The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SPB 7010
INTRODUCER:	For consideration by the Health Policy Committee
SUBJECT:	Health Access Dental Licenses
DATE:	December 19, 2013 REVISED: 1/14/14

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Peterson	Stovall		**HP Submitted as Committee Bill**

I. Summary:

SPB 7010 changes the requirements for obtaining a health access dental license. A health access license authorizes out-of-state dentists to practice in designated facilities that serve patients who otherwise would not have access to care. The bill removes language that would render an applicant ineligible based on a report to the National Practitioner Data Bank (NPDB). Instead, the Board of Dentistry (Board) is given authority to deny licensure if the applicant has violated or is being investigated for a violation of chapter 466, Florida Statutes., the dental practice act, or other licensing requirements. The bill also extends the sunset date of the program to January 1, 2020.

II. Present Situation:

The Importance of Oral Health Care

Mouth and throat diseases, which range from cavities to cancer, cause pain and disability for millions of Americans each year. Ninety-six percent of adults aged 50-64 years have had dental caries (tooth decay, cavities). In children, cavities are the most common form of chronic disease, which often begins at an early age. More than one-fourth of U.S. children aged 2-5 years and half of children aged 12-15 years have been affected by tooth decay. Children and adolescents from low-income families are hardest hit: about two-thirds of those aged 12-19 years have had caries, and one in four has untreated caries. Untreated tooth decay can cause pain, dysfunction, and absence from school, and poor appearance — problems that can greatly affect a child's quality of life.[1]

[1] Centers for Disease Control and Prevention and Nat'l Center for Chronic Disease Prevention and Health Promotion, *Oral Health Program Strategic Plan for 2011-2014*, 5 (March 2011) *available at* http://www.cdc.gov/OralHealth/pdfs/oral_health_strategic_plan.pdf (last visited Nov. 25, 2013).

While progress has been made over the last 40 years, the Healthy People 2010 Final Review[2] noted that during the period from 1988-94 to 1999-2004, there were several instances where caries was increasing. Dental caries and untreated caries increased among children aged 2-4 years. Untreated caries also increased for children aged 6-8 years and for adults aged 35-44 years.[3] Caries remains a problem for the increasing number of older adults who have retained most of their teeth. One-fourth of adults older than age 65 years have lost all of their teeth because of tooth decay and advanced gum disease. Tooth loss can affect a person's self-esteem and may contribute to nutrition problems by limiting the types of food that a person can eat.[4]

Disparities exist in the prevalence of caries across populations. The greatest racial and ethnic disparity among children aged 2-4 years and aged 6-8 years is seen in Mexican American and black, non-Hispanic children. Blacks, non-Hispanics, and Mexican Americans aged 35-44 years, experience untreated tooth decay nearly twice as much as white, non-Hispanics.[5] One of the greatest racial and ethnic disparities exists among adults aged 35-44 years for untreated tooth decay. The prevalence of untreated tooth decay among non-Hispanic blacks is more than twice that of non-Hispanic whites. Twice as many non-Hispanic blacks, and Mexican American adults aged 20-64 have untreated tooth decay as do non-Hispanic white adults.[6]

Disparities in oral health care also exist between geographic areas. Most research and surveillance information indicate that access to dental care is significantly more limited in rural areas than in metropolitan areas. According to the National Rural Health Association:[7]

- Even after controlling for population density and income, non-metropolitan counties have lower dentist-to-population ratios (62 dentists per 100,000 population in large metropolitan areas versus 29 dentists per 100,000 population in the most rural counties). The pattern is the same in Florida. Dentists are disproportionately concentrated in the more populous areas, particularly the coastal counties of south Florida (ratios ranging from 42 to 97 dentists per 100,000 population) versus ratios in the largely rural interior counties, as well as many central Panhandle counties (a range of ratios as low as 10 to 33 dentists per 100,000 population).[8]

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[2] The Healthy People initiative, which is administered by the U.S. Department of Health and Human Services, provides science-based, 10-year national objectives for improving the health of all Americans. Since its inception, Healthy People has established benchmarks and monitored progress over time in order to: encourage collaborations across communities and sectors; empower individuals toward making informed health decisions; and measure the impact of prevention activities. Since 1979, there have been four Healthy People initiatives. U.S. Dept. of Health and Human Services, *About Healthy People*, http://www.healthypeople.gov/2020/about/default.aspx (last visited Nov. 25, 2013).

[3] Nat'l Center for Health Statistics, *Healthy People 2010 Final Review*, 21-9 (Dec. 2012), *available at* www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review.pdf (last visited Nov.25, 2013).

[4] *Strategic Plan*, *supra* note 1, at 5.

[5] Centers for Disease Control and Prevention, *Disparities in Oral Health*, http://www.cdc.gov/OralHealth/oral_health_disparities (last visited Nov. 25, 2013).

[6] *Strategic Plan*, *supra* note 1, at 7.

[7] Nat'l Rural Health Association, *Meeting Oral Health Care Needs in Rural America*, 1 – 2 (April 2005) (on file with the Senate Health Policy Committee).

[8] Florida Dept. of Health, *Report on the 2009-2010 Workforce Survey of Dentists*, 4 & 59 (March 2011) (on file with the Senate Health Policy Committee). In 2009, the Department of Health developed this workforce survey for dentists. The survey was administered on a voluntary basis in conjunction with biennial renewal of dental licenses and 89 percent of dentists with an active Florida license responded to the survey.

- Rural residents are more likely to have lost all their teeth than their non-rural counterparts. In fact, adults aged 18 to 64 are nearly twice as likely to be edentulous if they are rural residents.
- Rural adults are significantly more likely than non-rural adults to have untreated dental decay: 32.6 percent versus 25.7 percent.
- In 2001, 67.1 percent of urban residents had visited a dentist in the previous year, while only 58.3 percent of rural Americans had done so.
- Rural residents are less likely than their urban counterparts to have dental insurance.
- Of the 2,235 Dental Health Professional Shortage Areas, 74 percent are in non-metropolitan areas.

According to the National Advisory Committee on Rural Health and Human Services, several factors contribute to the problems of rural oral health:

- *Geographic isolation*. People in remote rural areas have farther to travel to obtain care and fewer dentists, hygienists, and other professionals to provide it.
- *Lack of adequate transportation.* In many parts of rural America, private automobiles are the only source of transportation. Public transit is non-existent, as are taxicabs and other transportation for hire. Consequently, many rural residents — especially low-income residents — face great difficulty in going to the dentist or any other service provider.
- *Lack of fluoridated community water supplies*. This most basic preventative treatment against tooth decay is unavailable in countless rural communities.
- *Higher rates of poverty*. Low-income status prevents many people from seeking and obtaining oral health care. It also prevents them from purchasing dental insurance. In addition, rural employers are less likely to purchase or offer dental insurance for their employees due to the smaller average size for most rural employers.
- *Larger percentage of elderly population*. With increasing age come increasing dental and oral health problems. The percentages of rural Americans who are older and sicker are greater than those of urban Americans, and Medicare does not provide routine dental benefits.
- *Lower dental insurance rates*. Insurance reimbursement rates — both public and private — for dental procedures are typically lower in rural areas than in urban; however, the actual costs of providing the services are often higher in rural areas.
- *Acute provider shortages*. As indicated above, the ratio of dentists per 100,000 population in non-metropolitan counties is less than half of what it is in metropolitan counties. The acute shortage of dentists nationwide is expected to worsen in coming years as dental schools graduate fewer students, despite the fact that dental school applications were up some 18 percent between 2004 and 2005. With the closing of seven dental schools since 1986, and subsequent opening of only three new ones, more people want to become dentists than there are available slots. On top of that, many dentists are nearing retirement age - especially in rural areas. In addition, it can be predicted that the combination of increasing levels of dental school indebtedness and fee disparities between urban and rural locations will lead to a reduced percentage of the dental school graduates locating in rural locations.
- *Difficulty finding providers willing to treat Medicaid patients*. Because of low reimbursement rates, paperwork burdens, and a perception of a higher percentage of broken appointments, many dentists simply do not accept Medicaid or State Children's Health Insurance Program

(SCHIP) patients, of which there are many in rural America due to the higher proportion of people living in poverty.[9]

Health Access Dental Licensure

In 2008, the Legislature established the health access dental license in order to attract out-of-state dentists to practice in underserved health access settings.[10] With this license, a dentist actively licensed in good standing in another state, the District of Columbia, or a U.S. territory is authorized to practice dentistry in Florida in a health access setting if the dentist:

- Files a Board-approved application and pays the applicable fees;
- Has not been convicted or pled nolo contendre to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Submits proof of graduation from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association;
- Submits documentation that the dentist has completed, or will obtain prior to licensure, a continuing education equivalent to Florida's requirement for dentists for the last full reporting biennium before applying for a health access license;
- Submits proof of her or his successful completion of parts I and II of the National Boards and a state or regional clinical dental license examination that the Board has determined effectively measures the applicant's ability to practice safely;
- Has never had a license revoked from another state, the District of Columbia, or a U.S. territory;
- Has never failed an exam under s. 466.006, F.S., unless the applicant was reexamined and received a license to practice in Florida;
- Has not been reported to the NPDB, unless the applicant successfully appealed to have his or her name removed from the data bank; and,
- Submits proof that he or she has been engaged in the active, clinical practice of dentistry providing direct patient care for 5 years immediately preceding the date of application, or proof of continuous clinical practice providing direct patient care since graduation if the applicant graduated less than 5 years from his or her application.[11]

A health access dental license is subject to biennial renewal. The Board will renew a health access dental license if the applicant:

- Submits a renewal application and pays the required fees;
- Signs and submits a statement attesting that the applicant has completed all continuing education required of a licensed dentist;

[9] *Id.* (citing the National Advisory Committee on Rural Health and Human Services).
[10] A "health access setting" is defined in s. 466.003(14), F.S., as a program or institution of the Department of Children and Family Services, the Department of Health, or the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center (FQHC) or FQHC look-alike as defined by federal law, a school-based prevention program, or a clinic operated by an accredited college of dentistry or an accredited dental hygiene program in this state if such community service programs and institutions immediately report to the Board of Dentistry practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such settings.
[11] Section 466.0067, F. S.

- Submits documentation of continued employment in the health access setting;
- Has not been convicted or pled nolo contendre to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Has never failed an exam under s. 466.006, F.S., since initially receiving a health access dental license or since the last renewal; and,
- Has not been reported to the NPDB, unless the applicant successfully appealed to have his or her name removed from the data bank.[12]

The Board may revoke a health access dental license if the licensee is terminated from employment at the health access setting or practices outside of the health access setting, fails the Florida dental examination, or is found by the Board to have committed a violation of Chapter 466 (the dental practice act), other than a violation that is a citation offense or a minor violation.[13]

Currently, there are a total of 54 health access dental licenses. Of those 31 are in-state active, 5 are in-state delinquent, 13 are out-of-state active, 3 are out-of-state inactive, and 2 are retired.[14] According to data collected by the Department of Health, 14 dentists with health access licenses are currently practicing in county health departments (CHDs). Several CHDs reported they do not think they could have obtained a dentist without the availability of the health access license. CHDs also report that these dentists have been of high quality and have improved access to care on the part of the low income population.[15]

The program is scheduled for repeal effective January 1, 2015, unless reenacted by the Legislature.[16]

National Practitioner Data Bank

The NPDB was originally established by Title IV of the Health Care Quality Improvement Act of 1986, Public Law 99-660. The intent of the act is to improve the quality of health care by encouraging state licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior; and to restrict the ability of physicians, dentists, and other healthcare practitioners to move from state-to-state

[12] Section 466.00671, F.S.
[13] Section 466.00672, F.S.
[14] Florida Dept. of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan FY 2012-2013*, 8, *available at* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-12-13.pdf (last visited Nov. 25, 2013). "In-State Active" means the licensed practitioner has a Florida mailing address and is authorized to practice. "In-State Delinquent" means the licensed practitioner has a Florida mailing address and is not authorized to practice in the state because of failure to renew the license by the expiration date. "Out-of-State Active" means the licensed practitioner has an out-of-state mailing address and is authorized to practice. "Out-of-State Inactive" means the licensed practitioner has an out-of-state mailing address and is not authorized to practice. "Retired" means the licensed practitioner is not authorized to practice. The practitioner is not obligated to update licensure data. *Id.* at 10. s. 456.036, F.S.
[15] E-mail from Philip Street, Senior Policy Coordinator, Health Statistics and Performance Management, Florida Dept. of Health, (Nov. 19, 2013) (on file with the Senate Health Policy Committee).
[16] Section 466.00673, F.S.

without disclosure or discovery of previous medical malpractice payments and adverse actions. Adverse actions can involve licensure, clinical privileges, or professional society memberships.[17]

Information in the NPDB is available to:

- Hospitals requesting information concerning a practitioner on their medical staff or to whom they have granted clinical privileges, or with respect to peer review.
- Health care entities (including hospitals) that have entered or may be entering employment or affiliation relationships with a practitioner or to which the practitioner has applied for clinical privileges or appointment to the medical staff, or with respect to peer review.
- Practitioners requesting information about themselves.
- Boards of medical examiners or other state licensing boards.
- Attorneys or individuals representing themselves upon submission of proof that a hospital failed to submit a mandatory query.
- Persons or entities requesting information in a form which does not identify any particular practitioner or entity.[18]

Information in the NPDB is confidential. Violations of the confidentiality provisions are subject to civil money penalties.

According to the NPDB Handbook:

> The NPDB is intended to augment, not replace, traditional forms of credentials review. As a nationwide flagging system, it provides another resource to assist state licensing boards, hospitals, and other health care entities in conducting extensive, independent investigations of the qualifications of the health care practitioners they seek to license or hire, or to whom they wish to grant clinical privileges.

Settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician, dentist, or other health care practitioner. **Thus, a payment made in settlement of a medical malpractice action or claim shall not be construed as a presumption that medical malpractice has occurred.[19]**

III. Effect of Proposed Changes:

The bill removes reports to the National Practitioner Data Bank as a condition that renders an applicant ineligible for a health access dental license. The bill substitutes instead authority for the Board of Dentistry to deny initial or renewal licensure to any applicant who has committed or is under investigation or prosecution for an act that is grounds for discipline under chapter 466 or

[17] U.S. Dept. of Health and Human Services, Health Resources and Services Administration, *NPDB Guidebook*, A-2 (Sept. 2001) *available at* http://www.npdb-hipdb.hrsa.gov/resources/aboutGuidebooks.jsp (last visited Nov. 25, 2013).
[18] *Id.* at A-5.
[19] *Id.* at A-3 (emphasis in the original).

chapter 456. SPB 7010 also reauthorizes the program for an additional five years through January 1, 2020.

The bill has an effective date of July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Section 466.0067(2), F.S., authorizes the Board of Dentistry to charge an application license fee for a health access dental license, laws-and-rule exam fee, and an initial licensure fee, which are the same as fees charged to an applicant for an unrestricted dental license. Currently, those fees are:

- Application fee: $100.
- Exam Development fee: $80.
- Licensure fee: $305.

Because the effect of the bill is to reenact and continue an existing program, these fees are not new. Thus, the potential fiscal impact remains the same as when the program was created in 2008.

B. Private Sector Impact:

The health access dental license creates an incentive for out-of-state dentists to practice in settings—defined as "health access settings"—that provide dental care to underserved populations or communities. The definition includes certain nonprofit facilities. Thus, both the facilities and patients they serve may benefit from access to additional dentists.

C. Government Sector Impact:

The health access dental license creates an incentive for out-of-state dentists to practice in settings—defined as "health access settings"—that provide dental care to underserved populations or communities. The majority of these settings are publicly-operated. Thus, the facilities may benefit from access to additional dentists.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 466.0067, 466.00671, and 466.00673.

IX. Additional Information:

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

None.

B. Amendments:

None.