

IS THIS THE END OF GENERAL DENTISTRY AS WE KNOW IT?



An Exploration of the Growing Challenges Facing the Profession

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The traditional practice of general dentistry has long painted a picture of the solo or small group practice, sometimes with the dentist's family members working at the front desk or as the dental assistant, providing care under a fee-for-service model.

This picture is not, however, at the core of what has made the traditional practice of general dentistry a cost-effective modality of care. Rather, the heart of the profession has been prevention-focused, patient-centered primary oral health care.

Over the past few years, the traditional practice of general dentistry has faced numerous challenges. Proponents of the midlevel provider continue to advocate before various states for these non-dentist practitioners to provide care without the direct or indirect supervision of a dentist. Meanwhile, the definition and scope of a dental "specialist" is evolving to increasingly overlap the practice of general dentistry.

At the same time, it has become increasingly challenging to manage the business of general dentistry. Specifically, many general dentists have been compelled to go in-network with PPOs in order to fill their chairs, despite dental insurers reducing fees and placing other restrictions and requirements upon participation. American Dental Association (ADA) data from 2012 indicated that not having to deal with dental benefits and other administrative issues was among the top reasons dentists opt to work in corporate dentistry settings or settings affiliated with a dental service organization (DSO), rather than in non-DSO settings. By having the ability to execute group buying power, with consolidated overhead, the growth of corporate dentistry challenges the individual dentist to be creative in efforts to stay competitive, be it partnering with other dentists to develop group practices or expanding the scope of his or her practice.



Last but not least, dentistry continues on its slow but deliberate march toward adopting a value-based approach to paying for care. Unlike strict fee-for-service models, value-based payment models relate payment to the value or quality of care provided, rather than strictly to the type or volume of services rendered.

These challenges do not stand independently of one another, but rather, paint a picture of a prospective compression and commercialization of primary care dentistry, to bring dentistry in greater alignment with medicine, but with a greater focus on population health outcomes.

THE MIDDLELEVEL PROVIDER

Midlevel providers are non-dentists who work outside of the dentist's direct or indirect supervision, and in some cases, diagnose and treat the dental patient. Some midlevel providers may have as little as two or three years of post-high school training and may be allowed to provide irreversible dental procedures.

In the United States, Minnesota, Maine and Vermont have implemented the midlevel provider model, while Alaska, Washington and Oregon allow these providers to practice solely in tribal areas. In 2016 and 2017, proponents of midlevel providers drove the introduction of legislation to implement this model in Massachusetts, Connecticut, Arizona, Kansas, Maryland, Michigan, New Hampshire, New Mexico, North Dakota, Ohio and Texas. Midlevel provider proponents have been largely unsuccessful in these states, but such legislation is expected to be reintroduced in these and other states in the coming years.

A concern is that using such providers for the care of underserved patients may not be economically feasible or in line with the prevention model. According to the May 2016 *AGD Impact* article, "A Review of the Minnesota Dental Therapist Model," the Minnesota Board of Dentistry reported that there were 42 licensed dental therapists in the state in June 2015. The article goes on to say that "two licensees lived out of state. During this time, only three DTs [dental therapists] practiced in the region defined in the Robert Wood Johnson Foundation study, and only eight practiced in HPSAs [Health Professional Shortage Areas]. More than a quarter practiced in Hennepin County, home to the state's largest city, Minneapolis, while 73 percent practiced in the seven-county Twin Cities metro area."

This is consistent with the findings of a 2005 ADA study, "The Economic Aspects of Private Unsupervised Hygiene Practice and Its Impact on Access to Care," which found that the overhead costs of maintaining a practice drove independent midlevel providers away from underserved areas.

IMPENDING CHANGES TO THE DEFINITION AND PRACTICE OF DENTAL SPECIALTIES

For years, many states have determined what constitutes a dental specialty based upon the recognition of specialties by the ADA. Recent cases have challenged this notion. Specifically, the American Academy of Implant Dentistry (AAID) has, along with other plaintiffs, filed suits in states such as Florida, Texas and, most recently, Indiana. The lawsuits successfully challenged, on United States constitutional grounds, regulations

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that deferred to ADA designations of specialty for determining when a dentist may advertise as a specialist.

In October 2016, the ADA House of Delegates (HOD) adopted ADA HOD Resolution 65, which amended Section 5.H. of the *ADA Principles of Ethics and Code of Professional Conduct* (or the "ADA Code") in two substantive ways.

First, Resolution 65 broadened the specialties that can be ethically announced to include not only ADA-recognized specialties, but also any specialty legally recognized by the dentist's state, provided that the dentist meets the educational requirements required for specialty recognition within that state.

Second, Resolution 65 declared it ethical for a dentist who announces or advertises as a specialist to practice in all facets of dentistry, unless a specialist announces that his or her practice is "limited to" his or her specialty.

In essence, the amendments to the ADA Code removed some ethical hurdles to the individual states' exercising their discretion, both in defining a specialist for the purpose of advertising as one, as well as in defining the scope of practice for a specialist.

With regard to defining a specialist for the purpose of advertising as one, a state may, for example, choose to recognize an implant dentist or a dental anesthesiologist as a specialist, even though the ADA does not define implantology or dental anesthesiology as dental specialties. On one hand, this may benefit general dentists who have attained the education required by such a state to qualify as a specialist (e.g. in dental implantology) for the purpose of advertising as one. On the other hand, depending upon the statutes and regulations established by individual states, some states may allow a dilution of the meaning of a specialist, allowing an influx of various specialties to arise in competition with general dentistry.

In the coming years, professional organizations, including AGD, may play a key role in working with

states to explore educational requirements for defining a specialty in a manner that is neither overly restrictive nor overly permissive, such that the role of a general dentist as primary oral health care provider remains clear.

Another effect of the amendment to the ADA Code, whereby a specialist advertising as a specialist may now ethically practice in any area of dentistry, may be especially impactful on the practice of general dentistry. For example, in Arkansas, HB 1250 became law on March 16, 2017, and provides that a specialist license does not limit a licensed dentist's ability to practice in any other area of dentistry for which the dentist is qualified, including general dentistry.

Such legislation may impact referral relationships. Today, many general dentists foster collaborative relationships with their specialist colleagues. General dentists and pediatric dentists serve as the primary oral health care providers for patients, referring patients for more complex procedures. For example, a general dentist may refer a patient to an endodontist for a root canal, and the patient would return to the general dentist for the crown or other restoration. Removal of the ethical bar against the practice of general dentistry by one who advertises as a specialist now empowers states to enact statutes and regulations to allow that same endodontist to practice as the patient's primary care dental provider, providing restorative care, hygiene services and more. This may significantly impinge upon the role of the general dentist as a primary oral health care practitioner.

Additionally, in states that adopt the midlevel provider model, such as in Minnesota, which established the dental therapist and advanced dental therapist roles, a concern expressed by some is that midlevel providers may replace the general dentist as the primary oral health care provider and develop direct referral relationships with specialists for the practice of general dentistry and specialty care.

LEVERAGE OF THE DENTAL BENEFITS INDUSTRY

Broadly, AGD members have increasingly faced challenges with some of the following trends with insurance companies: reduced reimbursements and phase-out of higher reimbursement plans; loyalty program with penalty for non-exclusive participation; delayed payments alleging incomplete claims/radiograph requests; utilization audits and resulting "overpayment" refund requests; post-payment patient

ineligibility findings and resulting refund requests; network leasing; reduced benefits in the absence of diagnostic code submission; denial of coverage for periapical radiographs without presentation of symptoms; onerous PPO contract provisions; misleading information provided to patients; low annual limits; coverage for certain procedures limited to provision by specialists; requirements that referrals be to in-network specialists only; charges associated with requirements to accept electronic funds transfer (EFT) and demands to accept EFT; and refusal to honor direct assignment to non-network dentists.

Despite the increased volume of complaints, dentists have increased their participation with PPOs. According to Netminder, which compares provider network data, dentists were participating in more PPO networks and in larger PPO networks in 2013 than in 2009. The increased leverage of PPOs will likely compel general dentists to reduce or consolidate administrative costs, favoring group practice models.

CORPORATE DENTISTRY

According to November 2015 data featured in the ADA Health Practice Institute report, "How Big are Dental Service Organizations?" 7.4 percent of dentists in the United States are affiliated with DSOs. This percentage jumps to 10.2 percent for women, and 16.3 percent for dentists aged 21–34. The numbers also vary greatly by state, with Arizona leading the way with 17.5 percent of dentists affiliated with DSOs.

According to the 2013 report, "AGD Investigative Report on the Corporate Practice of Dentistry," corporate dentistry refers to any variety of practice modalities in which management services, at a minimum, are provided in a manner that is organizationally distinct from the scope of activities performed by a dentist within only his or her practice. Depending upon the model, dental management companies, DSOs, management service organizations and/or dental management service organizations provide or administer management services.

One model of corporate practice uses practicing dentists as shareholders who develop and implement business functions and expectations. Another model uses professional corporations — sometimes one per state, sometimes many per state or one per many states — with oversight over multiple practices and the responsibility of administering business services and expectations of outside owner(s) through business services contracts.

According to the report, while some models use outside owner(s) who are not investors or equity firms, other models do use investors or equity firms. While the former may base profits primarily on a percentage of actual net revenue of contracted dental practices, the latter also may base profitability on Wall Street valuations, including the use of the present value of future expectations of gross receipts to paint the business as a more lucrative opportunity for prospective investors.



Ultimately, the growth of corporate models may vary based upon the priorities of up-and-coming generations of dental school graduates, as well as the effects of the Patient Protection and Affordable Care Act of 2010 (PPACA), or its prospective revisions or replacements, and the varying and continually changing structures and contracts of DSOs.

While some economists expect continued growth of large group practices, including models of corporate dentistry, others predict that the market share of corporate models has reached a plateau or will reach a plateau at or about 20–25 percent of all practice modalities.

NUMEROUS OTHER TRENDS

Several additional trends, notably affiliated with health care reform, are also expected to provide challenges and opportunities for the dental practice. While most accountable care organizations (ACOs) have yet to integrate dentistry into their value-based and capitated payment models, it is not unlikely that this will happen, and group practices will likely be in a better position to integrate with ACOs and value-based payment models. Moreover, the effects of the PPACA have influenced trends in children versus adults seeking care. The ADA Health Practice Institute found that between 2000 and 2013, the percentages of the child and senior population with a dental visit increased, while the percentage of other adults who visited a dentist decreased. Prospective changes to the practice of general dentistry associated with federal regulatory changes and a move toward greater alignment of dental care with medical care, as well as technological advancements and the possibility of leaps in regenerative dentistry and other cutting-edge opportunities, are other trends that are not addressed at length here, but should be on the radar of general dentists.

ADVOCACY AT AGD

AGD would like all patients to receive the best possible oral health care and maintains that direct or indirect supervision by a licensed dentist is necessary to ensure patient safety. Although the access-to-care issue is complex, AGD has focused on oral health literacy and community water fluoridation as two viable strategies for reducing oral health disparities.

AGD also assists members by advocating for federal legislation (H.R. 372) for partial repeal of the McCarran-Ferguson Act, which shelters insurance companies from antitrust law, as well as advocating for state legislation to prohibit fee-capping of non-covered services, among other matters.

In addition, AGD advocates for dental practices by developing policies on dental benefits issues, meeting with dental directors and presenting at American Association of Dental Consultants meetings and assisting individual members with review of PPO contracts and claims issues.

To learn more about AGD's priority issues and advocacy efforts, visit agd.org.

WHAT DOES THIS ALL MEAN?

It means that general dentistry may have to evolve in order to remain sustainable and successful into the future. It also means that there may be an opportunity for general dentists who increase collaboration with other dentists and physicians, and provide additional services, to find greater success in the new health care landscape.

In some states, midlevel providers and specialists may collectively be allowed to provide the primary oral health care that general dentists provide today. This may compel general dentists to expand their role as the primary oral health care provider by ensuring that they adopt a broader systemic health view of oral health care — from screening for oral cancer to screening for diabetes — and working consistently with the patient's physician on systemic health issues such as sleep apnea, prenatal health and osteopathic care.

Moreover, the continued rise of DSOs, coupled with greater participation in multiple PPOs and large PPOs, may drive more general dentists to practice in group practices to have the buying power and consolidated overhead costs of corporate chains. The time and effort dedicated to practice management and administrative duties are likely to increase in light of dental benefits challenges and evolving payment systems, further driving general dentists to form group practices or otherwise affiliate with DSOs.

Ultimately, however, the heart of the profession of general dentistry lies in prevention and in being the primary care practitioner and dental home for patients. These core tenets need not be lost, and AGD will continue to play an active role in standing for general dentists and their patients, not only to ensure sustainability in a changing world, but to strengthen the foundation the profession was built upon, regardless of how it evolves. ♦

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