Joint SubCommittee On Postsecondary Education Policy and Budget (PEPB)

60TH Montana Legislature

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HJR 22 WORKING GROUP (DENTAL STUDY)

OPTIONS FOR EXPANDING THE CAPACITY OF DENTAL CLINICS AT COMMUNITY HEALTH CENTERS (CHC) IN MONTANA

Wednesday, June 11, 2008

At the March 12, 2008 meeting of the HJR 22 working group, members agreed to consider making a recommendation to the Postsecondary Education Policy and Budget subcommittee (PEPB) to request a bill draft that would amend Section 50-4-801, MCA (attached), and to request funding for the 2011 biennium that would expand the capacity of new and existing dental clinics within the community health center network in Montana and thus expand patient access to dental care in rural and underserved communities.

This report is intended to further define the options discussed by the HJR 22 working group relative to the community health center dental clinics, including the projected costs of each option, and to identify the decision points for each option that would lead to a recommendation for action by the PEPB. The HJR 22 working group was charged with submitting a report to PEPB by June of 2008 that would include recommendations for specific initiatives that would increase the supply of dental care professionals in Montana, especially in rural and underserved areas.

Community health centers are local, non-profit health care clinics with the specific mission and purpose of providing and expanding access to health care among low-income and medically underserved communities. Currently, there are 12 community health centers across Montana together with 12 satellite facilities affiliated with these health centers.[1]

The working group options associated with the community health centers include the following:

- Increase the capacity of the CHC system so that the dental clinics would be able to host dental students and dental residents working as extenders to the existing, ongoing dental services
- Increase the capacity of the CHC system so that new and existing dental clinics would be able to offer dental positions to WICHE and Minnesota Dental students returning to Montana to practice their profession and potentially to complete their required service payback if such a payback program is created in the future
- Provide funding for portable dental units

Dental Student and Dental Residents as CHC Clinic Extenders

In March, the working group heard a report that included a proposal to create a program that would allow the CHC dental clinics to employ dental students and dental residents as service extenders who would work under the supervision of the dentists working at the clinics. Such a program would consist of a statewide coordinator who would match the need for extenders in existing health center dental clinics with dental students and dental residents who are interested in the training and work opportunities with the clinics. Through the use of extenders, the clinics state that they would have increased capacity to see more dental patients in the existing operatories with existing dentists, and that the program would strengthen the partnership between academic programs and communities by providing hands-on student experience working with underserved populations.

The program needs would include funding for a new 0.50 FTE statewide coordinator together with funding for travel and stipends for students/residents to cover housing and other living costs. The projected cost of this option is $65,000 per year of ongoing funding to support the program. This cost would include 20 stipends of $1,200 each to support placement of 20 students/residents at CHC dental clinics across Montana.

This proposal is modeled after the Montana Search program that is affiliated with the National Health Services Corps program for primary care physician resident placements in underserved Montana communities.[2]

Funding for Additional Dentists in CHC Dental Clinics

The report at the March meeting also stated that a number of existing dental clinics have ongoing difficulties recruiting and retaining dentists, as well as managing a greater service demand than their existing dental staff is able to meet. It was suggested that all of these issues contribute to the lack of access to dental care in Montana communities, and that a potential option for addressing these issues would be increased funding to expand the number of dentists working in CHC dental clinics.

It was suggested by members of the working group that additional CHC dentists, if that capacity were to exist, could be recruited from among the Montana graduates of the WICHE and MN Dental programs funded as part of the Professional Student Exchange Program (PSEP). In addition, if the PSEP is amended to include a service payback component, whereby Montana students would be required to return to the state to practice their health profession, these returning service payback dentists would be potential recruits to fill expanded dentist positions at CHC clinics.

According to data presented by the Montana Primary Care Association, the average number of patient visits for each 1.0 FTE dentist in the existing dental clinics is 3,100 visits per year.[3] Therefore, it can be projected that each additional dentist funded in the CHC dental clinics would expand service capacity by 3,100 patient visits per year. This service level, however, represents programs at established dental clinics. New and start-up programs in frontier and rural areas may not meet this service level until the programs are up and running over a period of time.

The projected cost of this option is $150,000 per year of ongoing funding for each 1.0 FTE dentist. This funding would cover salary and benefits and would likely increase incrementally over time at personal services inflation rates. In addition, one-time-only funding of $90,000 would be required to establish each fully equipped permanent dental operatory (dental chair, hydraulics, plumbing, dental hand pieces, lights, etc.). It is recommended that an additional operatory be considered part of each dental FTE expansion in order to ensure that each additional dentist would be able to add maximum efficiency to any new or established dental clinic, thus increasing the capacity to serve more patients in each community.

Portable Dental Units

Finally, the March report also included a discussion of the option of funding portable dental units as a means to take dental services to patients in rural, underserved communities. The portable dental unit discussed in this report includes a patient chair, an x-ray machine, the dental hand tools and supplies, as well as the mechanized drill and other accessories.[4] The units are able to provide basic dental care with very little space required.

The projected cost of this option is $30,000 of one-time-only funding for each portable dental unit, together with $500 per year of ongoing funding to support maintenance of each portable dental unit.

Working Group Options

If the working group would like to include any or all of these options as part of the final report and recommendation to the PEPB, members would want to consider action in the following three areas:

1. Recommend a bill draft to amend Section 50-4-801, MCA, et.seq.[5], to expand the program expenditures and grants program in the Department of Public Health and Human Services to include:
    a. Funding for a statewide program of dental clinic extenders that utilizes dental students and dental residents
    b. Funding for some specific number of additional dentists and permanent operatories at existing or at newly established CHC dental clinics
    c. Funding for some specific number of portable dental units
2. Recommend that this bill draft include an appropriation section to fund the new programs in the 2011 biennium [this funding would then become part of the state budget in House Bill 2 (HB 2) in subsequent biennia]
3. Recommend that Section 50-4-805(5)(b), MCA, be amended to require a report to the legislature specific to these dental programs that identifies measureable performance measurement criteria that will be tracked and regularly reported as indicators of program impact and effectiveness in the future.

Respectfully submitted:

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Updated: Monday, May 19, 2008

[1] For more information about Community Health Centers see "Community Health Center Dental Options" on the PEPB website at: http://leg.mt.gov/content/publications/fiscal/subcommittees/PEPB/2007_interim/HJR22_CHC_Dental_Clinic_Options.pdf (accessed on April 24, 2008).

[2] For more information on this program see: http://www.mtsearch.info/dwnlds/MT%20Search%20Brochure.pdf (accessed on May 15, 2008).

[3] Op cit, "Community Health Center Options."

[4] Op cit, "Community Health Center Options."

[5] **50-4-801. Short title**. This part may be cited as the "Montana Community Health Center Support Act".

History: En. Sec. 1, Ch. 436, L. 2007.

50-4-802. Legislative intent and purpose. The legislature recognizes that the large number of uninsured and underinsured Montanans has a significant long-term human and economic impact on families, health care providers, and the state of Montana. It is the intent of the legislature through this part to enhance access to primary care and preventive care for Montana residents by strengthening and supporting Montana's community health centers.

History: En. Sec. 2, Ch. 436, L. 2007.

50-4-803. Definitions. As used in this part, the following definitions apply:

(1) "Advisory group" means the community health centers advisory group provided for in 50-4-810.

(2) "Department" means the department of public health and human services provided for in Title 2, chapter 15, part 22.

(3) "Federally qualified community health center" means a facility providing primary and preventive medical, dental, mental health, and substance abuse services to medically underserved, disadvantaged, or hard-to-reach populations on a sliding-scale fee basis, operating under federal regulations, and receiving federal funds under the Public Health Service Act, 42 U.S.C. 254b.

(4) "Federally qualified health center look-alike" means a facility that meets all of the expectations established for the federally funded community health center program but does not receive federal operating funds under the Public Health Service Act, 42 U.S.C. 254b.

(5) "Preventive care" means comprehensive care that emphasizes prevention, early detection, and early treatment of conditions, including but not limited to routine physical examinations, health screenings, immunizations, and health education.

(6) "Primary care" means the type of medical care that provides a patient with a broad spectrum of preventive and curative health care services over a long period of time and that coordinates all of the care a patient receives.

(7) "Section 330 funds" means the federal funds commonly known by that name and awarded by the health resources and services administration of the U.S. department of health and human services to health centers that qualify for funding under the Public Health Service Act, 42 U.S.C. 254b.

History: En. Sec. 3, Ch. 436, L. 2007.

50-4-804. Rulemaking authority. (1) The department shall adopt rules necessary for the administration of this part.

(2) The rules may include but are not limited to:

(a) eligibility requirements for entities applying for grants;

(b) criteria for awarding grants; and

(c) reporting procedures for grant recipients.

(3) The rules establishing eligibility for state grants must reflect the national model established for federally qualified community health centers receiving section 330 funds as provided by the Public Health Service Act, 42 U.S.C. 254b.

History: En. Sec. 8, Ch. 436, L. 2007.

50-4-805. Program expenditures -- report to legislature. (1) Subject to appropriation by the legislature, the department shall provide competitive grants in accordance with 50-4-806 and this section to community or tribal boards operating as a nonprofit entity in accordance with the Public Health Service Act, 42 U.S.C. 254b, to increase access to primary care and preventive health services for uninsured, underinsured, low-income, or underserved Montanans.

(2) Grants must be made each year to accomplish any of the following goals:

(a) to create and support new nonfederally funded community health centers until federal funds are granted. Successful applicants for the state grants shall also apply for federally qualified health center look-alike status and federal community health center grants at the first available opportunity.

(b) to expand the medical, mental health, or dental services offered by existing federally qualified community health centers or other facilities that have received federally qualified health center look-alike status; and

(c) to provide one-time grants for capital expenditures to existing federally qualified community health centers and facilities with federally qualified health center look-alike status.

(3) The department shall contract with an entity that is able to:

(a) provide technical assistance to new and existing federally qualified community health centers in their efforts to apply for federal funds;

(b) assist new and existing centers in their efforts to expand services; and

(c) collect standardized data on the provision of services to low-income and uninsured Montanans.

(4) The department shall require the contractor to provide an annual report on the services it has provided, the data it has collected, and the status of applications for federal community health center funding.

(5) (a) The department shall provide regular interim reports on the status of the program and program expenditures to the legislative finance committee and the children, families, health, and human services interim committee.

(b) The department shall report to the legislature, as provided for in 5-11-210, the following information for each year of the biennium:

(i) the status of the expenditures made pursuant to this part;

(ii) the number of people served by the expenditure of funds; and

(iii) the costs to the state of the services provided pursuant to this part.

History: En. Sec. 4, Ch. 436, L. 2007.

50-4-806. Grants -- application process -- obligation of communities. (1) In order to receive funds under 50-4-805, a community or tribal board shall submit a proposal to the department for:

(a) increasing access to health care services by:

(i) creating new primary care and preventive care services; and

(ii) developing sliding scale charge and billing systems; or

(b) expanding existing services by:

(i) increasing medical, dental, or mental health capacity;

(ii) purchasing equipment; or

(iii) renovating clinic facilities.

(2) A proposal funded under this part must ensure the board's commitment to attract federal funds for primary care services.

(3) Entities receiving a state grant to start up or expand services shall also seek section 330 funds for those services and may not receive state funding after federal funds are acquired.

History: En. Sec. 5, Ch. 436, L. 2007.

50-4-807 through 50-4-809 reserved.

50-4-810. Advisory group. (1) There is a community health centers advisory group. The group consists of nine members appointed as follows:

(a) two members appointed by the governor;

(b) two members of the Montana house of representatives appointed by the speaker, each from a different political party;

(c) two members of the Montana senate appointed by the president, each from a different political party;

(d) one member designated by the Montana primary care association; and

(e) two executive employees of Montana federally qualified community health centers, each designated by the governor from a list of names provided by the Montana primary care association and one of whom must be a chief financial officer.

(2) Members must be appointed in a manner that achieves the geographic representation of all regions of the state, including urban and rural communities.

(3) Members are appointed for terms of 2 years and may be reappointed for two additional terms. A legislative member position is vacant if the person no longer serves in the legislature. The position of the member appointed by the governor is vacant if that person is elected to the legislature. A vacancy must be filled in the manner of the original appointment.

(4) Legislative members of the advisory group are entitled to receive compensation and expenses as provided in 5-2-301 for each day spent on advisory group business. Other members are entitled to reimbursement for expenses, as provided in 2-18-501 through 2-18-503, while engaged in advisory group business.

(5) The advisory group is attached to the department of public health and human services for administrative purposes, and the department is responsible for the compensation of group members.

History: En. Sec. 6, Ch. 436, L. 2007.

50-4-811. Advisory group -- purpose and role. (1) The purpose of the advisory group is to oversee the grant award process developed by the department.

(2) The advisory group will recommend to the department the projects that it considers appropriate for funding in accordance with the requirements of 50-4-805 and 50-4-806. The advisory group's recommendations are not binding on the department, but when a recommendation is not followed by the department, the department shall provide the reasons to the advisory group.

History: En. Sec. 7, Ch. 436, L. 2007.

50-4-812 through 50-4-814 reserved.

50-4-815. Community health center account. (1) There is a community health center account in the state special revenue fund to the credit of the department to provide grants for community health centers.

(2) Money appropriated by the legislature for community health centers must be deposited into the account.

(3) Money must be allocated from the account in accordance with the procedures outlined in 50-4-805 and 50-4-806.

History: En. Sec. 9, Ch. 436, L. 2007.