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September 14, 2022

Mr. Shane Rogers
Designated Federal Official
Advisory Committee on Training in Primary Care Medicine and Dentistry
Division of Medicine and Dentistry
Bureau of Health Workforce
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857
srogers@hrsa.gov

Dear Mr. Rogers:

On behalf of its 40,000 members, the Academy of General Dentistry (AGD) would like to express its deep concerns with the Advisory Committee on Training in Primary Care Medicine and Dentistry's (ACTPCMD) recommendations in its Nineteenth Annual Report: *Supporting Dental Therapy Through Title VII Programs: A Meaningful Strategy for Implementing Equitable Oral Health Care*.[1]

The AGD strongly believes that all patients deserve the highest quality of care exemplified by the "dental home" wherein general dentists provide the full range of oral health care and coordinate specialty services when indicated and appropriate. Increasing access to dental care via a "dental home" allows all patients to be treated by the most highly educated and trained provider, the dentist. Allowing dental therapists to practice without supervision creates a two-tiered system of care where those most in financial need, who often have the most complicated dental needs, do not receive the same quality of care as those who receive care from a dentist.

Instead of creating a secondary, lesser-trained level of provider, improving access can be better dealt with by increasing Medicaid reimbursement for dental care and by expanding loan repayment programs to incentivize dentists to practice in underserved communities, among other initiatives.

Increasing oral health literacy will also assist in improving oral health access and outcomes. The AGD supports H.R. 4555, the Oral Health Literacy and Awareness Act, as a method to increase utilization of oral health care. The bill would establish a public health education campaign across existing HRSA programs. Improving oral health literacy would address the fact that less than half the population visits a dentist on an annual basis and that unplanned dental emergencies are responsible for the loss of more than 34 million school hours and $45 billion in productivity every year.

[1] https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/primarycare-dentist/reports/actpcmd-19th-report-dental-therapy.pdf

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Specifically, the AGD proposes the following steps to help increase access to care by incentivizing practice in underserved areas:

1. Extend the period during which student loans are forgiven to 10 years, without tax liabilities for the amount forgiven in any year;
2. Provide tax credits for establishing and operating a dental practice in an underserved area;
3. Offer scholarships to dental students in exchange for committing to serve in an underserved area;
4. Increase funding of and statutory support for expanded loan repayment programs (LRPs);
5. Provide federal loan guarantees and/or grants for the purchase of dental equipment and materials;
6. Increase appropriations for funding an increase in the number of dentists serving in the National Health Service Corps and other federal programs, such as Indian Health Service (IHS) and programs serving other disadvantaged populations, and HHS-wide loan repayment authorities;
7. Actively recruit applicants for dental schools from underserved areas; and
8. Assure funding for Title VII GPR and Pediatric Dentistry Residencies.

The AGD also supports these steps to facilitate effective compliance with government-funded dental care programs to achieve optimum oral health outcomes for indigent populations:

1. Raise Medicaid fees to at least the 75th percentile of dentists' actual fees;
2. Eliminate extraneous paperwork;
3. Facilitate e-filing;
4. Simplify Medicaid rules;
5. Mandate prompt reimbursement;
6. Educate Medicaid officials regarding the unique nature of dentistry;
7. Provide block federal grants to states for innovative programs;
8. Require mandatory annual dental examinations for children entering school (analogous to immunizations) to determine their oral health status;
9. Encourage culturally competent education of patients in proper oral hygiene and the importance of keeping scheduled appointments;
10. Utilize case management to ensure that the patients are brought to the dental office; and
11. Increase general dentists' understanding of the benefits of treating the indigent.

Access issues can be better addressed by the proposals outlined above rather than the utilization of dental therapists. The oral health access problem is not caused by a shortage of dentists. The number of dentists is expected to continue to increase until at least 2040. A study by the American Dental Association's Health Policy Institute concluded that the number of dentists per 100,000 people will rise from 60.7 in 2020 to 67.0 in 2040.[2]

[2] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_0521_1.pdf

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The difficulties states have had creating dental therapy educational programs attests to the lack of need for dental therapists. Vermont passed a law in 2016 allowing dental therapists to practice in the state. Yet there are still no practicing dental therapists in the state. Despite obtaining multiple grants the training program in Vermont has never been initiated. Similarly in Maine, which passed dental therapy legislation in 2014, the first dental therapist was licensed in 2021, after being educated in Minnesota.

Since care by dental therapists is reimbursed at the same rate as care provided by dentists, increasing the number of dental therapists will not increase patient access or decrease costs for the patient, insurers or the government. What will have a greater impact is supporting dentists in filling the large number of vacant dental hygienist and dental assistant positions, since a lack of staffing resulting from the pandemic is keeping many dentists from scheduling patients.[3]

The comparison of dental therapy expectations in the United States versus dental therapy practices in other countries is inapposite as even proponents of dental therapy recognize that in most countries dental therapists see children in public settings only, while in the United States, dental therapists are expected to see patients of all ages in both private and public settings.[4]

For all the above reasons AGD strongly disagrees with the recommendations included in ACTPCMD Annual Report. If you have any questions please contact Daniel J. Buksa, JD, Associate Executive Director, Public Affairs, by phone at (312) 440-4328 or via email at daniel.buksa@agd.org.

Sincerely,

Gerald J. Botko, MS, DMD, MAGD
President
Academy of General Dentistry

Myron (Mike) Bromberg, D.D.S.
Congressional Liaison
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GJB:jjf

[3] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/aug2022_hpi_economic_outlook_dentistry_report_main.pdf?rev=d3cc10bc451d48a1b175bf2940bf757c&hash=2ABAE5217EF18DD00215C774944DC290
[4] https://pubmed.ncbi.nlm.nih.gov/28898427/