Midlevel Dental Provider

By Dr. C.J. Henley

The call for a midlevel dental provider[1] (MDP) in dentistry has grown in the past few years. Organizations like Pew Charitable Trusts and The W.K. Kellogg Foundation have been some of the most outspoken advocates of the development and implementation of the MDP. In a recent report, the Pew Center states, "State leaders, dentists, public health advocates and other stakeholders should be heartened to know that expanding the dental team is an effective strategy to improve access to care, but they cannot overlook the importance of setting adequate Medicaid reimbursement rates."[2]

Often, the need for the MDP is propagated on the basis that there is an acute need for dentists in the United States. According to a study recently published by the American Dental Association (ADA), the population of dentists in the U.S. will steadily grow through 2035.[3] Indicating that, as the population in the U.S. grows, so will the number of dentists. However, this is in stark contrast with a report published by the Health Resources and Services Administration that estimates it would take a net increase of nearly 9,500 providers to address the unmet need today.[4]

Studies that highlight Alaska as a success story for the implementation and use of MDPs offer more support. There was — and is —little doubt that there is a need to improve the access to dental care in Alaska. This is based on the fact that Alaska has the largest landmass in the U.S., but as of 2014 there were only 736,732 residents and more than 14 percent of Alaskans are American Indian/Alaska Natives. There are roughly 215 villages spread throughout Alaska. Often, these remote locations are only accessible by boat, bush plane or snowmobile. Many of these communities have no on-site dental services. For these reasons, MDPs have been successful at helping promote dental care in underserved areas such as remote Alaskan villages.[5] It is difficult to use Alaska as an "apples-to-apples" comparison to what is going on elsewhere in the U.S. due to the geographic uniqueness of the state.

It's interesting that the push to introduce the MDP has gained so much traction, when attempting to improve our existing system would logically seem to be the simplest path to improving access to dental care. I reached out to Pew and asked them just that. Why is there such an emphasis on the MDP as opposed to improving Medicaid reimbursement? John Grant, director of Pew's dental campaign, stated, "For dental policy, we work in states on proven, cost-effective solutions that improve access to dental care."

Often, the MDP is compared to a physician assistant (PA) or a nurse practitioner (NP). But, is that really a fair comparison? If the ultimate goal of the MDP is to provide care to the underserved, then the comparison to the PA or the NP cannot be made. A study published in 1997 stated that of the total NPs practicing in the U.S., 85 percent were located in metropolitan counties.[6] How is this geographic distribution of NPs serving any benefit to underserved populations in rural areas? A 2009 RAND study found that in Massachusetts, visits to NPs and PAs cost 20 to 35 percent less than visits to physicians.[7] However, many of the costs in dentistry are fixed, such as rent, staff, restorative materials and sterilization costs. With states such as Florida, Medicaid reimbursements hover around 35 percent of the usual and customary rate. With reimbursements at this rate, it will still be difficult to generate enough revenue to sustain a viable practice.

In a recent study published by the ADA's Health Policy Institute, it was noted that in 2007, the Texas Medicaid program increased dental reimbursement by more than 50 percent, implemented loan forgiveness programs for dentists who agreed to practice in underserved areas and allocated more funds to dental clinics in underserved communities. By 2010, dental care among Medicaid-enrolled children in Texas had increased so much that it exceeded the rate among children with commercial dental insurance.[8]

The Affordable Care Act made dental care for children an "essential health benefit" so

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it is easier for children to obtain Medicaid coverage. However, Ron Waters, a contributor of Forbes.com, recently wrote an article entitled, "Ow! If You Think the U.S. Medical Care System is Broken, Take a Look at Dental Care." In his article, he stated that in the U.S., Medicare provides health care to almost all elderly people in the country, but it specifically excludes dental care. Seniors may buy their own private dental insurance, but only 12 percent do so and less than half of Medicare recipients saw a dentist in the past year. So, the question stands, how can we improve the issue of access to dental care in the U.S.?

I don't think that any dentist would deny that as health care providers, we have an obligation to help care for our underserved populations. Fortunately, programs like *Give Kids A Smile* and the *Mission of Mercy* have helped thousands find desperately needed oral health care. However, as amazing as these programs are, they are just scratching the surface of what the U.S. needs in order to help patients who need dental care the most. An often cited story tied to the access-to-care issue is the story of Deamonte Driver — a young man who died from a dental abscess in 2007. Deamonte's death and the ultimate cost of his care, which totaled more than $250,000,[9] underscore our country's issues with access to dental care and the cost to our communities for failing to treat dental problems in a timely manner.

The vast majority of dentists cite the reason for not taking Medicaid because the reimbursements are too low, and the patients' likelihood to no-show appointments.[10] According to the ADA, making Medicaid reimbursement rates for dental care closer to commercial dental insurance levels, in conjunction with other reforms, could increase provider participation and access to dental care for Medicaid enrollees. In order to close the gap in dental care utilization between low-income and high-income adults, policy makers can look to the success stories and "promising practices" of states, such as Texas, in considering reforms to their Medicaid program.[11]

It also is imperative not to understate the difference between lack of access to care versus under-utilization. I worked for a dental service group that provided Medicaid dental services to children in need in Florida for nearly three years. While many of the patients were grateful, it also was clear that many parents and caregivers were not educated about the importance of oral health care for themselves and their dependents. It is possible that a lack of education with respect to dietary considerations, oral hygiene and failure to understand the importance of good dental care are at the crux of the problem.

I am not enthralled by the idea of dentistry following the current model of medicine in the U.S. I believe that what makes our profession so great is our ability to own our own businesses, control the quality of care that we provide and spend time with our patients. I worry that if we introduce MDPs, dental practices will become "mills" and if anyone has been in a physician's office recently knows that the larger the practice, the more likely you are to be "just a number." Moreover, I hate the idea of legislators who are not dentists advocating for MDPs when they are not on the frontline of dentistry every day and don't understand how a private practice functions. I fail to understand how the introduction of the MDP in the continental U.S. truly is going to have a significant impact on access to care. I would encourage our legislators to increase Medicaid reimbursements and eliminate the "red tape" associated with becoming a provider. Lastly, we can all help solve the problem today by regularly treating a limited number of patients in need in our offices. In my practice, we make it a point to extract teeth, place fillings and fabricate partials for patients who typically could not afford the care. We ask only for them to "pay what they can, when they can." Protecting our profession starts with each one of us, in our communities, helping the people who need it the most – and not with legislators in Tallahassee and Washington, D.C.

Endnotes:

1. It should be noted that depending on the state, various names have been developed to describe the MDP such as Advanced Dental Therapist (ADT), Dental Therapist (DT), and Advanced Dental Hygiene Practitioner (ADHP) with varying scopes of practice, however for this discussion all variants will be grouped as a MDP.
2. The Pew Center on the States. It Takes a Team; How New Dental Providers can benefit patients and practices. Washington, DC: The Pew Center, 2010.
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4. A Report from Chairman Bernard Sanders Subcommittee on Primary Health and Aging U.S. Senate Committee on Health, Education, Labor & Pensions February 29, 2012.
5. Shoffstall-Cone, Sarah, Williard, Mary; Alaska Dental Health Aide Program. Int J Circumpolar Health 2013, 72: 21198.
6. Lin, Ge, Burns Patricia, Nochajski Thomas. The Geographic Distribution of Nurse Practitioners in the United States. Applied Geographic Studies, Vol. 1, No. 4, 287–30, 1997.
7. Rand Corporation Policy Brief. Controlling Health Care Spending in Massachusetts. 2009.
8. Kamyar Nasseh, Ph.D.; Marko Vujicic, Ph.D.; Cassandra Yarbrough, M.P.P. A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services. Washington, DC: American Dental Association, 2014.
9. Otto, Mary. For Want of a Dentist. Washington Post. February, 28, 2007.
10. Galewitz, Phil. Medicaid Patients Struggle to Get Dental Care. USA Today. February, 15, 2015.
11. Nasseh, Kamyar Ph.D.; Vujicic, Marko Ph.D.; Yarbrough, Cassandra M.P.P. A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services. Washington, DC: American Dental Association, 2014.

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