



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

Office of Policy Planning  
Bureau of Competition  
Bureau of Economics

December 2, 2013

Sherin Tooks, Ed.D., M.S.  
Director, Commission on Dental Accreditation  
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Chicago, IL 60611

Dear Dr. Tooks:

The staffs of the Federal Trade Commission Office of Policy Planning, Bureau of Economics, and Bureau of Competition<sup>1</sup> (collectively, “FTC staff”) appreciate the opportunity to comment on the *Accreditation Standards for Dental Therapy Education Programs* proposed by the Commission on Dental Accreditation (“CODA”).<sup>2</sup> Dental therapists are a relatively new type of “mid-level” provider that offers some of the same basic dental services offered by dentists. Expanding the supply of dental therapists by facilitating the creation of new dental therapy training programs, therefore, is likely to increase the output of basic dental services, enhance competition, reduce costs, and expand access to dental care. This could especially be true for underserved populations. Recognizing this potential, a number of state legislatures have expressed interest in creating dental therapy educational and training programs. At least one jurisdiction, the State of Minnesota, has created new training programs and has urged CODA to develop accreditation standards that would apply to its programs. The promulgation of accreditation standards could have a significant impact on the success of such programs. It would enhance the attractiveness of such programs to prospective students because it could more easily allow dental therapists licensed in one state to obtain licensing in another state. It could also spur the development of additional training programs.

As currently worded, however, the proposed CODA accreditation standards might be interpreted in ways that could impede competition. For example, the proposed standards state that diagnosis and treatment planning are the responsibility of a supervising dentist, even though such statements ordinarily are not found in the accreditation standards of education programs for other allied dental professionals who are also supervised by dentists. Such statements could have two interrelated effects. First, they may constrain states’ discretion to select the level of supervision that they determine is appropriate for different types of dental training programs that they may create, and to define broadly dental therapists’ scope of practice to include oral evaluation and treatment planning. Accordingly, we are concerned that such statements may hamper efforts to promote the use of dental therapists to enhance competition and expand access to dental services, especially in underserved areas where dentists are scarce or unavailable. Second, such statements may deter the development of dental education programs that would

train dental therapists to provide such services under the level of supervision required by each state. For example, if the statements are interpreted by educators to preclude dental therapists from conducting an oral evaluation and developing a treatment plan, and to require on-site dentist supervision during an evaluation or procedure – even when states determine that patient safety may not require such restrictions – it may result in less development of innovative provider models and education programs that are intended to better address dental care needs.

As discussed below in greater detail, to preserve flexibility at the state level and to foster innovation in dental care education and delivery models, we encourage CODA to consider two specific recommendations as part of its deliberations on the proposed standards:

- CODA should consider omitting categorical statements regarding a supervising dentist’s responsibility for diagnosis and treatment planning, topics that are typically addressed by individual states in their licensure and scope of practice laws; and
- CODA should consider developing accreditation standards for master’s or graduate level programs that train dental therapists to conduct oral evaluations and develop treatment plans without requirements for an on-site supervising dentist or at other supervisory levels that have been adopted by states.

This comment does not advocate a simple or uniform model for how best to define the scope of dental therapy practice. Nor does it purport to specify the appropriate level of supervision of dental therapists by dentists. Ultimately, state legislators and regulators, and dental care providers themselves, should make those determinations relying on their training, expertise, and the best available safety evidence. Based on FTC staff’s knowledge of health care competition, however, this comment highlights aspects of the proposed standards that could deter the adoption of innovative dental workforce models that would otherwise have the potential to increase competition in the provision of dental services, improve access for underserved populations, and decrease the costs of care.

## **I. The FTC’s Interest and Experience**

The FTC is charged with enforcing Section 5 of the FTC Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.<sup>3</sup> Competition is at the core of America’s economy, and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and innovation.<sup>4</sup> Competition in health care markets has long been an area of focus for the FTC’s law enforcement,<sup>5</sup> research,<sup>6</sup> and advocacy<sup>7</sup> activities.

The FTC has examined markets for the provision of dental services in the context of both law enforcement actions and policy initiatives. For example, in 2003 the Commission sued the South Carolina Board of Dentistry charging that the Board had illegally restricted the ability of dental hygienists to provide preventive dental services in schools,<sup>8</sup> thereby unreasonably restraining competition and depriving thousands of economically disadvantaged schoolchildren of needed dental care, with no justification.<sup>9</sup> The Board ultimately entered into a consent agreement settling the charges.<sup>10</sup>

As part of the agency's policy and advocacy functions, FTC staff also has provided comments on competition and consumer protection matters to state dentistry boards and state officials.<sup>11</sup> In 2009, staff provided several comments to Louisiana legislators and the Louisiana Board of Dentistry ("LBD") to highlight competition concerns raised by proposed bills and proposed LBD rules regarding the practice of in-school dentistry.<sup>12</sup> Consistent with staff's comments, the LBD ultimately adopted rules for portable and mobile dentistry that more closely align dental practice requirements in schools and other non-traditional settings with requirements applicable to the same dentists in traditional settings.<sup>13</sup> In December 2010, staff urged the Georgia Board of Dentistry not to adopt proposed rule changes that would have required the indirect supervision of a dentist for dental hygienists performing permitted treatments at approved public health facilities, and which could have been interpreted to require a dentist's initial diagnosis of all patients in such settings.<sup>14</sup> Staff expressed concern that the proposed changes likely would have raised the cost of such services and reduced the numbers of consumers receiving dental care, with no evidence that additional supervision was needed to prevent harm to dental patients.<sup>15</sup> In November 2011, staff urged the Maine Board of Dental Examiners not to adopt proposed rules that would have restricted the scope of practice of Independent Practice Dental Hygienists participating in a pilot project designed to improve access to care in underserved areas of the state, by preventing them from taking certain radiographs without a dentist present.<sup>16</sup>

As in these prior advocacy comments, the FTC's charge to promote competition for the benefit of consumers underlies the FTC staff's interest in commenting on CODA's proposed *Accreditation Standards for Dental Therapy Education Programs*.

## **II. Background on Dental Therapy and CODA's Proposed Accreditation Standards for Dental Therapy Education Programs**

Dental therapists provide preventive and basic reparative dental services. Dental therapists differ from other allied dental health professionals, such as dental hygienists, in that they are trained and licensed to provide some, but not all, services traditionally carried out only by licensed dentists. Although dental therapists have been practicing in other countries since the early twentieth century, they have only recently begun practicing in the United States and are becoming an emerging option for consumers of dental services.

### **A. Dental Workforce Innovations in Minnesota and Other States**

In 2009, Minnesota became the first state to enact legislation providing for the licensure of dental therapists.<sup>17</sup> The adoption of dental therapy legislation in Minnesota, as well as proposals for dental therapist licensure in other states, demonstrate states' interest in exploring innovative provider models to address their residents' dental care needs, including programs that would allow a dental therapist to conduct an oral evaluation and develop a treatment plan under the supervision of a remotely-located dentist. The ability of dental therapists to work without a dentist on the premises is critical to their ability to increase the availability of dental care in areas where dentists are scarce or unavailable.<sup>18</sup>

Minnesota's legislation created two types of mid-level oral health professionals: Dental Therapists ("DTs") and Advanced Dental Therapists ("ADTs"). The law authorizes both DTs and ADTs to provide basic preventive and limited restorative services, and provides them with limited authority to write prescriptions.<sup>19</sup> DTs and ADTs are also "limited to primarily practicing in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area."<sup>20</sup>

Under Minnesota law, ADTs can carry out all evaluative, preventative, restorative, and surgical procedures within their scope of practice, including "an oral evaluation and assessment of dental disease and the formulation of an individualized treatment plan," under "general supervision," which means that the supervising dentist need not be on the premises when a procedure is performed.<sup>21</sup> Minnesota law further provides that DTs can carry out many evaluative and preventative services under general supervision. Most basic restorative and surgical services within a DT's scope of practice must be performed under "indirect supervision," with a dentist on-site when the service is performed. DTs are not authorized to conduct an oral evaluation and formulate a treatment plan.<sup>22</sup>

Neither DTs nor ADTs are authorized to provide complex or advanced restorative and surgical procedures.<sup>23</sup> In Minnesota, both types of providers must practice pursuant to a "cooperative management agreement" with a supervising dentist who can impose scope of practice and supervision restrictions beyond those required by law.<sup>24</sup>

As a result of Minnesota's legislation, the University of Minnesota ("UMN") established educational programs providing the necessary training to practice as a DT, and an institution in the Minnesota State Colleges and Universities System, Metropolitan State University ("MSU"), began a master's program providing the necessary training to practice as an ADT.<sup>25</sup> Graduates of programs at both universities are initially licensed as DTs.<sup>26</sup> Graduates of MSU's master's program, which requires applicants to be licensed dental hygienists, may be certified as ADTs after a period of post-licensure practice as a DT and passage of a board-approved examination.<sup>27</sup> UMN also plans to offer a master's program leading to certification as an ADT.<sup>28</sup>

As permitted by Minnesota law, the programs at UMN and MSU are approved by the Minnesota Board of Dentistry ("MBD"),<sup>29</sup> which is sufficient for graduates of these programs to meet Minnesota's licensure requirements.<sup>30</sup> Still, the UMN, MSU, MBD, and Minnesota Dental Association ("MDA") asked CODA to establish national accreditation standards covering both the DT and ADT programs.<sup>31</sup> CODA is the only body recognized by the U.S. Department of Education for the accreditation of allied dental health programs, and CODA's promulgation of accreditation standards for dental therapy programs would be consistent with accreditation by CODA of education programs for other allied dental professions.<sup>32</sup> Moreover, a nationwide accreditation standard could foster the adoption by other states of dental therapy licensure laws, leading to the growth of dental therapy education programs nationally and establishing a basis for the reciprocal licensing of dental therapists in different states. This would likely have the benefit of increasing the supply of dental therapists, which could reduce the cost of obtaining certain dental services.<sup>33</sup>

Even without national accreditation standards, in the past year eight other states have considered bills to license dental therapists. Although none have passed, the number of bills suggests that interest in mid-level dental professionals is growing, especially in states with large rural populations. Proposed legislation in North Dakota was similar to Minnesota's, distinguishing the education requirements, scope of practice, and supervision provisions of dental therapists and advanced dental therapists.<sup>34</sup> Bills in the other seven states either would have allowed general supervision of all dental therapy practitioners or would have specifically provided that a supervising dentist need not be on-site.<sup>35</sup> The proposed legislation in at least six of these states also would have permitted a dental therapist to evaluate dental disease and formulate a treatment plan.<sup>36</sup> Such legislation could be especially effective in improving the availability of dental care in underserved areas where dentists are scarce or unavailable.<sup>37</sup>

## **B. Growth of the Dental Therapy Profession and Potential Competitive Benefits**

In dental care, as in other areas of health care, workforce modifications expanding the use of mid-level providers can increase the supply of basic services and improve the overall quality of care. Such measures are also viewed as an important strategy to address access and cost challenges.<sup>38</sup> Because the oral health workforce is not well distributed, access to dental care is inadequate in many areas.<sup>39</sup> In Minnesota, the state legislature empowered dental therapists to respond to this imbalance by requiring them to practice primarily in settings that serve low-income and underserved patient populations for whom dentists are often unavailable or unaffordable. Dental therapists are likely to be most effective in expanding access to care, especially to the underserved, when they are allowed under appropriate circumstances to evaluate a patient and develop a treatment plan under the supervision of a remotely-located dentist.<sup>40</sup> Conversely, if competition is hindered by laws that reserve the provision of even simpler services to more highly trained professionals, access may be compromised and cost savings may be inhibited.<sup>41</sup>

The ability of dental therapists to provide cost-effective care is also closely tied to their ability to offer services without a dentist on-site. Dental therapists tend to receive lower compensation than dentists because of their more limited training and the narrower scope of services they are typically authorized to provide as a result.<sup>42</sup> However, whether the use of dental therapists is actually "less costly will depend on whether duplication in providers arises and whether the profit arising from care provided by lower-paid therapists accrues to dentists, insurers, or patients."<sup>43</sup> A requirement to always utilize a dentist for evaluation and treatment planning, and/or have a supervising dentist on the premises, could undercut the cost savings that otherwise might arise from the use of lower-cost providers, effectively defeating the very purpose of expanding the supply of dental therapists.

FTC staff notes that similar scope of practice and supervision issues arise in the context of advanced practice registered nurses ("APRNs"), a subject on which FTC staff frequently has commented. With respect to APRNs, FTC staff has emphasized that overly broad scope of practice restrictions and supervision requirements, unsupported by legitimate health and safety concerns, may limit competition and decrease access without providing any countervailing benefits to health care consumers.<sup>44</sup>

### **III. Discussion**

FTC staff commends CODA's proposed accreditation standards as an important first step in encouraging the nationwide growth of a dental therapist profession. In commenting on the proposed standards, FTC staff in no way intends to offer judgments regarding important health and safety considerations that may inform states' policy choices surrounding dental therapist licensure and scope of practice. FTC staff is concerned, however, that some of the specific provisions of the proposed standards may effectively and unnecessarily constrain the discretion of states to determine dental therapists' scope of practice and authority, to the possible detriment of competition and consumers. As CODA itself has recognized, CODA may effectively "set[] the national scope of practice when it develops accreditation standards in a discipline of dentistry."<sup>45</sup> If that scope is unnecessarily narrow, competition and consumers may suffer.

#### **A. CODA's Response to Minnesota's Requests for Accreditation**

CODA has responded to requests for accreditation with proposed standards that raise two distinct concerns. First, they do not fully address the accreditation needs of Minnesota's existing dental therapy education programs. Specifically, the proposed standards address only baccalaureate programs, such as the UMN programs, leading to licensure as a DT. The proposed standards do not address graduate programs, such as MSU's, that lead to certification as an ADT, which is intended to have a broader scope of practice.<sup>46</sup>

Second, the proposed standards include a definition of dental therapists that inherently emphasizes limitations on their authority:

The dental therapist is a member of the oral healthcare team, who is supervised by a licensed dentist that is responsible for diagnosis, risk assessment, prognosis, and treatment planning for the patient.<sup>47</sup>

Similar statements appear in various parts of the standards.<sup>48</sup> By specifying that the dental therapist is supervised and that the dentist is responsible for diagnosis and treatment planning, the statement implies that a dental therapist's role must be limited to execution of a dentist's orders, and could be interpreted as a requirement either that a dentist first examine a patient or that the dentist be on-site for the patient's initial examination. It could be argued that such an interpretation is consistent with the position of the American Dental Association ("ADA") "that only a dentist, by virtue of education, training and clinical experience, should diagnose oral disease and perform surgical/irreversible procedures."<sup>49</sup> It is also consistent with the ADA's official policy that "to maintain the highest quality of oral health care . . . the dentist [must] be the health care provider that performs examinations/evaluations, diagnoses and treatment planning."<sup>50</sup>

Although the proposed standards do not specify the type of supervision, the standards could create a perception that dental therapists who graduate from CODA-accredited programs are *only* capable of practicing dental therapy when supervised by an on-site dentist, and/or only with an evaluation and treatment plan developed by a dentist, regardless of their level of training. Such provisions on supervision and scope of practice typically are a matter of state law, not the

subject of allied dental education accreditation standards.<sup>51</sup> In the case of Minnesota's existing law, the proposed CODA standards would not accommodate a Minnesota ADT's explicit authority to conduct an oral evaluation and formulate a dental treatment plan under the supervision of a remotely-located dentist. In other states, the standards may inhibit states' discretion to adopt supervisory standards appropriate to evolving training programs and the professional licensure provisions that they may create.

### **B. CODA's Proposed Dental Therapy Accreditation Standards May Chill Expansion of the Dental Therapy Profession**

Although the proposed CODA standards would not override state supervision and scope of practice laws, the CODA statements could influence other states considering proposed dental therapy legislation, as well as educational institutions considering the creation of dental therapy training programs. For example, the proposed standards could encourage states to adopt legislation requiring a dentist's evaluation and treatment plan in all cases, and could inhibit legislation modeled on MSU's master's-level ADT program that would allow dental therapists to conduct evaluations and formulate treatment plans even when a dentist is not on the premises. As a result, the accreditation standards could limit the competitive benefits that could be realized from expansion of the supply of providers of basic dental services.

In addition, "states may miss critical opportunities to serve greater numbers of individuals in need of care,"<sup>52</sup> even when state legislators determine that the interests of their state's health care consumers would be better served by enabling dental therapists to practice without the presence of an on-site dentist. Even if other states were to overlook the implied message of the CODA statements and adopt a licensure and scope of practice framework comparable to that adopted in Minnesota, CODA's proposed accreditation standards might discourage colleges and universities from developing education programs that would train dental therapists to evaluate oral health and formulate a treatment plan, and work without a dentist on-site.<sup>53</sup> Absent endorsement by nationwide accreditation standards, education programs that train practitioners to evaluate oral health, formulate a treatment plan, and work without an on-site dentist or under lesser levels of supervision might suffer, which in turn would decrease the number of graduates with that type of specialized training.

For schools that nevertheless might choose to offer training for dental therapists who could someday practice under the supervision of a remotely-located dentist or even independently, the lack of a nationwide accreditation standard covering these types of programs might make it difficult to attract a nationwide applicant pool or to facilitate licensure portability from state to state. This could ultimately lead to a decline in such programs. For example, MSU's program requiring applicants to be licensed dental hygienists could be affected by the lack of accreditation standards applicable to its programs. The lack of support for such programs could lead to a decline in the number of trained dental therapists, which would further limit the potential for increased competition among dental providers.<sup>54</sup>

### C. The Role of States in Evaluating Health and Safety

Although FTC staff believes that the potential benefits of competition among different types of dental care providers could be substantial, this comment is in no way intended to subordinate legitimate health and safety concerns that might limit dental therapists' scope of practice or their ability to practice without some level of supervision by a dentist. FTC staff recognizes that patient health and safety concerns are of critical importance when states regulate the scope of practice and supervision requirements of health care professionals. If states choose to enact laws providing for the licensure of dental therapists, each state will need to determine its own supervision and scope of practice limitations. State legislatures typically make these policy decisions, subject to debate and input from diverse sources.

FTC staff urges the ADA and CODA to avoid exercising their current authority in a way that could impede the development of this potentially valuable and innovative model of dental care delivery. According to CODA, the overall purpose of its accreditation standards is "to serve the public by ensuring quality education and patient safety."<sup>55</sup> The ADA has explained that its goal, as well as that of its component organization CODA, is "the provision of safe, effective dental care to patients."<sup>56</sup>

The ADA plays an important public safety role when it questions whether dental therapists can carry out some or all procedures safely. FTC staff is concerned, however, that consumers ultimately may be harmed if the proposed CODA accreditation standards curtail useful scientific inquiry and policy discussion on this issue. Both national and international experience suggest that dental therapists can safely evaluate dental disease, develop a treatment plan, and provide other services within their scope of practice without an on-site dentist or under lesser levels of supervision. For example, in Australia, where dental therapists have been providing dental care for many years, "dental therapists have practiced autonomously, including diagnosis, treatment planning, care provision, and referrals to dentists as appropriate."<sup>57</sup> Furthermore, international studies speak to "the safety and quality of care . . . provided by dental therapists as compared to dentists and about their acceptance by the populations served."<sup>58</sup> In the United States, evaluations of Alaska's Dental Health Aide Therapist ("DHAT") program "show that DHATs are performing within their scope of practice, patients are satisfied with their care, and there is no significant difference between the quality of the treatment provided by the DHATs as compared with dentists."<sup>59</sup>

In sum, at least some dental therapists "are performing well and operating safely and appropriately within their defined scope of practice."<sup>60</sup> Based on recent state legislative activity, it appears that a number of state legislatures are reviewing available safety evidence and actively considering whether, and to what extent, dental therapists under various levels of supervision, including supervision by a remotely-located dentist, might enhance the health care workforce in their states. Indeed, because the availability and cost of dental care may vary substantially across the United States, individual states may be best positioned to weigh competition, safety, and other policy objectives in light of local conditions, and to make the complex determination of "how to improve oral health care delivery within their borders."<sup>61</sup> In Minnesota, legislators made that calculation and enacted legislation providing for the licensure of DTs and certification of ADTs. We urge CODA to adopt accreditation standards that will support and facilitate, not stifle, this kind of state-level innovation in dental care delivery.



#### **D. Suggested Considerations for CODA’s Proposed Dental Therapy Accreditation Standards**

FTC staff suggests that CODA not take the unusual step of including supervision and scope of practice limitations in an education program accreditation standard. These statements, while not binding on state legislatures, could effectively constrain the discretion of the states in defining scope of practice and supervisory requirements for dental therapists. Without the statements on the role of a supervising dentist in diagnosis and treatment planning, states would determine the appropriate scope of practice and level of supervision without *de facto* limitations arising from an accreditation standard.

CODA’s accreditation standards for other allied dental professionals (such as dental hygienists and dental assistants) list required competencies, but are silent on the role of dentists in diagnosis, treatment planning, and supervision, even though such professionals are routinely supervised by a licensed dentist who carries out those functions.<sup>62</sup> Rather, scope of practice and supervision requirements are left to state law, and we agree with the ADA that “[s]tate officials charged with governing the delivery of dental care are the ultimate legal arbiters of what constitutes the appropriate scope of practice of the various dental team members.”<sup>63</sup>

Alternatively, CODA may wish to consider modifying the proposed accreditation standards to explicitly acknowledge that the standards do not endorse a particular model of care, and that states have the flexibility to adopt scope of practice and supervisory requirements that best meet the needs of their citizens.<sup>64</sup>

In addition, we respectfully suggest that CODA consider developing accreditation standards for graduate programs, such as Minnesota’s ADT program, that train students to conduct an oral evaluation, develop a treatment plan, and work without an on-site supervising dentist or at other supervisory levels that have been adopted by states.

#### **IV. Conclusion**

CODA’s proposed *Accreditation Standards for Dental Therapy Education Programs* may help to encourage the development of a nationwide dental therapy profession that could significantly enhance competition in the supply of dental care services. The standards’ effectiveness may be limited, however, by unnecessary statements on supervision, evaluation, and treatment planning. We respectfully suggest that CODA consider dropping such statements. We also encourage CODA to consider developing additional standards for master’s or graduate level programs that train dental therapists to conduct oral evaluations and develop treatment plans without an on-site supervising dentist or at other supervisory levels that states have adopted.

We appreciate your consideration of these issues.

Respectfully submitted,

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<sup>1</sup> This letter expresses the views of 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 (“Commission” or “FTC”) or of any individual Commissioner. The Commission has, however, voted to authorize us to submit these comments.

<sup>2</sup> COMM’N ON DENTAL ACCREDITATION (“CODA”), ACCREDITATION STANDARDS FOR DENTAL THERAPY EDUCATION PROGRAMS (2013), [http://www.ada.org/sections/educationAndCareers/pdfs/proposed\\_dental\\_therapy.pdf](http://www.ada.org/sections/educationAndCareers/pdfs/proposed_dental_therapy.pdf) [hereinafter CODA, ACCREDITATION STANDARDS]. CODA is a commission of the American Dental Association (“ADA”), the dentists’ trade organization. *See* ADA, CONSTITUTION AND BYLAWS ch. XV (2013) (“The commissions of this Association shall be: Commission on Dental Accreditation . . . .”); *See also* Karen Fox, *How CODA works*, ADA NEWS, Sept. 5, 2011, <http://www.ada.org/news/6179.aspx> (quoting Dr. Roger Kiesling, “CODA is an agency of the ADA . . . .”).

<sup>3</sup> FTC Act, 15 U.S.C. § 45 (2012).

<sup>4</sup> *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.”).

<sup>5</sup> *See generally* FTC STAFF, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2013), <http://www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf>.

<sup>6</sup> *See, e.g.*, FTC & U.S. DEP’T OF JUSTICE (“DOJ”), IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

<sup>7</sup> FTC and staff advocacies take many forms, including letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, and amicus briefs. *See, e.g.*, FTC Staff Letter to the Hon. Rep. Stephen LaRoque, North Carolina House of Representatives, Concerning North Carolina House Bill 698 and the Regulation of Dental Service Organizations and the Business Organization of Dental Practices in North Carolina (May 25, 2012), <http://ftc.gov/os/2012/05/1205ncdental.pdf>; FTC and DOJ Written Testimony before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws (Sept. 15, 2008), <http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf>; Brief of the FTC as Amicus Curiae in *Actelion Pharmaceuticals Ltd. v. Apotex Inc.*, No. 1:12-cv-05743-NLH-AMD (D.N.J.) (Mar. 11, 2013), <http://www.ftc.gov/os/2013/03/130311actelionamicusbrief.pdf>.

<sup>8</sup> S.C. State Bd. of Dentistry, 138 F.T.C. 229, 233-40 (2004), <http://www.ftc.gov/os/decisions/docs/Volume138.pdf#page=234>.

<sup>9</sup> *Id.* at 268-80; *see also Id.* at 232.

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<sup>10</sup> S.C. State Bd. of Dentistry, Dkt. No. 9311 (F.T.C. 2007), <http://www.ftc.gov/os/adjpro/d9311/070911decision.pdf> (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. In re South Carolina State Board of Dentistry, Opinion and Order of the Commission. *See also* N.C. State Bd. of Dental Examiners v. FTC, 717 F.3d 359 (4th Cir. 2013) (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).

<sup>11</sup> *Advocacy Filings by Subject, Dentistry*, FTC, [http://ftc.gov/opp/advocacy\\_subject.shtm#detg](http://ftc.gov/opp/advocacy_subject.shtm#detg) (last updated Nov. 2013).

<sup>12</sup> FTC Staff Comment to the Hon. Timothy G. Burns Concerning Louisiana H.B. 687 (May 1, 2009), <http://ftc.gov/os/2009/05/V090009louisianadentistry.pdf>; FTC Staff Comment to the Hon. Sam Jones Concerning Amendments to Louisiana H.B. 687 (May 22, 2009), <http://ftc.gov/os/2009/05/V090009louisianahb687amendment.pdf>; FTC Staff Comment Before the Louisiana State Board of Dentistry Concerning Proposed Modifications to Louisiana’s Administrative Rules Regarding the Practice of Portable and Mobile Dentistry (Dec. 18, 2009), <http://ftc.gov/os/2009/12/091224commentladentistry.pdf>.

<sup>13</sup> LA. ADMIN. CODE tit. 46, § 313 (2012), available at <http://www.lsbdo.org/applications/dentalact2010.pdf> (Portable and Mobile Dentistry).

<sup>14</sup> FTC Staff Comment Before the Georgia Board of Dentistry Concerning Proposed Amendments to Board Rule 150.5-0.3 Governing Supervision of Dental Hygienists (Dec. 30, 2010), <http://ftc.gov/os/2010/12/101230gaboarddentistryletter.pdf>.

<sup>15</sup> The Board ultimately adopted a revised rule that essentially left in place the status quo.

<sup>16</sup> FTC Staff Comment Before the Maine Board of Dental Examiners Concerning Proposed Rules to Allow Independent Practice Dental Hygienists to Take X-Rays in Underserved Areas (Nov. 16, 2011), <http://ftc.gov/os/2011/11/111125mainedental.pdf>. The Board subsequently voted to allow IPDHs to take only those certain x-rays. FTC staff also has submitted numerous advocacy comments addressing related scope of practice issues for Advanced Practice Registered Nurses. *See infra* note 44.

<sup>17</sup> *See infra* note 19.

<sup>18</sup> *See infra* note 40 and accompanying text.

<sup>19</sup> *See, e.g.*, Kavita R. Mathu-Muju, *Chronicling the dental therapist movement in the United States*, 71 J. PUB. HEALTH DENTISTRY 278, 279 (2011); American Dental Hygienists Association, *The History of Introducing a New Provider in Minnesota: A Chronicle of Legislative Efforts 2008-2009* (2009), [http://www.adha.org/resources-docs/75113\\_Minnesota\\_Story.pdf](http://www.adha.org/resources-docs/75113_Minnesota_Story.pdf). *See also* MINN. STAT. §§ 150A.105, 150A.106 (2013).

<sup>20</sup> MINN. STAT. § 150A.105, subdiv. 2 (2013).

<sup>21</sup> *Id.* § 150A.106, subdiv. 2. *See also* MINN. R. 3100.0100, subpart 21(D) (“‘General supervision’ means the supervision of tasks or procedures that do not require the presence of the dentist in the office or on the premises at the time the tasks or procedures are being performed but require the tasks be performed with the prior knowledge and consent of the dentist.”). The definition of general supervision varies from state to state. Supervision by a remotely-located dentist is also the norm in Alaska’s Dental Health Aide Therapist (“DHAT”) program, a federally-mandated program that allows village residents who have completed a two-year postsecondary program to provide dental services to Alaska Native Americans. DHATs work pursuant to a supervising dentist’s standing orders, which, like a cooperative management agreement, may restrict the scope of practice. *See, e.g.*, SCOTT WETTERHALL ET AL., EVALUATION OF THE DENTAL HEALTH AIDE THERAPIST WORKFORCE MODE IN ALASKA §§ 2.3-2.5 (2010), <http://depts.washington.edu/dentexak/wordpress/wp-content/uploads/2012/10/2010RTI-Report.pdf>. *See also* 25 U.S.C. § 1616l (2013). DHATs are trained in a two-year program at the University of Washington. *See DENTEX: Dental Health Aide Therapy Program*, UNIV. OF WASH., <http://depts.washington.edu/dentexak/> (last visited April 2, 2013).

<sup>22</sup> “‘Indirect supervision’ is more restrictive than general supervision. *See* MINN. R. 3100.0100, subpart 21 (C) (“‘Indirect supervision’ means the dentist is in the office, authorizes the procedures, and remains in the office while

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the procedures are being performed by the allied dental personnel.”). *See also* MINN. STAT. § 150A.105, subdiv. 4 (2013) (DT scope of practice and supervision).

<sup>23</sup> *See, e.g.*, BURTON L. EDELSTEIN, W.K. KELLOGG FOUND., TRAINING NEW DENTAL HEALTH PROVIDERS IN THE U.S. 7 (2010).

<sup>24</sup> *See* MINN. STAT. § 150A.105, subdiv. 3; § 105A.106, subdiv. 2, 3 (2013). Although Minnesota enacted laws requiring certain levels of supervision and a cooperative management agreement between dental therapists and dentists, other states may make different choices regarding the level of training and supervision, if any, and whether to require a cooperative management agreement.

<sup>25</sup> *See Dental Therapy - A New Profession*, UNIV. OF MINN., <http://www.dentistry.umn.edu/programs-admissions/dental-therapy/index.htm> (last updated Aug. 3, 2012) (B.S. and M.S degrees in dental therapy); *2012/2013 Graduate Catalog, Advanced Dental Therapy (MSADT)*, METRO. STATE UNIV., [http://www.metrostate.edu/msweb/explore/catalog/grad/index.cfm?lvl=G&section=1&page\\_name=master\\_science\\_advanced\\_dental\\_therapy.html](http://www.metrostate.edu/msweb/explore/catalog/grad/index.cfm?lvl=G&section=1&page_name=master_science_advanced_dental_therapy.html) (last visited Nov. 26, 2013). The MSU program is in collaboration with Normandale Community College. *See id.*

<sup>26</sup> *See* MINN. STAT. § 150A.06, subdiv. 1d (2013).

<sup>27</sup> *See id.* § 150A.106, subdiv. 1. MN law designates the post-licensure credential required for practicing as an ADT a certification rather than a license. Graduates of a master’s ADT program must complete 2,000 hours of post-licensure practice as a DT before taking the board-approved examination for certification as an ADT. *See id.*

<sup>28</sup> Minn. Bd. of Dentistry (“MBD”), Public Board Meeting Agenda, June 14, 2013, at 43, <http://www.dentalboard.state.mn.us/Portals/3/2013%20CommMinAgda/JUNE%202013%20Public%20Board%20Meeting%20Packet%20Final2%20shortversion.pdf>.

<sup>29</sup> *See Announcements*, MBD, <http://www.dentalboard.state.mn.us/> (last visited Nov. 26, 2013) (headline “Dental Therapist Licensure Update”). *See also* MBD, Public Board Meeting Minutes, Special Meeting of the Board, Aug. 13, 2010, at 2, <http://www.dentalboard.state.mn.us/Portals/3/2010%20CommMinAgda/08-13-2010%20Public%20Board%20Minutes%20Special.pdf>; MBD, Special Public Board Meeting Minutes, Feb. 25, 2011, at 1-2, <http://www.dentalboard.state.mn.us/Portals/3/2011%20CommMinAgda/02-25-2011%20Special%20Public%20Board%20Minutes.pdf>.

<sup>30</sup> *See* MINN. STAT. § 150A.06, subdiv. 1d (2013).

<sup>31</sup> *See* CODA, Minutes, Feb. 2010, at [http://www.ada.org/sections/educationAndCareers/pdfs/coda\\_minutes\\_feb2010.pdf](http://www.ada.org/sections/educationAndCareers/pdfs/coda_minutes_feb2010.pdf), at 18.

<sup>32</sup> *See Accreditation in the United States*, U.S. DEP’T OF EDUC., <http://www2.ed.gov/print/admins/finaid/accred/accreditation.html> (last visited April 1, 2013).

<sup>33</sup> *See infra* Section II.B.

<sup>34</sup> *See* H.B. 1454, 63rd Leg. Assem., § 43-20.1-10(3), (4) (N.D. 2013) (procedures that dental therapist may perform under general and indirect supervision) *with* § 43-20.1-11(2) (advanced dental therapist may perform all procedures under general supervision).

<sup>35</sup> *See* H.B. 2157 § 2(b), (c) (Kan. 2013) (providing for general supervision unless supervising agreement specifies otherwise); L.D. 1230, 126th Leg. § 1094-HH-2 (Me. 2013) (“dental hygiene therapist may provide the care and services listed in this section . . . only under the general supervision of a dentist”); H.B. 274, 188th Gen. Court, § 2 (Mass. 2013) (advanced dental hygiene practitioner must complete 500 hours of directly supervised practice before practicing “under general supervision;” ADHP may provide various services “without the supervision or direction of a dentist” but such services must be “authorized by the collaborating dentist . . .”); S.B. 193 § 317-A:22-b(II) (N.H. 2013) (“dental therapy services may be provided . . . without the patient first seeing a dentist for examination, diagnosis, or treatment plan if the supervising dentist has provided the dental therapist with written authorization . . .”); S.B. 567, 51st Leg., 1st Sess. § 61-5A-4(N) (N.M. 2013) (“A dental therapist-hygienist shall practice under the general supervision of a dentist pursuant to a written supervision agreement . . .”), § 61-5A-3(S) (“‘general supervision’ means . . . a dental therapist-hygienist” executes procedures “while the dentist is not physically present in the facility . . .”); H.B. 273 § 612(a) (Vt. 2013) (practitioner provides services “under the general supervision of

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a dentist within the parameters of a collaborative agreement”), § 561(8) (“General supervision’ . . . need not be on-site”); H.B. 1516, 63rd Leg., Reg. Sess. § 2(2) (Wash. 2013) (Washington’s bill, which was the only one of these seven with a post-baccalaureate program, proposed two types of dental therapist, one with postsecondary education and no DH license; the other with post-baccalaureate education and a DH license. The scope of practice differs for these providers, but both may be supervised by a remotely-located dentist: “Dental hygiene practitioner’ . . . provides dental therapy under the off-site supervision of a dentist pursuant to a written practice plan contract . . . .”), § 2(3) (“Dental practitioner’ . . . provides dental therapy under the off-site supervision of a dentist pursuant to a written practice plan contract . . .”).

<sup>36</sup> See, e.g., H.B. 2157 § 2(c)(12), (13) (Kan. 2013) (dental practitioner may carry out the “diagnosis of oral disease” and “the formulation of an individualized treatment plan”); H.B. 274, 188th Gen. Court, § 2 (Mass. 2013) (advanced dental hygiene practitioner may carry out “an oral evaluation and assessment of dental disease and the formulation of an individual treatment plan . . . .”); S.B. 193 § 317-A:22-a(II)(r), (s) (N.H. 2013) (dental therapist may perform “oral evaluation and assessment of dental disease” and “Formulation of an individualized treatment plan . . . .”); S.B. 567, 51st Leg., 1st Sess. § 61-5A-4(L) (N.M. 2013) (dental therapy-hygiene practice includes “diagnosis of dental disease and the formulation of an individualized treatment plan”); H.B. 273 § 612(b)(18), (19) (Vt. 2013) (dental practitioner may perform “oral evaluation and assessment of dental disease” and “formulating an individualized treatment plan . . . .”); H.B. 1516, 63rd Leg., Reg. Sess. § 5(1), (2) (Wash. 2013) (both dental practitioner and dental hygiene practitioner may carry out the “Oral evaluation and assessment of dental disease and the formulation of an individualized treatment plan”).

<sup>37</sup> See, e.g., INST. OF MED., NAT’L ACADS., *ADVANCING ORAL HEALTH IN AMERICA* 102-105 (2011); Caswell Evans, *Guest editorial—introduction to the special issue*, 71 J. PUB. HEALTH DENTISTRY S1 (2011) (describing articles in a special issue of the Journal of Public Health Dentistry about dental therapists); Burton L. Edelstein, *Training New Dental Health Providers in the United States*, 71 J. PUB. HEALTH DENTISTRY S3 (2011).

<sup>38</sup> See, e.g. INST. OF MED., *supra* note 37, at 105.

<sup>39</sup> *Id.*; see also *Shortage Areas*, HEALTH RESOURCES & SERVS. ADMIN., <http://datawarehouse.hrsa.gov/Topics/ShortageAreas.aspx> (last visited Nov. 26, 2013) (showing maps of Health Professional Shortage Areas (HPSA) and Medically Underserved Areas/Populations (MUA/P)).

<sup>40</sup> See, e.g., *Dental Crisis in America: The Need to Expand Access, Hearings Before the Subcomm. On Primary Health and Aging of the Senate Comm. On Health, Education, Labor, and Pensions*, 112<sup>th</sup> Cong. 3 (2012) (statement of Christy Jo Fogarty, Registered Dental Hygienist, Master of Science, Oral Health Practitioner) (dental therapists with a “requirement for a dentist to be on-site” don’t “do much to improve access to care for vulnerable populations”). See also Paul Glassman, *Registered Dental Hygienists in Alternative Practice and Virtual Dental Homes*, in INST. OF MED., NAT’L ACADS., *THE U.S. ORAL HEALTH WORKFORCE IN THE COMING DECADE* 86, 87 (2009) (“To better accommodate all members of society, services need to be delivered in community locations where people work, live, plan, and attend school. Delivery of many oral health services do not require a fully equipped dental operatory . . . .”).

<sup>41</sup> See, e.g., Gustav P. Chiarello, *Competition and Consumer Protection*, in INST. OF MED., *supra* note 40, at 58.

<sup>42</sup> See, e.g., EDELSTEIN, *supra* note 23, at 34; *Dental Crisis in America: The Need to Expand Access, Hearings Before the Subcomm. On Primary Health and Aging of the Senate Comm. On Health, Education, Labor, and Pensions*, 112<sup>th</sup> Cong. 7 (2012) (statement of Christy Jo Fogarty, RDH, MSOHP) (“In addition to opening access, mid-level dental providers can also help decrease costs. Mid-level advanced dental therapists are paid far less than dentists therefore employment at places like Children’s Dental Services can decrease costs and provide safe, quality, effective dental care for those most in need.”).

<sup>43</sup> Burton L. Edelstein, *Examining Whether Dental Therapists Constitute a Disruptive Innovation in U.S. Dentistry*, 101 AM. J. PUBLIC HEALTH 1831, 1832 (2011).

<sup>44</sup> See, e.g., FTC Staff Letter to the Hon. Theresa W. Conroy, Connecticut House of Representatives, Concerning the Likely Competitive Impact of Connecticut House Bill 6391 on Advance Practice Registered Nurses (Mar. 19, 2013), <http://www.ftc.gov/os/2013/03/130319aprnconroy.pdf>; FTC Staff Testimony Before Subcomm. A of the Joint Comm. on Health of the State of West Virginia Legislature on the Review of West Virginia Laws Governing the Scope of Practice for Advanced Practice Registered Nurses and Consideration of Possible Revisions to Remove

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Practice Restrictions (Sept. 10-12, 2012), <http://www.ftc.gov/os/2012/09/120907wvatestimony.pdf>; FTC Staff Comment Before the Louisiana House of Representatives on the Likely Competitive Impact of Louisiana House Bill 951 Concerning Advanced Practice Registered Nurses (Apr. 20, 2012), <http://www.ftc.gov/os/2012/04/120425louisianastaffcomment.pdf>.

<sup>45</sup> Karen Fox, *CODA votes to establish standards for dental therapy education programs*, ADA NEWS, Aug. 9, 2011, <http://www.ada.org/news/6111.aspx> (quoting ADA statement). *See also* CODA, Minutes, Aug. 2010, at 31, [http://www.ada.org/sections/educationAndCareers/pdfs/coda\\_minutes\\_aug2010.pdf](http://www.ada.org/sections/educationAndCareers/pdfs/coda_minutes_aug2010.pdf) (by developing accreditation standards, the dental profession can “get in front of this issue and have a major role in shaping the scope of practice” of dental therapy licensure legislation); CODA, Minutes, Feb. 2012, at 21, [http://www.ada.org/sections/educationAndCareers/pdfs/coda\\_minutes\\_feb\\_2012.pdf](http://www.ada.org/sections/educationAndCareers/pdfs/coda_minutes_feb_2012.pdf) (By developing accreditation standards, “the Commission has the opportunity to define the scope of practice for dental therapists, as there are several different models, proposed in several different states and provides an opportunity to set the national standard.”).

<sup>46</sup> *See* MBD, *supra* note 28, at 18 (requests from UMN, MSU, the MDA, and MBD reflected “broad-based desire to initiate accreditation of dental therapy programs by CODA” and “References within the standards to the education resulting in a baccalaureate degree need to be expanded to recognize/encourage masters-level training [or beyond]”).

<sup>47</sup> *See* CODA ACCREDITATION STANDARDS, *supra* note 2. *See also id.* at 9, 2-20.

<sup>48</sup> *See id.* at 11 (new graduates must have sufficient skills “to begin dental therapy practice under the supervision of a licensed dentist who will be responsible for assessment of the implications of the patient’s medical condition, diagnosis, risk assessment, prognosis and treatment planning.”); 12 (“the dental therapist provides care to address the patient’s oral condition or needs under the supervision of a licensed dentist who will be responsible for assessment of the implications of the patient’s medical condition, diagnosis, risk assessment, prognosis and treatment planning.”); 26 (“graduates **must** be competent in providing oral health care within the scope of dental therapy under the supervision of a licensed dentist . . .”).

<sup>49</sup> Fox, *supra* note 45.

<sup>50</sup> Kelly Soderlund, *House workforce resolutions emphasize dentist’s role as team leader*, ADA NEWS, Nov. 1, 2010, <http://www.ada.org/news/5023.aspx> (discussing ADA resolutions on the performance of procedures by providers who are not dentists).

<sup>51</sup> *See infra* notes 62-63.

<sup>52</sup> INST. OF MED. & NAT’L RESEARCH COUNCIL, NAT’L ACADS., IMPROVING ACCESS TO ORAL HEALTH CARE FOR VULNERABLE AND UNDERSERVED POPULATIONS 234 (2011).

<sup>53</sup> Legislation could require dental therapy education programs to be consistent with programs in other states. *See, e.g.*, Maine 1094-AA(2)(B) (2013) (proposed legislation).

<sup>54</sup> We take no position on whether training in dental hygiene should be a required competency for a dental therapist. However, if the education and training of dental therapists overlaps with that of dental hygienists, a “dental hygiene track” for the dental therapy education standards could appropriately reduce redundant education and training. That should encourage licensed hygienists seeking career advancement to go into dental therapy. Assuming that a dental hygiene track would increase the number of dental therapists entering the field, especially ones who could provide both preventive and restorative care, that would enhance competition, with the potential for expanded access and lower costs. Accordingly, we answer CODA’s question on whether the proposed standards should be modified to support a dental hygiene track in the affirmative.

<sup>55</sup> *See, e.g.*, CODA, Minutes, Aug. 2011, at 23, [http://www.ada.org/sections/educationAndCareers/pdfs/coda\\_minutes\\_aug2011.pdf](http://www.ada.org/sections/educationAndCareers/pdfs/coda_minutes_aug2011.pdf).

<sup>56</sup> Fox, *supra* note 45. *See also supra* note 50 and accompanying text.

<sup>57</sup> Julie Satur et al., *Dental and Oral Health Therapists in Australia*, in INST. OF MED., *supra* note 40, at 74.

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<sup>58</sup> INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 52, at 133. *See also* Satur et al., *supra* note 57, at 75. (Research has “demonstrated that the quality of care provided by dental therapists for the services they provide is equivalent to that of dentists”).

<sup>59</sup> INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 52, at 133. *See also* 25 U.S.C. § 1616*l* (2013). DHATs work primarily under the supervision of a remotely-located dentist. *See supra* note 21.

<sup>60</sup> WETTERHALL ET AL., *supra* note 21, at ES4.

<sup>61</sup> *Id.* at 5.

<sup>62</sup> *See* CODA, ACCREDITATION STANDARDS FOR DENTAL HYGIENE EDUCATION PROGRAMS (2013), <http://www.ada.org/sections/educationAndCareers/pdfs/dh.pdf>; CODA, ACCREDITATION STANDARDS FOR DENTAL ASSISTING EDUCATION PROGRAMS (2008), <http://www.ada.org/sections/educationAndCareers/pdfs/da.pdf>. Although CODA accreditation standards set forth competencies required of graduates, scope of practice is determined by state law, not an accreditation standard.

<sup>63</sup> ADA, BREAKING DOWN BARRIERS TO ORAL HEALTH FOR ALL AMERICANS: THE ROLE OF WORKFORCE 6 (2011), [http://www.ada.org/sections/advocacy/pdfs/ada\\_workforce\\_statement.pdf](http://www.ada.org/sections/advocacy/pdfs/ada_workforce_statement.pdf).

<sup>64</sup> *See* CODA, Minutes, Aug. 5-6, 2010, at 31, [http://www.ada.org/sections/educationAndCareers/pdfs/coda\\_minutes\\_aug2010.pdf](http://www.ada.org/sections/educationAndCareers/pdfs/coda_minutes_aug2010.pdf).