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 Appropriations

BILL:	PCS/SB 606 (161922)
INTRODUCER:	Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services); Health Policy Committee; and Senator Gaetz and others
SUBJECT:	Dental Care
DATE:	April 8, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Recommend: Fav/CS**
3.	Brown	Kynoch	AP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 606 authorizes the creation of joint state and local dental care access accounts to promote local economic development and to encourage Florida-licensed dentists to practice in dental health professional shortage areas or medically underserved areas, or serve a medically underserved population, subject to the availability of funds.

The Department of Health estimates first-year implementation expenditures of $130,341 from the General Revenue Fund and recurring maintenance and support costs of $152,050 from the General Revenue Fund.

The bill provides an effective date of July 1, 2015.

II. Present Situation:

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are designated by the Health Resources and Services Administration (HRSA) within the U.S. Department of Health and Human Services according to criteria developed in accordance with section 332 of the Public Health Services Act. HPSA designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals.

There are three categories of HPSA designation: (1) primary medical; (2) dental; and (3) mental health. For each discipline category, there are three types of HPSA designations based on the area or population group that is experiencing the shortage: (1) geographic area; (2) population group; and (3) facility.

A geographic HPSA indicates that the entire area may experience barriers in accessing care, while a population HPSA indicates that a particular subpopulation of an area (e.g., homeless or low-income) may be underserved. Finally, a facility HPSA is a unique facility that primarily cares for an underserved population.

The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. The threshold for a dental HPSA is a population-to-provider ratio of at least 5,000 to 1 (or 4,000 to 1 in high need communities).

Medically Underserved Area

Medically Underserved Areas (MUA) are also designated by the U.S. Department of Health and Human Services. These areas are designated using one of three methods and can consist of a whole county, a group of contiguous counties, or census tracts.[1]

The first method, the Index of Medical Underservice (IMU), calculates a score based on the ratio of primary medical care physicians per 1,000 in population, percentage of the population with incomes below the federal poverty level, infant mortality rate, and percentage of population aged 65 or older.

The second method, Medically Underserved Populations (MUP), is based on data collected under the MUA process and reviews the ratio of primary care physicians serving the population seeking the designation. A MUP is a group of people who encounter economic or cultural barriers to primary health care services.

The third process, Exceptional MUP Designations, includes those population groups which do not meet the criteria of an IMU but may be considered for designation because of unusual conditions with a request by the governor or another senior executive level official and a local state health official.[2]

The Dental Workforce

Nationally, the pool of dentists to serve the growing population of Americans is shrinking. The American Dental Association has found that 6,000 dentists retire each year in the U.S., while there are only 4,000 dental school graduates each year to replace them. The projected shortage of dentists is even greater in rural America. Of the approximately 150,000 general dentists in

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Shortage Demonstration: Health Professional Areas & Medically Underserved Areas/Populations* http://www.hrsa.gov/shortage/ (Last visited Mar. 2, 2015).
[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Medically Underserved Areas/Populations* http://www.hrsa.gov/shortage/mua/index.html (last visited Mar. 2, 2015).

practice in the U.S., only 14 percent practice in rural areas, 7.7 percent practice in large rural areas, 3.7 percent practice in small rural areas, and 2.2 percent practice in isolated rural areas. In 2003, there were 2,235 federally designated dental health professional shortage areas (HPSAs).[3] Today, the number of dental HPSAs has increased to over 4,900.

While the dental workforce is projected to grow by six percent between 2012 and 2025, it is not expected to meet the overall national demand. States expected to have the greatest shortfall are California, which has the largest number (1,234 fewer dentists than needed), followed by Florida, which has 1,152 fewer dentists than needed.[4]

Similar to the national trend, most dentists in Florida are concentrated in the more populous areas of the state, while rural areas, especially the central Panhandle counties and interior counties of south Florida, have a noticeable dearth of dentists.[5] This is true for both general dentistry as well as for dental specialists. Over 20 percent of Florida licensed dentists that responded to the 2011-2012 *Florida Workforce Survey of Dentists* (survey) currently do not practice in Florida.[6]

Most dentists – 77.8 percent – practice in general dentistry.[7] In many rural communities, the county health department may be the primary provider of health care services, including dental care. Florida currently has 220 designated dental HPSAs, which have only enough dentists to serve 17 percent of the population living within them. For 2012, HRSA estimated that 853 additional dentists were required to meet the total need. This puts Florida among the states with the highest proportion of their populations that are deemed underserved. By 2025, Florida's need grows to 1,152 dentists.[8]

The American Dental Association has also studied this issue and found that while there may be a sufficient number of dentists overall, there may be an inadequate number among certain populations or in certain geographic areas.[9] Children are acutely affected by the shortage of dentists to serve low income patients. In 2012, 26 percent of Medicaid-enrolled children in Florida received one or more dental care services, according data from the Agency for Health

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[3] National Rural Health Association, *Issue Paper: Recruitment and Retention of a Quality Health Workforce in Rural Areas*, (November 2006) (on file with the Senate Committee on Health Policy).

[4] U.S. Department of Health and Human Services, Health Resources and Services Administration, *National and State Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2015*, pp.-3-4 (February 2015) http://bhpr.hrsa.gov/healthworkforce/supplydemand/dentistry/nationalstatelevelprojectionsdentists.pdf (last visited Feb. 27, 2015).

[5] Florida Dept. of Health, *Report on the 2011-2012 Workforce Survey of Dentists*, p. 6 (April 2014) http://www.floridahealth.gov/programs-and-services/community-health/dental-health/workforce-reports/florida-workforce-survey-of-dentists-2011-2012.pdf (last visited Feb. 27, 2015). In 2009, the department developed this workforce survey for dentists. The survey was administered on a voluntary basis in conjunction with biennial renewal of dental licenses and 87 percent of dentists with an active Florida license responded to the survey; a drop of 2 percent points from the 2009-2010 survey.

[6] Id. at 46.

[7] Id.

[8] *Supra* note 4, at 9.

[9] Bradley Munson, B.A., and Marko Vujicic, Ph.D.: Health Policy Institute Research Brief, American Dental Association, *Supply of Dentists in the United States Likely to Grow*, p.2. (October 2014) http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_1.ashx (last visited Feb. 27, 2015).

Care Administration (AHCA).[10] The survey noted a noticeable participation difference between private-practice dentists and those who practice in a safety-net setting. Of those in a private-office setting, only 13.7 percent report seeing Medicaid enrollees while over 60 percent of safety-net providers report Medicaid participation.[11]

In 2011, the Legislature passed HB 7107[12] creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. The program has two primary components: Managed Medical Assistance program (MMA) and Long Term Care program. To implement MMA, the law required the AHCA to create an integrated managed care program for the delivery of delivery of Medicaid primary and acute care, including dental. Medicaid recipients who are enrolled in MMA receive their dental services through managed care plans. Although most dental services are designated as a required benefit only for Medicaid recipients under age 21, many of the managed care plans also provide, as an enhanced benefit, dental services for adults.

The Cost of Dental Education

Among U.S. dental schools, the cost of a four-year degree has risen dramatically over the last 10 years – by 93 percent for in-state residents (from about $89,000 to $171,000) and by 82 percent for out-of-state residents (from $128,000 to $234,000). Dental school debt has increased proportionately. The average debt for dental school graduates in 2011 was $245,497.[13] Some studies indicate that increasing education costs and the prospect of indebtedness after dental school graduation could further erode access to care for vulnerable, underserved populations.[14] At least three studies, including a 2011 Florida Senate Report,[15] have recommended consideration of loan forgiveness programs as one strategy for addressing dental workforce shortage concerns.[16]

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[10] *Supra* note 5, at 8.
[11] *Supra* note 5, at 35.
[12] *See* ch. 2011-134, Laws of Fla.
[13] *Supra* note 4, at 6.
[14] American Dental Education Association, *A Report of the ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing*, pp. 17-18 (March 2013) http://www.adea.org/uploadedFiles/ADEA/Content_Conversion_Final/publications/Documents/ADEACostandBorrowingReportMarch2013.pdf (last viewed Feb. 27, 2015). *See* also U.S. Dept. of Health and Human Services, Health Resources and Services Administration, *Financing Dental Education: Public Policy Interests, Issues and Strategic Considerations*, p. 39 (2005) http://bhpr.hrsa.gov/healthworkforce1/reports/financedentaledu.pdf (last visited Feb 27. 2015).
[15] Comm. on Health Regulation, The Florida Senate, *Review Eligibility of Dentist Licensure in Florida and Other Jurisdictions*, p.15 (Interim Report 2012-127) (Sept. 2011) http://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-127hr.pdf (last visited Mar. 2, 2015). The report concluded, in part: "Florida may become more competitive in its recruitment of dentists in rural areas and may enhance Florida's dental care for underserved populations if it offers a loan forgiveness program. The program could require dentists seeking loan assistance to serve in a rural area (the Panhandle or central, south Florida) and require dentists to serve a certain percentage of Medicaid recipients or participate in the provider network of managed care entities participating in the Medicaid program for a particular period of time. Considering the current lack of state resources, it may be beneficial to limit the number of dentists that may apply to the loan forgiveness program and target resources to areas with the most need for general dentists or specialists." At the time, Florida was one of only eight states that did not have a state loan forgiveness program. According to the American Dental Association, it is one of only 11 states: Alabama, Arkansas, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Montana, Texas, and Utah as of July 2014. http://www.ada.org/~/media/ADA/Education%20and%20Careers/Files/dental-student-loan-repayment-resource.ashx (Last visited Mar. 2, 2015).
[16] American Dental Education Association, *supra* note 14, at 26; *Financing Dental Education*, *supra* note 14, at 40.

Florida Health Services Corps

In 1992, the Legislature created the Florida Health Services Corps (FHSC), administered by the Department of Health (DOH), to encourage medical professionals to practice in locations that are underserved because of a shortage of qualified professionals.[17] The FHSC was defined[18] as a program that offered scholarships to allopathic, osteopathic, chiropractic, podiatric, dental, physician assistant, and nursing students, and loan repayment assistance and travel and relocation expenses to allopathic and osteopathic residents and physicians, chiropractic physicians, podiatric physicians, nurse practitioners, dentists, and physician assistants, in return for service in a public health care program[19] or in a medically underserved area.[20] Membership in the FHSC could be extended to any health care practitioner who provided uncompensated care to medically indigent patients.[21] All FHSC members were required to enroll in Medicaid and to accept all patients referred by the DOH pursuant to the program agreement.[22] In exchange for this service, an FHSC member was made an agent of the state and granted sovereign immunity under s. 768.28(9), F.S., when providing uncompensated care to medically indigent patients referred for treatment by the DOH.[23]

The statute authorized the DOH to provide loan repayment assistance and travel and relocation reimbursement to allopathic and osteopathic medical residents with primary care specialties during their last two years of residency training or upon completion of residency training, and to physician assistants and nurse practitioners with primary care specialties, in return for an agreement to serve a minimum of two years in the FHSC. During the period of service, the maximum amount of annual financial payments was limited to no more than the annual total of loan repayment assistance and tax subsidies authorized by the National Health Services Corps (NHSC) loan repayment program.[24]

During the 20 years the program was authorized by law, it was funded only three times. A total of $3,684,000 was appropriated in the 1994-1995 fiscal year, 1995-1996 fiscal year, and 1996-1997 fiscal year for loan assistance payments to all categories of eligible health care practitioners. Of that amount, $971,664 was directed to 18 dentists for an average award of $25,570 per year of service in the program.[25] The 2007 Legislature attempted to reinvigorate the

[17] Ch. 92-33, s. 111, Laws of Fla. (creating s. 381.0302, F.S., effective July 1, 1992).
[18] Section 381.0302(2)(b)1., F.S. (2011).
[19] "Public health program" was defined to include a county health department, a children's medical services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department. Section 381.0302(2)(e), F.S. (2011).
[20] "Medically underserved area" was defined to include: a geographic area, a special population, or a facility that has a shortage of health professionals as defined by federal regulations; a county health department, community health center, or migrant health center; or a geographic area or facility designated by rule of the department that has a shortage of health care practitioners who serve Medicaid and other low-income patients. Section 381.0302(2)(c), F.S. (2011).
[21] "Medically indigent person" was defined as a person who lacks public or private health insurance, is unable to pay for care, and is a member of a family with income at or below 185 percent of the federal poverty level. Section 381.0302(2)(d), F.S. (2011).
[22] Section 381.0302(10), F.S. (2011).
[23] Section 381.0302(11), F.S. (2011).
[24] Section 381.0302(6), F.S. (2011).
[25] Email from Karen Lundberg, Florida Dept. of Health, to Joe Anne Hart, Florida Dental Association (Sept. 16, 2005) (on file with the Senate Committee on Health Policy).

program by appropriating $700,000 to fund loan repayment assistance for dentists only.[26] However, the appropriation and a related substantive bill were vetoed by the governor.[27] The Legislature repealed the program in 2012.[28]

National Health Service Corps

The NHSC programs provide scholarships and educational loan repayment to primary care providers[29] who agree to practice in areas that are medically underserved. NHSC loan repayment program (LRP) participants fulfill their service requirement by working at NHSC-approved sites in HPSAs. The NHSC-approved sites are community-based health care facilities that provide comprehensive outpatient, ambulatory, primary health care services. Eligible dental facilities must be located in a dental HPSA and offer comprehensive primary dental health services. NHSC-approved sites (with the exception of correctional facilities and free clinics) are required to provide services for free or on a sliding fee scale (SFS) or discounted fee schedule for low-income individuals. The SFS or discounted fee schedule is based upon the Federal Poverty Guidelines, and patient eligibility is determined by annual income and family size.[30]

The LRP provides funds to participants to repay their outstanding qualifying educational loans. Maximum loan reimbursement under the program is $50,000 for a two-year, full-time practice or up to $15,000 for a two-year, half-time clinical practice, although participants may be eligible to continue loan repayment beyond the initial term.[31,32] Participants who breach their LRP agreement are subject to monetary damages, which are the sum of the amount of assistance received by the participant representing any period of obligated service not completed, a penalty, and interest. Loan repayments are exempt from federal income and employment taxes and are not included as wages when determining benefits under the Social Security Act.[33] In 2013, there were 38.5 full-time-equivalent NHSC dentists in Florida.[34]

A second NHSC program, the State Loan Repayment Program (SLRP) offers cost-sharing grants to states to operate their own state educational loan repayment programs for primary care providers, including dental professionals, working in HPSAs within the state. The SLRP varies

[26] Ch. 2007-72, Laws of Fla. The funding was contained in Specific Appropriations 677A of the General Appropriation Act, but later vetoed pursuant to the Governor's line item veto authority.
[27] *Journal of the Florida Senate*, at 3 (June 12, 2007).
[28] Ch. 2012-184, s. 45, Laws of Fla.
[29] Primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and behavioral and mental health providers, including health service psychologists, licensed clinical social workers, marriage and family therapists, psychiatrist nurse specialists, and licensed professional counselors.
[30] U.S. Dept. of Health and Human Services, Health Resources and Services Administration, *National Health Service Corps Site Reference Guide*, (April 14, 2014) http://nhsc.hrsa.gov/downloads/sitereference.pdf (last visited Mar. 2, 2015).
[31] The definition of part-time and full-time vary by discipline. The guidelines for both can be found in the *Fiscal Year 2015 Application and Program Guidance* packet beginning on 19 http://www.nhsc.hrsa.gov/loanrepayment/lrpapplicationguidance.pdf (last viewed Feb, 27, 2015).
[32] U.S. Department of Health and Human Services, Loan Repayment Program - *Fiscal Year 2015 Application and Program Guidance*, pp. 4-5 (January 2015) http://www.nhsc.hrsa.gov/loanrepayment/lrpapplicationguidance.pdf (last viewed Feb. 27, 2015).
[33] U.S. Dept. of Health and Human Services, Health Resources and Services Administration, *National Health Service Corps 101* (on file in the Senate Health Policy Committee).
[34] Email from Philip Street, Senior Policy Coordinator, Health Statistics and Performance Management, Florida Dept. of Health (Nov. 19, 2013) (on file with the Senate Committee on Health Policy).

from state-to-state and may differ in eligible categories of providers, practice sites, length of required service commitment, and the amount of loan repayment assistance offered. However, there are certain statutory requirements SLRP grantees must meet. There is a minimum two-year service commitment with an additional one-year commitment for each year of additional support requested. Any SLRP program participant must practice at an eligible site located in a federally-designated HPSA. Like the NHSC loan repayment program awards, assistance provided through an SLRP is not taxable.

In addition, the SLRP requires a $1 state match for every $1 provided under the federal grant. While the SLRP does not limit award amounts, the maximum award amount per provider that the federal government will support through its grant is $50,000 per year, with a minimum service commitment of two years.

Florida does not currently participate in SLRP.

III. Effect of Proposed Changes:

The bill creates the dental care access accounts initiative at the Department of Health (DOH). The initiative is conditioned on the availability of funds and is intended to encourage dentists to practice in dental health professional shortage areas or medically underserved areas or serve a medically underserved population. The bill defines several key terms:

- Dental health professional shortage area: A geographic area so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services;
- Medically underserved area: A designated health professional shortage area that lacks an adequate number of dental health professionals to serve Medicaid and other low income patients; and
- Public health program: A county health department, the Children's Medical Services program, a federally qualified community health center, a federally-funded migrant health center, or other publicly-funded or not-for-profit health care program designated by the DOH.

The initiative will be developed by the DOH to benefit dentists licensed to practice in this state who demonstrate, as required by DOH rule:

- Active employment by a public health program in a dental health professional shortage area or a medically underserved area; or
- A commitment to opening a private practice in a dental health professional shortage area or medically underserved area by residing in the area, maintaining a Medicaid provider agreement, enrolling with one or more Medicaid managed care plans, expending capital to open an office to serve at least 1,200 patients, and obtaining community financial support.

The DOH is required to establish dental access accounts for dentists who meet the requirements in the bill and to implement an electronic benefits transfer system. Funds from the account may be used only for specific purposes, such as payment of student loans; investment in property, facilities, or equipment necessary to establish an office and payment of transitional expenses related to relocating or opening a dental practice.

Subject to available appropriations, the DOH is required to distribute funds to the dental access accounts in amounts not to exceed $100,000 and no less than $10,000. A state award may not exceed three times the amount contributed to an account in the same year from a local source. The DOH is authorized to accept funds for deposit from local sources.

If a dentist qualifies for an account on the basis of his or her employment with a public health program, the dentist's salary and associated employer expenditures may count as local match for a state award if the salary and employer expenditures are not state funds. State funds may not be used to calculate amounts contributed from local sources.

Accounts may be terminated if the dentist no longer works for a public health program and does not open a dental practice in a designated area within 30 days of terminating employment, the dentist's practice is no longer located in a dental professional shortage area or a medically underserved area, the provider has been terminated from Medicaid, or the provider has participated in any fraudulent activity. The DOH is directed to close an account five years after the first deposit or upon a dentist's termination from the program.

Any remaining funds after five years or from terminated accounts may be awarded to another account or returned to the donor. A dentist is required to repay any funds withdrawn from the account after the occurrence of an event which requires account closure, if the dentist fails to maintain eligibility for the program through employment in a public health program or establishing a dental practice for a minimum of two years, or uses the funds for unauthorized purposes. The DOH is authorized to recover the withdrawn funds through disciplinary enforcement actions and other methods authorized by law.

The DOH is authorized to adopt rules for application procedures that:

- Limit the number of applicants;
- Incorporate a documentation process for evidence of sufficient capital expenditures in opening a dental practice, such as contracts or leases or other acquisitions of a practice location of at least 30 percent of the value of equipment or supplies necessary to operate a practice; and
- Give priority to those applicants practicing in the areas receiving higher rankings by the Department of Economic Opportunity.

The DOH may also establish by rule a process to verify that funds withdrawn from an account have been used for the purposes authorized.

The Department of Economic Opportunity shall rank the dental professional shortage areas and medically underserved areas based on the extent to which limited access to dental care is impeding economic development.

The DOH must develop a marketing plan for the dental care access account initiative with the University of Florida College of Dentistry, the Nova Southeastern College of Dental Medicine, the Lake Erie College of Osteopathic Medicine School of Dental Medicine, and the Florida Dental Association.

The bill provides an effective date of July 1, 2015.

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:

None.

B. Private Sector Impact:

Under PCS/CS/SB 606, Floridians living in those areas identified as medically underserved and have little to no access to dental care could benefit from this initiative as it could bring additional dental professionals to their communities. The initiative also permits the grantees to utilize the funds to transition or relocate to new areas and to build or renovate office space in rural communities, which would generate economic growth for small towns and cities.

The ability to maintain good oral health for adults and children enables workers to also be more productive and for children to participate more actively in school activities.

Additionally, dentists who qualify for loan repayment assistance will benefit from a reduction in their student loan debt.

C. Government Sector Impact:

This bill will create a fiscal impact to the Department of Health (DOH) for the costs related to the implementation and management of the dental care access account initiative. The projected impact is $130,341 from the General Revenue Fund for the 2015-2016 fiscal year with a recurring cost of $152,050 from the General Revenue Fund beginning with Fiscal Year 2016-2017.

The initial cost for the electronic benefit transfer contract/vendor is unknown, but the DOH reports a nominal cost of approximately $0.50 per participant per month as a maintenance fee. The DOH also anticipates a withdrawal fee of at least $1 per transaction

when a dentist makes a withdrawal from his or her account. The number of dentists qualifying for this initiative is unknown.[35]

The DOH also reports the bill will create a workload impact that current staff is unable to meet. Two additional staff members (2 FTEs) would be required to develop the application process and adopt rules. Staff will also be needed to monitor activity, dentist conduct, dentist membership status, and rulings by the Board of Dentistry on recipients.

The following are the estimated expenditures for the DOH:[36]

Estimated Expenditures (General Revenue)	1st Year	2nd Year Annualization/Recurring
SALARIES		
1 FTE **Health Care Program Analyst @ $40,948 - pay grade 24**	$41,460	$55,280
1 FTE **Senior Management Analyst II @ $46,381 - pay grade 26**	$46,961	$62,614
EXPENSES		
2 FTEs Calculated with standard DOH professional package (limited travel) @ $15,616	$31,232	$23,468
HUMAN RESOURCES SERVICES		
2 FTEs Calculated with standard DOH Central Office package @ $344	$688	$688
Operating Capital Outlay		
Operating Capital Outlay	$0.00	$0.00
Contractual Services		
Estimate for the development, implementation and maintenance of an electronic benefit transfer (EBT) system	$10,000	$10,000
TOTAL ESTIMATED EXPENDITURES	**$130,341**	**$152,050**

The DOH is also directed to develop a marketing plan with Florida-based dental schools. The cost of that marketing plan has not yet been developed by the DOH.

VI. Technical Deficiencies:

None.

[35] Florida Department of Health, *Senate Bill 606 Analysis*, pp.4-5, (Feb. 6, 2015) (on file with the Senate Committee on Health Policy).
[36] Id.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 381.4019 of the Florida Statutes.

IX. Additional Information:

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

Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on March 19, 2015:
The committee substitute clarifies the definition of "public health program" to include federally *qualified* community health centers, instead of federally *funded* community health centers, thereby referencing federally qualified health centers as defined under the federal Public Health Service Act.

CS by Health Policy on March 4, 2015:
The committee substitute:

- Adds medically underserved populations to the focus areas of the dental care access account initiative;
- Authorizes the salary and associated employer expenditures of an employee in a public health program to qualify as local match if no state funds contribute to these costs and specifically prohibits state funds from counting toward local match;
- Provides that local funds are to be returned on a pro rata basis;
- Provides standards for rulemaking regarding the demonstration of sufficient capital to show substantial progress in opening a dental practice;
- Requires rule to verify funds are used for allowable purposes; and
- Requires the Department of Health to develop a marketing plan with the state dental schools.

B. Amendments:

None.