American Dental Hygienists' Association

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Mr. Donald S. Clark
Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Ave NW
Washington, D.C. 20580

Re: Comments on the Health Care Workshop, Project No. P131207

Dear Mr. Clark:

The American Dental Hygienists' Association (ADHA) applauds the Federal Trade Commission (FTC) for holding the March 20-21, 2014 workshop "Examining Health Care Competition." ADHA shares the FTC's convictions that competition is good for consumers because it expands access and choice, particularly in underserved communities, and that professional practice limits should be no stricter than patient protection requires. ADHA deeply appreciates the FTC's interest and engagement in health care generally and in the oral health sector specifically.

An active FTC presence in the oral health sector is necessary because too many Americans face unwarranted barriers to their ability to cost-effectively access needed oral health services. While many states, for example, are pioneering less restrictive regulations governing dental hygiene scope of practice, supervision, and settings, in other states unjustified constraints persist. ADHA is committed to working to open up additional entry points into the oral health care delivery system and to enable dental hygienists to practice to the full extent of their education and experience. As the links between oral health and total health continue to emerge, it is increasingly important to increase access to and coverage for oral health care services.

ADHA believes that the FTC is a demonstrated and powerful force for improving access to oral health care and for promoting competition in the oral health sector. Indeed, ADHA believes that the FTC is uniquely positioned to assist in removing unwarranted restrictions on the delivery of oral health services and in promoting innovative service delivery models in the oral health sector. For example, the parallels between the successful efforts to create the nurse practitioner in the medical field and the ongoing efforts to create a mid-level provider in the oral health field are striking. The FTC played an essential role in launching the advanced practice nurse and ADHA looks forward to a similar role for the FTC in in the oral health industry. As discussed below, the FTC's comprehensive comment letter on draft accreditation standards for new dental providers has already produced significant ameliorative changes to those draft standards, which

are an essential element of the multi-faceted effort needed to successfully create a new dental provider.

Accordingly, ADHA respectfully encourages the FTC to deepen its engagement in the oral health sector through enforcement, study and advocacy, and offers the following specific suggestions:

- ADHA urges the FTC to issue a policy paper on competition and the regulation of dental hygienists similar to the March 2014 *"Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses."*

- ADHA thanks the FTC for its December 2013 comment letter on the Commission on Dental Accreditation's (CODA) proposed *Accreditation Standards for Dental Therapy Education Programs.* The FTC comments rightly recognized that restrictive accreditation standards, like imposing dentist supervisory responsibilities over dental therapists, can "hamper efforts to promote the use of [new providers] to enhance competition and expand access to…services, especially in underserved areas." ADHA believes that the FTC comments spurred CODA to revise its draft accreditation standards and remove restrictions that might reduce competition, increase costs, and reduce access to care. Indeed, ADHA believes that when future health care workforce historians look back on the history of the oral health workforce, the aforementioned FTC comment letter will be viewed as the tipping point for a new profession, the oral health mid-level provider, and the introduction of more robust competition in the oral health care marketplace.

  CODA has again asked for public comment on its newly revised draft accreditation standards, and the ADHA encourages the FTC to not only comment once again on the revised standards by the December 1, 2014, deadline but to encourage CODA to finalize and adopt the standards.[1] Failure to promptly finalize accreditation standards for new oral health care providers would unnecessarily discourage efforts by states to explore dental workforce innovations.

- In 2009, Minnesota passed legislation creating two new types of dental providers: Dental Therapists and Advanced Dental Therapists. A February 2014 Report to the Minnesota Legislature on the early impact of these providers found that benefits attributable to the new providers include "direct cost savings, increased dental team productivity, improved patient satisfaction and lower appointment fail rates."[2] A "deeper dive" by the FTC into the Minnesota data to explore the legislation's effectiveness at improving access to care for vulnerable populations and maintaining quality of care would be a tremendous resource and tool for other states that are in the midst of their own oral health care workforce deliberations.

[1] *See* http://www.ada.org/sections/educationAndCareers/pdfs/propsed_dentaltherapy_apx5.pdf.
[2] *Available at* http://www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf.

- During the panel on professional regulation of health care providers, FTC staff asked for examples of "natural experiments" that the FTC could review to determine where professional regulation is or is not working to optimize competition. FTC staff also asked for examples of areas where more empirical research might be beneficial. The scope of practice for dental hygienists is regulated on a state-by-state basis. Currently, 36 states allow dental hygienists to initiate patient care in a setting outside of a private dental office without the presence of a dentist. These states' practice acts enable dental hygienists to practice in community settings and reach a variety of patient populations, particularly underserved populations. For example, Oregon and Colorado have progressive practice acts regarding dental hygienists, and Colorado specifically allows dental hygienists to practice without the supervision of a dentist for most services.[3] ADHA encourages the FTC to study these states and others with progressive practice acts and ascertain data on the role provided by dental hygienists and their effect on quality of care.[4]

- While there is no evidence base to support such restrictions, some states have restrictive practice acts that prevent dental hygienists from practicing to their full education, experience and ability by requiring burdensome and unnecessary supervisory restrictions. Indeed, a July 2011 Institute of Medicine Report Brief concluded that hygienists, dentists, and other providers can have overlapping scopes of practice and increase access to care "without compromising quality, safety or patient satisfaction."[5] Put simply, these states do not have the data necessary to continue to support these professional barriers to competition. Accordingly, the ADHA encourages the FTC to explore why some states limit the dental hygiene scope of practice and the settings in which a dental hygienist may provide services without any evidence base to support such restrictions.

- A number of states are actively exploring new dental workforce models. Regrettably, earlier this year in Maine, for example, legislation to create new dental providers that would increase access to care for the dentally underserved was amended to require direct dentist supervision even though no empirical evidence was presented to support the supervision requirement. ADHA – which has state and local organizations throughout the country – will encourage our state associations that they should, when appropriate,

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[3] COLO. REV. STAT. § 12-35-124 (2010).

[4] See e.g., HRSA's National Center for Health Workforce Analysis Dental Hygiene Professional Practice Index (DHPPI), which assessed the impact of dental hygienists on access to care for underserved populations. The findings of this 2004 study suggest that expanding the professional practice environment of dental hygienists improves access to oral health services, utilization of oral health services and oral health outcomes. The study noted that "more can be done to increase the impact of these professionals [dental hygienists] on improved access and quality of care and reduced costs of care. More can be done to align DH [dental hygiene] scope of practice with demonstrated DH [dental hygiene] clinical skills and competencies." Health Resources and Services Administration, The Professional Practice Environment of Dental Hygienists in the Fifty States and the District of Columbia, 2001, National Center for Health Workforce Analysis, Bureau of Health Professions, Rockville, MD, 2004.

[5] *Available at* http://www.iom.edu/~/media/Files/Report%20Files/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations/oralhealthaccess2011reportbrief.pdf.

encourage state legislators to invite FTC staff to weigh in on dental access legislation, and we hope the FTC will be receptive to such overtures.

This is important because we know that this type of FTC intervention can be very impactful. In November 2011, for example, FTC staff commented on Maine's proposed rules to implement a 2-year pilot project for independent practice dental hygienists (IPDHs) to process certain dental radiographs in underserved areas in Maine.[6] In that letter, the FTC explained that the proposed restrictions [limiting hygienists from taking certain types of x-rays), "would impede the development of new arrangements for delivering oral health care services in ways contrary to the very intent of the pilot project. Notably, the Notice [proposing the restrictions] does not provide any statement of the Board's basis for its proposed restrictions. Nor does the Notice cite to evidence – and we are aware of no evidence – that allowing licensed IPDHs independently to process the x-rays that the proposed rule would restrict is likely to harm the public. Absent such evidence, the proposed restrictions could have the unfortunate effect of harming the members of the public by limiting their choices, limiting access or oral health care, and impeding price competition. Therefore, the FTC staff at this time believes that the residents of Maine in underserved areas would be better served if the Board eliminates the restrictions."

ADHA appreciates the opportunity to provide these suggestions. The nation's oral health access crisis demands new ways of safely and effectively delivering oral health services. Over the past 20 years, the number of dental Health Professional Shortage Areas (dental HPSAs) has increased dramatically, from 800 in 1993, to more than 2,300 in 2010, to approximately 4,800 in 2014.[7] In addition, more than 2,000 facilities, including HRSA-supported Health Centers and some Rural Health Clinics, have been added as shortage facilities since 2002. This means that more than 49 million Americans live in areas without enough dental practitioners.[8]

The Department of Health and Human Services estimates that more than 7,000 additional dentists would be needed to eliminate the current dental workforce shortage in underserved areas.[9] More than 20 million Medicaid-eligible children did not receive any dental or oral health services in fiscal year 2012. This means that fully 56% of Medicaid-eligible children – who have dental insurance coverage and benefits through Medicaid's Early and Periodic Screening, Diagnosis and Treatment program – did not receive any dental or oral health service in fiscal year 2012.[10]

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[6] *See* http://www ftc.gov/os/2011/11/111125mainedental.pdf.
[7] *See* http://www hrsa.gov/shortage/ and http://www hrsa.gov/publichealth/clinical/oralhealth/workforce.html.
[8] *See* http://www hrsa.gov/publichealth/clinical/oralhealth/workforce.html.
[9] See http://www.hrsa.gov/shortage/.
[10] Annual EPSDT Participation Report Form CMS-416 (National) Fiscal Year: 2012, Line 12g, December 23, 2013. Available as zip file download under EPSDT Data at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment html.

A major factor hindering children and adults' access to dental care is the dentist shortage that exists in many areas of the country. In six states, at least 20% of the population has little or no access to dentists.[11] Not surprisingly, preventable dental conditions were the primary reason for 857,712 emergency room visits in the United States in 2011.[12] Dental problems adversely impact the nation's workforce, causing an estimated 164 million hours of lost work time each year, and dental problems can inhibit a person's ability to find a job.[13] Further underscoring the nation's oral health access crisis, 52% of new armed forces recruits were determined to be Class 3 in "dental readiness," which means that they had oral health problems requiring urgent attention that delayed overseas deployment.[14] Despite the fact that dental caries (tooth decay) is largely preventable, dental caries is the single most common chronic childhood infection, five times more common than asthma. While dental caries has significantly decreased for most Americans over the past four decades, the National Institute of Dental and Craniofacial Research reports that "this downward trend has recently reversed for young children."[15]

Rigorous research demonstrates the quality, safety and cost-effectiveness of services provided by oral health mid-level providers.[16] Alaska, Minnesota and 52 other countries already utilize dental mid-level providers. ADHA views dental mid-level providers as part of a comprehensive, team-based approach to the delivery of oral health services.

ADHA, founded in 1923, is the largest national organization representing the more than 150,000 registered dental hygienists in the United States. ADHA works to improve access to oral health care services and advocates in support of federal oral health programs, expanding access to care for underserved populations, optimizing the dental workforce, and maximizing coverage for oral health services. To become a dental hygienist in the United States, an individual must graduate from one of the 335 accredited dental hygiene education programs in the United States and successfully complete a national written exam and a state or regional clinical exam.

Dental hygienists are prevention specialists in oral health. The dental hygiene profession is one of the fastest growing health care professions, with employment of dental hygienists expected to grow 33% between 2012 and 2022.[17] As a January 2014 Paper by the National Governors Association on *"The Role of Dental Hygienists in Providing Access to Oral Health Care"* noted, "increased use of dental hygienists can promote access to oral health care, particularly for

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[11] *See* http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/In_search_of_dental_care.pdf.
[12] HCUPnet, Healthcare Cost and Utilization Project, "Information on ED visits from the HCUP Nationwide Emergency Department Sample (NEDS)," "Agency for Healthcare Research and Quality, Rockville, MD http://hcupnet.ahrq.gov/.
[13] U.S. Department of Health and Human Services, *"Oral Health in America: A Report of the Surgeon General,"* DHHS, Rockville, MD 2000.
[14] T.M. Leiendecker, G.C. Martin et al., "2008 DOD Recruit Oral Health Survey: A report on Clinical Findings and Treatment Need," Tri-Service Center for Oral Health Studies (2008), 1.
[15] *See* https://www nidcr nih.gov/DataStatistics/FindDataByTopic/DentalCaries/.
[16] *See, e.g.*, Testimony of S. Gehshan before the Minnesota Senate Committee on Health, Housing and Family Security, March 11, 2009.
[17] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook*, 2014-15 Edition, Dental Hygienists, http://www.bls.gov/ooh/healthcare/dental-hygienists htm.

underserved populations, including children" and "such access can reduce the incidence of serious tooth decay and other dental disease in vulnerable populations."[18]

ADHA applauds the FTC's increasingly visible role in advancing competition in the delivery of oral health services, and ADHA deeply appreciates the FTC's attention to the topic of professional regulations and how those regulations may impede innovation, inhibit competition, increase costs, and reduce access to care, particularly for the most vulnerable populations in the United States.

With the continued willingness of the FTC to scrutinize the oral health sector, we look forward to a future where the oral health marketplace is free from the constraints of anti-competitive behavior so that access and quality will improve and cost will decrease.

Please do not hesitate to contact either of us or ADHA Director of Governmental Affairs Ann Lynch (312.440.8942 or annl@adha.net) or ADHA Washington Counsel Karen Sealander at McDermott Will & Emery (202.756.8024 or ksealander@mwe.com) with questions or for further information.

Sincerely,

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[18] *Available at* http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf.