# 2023 UPDATED INDEX

## COMMITTEE B (DENTAL BENEFITS, PRACTICE AND RELATED MATTERS)

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* Material Not Included in Early Posting  
** Material Posted on August 4  
+** Newly Received (Received and Processed September 8-13; Posted September 22)  

Updated Index-Committee B (Dental Benefits, Practice and Related Matters)
Resolution No. 301 __________________________ New

Report: N/A __________________________ Date Submitted: June 2023

Submitted By: Council on Dental Benefit Programs

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None __________________________ Net Dues Impact: __________________________

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

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AMENDMENT OF POLICY, STATEMENT ON PREVENTIVE COVERAGE IN DENTAL BENEFITS PLANS

Background: The Council on Dental Benefit Programs has reviewed the ADA policy titled Statement on Preventive Coverage in Dental Benefits Plans (Trans.1992:602; 1994:656; 2013:306; 2018:312) and proposes that it be amended.

As new preventive procedures are developed, the Council noted the importance of amending the third resolving clause to make it clear that the list of preventive procedures is not all-inclusive. The Council also suggests removing certain redundancies within the policy statement.

Therefore, the Council on Dental Benefit Programs recommends that the following resolution be adopted.

Resolution


Statement on Preventive Coverage in Dental Benefits Plans

Resolved, that preventive dentistry refers to the procedures in dental practice and health programs which aid in the prevention of oral diseases, and be it further

Resolved, that the American Dental Association recognizes the importance of implementing preventive oral health practices as an effective means of promoting optimal oral health to all individuals, and be it further

Resolved, that the ADA urges that all dental benefit plans should include, but not be limited to, the following preventive procedures as covered services for all patients unless otherwise indicated:

- prophylaxis;
- topical fluoride applications;
- application of pit and fissure sealants and reapplication as necessary;
- interim caries arresting medicament application (e.g., silver diamine fluoride);
• space maintainers at appropriate developmental stages;
• oral health risk assessments;
• screening and education for oral cancer and other dental/medical related conditions;
• preventive resin restorations;
• resin infiltrations;
• fixed and removable appliances to prevent malocclusion;
• athletic mouth guards;
• prescription or use of supplemental dietary or topical fluoride for home use; and
• in-office patient education, (i.e., oral hygiene instruction, dietary counseling, dental- and medical-related conditions, and tobacco cessation counseling with regard to the promotion of good oral and overall health).

and be it further

Resolved, that the Council on Dental Benefit Programs continue to recommend to third-party payers, service plans, prospective purchasers and policyholders that contract limitations on frequency of providing benefits allow for coverage of preventive services at least “twice in a calendar (or contract) year” and more frequently if risk factors are identified that warrant increased frequency.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
Resolution No. 302 

Report: N/A 

Date Submitted: June 2023 

Submitted By: Council on Dental Benefit Programs 

Reference Committee: B (Dental Benefits, Practice and Related Matters) 

Total Net Financial Implication: None 

Net Dues Impact: 

Amount One-time 

Amount On-going 

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered. 

How does this resolution increase member value: See Background 

**AMENDMENT OF POLICY, STATEMENT ON MANAGED CARE AND UTILIZATION MANAGEMENT**

**Background:** The Council on Dental Benefit Programs has reviewed the following ADA policies addressing managed care and utilization management: 

1. Statement on Managed Care and Utilization Management (Trans.1995:624) 
2. Utilization Management (Trans.1990:541) 
3. Regulation of Utilization Management Organizations (Trans.1991:636) 

The Council has assessed that these policies are duplicative and, in some cases, contain outdated information not relevant to ADA’s current positions. In addition, the policies include directives. The Council on Dental Benefit Programs recommends that the following resolution be adopted to address these concerns. 

**Resolution** 

302. Resolved, that the policy titled, Statement on Managed Care and Utilization Management (Trans.1995:624), be amended as follows (additions underscored; deletions stricken). 

**Statement on Managed Care and Utilization Management** 

The American Dental Association shares the national concern expressed by government, business, industry, and the professions about the rising cost of health care. The Association supports legitimate, valid efforts to stabilize the cost of health care in the United States. However, in addressing the problem, it is all too easy to adopt simplistic solutions that, in the short term, will result in less-than-optimum care for patients, and in the long term, will result in increased costs. 

The concept of “managed care” has been universally promoted as a method of containing health care costs. After examination of this concept by the Association, it became evident that while the term is widely used, its meaning could not be more elusive. 

The American Dental Association defines managed care as follows: 

Managed care is any contractual arrangement where payment or reimbursement and/or utilization are controlled by a third party.
This concept represents a cost-containment system that directs the utilization of health care by:

a. restricting the type, level and frequency of treatment;

b. limiting the access to care;

c. controlling the level of reimbursement for services; and

d. controlling referrals to other practitioners.

The Association believes that the public must be served and protected through the appropriate management of:

1. **Dental Care.** Dental care is managed by the treating dentist. The dentist should provide care, in consultation with the patient, that is evidence-based or scientifically sound and necessary for the diagnosis and treatment of disease to promote, preserve and restore oral health form and function. Dental care is provided by the treating dentist based on a dental evaluation, the development of an individualized treatment plan and a consultation with the patient.

2. **Benefit Plan Design.** Benefit plan design is managed by plan purchasers. Benefit plan design must be evidence-based or scientifically sound and promote, preserve and restore oral health form and function clinically relevant and reliable. Plan design may also include cost containment measures, such as annual maximums, copayments, limitations, predeterminations, exclusions, enrollment periods and patient incentives for maintaining oral health.

3. **Program Costs.** Program costs are managed by plan administrators. Oversight of the program may include implementation of the plan agreement through monitoring utilization, preauthorizing treatment, requiring second opinions, reviewing claims and collecting and evaluating claims data.

Definitions of the terms “cost containment” and “managed care” vary greatly and are open to interpretation by various organizations. The Association believes that “managed care,” as currently applied to the practice of medicine, is not relevant to the practice of dentistry. Dentistry is, by and large, a self-contained discipline. In most instances, a general dentist can diagnose and treat a patient’s condition from beginning to end. This fact is reflected in the demographics of the dentist population in the United States: approximately 86% are general practitioners and 14% are in specialty practice, compared with 12% general practitioners and 88% specialists in medicine.

The practice of dentistry is procedural and cognitive. While there are eight recognized dental specialty areas of practice, the licensed general dentist is trained to perform services in all areas of dentistry. When compared with the numerous specialties and subspecialties of medicine, and the increasingly limited area of practice commanded by the “family physician,” the latitude of a dentist’s license to diagnose and treat a patient’s oral health condition becomes clear. In addition, dentistry is almost exclusively an outpatient service, although there are limited situations where treatment is most appropriately performed in a hospital setting. The concept of “case management” has long been a foundation of dental practice in the United States.

Outside the practice of dentistry, there are additional factors that influence the utilization of dentistry, such as benefit plan design which integrates controls through copayments, annual maximums, exclusions and limitations, preauthorizations, etc.
Statement on Utilization Management

For these reasons, The Association believes that the concept of managed care is financial in nature and, regardless of the type of plan, refers only to cost containment. Utilization management refers to administration of the plan as it relates to plan design. The Association defines utilization management as “...a set of techniques used by or on behalf of purchasers of health care to manage the cost of health care prior to its provision by influencing patient care decision making through case-by-case assessment of the appropriateness of care based on accepted dental practices.”

The techniques embraced by utilization management, as defined, should equally serve patients, plan purchasers and the dental profession, by providing the following:

- **Patients**—parameters of care should be based on scientifically sound, clinically relevant and reliable research; plan coverage should be designed and maintained through evaluation and analysis of data; education and information about different types of procedures and their outcomes should be provided; patients should have the opportunity to make treatment decisions based on a clear understanding of available options.
- **Plan Purchasers**—should provide constant feedback regarding the effectiveness of their plans, thus ensuring a meaningful benefit for their employees; should request data regarding the plan’s loss ratio; should communicate with the Association regarding advances in procedures and technology for consideration in updating plan coverage.
- **Dental Profession**—should have the opportunity for involvement in the process of plan design to ensure appropriate treatment based on parameters of care developed and maintained by the profession.

An area of concern for the Association and others is the increased reliance on statistically-based utilization review of claims as a complete program for managing costs.

In dentistry, utilization review initiatives are classified as retrospective review of treatment. This usually takes the form of a statistically-based, dentist-specific system which analyzes patterns of claims reporting under dental care plans.

The statistics compiled under this system are procedure-specific and are used by the utilization review administrator to develop various statistical “norms” which are used to establish dental practice patterns by which all dentists are judged.

The Association believes that statistically-based utilization review should not be used to determine acceptable norms or clinical standards of dental practice. The Association has defined statistically-based utilization review as a system “...that examines the distribution of treatment procedures based on claims information and in order to be reasonably reliable, the application of such claims analyses of specific dentists should include data on type of practice, dentist’s experience, socioeconomic characteristics and geographic location.”

Statistically-based utilization review has fostered a new service area, and the growth of utilization review companies competing for this business must be recognized for its potential to help solve the problem of healthcare costs, or to substantially add to or create new problems. Treatment plans and claims are being reviewed by clerks, statisticians and actuaries, not by licensed practitioners. Patients are being denied coverage for care based on such reviews.

The Association believes that utilization management, prescribed by the patient’s dentist which protects the lifetime long-term care concerns of the public, is a concept that offers opportunities for patients, plan purchasers, dentists and plan administrators to jointly achieve their common goals: to share information and concerns regarding standards of care; to improve patient
education; to develop meaningful benefit coverage; to respond to advances in technology; and to stabilize the cost of health care in the United States.

and be it further

Resolved, that the policies titled, Utilization Management \((Trans.1990:541)\) and Regulation of Utilization Management Organizations \((Trans.1991:636)\), be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
WORKSHEET ADDENDUM
POLICIES TO BE RESCINDED

Utilization Management
(Trans. 1990:541)

1. The term “managed care” refers to a cost containment system that directs the utilization of health
   benefits by:
   a. restricting the type, level and frequency of treatment;
   b. limiting the access to care; and
   c. controlling the level of reimbursement for services.

2. A system of “statistically based utilization review” is one that examines the distribution of treatment
   procedures based on claims information and in order to be reasonably reliable, the application of such
   claims analyses of specific dentists should include data on type of practice, dentist’s experience,
   socioeconomic characteristics and geographic location.

3. “Utilization management” is a set of techniques used by or on behalf of purchasers of health care
   benefits to manage the cost of health care prior to its provision by influencing patient care decision-
   making through case-by-case assessments of the appropriateness of care based on accepted dental
   practices.

Regulation of Utilization Management Organizations
(Trans. 1991:636)

Resolved, that the constituent societies be encouraged to seek state legislation to establish standards for
the regulation and oversight of all organizations that provide dental utilization management, managed
care review or prior review of dental treatment services, and be it further

Resolved, that the constituent societies be encouraged to seek state legislation and regulations to
require certification of all organizations that provide dental utilization management, managed care review
or prior review of dental treatment services and that persons involved in the utilization management
process in decisions affecting patient care are licensed dentists and are appropriately qualified, and be it
further

Resolved, that the Association study the feasibility of seeking federal legislation to regulate utilization
review and management organizations and report back to the 1992 House of Delegates.
Resolution No. 303 Resolution 303
New

Report: N/A Date Submitted: June 2023

Submitted By: Council on Dental Practice
Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: 

AMENDMENT OF POLICY, STATEMENT TO ENCOURAGE U.S. DENTAL SCHOOLS TO INTERACT WITH U.S. DENTAL LABORATORIES

Background: The Council on Dental Practice proposes amending the policy titled “Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories” (Trans.2010:547).

As new technological advances are developed, the Council noted the importance to amend the third resolving clause for continued relevance to current situation.

Resolution

303. Resolved. That the following policy entitled Statement to Encourage U.S. Dental Schools to Interact With U.S. Dental Laboratories (Trans.2010:547), be amended as follows (additions are underscored, deletions are struck).

Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories

Resolved, that the ADA encourage all U.S. dental schools to use U.S. dental laboratories for fabrication of undergraduate and graduate dental students’ restorative prostheses, in lieu of sending the prescription for these medical devices abroad, and that the ADA believes that the educational process of U.S. dental students would be enhanced by interaction with local dental laboratories, and be it further

Resolved, that the ADA encourage U.S. dental schools to use their own in-house dental laboratories wherever possible in order to facilitate the valuable interaction between dental students and certified dental laboratory technicians as this will afford the dental students with the valuable experience necessary to facilitate the successful fulfillment of a prescription for fabrication of dental prostheses, and be it further

Resolved, that the ADA encourage U.S. dental schools to combine dental education programs with dental laboratory technology programs wherever dental laboratory technology programs are located within commuting distance of the dental school,, and that these programs/certificates could include, but are not limited to, dental morphology/occlusion, prosthetic design and fabrication,
DRAFT BOARD COMMENT: The Board appreciates the Council’s efforts to update this policy and believes that a more general statement is warranted to keep the policy current as curricula and technology are constantly evolving.

Accordingly, the Board urges adoption of the following substitute resolution:

303B. Resolved. That the following policy entitled Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories (Trans.2010:547), be amended as follows (additions are underscored, deletions are stricken).

Statement to Encourage U.S. Dental Schools to Interact with U.S. Dental Laboratories

Resolved, that the ADA encourage all U.S. dental schools to use U.S. dental laboratories for fabrication of undergraduate and graduate dental students’ restorative prostheses, in lieu of sending the prescription for these medical devices abroad, and that the ADA believes that the educational process of U.S. dental students would be enhanced by interaction with local dental laboratories, and be it further

Resolved, that the ADA encourage U.S. dental schools to use their own in-house dental laboratories wherever possible in order to facilitate the valuable interaction between dental students and certified dental laboratory technicians as this will afford the dental students with the valuable experience necessary to facilitate the successful fulfillment of a prescription for fabrication of dental prostheses, and be it further

Resolved, that the ADA encourage U.S. dental schools to combine dental education programs with dental laboratory technology programs wherever dental laboratory technology programs are located within commuting distance of the dental school.

Resolved, that the ADA encourage U.S. dental schools to combine dental education programs with dental laboratory technology programs wherever dental laboratory technology programs are located within commuting distance of the dental school, and that these programs/curricula could include, but are not limited to, dental morphology/occlusion, prosthetic design and fabrication, waxing, casting, surveying of study casts, and incorporation of CAD/CAM technology. These programs be encouraged to collaborate on curricula including current prosthetic design trends and techniques.

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS.
NOTES
Resolution No. 304  
Report: N/A  
Date Submitted: June 2023  
Submitted By: Council on Dental Practice  
Reference Committee: B (Dental Benefits, Practice and Related Matters)  
Total Net Financial Implication: None  
Net Dues Impact:  

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

AMENDMENT OF POLICY, GUIDING PRINCIPLES FOR DENTIST WELL-BEING ACTIVITIES AT THE STATE LEVEL


The National Academy of Medicine launched the Clinician Well-Being Action Collaborative focused on implementing the National Plan for Health Workforce Well-Being in October 2022. The Council notes that incorporating the current terminology regarding “reducing barriers” and “stigma,” was determined to add value and be substantive with regards to all physical and mental well-being.

Resolution

304. Resolved: That the following policy titled, Guiding Principles for Dentist Well-Being Activities at the State Level (Trans.2005:330; 2012:442) be amended as follows (additions are underscored; deletions are stricken).

Guiding Principles for Dentist Well-Being Activities at the State Level

Resolved, that the ADA supports efforts by constituent and component dental societies in the development, maintenance, and collaboration with effective programs to identify and assist those dentists and dental students affected by conditions which potentially impair their ability to practice dentistry, and be it further

Resolved, that constituent and/or component dental societies be urged to adopt the following Guiding Principles for Dentist Well-Being Activities at the State Level.

Guiding Principles for Dentist Well-Being Activities at the State Level

1. Constituent dental societies, on behalf of their well-being programs, are encouraged to negotiate contracts or agreements with state dental boards, licensing agencies and other regulatory agencies to encourage dentists with substance use disorders to get into treatment before they have an alcohol- or drug-related incident.
2. State-level programs to prevent and intervene in dentist and dental team member impairment should be strengthened, supported and well publicized as the most humane and effective method of protecting the interests of the public and of dental professionals.

3. Component and constituent societies are encouraged to engage with state regulatory agencies in their mission to protect the public and providing support for dentists by eliminating barriers to reducing stigma associated with seeking services needed to address mental health challenges.

3-4. Dental societies should be advocates for dentists to have the same rights of privacy and confidentiality of personal medical information as other persons.

4-5. Those dental societies that administer dentist well-being programs are urged to maintain a strong working relationship with their state boards of dentistry and with the appropriate ADA agencies.

5-6. The dental society should ensure that those who serve as dentist peer assistance volunteers are provided immunity from civil liability, except for willful or wanton acts.

6-7. The dental society should also ensure that those who serve as dentist peer assistance volunteers are appropriately trained and supervised in these activities.

7-8. Dental societies in states where services are provided to dentists by multidisciplinary or physician health programs are urged to develop strong relationships with those programs, in order to:

   a. educate service providers about the particular needs of dentists and the dynamics of dental practice
   b. assist providers in outreach to dentists in need of assistance
   c. support dentists and families if treatment is necessary
   d. assist program providers in developing monitoring contracts appropriate to individual dentist’s practice situations
   e. assist program providers in advocating for program participants with the dental board or licensing agency

8-9. Constituent and component dental societies are strongly encouraged to offer continuing education programs on the prevention, recognition and treatment of professional impairment.

9-10. Dental societies are encouraged to support well-being volunteer liaison activities to their dental schools.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
Resolution No. 305  
New

Report: N/A  
Date Submitted: June 2023

Submitted By: Council on Dental Benefit Programs

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None  
Net Dues Impact: 

Amount One-time  
Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

 PROPOSED POLICY, PAYMENT FOR SERVICES FOR MEDICALLY COMPROMISED INDIVIDUALS IN PUBLICLY FUNDED PROGRAMS

Background: The Council on Dental Benefit Programs (CDBP) reviewed the following policies and proposes rescinding these policies and replacing them with a proposed, new policy. The Council concluded that these policies could be combined with revisions for brevity and clarity.

1. Elimination of Disparities in Coverage for Dental Procedures Provided Under Medicare  
   (Trans.1993:705)
2. Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion  
   (Trans.2020:347)

The Council also reviewed the policy titled “Financing Oral Health Care for Adults Age 65 and Older” (Trans.2020:285) and wishes to emphasize that the policy is being retained as is. This new proposed policy is meant to be complimentary. While the “Financing Oral Health Care for Adults Age 65 and Older” (Trans.2020:285) policy addresses a dental benefit for all adults over age 65, this new policy proposal, addresses:

   1. payment for clearance of dental infection prior to a medical procedure and
   2. a dental benefit for individuals with chronic medical conditions (aka “medically necessary”).

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) finalized the Calendar Year 2023 Physician Fee Schedule (PFS) rule, which codified payment for certain dental services that are considered “inextricably linked” and integral to specific Medicare Covered Medical Services beginning January 1, 2023. The following provisions were included in the final CMS rule:

- Dental or oral examination as part of a comprehensive workup prior to a renal organ transplant surgery
- Reconstruction of a ridge when it is performed as a result of and at the same time as the surgical removal of a tumor
- Stabilization or immobilization of teeth when done in connection with the reduction of a jaw fracture
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease
- Dental splints when performed in conjunction with treatment that is determined to be a covered medical condition
- Dental services — including both examination and treatment — prior to cardiac valve replacement, valvuloplasty or organ transplant procedures
- Examination and treatment prior to head and neck cancer therapies (beginning 2024)

Even though these changes to the PFS rule only impact a small number of Medicare recipients, the scope of dental services that are covered is broader. The final rule stated that Medicare payment would be provided if these procedures were done on an outpatient or an inpatient basis. Coverage would also be provided for ancillary services such as radiographs, anesthesia, or the use of an operating room for medically necessary procedures that fall under the rule. The ADA supported payment for dental services prior to the aforementioned medical procedures as proposed by CMS based on the policy titled “Elimination of Disparities in Coverage for Dental Procedures Provided Under Medicare” (Trans.1993:705) which states “…Association seek legislation which would provide for payment of dental services under Part B of Medicare in cases where the dental procedure is necessary and directly associated with a medical procedure or diagnosis”.

As a follow-up to these activities and as part of the Council’s routine policy review exercise, the Council believed that it was important to clarify the policy titled “Elimination of Disparities in Coverage for Dental Procedures Provided Under Medicare (Trans.1993:705)”.

The Council tried to combine all Medicare policies into one single comprehensive policy but determined that separate policies addressing the different populations (“all seniors” versus “medically necessary”) would offer more clarity to the ADA’s position because there are independent legislative/regulatory efforts addressing these populations. Thus, the policy titled “Financing Oral Health Care for Adults Age 65 and Older” (Trans.2020:285) would address a dental benefit for all seniors over age 65 while the new proposed policy would address the ADA’s position on “medically necessary” coverage. Examples of chronic medical conditions include diabetes and hypertension among others with data from CMS indicating that 26% of traditional Medicare beneficiaries suffer from diabetes and another 26% suffer from heart disease.

The Council has deliberately tried to align these policies as much as possible. The Council is aware that the desired program funding in this proposed policy is set at the 80th percentile and is different from the 2020 policy which stipulates the 50th percentile. The Council will work on further alignment based on the final action from the House of Delegates. The Council estimates, based on data from the National Association of Dental Plans, that currently seven to eight in 10 dentists participate in commercial PPO plans which serves about 184 million individuals in the United States. This proposed policy stipulates that program funding should be based on achieving an 80th percentile reimbursement rate because adequate program funding is critical to supporting access to care especially for a medically compromised patient population.

The Council on Dental Benefit Programs recommends that the following resolution be adopted:

**Resolution**

305. Resolved, that the following proposed policy be adopted.

**Payment for Services for Medically Compromised Individuals in Publicly Funded Programs**

Resolved, that the American Dental Association support payment for dental services, under Medicare, for medically compromised individuals requiring clearance of dental infection, before medical procedures, and be it further
Resolved, that if legislators or regulators seek to support payment for regular dental care for older adults with chronic medical conditions in any taxpayer funded public program, then the ADA shall support a program that:

- covers chronic medical conditions that have evidence supporting improved health outcomes with regular dental care
- covers the range of services on both in-patient and out-patient basis necessary to achieve the desired improvement in health outcomes
- is adequately funded to support an annually reviewed reimbursement rate such that 80% of dentists within each geographic area receive their full fee (80th percentile) to support access to care
- includes minimal and reasonable administrative requirements including the use of the CDT Code for reporting dental procedures and use of the dental claim form (837D electronic standard or the ADA paper claim form)
- allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit

and be it further

Resolved, that the following ADA policies be rescinded:

- Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion (Trans.2020:347)
- Oral Health Care for the Elderly (Trans.2020:279)

BOARD COMMENT: The Board appreciates the Council on Dental Benefit Programs efforts regarding the proposed policy. In proposing its substitute, the Board wishes to address the following concerns.

- The term “medically compromised” is an undefined term. The amendment to the title and content of the resolving clauses, remove this term to improve clarity.
- As noted in the background, the Centers for Medicare & Medicaid Services (CMS) addresses several medical conditions as “chronic medical conditions”. The amendment to this term offers greater specificity around the intent of this resolution.
- While the Board appreciates the reliance on evidence when assessing our support for a dental benefit associated with covered medical conditions, the Board believes that the type of evidence should be verified. The Board is aware that there are accepted mechanisms to assess the quality of evidence within the scientific community.
- The Board believes strongly that the differences between a medical and dental office must be highlighted in any communication applicable to public programs. The Board emphasizes that the current RVU system that is used in Medicare is unacceptable for dentistry.

Accordingly, the Board urges adoption of the following substitute resolution:

305B. Resolved, that the following proposed policy be adopted.

Payment for Services for Medically Compromised Individuals with Medical Conditions in Publicly Funded Programs

Resolved, that the American Dental Association support payment for dental services, under Medicare, for medically compromised individuals requiring clearance of dental infection, before medical procedures, and be it further
Resolved, that if legislators or regulators seek to support payment for regular dental care for older adults for dental services associated with otherwise covered medical services with chronic medical conditions in any taxpayer funded public program, then the ADA shall support a program that:

- covers provides a dental benefit for individuals only when high-quality peer-reviewed current chronic medical conditions that have evidence as assessed by the ADA supports supporting improved health outcomes for that medical condition when the individual is provided with regular dental care
- covers the range of services on both in-patient and out-patient basis necessary to achieve the desired improvement in health outcomes
- is adequately funded to support an annually reviewed reimbursement rate such that 80% of dentists within each geographic area receive their full fee (80th percentile) to support access to care
- includes minimal and reasonable administrative requirements including the use of the CDT Code for reporting dental procedures and use of the dental claim form (837D electronic standard or the ADA paper claim form)
- allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit

and be it further

Resolved, that the ADA emphasize that dental offices are essentially surgical centers and the current Relative Value Unit (RVU) system in medicine is not applicable to dentistry.

and be it further

Resolved, that the following ADA policies be rescinded:

- Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion (Trans.2020:347)
- Oral Health Care for the Elderly (Trans.2020:279)

BOARD RECOMMENDATION: Vote Yes on the Substitute.

BOARD VOTE: UNANIMOUS
Resolution 305
Reference Committee B

WORKSHEET ADDENDUM
POLICIES TO BE RESCINDED

Elimination of Disparities in Coverage for Dental Procedures Provided Under Medicare
(Trans.1993:705)

Resolved, that the Association seek legislation to provide fair and equitable treatment to all Medicare recipients by eliminating disparities in coverage for dental procedures, and be it further

Resolved, that the Association seek legislation which would provide for payment of dental services under Part B of Medicare in cases where the dental procedure is necessary and directly associated with a medical procedure or diagnosis.

Modifying the Existing Medicare Dental Coverage: Statutory Dental Exclusion
(Trans.2020:347)

Resolved, that the appropriate ADA agencies should consider conducting a review of the current scientific evidence that would support expanding the oral health services provided to medically frail recipients prior to major medical or surgical treatments available through Medicare in order to determine next steps for modifying the Medicare statutory exclusion, with the recommendation that the review include but not be limited to the following:

• head and neck radiation therapies
• osteoclast inhibitor therapy
• organ transplants
• cancer chemotherapy including hematopoietic cell transplantation
• joint replacement
• cardiac valve replacement

Oral Health Care for the Elderly
(Trans.2020:279)

Resolved, that the American Dental Association supports the development of policy at the federal, state, and local levels that supports the fair, equitable, choice-driven provision of dental care to promote improved health and well-being in elderly patients.
Resolution No. 306  
Report: N/A  
Date Submitted: June 2023  
Submitted By: Council on Dental Benefit Programs  
Reference Committee: B (Dental Benefits, Practice and Related Matters)  
Total Net Financial Implication: None  
Net Dues Impact:  
Amount One-time  
Amount On-going  
ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.  
How does this resolution increase member value: See Background  

**AMENDMENT OF POLICY, DENTAL BENEFITS WITHIN AFFORDABLE CARE ACT MARKETPLACE AND A PUBLIC OPTION**

**Background:** The Affordable Care Act (ACA) includes stipulations that all health insurance plans available through the ACA Marketplaces are required, at a minimum, to include what are called “Essential Health Benefits” (EHB). ACA also requires non-grandfathered health plans in the individual and small group markets to cover EHBs. These EHB include: ambulatory patient services; emergency services; hospitalization; pregnancy, maternity and newborn care; mental health and substance use disorder services including behavioral treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including comprehensive dental and vision care. Dental benefit coverage for adults is currently not considered an EHB. In fact, on its website, the Centers for Medicare & Medicaid Services (CMS) notes that “Dental coverage isn’t an essential health benefit for adults.” The ADA receives inquiries periodically seeking ADA position on classifying adult dental benefits as an EHB. The proposed amendment from the Council on Dental Benefit Programs (CDBP) is meant to clearly state the ADA’s position on EHB.

CMS reports that in 2023, over 90% of the 16.4 million enrollees were between 18 and 64 years of age and, over 90% of enrollees were below 400% Federal Poverty Level (FPL).

Due to the unique nature of dental benefits, implementation of the “pediatric dental EHB” was vastly different from how other EHB were handled. Pediatric dental EHB has been implemented as an “optional” rather than mandatory coverage element unlike every other EHB, (i.e. for someone 18 or younger, dental coverage must be available but does not need to be purchased). Given this, the dental industry has not seen very large impacts since the ACA was enacted in 2012. Experience, thus far, indicates that most ACA compliant plans use their commercial networks, (i.e. reimbursement levels are more closely aligned with commercial fees and not Medicaid). CDBP believes that if adult dental benefits are added as EHB’s, then the ADA should advocate that annual maximums should not apply to these plans mimicking the pediatric plans. However, CDBP strongly believes that the implementation issues related to the pediatric plans (e.g. treating them as “optional” benefits) should not occur if adult dental is classified as an EHB.

In 2021, the House of Delegates adopted the policy titled “Dental Benefits within Affordable Care Act Marketplace and a Public Option” (Trans.2021:284). While this policy stipulates ADA’s position on a number of issues regarding regulating dental plans offered on ACA Marketplaces, the ADA’s position on classifying adult dental benefits as an “Essential Health Benefit” remains unclear. CDBP conducted in-depth policy research to understand the experience from classifying pediatric dental benefits as an EHB and the potential implications of classifying adult dental benefits as an EHB.
As a result, CDBP recommends that the following resolution be amended to clearly state ADA’s position regarding dental benefits as Essential Health Benefits.

Resolution

306. Resolved, that the policy titled, Dental Benefits within Affordable Care Act Marketplace and a Public Option (Trans.2021:284), be amended as follows (additions are underscored; deletions stricken).

DENTAL BENEFITS WITHIN AFFORDABLE CARE ACT MARKETPLACE AND A PUBLIC OPTION

Resolved, that within the Marketplaces established by the Affordable Care Act:

- Dental benefits, both pediatric as well as adult benefits should be considered “Essential Health Benefits”.
- Coverage inside and outside of the Marketplaces must include pediatric and adult dental benefits.
- There should be no dollar-value annual and lifetime maximums in and out of the ACA Marketplaces.
- Dental coverage should be available to consumers through Stand Alone Dental Plans.
- Diagnostic and preventive dental services embedded within Qualified Health Plans should be covered without any additional co-payment, co-insurance or deductibles.
- Dental care is essential across the individual’s life span. Individuals seeking to purchase benefits in the Marketplaces must be able to purchase dental benefits without having to first purchase a medical plan.
- Plan designs should remain flexible and offer consumers adequate choices balancing cost and benefit value.
- Dental Plans offered in the Marketplaces must be required to transparently report Medical (Dental) Loss Ratios (MLR/DLR).
- Cost sharing assistance or premium tax credits should be available to consumers purchasing dental plans.
- Dependent children should be allowed to remain on their parents plans until age 26 in any dental plan.

and be it further,

Resolved, that if any plan, including a public option plan, that provides dental coverage includes pediatric or adult dental benefit plans were introduced within the Marketplaces established by the Affordable Care Act, then such plans should:

- Allow freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.
- Not force any providers, including those already participating in existing public programs, to join a Marketplace plan network and instead should support fair market competition, including meaningful negotiation of contracts and annual adjustment of fee schedules.
- Only include minimal and reasonable administrative requirements to promote participation and provide meaningful access.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
Resolution No. 307  

Report: Medicaid Task Force Report  

Date Submitted: June 2023  

Submitted By: Medicaid Task Force  

Reference Committee: B (Dental Benefits, Practice and Related Matters)  

Total Net Financial Implication: None  

Net Dues Impact: 0  

Amount One-time  

Amount On-going  

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.  

How does this resolution increase member value: See Background  

PROPOSED POLICY, COMPREHENSIVE STATEMENT ON DENTAL MEDICAID PROGRAMS  

Background: More than 91 million Americans are covered by Medicaid, with just less than half being children. Medicaid is a $12 billion annual national expenditure and makes up about 20% of the dental insurance market.  

State Medicaid dental programs vary significantly across state lines in their funding and administration, and many enrollees are left with subpar benefits and barriers to use their benefits. As a significant source of dental care coverage for the US population, the ADA and dentists cannot afford to be indifferent to the program but should seek ways to improve the program for both patients and providers.  

The Medicaid Task Force (established pursuant to Resolution 83H-2021 – Establishment of a Medicaid Task Force (Trans.2021:331) and reauthorized pursuant to Resolution 513H-2022) reviewed existing ADA policy and spent significant time developing a comprehensive policy statement. Members of the Task Force reviewed the toolkit titled “Medicaid: Considerations When Working with States to Develop an Effective RFP/Dental Contract” and wish to highlight this as a resource applicable to this proposed policy statement.  

The creation of this new comprehensive statement removes the need for the separate policies adopted previously by the House of Delegates. The Task Force has strived to ensure that all salient features of those resolutions are included in this new comprehensive statement and believes that having a clean, clear, defined policy will allow the ADA to utilize resources optimally to proceed with Medicaid dental program reform.  

The Medicaid Task Force recommends that the following resolution be adopted:  

Resolution 307. Resolved, that the following proposed policy be adopted.
Comprehensive Statement on Dental Medicaid Programs

Medicaid is a taxpayer funded public health insurance program based on federal-state partnership. Medicaid covers low-income people including families and children, pregnant women, the elderly, and people with disabilities. Each state and territory determine eligibility criteria and program structure to support delivery of care to underserved populations.

General Program Considerations: While children covered by Medicaid programs have access to a mandatory Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, the ADA strongly supports a comprehensive adult dental benefit for the Medicaid-eligible population in an adequately funded program and encourages the federal and state governments to institute an adult dental benefit in Medicaid. The ADA believes that the federal Medicaid match for children and adult dental care should be enhanced to 90/10 or better (FMAP).

Medicaid Program Structure: The ADA believes that successful Medicaid programs are those that are supported by a strong state level multi-stakeholder Medicaid Dental Advisory Committee that can provide guidance and analysis of program success, support program integrity and participate in program improvement initiatives. Such a committee should also be supported by a full-time Chief Dental Medicaid Director.

In addition to a Medicaid Dental Advisory Committee, the ADA believes that state-level peer-review committees with dentists licensed in the state can support Medicaid programs in assessing clinical issues related to administering the Medicaid benefit.

The ADA encourages state dental associations to remain a significant voice within their state Medicaid programs and in turn should encourage their Medicaid programs to share program decisions which impact access, quality of care and availability of specialty care. The ADA encourages all state dental associations to actively participate in the establishment or continuation of an existing Medicaid Dental Advisory Committee that is recognized by the state Medicaid agency as the professional body to provide recommendations on Medicaid dental issues.

The ADA strongly believes that every patient should have a dental home and a managed care plan should never be addressed as the “dental home” for a Medicaid enrolled beneficiary. The ADA also supports the rights and freedom of patients to choose their own dentist, as well as their own Medicaid Managed Care Plan.

Provider Participation: The ADA encourages dentists to participate in the Medicaid program. The ADA encourages dentists to refer patients seeking care, to dentists enrolled in Medicaid in those instances wherein they are unable to accommodate them. The ADA supports a dentist’s autonomy to choose their level of participation in Medicaid programs.

Network adequacy for Medicaid programs is dependent on the adequate number and diversity of providers to address the disease burden and promote prevention. The ADA believes that Medicaid programs should establish policies that incentivizes any dentist willing to provide a dental home for children from birth to age 5. Dentists should be allowed to claim a tax credit for the first $10,000 of services (based on the most recent Code on Dental Procedures and Nomenclature (CDT) codes) and credited at a rate consistent with the dentists’ full fees for that region or state.

Opportunities for early-career dentists to engage with state Medicaid programs can be enhanced through loan repayment programs for dentists who are willing to treat a disproportionate number of Medicaid beneficiaries. Such loan repayment programs should be commensurable with the level of Medicaid participation. The ADA also supports additional funding such as enhanced reimbursement to dental schools that treat Medicaid beneficiaries.

Annually reviewed reimbursement, aligned with current Fair Health provider charges data, is necessary to assure adequate compensation such that the majority of dentists in a region would be encouraged/motivated to participate in the program.

**Transparency & Reporting:** The ADA believes that transparency and standardization of reporting data in all Medicaid programs relating to access to care, patient / provider satisfaction rates, and network adequacy is essential for the public, state dental associations, researchers and other stakeholders to effectively assess the success of the Medicaid program regardless of whether the program is administered directly by the state or through managed care contracts. Data should be publicly available on an annual basis. When the Medicaid benefit is administered through managed care contracts, information regarding medical/dental loss ratio should also be made publicly available.

**Administrative Practices:** To better ensure patient safety and access to care, the ADA believes that Medicaid programs should:

- Based on provider experience, use a single credentialing system across all managed care plans within Medicaid (state specific) to decrease administrative burdens, such that providers who are willing to participate can join the program in a timely manner thus ensuring an adequate network.
- Establish uniform processes to transfer prior authorizations between managed care plans.
- Support coverage for caries risk assessment, case management, transportation, language services, appointment compliance, desensitization visits for patients with disabilities and coordination of other medical appointments.
- Support coverage for preventive services related to tobacco cessation, nutritional counseling, home care practices, and any other services that improve overall health outcomes.
- Conduct any necessary audits through dentists who have similar educational backgrounds and credentials as the dentists being audited, as well as being licensed within the state in which the audit is being conducted.
- Ensure that each managed care entity establishes a designated Provider Advocate position to conduct educational sessions for participating providers and provide ongoing technical and navigational support.
- Address case management for Special Needs patients through enhanced payment schedules.

The ADA encourages state dental associations, whenever possible, to actively participate in any request for information, request for proposals, or contract development processes using resources developed by the Association to ensure appropriate administration of Medicaid managed care.

and be it further

**Resolved,** that the following ADA policies be rescinded:

- Federal Medicaid Funding (Trans.2020:338)
- Tax Incentives for Medicaid Participation (Trans.2020:338)
• State Medicaid Dental Peer Review Committee (*Trans.*2018:361)
• Peer-to-Peer State Dental Medicaid Audits (*Trans.*2017:234)
• Chief State Medicaid Dental Officer and Medicaid Dental Advisory Committee (*Trans.*2015:275)
• Medicaid and Indigent Care Funding (*Trans.*2006:338; 2014:499; 2021:319)
• Support for Adult Medicaid Dental Services (*Trans.*2004:327; 2021:323)
• Fee-For-Service Medicaid Programs (*Trans.*1999:957; 2021:319)

**BOARD RECOMMENDATION:** Vote Yes.

**BOARD VOTE:** UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)
WORKSHEET ADDENDUM
POLICIES TO BE RESCINDED

Federal Medicaid Funding
(Trans.2020:338)

Resolved, that the federal Medicaid match for dental care should be enhanced to 90/10 or better.

Tax Incentives for Medicaid Participation
(Trans.2020:338)

Resolved, that dentists should be allowed to claim a tax credit for the first $10,000 of services provided under the Medicaid program, and be it further

Resolved, that the tax credit should be based upon the most recent Code on Dental Procedures and Nomenclature (CDT) codes and credited at a rate consistent with the most recent ADA Survey of Dental Fees for that region or state.

State Medicaid Dental Peer Review Committee
(Trans.2018:361)

Resolved, that the American Dental Association encourages all state dental associations to work with their respective state Medicaid agency to create a dental peer review committee, made up of licensed current Medicaid providers who provide expert consultation on issues brought to them by the state Medicaid agency and/or third-party payers.

Peer-to-Peer State Dental Medicaid Audits
(Trans.2017:234)

Resolved, that the American Dental Association encourages all state dental associations to work with their respective state Medicaid agency to ensure that Medicaid dental audits be conducted by dentists who have similar educational backgrounds and credentials as the dentists being audited, as well as being licensed within the state in which the audit is being conducted.

Chief State Medicaid Dental Officer and Medicaid Dental Advisory Committee
(Trans.2015:275)

Resolved, that the American Dental Association encourages all state dental associations to work with their state Medicaid agency in hiring a Chief Medicaid Dental Officer, who is a member of organized dentistry, and be it further

Resolved, that the American Dental Association encourages all state dental associations to actively participate in the establishment or continuation of an existing Medicaid dental advisory committee that is recognized by the state Medicaid agency as the professional body to provide recommendations on Medicaid dental issues.

Medicaid and Indigent Care Funding

Resolved, that the American Dental Association supports adequate funding to provide oral health care to Medicaid and other indigent care populations.
Support for Adult Medicaid Dental Services

(Trans.2004:327; 2021:323)

Resolved, that comprehensive adult dental services should be included in the federal Medicaid program as an integral part of overall health, and be it further

Resolved, that adult coverage under Medicaid should not be left to the discretion of individual states but rather, should be provided consistent with all other basic health care services.

Fee-For-Service Medicaid Programs

(Trans.1999:957; 2021:319)

Resolved, that states should adopt adequately funded fee-for-service models for Medicaid programs to increase dentist participation and increase access to care for Medicaid participant.
Resolution No. 308 New

Report: N/A Date Submitted: June 2023

Submitted By: South Dakota Dental Association

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None Net Dues Impact: 

Amount One-time Amount On-going

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

PROMOTING USE OF DICOM IN DENTISTRY

The following resolution was submitted by the South Dakota Dental Association and transmitted on June 14, 2023, by Paul Knecht, Executive Director.

Background: There are multiple CBCT systems for dentistry, each with a unique method for exporting CBCT data to a DICOM (Digital Imaging and Communication in Medicine) format. Due to the number of different formats, it is difficult for most dental offices to open DICOM images transferred from other dental offices. As a result, many offices need to retake a CBCT, creating unnecessary expense as well as unnecessary radiation to the patient.

Resolution

308. Resolved, that the appropriate agencies in the ADA urge legislators and/or regulators to require the use of DICOM standards across any product or system that exchanges images in dentistry, and be it further

Resolved, that the ADA urge the dental software industry to adopt DICOM standards to ensure interoperability between systems.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.
Resolution No. 309

Report: Board Report 4

Date Submitted: July 2023

Submitted By: Board of Trustees

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None

Net Dues Impact: 

Amount One-time 

Amount On-going 

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

REPORT 4 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: AMENDMENT TO THE POLICY, POLICIES AND RECOMMENDATIONS ON DIET AND NUTRITION

Background: At its meeting of October 19, 2022, the Board of Trustees adopted Resolution B-129-2022, which authorized a task force to identify gaps in the Association’s policy on sugar consumption, recommend revisions, and identify strategy considerations to help curb excessive sugar intake. ADA President George Shepley appointed the following individuals to serve on the Task Force:

Members: Dr. Michele Tulak-Gorecki, chair (District 9 and Board of Trustees); Dr. Brett Kessler (District 14 and Board of Trustees); Dr. James Mancini (District 3 and Council on Access for Advocacy and Prevention); Dr. Jessica Robertson (District 14 and Council on Access for Advocacy and Prevention); Dr. David Clemens (District 9 and Council on Government Affairs); Dr. Jennifer Holtzman (District 4 and Council on Scientific Affairs); Dr. Scott Sutter (District 14); Dr. Dewitt Wilkerson (District 17).

Consultants: Dr. Domenick Zero (Indiana University School of Dentistry); Dr. Teresa Marshall (University of Iowa School of Dentistry); Dr. Gregory Chadwick (FDI World Dental Federation); Dr. Robert Lustig (University of California, San Francisco School of Medicine).

Over several months, the Task Force reviewed the policy titled Policies and Recommendations on Diet and Nutrition (Trans.2016:330); examined the findings and recommendations of several previous ADA panels, heard presentations from experts in the field, and circulated studies of interest among themselves. The Task Force ultimately determined that the policy should be updated to reflect the latest developments in the field. Specifically, the Task Force recommended:

- Emphasizing that healthy foods need to be an attractive, available, and affordable alternative to added sugar products.

- Incorporating the modern concept of “ultra-processed foods,” which are edible products made from manufactured ingredients that have been extracted from foods, processed, then reassembled to create shelf-stable, tasty, and convenient meals.

- Promoting widespread access to potable water.
• Withdrawing support for the findings and recommendations of a 2012 report from the Council on Access, Prevention, and Interprofessional Relations (now the Council on Advocacy for Access and Prevention), as the science may have evolved since it was published.

• Broadening the vernacular to include the entire “dental professional community.”

Based on these recommendations, the Board urges that the following resolution be adopted:

Resolution

309. Resolved, that the policy titled Policies and Recommendations on Diet and Nutrition (Trans.2016:330) be amended as follows (additions are underscored; deletions are stricken):

Resolved, that oral health depends on proper nutrition and healthy eating habits, and necessarily includes avoiding a steady diet of foods containing natural and added sugars, processed starches and low pH-level acids, and be it further

Resolved, that the ADA American Dental Association acknowledges that oral health depends on proper diet and nutrition, and it is beneficial for consumers to avoid a steady diet of ultra-processed foods—defined as industrial creations reformulated with little if any whole foods, often additives and containing large amounts of added sugar and salt—especially those containing natural and added sugars, processed starches and low pH-level acids as way to help maintain optimal oral health, and be it further

Resolved, that the ADA supports the findings and recommendations in the Council on Access, Prevention and Interprofessional Relations Supplemental Report 3 to the 2012 House of Delegates: Formulation a Strategic Approach for Addressing the Complex Emerging Issues Related to Oral Health and Nutrition in the United States (Trans.2012:4114), and be it further

Dentist's Role in Nutrition and Oral Health

Resolved, that the ADA encourages dentists to routinely counsel their patients about the oral health benefits of maintaining a well-balanced diet and limiting the number of between-meal snacks the dental professional community to pursue continuing education credit opportunities that highlight nutritional science and motivational counseling, so that they may empower their patients to adopt a healthy dietary pattern of consuming a balanced diet with little to no ultra-processed foods, and be it further

Resolved, that the ADA encourages dentists to stay abreast of the latest science-based nutrition recommendations and nutrition-related screening, counseling and referral techniques, and be it further

Resolved, that the ADA encourages dentists to serve on local school wellness planning boards to establish and maintain local school wellness policies that the dental professional community to support their communities to:

- Appropriately balance the nutritional benefits of consuming certain foodstuffs and the risk of tooth decay.

- Promote lifelong mouth healthy behaviors, such brushing twice a day, flossing once a day, limiting consumption of sugary snacks and beverages and seeing the dentist regularly.

- Reflect the inextricable link between oral health and overall health and well-being.

- Promote widespread access to safe drinking water.
• Reduce the consumption of added sugar and sugar-sweetened beverages.

• Promote lifelong healthy behaviors, including appropriate oral hygiene measures, limiting consumption of ultra-processed foods, and seeing the dentist regularly.

• Reflect the link between oral health and overall health and well-being.

• Create environments where healthy foods are an attractive and affordable choice for all students.

• Oppose programs that promote or otherwise incentivize consumption of ultra-processed foods (e.g., pouring rights contracts, etc.).

and be it further

**Access and Prevention**

Resolved, that the ADA supports its members by providing access to current information and educational materials, and cultivating learning opportunities (e.g., continuing education modules, etc.), for dentists, the dental professional community to learn more about the relationship between diet, nutrition, and oral health—including latest science-based nutrition recommendations and nutrition-related screening and counseling techniques, and be it further

Resolved, that the ADA encourages collaborations with health care professionals, dietitians, social workers, community health workers, and other nutrition experts, stakeholders to raise interprofessional awareness about the relationship between diet, nutrition, and oral health, and be it further

Resolved, that the ADA supports projects, as appropriate and feasible, to educate the public about the oral health benefits of maintaining a healthy diet, and to encourage consumers to adopt healthier diets and establish better eating habits to educate the public to maintain a healthy diet and to reduce consumption of added sugar, and be it further

Resolved, that the ADA supports public information campaigns to reduce the amount of added sugars consumed in American diets, and be it further

Resolved, that the ADA encourages constituent and component dental societies to work with state and local officials to ensure locally-administered nutrition and food assistance programs have an oral health component (e.g., WIC, SNAP, NSLP, etc.), and be it further

Resolved, that the ADA encourages constituent and component dental societies to work with state and local school officials to prohibit schools from entering into contractual arrangements, including school pouring rights contracts, that incentivize schools to sell and aggressively advertise foods and beverages with high added sugar content on school grounds (e.g., providing free samples, posting signage, branding school equipment, sponsoring events, etc.), collaboration with state and local officials to reduce consumption of ultra-processed foods, especially those containing added sugars, and promote nutritious and healthy diets in schools, and be it further

Resolved, that the ADA supports the World Health Organization’s 2015 Guideline on Sugar Intake for Adults and Children, and be it further

**Government Affairs**

Resolved, that the ADA should give priority to the following when advancing public policies on diet, nutrition, and oral health:
1. Ensuring government-supported nutrition education and food assistance programs (e.g., WIC, SNAP, NSLP, etc.) have an oral health component, such as and general guidelines that promote good oral health.

2. Encouraging federal research agencies to develop the body of high-quality scientific literature examining, among other things, oral health associations with ultra-processed foods and the extent to which dental caries rates fluctuate with changes in total added sugar consumption and over what period(s).

3. Maintaining the separate line-item declaration of added sugars content on Nutrition Facts labels and listing the declared added sugars content in relatable terms (e.g., teaspoons, grams, etc.).

4. Supporting legislative and regulatory actions, as appropriate and feasible, to increase consumer awareness about the role dietary sugar consumption may play in maintaining optimal oral health and, including the potential benefits of limiting added sugar consumption in relation to general and oral health.

5. Requiring third-party payers to cover nutrition counseling in dental offices as an essential plan benefit.

**BOARD RECOMMENDATION:** Vote Yes.

**BOARD VOTE:** UNANIMOUS* (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)

*Dr. Irani was not in attendance.
Resolution No. 310

Report: N/A

Date Submitted: July 2023

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None

Net Dues Impact: __________

Amount One-time __________ Amount On-going __________

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

**AMENDMENT OF POLICY, OROFACIAL PROTECTORS**


The Council on Advocacy for Access and Prevention recommends that the following resolution be amended to include additional aspects of facial and head protection as well as the acknowledgement of the role they play in overall health.

**Resolution**

310. **Resolved,** that the policy titled Orofacial Protectors (Trans.1994:654; 1995:613; 2016:322) be amended as follows (additions are underscored; deletions are stricken):

Resolved, that the American Dental Association recognizes the preventive value of orofacial protectors including mouthguards, helmets, and face shields, and endorses the use of orofacial protectors by all participants in recreational and sports activities with a significant risk of injury at all levels of competition including practice sessions, physical education and intramural programs, and be it further

Resolved, that the ADA supports collaboration with international and national organizations, sports conferences, sanctioning bodies, school federations, and others to mandate the use of orofacial protectors to promote sports dentistry, and be it further

Resolved, that the ADA supports sports dentistry as the branch of sports medicine that deals with the prevention and treatment of dental injuries and related oral diseases associated with sport and exercise as an approach to whole health.

**BOARD RECOMMENDATION:** Vote Yes.

**BOARD VOTE:** UNANIMOUS* (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)

*Dr. Irani was not in attendance.
Resolution No. 311                                      New

Report: N/A                                      Date Submitted: July 2023

Submitted By: Council on Advocacy for Access and Prevention

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None  Net Dues Impact: 

Amount One-time  Amount On-going  

ADA Strategic Plan Objective: Public Goal Obj-9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

How does this resolution increase member value: See Background

RECISSION OF POLICY, PREVENTION RESEARCH TO AID LOW INCOME POPULATIONS


The Council on Advocacy for Access and Prevention found that the language of this policy was redundant considering the Oral Health Equity policy passed in 2021 (Trans.2021:329). Therefore, the Council recommends that the following resolution be adopted.

Resolution

311. Resolved, that the policy titled Prevention Research to Aid Low Income Populations (Trans.2001:441) be rescinded.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS* (BOARD OF TRUSTEES CONSENT CALENDAR ITEM)

*Dr. Irani was not in attendance.
Prevention Research to Aid Low Income Populations (Trans.2001:441)

Resolved, that the ADA continue to propose and/or support legislation and federal and state programs which will address the issue of the disproportionately high levels of dental disease in lower socioeconomic populations, direct extensive research to accurately identify the factors that are causing such discrepancies, and develop programs through working with other organizations and government agencies that will be effective with these populations, and be it further

Resolved, that the ADA through its appropriate agencies monitor the progress on all efforts both private and public towards improved oral health of lower socioeconomic group populations.
HUMAN PAPILLOMAVIRUS (HPV) EDUCATION AND COLLABORATION

Background: Since HPV vaccination is associated with dramatically reduced rates of HPV infection, HPV vaccination can serve to stem the increasing rates of HPV-related oropharyngeal cancer in the United States, which now surpasses cervical cancer. Current HPV vaccination rates in the U.S. are approximately 30%.

As dentists discuss overall health topics such as tobacco use/vaping, mouthguard use, sleep apnea and health nutrition with their patients, the opportunity to appropriately refer young patients to medical teams for HPV vaccinations is significant. Research comparisons show that, while physician visits were more common than dental visits at very young ages, that dynamic changed at age 9. Children older than nine begin to average more dental visits than physicians visits per year.

Dentists have an important professional role as healthcare advocates to raise awareness among their patients about HPV-related oropharyngeal cancer, promote HPV vaccination of appropriately aged patients and discuss the important role of the vaccine in cancer prevention with the parents/guardians of younger patients.

HPV vaccination, as recommended by the CDC Advisory Committee on Immunization Practices, is a safe and effective intervention to decrease the burden of oral/oropharyngeal HPV infection but will be effective only when the entire healthcare team is engaged in connecting appropriately aged patients to the vaccine. The CDC Committee also urges dentists and state dental societies to support the use of the HPV vaccine and research to improve understanding of the natural history of oral HPV infection, transmission risks, screening and testing.

In 2018, the House of Delegates adopted Resolution 53H (Trans.2018:351), Human Papillomavirus (HPV) Vaccination for the Prevention of Infection with HPV Types Associated with Oropharyngeal Cancer. The Council on Scientific Affairs (CSA) has recently reviewed the policy and has recommended that it be retained as written.

Human Papillomavirus (HPV) Vaccination for the Prevention of Infection with HPV Types Associated with Oropharyngeal Cancer

53H-2018. Resolved, that the American Dental Association (ADA) adopts the position that HPV vaccination, as recommended by the CDC Advisory Committee on Immunization Practices, is a
safe and effective intervention to decrease the burden of oral and oropharyngeal HPV infection,
and be it further

Resolved, that the ADA urges dentists, as well as local and state dental societies, to support the
use and administration of the HPV vaccine as recommended by the CDC Advisory Committee on
Immunization Practices, and be it further

Resolved, that the ADA encourages appropriate external agencies to support research to
improve understanding of the natural history of oral HPV infection, transmission risks, screening
and testing.

The Council on Advocacy for Access and Prevention met in July 2023, and strongly believes more
actionable language is warranted for this critically important issue to engage dental teams to actively
coordinate patient vaccination with medical providers.

Therefore, the Council on Advocacy recommends that the following Resolution be adopted.

Resolution

312. Resolved, that the ADA encourages education of the dental profession at the state and local
levels on the importance of preventing HPV cancers, and be it further

Resolved, that the ADA encourages collaboration with other health care organizations to support
patient education on HPV prevention.

BOARD RECOMMENDATION: Vote Yes.

BOARD VOTE: UNANIMOUS.
The following resolution was submitted on September 8, 2023, and transmitted by Ms. Molly Pereira, Executive Director, Colorado Dental Association and Dr. Eric Curtis, Chair, Fourteenth District Resolution Committee Chair.

Background: Dentists have the lowest Prescription Drug Monitoring Program (PDMP) registration/use compliance of any profession. A study in conjunction with the ADA in October 2019, showed that 46.6% of dentists who prescribed a narcotic had never utilized the PDMP data bank. Although dentists prescribe very few opioid pills per prescription, dentistry as a profession, is one the top prescribing healthcare providers of opioids. It is well known that deaths due to opioids are at an all-time high with over 110,000 deaths due to opioids reported in 2022. Of these deaths, 30-40% can be linked to the use of prescription opioids.

The PDMP has been in existence for a number of years and was designed to help combat the misuse, abuse and diversion of controlled prescription drugs. In 2014, pharmacies were required to submit data on all dispensed controlled substances to the PDMP. States are now requiring prescribers with a federal DEA registration to be registered with the PDMP database.

Many states have made it mandatory for MEDICAL electronic records to be linked to the RX Check status for the PDMP program.

In addition, there are new requirements making it mandatory that any prescriber who writes a prescription for an opioid or a benzodiazepine query the PDMP database.

Given that medicine has had their electronic health records (EHR) linked to the PDMP database for many years, it is now time for dentistry to follow suit and require this of any software provider who sells a product to dentists. Before EHR/PDMP links were established, the average amount of time to use the database was approximately five minutes. One of the main reasons for non-use of the PDMP database was difficulty using the program, so better integration can alleviate this barrier. Having PDMP software links in all dental EHRs make it as simple as one click to potentially save a life.
Resolution

313. Resolved, that the American Dental Association encourage dental and prescription software vendors to include PDMP compliance tools in software they sell to dental professionals in all new and updated versions of their software, and be it further

Resolved, that the ADA recommends that dentists request that their software vendors include PDMP compliance tools in the software they provide, and be it further

Resolved, that the ADA agencies that develop standards for dental software include PDMP compliance tools as an essential element of dental practice management and prescription software.

BOARD COMMENT: Received after the July-August 2023 Board of Trustees Meeting.
NOTES
Resolution No. 314

Report: N/A

Date Submitted: September 2023

Submitted By: Fourteenth Trustee District

Reference Committee: B (Dental Benefits, Practice and Related Matters)

Total Net Financial Implication: None

Net Dues Impact: 

ADA Strategic Plan Objective: Public Goal Obj-10: Dental benefit programs will be sufficiently funded and efficiently administered.

How does this resolution increase member value: See Background

MEDICARE ADVANTAGE PLAN TOOLKIT

The following resolution was submitted by the Fourteenth Trustee District and transmitted on September 13, 2023, by Molly Pereira, executive director, Colorado Dental Association.

Background: Dentists are often asked by their patients about selecting a Medicare Advantage plan. Many patients do not have enough information or background to make decisions. Often, they turn to their dentists for advice. It would be helpful for dentists to have an educational resource to assist patients in evaluating their options.

Resolution

314. Resolved, that the ADA develop a Medicare Advantage toolkit to equip dentists to assist patients in evaluating and choosing Medicare Advantage plans that have a dental benefit.

BOARD COMMENT: Received after the July-August 2023 Board of Trustees Meeting.