UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

November 15, 2019

Bobby D. White
Chief Executive Officer
North Carolina State Board of Dental Examiners
2000 Perimeter Park Drive, Suite 160
Morrisville, NC 27560

Re: Proposed Rule Changes to 21 N.C. ADMIN. CODE 16W

Dear Mr. White:

The staffs of the Federal Trade Commission's ("FTC") Office of Policy Planning, Bureau of Economics, and Bureau of Competition[1] (collectively, "FTC staff") appreciate the opportunity to respond to the North Carolina State Board of Dental Examiners' ("Board") request for comments on its proposed amendments to 21 N.C. ADMIN. CODE 16W.0101 and its proposed new rule, 21 N.C. ADMIN. CODE 16W.0104.[2]

In certain facilities in dental access shortage areas, the proposed changes would eliminate a requirement that public health dental hygienists work under the direction of a supervising dentist who has carried out an in-person, comprehensive oral examination of the patient. Instead, the proposed rules would give dentists the option of providing a written standing order to allow public health dental hygienists to provide clinical hygiene care. The proposal would also allow dentists who supervise public health hygienists to supervise more than two hygienists at a time.[3]

The proposed changes may expand the ability of public health hygienists to provide preventive services to patients in underserved areas, where dentists are scarce. Accordingly, the proposed changes could provide access to care for those who would otherwise be unserved, as well as enhance competition in the provision of preventive dental care services, thereby benefitting North Carolina consumers.

Under the proposed rule, however, individual dentists would still have the option of requiring a prior examination rather than providing a written standing order. Hence, the competitive benefits of the rule would depend on whether the supervising dentist chooses to

provide a written standing order authorizing a public health hygienist to provide preventive services without a dentist's comprehensive oral examination.

Thus, although we support the proposed rules, we encourage the Board to consider whether allowing individual dentists to require a prior examination would weaken the proposed rule's potential to increase access to preventive services in shortage areas. We urge the Board to consider whether less restrictive alternatives could address any well-founded patient health and safety concerns.

I. Interest and Experience of the Federal Trade Commission

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Competition is at the core of America's economy,[5] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, more choices, and greater innovation. Competition is also essential to ensuring workers a competitive marketplace for their labor.[6] Because of the importance of health care competition to the economy and consumer welfare, competition in health care markets has long been a key focus of FTC law enforcement,[7] research,[8] and advocacy activities.[9] Many of our recent advocacy comments have addressed scope of practice and supervision requirements that may unnecessarily limit the range of procedures or services a health care practitioner may provide, or unnecessarily restrict a particular type of practitioner from competing in the market.[10]

FTC staff has addressed competition issues related to oral health care,[11] including supervision of dental hygienists in public health settings, in both law enforcement actions[12] and advocacy letters. For example, in January 2016, FTC staff urged the Georgia State Senate to consider the procompetitive benefits of a bill that sought to broaden the availability of dental hygiene services by expanding the settings where hygienists could provide their services without direct supervision by a dentist on the premises. The bill could have increased access to hygiene services in rural or underserved areas where dentists are scarce or unavailable.[13] FTC staff comments have also supported licensing of dental therapists—a relatively new type of "mid-level" dental practitioner who offers some of the same basic services offered by dentists—to enhance competition, reduce costs, and expand access to dental care.[14]

II. Current North Carolina Law and Regulations on Supervision of Dental Hygienists and the Board of Dental Examiners' Proposed Changes

A. North Carolina Law on Supervision of Dental Hygienists

Under North Carolina law, dental hygienists may perform the following functions: oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicines prescribed by a licensed dentist, preparation of diagnostic aids and records of oral conditions for interpretation by the dentist, and other similar functions permitted by regulation.[15]

Current North Carolina law, with limited exceptions, requires hygienists to work under the supervision of a licensed dentist who is physically present at the location where the hygienist is providing care.[16] The exceptions apply both to private hygienists who have met certain experience and credential requirements and provide services in underserved settings,[17] and to certain public health dental hygienists who work for state and local government health departments.[18] Both experienced private hygienists who provide services in underserved settings and public health hygienists must provide their services under the "direction" of a dentist, and "pursuant to the dentist's order, control and approval."[19]

However, private and public dental hygienists are subject to different requirements in order to provide services without the physical presence of a dentist, particularly in regard to the requirement of a prior examination by a dentist. Private dental hygienists must be "designated by the employing dentist as being capable of performing clinical hygiene procedures without the direct supervision of the dentist," and must have at least three years' experience or 2,000 hours in practice, and CPR certification.[20] They may only perform services in nursing homes, rest homes, long-term care facilities, community clinics, and other specified facilities operating in dental access shortage areas.[21] In addition, they are only allowed to provide care on the basis of a complete oral examination of the patient by a dentist.[22]

Public health dental hygienists, by contrast, are not subject to a statutory requirement to provide services pursuant to a dentist's oral examination. Rather, they meet their supervision requirements by performing their duties "under the direction of a duly licensed dentist employed by" local or state health departments or by the Dental Health Section of the North Carolina Department of Health and Human Services.[23] However, "direction" is not specifically defined by statute.

B. Board Regulations on Supervision of Public Health Dental Hygienists

1. The Board's Current Regulations

While no North Carolina statute requires a prior examination by a dentist for public health hygienists, under North Carolina's current regulatory definition of "direction," public health hygienists are only allowed to provide services on the basis of a dentist's comprehensive oral examination.[24] The regulation requires a public health hygienist to "perform clinical procedures 'under the direction of a licensed dentist,' . . . who is employed by a State government dental public health program or a local health department as a public health dentist."[25] It also requires the hygienist to complete delegated procedures "in accordance with a written order from the dentist, within 120 days of the dentist's in-person evaluation of the patient."[26] Moreover, the current regulation specifies that the "dentist's evaluation of the patient shall include a comprehensive oral examination, medical and dental health history, and diagnosis of the patient's condition."[27]

2. The Board's Proposed Rule

The Board's proposed rule would eliminate the requirement of an in-person, comprehensive oral examination by a dentist for public health hygienists who provide services in

"public schools, nursing homes, long-term care facilities, and rural and community clinics" operated by governments in dental access shortage areas.[28] Public health dental hygienists working in such settings would be allowed to provide services on the basis of a dentist's written standing order, rather than based on directions arising from a dentist's comprehensive examination of an individual.[29] In addition, the proposed rule makes other changes that could ease burdens on public health hygienists and their supervising dentists, such as extending the time in which hygienists must complete procedures specified in written orders of a dentist from 120 days to 270 days,[30] allowing a public health hygienist to supervise a dental assistant,[31] and allowing dentists who supervise public health hygienists to supervise more than two hygienists at the same time.[32]

III. Likely Competitive Impact of the Board's Proposed Rule

A. Background on the Development of the Board's Proposed Rule

The Board's proposed rule was developed by the North Carolina Dental Society Council on Prevention and Oral Health ("NCDSCPOH") to help address North Carolina's unmet oral health needs. The NCDSCPOH includes the North Carolina Oral Health Collaborative, the North Carolina Dental Hygienists' Association, advocates from state offices, representatives of the state's two dental schools, and other organizations.[33] It has sought to improve access to dental hygiene services to address the state's dental health needs and build on a public-private partnership experiment in two North Carolina counties.[34] The experimental program facilitates the provision of services at safety-net settings by utilizing dental hygienists from private practices on days when the dentist is not working. Dentists participating in the program contract with county health departments to allow their dental hygienists and dental assistants to work as "public health" providers on Fridays when they would not be working at their private practices. On Fridays, the hygienists and dental assistants provide screenings, cleanings, sealants, and other preventive services at high-needs settings, such as schools with a high percentage of students from low-income households.[35] The proposed rule would build on this innovative model of delivering care, enabling hygienists to perform clinical hygiene procedures at schools, nursing homes, and clinics operated by federal, state, and local governments in dental health shortage areas across North Carolina, without a dentist on site and without a prior examination by a dentist.[36]

B. The Board's Current Regulations Restrict the Provision of Dental Hygiene Services

The Board's current regulatory requirement of a prior examination before a public health dental hygienist may provide services likely limits competition between dentists and dental hygienists in the provision of hygiene services, limits competition among dental hygienists, and decreases access to dental hygienists, without any apparent health and safety benefits. According to the National Governors Association, there is no clear evidence to support state dental boards' concerns about the quality and safety of oral health services provided by dental hygienists, which boards sometimes raise to justify restricting hygienists from practicing without supervision in settings where dentists are not available.[37] The Institute of Medicine has likewise concluded that restrictive scope of practice and supervision laws and regulations governing dental hygienists

"are often unrelated to competence, education and training, or the safety" of the services they provide.[38]

Requiring the prior or subsequent examination of a patient by a dentist, regardless of whether that examination is medically necessary, restricts the provision of hygiene services, especially in dental shortage areas.[39] Prior examination rules can be a major barrier to the ability of dental hygienists to provide preventive care to children at school. For example, prior examination rules inhibit the use of school-based sealant programs, even though dental hygienists can determine whether to place a sealant based on a visual inspection of a tooth, and sealants are very effective in reducing the risk of decay.[40]

The Federal Trade Commission raised these issues in 2003 when it sued the South Carolina Board of Dentistry, charging that the Board had violated federal law by restricting dental hygienists from providing preventive dental services in schools unless students were first examined by a dentist, thereby restraining competition and depriving thousands of economically disadvantaged schoolchildren of needed dental care.[41] The South Carolina Board of Dentistry ultimately entered into a consent agreement settling the charges.[42] Under this agreement, the Board agreed to publish notice expressing agreement with an earlier South Carolina legislative amendment. The earlier amendment prohibited the Board from requiring that a dentist conduct an examination as a condition of a dental hygienist performing oral prophylaxis or applying sealants or topical fluoride in a public health setting.[43] In addition, the South Carolina Board of Dentistry was required to notify the FTC of any proposed or final rules, regulations, policies, or disciplinary actions relating to the provision of preventive dental services by dental hygienists in a public health setting.[44]

C. Supervision of North Carolina Dental Hygienists is More Restrictive than in Most Other States

Eliminating the prior examination requirement could be particularly helpful in improving access to preventive care in North Carolina, which is one of the more restrictive states with regard to supervision of dental hygienists. For dental hygienists in private practice, North Carolina's statute appears effectively to require direct supervision, which requires the physical presence of the dentist.[45] Laws and regulations that require hygienists to work under the direct supervision of dentists are a significant barrier to the use of dental hygienists outside of dentists' offices and in dental shortage areas.[46] As discussed above, the state allows a limited set of public health hygienists and hygienists who work in underserved settings to work under general supervision, without a dentist present. Nonetheless, even these hygienists are not allowed to provide services without a prior examination by a dentist, which limits their ability to provide services in schools and other settings where dentists are not generally present.

Over the last 20 years, the trend among most states has been to expand access to dental hygienists by relaxing supervision requirements and requiring only general supervision.[47] Many states have gone beyond general supervision, allowing "direct access" to dental hygienists, especially those who provide services to underserved patients in dental health access shortage areas.[48] Several states have eliminated prior examination requirements during the last decade. North Carolina is one of only 10 states and the District of Columbia that still have them.[49]

D. The Board's Proposed Rules Could Increase the Supply of Preventive Services in Underserved Areas and Improve Access to Preventive Services

The Board's proposed regulatory changes appear to allow direct access to public health dental hygienists who are supervised by dentists who authorize them to provide preventive services under a written standing order. These changes could be especially valuable in enhancing the supply of available providers in North Carolina's underserved areas, where dentists may not be available. In the United States, the oral health workforce is not well distributed, and access to dentists and dental care is inadequate in many areas. This is the case in some parts of North Carolina, where more than 2.4 million residents live in 175 locations that have been designated as Dental Care Health Professional Shortage Areas ("DCHPSA").[50] In North Carolina, 23% of the population lives in a DCHPSA,[51] and the percent of need met by dentists is only 19%.[52] In addition, in light of the state's large rural population, dentist offices may be located far from the patients, making it difficult for many patients to access care. Costs are also a significant barrier to dental care for North Carolina's low-income residents.[53] Giving dentists the option to provide a standing order that would allow public health hygienists to work at certain settings in dental access shortage areas, and allowing dentists to supervise more than two public health hygienists at the same time, could increase the pool of hygienists available to provide care in high needs settings, where patients might otherwise go without care.[54]

By increasing the availability of dental hygienists' services without a dentist's prior examination, the Board's proposed rules could increase the number of available providers of preventive dental care and the convenience of care, especially at times and locations where dentists are not available.[55] The resulting increase in competition, greater use of lower cost practitioners, and avoidance of unnecessary payments to dentists could reduce the cost of providing dental care and prices.[56] Increasing the availability of dental hygienists at settings where dentists are unavailable could not only make care more convenient, but also would likely reduce patients' transportation costs, potentially leading to savings for government benefit programs that pay for non-emergency transportation services.[57] Greater competition arising from direct access may thus enhance access to affordable preventive services and mitigate the broader health consequences of dentist shortages.[58] Indeed, one study found that enabling "hygienists to provide services within their professional competencies under reasonable supervision requirements may yield improvements over time in the oral health status of the populations served."[59]

Nonetheless, a potential limitation of the proposed provisions is that the proposed regulation does not guarantee improvement. Rather, it gives dentists the choice of whether to provide a standing order, or to require a prior examination. If most dentists decide not to provide a written standing order, there would be little change from the current prior examination requirement. Thus, the extent of the change resulting from the proposal would depend entirely on the decisions of dentists regarding whether to provide a standing order. While granting such discretion to a dentist provides flexibility, it could undercut the potential of the proposed rule to increase access to preventive services in shortage areas where dentists are scarce. Additionally, if some dentists perceive a threat of competition from dental hygienists for the provision of preventive dental services, dentists may be less willing to provide a written standing order. In

another state, where dentists were allowed to decide whether to reduce the level of supervision of hygienists providing services in dental health resource shortage areas, participation by dentists was very low.[60]

Accordingly, although we support the Board's proposed rules, we encourage the Board to consider the potential effects on competition and access of a system that relies on individual dentists to decide whether to require a prior examination. We also urge the Board to consider less restrictive alternatives that would still address any legitimate and substantiated health and safety concerns. For example, the Board could make direct access the default basis on which public health dental hygienists provide services in approved settings in dental access shortage areas, with no prior examination requirements.[61]

IV. Conclusion

By eliminating the requirement for a dentist to conduct a comprehensive oral examination before public health dental hygienists can provide services in safety-net settings, the Board's proposed rules take a step toward loosening North Carolina's restrictive scope of practice requirements and reducing barriers to preventive oral care in North Carolina. The proposed rule will likely promote greater competition in the provision of preventive dental care services, leading to increased access and more cost-effective care, especially for North Carolina's most vulnerable populations.

Accordingly, we support the Board's proposed rules because they appear to be a procompetitive improvement that would benefit North Carolina's health care consumers. In addition, we respectfully suggest that the Board consider whether giving dentists the choice of providing a written standing order or requiring a comprehensive oral examination is the best way to achieve the Board's goals of improving access to care in underserved areas, or whether a less restrictive alternative might be equally effective.

We appreciate your consideration. If you have any questions regarding this letter, please contact Karen Goldman at (202) 326-2574 or kgoldman@ftc.gov.

Respectfully submitted,

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[1] This letter expresses the views of staff in the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has authorized us to submit these comments.

[2] *See* 34 N.C. Reg. 502 (Sept. 16, 2019).

[3] *See id*.

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

[5] Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[6] *See* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDANCE FOR HUMAN RESOURCE PROFESSIONALS (2016), https://www.ftc.gov/system/files/documents/public_statements/992623/ftc-doj_hr_guidance_final_10-20-16.pdf; Chairman Simons' Responses to Questions for the Record, Senate Judiciary Committee, "Oversight of the Antitrust Laws," (Oct. 3, 2018), https://www.judiciary.senate.gov/imo/media/doc/Simons%20Responses%20to%20QFRs.pdf.

[7] *See generally* MARKUS H. MEIER ET AL., FTC, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care (most recent version under "Core Health Care Competition Documents").

[8] *See, e.g.*, FTC & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[9] FTC and staff advocacy can include letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, Comment from FTC Staff to Paul Graves, Representative, Washington State Legislature (Feb. 9, 2018), https://www.ftc.gov/policy/advocacy/advocacy-filings/2018/02/ftc-staff-comment-washington-state-rep-paul-graves (regarding bill to restrict telehealth eye care); Brief of Amicus Curiae FTC in Support of No Party, In re Nexium (Esomeprazole) Antitrust Litig., No. 15-2005 (1st. Cir. Feb. 12, 2016), https://www.ftc.gov/system/files/documents/amicus_briefs/re-nexium-esomeprazole-antitrust-litigation/160212nexiumbrief.pdf (explaining that a reverse payment from a brand-name drugmaker that is used to settle patent litigation can violate the antitrust laws if it induces a generic drugmaker to abandon its patent challenge and stay out of the market); FTC STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES ("APRNs") (2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf (presenting an overview of FTC staff comments regarding APRNs, and an in depth analysis of the competitive effects of statutes and rules governing APRN scope of practice and supervision).

[10] *See, e.g.*, Comment from FTC Staff to the Iowa Dep't of Public Health (Dec. 20, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-professional-licensure-division-iowa-department-public-health-regarding-proposed/v170002_ftc_staff_comment_to_iowa_dept_of_public_health_12-21-16.pdf (describing the appropriate level of supervision of physician assistants); Comment from FTC Staff to the Dep't of Veterans Affairs (July 25,

2016), https://www.ftc.gov/system/files/documents/advocacy_documents/comment-staff-ftc-office-policy-planning-bureau-competition-bureau-economics-department-veterans/v160013_staff_comment_department_of_veterans_affairs.pdf(supporting proposed rule that would allow APRNs to provide services required by the VA without the oversight of a physician). Most FTC staff competition advocacy comments have focused on proposed state-level changes to statutes and rules. *See, e.g.*, FTC STAFF, POLICY PERSPECTIVES, *supra* note 9.

[11] Many advocacy letters addressing oral health care have focused on issues other than scope of practice and supervision. *See, e.g.*, Comment from FTC Staff to the New York State Education Dep't (April 6, 2018), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-new-yorks-proposal-allow-licensure-endorsement-canadian-dental-licenses/v180007_ftc_staff_comment_to_nys_ed_dept_re_dental_licensure_requirements.pdf (supporting a proposed regulation that would allow licensed Canadian dentists to use the same endorsement procedures that practicing dentists in other U.S. states follow to become licensed in New York State); Comment from FTC Staff to the Tex. State Bd. of Dental Exam'rs (Oct. 6, 2014), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-state-board-dental-examiners/141006tsbdecomment1.pdf (concerning proposed restrictions on the ability of Texas dentists to enter into agreements with non-dentists for administrative services); Comment from FTC Staff to the La. State Bd. of Dentistry (Dec. 18, 2009), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-louisiana-state-board-dentistry-concerning-proposed-modifications-louisianas/091224commentladentistry.pdf (concerning proposed rules on the practice of portable and mobile dentistry); Comment from FTC Staff to Sam Jones, State Representative, La. House of Representatives (May 22, 2009), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-louisiana-house-representatives-concerning-louisiana-house-bill-687-practice/v090009louisianahb687amendment.pdf (concerning legislation on the practice of in-school dentistry); Comment from FTC Staff to Timothy G. Burns, State Representative, La. House of Representatives (May 1, 2009), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-louisiana-house-representatives-concerning-louisiana-house-bill-687-practice/v090009louisianadentistry.pdf. To search for advocacy filings about any aspect of oral health care, *see generally Advocacy Filings by Subject, Dentistry*, FED. TRADE COMM'N, https://www.ftc.gov/policy/advocacy/advocacy-filings?_field_advocacy_document_terms_tid=5302.

[12] *See, e.g.*, N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101 (2015) (upholding an FTC ruling that the North Carolina State Board of Dental Examiners illegally thwarted lower-priced competition by engaging in anticompetitive conduct to prevent non-dentists from providing teeth whitening services to consumers in the state); S.C. State Bd. of Dentistry, 138 F.T.C. 229 (2004) (opinion and order of the Commission regarding the Board's motion to dismiss the complaint).

[13] *See* Comment from FTC Staff to Valencia Seay, Senator, Ga. State Senate (Jan. 29, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-georgia-state-senator-valencia-seay-concerning-georgia-house-bill-684/160201gadentaladvocacy.pdf (regarding removal of direct supervision requirements for dental hygienists). The Georgia State Senate did not adopt the bill. Similarly, FTC staff opposed rules proposed by the Maine Board of Dental Examiners in 2011 because they would have required a dentist to be present for a dental hygienist to provide certain preventive services, which would have reduced access and increased costs. *See* Comment from FTC Staff to the Me. Bd. of Dental Exam'rs (Nov. 16, 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-maine-board-dental-examiners-concerning-proposed-rules-allow-independent-practice/111125mainedental.pdf (opposing adoption of proposed rules that would have restricted the scope of practice of Independent Practice Dental Hygienists ("IPDH") participating in a pilot project designed to improve access to care in underserved areas of the state). In December 2010, FTC staff urged the Georgia Board of Dentistry to reject proposed amendments to Board rules that could be interpreted to require a dentist's initial diagnosis of all patients at certain government-approved dental facilities before they could receive any specific treatment from a dental hygienist. Consistent with FTC staff's recommendation, the Board ultimately did not adopt the amendments to increase the level of supervision of dental hygienists in these covered public health settings, thus maintaining access for vulnerable populations. *See* Comment from FTC Staff to the Ga. Bd. of Dentistry (Dec. 30, 2010), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-georgia-board-dentistry-

concerning-proposed-amendments-board-rule-150.5-0.3-governing-supervision-dental-hygienists/101230gaboarddentistryletter.pdf.

[14] *See* Comment from FTC Staff to Peggy Lehner, State Senator, Oh. State Senate (March 3, 2017), https://www.ftc.gov/policy/advocacy/advocacy-filings/2017/03/ftc-staff-comment-ohio-state-senate-regarding-competitive (addressing the competitive effects of SB 330, including its provisions on general supervision and licensure of dental therapists); Comment from FTC Staff to the Commission on Dental Accreditation ("CODA") (Nov. 21, 2014), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-commission-dental-accreditation-concerning-proposed-accreditation-standards-dental/141201codacomment.pdf (urging implementation of accreditation standards for dental therapists); Comment from FTC Staff to CODA (Dec. 2, 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-commission-dental-accreditation-concerning-proposed-accreditation-standards-dental/131204codacomment.pdf (concerning supervision requirements in proposed accreditation standards for dental therapists).

[15] *See* N.C. GEN. STAT. § 90-221(a).

[16] *See* N.C. GEN. STAT. § 90-233 (a "dental hygienist may practice only under the supervision of one or more licensed dentists."); N.C. GEN. STAT. § 90-221(f) (a hygienists' acts "are deemed under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts").

[17] *See* N.C. GEN. STAT. § 90-233(a1).

[18] *See* N.C. GEN. STAT. § 90-233(a).

[19] N.C. GEN. STAT. § 90-221(f).

[20] *See* N.C. GEN. STAT. § 90-233(a1).

[21] *See* N.C. GEN. STAT. § 90-233(a1)(4).

[22] *See* N.C. GEN. STAT. § 90-233(a1)(2).

[23] N.C. GEN. STAT. § 90-233(a).

[24] *Compare* 21 N.C. ADMIN. CODE 16W.0101(b),(c), *with* N.C. GEN. STAT. § 90-233(a).

[25] 21 N.C. ADMIN. CODE 16W.0101(a). This regulation also requires a public health hygienist to work "'under the direction of a dentist' as defined by 21 N.C. ADMIN. CODE 16Y.0104(c) . . . ." This provision may have created confusion about whether the physical presence of a dentist was required, because of the lack of conforming amendments to 21 N.C. ADMIN. CODE 16W.0101(a) when a new paragraph (c) was added to 21 N.C. ADMIN. CODE 16W.0104 when it was amended in 2017.

Before amendment, paragraph (c) of 21 N.C. ADMIN. CODE 16Y.0104 stated, "For purposes of this Section, the acts of a permit holder are deemed to be under the direction of a licensed dentist when performed in a locale where a licensed dentist is not always required to be physically present during the performance of such acts and such acts are being performed pursuant to the dentist's order, control, and approval." 21 N.C. ADMIN. CODE 16Y.0104(c) (amended effective July 1, 2015).

Effective Nov. 1, 2017, a new paragraph (c) was added that did not address the physical presence of the dentist, but no conforming amendments were made to 21 N.C. ADMIN. CODE 16W.0101(a) to change the reference to 21 N.C. ADMIN. CODE 16W.0104(c) to 21 N.C. ADMIN. CODE 16W.0101(d).

Proposed 21 N.C. ADMIN. CODE 16W.0101(a) would strike the erroneous reference to 21 N.C. ADMIN. CODE 16Y.0104(c) and eliminate any reference to whether the supervising dentist is physically present at the locale where the hygienist is delivering services as well as allow a public health dental hygienist to practice under a written standing order. *See infra* note 29 and accompanying text. Reliance on a written standing order implies that the dentist does not have to be physically present while the hygienist is providing preventive services, but the Board could consider whether it would be clearer to expressly state that in its proposed regulation.

[26] 21 N.C. ADMIN. CODE 16W.0101(b).

[27] 21 N.C. ADMIN. CODE 16W.0101(c).

[28] Proposed 21 N.C. ADMIN. CODE 16W.0104(a)(1).

[29] *See* Proposed 21 N.C. ADMIN. CODE 16W.0104(a)(1).

[30] *See* Proposed 21 N.C. ADMIN. CODE 16W.0104(b).

[31] *See* Proposed 21 N.C. ADMIN. CODE 16W.0104(a)(2). Currently, North Carolina only allows dentists to supervise dental assistants. *See* 21 N.C. ADMIN. CODE 16H.0103, 16H.0203, 16H.0206.

[32] *See* Proposed 21 N.C. ADMIN. CODE 16W.0104(c).

[33] *See* E-mail from Frank Courts, D.D.S., Ph.D., Chair of the NCDSCPOH, to Karen A. Goldman, Attorney Advisor, Office of Policy Planning, FTC (Oct. 7, 2019, 09:00 EST) (NCDSCPOH membership includes the N.C. Dental Society, N.C. Academy of General Dentistry, N.C. Academy of Pediatric Dentists, N.C. State Board of Dental Examiners, N.C. Division of Medical Assistance, the N.C. Oral Health Section, N.C. Oral Health Collaborative, N.C. Dental Hygienists Ass'n, N.C. Dental Assistants Ass'n, East Carolina University School of Dental Medicine, University of North Carolina School of Dentistry, Blue Cross Blue Shield of North Carolina Found., Duke Endowment, Access Dental Care).

[34] *See* Anne Blythe, *Can North Carolina dental hygienists help fill coverage gaps through a public-private partnership program?*, N.C. Dental News (July 31, 2019).

[35] *See id.* Dentists who participate in the program provide "a dental home" for patients who need care beyond what a dental hygienist or assistant can provide. They also bill Medicaid for services provided by hygienists and their own services. Dental hygienists cannot bill Medicaid directly in North Carolina. *See id.*; *see also* American Dental Hygienists' Ass'n, *Direct Medicaid Reimbursement 2018 - 18 States* (May 2019), https://www.adha.org/resources-docs/7526_Medicaid_Map.pdf (North Carolina is not one of the 18 states that offer direct Medicaid reimbursement of dental hygienists).

[36] *See* Proposed 21 N.C. ADMIN. CODE 16W.0104; *see also* Blythe, *supra* note 34.

[37] *See* Nat'l Governors Ass'n, *The Role of Dental Hygienists in Providing Access to Oral Health Care* 10 (Jan. 2014), http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf. *See also* April V. Catlett & Robert Greenlee, *A Retrospective Comparison of Dental Hygiene Supervision Changes from 2001 to 2011*, 87 J. DENTAL HYGIENE 110, 111 (2013) (requiring the physical presence of a dentist is unnecessary for most dental hygiene care because "there is little possible danger in most dental services provided"); James R. Freed, Dorothy A. Perry & John E. Kushman, *Aspects of Quality of Dental Hygiene Care in Supervised and Unsupervised Practices*, 57 J. PUB. HEALTH DENTISTRY 68, 74 (1997) (suggesting that even without any supervision, dental hygienists' preventive care is "at least as good as hygiene care provided with dentists' supervision," and does not "increase the risk to the health and safety of the public or pose an undue risk of harm to the public.").

[38] INST. OF MED. & NAT'L RESEARCH COUNCIL, IMPROVING ACCESS TO ORAL HEALTH CARE FOR VULNERABLE AND UNDERSERVED POPULATIONS 234 (2011) (The Institute of Medicine became the National Academy of Medicine in 2015). *See also id.* at 120 (while restricting scope of practice is generally attributed to protecting consumers from unsafe or untrained professionals, data suggest that restrictive licenses lead to increased income for dentists).

[39] *See* Margaret Langelier et al., *Expanded Scopes of Practice for Dental Hygienists Associated with Improved Oral Health Outcomes for Adults*, 35 HEALTH AFF. 2207, 2208 (2016) (because some people lack access to dentists, regulations "requiring a dental visit before being seen by a dental hygienist may be a barrier to receiving preventive care").

[40] *See* PEW CHARITABLE TRUSTS, WHEN REGULATIONS BLOCK ACCESS TO HEALTH CARE, CHILDREN AT RISK SUFFER: THE SCHOOL DENTAL SEALANT PROGRAM DILEMMA 1-4 (Aug. 2018), https://www.pewtrusts.org/-/media/assets/2018/08/schooldentalsealant_brief_final.pdf (discussing barriers, such as prior exam rules, employment requirements, restrictive supervision requirements, and Medicaid policy barriers) to the use of dental hygienists in school-based sealant programs).

[41] *See* S.C. State Bd. of Dentistry, 138 F.T.C. 229, 232-240, 268 (2004) (the Board instituted its prior examination requirement after South Carolina's legislature eliminated the requirement in school settings).

[42] S.C. State Bd. of Dentistry, 144 F.T.C. 615, 628 (2007) (decision and order). The Board sought to have the complaint dismissed on the ground that its actions were exempt from the antitrust laws by virtue of the state action doctrine, but the Commission denied the motion to dismiss. *See* S.C. State Bd. of Dentistry, 138 F.T.C. 229 (2004).

[43] *See* S.C. State Bd. of Dentistry, 144 F.T.C. 615, 634 (2007) (Appendix to Decision and Order).

[44] *Id.* at 630.

[45] *See supra* note 16 and accompanying text. There are no express provisions for direct, indirect or general supervision in North Carolina laws or regulations, but the statutory requirement of a dentist's presence while dental hygienists provide services appears comparable to a requirement of direct supervision, and the exceptions that allow certain hygienists to work without the physical presence of a dentist appear comparable to general supervision. The ADHA characterizes North Carolina supervision requirements this way. *See* AM. DENTAL HYGIENISTS' ASS'N, DENTAL HYGIENE PRACTICE ACT OVERVIEW: PERMITTED FUNCTIONS AND SUPERVISION LEVELS BY STATE (Sept. 2019) , https://www.adha.org/resources-docs/7511_Permitted_Services_Supervision_Levels_by_State.pdf (defining direct supervision as a "dentist needs to be present;" indirect supervision as a "dentist must authorize [the] procedure and be in the dental office when the procedure is performed;" general supervision as a "dentist needs to authorize prior to services, but need not be present;" and direct access as "hygienists can provide services as s/he determines appropriate without specific authorization"). *See also* April V. Catlett & Robert Greenlee, *supra* note 37, at 110, 112.

[46] *See* Comment from FTC Staff to Peggy Lehner, State Senator, Oh. State Senate, *supra* note 14, at notes 40-41 (regarding direct supervision requirements for dental hygienists); Nat'l Governors Ass'n, *The Role of Dental Hygienists in Providing Access to Oral Health Care* 4-5 (Jan. 2014), http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf; April V. Catlett & Robert Greenlee, *A Retrospective Comparison of Dental Hygiene Supervision Changes from 2001 to 2011*, 87 J. DENTAL HYGIENE 110 (2013), http://jdh.adha.org/content/87/3/110.full.pdf ("direct supervision confines the dental hygienist to a facility where the dentist is physically present"); INST. OF MED., ALLIED HEALTH SERVICES: AVOIDING CRISES 108 (1989) ("The opportunities for hygienist employment outside dental offices today are limited by regulations that require them to work with dentists on site. Thus, populations such as the elderly in long-term care facilities and physically and mentally retarded people in institutions, whose access to care is limited by their lack of mobility, cannot be served by hygienists alone.").

[47] *See* Langelier et al., *supra* note 39, at 2211 (from 2001-2014, many states adopted regulatory changes "that reduced the direct supervision required for dental hygienists, most notably in public health settings"); Catlett & Greenlee, *supra* note 37, at 114-15 (45 out of 51 jurisdictions reduced dental hygienists' supervision requirements from 2001-2011, as compared to the period from 1993-2000, but Alabama, Georgia, Mississippi, and North Carolina have continued to rely on direct supervision); *see also* AM. DENTAL HYGIENISTS' ASS'N, *supra* note 45.

[48] *See* AM. DENTAL HYGIENISTS' ASS'N, CURRENT DIRECT ACCESS MAP (Apr. 2018), https://www.adha.org/resources-docs/7524_Current_Direct_Access_Map.pdf. The American Dental Hygienists' Association defines direct access as "the ability of a dental hygienist to initiate treatment based on their assessment of a patient's needs without the specific authorization of a dentists, treat the patient without the presence of a dentist, and maintain a provider-patient relationship." AM. DENTAL HYGIENISTS' ASS'N, DIRECT ACCESS STATES (June 2019), https://www.adha.org/resources-docs/7513_Direct_Access_to_Care_from_DH.pdf. *See also* Doreen K. Naughton, *Expanding Oral Care Opportunities: Direct Access Care Provided by Dental Hygienists in the United States*, 14 J. EVIDENCE-BASED DENTAL PRAC. (SUPPLEMENT) 171 (2014).

Although states sometimes allow less restrictive supervision in underserved settings to improve access in those areas, that limitation is not based on a health and safety rationale, and the need for improved access is not limited to such settings. *See* INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 38, at 234-35 (recommending that state legislatures increase access to basic oral health care by amending dental practice acts to allow allied dental professionals such as hygienists to work to the full extent of their education and training "in a variety of settings under evidence-supported supervision levels[.]").

[49] *See* PEW CHARITABLE TRUSTS, *supra* note 40, at 3 ("Over the last decade, advocacy efforts have led to the repeal of prior exam rules in several states," but they remain in the District of Columbia, Alabama, Delaware, Hawaii, Indiana, Louisiana, Maryland, Mississippi, North Carolina, Texas, and Wyoming).

[50] *See* BUREAU OF HEALTH WORKFORCE, HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA), U.S. DEP'T OF HEALTH & HUMAN SERVICES, FOURTH QUARTER OF FISCAL YEAR 2019 – DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREAS QUARTERLY SUMMARY 8 (Sept. 30, 2019), https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport (accessed Oct. 8, 2019). *See also* OFFICE OF RURAL HEALTH, N.C. DEP'T OF HEALTH & HUMAN SERVICES, NORTH CAROLINA HEALTH PROFESSIONAL SHORTAGE AREA 2 (2018), https://files.nc.gov/ncdhhs/2018%20NC%20DHHS%20ORH%20HPSA%20One%20Pager_0.pdf (map showing 74 North Carolina counties with a geographic or population health professional shortage area for dental health).

[51] The percentage of North Carolina's population living in a DCHPSA was calculated using the U.S. Census Bureau's estimated population of 10,383,620 for North Carolina on July 1, 2018. *See* U.S. Census Bureau, Quick Facts North Carolina Table, https://www.census.gov/quickfacts/fact/table/NC,US/PST045218.

[52] *See* BUREAU OF HEALTH WORKFORCE, HRSA, *supra* note 50, at 8. *See also id.* at 14 ("The percent of need met is computed by dividing the number of dentists available to serve the population of the area, group, or facility by the number of dentists that would be necessary to reduce the population to provider ratio below the threshold for designation so that it would eliminate the designation as a dental HPSA. Federal regulations stipulate that, in order to be considered as having a shortage of providers, a designation must have a population-to-provider ratio that meets or exceeds a certain threshold. For dental geographic designations, the ratio must be at least 5,000 to 1. For dental population designations or geographic designations in areas with unusually high needs, the threshold is 4,000 to 1. For correctional facilities, the threshold is 1,500:1 and takes into account the average length of stay, and whether or not intake examinations are routinely performed.").

[53] *See* JORDAN ROBERTS & JENNIFER MINJAREZ, JOHN LOCKE FOUND./TEXAS PUBLIC POL'Y FOUND., DENTAL THERAPY IN NORTH CAROLINA: ADDRESSING THE SHORTAGE OF PRIMARY AND RESTORATIVE DENTAL CARE, Spotlight #505 8-10 (May 2019), https://www.johnlocke.org/app/uploads/2019/05/Spotlight-505-rev2.pdf (North Carolina's rural population is the second largest of all states, and in "many cases, costs of dental care present a significant barrier").

[54] *See* PEW CHARITABLE TRUSTS, *supra* note 40, at 3 (discussing the barriers to sealing students' teeth created by prior examination rules and employment requirements, such as those in North Carolina, that limit the number of public health hygienists that a dentist can supervise to two); JORDAN ROBERTS & JENNIFER MINJAREZ, *supra* note 53, at 8-10 (discussing the need for more dental care in North Carolina).

[55] *See* JORDAN ROBERTS & JENNIFER MINJAREZ, *supra* note 53, at 8 ("Insufficient supply and cost are the two main barriers that many populations in North Carolina fae when it comes to receiving the appropriate oral care.").

[56] Dental hygienists earn considerably less than dentists. *See* INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 38, at 87 (mean annual wage of $143,000 for salaried general dentists, compared to $66,500 for dental hygienists). Requirements for examination of patients by a dentist could undercut the cost savings that would otherwise arise from the use of a dental hygienist because they entail payment for a dentist's services.

[57] *See, e.g.*, Brian E. Whitacre, *Estimating the Economic Impact of Telemedicine in a Rural Community*, 40 AGRIC. & RES. ECON. REV. 172, 176-78 (presenting transportation savings and savings from not missing work arising from local (virtual) availability of a health care provider in a rural community). Savings on patients' transportation costs may reduce state health care costs, because state Medicaid programs cover transportation and related travel expenses necessary for treatment. *See* 42 C.F.R. § 440.170; Div. Health Benefits, N.C. Medicaid, N.C. Dep't Health & Human Services, *Non-Emergency Medical Transportation (NEMT)* (MA-2910) (Dec. 2018), *in* Aged, Blind, and Disabled Medicaid Manual & *Non-Emergency Medical Transportation (NEMT)* (MA-3550) (Oct. 2018), *in* Family and Children's Medicaid Manual.

[58] *See* Catlett & Greenlee, *supra* note 37, at 110-11, 116; Nat'l Governors Ass'n, *supra* note 37, at 4.

[59] Langelier et al., *supra* note 39, at 2213.

[60] *See* Comment from FTC Staff to Peggy Lehner, State Senator, Oh. State Senate, *supra* note 14, note 45 and accompanying text (only about 0.4% of Ohio dentists and 1.2% of hygienists obtained permits to participate in a voluntary program to reduce restrictive supervision in certain public health settings).

[61] Although as discussed above, many states allow direct access to dental hygienists who provide services in dental health resource shortage areas, a broad approach applicable to both private and public health hygienists in North Carolina might require changes to the state's dental practice act, because the state's prior examination requirement for services provided by private hygienists is statutory.