Administration data on encounter claims files as of September 14, 2016.

Expanded dental benefits for adults are one measure of value of the MMA program. As negotiated, MMA health plans provide expanded adult dental services at no additional cost to the state; the value of adult services is estimated based on the fee assigned to procedures under the Medicaid fee-for-service schedule for children's dental services. The agency estimated that, since the inception of the MMA program, the value of the adult expanded dental services the health plans' dental networks provided is more than $234 million.[43] (See Exhibit E-3.)

[43] In the bill analysis for House Bill 819 (2016), the agency calculated the estimated value for the expanded dental benefits using actual health plan expenditures, a conservative measure of the value of expanded dental benefits. Some health plan information is reported to the agency on an encounter basis. While encounters may include units of service, they may specify zero dollar amounts. To account for the value of these units of service, the agency calculated the value of these services by using the costs if the state had provided services on the basis of the state Medicaid fee-for-service rates.

Exhibit E-3
Since the Beginning of the MMA Program, Health Plans Have Provided Adult Expanded Dental Services With an Estimated Valued of More Than $234 Million

Managed Care Plan[1]	Estimated Value of Adult Expanded Dental Services[2, 3]
Humana	$74,917,175.92
Staywell	$43,918,182.40
Sunshine State Health Plan	$26,069,284.10
Prestige Health Choice	$24,676,248.67
United Healthcare Of Florida	$24,334,478.76
Amerigroup	$14,940,140.30
Molina Healthcare of Florida	$11,032,430.87
Magellan Complete Care	$6,058,034.28
Simply	$5,070,283.93
Better Health	$2,094,967.33
Integral Quality Care[4]	$518,071.52
Coventry Health Care	$507,071.88
Community Care Plan[5]	$157,140.01
Preferred Medical Plan[6]	$114,562.77
First Coast Advantage[7]	$70,798.44
Total	**$234,478,871.18**

[1] The list of health plans does not include specialty plans serving only children or plans without any expenditures.

[2] The estimated value of adult expanded dental services was calculated by repricing adult services using the children's fee-for-service rates. MMA began implementation in May 2014 and the Long-Term Care program began in August 2013. Reported amounts represent claims beginning with those dates and extending until September 14, 2016. Information is based on unverified encounter data reported by the Medicaid managed care plans.

[3] Comprehensive oral evaluations, panoramic x-rays, and the intraoral complete series are covered under the Medicaid state plan for one procedure every three years when accompanied by another covered adult dental procedure (such as denture fitting, etc.) and are not covered as preventative procedures for adults under the state plan. Costs shown in the table and usage noted in the preceding text are adjusted to reflect removal of the state plan component of expenditures related to those procedures.

[4] Integral Quality Care's Medicaid contract was assumed by Molina Healthcare of Florida in August 2015.

[5] Community Care Plan is formerly South Florida Community Care Network.

[6] Preferred Medical Plan's Medicaid contract was assumed by Molina Healthcare of Florida in July 2015.

[7] First Coast Advantage's Medicaid contract was assumed by Molina Healthcare of Florida in November 2014.

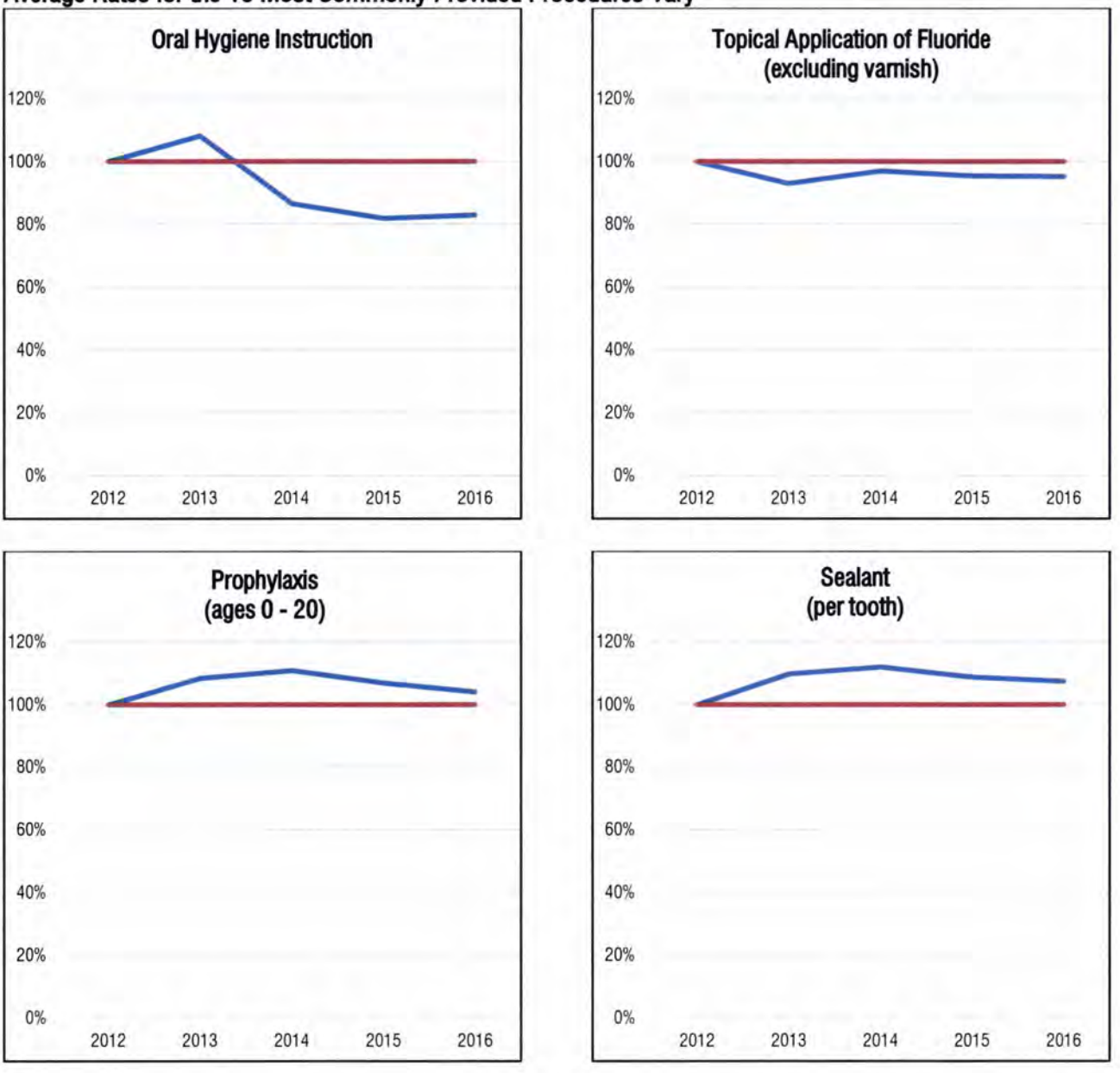
Source: OPPAGA analysis of Agency for Health Care Administration data on encounter claims files as of September 14, 2016.

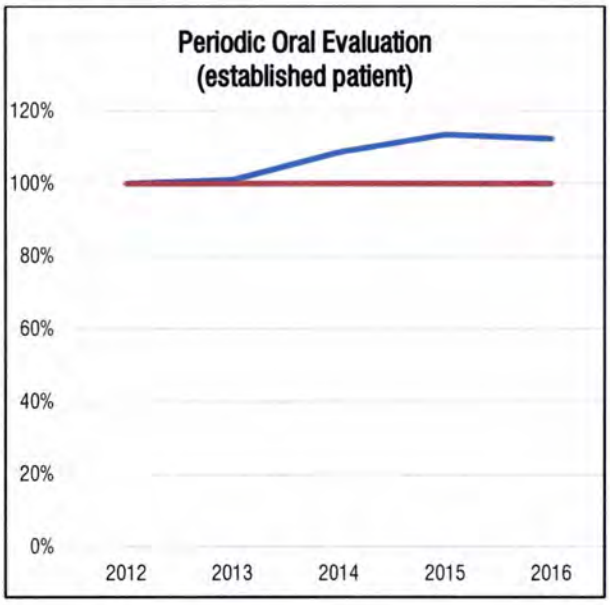
Appendix F

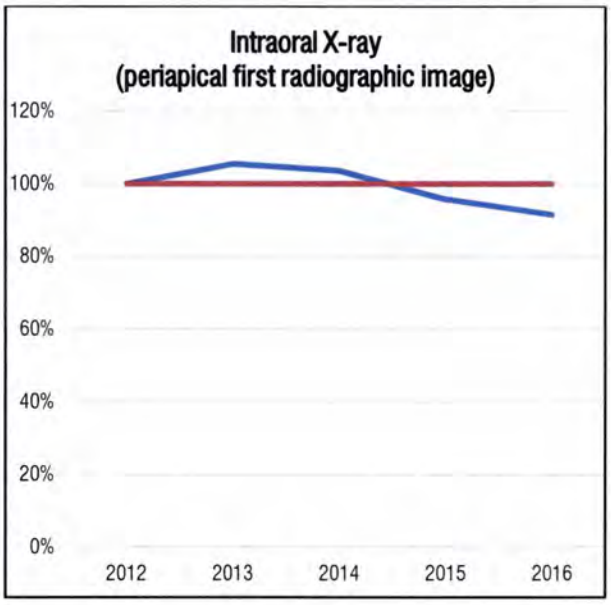
Average Rates for the 10 Most Frequently Provided Procedures Vary

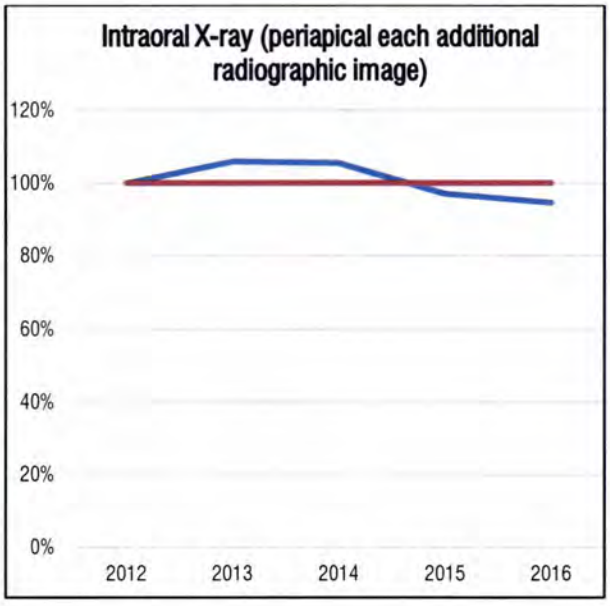
We examined the trend in average rates for the 10 most frequently provided procedures. Of the 111 procedures that we could examine across all five years, these 10 procedures accounted for approximately 71% of dental services provided to children. To provide for a consistent scale, each procedure's average rates (blue) are shown as a percentage of the 2012 average rates (red) for that procedure. Exhibit F-1 shows that the trends in average rates across these procedures varied.

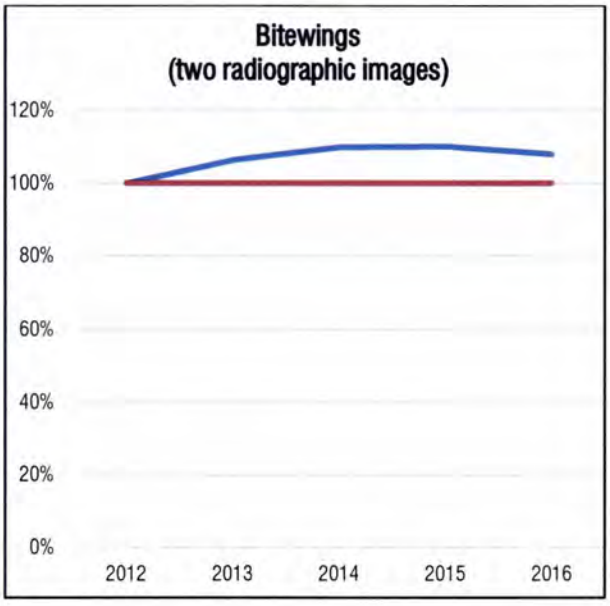
Exhibit F-1
Average Rates for the 10 Most Commonly Provided Procedures Vary

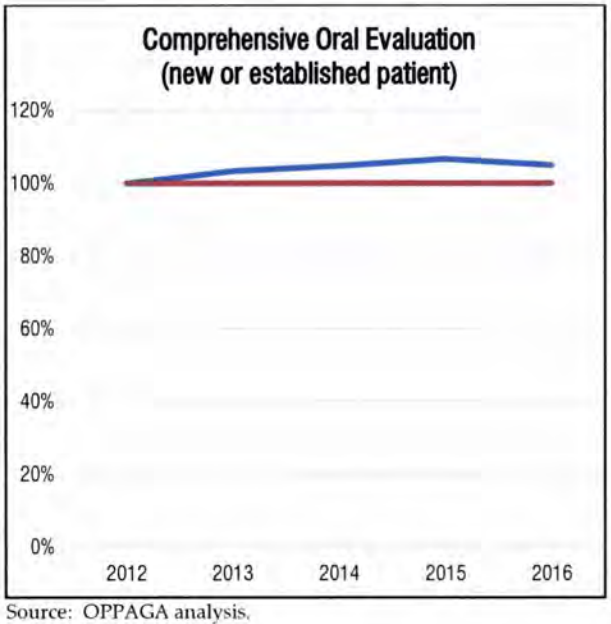


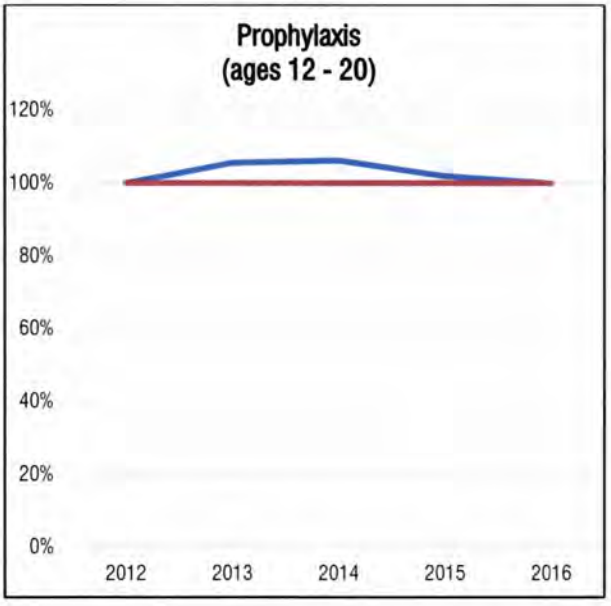

Periodic Oral Evaluation
(established patient)
120%
100%
80%
60%
40%
20%
0%
2012
2013
2014
2015
2016


Intraoral X-ray
(periapical first radiographic image)
120%
100%
80%
60%
40%
20%
0%
2012
2013
2014
2015
2016


Intraoral X-ray (periapical each additional
radiographic image)
120%
100%
80%
60%
40%
20%
0%
2012
2013
2014
2015
2016


Bitewings
(two radiographic images)
120%
100%
80%
60%
40%
20%
0%
2012
2013
2014
2015
2016





Source: OPPAGA analysis.

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CHAPTER 2016-109

House Bill No. 819

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 Office of Program Policy Analysis and Government Accountability to provide a report to the Governor and Legislature; specifying requirements for the report; providing for use of the report's findings; requiring the Agency for Health Care Administration 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 Office of Program Policy Analysis and Government Accountability 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 Office of Program Policy Analysis and Government Accountability 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. To qualify as a provider under the prepaid dental health program, the entity must be licensed as a prepaid limited health service organization under part I of chapter 636 or as a health maintenance organization under part I of chapter 641. 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.

Approved by the Governor March 24, 2016.

Filed in Office Secretary of State March 24, 2016.

HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #: HB 819

SPONSOR(S): Diaz, J. and others

COMPANION BILLS: SB 994

FINAL HOUSE FLOOR ACTION:
100 **Y's** 15 **N's**

GOVERNOR'S ACTION: Approved

SUMMARY ANALYSIS

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

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

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

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

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

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

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

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

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

Medicaid

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

Statewide Medicaid Managed Care

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

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

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.[5] AHCA selected 19 managed care plans (MMA plans) and executed 5-year contracts in February 2014. The MMA program was fully implemented statewide by of August 1, 2014.[6] As of February 2016, approximately 3.91 million Medicaid recipients are enrolled in the MMA program.[7]

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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 March 14, 2016).
[4] The other component of the SMMC program is the Long-Term Care Managed Care Program.
[5] AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Addendum 2, Solicitations Number: AHCA ITN 017-12/13*; dated February 26, 2013, http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm; AHCA Invitation to Negotiate, *Statewide Medicaid Managed Care, Solicitation Number: AHCA ITN 017-12/13*; dated December 28, 2012, http://www.govcb.com/Statewide-Medicaid-Managed-Care-ADP13619273520001182.htm (last visited March 14, 2016).
[6] Agency for Health Care Administration, *Agency Analysis of 2016 House Bill 819*, p. 3, January 6, 2105 (on file with Health and Human Services Committee staff).
[7] Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Report: February 2016*, available at: http://www.fdhc.state.fl.us/medicaid/Finance/data_analytics/enrollment_report/docs/ENR_February_2016.xls (last visited March 14, 2016).

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

Waivers for Medicaid Managed Care

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

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

Dental Care in the MMA Program

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

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

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[8] Supra, note 6 at pg. 6.
[9] Id.
[10] 42 U.S.C. § 1396a(72).
[11] S. 409.906(1), (6), F.S. Adults must be provided dentures and medically necessary, emergency dental procedures to alleviate pain or infection.
[12] A Medicaid PDHP is a risk-bearing entity paid a prospective per-member, per-month payment by AHCA to provide dental services to enrollees.
[13] Supra, note 6 at pgs. 3-4.
[14] Information provided by AHCA and on file with the Health Human Services Committee.
[15] Agency for Health Care Administration, *Agency Analysis of 2014 House Bill 27*, November 25, 2013 (on file with Health and Human Services Committee).
[16] Id.
[17] Email from Orlando Pryor, Deputy Director of Legislative Affairs, Agency for Health Care Administration Staff, Questions, February 1, 2016, (on file with Health and Human Services Committee). The amount was calculated based on the approved expanded adult dental procedures codes for encounters for dental claims and procedures for recipients over the age of 18.

Dental Service Accountability and Performance in the MMA Program

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

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

Provider Type[22]	*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.[23] The MLR measures the amount of money spent on providing services to enrollees against the amount of money spent on administrative functions;[24] an MLR of 85 percent requires 85 percent of the capitation paid to the MMA plan to be expended on health care services, including dental services. The MLR must also take into account, as required in the terms and conditions of the 1115 waiver, any payments of the achieved savings rebate, which requires:

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

Third, under the terms and conditions of the 1115 waiver, AHCA must work with MMA plans on an oral health quality improvement initiative. The MMA program contracts[26] have specific performance goals for pediatric dental services and penalties for not reaching these goals. Each MMA plan is required to provide a Child Health Check-Up (CHCUP) to every enrollee. The CHCUP includes dental screenings and referrals starting at age three, or earlier if indicated.[27] The MMA plans must achieve a CHCUP rate of at least 80 percent for children enrolled for eight continuous months.[28] A plan that fails to meet this

[18] *MMA Model Agreement, Attachment II, Exhibit II A*, Medicaid Managed Medical Assistance Program, Agency for Health Care Administration, February, 2014, available at: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-A-Managed_Medical_Assistance_MMA_Program_2015-11-01.pdf (last visited March 14, 2016).
[19] Id. at pg. 103.
[20] Email correspondence with Agency for Health Care Administration Staff on HB 819, December, 28, 2015 (on file with Health and Human Services Committee).
[21] Id.
[22] Participating Providers are providers that have submitted a paid claim within twelve months of the report's run date.
[23] Supra, note 18.
[24] U.S. Centers for Medicare and Medicaid Services, *Medical Loss Ratio (MLR)*, https://www.healthcare.gov/glossary/medical-loss-ratio-MLR/ (last visited March 14, 2016).
[25] S. 409.967(3), F.S.; AHCA established a uniform method for the plans to use for annually reporting premium revenue, medical and administrative costs, and income or losses. Using the reporting method, the plans calculate whether they have achieved a savings for the reporting year and whether they must pay a rebate to the state.
[26] Agency for Health Care Administration, *SMMC Plans: Model Contract*, available at: http://ahca.myflorida.com/Medicaid/statewide_mc/plans.shtml (last visited March 14, 2016).
[27] Supra, note 18 at pg. 22.
[28] Id. at pgs. 22, 109.

goal is subject to a corrective action plan[29] and liquidated damages of $50,000 per occurrence and $10,000 for each percentage point less than the target.[30]

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

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

Dental Care Prior to the SMMC Program

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

Prepaid Dental Health Plans (PDHPs)

In 2001, Florida began using a PDHP to deliver dental services to children as a pilot program in Miami-Dade County.[39] In 2003, the Legislature expanded the PDHP initiative beyond Miami-Dade County by authorizing AHCA to contract with PDHPs in other areas[40] and permitted AHCA to include the Medicaid reform pilot counties.[41] In 2011, the Legislature made PDHP contracting mandatory, not discretionary, outside the reform pilot counties and Miami-Dade County.[42] However, the Legislature limited the use of

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[29] The Corrective Action Plan details the actions to be taken by the MMA Plan to reach the rate.
[30] Supra, note 18 at pgs. 22, 109.
[31] Id. at pgs. 22, 110.
[32] Id.
[33] HEDIS measures are developed by the National Committee for Quality Assurance (NCQA), and allow for comparison of otherwise dissimilar health plans.
[34] Supra, note 18 at pg. 109.
[35] Supra, note 6 at pg. 4.
[36] Id.
[37] Id.
[38] S. 409.906(1), F.S.
[39] Proviso language in the 2001 General Appropriations Act (GAA) authorized AHCA to initiate a PDHP pilot program in Miami-Dade County. Similar statutory authority was provided in 2003.
[40] Ch. 2003-405 s. 18, Laws of Fla. (codified as. 409.912(42), F.S.).
[41] In 2005, the Legislature enacted laws to reform the delivery and payment of services through the Medicaid program and directed AHCA to seek a federal waiver for a Medicaid managed care pilot program over five years. The program began in Broward and Duval counties in 2006 and later expanded to Baker, Clay and Nassau counties in 2007, as authorized in statute. The five-year waiver was set to expire June 30, 2011, but was renewed through June 30, 2014.
[42] Ch. 2011-135, s. 17, Laws of Fla. (codified as s. 409.912(41), F.S.). This subsection expired October 1, 2014.

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

AHCA issued a competitive procurement for the statewide PDHP program in 2011 and awarded contracts to two PDHPs to provide dental services to Medicaid recipients in all Florida counties with the exceptions noted above.[44] The contracts with PDHP providers expired on September 30, 2014.[45] On October 1, 2014, the statutory authority for AHCA to contract with PDHPs expired, as the program transitioned to the comprehensive managed care contracts in the new MMA program.

PDHP Accountability and Performance

Like the MMA program contracts, PDHP contracts imposed specific requirements for network adequacy;[46] required plans to meet an MLR of 85 percent (although this MLR was dental-specific);[47] and required plans to provide CHCUP to enrollees[48] and achieve an annual screening and participation CHCUP rate of 80 percent.[49] However, in calendar year 2013, both PDHPs, MCNA and DentaQuest, failed to meet their contractually required MLRs and, as a result, were required to repay AHCA an estimated $20 million.[50]

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

Performance of the PDHPs and MMA Plans, Compared

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

AHCA conducted an independent analysis to determine the percentage of MMA enrollees ages 2 – 21 years who received at least one dental service during the first year of MMA implementation, from August 1, 2014 through July 31, 2015.[53] AHCA used the same parameters used to calculate the HEDIS scores for children's dental care annual dental visits, with two variations:

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

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[43] Ch. 2012-119, s. 9, Laws of Fla. (codified as s. 409.912(41)(b), F.S.). This paragraph expired July 1, 2013.
[44] During 2012, AHCA implemented the statewide PDHP program in Medicaid Area 9 on January 1; Areas 5, 6, and 7 on October 1; and Areas 1, 2, 3, 4, 8, and 11 (Monroe County only) on December 1, 2012.
[45] The original procurement period was December 1, 2011 through September 30, 2013. The program was renewed once, which extended the contracts through September 30, 2014.
[46] Agency for Health Care Administration, *Medicaid Prepaid Dental Health Plan Contract, Attachment II, January, 2012*, p. 60 (on file with Health and Human Services Committee).
[47] Agency for Health Care Administration, *Agency Analysis of 2015 House Bill 601*, January 28, 2015 (on file with Health and Human Services Committee).
[48] Supra, note 46 at pgs. 53-54.
[49] Id.
[50] Supra, note 47.
[51] Id. at pg. 83. "Acceptable HEDIS score" was not defined in the PDHP contracts.
[52] National Committee for Quality Assurance, *HEDIS and Quality Measurement: What is HEDIS?*, http://www.ncqa.org/HEDISQualityMeasurement/WhatisHEDIS.aspx (last visited March 14, 2016).
[53] Supra, note 20; infra, note 56.
[54] Id.

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

HEDIS Annual Dental Visit Scores for Children Ages 2-21 Years[56]

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

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

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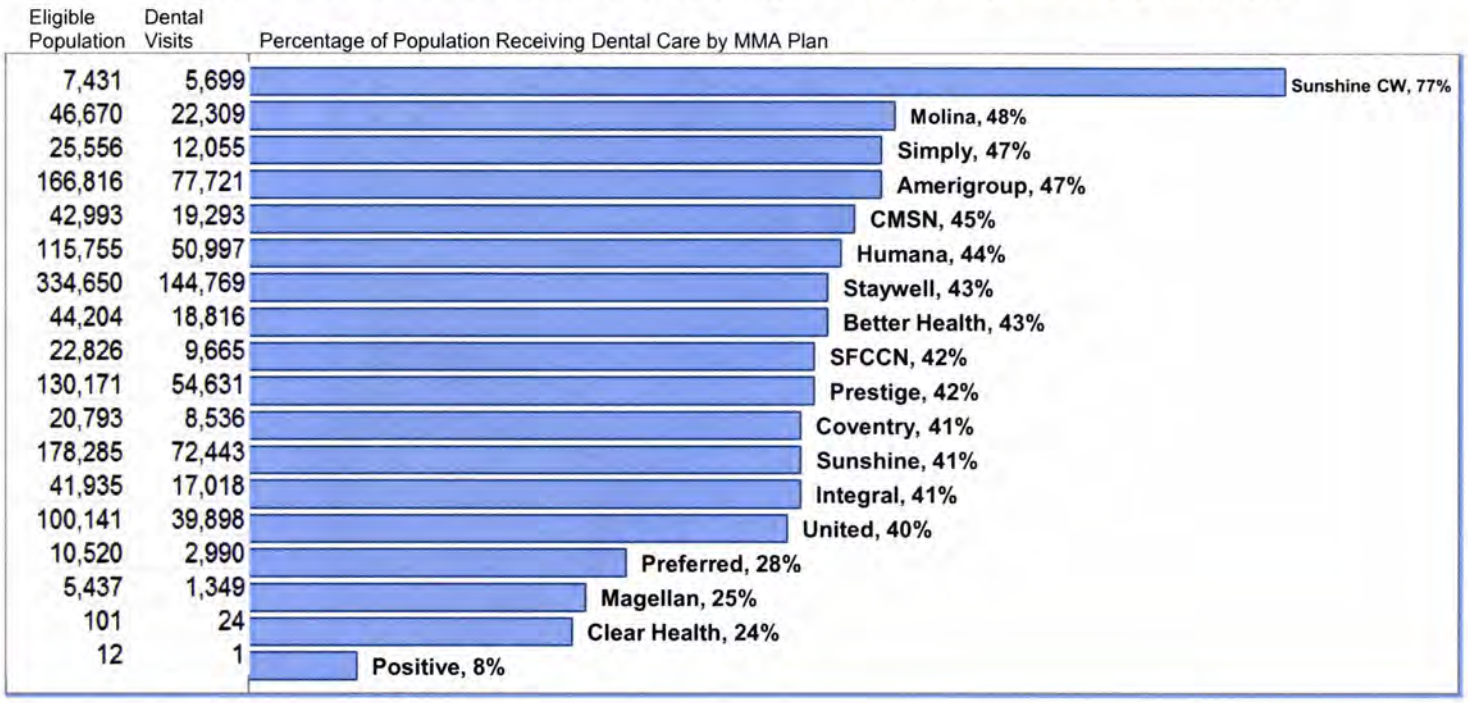
[55] Id.
[56] Justin M. Senior, Florida Medicaid Director, Agency for Health Care Administration, *Florida Medicaid: Statewide Medicaid Managed Care*, PowerPoint Presentation to the House Health and Human Services Committee, January 2016. (Presentation on file with Health and Human Services Committee).
[57] The data for the Reform Pilot Plans indicate an initial improvement from 2007 to 2009, followed by relatively static numbers over the next few years from 2009 to 2011, followed by another improvement from 2011 to 2013.
[58] MCNA self-reported *unaudited* HEDIS scores for its Miami-Dade County PDHP Pilot from 2010 to 2011 showing 34.8 and 35 percent, respectively. (Information on file with Health and Human Services Committee).
[59] DentaQuest self-reported *unaudited* HEDIS scores for its Miami-Dade County PDHP Pilot from 2005 to 2011 showing an increase from 20 percent in 2005 to 39.1 percent in 2011. (Information on file with Health and Human Services Committee).
[60] For enrollees to be counted, for the purpose of the HEDIS score, they must have been in a single plan for at least 11 out of 12 months and must have been enrolled in that plan as of December 31, 2014. Neither the PDHP nor reform pilot plans remained in effect as of December 31, 2014. Additionally, data for the MMA plans 2014 calendar year is not accurate because the number of enrollees counted in the scores are artificially low. Due to the transition to MMA program throughout 2014, there were very few enrollees who had been in an MMA plan for the required time that could then be counted for the 2014 HEDIS score.

HEDIS Annual Dental Visit Scores for Children Ages 2-21 Years by MMA Plan, MMA Year 1[61]



Effect of the Proposed Changes

Dental Services Carve-Out

Removal of Dental Services from MMA Plan Coverage

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

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

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

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

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

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

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

Creation of a Statewide Medicaid PDHP Program

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

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

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

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

Comprehensive Report on Provision of Dental Services under the SMMC Program

The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to complete a comprehensive report[66] on the provision of dental services under the SMMC program. OPPAGA's report must examine the effectiveness of MMA plans in:

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

[63] S. 409.967(4), F.S.
[64] Supra, note 6 at pg. 7.
[65] Id.
[66] The bill grants OPPAGA the authority to contract with an independent third party to assist in the preparation of the report.

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

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

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

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

Legislative Use of the Comprehensive Report

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

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

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

1. Expenditures:

   A contract with an independent entity to assist in preparing the comprehensive report is estimated to cost $250,000.[67]

   If AHCA implements a statewide PDHP program, it estimates that it would need an additional $200,000 per year for the current contracted actuarial firm to perform analysis services necessary to amend the current plan capitation rates to remove dental services and to create capitation rates for the selected plans.[68] AHCA also anticipates using outside counsel for the defense of competitive procurement specifications and bid awards for the statewide PDHP program, at a cost of $100,000.[69]

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

[67] Supra, note 6 at pg. 9.
[68] Id.
[69] Id.

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

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

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

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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

D. FISCAL COMMENTS:

None.

[70] Id. at pg. 7.
[71] Id. at pg. 5.

AHCA

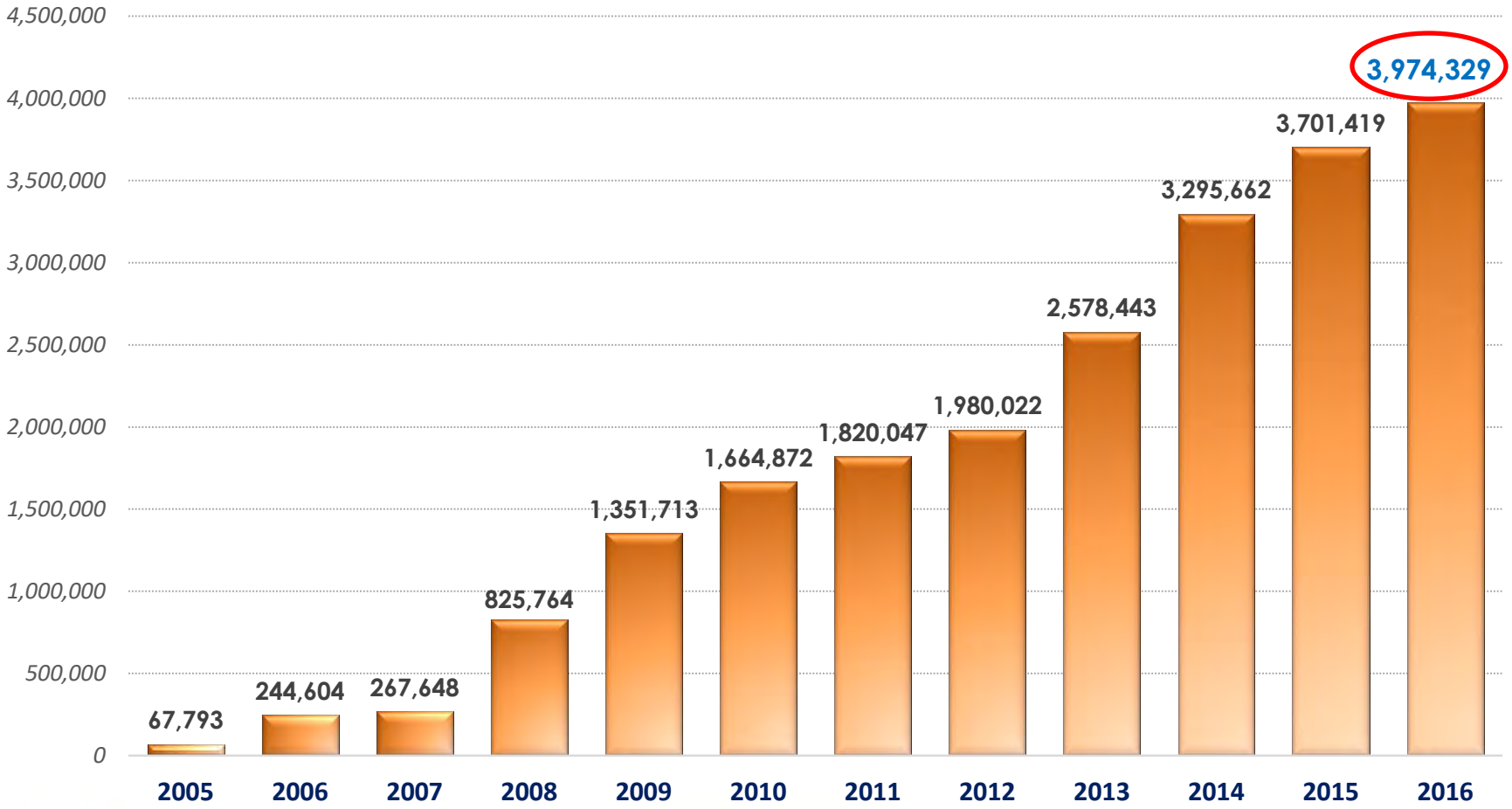
Health Care Transparency

Molly McKinstry
Deputy Secretary
Agency for Health Care Administration

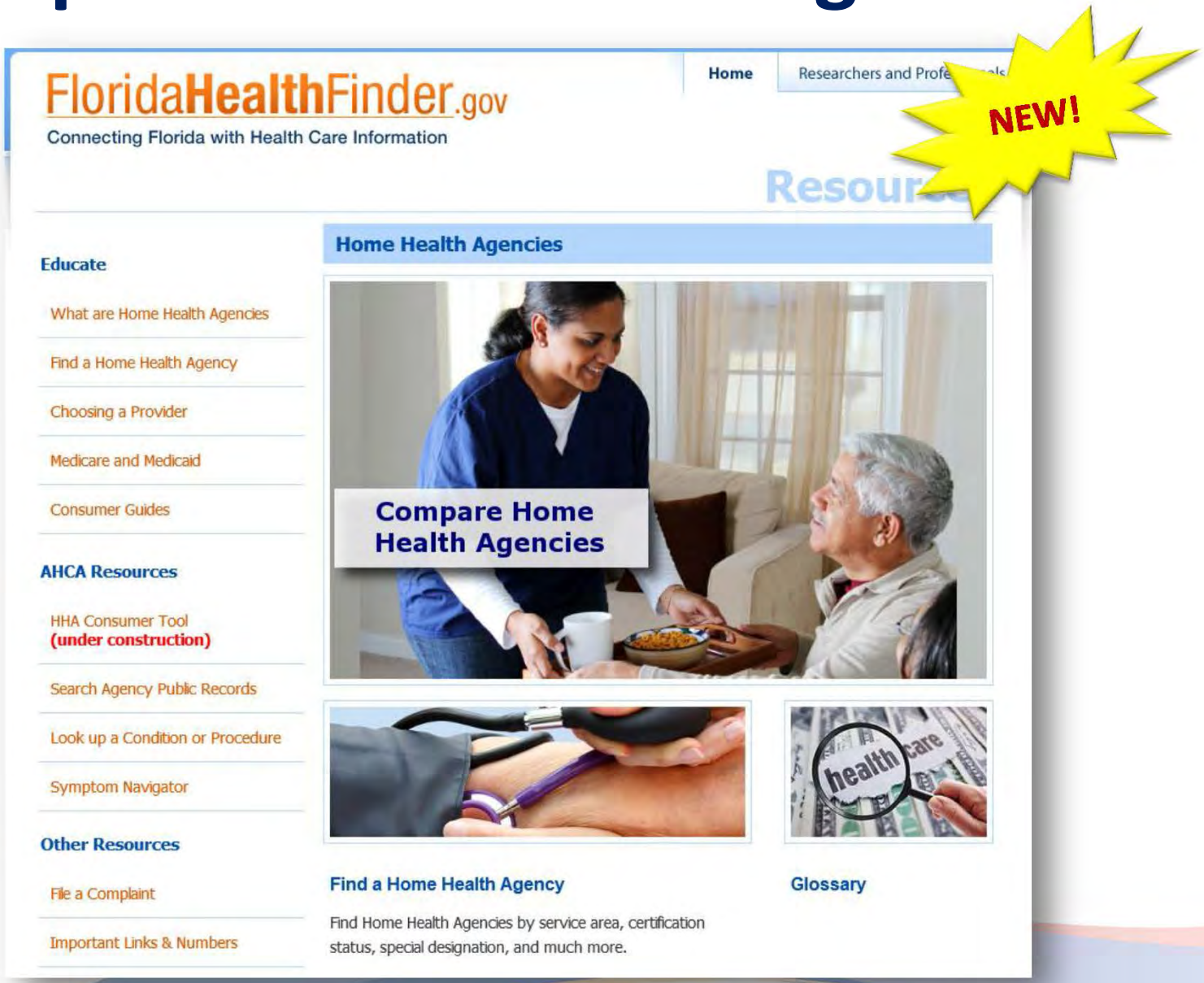
Health & Human Services Committee
January 24, 2017

Florida Heath Finder: Digital Government Achievement Award Recipient

Visits to FloridaHealthFinder.gov



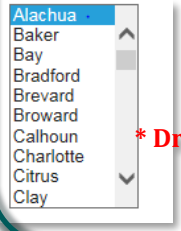
Compare Home Health Agencies



Better Health Care for All Floridians
AHCA.MyFlorida.com

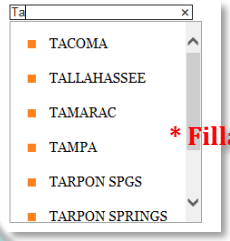
Compare Home Health Agencies

Select Providers by County/Service Area:
Click on a county. To select multiple counties, hold the *CTRL* key when clicking on a county name.



* Drop-down List

Select Providers by City/Service Area:
Enter the name of a Florida city to find providers in that area.



* Fillable Text

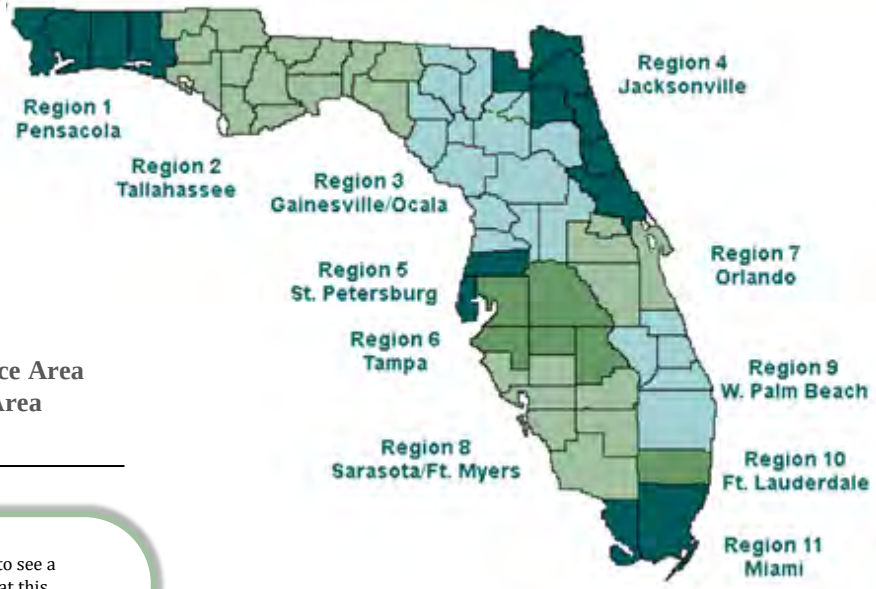
Directions:

Click one of the options to choose providers or use the map and click a county to choose providers.
Use the buttons at the bottom of the page to continue

Select Providers by type:
Click on a provider. To select multiple providers, hold the *CTRL* key when clicking on a provider.

HHA Types:

- Licensed only
- Licensed and Medicare certified
- Licensed and Medicaid certified
- Licensed and Medicare/Medicaid certified



- Providers by County/ Service Area
- Providers by City/Service Area
- Providers by Name

View Results

Select Providers by Name:
Begin typing a provider's name in the box to see a list, then select from the list. You may repeat this to select multiple providers by name.

* Fillable Text

Compare Home Health Agencies

This page provides the Survey/Complaint data as well as the links to profiles for each provider and glossary information.

Home Health Agency Comparative Information

Selected Service Area: Duval

Time Period: March 3, 2009 - March 2, 2016

Directions:

This symbol directs you to the inspection details for this Agency. These web pages list violations of a regulation that are found during an inspection o

For a listing of what services are offered, hover over the number.

View the results below or if you would like to change the "sort-by-column" use the drop-down and click "View Results".

View Results | - Sort by Column - | Ascending (A-Z, 0-9) | Descending (Z-A, 9-0)

Quality of Care: 1 to 5 stars

Special Designations: Skilled, Nonskilled Only, Pediatric

Name/ City	Number of Counties/ Service Areas	Type	Accreditation	Complaints	Sanctions / Final Orders	Fines	Number of Deficiencies						Patient Count	Medicare Quality of Patient Care	Special Designation	Number of Services Offered
							Total	Class 1	Class 2	Class 3	Class 4	Unclassified				
A HOME SWEET HOME OF JAX, INC JACKSONVILLE	2 (Duval, Nassau)	Licensed only	JC	0	1	$0.00	0	0	0	0	0	0	78	N/A	Pediatric	6 (Home Health Aid, Medical Services, Nursing Care, Occupational Therapy, Physical Therapy, Speech Therapy)
A1 CARE SYSTEMS INC JACKSONVILLE	3	Medicaid	CHAP	0	0	$0.00	0	0	0	0	0	0	186	N/A	Pediatric	4
ACACIA GROVE LLC ORANGE PARK	1	Medicare	CHAP	0	0	$1,000.00	5	0	0	5	0	0	104	★★★★★	Skilled	3
ALI ANGEL'S NEST JACKSONVILLE	2	Licensed only	No	0	0	$2,500.00	5	0	0	5	0	0	52	N/A	Nonskilled Only	1

HHA Types:
Licensed only
Medicare
Medicaid
Medicare/Medicaid

Accreditation Agencies:
ACHC – Accreditation Commission for Health Care
JC – The Joint Commission
CHAP – Community Health Accreditation Program

Services Offered:

CNA– Certified Nurse Assistant
HHA – Home Health Aide
HM – Homemaker
IV – IV Therapy
MSV – Medical Services
MSP – Medical Supplies
NC – Nursing Care
NR – Nutritional
OH – Other
OT – Occupational Therapy
PT – Physical Therapy
RT – Respiratory Therapy
ST – Speech Therapy

Prescription Drug Pricing Data

- MyfloridaRx website is created by 408.062(1)(h), F.S.
  - Attorney General's Office manages and maintains website

http://www.myfloridarx.com/

- 150 of the most commonly prescribed brand name drugs and associated generic equivalents
- Pricing based on usual and customary price submitted to the agency on pharmacy claims and Medicaid HMO encounters
  - Data is submitted to the AGOs office monthly
  - AGO loads information and maintains website
  - Website is included as a page on FloridaHealthFinder.gov

Transparency in Health Care Chapter 2016-234, Laws of Florida

HB 1175 (2016) goals:

- Promote health care price and quality transparency
- Enable consumers to make informed choices regarding health care treatment
- Improve competition in the health care market

Transparency Bill Components

Improve consumer access to information for health care estimates and actual charges

- Non-emergency service focus
- Establish a Florida paid claims database
  - Collect data from health insurers
  - Display service bundles
- Require hospitals and ambulatory surgery centers (ASCs) to assist in consumer information access

Hospitals and ASCs: Websites

Hospitals and ASCs must post information regarding:

- Billing, collection, and financial assistance policies
- Contract providers who may bill separately and may be out of the consumer's health insurance network
- Insurance plans for which the facility is a participating network provider with links to plans
- Pricing and information published by the agency about average payments for defined ***service bundles***
- Quality data published by the agency

Hospitals and ASCs: Pre-Treatment Cost Estimates

Hospitals and ASCs must provide estimates:

- In writing or electronically, non-adjusted charges
- By defined ***service bundles***, or more personalized on request
- Within 7 business days

Estimates must:

- Detail facility fees, contract providers who may bill separately, and information to contact consumer's health plan for copayment and cost-sharing information
- Include information regarding financial assistance, billing, and collections policies
- Inform the public that estimates are available

Hospitals and ASCs: Post-Treatment Billing

Hospitals and ASCs must:

- Provide a bill for any visit upon request and after discharge or upon request within 7 business days of discharge or request
- Detail all services provided by date and provider
- Identify and explain the purpose of facility fees
- List all items as paid, pending payment by a third party, or pending payment by the patient, amount and due date for any patient balance
- Include notice of hospital-based physicians and other health care providers who bill separately
- Direct the patient to contact their health insurer for information on cost-sharing responsibilities
- Include contact information for patient billing liaison

Hospitals and ASCs: Post-Treatment Billing

Hospitals and ASCs must:

- Provide records to substantiate billing within 10 business days, onsite or electronic
- Have a method to respond to billing questions within 7 business days
- Provide contact information for the agency if resolution cannot be reached

Other Health Care Providers

- **Practitioners**
  - Non-Emergent Procedures in a Hospital or Ambulatory Surgery Center
  - Written, Good-Faith Estimate, Non-Discounted Charges Within 7 Business Days of Request
- **Hospital-Operated Diagnostic Imaging Centers**
  - Must Post a Schedule of Charges for Common Procedures

Health Insurers: Websites

Make Available on Website:

- A Method for Policyholders to Estimate Copayments, Deductibles, and Other Cost-Sharing Responsibilities… by the Defined ***Service Bundles***
  - Calculated According to Individual Policy and Known Plan Usage During the Coverage Period
  - Calculated Based on a More Personalized Estimate Received from a Health Care Facility
- Link to Quality Information Published by the Agency
- Inform Policyholders of Availability of this Information

Paid Claims Database

AHCA must contract with a vendor to build a paid claims database:

- The vendor will collect paid claims data from health plans and insurers
- The database will be used to build a consumer-friendly, searchable price website using a bundled pricing methodology
- De-identified claims data will be made available to researchers

The vendor must meet statutory criteria:

- Be Medicare-qualified
- Have a bundled pricing methodology in the public domain
- Have an existing national paid claims database with data from multiple payers

All insurers that participate in Medicaid or the State Group Health Insurance Plan must submit claims data

- Insurers must submit all claims data from Florida policyholders to the Contracted Vendor

Paid Claims Database: Procurement Criteria

Consumer Pricing Website:

- Consumer-friendly, with a seamless experience with FloridaHealthFinder.gov.
- Frequency of data updates, capacity for design flexibility and customization, and the ability to provide a staged (i.e. earlier) implementation
- Bundling methodology must be mathematically sound, scalable, understandable, and in the public domain.

Data Governance and Access/Availability:

- Approach to data access and security (enclave vs. data distribution)
- Quality checks and validations, compliance tracking and reporting, and security
- Level of burden on submitters and technical support provided to submitter
- Agency access to the data and ability to apply business intelligence tools
- Public access to de-identified data, and confidential data access and release policies for researchers

Paid Claims Database: Vendor Selection Criteria

- **Ability to Meet Statutory Requirements**, including if required submitters change over time.
- **Data Collection** – Frequency, flexibility, level of burden on submitters and technical support provided to submitters, quality checks and validations, compliance tracking and reporting, and security were key factors.
- **Bundling Methodology** – Must be mathematically sound, scalable, understandable, and in the public domain. Actuarial review was considered as added value.

Paid Claims Database: Vendor Selection Process

- **Two Highly Qualified Primary Applicants**
  - Health Care Cost Institute (HCCI)
  - Fair Health
- Proposals were Independently Evaluated
- Negotiation Meetings and Correspondence with both Vendors Occurred during 12/12/16–12/23/16
- **Notice of Award Posted on 1/3/2017**

Paid Claims Database: Selected Vendor

Health Care Cost Institute (HCCI)

- Founded in 2011 as an independent, nonprofit, non-partisan, non-advocacy research institute devoted to studying the drivers of health care costs and utilization in the United States.
- Currently holds more than 15 billion health care medical claim lines (with allowed/paid amounts), representing more than $1 trillion dollars of health care spending, over 5,000 hospitals, and 1 million different medical service providers.

Paid Claims Database: Consumer Website

Guroo.com - HCCI's Existing National Consumer Website

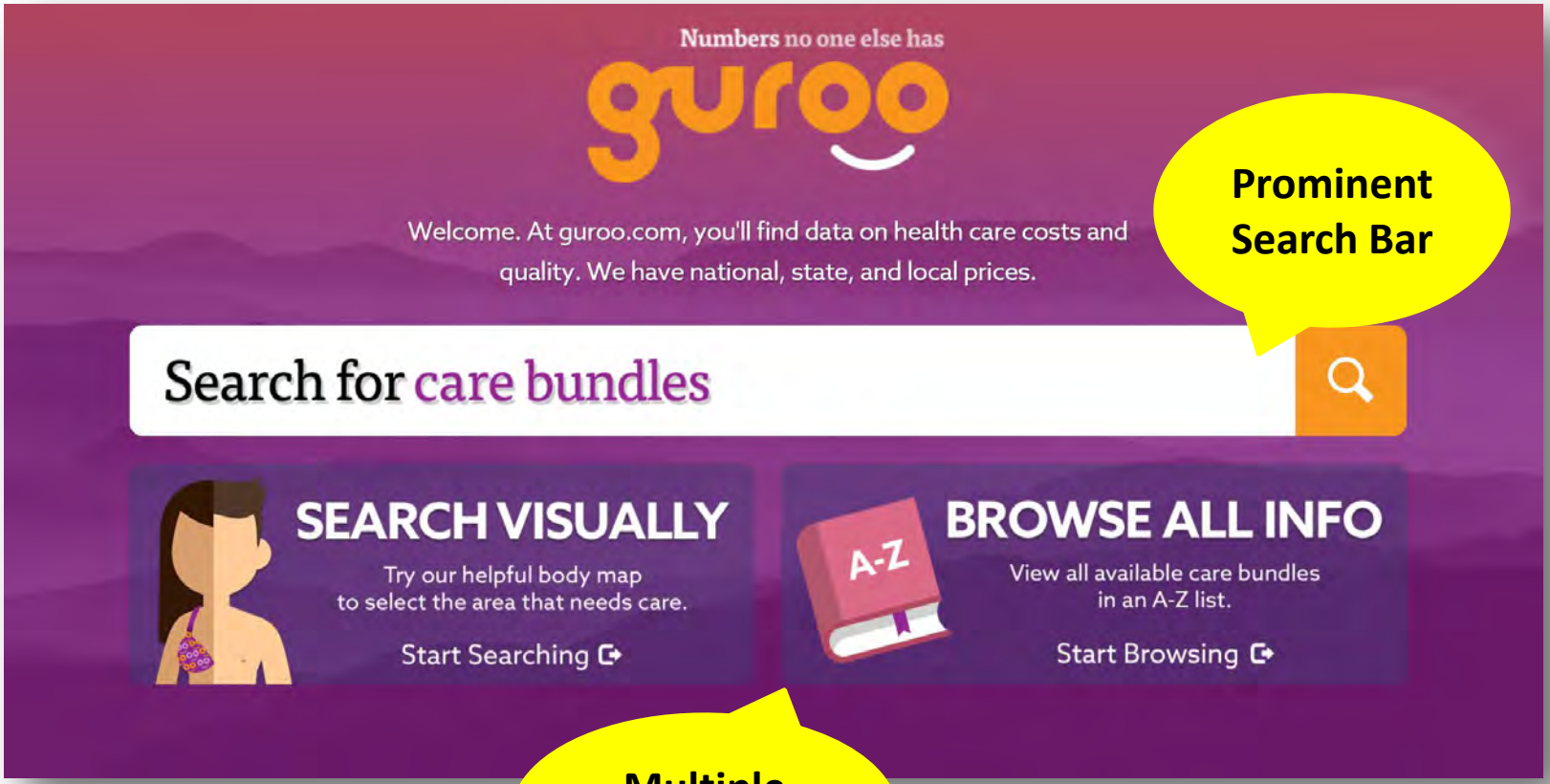
- Released in 2015
- 295 active service bundles *(covers 98% of all consumer searches)*
- ADAM symptom navigator tool and graphical search
- Geographic level price comparison
- Average price and price range *(25th to 75th percentiles)*
- Quality measures (*up to 90 clinical conditions and nearly 600 measures of care available; 6 currently live)*
- 30 bundles broken out by place of service ***(coming January 2017)***

Paid Claims Database: Florida's Consumer Website

- Co-Branded to Align with Look and Feel of FloridaHealthFinder.gov *(seamless for consumers)*
- Visitors to Guroo.com from Within Florida or Searching Florida Zip Codes will be Automatically Redirected to Florida-Guroo
- Same Bundles, Content, Functionality as Guroo
- Add Ability to Search by Zip-Code
- Add Provider-Specific Results

Paid Claims Database: Consumer Website

Guroo.com - Homepage



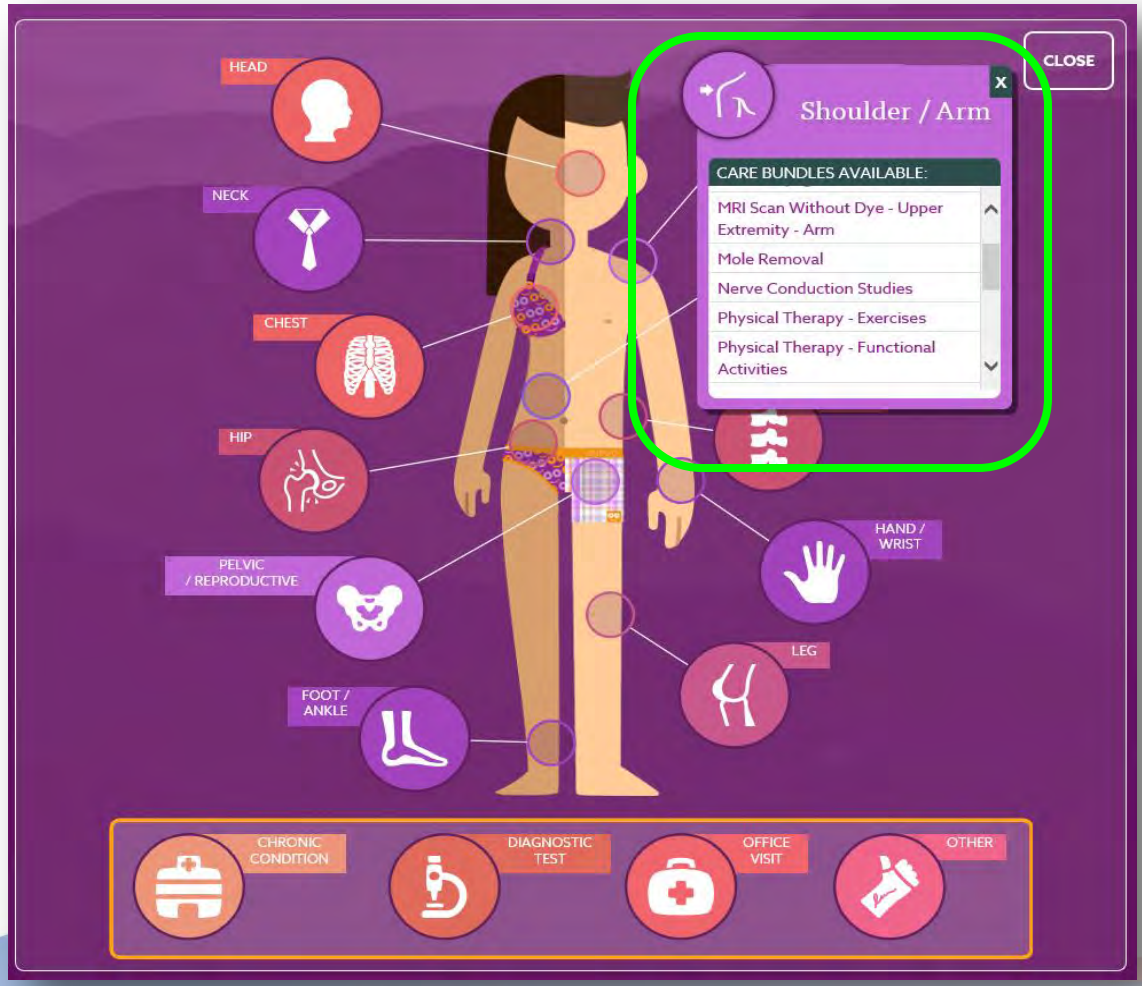
Prominent Search Bar

Multiple Search Options

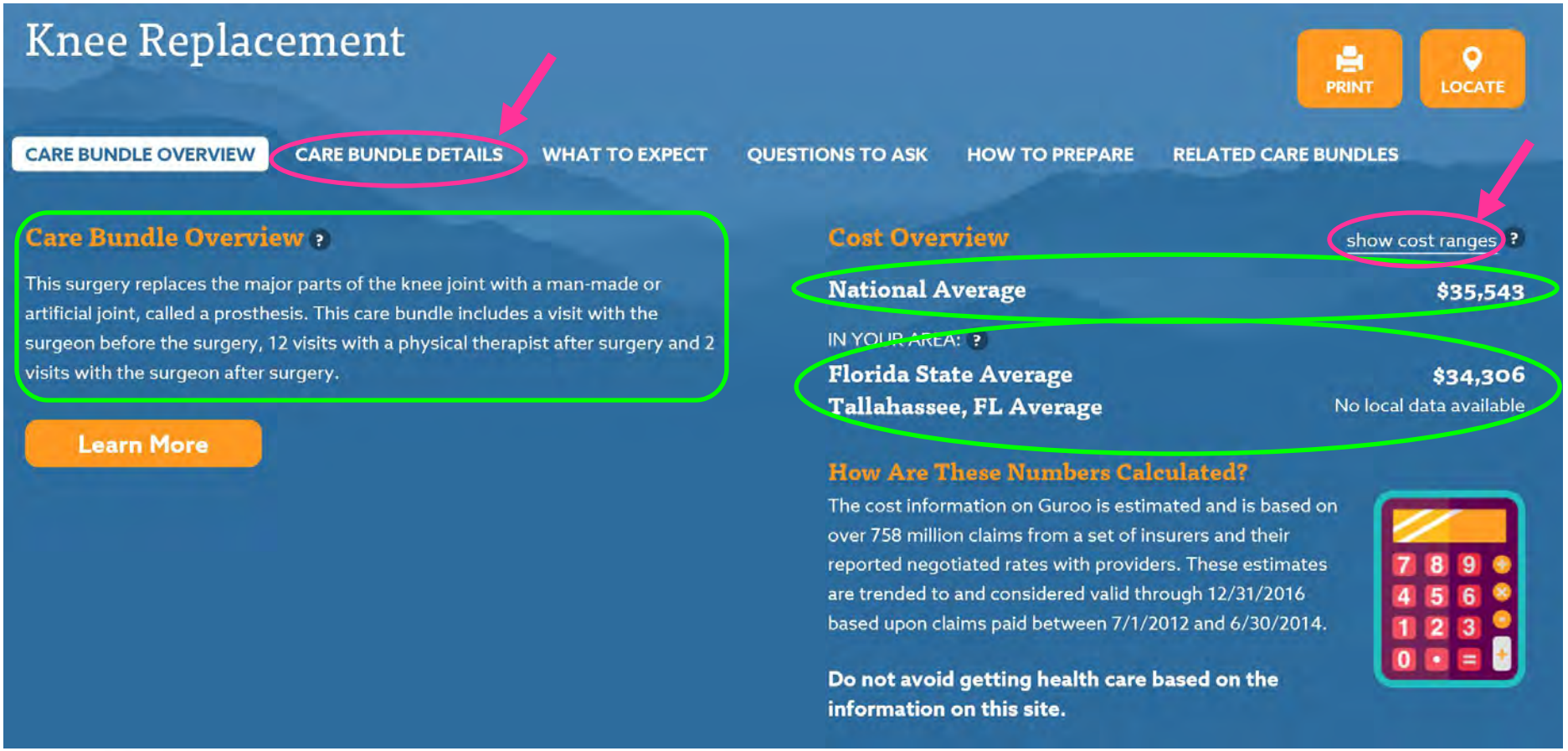
Paid Claims Database: Consumer Website

Guroo Visual Search Feature

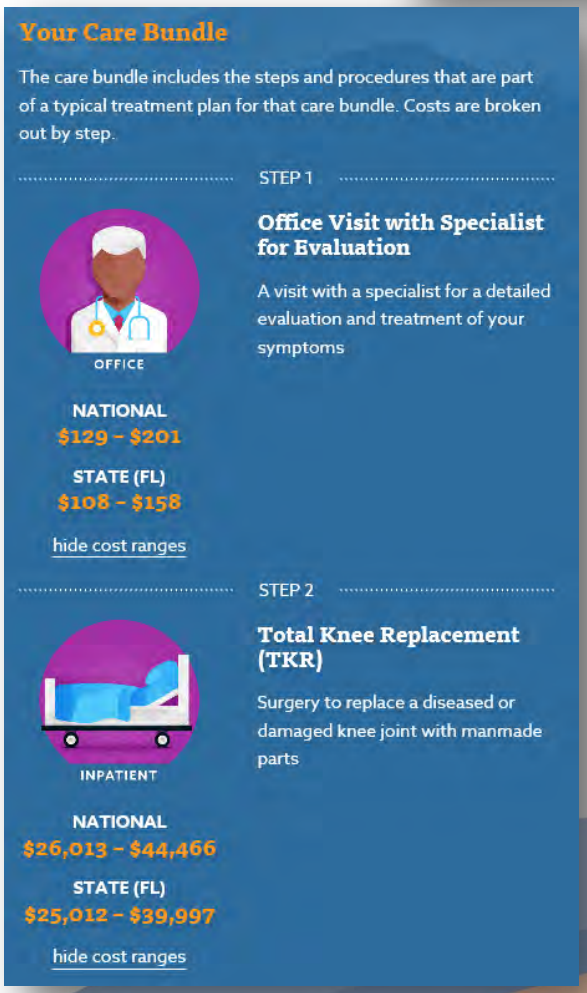
User "hovers" over body graphic to see information available for each area

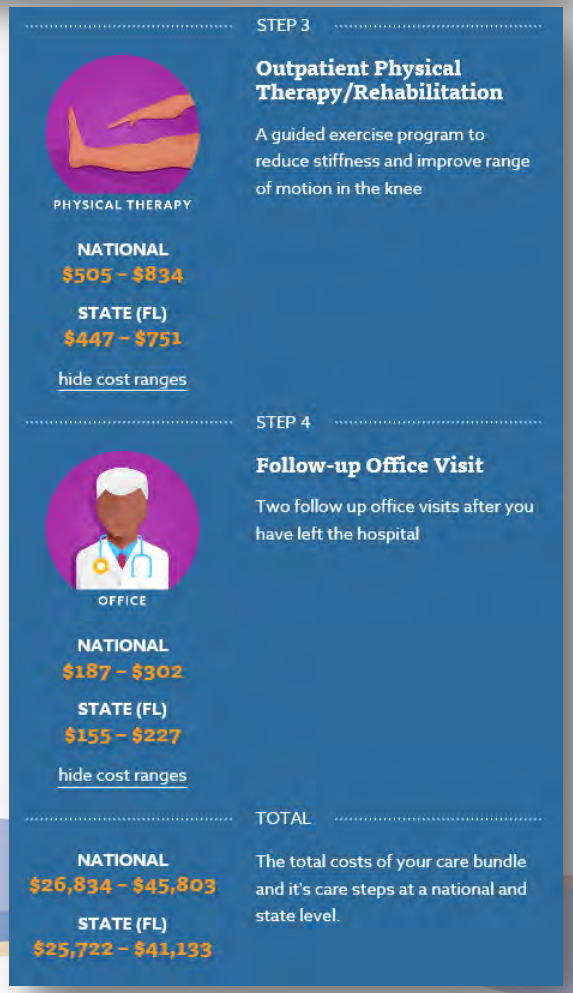


Sample Care Bundle Pricing: Knee Replacement



Range of Prices and Care Bundle Breakout:

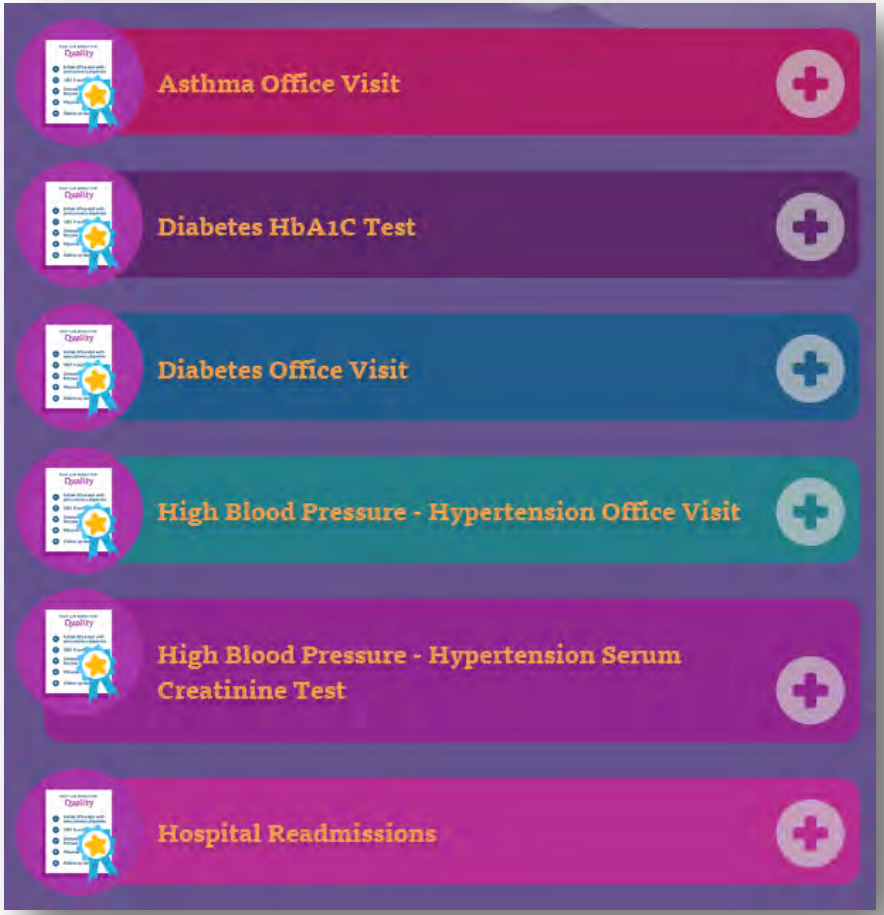




Guroo.com Current Quality Metrics

Clinical Care Process and Quality Measures:

- Asthma
- Diabetes
- Hypertension



Guroo.com Current Quality Metric: Hospital Readmissions

Hospital Readmissions

Patient(s) 18 years of age or older with a recent hospitalization that had a hospital readmission within 30 days of discharge.

Description

Hospital readmission within 30 days of a hospitalization discharge may indicate poor quality of care. This measure reports the percentage of people 18 years of age or older with a recent hospitalization that had a hospital readmission within 30 days of discharge. For this measure, a lower score is better.

National	13.61 %
Florida State	13.46 %
Tallahassee, FL	14.55 %

For this measure, LOWER numbers indicate better scores

Related Care Bundle

This quality metric does not relate to a specific care bundle. It measures quality for a specific treatment type or location that may be utilized in a variety of care bundles.

Claims Data Access and Availability

- Data will be housed in a secure data enclave
- Authorized users will be granted controlled, secure access to the data
- The enclave includes a complete suite of statistical analysis and reporting tools
- External data may be imported to the enclave (with appropriate permissions) and linked to the claims data using unique identifiers
- A de-identified public-use data file will be created and made available
- Optional business intelligence tools are available to be applied to the data to create standard dashboards/reports

Florida Consumer Pricing Website

- **Release of Version 1.0 Planned for July 2017**
  - Co-Branded to interact with FloridaHealthFinder
  - Pricing calculations based on HCCI's existing data holdings
- **Final Release – January 2018**
  - Florida specific data
  - Facility level pricing (as data availability allows)

Implementation Status

- **Hospital & ASC Websites – Financial and Other Disclosures**
  - Modifications to facility licensure/renewal application to collect specific facility website for required information
  - Revised application form to be incorporated by rule
- **Pre-Treatment Estimates and Post-Treatment Itemized Billing**
  - Updated complaint review process to assess for compliance with new transparency and balance billing requirements
  - Rule development for hospital and ASC standardized billing requirements
- **Claims Data Submission by Insurers**
  - Rule workshop and guidelines for frequency, timing, format and data elements

THANK YOU

For more information:

FloridaHealthFinder.gov