HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 595 Reimbursement to Health Access Settings for Dental Hygiene Services for Children
SPONSOR(S): Health Innovation Subcommittee; Plasencia
TIED BILLS: **IDEN./SIM. BILLS:** SB 580

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	10 Y, 0 N, As CS	McElroy	Poche
2) Health Care Appropriations Subcommittee	13 Y, 0 N	Clark	Pridgeon
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Section 466.024(2), F.S., authorizes licensed dental hygienists to perform a limited number of unsupervised remediable tasks in health access settings, such as county health departments, Head Start programs, and other facilities, as defined in s. 466.003(14), F.S. These remediable tasks are reimbursable pursuant to s. 466.024(4), F.S.; however, reimbursement is barred under the Managed Medical Assistance (MMA) program as s. 409.906(6), F.S., authorizes reimbursement for dental services only when performed under the supervision of a licensed dentist.

CS/HB 595 eliminates the conflict by amending s. 409.906(6), F.S., to allow for reimbursement to the health access setting by the Agency for Health Care Administration for the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2), F.S., on children under the age of 21 in the MMA program.

The bill has an indeterminate but likely insignificant fiscal impact on the Agency for Health Care Administration.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Oral Health

Oral health has a significant impact on an individual's physical and mental health. It can influence how individuals grow, enjoy life, look, speak, chew, taste food and socialize, as well as their feelings of social well-being.[1] It can also affect, be affected or contribute to various diseases and conditions including:[2]

- Endocarditis;
- Cardiovascular disease;
- Diabetes;
- HIV/AIDS;
- Osteoporosis; and
- Alzheimer's disease.

For children, poor oral health can result in pain, discomfort, disfigurement, acute and chronic infections, eating and sleep disruption and an overall reduction of quality of life.[3] Children with poorer oral health are also more likely to miss school, have a lower grade-point average and otherwise perform poorly in school.[4] In fact, one study concluded that visits or dental problems accounted for 117,000 hours of school lost per 100,000 children.[5]

Tooth decay is one of the most common, and easily preventable, chronic conditions of childhood in the United States.[6] About 20% of children aged 5-11 and 13% of adolescents aged 12-19 have at least one untreated tooth decay.[7] The prevalence of tooth decay is more than twice as high, 25% compared to 11%, for children from low-income families.[8]

Dental Workforce

Currently, there is a national workforce shortage of dentists, and it is projected to worsen in the future. In 2012, there were 190,800 dentists with an estimated need of 197,800 dentists, resulting in a shortage of 7,000 dentists.[9] By 2025, projections have 202,600 dentists in practice with a need for

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[1] *Oral Health, General Health and Quality of Life*, World Health Organization, Aubrey Sheiham, Volume 83, Number 9, September 2005, 641-720. http://www.who.int/bulletin/volumes/83/9/editorial30905html/en/ (last visited November 23, 2015).
[2] *What Conditions May be Linked to Oral Health*, Mayo Clinic. http://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475?pg=2 (last visited on November 23, 2015).
[3] Id.
[4] *Impact of Poor Oral Health on Children's School Attendance and Performance*, Stephanie L. Jackson, DDS, MS, corresponding author William F. Vann, Jr, DMD, PhD, Jonathan B. Kotch, MD, MPH, Bhavna T. Pahel, PhD, MPH, BDS, and Jessica Y. Lee, DDS, PhD, MPH, American Journal of Public Health, Am J Public Health. 2011 October; 101(10): 1900–1906. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222359/ (last visited on November 23, 2015); *The Impact of Oral Health on the Academic Performance of Disadvantaged Children*, Hazem Seirawan, DDS, MPH, MS, Sharon Faust, DDS, and Roseann Mulligan, DDS, MS, American Journal of Public Health, Am J Public Health. 2012 September; 102(9): 1729–1734. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3482021/ (last visited on November 23, 2015).
[5] *Supra* footnote 1.
[6] *Children's Oral Health*, Centers for Disease Control and Prevention, Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. http://www.cdc.gov/oralhealth/children_adults/child.htm (last visited November 23, 2015).
[7] Id.
[8] Id.
[9] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. National and State-Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2025. Rockville, Maryland, 2015. http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjv-aSQyKfJAhUBZiYKHRlGCSMQFggdMAA&url=http%3A%2F%2Fbhpr.hrsa.gov%2Fhealthworkforce%2Fsupplydemand%2Fdentistry%2

211,200 dentists.[10] This projected shortage of 8,600 dentists, combined with the 2012 shortage, results in a shortage of 15,600 dentists by the year 2025. All 50 states and the District of Columbia are projected to have a shortfall of dentists with Florida projected to have the second highest shortfall in the nation (1,152) by 2025.[11]

Dental hygienists are trending in the opposite direction of dentists. There is currently an excess supply of dental hygienists and by 2025 the national excess supply is projected to be 28,100.[12] Florida again follows the national trend and is projected to have the third largest excess supply of dental hygienists (2,768) by 2025.[13] However, not all states are projected to have an excess supply.[14]

Medicaid

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

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

The federal government sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[15] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, dental services, and dialysis.[16]

Statewide Medicaid Managed Care[17]

In 2011, the Legislature established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC program is an integrated managed care program which provides all the mandatory and optional Medicaid benefits to enrollees. Within the SMMC program, the Managed Medical Assistance (MMA) program provides primary and acute medical assistance and related services, including dental services.[18]

In the SMMC program, each Medicaid recipient has one managed care organization to coordinate all health care services, rather than various entities.[19] Such coordinated care is particularly important in the area of oral health, which is connected to overall health outcomes.[20]

Fnationalstatelevelprojectionsdentists.pdf&usg=AFQjCNG2CoEtGnpvOZgQmrtmRhCMWC85BA&bvm=bv.108194040,d.eWE (last visited on November 23, 2015).
[10] Id.
[11] Id.
[12] Id.
[13] Id.
[14] Id.
[15] S. 409.905, F.S.
[16] S. 409.906, F.S.
[17] The delivery of Medicaid services through managed care is not expressly authorized by federal law. If a state wants to use a managed care delivery system, it must seek a waiver of certain requirements of Title XIX of the Social Security Act (Medicaid). To implement the SMMC program, AHCA applied for and obtained section 1115 waiver authority.
[18] The other component of the SMMC program is the Long-Term Care Managed Care Program.
[19] This comprehensive coordinated system of care was successfully implemented in the 5-county Medicaid reform pilot program, 2006-2014.

In December 2012, AHCA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a regional basis for the MMA program.[21] AHCA selected 19 managed care plans and executed 5-year contracts in February, 2014. The MMA program was fully implemented statewide as of August 1, 2014.

Dental Care in the MMA Program

Dental services are an optional Medicaid benefit. Florida provides full dental services for children and only dentures and medically necessary, emergency dental procedures to alleviate pain or infection for adults.[22] As of November 2015, approximately 3.1 million Medicaid recipients are enrolled in the MMA program and receive their dental services through managed care plans that offer a full array of medical, behavioral, and dental health benefits.[23]

Dental Service Accountability and Performance in the MMA Program

The MMA program contracts impose various accountability provisions and performance measures on the MMA plans specific to dental services, which include requirements for:[24]

- Network adequacy;
- Annual medical loss ratio for the first full year of MMA program operation;
- Preventive dental services rate for children enrolled for 90 continuous days;
- Transportation to and from the child's dental appointment, if needed; and
- Healthcare Effectiveness Data and Information Set scores.[25]

MMA plans are subject to corrective actions and liquidated damages for failure to meet accountability provisions and performance measures set forth in the contracts.

In addition, under federal terms and conditions, AHCA must work with MMA plans on an oral health quality improvement initiative. For this initiative, the MMA contracts[26] have specific performance goals for pediatric dental services and penalties for not reaching the performance standards.

Dental Care Reimbursement for Children's Dental Services

The MMA program authorizes reimbursement for children's dental services rendered by dentists, dental hygienists and dental assistants. A dentist may delegate remediable tasks[27] to dental hygienists or dental assistants when such tasks pose no risk to the patient.[28] AHCA is statutorily authorized to pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist.[29] Thus, a dentist must

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[20] 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. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBJT/ (last visited on November 23, 2015).

[21] 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-ADP136192735200001182.htm (last visited on November 23, 2015); 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-ADP136192735200001182.htm (last visited on November 23, 2015).

[22] S. 409.906(1), (6), F.S.

[23] Comprehensive Medicaid Managed Care Enrollment Reports, AHCHA, November 2015. http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/MHMO/med_data.shtml (last visited on November 23, 2015).

[24] The Managed Medical Assistance Model Contract is available at https://ahca.myflorida.com/medicaid/statewide_mc/plans.shtml (last visited on November 23, 2015).

[25] AHCA measures the performance of the MMA plans based on standards established by the National Committee for Quality Assurance called the Healthcare Effectiveness Data and Information Set (HEDIS).

[26] *Supra* footnote 25.

[27] "Remediable tasks" are those intraoral treatment tasks which are reversible and do not create unalterable changes within the oral cavity or the contiguous structures and which do not cause an increased risk to the patient. S. 466.003(12), F.S.

[28] S. 466.024(1), F.S.

[29] S. 409.906 (6), F.S.

supervise any delegable tasks performed by a dental hygienist or dental assistant if reimbursement is being sought under the MMA.

Dental Hygienists

Dental Hygienists are regulated by ch. 466, F.S., and by the Board of Dentistry (Board) within the Department of Health. Dental hygienists are focused on preventing dental disease. They are educated and trained to evaluate the patient's oral health; expose, process and interpret dental X-ray films; and remove calculus deposits, stains, and plaque above and below the gumline.[30] They also apply preventive agents such as fluorides and sealants to teeth when allowed by state regulations.[31] Dental hygienists may also perform certain tasks which are delegated by a licensed dentist. These delegable tasks are established either in statute or by rule and include:[32]

- Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance;
- Placing periodontal dressings;
- Removing periodontal or surgical dressings;
- Removing sutures;
- Placing or removing rubber dams;
- Placing or removing matrices;
- Placing or removing temporary restorations;
- Applying cavity liners, varnishes, or bases;
- Polishing amalgam restorations;
- Polishing clinical crowns of the teeth for the purpose of removing stains but not changing the existing contour of the tooth;
- Dental charting[33];
- Obtaining bacteriological cytological specimens not involving cutting of the tissue; and
- Administering local anesthesia pursuant to s. 466.017(5).

The Board establishes by rule whether these tasks are to be performed under direct, indirect, or general supervision of the dentist.[34] A dental hygienist may perform these tasks in multiple settings, including:[35]

- In the office of a licensed dentist;
- In public health programs and institutions of the Department of Children and Families, Department of Health, and Department of Juvenile Justice under the general supervision of a licensed dentist; and
- In a health access setting.

Scope of Practice in Health Access Settings

In 2011, the Legislature expanded the scope of practice for dental hygienists providing dental services to children under the age of 21 in health access settings[36] in an effort to maximize the existing dental

[30] S. 466.023, F.S.
[31] See Rule 64B5-16.006, F.A.C.
[32] S. 466.024 (1), F.S.
[33] "Dental Charting" is a recording of visual observations of clinical conditions of the oral cavity without the use of X rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets. S. 466.0235.
[34] S. 466.023(1), F.S. "Direct supervision" means supervision whereby a dentist diagnoses the condition to be treated, a dentist authorizes the procedure to be performed, a dentist remains on the premises while the procedures are performed, and a dentist approves the work performed before dismissal of the patient. "Indirect supervision" means supervision whereby a dentist authorizes the procedure and a dentist is on the premises while the procedures are performed. "General supervision" means supervision whereby a dentist authorizes the procedures which are being carried out but need not be present when the authorized procedures are being performed. The authorized procedures may also be performed at a place other than the dentist's usual place of practice. The issuance of a written work authorization to a commercial dental laboratory by a dentist does not constitute general supervision. S. 466.003 (8), (9) and (10), F.S.
[35] S. 466.023(2), F.S.

workforce. The legislation authorized licensed dental hygienists to perform certain remediable tasks in a health access setting without the physical presence, prior examination or authorization of a dentist.[37] These tasks include:

- Perform dental charting as defined in s. 466.0235 and as provided by rule;
- Measure and record a patient's blood pressure rate, pulse rate, respiration rate, and oral temperature;
- Record a patient's case history;
- Apply topical fluorides, including fluoride varnishes, which are approved by the American Dental Association or the Food and Drug Administration;
- Apply dental sealants; and
- Remove calculus deposits, accretions, and stains from exposed surfaces of the teeth and from tooth surfaces within the gingival sulcus. [38]

Numerous safeguards are in place to ensure patient safety when unsupervised services are provided in health access settings. For example, when a dental hygienist performs one of the above procedures, the patient must be notified that the visit with the dental hygienist is not a substitute for a comprehensive dental exam.[39] Additionally, a dentist is required to conduct an oral examination within 13 months of a dental hygienist removing calculus deposits, accretions, and stains from a patient's teeth.[40] Also, a dental hygienist providing such services must maintain professional malpractice insurance coverage that has minimum limits of $100,000 per occurrence and $300,000 in the aggregate through the employing health access setting or through an individual policy.[i41]

Reimbursement for Children's Dental Care Services Provided in Health Access Settings

The absence of dentist supervision of the tasks performed by a dental hygienist in a health access setting does not preclude reimbursement for those services. Specifically, s. 466.024(4), F.S., states:

> This section does not prevent a program operated by one of the health access settings as defined in s. 466.003 or a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code and described in s. 501(c)(3) of the Internal Revenue Code from billing and obtaining reimbursement for the services described in this section which are provided by a dental hygienist or from making or maintaining any records pursuant to s. 456.057 necessary to obtain reimbursement.

As such, programs providing dental care in health access settings may seek reimbursement for specified dental services provided by dental hygienists, irrespective of whether those services were supervised by a dentist.

Effect of Proposed Changes

Section 466.024(2), F.S., authorizes licensed dental hygienists to perform a limited number of unsupervised remediable tasks in health access settings, such as county health departments, Head Start programs, and other facilities, as defined in s. 466.003(14), F.S. These remediable tasks are reimbursable pursuant to s. 466.024(4), F.S.; however, reimbursement for these unsupervised tasks is

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[36] "Health access setting" means a program or an institution of the Department of Children and Families, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center or look-alike as defined by federal law, a school-based prevention program, a clinic operated by an accredited college of dentistry, or an accredited dental hygiene program in this state if such community service program or institution immediately reports to the Board of Dentistry all violations of s. 466.027, s. 466.028, or other 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 setting. S. 466.003(14), F.S.
[37] S. 466.024 (2), F.S.
[38] Id.
[39] S. 466.024 (3)(a), F.S.
[40] S. 466.024 (2)(f) 2, F.S.
[41] S. 466.024 (5)(c), F.S.

barred under the MMA program as s. 409.906(6), F.S., authorizes reimbursement for children's dental services only if the tasks were performed under the supervision of a licensed dentist.

HB 595 eliminates this conflict by amending s. 409.906(6), F.S., to allow for the reimbursement to the health access setting by AHCA for the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2), F.S., without supervision by a licensed dentist, when the services are provided to children under the age of 21 in the MMA program.

B. SECTION DIRECTORY:

Section 1: Amending s. 409.906, F.S., relating to optional Medicaid services.
Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

AHCA would be permitted to reimburse health access settings for remediable tasks performed by licensed dental hygienists, as outlined in s. 466.024(2), F.S., on children under age 21 in the MMA program. The majority of the expenditures for this reimbursement would be through Medicaid capitation payments to managed care organizations participating in the MMA program. It is unknown how many additional services would be provided by licensed dental hygienists in lieu of services provided and reimbursed under the supervision of a dentist. The potential costs to managed care organizations would not be reflected in the capitation rates for at least one year as capitation rates are set each September. Additionally, the increased costs would likely be minimal and result in an immaterial increase or no increase at all to managed care capitation rates.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health access settings may be reimbursed for remediable tasks performed by licensed dental hygienists, as authorized under s. 466.024(2), F.S., on children under age 21 in the MMA program.

D. FISCAL COMMENTS:

In Fiscal Year 2014-15 AHCA reported that approximately $16.2 million was reimbursed to health care access settings under the supervision of a dentist either through the fee-for-service system or through encounters with managed care organizations under contract with AHCA.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:
Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On December 2, 2015, the Health Innovation Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment clarified that the health access setting could be reimbursed by AHCA for remediable tasks performed by licensed dental hygienists, as authorized under s. 466.024(2), F.S., on children under age 21 in the MMA program.

The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.

[42] Email from Agency from Health Care Administration dated January 6, 2016, on file with Health Care Appropriations Subcommittee Staff.