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April 27, 2026

Missouri Dental Board
c/o Mr. Brian Barnett, Executive Director
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RE: Supplemental Opposition to Missouri Dental Association Proposal for Rule Change to Create a Periodontal Expanded Function Dental Assistant

Dear Members of the Missouri Dental Board:

I write on behalf of my client, the Missouri Dental Hygienists' Association ("MDHA"), to further supplement its previously submitted formal opposition to the Missouri Dental Association ("MDA") proposal to amend 20 CSR 2110-2.120 to create a new "Periodontal" Expanded Function Dental Assistant ("Periodontal EFDA") authorized to perform supragingival scaling and comprehensive periodontal charting. The proposed rule is intended to extend the OPA-EFDA Pilot Project created pursuant to Section 332.325, RSMo, a 2022 statute authorizing the Board to collaborate with the Department of Health and Senior Services ("DHSS") on pilot projects for new methods of care delivery to medically underserved populations that expires by operation of law on August 28, 2026 (the "Pilot Project").

As detailed below, the proposed rule exceeds the Board's statutory authority, rests on a fatally flawed pilot study, raises serious patient safety concerns, and conflicts with well-established Missouri law protecting the practice of dental hygiene. In addition, MDHA recently learned that after submitting an initial report to the Board on December 11, 2025 to satisfy the statutory deadline, the MDA subsequently produced a second, revised "final" report on March 20, 2026 (the "New Report") — approximately 109 days after the statutory deadline established by Section 332.325.3, RSMo — that materially changes data and conclusions from the December submission. MDA's attempt to rely on this New Report is unlawful and cannot be considered by the Board in connection with the proposed rulemaking and, even if it could be considered, the New Report does not cure the fundamental legal deficiencies precluding the proposed rule.

Finally, this letter further responds to the MDA's April 23, 2026 letter to the Board ("MDA Response Letter") and the accompanying letter dated November 12, 2024 from attorney Heidi Doehoff Vollet ("Vollet Letter"), neither of which provide legal or policy support for promulgating the proposed

rule without further action by the Missouri General Assembly. Accordingly, the Board should reject MDA's proposal and avoid embarking on the perilous path advocated by MDA that will almost certainly embroil the Board in protracted legal action.

I. The Board Lacks Statutory Authority to Adopt the Proposed Rule.

MDA's proposal asks the Board to create, through rulemaking, an entirely new category of dental worker (the Periodontal EFDA) authorized to perform scaling, even though scaling—which is the removal of deposits from teeth—is a function that Missouri law expressly reserves to licensed dentists and licensed dental hygienists. *See* Section 332.091, RSMo (defining the practice of dental hygiene to include any person who "undertakes to or does remove hard and soft deposits from teeth."). This statutory language is mandatory, not permissive, and it expressly delineates scaling of any kind as scope of practice reserved for dental hygienists (and dentists).

Section 332.093, RSMo, governing dental assistants, is equally clear and unequivocal. While a dentist may delegate to a dental assistant, certified dental assistant, or expanded functions dental assistant "such reversible acts that would be considered the practice of dentistry," such delegation may occur only pursuant to a rule promulgated by the Board and "no such rule may allow delegation of acts that conflict with the practice of dental hygiene as defined in section 332.091." The statute enumerates few narrow exceptions that allow the Board to promulgate a rule authorizing dentists' delegation of certain acts that conflict with the practice of dental hygiene—namely, polishing of teeth, placement of pit or fissure sealants, and application of topical fluoride. Supragingival scaling is not among the exceptions.

MDA's proposed "Periodontal EFDA" would perform supragingival scaling — a function squarely within the statutory definition of dental hygiene and squarely outside the enumerated exceptions to the bar on delegating dental hygiene acts to dental assistants. Because the Board cannot lawfully adopt a rule that conflicts with the plain language of statute—including Sections 332.091 and 332.093, RSMo—creating this new provider category through Board rulemaking would be an ultra vires exercise of the Board's regulatory authority and subject to an immediate and successful legal challenge.

Any permanent expansion of the OPA-EFDA model into the standard rules governing dental assistants requires legislative action to amend Missouri's dental practice statutes and, as such, is a decision for the General Assembly, not the Board. Notably, the New Report's Conclusion (Section 17.7) expressly acknowledges that legislation would be required in recommending that "Missouri and other states and territories should consider amending their dental practice acts" to allow OPA-EFDAs.

II. Section 332.325, RSMo Expires August 28, 2026, and the Board Cannot Use General Rulemaking Authority to Circumvent That Legislative Judgment.

The OPA-EFDA Pilot Project upon which the proposed rule is based exists solely by virtue of Section 332.325, RSMo, a 2022 statute authorizing the Board to collaborate with DHSS on pilot projects for new methods of care delivery to medically underserved populations. That statute contains an explicit sunset provision, stating that the section "shall expire on August 28, 2026." Section 332.325.3, RSMo. That same subsection requires the Board to provide a final report to the General Assembly on approved projects by no later than December 31, 2025, plainly contemplating that the legislature would then decide, with the benefit of that report, whether to reauthorize the program.

The rulemaking authority the Board exercised in establishing the Pilot Project — including the waivers to 20 CSR 2110-2.120 that permitted OPA-EFDAs to perform supragingival scaling — is provided exclusively by Section 332.325, RSMo. Thus, when the statute expires on August 28, 2026 due to lack of legislative re-authorization, the rulemaking authority the statute delegates expires with it. Accordingly, no rule promulgated under Section 332.325, RSMo can lawfully survive the section's expiration date, and the Board lacks statutory authority to maintain, extend, or convert Pilot Project operations after that date.

MDA's proposed rule is a transparent attempt to circumvent this legislative judgment that the program must end on August 28, 2026, absent further legislative action. Instead of seeking reauthorization from the General Assembly, the MDA is instead asking this Board to usurp the legislature's authority by amending the permanent dental assistant rules under 20 CSR 2110-2.120 to make the Periodontal EFDA a standing feature of Missouri dental practice. This would be a massive overreach on the part of the Board and a wholly impermissible exercise of the Board's general rulemaking authority under Section 332.031, RSMo, which is limited to adopting rules "within the scope and purview of the provisions of this chapter" and to "regulate and define the acts and areas of practice" of dental assistants. This general rulemaking authority does not authorize the Board to unilaterally override the express statutory reservation of scaling to the scope of practice of licensed dental hygienists under Section 332.091, RSMo, or to perpetuate a pilot program the General Assembly has expressly directed to expire.

Promulgating the proposed rule after August 28, 2026 would be plainly ultra vires because the Board would be acting without any statutory authority to do so. However, adopting the proposed rule before August 28, 2026 would not make it any less infirm, since any rule purporting to authorize Periodontal EFDAs to operate in perpetuity would conflict with the express expiration date in the statute that authorized the Pilot Program in the first place. The General Assembly structured Section 332.325, RSMo precisely to reserve the legislative decision of whether to make the Periodontal EFDA permanent. The Board must respect that legislatively established structure and make clear to MDA that if it believes the program has merit, it must make that case to the legislature instead of asking this Board to substitute its judgment for that of the legislature.

The MDA Response Letter responds to this clear and unequivocal statutory language with the conclusory statement that Section 332.325 "in no way limits any agency of state government, including the Missouri Dental Board, from interpreting the results and implementing actions based on the results of the pilot study." Not only is this statement non-responsive, it is wrong as a matter of law. MDA's position would render the express sunset provision meaningless surplusage by suggesting that the Board could simply ignore the express legislative judgment that the program should expire if not re-authorized by the legislature. Moreover, under MDA's erroneous reading, the Board could make a pilot program permanent simply by "interpreting" the results favorably, without legislative reauthorization. Courts construe statutes to give effect to every provision, not to render a provision superfluous and allowing the Board to unilaterally extend a program the legislature has expressly called for to sunset would make the sunset provision meaningless.

III. The New Report Is Untimely, Was Never Provided to the General Assembly, and Cannot Properly Serve as a Basis for the Proposed Rulemaking.

Section 332.325.3, RSMo, required the Board to provide a "final report on approved projects and related data or findings to the general assembly on or before December 31, 2025." This deadline is a mandatory statutory requirement tied directly to the mechanism by which the General Assembly was to receive the information necessary for it to decide whether to reauthorize the program before the statute's August 28, 2026 expiration. Section 332.325 contains no provision authorizing the Board to ignore or extend that statutory deadline.

MDA conceded that the report filed with the Board on December 11, 2025 was only intended to "to satisfy statutory requirements" and the New Report was only filed on March 20, 2026—approximately 109 days past the express statutory deadline—and was not provided to the General Assembly in a timely manner. Indeed, MDA did not provide MDHA or other stakeholders a copy of the New Report and MDHA only learned of the report after obtaining it from a third party who, like MDHA, noted that the data and conclusions differed materially from the December 2025 submission.

To the extent MDA may claim that the statutory deadline should be extended or otherwise ignored, any such claim must be rejected. Only the General Assembly has the power to amend the law in order to extend a mandatory statutory deadline, and it has not done so here. Furthermore, the Board has no statutory authority to waive or extend a deadline imposed by the legislature. The MDA Response Letter does not address the untimeliness of this New Report, the basis for any claim that the statutory deadline was extended, or any authority for the Board to consider the findings of the New Report.

The fact that conclusions and data changed between the December report and the New Report does not permit the Board to rely on the New Report because it was not provided to the General Assembly prior to the statutory deadline. Moreover, the revisions between the December report and the New Report raise serious questions about which set of data and conclusions is accurate and the relationship between the data and conclusions in each report. At the very least, the integrity of the evidentiary record before the Board is compromised. In addition, the New Report was produced with the editorial involvement of the ADA's Health Policy Institute, which is the research and policy arm of the national organization that has been actively advocating for the OPA model , meaning that this post-deadline "upgrade" was produced by an advocacy organization with a direct interest in a favorable outcome and not subject to independent peer review. Finally, MDHA and other stakeholders, including members of the public, were not provided the New Report and have been afforded no opportunity to respond to its revised conclusions and the troubling lack of transparency by MDA.

The Board should not consider the New Report in connection with this proposed rule. The legally operative report under Section 332.325.3 is the December 2025 report and any rulemaking regarding the Pilot Project can only proceed with legislative re-authorization based on a timely-submitted report.

IV. The OPA-EFDA Pilot Project Should Not Be Extended Because the Record Demonstrates That None of Its Objectives Were Met.

Even if the Board had the authority to initiate a rulemaking to make the Pilot Project permanent and even if the untimely New Report could properly be considered by the Board, the record does not support the proposed rule. The December 2025 Report acknowledges that the Pilot Project failed to achieve its stated objectives, and the MDA's attempts in the New Report and the MDA Response Letter to recharacterize the results are based in self-interested advocacy not scientific data.[1]

1. **Objective 1 — Assess treatment outcomes:** The New Report claims that 76% of OPA-EFDA-treated gingivitis patients "improved," compared to 93% improvement in the control group treated by dentists and hygienists. The OPA-EFDA outcome is therefore meaningfully worse than the established standard, yet the report characterizes this as within "expected clinical standards." The MDA's response ignores this 17-percentage-point gap entirely and instead points to patient satisfaction scores (9.8/10 for OPA-EFDAs versus 9.7/10 for dentists and hygienists) and supervisor performance evaluations averaging 9.6/10. Neither metric measures clinical effectiveness. As Dr. Gurenlian confirms, "reliance on patient satisfaction scores and supervisor performance evaluations does not constitute evidence of improved periodontal health or clinical efficacy." Patient satisfaction measures a patient's subjective experience of care, not whether the care was clinically effective. Supervisor evaluations are inherently compromised when the supervisors are the same individuals who trained, implemented, and are advocating for the program being evaluated. Moreover, the New Report itself acknowledges that the 93% control

[1] MDHA hereby incorporates by reference as if set fully herein the attached analysis of Dr. JoAnn Gurenlian, RDH, MS, PhD, Director of Education, Research & Advocacy for the American Dental Hygienists' Association, a nationally recognized expert in dental hygiene research, who independently concludes that "the pilot does not meet its own stated objectives" and that "at best, it offers descriptive operational observations; it does not provide the level of evidence necessary to justify regulatory expansion."

figure is inflated by provider-evaluator bias, meaning the true performance gap between OPA-EFDAs and licensed providers is likely even larger than reported. On a sample of only 33 OPA-EFDA-treated gingivitis patients, these results do not support permanent regulatory expansion.

2. **Objective 2 — Increase clinic capacity and access to care:** The New Report attempts to salvage this objective by cherry-picking a subset of three "higher deploying" clinics (those where OPA-EFDAs saw 4–9% of total appointments) that showed capacity gains, while acknowledging that in the other four clinics where OPA-EFDAs involving the majority of total appointments, positive trends "could not be confidently attributed to OPA-EFDAs." The MDA Response Letter selects the most favorable single-clinic result (Clinic 5's 26.3% increase in new patients) without disclosing that this result was confounded with staffing changes for which the study could not control. Average deployment across all clinics remained only 2.4% of total appointments, and the study's own design prevented full-time OPA-EFDA deployment because participants were restricted to existing employees with other full-time responsibilities. The Second Report's capacity conclusions rest on only three clinics under constrained conditions, then extrapolate to projections about what "full-time" OPA-EFDAs might achieve, which is a speculative leap that the data does not support. Selective results from isolated clinics, without standardized baselines, control groups, or longitudinal analysis, do not satisfy the stated objective of demonstrating meaningful or scalable access improvement.

3. **Objective 3 — Enhance access for patients with more serious periodontal needs:** For the same reasons indicated above for Objective 2, this objective was not met, as the data reflects no meaningful reallocation of hygienist or dentist time to more complex periodontal patients. The MDA Response Letter points to Clinic 7 (7.1% increase in periodontal services) and Clinic 6 (17.5% increase) out of seven total clinics. However, reallocating dentists or dental hygienists to different services does not, in and of itself, establish that patients experienced better periodontal outcomes. Indeed, the pilot provides no evidence of reduced disease progression, improved periodontal stability, or enhanced long-term oral health. Several clinics reported *declines* in periodontal services during the study period, which the MDA Response Letter fails to acknowledge.

A pilot program that failed to achieve its stated objectives under controlled conditions, and whose supplemental report was filed 109 days after the statutory deadline and relies on cherry-picked clinic data and speculative extrapolations, does not warrant permanent rulemaking, particularly where, as here, Missouri law does not permit such rulemaking in any event.

V. The Pilot Project Was Conducted Without Transparency, With Apparent Conflicts of Interest, and Without Adequate Research Safeguards.

Independent of its substantive failures, the Pilot Project's methodology remains fatally compromised notwithstanding the New Report. A full and independent evaluation of the program was made impossible by MDA when it withheld the Periodontal EFDA curriculum from public disclosure as "proprietary information." The New Report confirms that MDA designed, funded, delivered, and editorially reviewed the report itself — the same organization that developed the curriculum, trained the OPA-EFDAs, selected the participating clinics, and now proposes the rulemaking to make the program permanent. This is not independence; it is a single organization controlling every material aspect of a study intended to justify its own proposal.

The MDA Response Letter now asserts that BeyondBound IRB — registered with the Federal Office for Human Research Protections ("OHRP") — "thoroughly reviewed study construct, methodology, patient safety, bias control, and data integrity." However, OHRP registration means only that BeyondBound has submitted an assurance of compliance with federal human subjects regulations —

it is not a certification of scientific rigor or lack of commercial bias. BeyondBound is a for-profit commercial IRB operating as a paid service provider to research sponsors. IRB approval addresses the ethical conduct of research with human subjects, but it **does not** validate the study's methodology, cure conflicts of interest in study design and administration, or authorize the Board to promulgate rules based on the study's conclusions. Even if ClinicalTrials.gov registration was not legally required for this study, the study nonetheless lacks an independent, prospectively registered oversight mechanisms that is necessary for the Board to have confidence in research findings. The MDA Response Letter resorts to technical compliance arguments that fail to address the substantive concern that the study's design, execution, and reporting were controlled by the same organization now advancing the proposed rule.

The conflicts of interest documented in MDHA's prior submission in opposition remain unaddressed. The New Report further confirms that Dr. Guy Deyton — who served as Principal Investigator of the Pilot Project — is also a past president of the MDA and a former member of the Missouri Dental Board. Indeed, the MDA Response Letter is signed jointly by MDA President Dr. Ron Wilerson and by Dr. Deyton in his capacity as "OPA-EFDA Pilot Project Principal Investigator," which further illustrates the obvious conflict of interest that exists here between the researcher, the advocacy organization, and the rulemaking proponent. Further, the American Dental Association's Health Policy Institute ("HPI"), which provided "technical input," "reviewed and validated" the analyses, and performed "final copyediting and layout" and other post-deadline editorial involvement in the New Report, is the policy arm of the ADA, which developed and is actively advocating for the OPA model nationwide even in the face of disappointing pilot projects like this one. Training sites included the dental practice of the current MDA president and the former office of a sitting Board member and his daughter. A newly appointed Board member participated in training OPA-EFDAs. Any Board member connected to the Pilot Project must recuse themselves from any vote on this proposal. More broadly, the layered conflicts among the Principal Investigator, the study funder and administrator, the peer reviewer, and the rulemaking proponent are irreconcilable with the standards of independent research.

With respect to curriculum review, the MDA Response Letter now states for the first time that "the full OPA-EFDA curriculum was appropriately submitted, reviewed and approved by the Missouri Dental Board." If true, this is directly contradicted by MDA's prior characterization of the curriculum as "proprietary information" that could not be disclosed to MDHA and other stakeholders. If the Board did in fact review and approve the curriculum, we hereby request pursuant to Chapter 610 of the Missouri Revised Statues that such curriculum and any minutes, correspondence, meeting notices, agenda or other records related to such purported review and approval by the Board be produced to MDHA and published for review and comment by interested parties before taking any vote on the proposed rulemaking.

VI. The Proposed Rule Raises Serious Patient Safety Concerns.

There is no credible evidence-based research supporting supragingival-only scaling as clinically effective care. Periodontal disease is a condition that exists both above and below the gumline. Removing only supragingival calculus while leaving subgingival deposits untreated addresses only part of the disease process and may actually contribute to disease progression, abscess formation, and tooth loss, particularly where patients or providers believe that a "cleaning" has been completed. A dental assistant with limited training, who may have completed only a single EFDA course in an unrelated specialty, is not equipped to assess, diagnose, plan, implement, or evaluate periodontal care. The New Report's own data shows that 24% of OPA-EFDA-treated gingivitis patients did not improve — and the report does not track those patients' long-term outcomes. In addition, comprehensive probing is even difficult for experienced dental hygienists and dentists.

The MDA's Response Letter makes a conclusory statement that: (1) there were no adverse incidents or patient complaints during the pilot; and (2) patient satisfaction scores were high. However,

this improperly equates the absence of reported adverse events with proof of safety. In a limited, non-blinded, non-comparative pilot involving 1,626 total patient visits over approximately eight months under direct dentist supervision in carefully selected clinic settings, the absence of reported adverse events does not constitute affirmative evidence that the OPA-EFDA role is safe for broad, permanent implementation across Missouri. Patient safety conclusions require robust, objective data, not mere inference from the absence of incidents in a controlled pilot.

The MDA Response Letter also references a Johns Hopkins University study of the periodontal EFDA in the Indian Health Service, claiming it found a 12.1% increase in procedures delivered and a 25% increased rate of access to care. MDHA notes that this study involved the Indian Health Service, which is a federally operated system with distinct workforce structures, supervision models, patient populations, and regulatory frameworks that differ materially from Missouri's private practice environment. The MDA Response Letter also provides no citation for this study, no information about its methodology, sample size, controls, or peer review status. The Board should not rely on MDA's characterization of an uncited external study to justify permanent rulemaking of this magnitude.

With respect to patient safety, it is readily apparent that the proposed rule would have the effect of establishing a lower standard of care for patients in underserved or rural settings, which is the targeted deployment population for these providers. Differential access to qualified care based on geography or socioeconomic status is ethically unacceptable and institutionalizing that disparity through Board rulemaking would expose patients in those communities to heightened risk of harm without any factual or legal basis for doing so.

Finally, Periodontal EFDA services require use of miscellaneous billing codes with substantially lower reimbursement and more extensive documentation than standard prophylaxis codes. Clinics cannot appropriately bill standard codes for incomplete care, creating both financial pressure on providers and potential exposure under the federal False Claims Act, particularly for Medicaid-participating practices.

VII. Effective, Evidence-Based Solutions Already Exist.

Undoubtedly Missouri faces real and significant dental access challenges. However, the solution to those challenges is not to create a less-trained, less-regulated, less-reimbursed provider to deliver a subset of hygiene services to underserved populations. Moreover, it is the legislature who sets policy in this area, not the Board acting unilaterally and in contravention of express statutory provisions. The MDA Response Letter argues that dental hygiene program expansion would take "a decade or more" and cost "millions of dollars." But this is a policy preference argument that should be directed to the General Assembly, not this Board. The legislature is the appropriate body to weigh costs, timelines, patient safety implications, and workforce policy choices in determining whether to make the OPA-EFDA role permanent, which is a point that the New Report concedes in its conclusion.

MDHA supports expanding access to dental care through approaches that improve quality rather than stratify it, including expanding accredited dental hygiene programs (including the distance education programs the Missouri legislature appropriated funding to create), allowing hygienists to practice at the full extent of their licensed scope of practice, expanding permissible practice settings, supporting teledentistry, enabling direct reimbursement for dental hygiene services, and addressing workforce retention through compensation and autonomy improvements.

VIII. The Vollet Letter Does Not Provide Board Authority to Adopt the Proposed Rule.

The MDA Response Letter's primary response to the express statutory language sunsetting the program and thereby prohibiting rulemaking to unilaterally extend the program in the absence of legislative action is based on the Vollet Letter dated November 12, 2024. After obtaining the MDA Response Letter, MDHA was able to finally obtain and review the Vollet Letter upon which MDA relies.

Based upon that review, for the reasons discussed below, it is clear that Vollet Letter is incomplete, unpersuasive and inapposite to the precise issue before the Board in the proposed rulemaking.

First, the Vollet letter was written to answer a different question than the one before the Board today. In particular, this November 2024 letter was written before the OPA-EFDA Pilot Project had concluded, before the December 2025 Report and New Reports were submitted, and most critically, before the legislature had conclusively failed to take action to reauthorizing the program during the 2025 or 2026 legislative sessions prior to its expiration on August 28, 2026. It appears that Ms. Vollet was asked the general abstract question of whether she believed the Board could lawfully adopt a rule "permitting Oral Preventative Assistant (OPA) Expanded Function Dental Assistants to perform supragingival scaling on healthy patients under the direct supervision of a licensed dentist." Tellingly, the Vollet Opinion does not address, analyze, or even mention the more specific Section 332.325, RSMo, which was enacted in 2022 and which actually authorized and governed the OPA-EFDA Pilot Project, established the reporting deadline that was missed, and mandates the program's expiration on August 28, 2026 unless re-authorized by legislative action of the General Assembly. Unlike the context for the Vollet letter, the rulemaking MDA has now proposed to the Board is not requesting an abstract exercise of the Board's general powers under Section 332.031, it is a direct attempt to make permanent a program created under and expressly subject to the expiration of Section 332.325. Because the Vollet Letter ignores completely the operative statute and the limit this specific provision imposes the operative statutory framework entirely, it provides no legal authority for the specific rulemaking before this Board.

Second, the Vollet Letter's central argument on the merits is that allowing EFDAs to perform supragingival scaling does not "conflict" with the practice of dental hygiene because scaling is also within the definition of the practice of dentistry under Section 332.071, and therefore is not "exclusive" to dental hygienists. However, Section 332.093, RSMo, does not bar delegation only of acts that are *exclusive* to dental hygienists, it also bars delegation of acts that "conflict with the practice of dental hygiene as defined in section 332.091." Section 332.091 defines the practice of dental hygiene to include any person who "undertakes to or does remove hard and soft deposits from teeth," which is precisely what a Periodontal EFDA would do. If the Vollet Letter's interpretation were correct, polishing of teeth, which similarly appears in both the dentistry and dental hygiene definitions, would not have needed a specific legislative exception in Section 332.093 to be delegable to dental assistants. The legislature's deliberate inclusion of that narrow exception demonstrates the recognition that activities appearing in both definitions could nonetheless "conflict" with the practice of dental hygiene. While the legislature elected to create specific exceptions for polishing, sealant placement, and fluoride application, it did not create one for supragingival scaling and therefore the Board cannot create one by rule.

Third, the Vollet Letter argues that the delegation is not incompatible with dental hygiene practice because supragingival scaling is only a "small subset" of what hygienists do. However, the statutory prohibition is categorical: "no such rule may allow delegation of acts that conflict with the practice of dental hygiene." The tiered-worker structure of Chapter 332 that the Vollet Letter discusses supports MDHA's position that the existing narrow exceptions — polishing, sealants, fluoride — are each the product of explicit, deliberate legislative choices made over many years of legislative enactments. The MDA's proposed rule asks the Board to unilaterally add supragingival scaling to that list without legislative authorization, which is not a simple regulatory detail the Board may fill in under its general rulemaking authority. This would be a substantive expansion of the dental assistant role at the direct expense of the dental hygiene scope of practice, which requires legislative action to implement.

IX. Conclusion

For the foregoing reasons, MDHA respectfully urges the Board to decline to adopt the MDA-proposed rule to create a Periodontal Expanded Function Dental Assistant. The proposed rule exceeds the

Board's statutory authority under Sections 332.091, 332.093, and 332.325, RSMo; is not supported by the Pilot Project's own data; poses unacceptable risks to patient safety; and represents an outright end-run around the legislative sunset on August 28, 2026, which will be immediately recognized as such by the legislature and the courts. The New Report — filed 109 days after the mandatory statutory deadline does not cure these deficiencies and should not be considered by the Board. Whether to make the Periodontal EFDA model permanent in Missouri is a decision that belongs to the Missouri General Assembly, not to this Board, as even the New Report's own conclusions acknowledge, and therefore MDA should direct its proposal there.

MDHA is prepared to provide additional information, written materials, or testimony in support of this position. Please do not hesitate to contact me if you have any questions or if there is any additional information we can provide. Thank you for your attention to this matter and all that you do supporting dental care access in our state.

Respectfully submitted,

Christopher R. Pieper
Member, Blitz, Bardgett & Deutsch, L.C.
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Enclosure

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April 27, 2026

Missouri Dental Board
c/o Mr. Brian Barnett, Executive Director
Missouri Division of Professional Registration
3605 Missouri Boulevard
Jefferson City, MO 65109

RE: Opposition to Missouri Dental Association Proposal for Rule Change to Create a Periodontal Expanded Function Dental Assistant

Dear Members of the Missouri Dental Board:

I am writing on behalf of the American Dental Hygienists' Association (ADHA) in response to the Missouri Dental Association's Report of the OPA-EFDA Pilot project for Rule Change to Create a Periodontal Expanded Function Dental Assistant.

For purposes of this discussion, we do not dispute the assertion that registration on ClinicalTrials.gov was not legally required for this project. Even accepting that point, however, the central and more consequential issue remains unresolved: **the OPA EFDA pilot failed to meet its stated objectives**, and the conclusions advanced by the Missouri Dental Association are not supported by the study's own design, methodology, or results.

The stated objectives of the pilot were not merely descriptive. They were to evaluate whether introducing a new periodontal provider role would safely and effectively improve access to care, enhance clinical outcomes, and increase system capacity in a manner sufficient to justify permanent regulatory expansion. By those standards, the pilot was unsuccessful.

First, the study fails to demonstrate effectiveness through objective clinical outcome measures. Reliance on patient satisfaction scores and supervisor performance evaluations does not constitute evidence of improved periodontal health or clinical efficacy. These metrics are inherently subjective and particularly vulnerable to confirmation bias when supervisors are engaged in the training, implementation, or promotion of the new role. The pilot does not report validated periodontal outcome measures, comparative disease indicators, or independent assessments of clinical impact.

Second, the claims regarding improved access to care are methodologically weak and unsupported by the data presented. The pilot does not establish that any observed changes in clinic capacity were attributable to the introduction of OPA EFDAs rather than to routine operational variability, staffing changes, scheduling practices, or short-term pilot conditions. Selective increases reported in isolated clinics, absent standardized baselines, control groups, or longitudinal analysis, do not satisfy the stated objective of demonstrating meaningful or scalable access improvement.

Third, the pilot does not demonstrate improved care for patients with more serious or urgent periodontal needs. Reallocating dentists or dental hygienists to different services does not, in and of itself, establish that patients experienced better periodontal outcomes. The pilot provides no evidence of reduced disease progression, improved periodontal stability, or enhanced long-term oral health for these patients.

Finally, the pilot improperly equates the absence of reported adverse events with proof of safety. In a limited, non-blinded, non-comparative pilot, the absence of reported incidents does not constitute affirmative evidence that a new clinical role is safe for broad implementation. Patient safety conclusions require robust, objective outcome data—not inference.

In sum, even setting aside procedural questions regarding study registration, **the pilot does not meet its own stated objectives**. At best, it offers descriptive operational observations; it does not provide the level of evidence necessary to justify regulatory expansion that alters established standards of care, licensure, and professional responsibility in periodontal treatment. The appropriate conclusion from this study is not expansion, but caution.

Sincerely,

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