Comprehensive Dental Therapist Legislative Toolkit

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Introduction

On September 7, 2018, the AGD hosted the Midlevel Provider Conference at its Chicago Headquarters, with the goal of discussing advocacy strategies and tactics to combat legislation seeking to create midlevel providers, as well as alternative access to care solutions that can be proposed to legislators.

This toolkit grew out of that Conference and should be used as a resource by AGD constituents to assist in their legislative advocacy efforts on the midlevel provider issue.

In 2009, Minnesota became the first state to authorize dental therapists to be licensed and to practice statewide. Minnesota's dental therapist educational programs graduated their first classes in 2011.

Since then, eleven other states have enacted dental therapy legislation: Arizona, Colorado, Connecticut, Maine, Michigan, Nevada, New Mexico, Oregon, Vermont, and Washington.

In addition, Dental Health Aide Therapists (DHAT) practice on federally-recognized tribal lands on members of federally-recognized tribes. Federal law requires state legislatures to authorize the licensure of DHATs. DHATs have been practicing in Alaska since 2004, and more recently were authorized in Washington, Montana and Idaho.

NOTE: This toolkit may be used as a resource exclusively to address actual midlevel provider legislation. The AGD expressly prohibits and disclaims use of this toolkit, or any part thereof, for any purpose other than as stated herein.

If you have any questions, or would like further information regarding this toolkit, please contact AGD Government Relations at advocacy@agd.org.

Common Midlevel Provider Arguments and Counterarguments

Safety

Given the lower training and education requirements for dental therapists, and their authorization to carry out irreversible surgical procedures, patient safety is an obvious concern. As such, midlevel provider proponents have adapted and retooled their arguments in response to organized dentistry's campaign and will cite literature finding that dental therapists have practiced without patient safety being compromised. Additionally, midlevel provider proponents have referred to CODA's passage of dental therapist accreditation standards as supporting their arguments about patient safety.

Therefore, while patient safety remains a critical concern, it should not be put forth as the primary argument in opposition to midlevel providers in testimony.

However, patient safety continues to be a concern and can still be an effective talking point to use at the interpersonal level with legislators, as the issue conjures images and draws emotional reactions. For example, you may ask a legislator, "Would you be comfortable with an individual with just three years of training carrying out an irreversible surgical procedure using a 500,000 rpm handpiece on your grandchild?"

Efficacy

With several years of data since the program's implementation in 2011, the Minnesota dental therapist program provides organized dentistry with many data points regarding the efficacy of the program in delivering access to care to underserved areas.

As of September 2023, there were 143 dental therapists licensed in Minnesota. A study from September 2019 by the Office of Rural Health and Primary Care of the Minnesota Department of Health showed that 64% of therapists practice in the Twin Cities and 73% practice in metropolitan areas. The Twin Cities have partial HPSAs compared to most of the rural counties that are full HPSAs.

In April 2017, the U.S. Centers for Medicare and Medicaid Services (CMS) sent a letter to the Minnesota Department of Health, warning that access and utilization rates of Medicaid dental

benefits among children in Minnesota had fallen so low that the state was in danger of losing federal funds.

The letter states:

“There are indications both that Minnesota children enrolled in Medicaid do not currently have sufficient access to dental services and that not enough dental providers participate in Minnesota Medicaid to ensure access to dental care for the state’s child enrollees.”

The letter cites Minnesota’s low Medicaid dental reimbursement rates as a cause for the low access and utilization rates.

As such, Medicaid-eligible children’s access to care declined in the period since the dental therapist program was implemented. This happened despite the requirement for dental therapists to practice in areas where their patient base would consist of at least 50% Medicaid eligible patients.

International Programs

Dental therapists currently are authorized to practice in 54 countries, including New Zealand, where they originated in 1921. The focus of dental therapy internationally is children in public settings such as schools.

In 2012, a study funded by the W.K. Kellogg Foundation entitled “A Review of the Global Literature on Dental Therapists”, and authored by David Nash, DMD, MS, Ed.D, Jay Friedman, DDS, MPH, and Kavita Mathu-Maju, DMD, MPH, was published. The study is still cited by midlevel provider proponents as validating the dental therapist model as effective in increasing access to care.

However, the same authors published a 2017 paper, “The Dental Therapist Movement in the United States: A Critique of Current Trends” in the Journal of Public Health Dentistry. In it, the authors criticize the dental therapist model as it has been proposed and implemented in the U.S. and concede that allowing dental therapists to work in private practice and on adults exhibiting complex oral conditions is not consistent with the effectiveness they observed in international dental therapist programs.

Free Market

Midlevel provider proponents will often use a messaging strategy which frames the dental therapist model as a free market solution to the access to care issue and restrictions on non-dentists performing surgical and irreversible procedures as an example of regulatory overreach.

However, the experience of states where dental therapy has been authorized shows that the market does not favor dental therapy.

Canada's dental therapist program, established in the 1960s, was entirely subsidized by federal and provincial governments, and required dental therapists to work in rural, public settings. When they were authorized to practice in private settings in 1978, most dental therapists moved to urban and suburban areas where there were no shortages of providers. When federal funding was eliminated for their dental therapist training programs in 2011, they were unable to sustain themselves and shut down. A new training program just opened in Saskatchewan in 2023 funded by Indigenous Services Canada, a federal government agency. There are currently about 300 dental therapists practicing in Canada, many in tribal territories.

Dental Health Aide Therapist (DHAT) programs operating in Alaska, Oregon, and Washington are similarly subsidized by the federal government, and require DHATs to practice in tribal territories and on tribal members.

If dental therapists represented a free market solution, they would be self-sufficient and would not require subsidies. Legislators should be informed of government and other subsidies dental therapist programs have received. One such example is the grant received by Vermont Technical College by the U.S. Health Resources and Services Administration (HRSA). To implement a CODA-accredited dental therapist program, the College received a $1.6 million HRSA grant. In total over $2.6 million has been spent since 2016, but a dental therapy program is still years away from starting.

Of the eleven states that have authorized dental therapy there are 143 licensed DTs in Minnesota, 13 in Oregon, 2 in Maine (one with a New Jersey address) and 1 in Colorado (with a South Carolina address). The other seven states have zero licensed dental therapists.

One argument proponents make is that dental therapy will lower costs to the states. In most states, Medicaid reimburses by procedure not provider type so dental therapists would be reimbursed by Medicaid at the same rate as dentists for a procedure, so the state would realize no savings by having dental therapists.

Alternatives to Midlevel Providers

When presented with the Pew Charitable Trusts and W.K. Kellogg Foundation's talking points and accompanying literature in support of dental therapists, legislators often fall victim to the Politician's Fallacy: "We must do something; this is something; therefore, we must do this."

For this reason, legislators will respond more favorably to arguments debunking myths related to dental therapists when they are coupled with steps organized dentistry has taken to address access to care, as well as an action plan going forward. This may require working with your state dental association, or another like-minded organization.

Constituents may consider following an example set by the Maryland State Dental Association, when they presented a multiple step action plan to increase access to care to the legislature in response to dental therapist legislation, which entailed:

1. Establishing an adult dental Medicaid benefit
2. Increase reimbursement rates for pediatric dental Medicaid
3. Establishment of an ER diversion program
4. Continue training of Community Dental Health Coordinators (CDHCs)

In Michigan, the Michigan Dental Association (MDA), with the Michigan AGD's support, proposed to the legislature modifying the state's P.A. 161 program, which enables hygienists to practice in underserved areas, under the supervision of a dentist. The proposal was a logical counterpart to the assertion that Michigan's existing workforce is adequate.

The Wisconsin AGD used an AGD Advocacy Fund grant to work against dental therapy legislation. In conjunction with their opposition to dental therapy, Wisconsin AGD supported legislation to license expanded function dental auxiliaries and successfully lobbied to get a 40% increase in Medicaid dental reimbursement rates as ways to address access to care issues.

Below are alternatives to increase access to care commonly proposed in state legislatures:

Student Loan Forgiveness Incentives

According to the American Dental Education Association (ADEA), the average student loan debt for indebted dental school graduates in the class of 2022 was $293,900. This high level of debt puts pressure on new dentists to pursue opportunities in areas that will provide the most immediate income, commonly in urban and suburban areas, where there are no dentist shortages.

Loan forgiveness programs provide a means of improving access to care, by incentivizing dentists to practice in rural or otherwise underserved areas. A full list of loan forgiveness programs is available here.

Some examples include:

Maine
The Maine Dental Education Loan Program provides up to $25,000/year in loan forgiveness for up to four years.

Utah
The Utah Health Care Workforce Financial Assistance Program provides up to $25,000/year in loan forgiveness for dentists for three years.

Alabama
Alabama provides scholarships to students who agree by contract to practice for one to two years in underserved communities.

Mississippi
The Mississippi Rural Dentists Scholarship Program was created in 2013, and provides up to five recipients with a $35,000 scholarship to attend the University of Mississippi Medical Center School of Dentistry. Upon graduation, recipients are required to practice in a rural area for four years.

Alaska
The Alaska program provides for $35,000 to $47,250 in incentives and loan forgiveness.

Nevada
In 2023 Nevada passed the Student Loan Repayment for Providers of Health Care in Underserved Communities Program which provides for up to $120,000 in loan forgiveness.

West Virginia
West Virginia provides scholarships and loan forgiveness for dentists who agree to practice in underserved communities.

Medicaid Dental Benefits and Reimbursement Rates

Pew and other dental therapy proponents assert that dentists simply do not want to practice in underserved areas or accept Medicaid patients. Pew repeatedly says that the rate of dentists

accepting Medicaid is lower than that of physicians; however, they fail to make any mention of the differences in Medicaid coverage and reimbursement rates between medicine and dentistry.

Research has shown that among the most significant factors contributing to low dentist participation in Medicaid is low reimbursement rates. When Medicaid reimbursement rates are increased, dental care utilization, as well as dentist participation in Medicaid, will also increase.

Data from the ADA Health Policy Institute of 2022 Medicaid fee-for-service reimbursement for adult dental services versus average dentist charges showed a range from 13.3% in New Jersey to a high of 76.9% in Delaware. For children the range between Medicaid and average rates goes from 24.4% in Illinois to 78.9% in Delaware.

A 2008 study by the National Academy for State Health Policy (NASHP) examined the effects of increasing reimbursement rates on access to care for Medicaid beneficiaries. In the six states studied "provider participation increased by at least one-third, and sometimes more than doubled, following rate increases. Not only did the number of enrolled providers rise, but so did the number of patients treated. Patients' access to care, as measured by the number of enrollees using dental services, also increased after rates rose." The study found that easing administrative burdens is also a necessary reform.

ER Diversion Programs

Emergency Room diversion provides a framework by which patients can address their dental needs before they become emergencies. One aspect is the development of "Dental Homes" whereby patients are connected to a dentist who can provide routine preventive and restorative care. This is closely tied to Medicaid and the benefits provided to patients in their state. If a patient has a regular dentist and is able to receive regular preventive and restorative care, dental problems can be addressed before they become emergencies, saving money and time and improving oral health.

Community Dental Health Coordinator (CDHC)

The ADA's CDHC program trains dental hygienists and dental assistants to provide oral health prevention, patient navigation, and case management services to patients. The curriculum for CDHCs has been released by the ADA for free, can easily be integrated into existing dental hygiene or dental assisting programs and is truly a tax dollar neutral, free market solution to unmet dental need.

CDHCs are currently working in 48 states and educational programs to become a CDHC are available in many states. Legislators respond positively to testimony about successful CDHC programs in their states.

Interacting with Legislators

Building relationships with legislators is the central component to any advocacy program. Whether you already have an established relationship with a legislator, or are trying to create one, it is critical to schedule meetings with them on an ongoing basis.

Your meeting can take place either at the legislator's office, or at your own practice. Hosting a legislator at your practice has the added benefit of familiarizing them with the operations of a dental practice, and the constituent outreach that can be publicized by the legislator.

Be sure to introduce the AGD to the legislator, and let them know that we are an educational organization with 40,000 general dentist members. Remember that you are speaking on behalf of the AGD, so familiarize yourself with the AGD's policy on midlevel providers.

If you are meeting your legislator alongside other colleagues, formulate and review a plan to ensure all relevant talking points will be covered, and who among your group will cover which points. Do not provide an opportunity for the legislator to dismiss you early if there is lag in the conversation.

When discussing issues with legislators, AGD members must communicate policies in a respectful and measured manner, regardless of the legislator's viewpoint on a given issue. Some legislators may have pre-conceived notions that organized dentistry is motivated by self-interest in advocating against midlevel providers. An overly disagreeable approach is unlikely to make headway, particularly when the oral health care of a legislator's constituents is the topic of debate.

Instead, frame your interactions with legislators as a productive, back-and-forth dialogue. Make sure they know you want to be part of the solution. Make clear that your primary interest as a dentist is the oral health of your patients, and support this by providing examples, such as volunteer work, Medicaid patients, or a particular story in which you made sure your patients received the care they needed, regardless of the personal sacrifice.

Throughout your dialogue, emphasize the extent of the training you received to become a dentist. Make sure they are aware that you are a surgeon, and are carrying out surgery all day long. As a general dentist, your expertise on oral health care is unmatched. Conversely, given the nature of their job, legislators tend to have a generalist knowledge base. Avoiding technical jargon and

speaking plainly will ensure your legislator is aware of exactly what skills and knowledge you possess, so that the gap between a dentist and dental therapist is fully exposed.

Do not be afraid to discuss low Medicaid reimbursement rates with legislators, or administrative hurdles. Many state legislators are also businesspeople, and they will understand that a dental practice simply cannot stay in business when reimbursement rates are too low. Within this context, be sure to tell them about any time you have provided services for free. This will help to illustrate that, as a dentist, you are doing everything possible to provide care, and combat the perception of self-interest.

Whenever possible, include dental students in your meetings. Legislators typically respond well to the enthusiasm dental students bring and will be more receptive to the overall message. Also, dental students can illustrate and personalize for legislators the challenges presented by dental student loan debt, and how it affects their career choices. Finally, including students in legislator meetings has the long-term benefit of helping to recruit and mentor future leaders in organized dentistry.

Make sure this meeting with your legislator is either the beginning of a long-term relationship, or the maintenance of an existing one. Reach out to your legislator again in the future, even on other issues. Doing that will help you develop a positive relationship and could one day result in your legislator reaching out to you for input.

Strengthening AGD Constituent Advocacy

Each AGD constituent varies in terms of their membership, resources, and political capital. Even if your constituent is smaller and traditionally has limited involvement with advocacy, there are steps you can take to increase your presence at the state capitol, and the AGD is ready to assist you.

Successful dental advocacy requires knowledge and action. Now that you know what the issue is, it’s time to take action, which can be as simple as:

- Responding to an AGD action alert
- Visiting legislators
- Telephoning a legislator’s office or connecting with staffers
- Attending town hall meetings or fundraisers (maybe even hosting one)
- Encouraging your colleagues to voice their concerns
- Presenting testimony at hearings.

Each of these actions is easy to do and can be successful –especially if it's combined with the voices of your colleagues.

State Capitol Visit Days

At the national level, the AGD hosts an annual Hill Day, in which invited members fly to Washington, D.C. to visit with their legislators or appropriate legislative staff in their offices.

Similarly, some AGD constituents either conduct their own state capitol visit days or participate alongside their state dental association. Participating in such an event has many benefits for an advocacy program. When they are highly attended, these events lend a high degree of visibility to the issue being advocated, while providing a show of strength on the part of organized dentistry for legislators.

State capitol visit days may also serve as an introduction for some members who have not traditionally been active in advocacy, but would like to get involved.

If your constituent is considering planning a capitol visit day, the AGD's Hill Day may serve as a useful model. AGD Hill Day is a two day program, and is held at an event space close to Capitol Hill. The first day's activities aim to prepare the attendees for their meetings, with panel presentations given by legislators, legislative staff, or AGD members on issues, as well as best practices for meeting with legislators. Additionally, the AGD presents an award for a Member of Congress who has demonstrated their commitment to sound oral health policies.

On the second day, attendees meet with their legislators or their staff.

When planning your constituent's state capitol visit day, take into consideration:

Your issue
While midlevel providers will be the general issue, familiarize yourself with the specific legislation being proposed in your state. Consider the provisions in the bill such as practice settings, authorized procedures, supervision levels, and training and education requirements. Also, find who the sponsors of the bill are, what committee it has been assigned to, and what activity has taken place relative to midlevel provider bills in past legislative sessions.

Handouts and Messaging
Create a one-page handout that succinctly describes for legislators what is being proposed with regard to midlevel providers, why the AGD is opposed to it, and what alternatives they may wish to consider.

Target critical members
Members of committees of jurisdiction for access to care and scope of practice issues will be the most critical members to target. Midlevel provider legislation is typically assigned to a given state's House or Senate Health Committee. For information on committee assignments, rosters, and hearing dates, please contact AGD Government Relations staff.

Make sure that each member of the pertinent committee is visited by an AGD member.

Follow-Up
Following your meetings, send a note to the legislator's office, thanking them for their time, briefly reiterating the issue, and offering your assistance going forward.

Advocacy Fund

Constituents are encouraged to apply to the AGD Advocacy Fund to fund certain one-time advocacy efforts. For example, a constituent can apply for funds to hire a lobbyist to assist them in their advocacy efforts, or to carry out a public affairs campaign.

To apply for funds, an Action Item Report (AIR) must be filled out, detailing your constituent's request and how the constituent is planning on using the funds. Next, the Legislative and Governmental Affairs (LGA) and Dental Practice (DP) Councils will review the AIR and offer input. Finally, the AGD Board makes the decision whether or not to disburse the funds.

If your constituent is interested in utilizing the Advocacy Fund, please contact AGD Government Relations staff at advocacy@agd.org. Please note that the Advocacy Fund cannot be used for the hosting of fundraisers.

Build Grassroots Support

While the AGD is the eyes, ears and voice of the general dentist, its representation of you and your profession are only as strong as the involvement of individual members.

AGD Government Relations staff monitors legislation and regulations relevant to dentistry at the state level.

The AGD encourages each constituent to appoint a legislative chairperson to monitor important issues and to alert the board of any pending legislation and/or regulation that could be problematic. In many cases, this individual also serves as the conduit for promoting discussion with the state dental association and other professional groups that might have a stake in the issue.

Be sure not to overlook the state dental board since this agency determines what is and is not allowed within the various scopes of practice. Because this agency is so important, AGD constituents are encouraged to have a member appointed to the board or, at the very least, to have a member attend dental board meetings to monitor the topics discussed and to present testimony when appropriate.

Action Alerts

AGD Government Relations staff can assist constituents in their advocacy efforts by issuing action alerts. The AGD can develop a form letter regarding a specific issue, and have it posted to the AGD website. Members typically have the option of editing the letters if they so choose before it is sent to their legislator(s). In most cases, constituent leaders work in partnership with AGD Headquarters' staff to develop blast emails and action alerts.

Build Coalitions

Cultivating relationships is the cornerstone of any successful grassroots advocacy campaign. It doesn't matter if those relationships are with legislators, their staffers, leaders of other dental associations or members of other professions who care about the issue.

Coalitions can make a difference since there is strength in numbers and other coalition members might have access to valuable information that can be shared with legislators. Your constituent and your state dental association likely already have an established relationship which in most cases can be used to send a strong and powerful message to legislators.

Host a Midlevel Provider Conference at the Constituent Level

It is important to remember that many AGD members are likely not as knowledgeable about the midlevel provider issue, or advocacy in general, as you are. Midlevel provider proponents are well-funded and well-resourced, and in order to defeat them in the legislative arena, and to promote effective oral health legislation instead, AGD members will have to be aware of what is at stake and be willing to take action.

Identify and organize a cadre of AGD members in your constituent who are passionate about advocacy, and willing to take action. Consider creating a "workforce workgroup," dedicated to disseminating and communicating legislative developments related to midlevel providers, setting up meetings with legislators, or conducting media outreach.