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Missouri Dental Board
c/o Mr. Brian Barnett, Executive Director
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RE: Opposition to Missouri Dental Association Proposal for Rule Change to Create a Periodontal Expanded Function Dental Assistant (Agenda Item No. 9 - April 10, 2026)

Dear Members of the Missouri Dental Board:

I write on behalf of my client, the Missouri Dental Hygienists' Association ("MDHA"), to formally oppose Agenda Item No. 9 at the April 10, 2026 open session of the Missouri Dental Board ("Board") relating 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. Accordingly, the Board should reject this proposal to avoid immediate legal action to prevent the proposed rule from being promulgated absent legislative 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.

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.

III. The OPA-EFDA Pilot Project Should Not Be Extended Because Its Own Final Report Confirms That None of Its Objectives Were Met.

Even if the Board had the authority to adopt a rule making the Pilot Project permanent, there would be no reason for doing so because MDA's own final report, submitted in December 2025 (the "Final Report"), demonstrates that the Pilot Project failed to achieve any of its three stated objectives:

1. **Objective 1 — Assess treatment outcomes:** Treatment outcomes were assessed by patient satisfaction comments rather than objective clinical evaluation of patient health. Periodontal EFDA trainees were evaluated internally by clinic supervisors with a financial interest in the program — not by independent outside evaluators — creating pervasive bias throughout the research design, data collection, and conclusions. The sample sizes were far too small, with only ten patients accepting gingivitis therapy and returning for re-evaluation. The Final Report's use of undefined terms such as "improved" further undermines any clinical significance.
2. **Objective 2 — Increase clinic capacity and access to care:** The Final Report itself concedes that the Pilot Project "did NOT demonstrate a significant increase in clinic capacity or improved access" (emphasis in original). Periodontal EFDAs were involved in only 2.4% of appointments across all participating clinics during the study period, which is a negligible figure that the Final Report acknowledges was constrained due to the design of the Pilot Project.

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.

A pilot program that, by the program proponent's own admission, failed to achieve a single stated objective does not warrant an extension of any kind, much less one that would make an unsuccessful program permanent, even if Missouri law permitted such, which as discussed above, does not.

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

Independent of its substantive failures, the Pilot Project's methodology is also fatally compromised. 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" of the MDA. Because the very organization that designed, funded, and administered the program withheld even basic information regarding its design, stakeholders such as MDHA and others were denied the ability to meaningfully evaluate or respond to the core educational content during the rulemaking process.

In addition, the Final Report contains no reference to Institutional Review Board oversight, no Collaborative Institutional Training Initiative program compliance certification, and no registration with ClinicalTrials.gov. These are standard requirements for ethically-conducted research involving human subjects, and the lack of these safeguards reflects a research process that lacked the independent oversight necessary to generate reliable findings.

Compounding these concerns, training sites included the dental practice of the current president of the MDA and the office of a member of the Board. In addition, a newly appointed Board member also participated in training Periodontal EFDAs. At the very least, any Board member who participated in or are otherwise connected to the Pilot Project should recuse themselves from any consideration and vote on this proposed rule. But more broadly, the participation of these individuals in generating the proposal undermines any assertion that the program was developed and implemented free of any conflicts of interest.

V. 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. In addition, comprehensive probing is even difficult for experienced dental hygienists and dentists.

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.

VI. 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. 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 the scope of practice authorized under their licensure, expanding permissible practice settings, supporting teledentistry, enabling direct reimbursement for dental hygiene services, and addressing workforce retention through compensation and improvements to dental hygienists' autonomy.

VII. 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. Whether to make the Periodontal EFDA model permanent in Missouri is a decision that belongs to the Missouri General Assembly, not to this Board, and 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,



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Association