<table>
<thead>
<tr>
<th>Resolution Number</th>
<th>House Action</th>
<th>Resolution</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>101H.</td>
<td>Adopted</td>
<td>Board of Trustees Resolution 101—Nominations to Councils</td>
<td></td>
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<td></td>
<td></td>
<td>Resolved, that the nominees put forward for membership on ADA councils be elected.</td>
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<tr>
<td>102H.</td>
<td>Adopted</td>
<td>Standing Committee on Credentials, Rules and Order Resolution 102—Approval of Certified Delegates</td>
<td>Resolved, that the list of certified delegates and alternate delegates posted on the HOD Supplemental Information library on the House of Delegates community of ADA Connect be approved as the official roster of voting delegates and alternate delegates that constitute the 2022 House of Delegates of the American Dental Association.</td>
</tr>
<tr>
<td>103H.</td>
<td>Adopted</td>
<td>Standing Committee on Credentials, Rules and Order Resolution 103—Minutes of the 2021 Session of the House of Delegates</td>
<td>Resolved, that the minutes of the 2021 session of the House of Delegates be approved.</td>
</tr>
<tr>
<td>104H.</td>
<td>Adopted</td>
<td>Standing Committee on Credentials, Rules and Order Resolution 104—Adoption of Agenda and Order of Agenda Items</td>
<td>Resolved, that the agenda as presented in the 2022 Manual of the House of Delegates and Supplemental Information be adopted as the official order of business for this session, and be it further Resolved, the Speaker is authorized to alter the order of the agenda as deemed necessary in order to expedite the business of the House.</td>
</tr>
<tr>
<td>105H.</td>
<td>Adopted</td>
<td>Standing Committee on Credentials, Rules and Order Resolution 105—Referrals of Reports and Resolutions</td>
<td>Resolved, that the list of referrals recommended by the Speaker of the House of Delegates be approved.</td>
</tr>
<tr>
<td>200H.</td>
<td>Adopted</td>
<td>Reference Committee A (Budget, Business, Membership and Administrative Matters) Resolution 200—as amended—Consent Calendar</td>
<td></td>
</tr>
</tbody>
</table>
**Resolved,** that the recommendations of Reference Committee A on the following resolutions be accepted by the House of Delegates.

1. **Resolution 203**—Adopt—Amendment of the Policy, Transparency
   (Worksheet:2000) $: None
   **COMMITTEE RECOMMENDATION:** Vote Yes

2. **Resolution 204**—Adopt—Amendment of the Policy, Utilization of Multi-Council Task Forces (Worksheet:2001) $: None
   **COMMITTEE RECOMMENDATION:** Vote Yes

3. **Resolution 207**—Adopt—Proposed Policy, Retirement Account Distributions for Educational Expenses (Worksheet:2044) $: None
   **COMMITTEE RECOMMENDATION:** Vote Yes

4. **Resolution 208**—Adopt—Proposed Resolution to Reauthorize Task Force (Worksheet:2050) $: 45,000
   **COMMITTEE RECOMMENDATION:** Vote Yes

5. **Resolution 210**—Adopt—COVID-19 Pandemic Effects on Maintaining Continuity of ADA Membership (Worksheet:2063) $: None
   **COMMITTEE RECOMMENDATION:** Vote Yes

6. **Resolution 211**—Adopt—Data on New Dentist Changes Between Practice Modalities During the 10-Year New Dentist Time Period (Worksheet:2135) $: None
   **COMMITTEE RECOMMENDATION:** Vote Yes

7. **Resolution 212**—Adopt—Insurance for Paid Extended Leave (Worksheet:2137) $: None
   **COMMITTEE RECOMMENDATION:** Vote Yes

8. **Resolution 213RC**—Adopt Resolution 213RC in lieu of Resolution 213—Improvements to the ADA Career Center National Job Board (Worksheet:2138): ($50,000) Lost Revenue
   **COMMITTEE RECOMMENDATION:** Vote Yes
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<th>Action</th>
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<th>Text</th>
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<tbody>
<tr>
<td>201H.</td>
<td>Adopted</td>
<td>Board of Trustees Resolution 201—Approval of 2023 Budget</td>
<td><strong>Resolved,</strong> that the 2023 Annual Budget of revenue and expenses, including net capital requirements, be approved.</td>
</tr>
<tr>
<td>202H.</td>
<td>Adopted by a 60% affirmative vote</td>
<td>Board of Trustees Resolution 202—as amended—Establishment of Dues Effective January 1, 2023</td>
<td><strong>Resolved,</strong> that the dues of the ADA active members shall be $596.00 $600.00, effective January 1, 2023.</td>
</tr>
</tbody>
</table>
| 203H. | Adopted—Consent Calendar Action | Board of Trustees Resolution 203—Amendment of the Policy, Transparency | **Resolved,** that the ADA policy, Transparency (Trans.2009:404;2017:254) be amended as follows (additions are underscored; deletions are stricken):  
  - **Resolved,** that action items and approved minutes of all open meetings of ADA councils, committees and of the Board of Trustees be promptly posted in the Members Only section on ADA.org, and be it further  
  - **Resolved,** that the ADA, as the sole shareholder of ADABEL, shall direct the ADA Foundation ADABEL and any other subsidiaries to post on ADA Connect or its equivalent for the House of Delegates, all approved minutes of Board meetings, and be it further  
  - **Resolved,** that security in the Members Only section on ADA.org be enhanced as may be necessary so as to ensure that members will have exclusive access to the information contained in this Web site area. |
| 204H. | Adopted—Consent Calendar Action | Board of Trustees Resolution 204—Amendment of the Policy, Utilization of Multi-Council Task Forces | **Resolved,** that the ADA policy, Utilization of Multi-Council Task Forces (Trans.2001:447), be amended as follows (additions are underscored; deletions are stricken):  
  - **Resolved,** that the American Dental Association utilize multi-council task forces when rapid responses are required to address emerging issues, and include the necessary expertise from members of relevant councils on these task forces as provided in Chapter XI, Section 10 of the Bylaws, the Bylaws, Chapter X., Section 20, Special Committee; and the Governance and Organizational Manual, Chapter X. Committees, Special Committees and Subcommittees. |
Fourth Trustee District Resolution 205S-1—as amended—adopted in lieu of Board of Trustees Resolution 205—Amendment of the ADA Bylaws Regarding Establishment of the Strategic Forecasting Committee and its Corresponding Duties and Responsibilities

Resolved, that Chapter III. HOUSE OF DELEGATES, Section 50 DUTIES, of the ADA Bylaws be amended as follows (additions underscored, deletions stricken through):

Section 50. DUTIES: It shall be the duty of the House of Delegates to:

* * *

E. Establish, in collaboration with the Board of Trustees, the strategic direction of the Association in alignment with the mission and vision of the Association, which shall be established by the House of Delegates.

F. Establish a mechanism by which the Strategic Forecasting Plan, including the progress of each of the strategic initiatives of the American Dental Association to achieve and confirm the progress for the current five-year vision, is reported on, amended if necessary, and adopted by majority vote, at least annually.

G. Adopt an annual budget and establish the dues of active members for the following year.

FH. Serve as the court of appeal from decisions of the Council on Ethics, Bylaws and Judicial Affairs involving disputes arising between constituents or between a constituent and a component, as provided in of these Bylaws.

GI. Provide sufficient support to the ADA Foundation in addition to non-Association funding to assure the continued viability of the Foundation’s research activities.

and be it further

Resolved, that Chapter III. HOUSE OF DELEGATES, Section 110 COMMITTEES, of the ADA Bylaws be amended as follows (additions underscored, deletions stricken through):

Section 110. COMMITTEES: The standing committees of the House of Delegates shall be the Committee on Constitution and Bylaws, the Committee on Credentials, Rules and Order, the Strategic Forecasting Committee and such Reference Committees as shall in the determination of the Speaker of the House of Delegates be necessary to complete the business of the House of Delegates.

and be it further
Resolved, that Chapter V. BOARD OF TRUSTEES, Section 80. DUTIES, of the ADA Bylaws be amended as follows (additions underscored, deletions stricken through):

Section 80. DUTIES: It shall be the duty of the Board of Trustees to:

* * *

F. Collaborate with the House of Delegates in setting the strategic direction of the Association in alignment with the mission and vision of the Association.

G. Prepare and propose Adopt a budget to the House of Delegates for each the ensuing following fiscal year, including a recommendation for consistent with the Strategic Forecasting Plan.

H. Recommend the dues of active members for the following year.

GI. Establish recommended qualifications for the offices of Treasurer and Speaker of the House of Delegates.

HJ. Submit to the House of Delegates nominations for membership to the councils and commissions, except as otherwise provided in these Bylaws.

IK. Act upon commission and committee nominations for consultants as set forth in the Governance Manual.

JL. Review the reports of councils and special committees of the Association and to make recommendations concerning such reports to the House of Delegates.

KM. Submit an annual report of its activities to the House of Delegates.

LN. Appoint special committees of the Association in accordance with these Bylaws.

MQ. Render a final judgment on what constitutes a conflict of interest except with respect to the work of the Commission on Dental Accreditation.

NP. Establish dues for the international member category.

QQ. Ask that the ADA Foundation provide the Board of Trustees with a request for any funding in furtherance of Chapter III, Section 50.G of these Bylaws so said request can be considered during the Association’s annual budgeting activities.

RR. Perform such other duties as are provided for in these Bylaws.

and be it further
Resolved, that Chapter XII. FINANCES, Section 40. APPROVAL OF ANNUAL BUDGET of the ADA Bylaws be amended as follows (additions double underscored, deletions stricken through):

Section 40. APPROVAL OF ANNUAL BUDGET. The proposed annual budget shall be submitted by the Board of Trustees to the members of the House of Delegates at least thirty (30) days prior to the opening meeting of the annual session. Following the adoption of a resolution on the Strategic Forecasting Plan, and by the end of the calendar year, the Board of Trustees shall adopt a budget for the following year incorporating the Strategic Forecasting Plan as approved by the House of Delegates, shall be referred to a reference committee on budget for hearings at the annual session and then shall be considered for approval as a special order of business. In the event the budget as submitted is not approved, all recommendations for changes shall be referred to the Board of Trustees to prepare and present a revised budget. This procedure shall be repeated until a budget for the ensuing fiscal year shall be adopted.

and be it further

Resolved, that amendments to the following become effective at adjournment sine die of the 2022 House of Delegates:

1. Chapter III. House of Delegates, Section 50.G. Duties, of the ADA Bylaws

2. Chapter XII. FINANCES, Section 40. APPROVAL OF ANNUAL BUDGET of the ADA Bylaws.

206H. Adopted

Reference Committee A (Budget, Business, Membership and Administrative Matters) Resolution 206RC—as amended—adopted in lieu of Board of Trustees Resolution 206—Establishment of the Standing Committee of the House of Delegates: Strategic Forecasting Committee

Resolved, that the Manual of the House of Delegates and Supplemental Information, page 21, be amended as follows (additions underscored, deletions stricken through):

Standing Committees of the House of Delegates

In order to conduct its business, the House of Delegates uses two three standing committees: (1) the Committee on Credentials, Rules and Order; and (2) the Committee on Constitution and Bylaws; and (3) the Strategic Forecasting Committee. The Committee on Credentials, Rules and Order is composed of nine members of the House of Delegates appointed by the President. The Committee on Constitution and Bylaws is composed of not more than eight nor less than six members of the Council on Ethics, Bylaws and Judicial Affairs appointed by the President in consultation with the Speaker of the House of Delegates and the
Council Chair. These committees are largely concerned with procedural matters. The following is a description of their specific duties follows.

and be it further

Resolved, that the *Manual of the House of Delegates and Supplemental Information* be further amended to add the Strategic Forecasting Committee definition and its governance structure under this new Standing Committee as follows:

**Strategic Forecasting Committee.** The Strategic Forecasting Committee and its associated entities are generally related to the ongoing provision of strategic plan review and guidance for the Association. The complete composition, including a subcommittee structure and attached action groups, are outlined below, as well as the specific duties and other governance considerations.

During the inaugural year of the Strategic Forecasting Committee, the following geographically selected members from the 2022 Strategic Forecasting Task Force shall serve a one-year appointment as the House of Delegates representatives to the Committee. These appointments shall begin at adjournment *sine die* of the 2022 House of Delegates and shall end at adjournment *sine die* of the 2023 House of Delegates and shall not be taken into account toward any calculation with regard to future service on the Strategic Forecasting Committee:

- North Geographic Trustee District Region (Districts 6, 7, 8, 9) Dr. Cissy Furusho and Dr. Rachel Hymes;
- East Geographic Trustee District Region (Districts 1, 2, 3, 4, 16): Dr. Chris Liang and Dr. Justin Norbo;
- West Geographic Trustee District Region (Districts 10, 11, 13, 14): Dr. Steve Kend and Dr. Michael Varley; and
- South Geographic Trustee District Region: (Districts 5, 12, 15, 17): Dr. Cody Graves and Dr. Tom Brown.

The 2022 Reference Committee on Budget, Business, Membership and Administrative Matters strongly encourages the President to appoint four (4) Trustee members from non-represented districts.

I. Strategic Forecasting Committee.

A. Composition and Eligibility. The Strategic Forecasting Committee shall be composed of eight (8) individuals who are members of the House of Delegates at the time of nomination, four (4) individuals who are members of the Board of Trustees at the time of appointment and one (1) individual who is a new dentist member of the ADA at the time of appointment, each
selected, nominated and/or appointed as set forth below.* The President, President-elect, Treasurer and ADA Executive Director shall also each serve as a member of the Strategic Forecasting Committee without the right to vote. No member of the Committee shall concurrently serve as a member of an Association council or commission nor shall concurrently serve as a member of another committee of the House of Delegates. The Committee will also include a chair, who shall be a non-voting member of the Committee.

B. Experience Criteria, Selection, Nomination and Appointment.

1. House of Delegates Members.

a. Experience Criteria. House of Delegates members of the Strategic Forecasting Committee shall possess knowledge or experience in one or more of the subject matter areas of membership, fiscal management, advocacy, dental education, licensure, science and research, strategic planning, generational trends and social engagement, dental industry, practice modality trends, governance, and practice trends.

b. Selection and Nomination. To achieve geographic diversity among members of the Strategic Forecasting Committee, four (4) geographic groups of Trustee Districts shall each select two eligible members of the House of Delegates from different constituents within their Districts for nomination to the Strategic Forecasting Committee and shall forward those nominations to the Board of Trustees, together with information that summarizes the experience of each nominee for service on the Committee. The four geographic Trustee District regions are as follows:

i. North Geographic Trustee District Region: Districts Six, Seven, Eight and Nine ("North Region");

ii. East Geographic Trustee District Region: Districts One, Two, Three, Four and Sixteen ("East Region");

iii. West Geographic Trustee District Region: Districts Ten, Eleven, Thirteen and Fourteen ("West Region"); and

iv. South Geographic Trustee District Region: Districts Five, Twelve, Fifteen and Seventeen ("South Region").

* In the context of the Strategic Forecasting Committee and action groups, the term “new dentist member” shall mean a dentist who received their DDS or DMD degree less than ten (10) years before their selection for appointment to the Strategic Forecasting Committee or one of its action groups.
The District caucus chairs for the Districts within each geographic Trustee District region shall develop and the Districts shall adopt the process by which Strategic Forecasting Committee nominees are selected.

c. Appointment. The Board of Trustees shall review the nominations and shall vote on the appointment of each House of Delegates Strategic Forecasting Committee nominee. Should any nominee not be appointed to serve on the Committee by the Board of Trustees, the geographic Trustee District region that nominated the candidate shall forward the identity of a substitute nominee to the Board of Trustees for its consideration.

d. The slate of Strategic Forecasting Committee House of Delegates members shall be forwarded to the House of Delegates for ratification. Should any member not be ratified by the House of Delegates, the geographic Trustee District region that nominated the candidate shall forward the identity of a substitute nominee to the Board of Trustees for its approval.

2. Board of Trustees Members. Four (4) Board of Trustees members, one from each of the geographic Trustee District regions shall be appointed to the Strategic Forecasting Committee by the President with the approval of the Board of Trustees.

3. New Dentist Member. The New Dentist Committee shall develop and adopt the process by which it selects a new dentist to serve on the Strategic Forecasting Committee and shall forward that nomination to the Board of Trustees. The nominee shall be appointed by vote of the Board of Trustees. Should the new dentist nominee not be appointed to serve on the Committee by the Board of Trustees, the New Dentist Committee shall forward the identity of a substitute nominee to the Board of Trustees for its consideration.

C. Term and Tenure.

1. House of Delegates and New Dentist Members. House of Delegates members and the new dentist member of the Strategic Forecasting Committee shall serve one term of two (2) years and, if continuing as a member of the House of Delegates or continuing to be qualified as a new dentist, respectively, at the conclusion of the member's initial term,
may be renominated and reappointed once for a total tenure on the Committee of four (4) years.

2. Board of Trustees Members. Board of Trustees members of the Strategic Forecasting Committee shall serve one (1) term of two (2) years and shall not be eligible for reappointment to the Committee."

D. Removal. A member of the Strategic Forecasting Committee may be removed for cause by the Board of Trustees.

1. Causes for Removal. The following are causes for the removal of a member from the Strategic Forecasting Committee:

   a. Continued, gross or willful neglect of the duties of a member;
   b. Failure to comply with the Association’s policies on conflict of interest;
   c. Failure or refusal to disclose necessary information on matters of Association business;
   d. Failure to keep confidential any exclusive information protected by secrecy that becomes known to the member by reason of the performance of his or her duties on the Committee’s behalf;
   e. Failure to comply with the Association’s professional conduct policy and prohibition against harassment;
   f. Unauthorized expenditures or misuse of Association funds;
   g. Unwarranted attacks on the Association, any of its agencies or any person serving the Association in an elected, appointed or employed capacity;
   h. Unwarranted refusal to cooperate with any officer, trustee, Committee member or Committee staff;
   i. Misrepresentation of the Association and any person serving the Association in an elected, appointed or employed capacity to outside persons;

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* To stagger the terms of the House of Delegates members of the Strategic Forecasting Committee so that fifty percent (50%) of the members turn over each year, the initial term of one Committee member from each geographic Trustee District region shall be three years and shall thereafter revert to the two (2) year term specified in this provision. This footnote shall automatically expire at the adjournment sine die of the 2025 House of Delegates annual session.

** To stagger the terms of the Board of Trustee members of the Strategic Forecasting Committee so that fifty percent (50%) of the members turn over each year, the initial terms of two (2) of the Board of Trustees members appointed by the President shall be three (3) years and shall thereafter revert to the two (2) year term specified in this provision. This footnote shall automatically expire at the adjournment sine die of the 2025 House of Delegates annual session.
j. Being found to have engaged in conduct subject to discipline pursuant to Chapter XI of the ADA Bylaws;

k. Violation of the Association’s Member Conduct Policy;

l. Conviction of a felony; and

m. For Strategic Forecasting Committee members only, lapse of membership.

2. Procedure for Removal. Before a Committee member is removed for cause, the following procedures shall be followed:

a. The President shall notify the accused member in writing of the allegations concerning the member’s performance or conduct. The written notice shall include a description of the conduct purported to constitute each charge. The accused shall be invited to respond in writing. If the accused member wishes, he or she may resign their Committee position voluntarily or may request the opportunity to appear before the Board of Trustees to respond to the allegations received. If an appearance is requested, the Board shall schedule it during the next meeting of the Board.

b. Formal rules of evidence shall not apply to the appearance to discuss the allegations made, but if requested, the Board of Trustees shall permit the accused member to be assisted by legal counsel. Following the appearance, the Board shall decide by a two thirds (2/3) vote whether the accused member should be removed from the Strategic Forecasting Committee. Every decision that results in removal of a Committee member for cause shall be reduced to writing and shall specify the findings of fact which support the decision to remove the accused member. If a decision to remove a Committee member is made, that action shall create a vacancy that shall be filled in accordance the Vacancy provisions of these procedures.

E. Vacancy. Should a vacancy arise on the Strategic Forecasting Committee, the entity that selected the member whose position has been vacated shall select a replacement member for the remainder of the unexpired term and shall forward that selection to the Board of Trustees together with, if applicable, the information that summarizes the basis for each nominee's experience that qualifies the nominee to serve on the Committee. The Board of Trustees shall then vote on the vacancy appointment. If the vacancy is for a House of Delegates or the new dentist position on the Committee, at the conclusion of the partial term, the replacement member shall be eligible for
reappointment to one additional, consecutive two (2) year term. If the vacancy is for a Board of Trustees position, if the vacated position has less than fifty percent (50%) of a full two (2) year term remaining at the time the successor Committee member is appointed, the successor Board of Trustees member may, if otherwise eligible, be nominated and appointed to a new, consecutive two (2) year term. If fifty percent (50%) or more of the vacated term remains to be served at the time of the appointment, the successor Board of Trustees member shall not be eligible for another term.

F. Powers. The Strategic Forecasting Committee shall have the power to:

1. Establish rules and regulations not inconsistent with the ADA Bylaws or these provisions for its own governance.

2. By a majority vote, request the chair to call and convene a special session of the Strategic Forecasting Committee.

3. Remove a member of any subcommittee of the Strategic Forecasting Committee for cause.

4. Elect or appoint members of the subcommittees of the Strategic Forecasting Committee.

5. Monitor and guide the activities of the subcommittees of the Strategic Forecasting Committee.

G. Duties. The duties of the Strategic Forecasting Committee shall be:

1. Periodically review and propose revisions to the mission and vision statements of the American Dental Association.

2. Collaborate with the Board of Trustees in setting the strategic direction of the Association in alignment with the Association’s vision and mission statements.

3. Elect a chair of the Strategic Forecasting Committee.

4. Annually provide to the House of Delegates a report on the Strategic Forecasting Plan, including the progress of each of the strategic initiatives of the American Dental Association to achieve and confirm the progress for the current five-year vision.

H. Meetings.

1. Regular Meetings. The Strategic Forecasting Committee shall hold a minimum of four (4) meetings per year. The number and dates of regular
meetings to be held for the following year shall be determined in advance by the Committee.

2. Special Meetings. Special meetings of the Strategic Forecasting Committee may be called at any time either by the chair or at the request of a majority of the voting members of the Committee, provided notice is given to each member in advance of the meeting.

3. Place of Meetings: Regular or special meetings may be held in a single geographic location or virtually using suitable communications platforms.

I. Quorum. A majority of the voting members of the Strategic Forecasting Committee shall constitute a quorum.

J. Chair. The chair of the Strategic Forecasting Committee shall be an ADA member selected biennially by the Strategic Forecasting Committee immediately preceding the expiration of the term of the current chair from nominations received by the Committee. The chair shall be a non-voting member of the Committee and shall be eligible to serve two (2) two-year terms as chair. If the selected chair is a voting member of the Committee at the time of election, the member shall relinquish voting privileges and a vacancy on the Committee shall be created, to be filled in accordance with the provisions of the vacancy provisions of these procedures (Section I.E., above).

K. Vice Chair. The President-elect shall serve as the non-voting vice chair of the Strategic Forecasting Committee and shall assume the office of chair until the office of chair is filled by the Strategic Forecasting Committee in the event of a vacancy in that office, or if the chair is otherwise unavailable.

L. Consultants and Staff.

1. Consultants. The Strategic Forecasting Committee shall have the authority to appoint consultants as needed to assist it in its duties, in conformity with the ADA Bylaws and the Governance and Organizational Manual of the American Dental Association ("Governance Manual"). As a condition of appointment, consultants shall file conflict of interest statements with the Executive Director of this Association. The Committee shall also provide notice of the appointment of each consultant to the Board of Trustees.

2. Staff. The Executive Director of the Association shall assign such staff as needed to assist the Committee and shall select the titles for such staff positions.
II. Strategic Forecasting Subcommittees. The Strategic Forecasting Committee shall have the authority to establish subcommittees, each of which shall focus on a single category of ADA customers. Initially, there shall be four (4) subcommittees, each focusing on one of the following customer groups: Dentist, Tripartite, Enterprise and Professional/Public.

A. Composition. Each Strategic Forecasting subcommittee shall be composed of four (4) members selected by the Strategic Forecasting Committee from among nominees submitted by each of the geographic Trustee District regions and two (2) Board of Trustees members appointed by the President and with the approval of the Board of Trustees. Each of the foregoing subcommittee members shall have the right to vote. The President, President-elect, Treasurer and ADA Executive Director shall also serve as members of each Strategic Forecasting subcommittee without the right to vote.

B. Term and Tenure.

1. Non-Board of Trustee Voting Members. Voting members of the Strategic Forecasting subcommittees who are not Board of Trustee members shall serve a term of two (2) years and may be reappointed once for a total tenure on the subcommittee of four (4) years.

2. Board of Trustee Members. Board of Trustee members of the Strategic Forecasting subcommittees shall serve one (1) term of two (2) years and shall not be eligible for reappointment to the Committee.

C. Removal. A member of a Strategic Forecasting subcommittee may be removed by the Strategic Forecasting Committee for any of the causes enumerated in Section I.D.1., above. When considering the removal of any Strategic Forecasting subcommittee member, the Strategic Forecasting Committee shall follow the procedures outlined in Section I.D.2., above.

D. Vacancies. Should a vacancy on a Strategic Forecasting subcommittee occur, a successor member shall be appointed for the unexpired term. If the previous member was a member of the subcommittee nominated by a geographic Trustee District region, the chair of the Strategic Forecasting Committee shall automatically expire at the adjournment sine die of the 2025 House of Delegates annual session.

* To stagger the terms of the non-Board of Trustee voting members of each Strategic Forecasting subcommittee so that fifty percent (50%) of such members turn over each year, the initial terms of two members shall be three years and shall thereafter revert to the two (2) year term specified in this provision. This footnote shall automatically expire at the adjournment sine die of the 2025 House of Delegates annual session.

** To stagger the terms of the Board of Trustee members of each Strategic Forecasting subcommittee so that fifty percent (50%) of the Board of Trustee members turn over each year, the initial terms of one (1) of the Board of Trustees members appointed by the Board of Trustees shall be three (3) years and shall thereafter revert to the two (2) year term specified in this provision. This footnote shall automatically expire at the adjournment sine die of the 2025 House of Delegates annual session.
Committee shall appoint a successor member nominated by that same region. If the previous member was a Board of Trustees member of the subcommittee, the Board of Trustees shall appoint the successor member. If the successor member remains eligible, the successor member may be reappointed for a single full subcommittee term of two (2) years.

E. Powers. Each Strategic Forecasting subcommittee shall have the power to:

1. Direct specific objectives within its scope of assigned responsibility to its action groups, if any.
2. Name consultants as necessary to assist the subcommittee in addressing its assigned objectives.
3. Request additional staff as necessary to complete its assigned objectives.
4. Assist the Strategic Forecasting Committee in completing tasks within its assigned area of responsibility as requested by the Strategic Forecasting Committee.

F. Duties. Each Strategic Forecasting subcommittee shall have the following duties:

1. Provide information within the scope of its assigned responsibility to the Strategic Forecasting Committee as requested by the Strategic Forecasting Committee.
2. Assimilate information within the scope of its assigned responsibility provided to it by its action groups or other entities and provide a summary of such information to the Strategic Forecasting Committee.
3. As requested but at least annually, provide the Strategic Forecasting Committee with a report that uses accepted metrics to provide an accounting of the subcommittee’s achievements in meeting its assigned objectives within the scope of its area of responsibility.
4. Assist the Strategic Forecasting Committee in completing tasks within its assigned area of responsibility as requested by the Strategic Forecasting Committee.

G. Meetings.

1. Regular Meetings. Each Strategic Forecasting subcommittee shall hold a minimum of four (4) meetings per year. The number and dates of regular meetings to be held for the following year shall be determined in advance by the subcommittee.
2. Special Meetings. Special meetings of the Strategic Forecasting subcommittee may be called at any time either by the chair or at the request of a majority of the voting members of the subcommittee, provided notice is given to each member in advance of the meeting.

3. Place of Meetings: Regular and special meetings shall be held virtually via one or more suitable communications platforms.

H. Quorum. A majority of the voting members of the Strategic Forecasting subcommittee shall constitute a quorum.

I. Chair. The chair of each subcommittee shall be selected annually by the Strategic Forecasting Committee from among the House of Delegates members of the Strategic Forecasting Committee, shall be a member of the subcommittee, and shall have the right to vote. The chair of the subcommittee shall be eligible to serve two (2) terms as chair if continuing as a voting member of the Strategic Forecasting Committee at the conclusion of the initial term as chair.

J. Consultants and Staff.

1. Consultants. Each Strategic Forecasting subcommittee shall have the authority to appoint consultants as needed to assist it in fulfilling its duties, in conformity with the ADA Bylaws and the Governance Manual. As a condition of appointment, consultants shall file conflict of interest statements with the Executive Director of this Association. The subcommittee shall also provide notice of the appointment of each consultant to the Strategic Forecasting Committee and the Board of Trustees.

2. Staff. The Executive Director of the Association shall assign such staff as needed to assist the subcommittees and shall select the titles for such staff positions.

III. Action Groups. With the exception of the Enterprise subcommittee, each of the Strategic Forecasting subcommittees shall have four (4) action groups. The Enterprise subcommittee shall function as its own action group.

A. Composition. The action groups for the Strategic Forecasting subcommittees shall have the following composition:

1. Dentist Customer Strategic Forecasting Subcommittee Action Groups. The Dentist Customer Strategic Forecasting subcommittee shall have four (4) geographically based action groups as follows:
a. North:
   i. One (1) dentist from each of the Trustee Districts within the North Region;
   ii. One (1) constituent or component Executive Director from each Trustee District within the North Region;
   iii. Two (2) full time faculty members* from academic institutions within the North Region, except that the faculty members should be from institutions in different Trustee Districts;
   iv. Two (2) new dentists, each from a different Trustee District within the North Region; and
   v. Two (2) members of the American Student Dental Association who attend dental school within the North Region, except that the ASDA members should attend dental schools in different Trustee Districts.

b. East:
   i. One (1) dentist from each of the Trustee Districts within the East Region;
   ii. One (1) constituent or component Executive Director from each Trustee District within the East Region;
   iii. Two (2) full time faculty members from academic institutions within the East Region, except that the faculty members should be from institutions in different Trustee Districts;
   iv. Two (2) new dentists, each from a different Trustee District within the East Region; and
   v. Two (2) members of the American Student Dental Association who attend dental school within the East Region, except that the ASDA members should attend dental schools in different Trustee Districts.

c. West:

* In the context of the Strategic Forecasting action groups, the term “full time faculty member” shall mean one who works for a school of dentistry in a CODA accredited academic setting providing dental education more than two (2) days or sixteen (16) hours per week.
i. One (1) dentist from each of the Trustee Districts within the West Region;

ii. One (1) constituent or component Executive Director from each Trustee District within the West Region;

iii. Two (2) full time faculty members from academic institutions within the West Region, except that the faculty members should be from institutions in different Trustee Districts;

iv. Two (2) new dentists, each from a different Trustee District within the West Region, and

v. Two (2) members of the American Student Dental Association who attend dental school within the West Region, except that the ASDA members should attend dental schools in different Trustee Districts.

d. South:

i. One (1) dentist from each of the Trustee District within the South Region;

ii. One (1) constituent or component Executive Director from each Trustee District within the South Region;

iii. Two (2) full time faculty members from academic institutions within the South Region, except that the faculty members should be from institutions in different Trustee Districts;

iv. Two (2) new dentists, each from a different Trustee District within the South Region; and

v. Two (2) members of the American Student Dental Association who attend dental school within the South Region, except that the ASDA members should attend dental schools in different Trustee Districts.

2. Tripartite Customer Strategic Forecasting Subcommittee Action Groups. The Tripartite Customer Strategic Forecasting subcommittee shall have four (4) geographically based action groups as follows:

a. North:
<table>
<thead>
<tr>
<th>Region</th>
<th>Selection Requirements</th>
</tr>
</thead>
</table>
| North Region | i. One (1) dentist from the North Region, selected according to a process developed by the caucus chairs and approved by the Trustee Districts of the North Region;  

ii. Two (2) constituent or component Executive Directors from each of the Trustee Districts within the North Region;  

iii. One (1) new dentist from the North Region;  

iv. One (1) member of the American Student Dental Association who attends dental school within the North Region;  

v. One (1) representative of dental industry who works within the North Region; and  

vi. Two (2) management or administrative representatives of dental service organizations who work within the North Region, except that such representatives should be from different Trustee Districts. |
| East Region | b. One (1) dentist from the East Region, selected according to a process developed by the caucus chairs and approved by the Trustee Districts of the East Region;  

ii. Two (2) constituent or component Executive Directors from each of the Trustee Districts within the East Region;  

iii. One (1) new dentist from the East Region;  

iv. One (1) member of the American Student Dental Association who attends dental school within the East Region;  

v. One (1) representative of the dental industry who works within the East Region; and  

vi. Two (2) management or administrative representatives of dental service organizations who work within the East Region, except that such representatives should be from different Trustee Districts. |
| West Region | c. One (1) dentist from the West Region, selected according to a process developed by the caucus chairs and approved by the Trustee Districts of the West Region;  

ii. Two (2) constituent or component Executive Directors from each of the Trustee Districts within the West Region;  

iii. One (1) new dentist from the West Region;  

iv. One (1) member of the American Student Dental Association who attends dental school within the West Region;  

v. One (1) representative of the dental industry who works within the West Region; and  

vi. Two (2) management or administrative representatives of dental service organizations who work within the West Region, except that such representatives should be from different Trustee Districts. |
i. One (1) dentist from the West Region, selected according to a process developed by the caucus chairs and approved by the Trustee Districts of the West Region;

ii. Two (2) constituent or component Executive Directors from each of the Trustee Districts within the West Region;

iii. One (1) new dentist from the West Region;

iv. One (1) member of the American Student Dental Association who attends dental school within the West Region;

v. One (1) representative of the dental industry who works within the West Region; and

vi. Two (2) management or administrative representatives of dental service organizations who work within the West Region, except that such representatives should be from different Trustee Districts.

d. South:

i. One (1) dentist from the South Region, selected according to a process developed by the caucus chairs and approved by the Trustee Districts of the South Region;

ii. Two (2) constituent or component Executive Directors from each of the Trustee Districts within the South Region;

iii. One (1) new dentist from the South Region;

iv. One (1) member of the American Student Dental Association who attends dental school within the South Region;

v. One (1) representative of the dental industry who works within South Region; and

vi. Two (2) management or administrative representatives of dental service organizations who work within the South, except that such representatives should be from different Trustee Districts.

3. Professional/Public Customer Strategic Forecasting Subcommittee Action Groups. The Professional/Public Customer Strategic Forecasting subcommittee shall have four (4) geographically based action groups as follows:
a. North:
   i. One (1) dentist from each of the Trustee Districts within the North Region;
   ii. One (1) constituent or component Executive Director from each of the Trustee Districts within the North Region;
   iii. Two (2) full time faculty members from academic institutions within the North Region, except that the faculty members should be from institutions in different Trustee Districts;
   iv. Two (2) new dentists, each from different Trustee Districts within the North Region, and
   v. Two (2) members of the American Student Dental Association who attend dental school within the North Region, except that the ASDA members should attend dental schools in different Trustee Districts.

b. East:
   i. One (1) dentist from each of the Trustee Districts within the East Region;
   ii. One (1) constituent or component Executive Director from each of the Trustee Districts within the East Region;
   iii. Two (2) full time faculty members from academic institutions within the East Region, except that the faculty members should be from institutions in different Trustee Districts;
   iv. Two (2) new dentists, different Trustee Districts within the East Region, and
   v. Two (2) members of the American Student Dental Association who attend dental school within the East Region, except that the ASDA members should attend dental schools in different Trustee Districts.

c. West:
   i. One (1) dentist from each of the Trustee Districts within the West Region;
ii. One (1) constituent or component Executive Director from each of the Trustee Districts within the West Region;

iii. Two (2) full time faculty members from academic institutions within the West Region, except that the faculty members should be from institutions in different Trustee Districts;

iv. Two (2) new dentists, each from different Trustee Districts within the West Region, and

v. Two (2) members of the American Student Dental Association who attend dental school within the West Region, except that the ASDA members should attend dental schools in different Trustee Districts.

d. South:

i. One (1) dentist from each of the Trustee Districts within the South Region;

ii. One (1) constituent or component Executive Director from each of the Trustee Districts within the South Region;

iii. Two (2) full time faculty members from academic institutions within the South Region, except that the faculty members should be from institutions in different Trustee Districts;

iv. Two (2) new dentists, each from different Trustee Districts within the South Region, and

v. Two (2) members of the American Student Dental Association who attend dental school within the Region, except that the ASDA members should attend dental schools in different Trustee Districts.

B. Selection and Appointment. Except for the Enterprise Strategic Forecasting subcommittee action group, members of action groups shall be appointed by their respective Strategic Forecasting subcommittees, subject to notification to and approval by the Strategic Forecasting Committee.

C. Term and Tenure.

1. Action Groups of the Dentist, Tripartite and Professional/Public Subcommittees. Members of action groups of the Dentist, Tripartite and Professional/Public subcommittees shall serve a term of two (2) years
and may be eligible for one additional term for a total tenure of four (4) years if they remain within their member category (i.e., faculty, executive director, new dentist, student or dental industry or dental service organization representative) at the time of their appointment to a second term.

2. Enterprise Strategic Forecasting Subcommittee.

   a. The House of Delegates members of the Enterprise Strategic Forecasting subcommittee shall serve a term of two (2) years and may be reappointed once for a total tenure on the subcommittee of four (4) years.

   b. Board of Trustee members of the Strategic Forecasting Committee shall serve one (1) term of two (2) years and shall not be eligible for reappointment to the subcommittee.

D. Removal. A member of a Strategic Forecasting subcommittee action group may be removed by the applicable Strategic Forecasting subcommittee for any of the causes enumerated in Section I.D.1., above. When considering the removal of any Strategic Forecasting action group member, the Strategic Forecasting subcommittee shall follow the procedures outlined in Section I.D.2., above.

E. Vacancies. Should a vacancy on an action group occur, the respective Strategic Forecasting subcommittee shall appoint a successor action group member who processes the same qualifications as the previous member, subject to notification to and approval of the Strategic Forecasting Committee. If the successor member remains eligible, the successor member may be reappointed for a single full action group term of two (2) years.

F. Powers. Each action group shall have the power to:

1. Direct activities to achieve specific and defined objectives.

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* To stagger the terms of the members of the action groups so that fifty percent (50%) of the action group members turn over each year, the initial terms of certain of the action group members shall vary from the regular two (2) year term. In each of the Dentist and Professional/Public Strategic Forecasting subcommittee action groups, two (2) ADA members, two (2) executive directors, one (1) faculty member, one (1) new dentist and one (1) student shall have an initial term of three (3) years; the term of those positions shall thereafter revert to the two (2) year term specified in this provision. In each of the action groups of the Tripartite Strategic Forecasting subcommittee, one (1) executive director from each trustee district and one (1) dental service organization representative shall have an initial term of three (3) years; the term of those seats shall then revert to the two (2) year term specified in this provision. This footnote shall automatically expire at the adjournment sine die of the 2025 House of Delegates annual session.

** To stagger the terms of the House of Delegates members of the Enterprise Strategic Forecasting subcommittee so that fifty percent (50%) of such members turn over each year, the initial terms of two members shall be three years and shall thereafter revert to the two (2) year term specified in this provision. This footnote shall automatically expire at the adjournment sine die of the 2025 House of Delegates annual session.
G. Duties. Each action group shall have the following duties:

1. Recommend members to serve on the Strategic Forecasting subcommittees.

2. Provide insights on future trends, outlook and goals to its Strategic Forecasting subcommittee.

3. Provide information, as applicable, to its Strategic Forecasting subcommittee relating to the following areas:
   a. Generational trends and social engagement;
   b. Science and research;
   c. Fiscal management and financial projections;
   d. Dental industry and trends;
   e. Practice trends;
   f. Advocacy;
   g. Current and future social cultural trends and technological interactions; and
   h. Other areas as may be assigned by the Strategic Forecasting subcommittees.

4. Provide metrics to measure and define future strategic goals for the Association.

5. Assist its Strategic Forecasting subcommittee in completing tasks within its assigned area of responsibility as requested by the Strategic Forecasting subcommittee.

H. Meetings.
1. **Regular Meetings.** Each action group shall hold a minimum of four (4) meetings per year. The number and dates of regular meetings to be held for the following year shall be determined in advance by the chair of the action group.

2. **Special Meetings.** Special meetings of the action group may be called at any time either by the chair or at the request of a majority of the members of the action group, provided notice is given to each member in advance of the meeting.

3. **Place of Meetings.** Regular and special meetings shall be held virtually via one or more suitable communications platforms.

   I. **Quorum.** A majority of the voting members of an action group shall constitute a quorum for that group.

   J. **Chair.** The chair of the Dentist, Tripartite and Professional/Public action groups shall be selected annually by the chair of the action group’s respective Strategic Forecasting subcommittee from among the action group’s voting members. The chair of the action group shall be eligible to serve two terms as chair if continuing as a voting member of the action group at the conclusion of the initial term as chair. The Strategic Forecasting Committee chair shall serve as the chair of the Enterprise action group.

<table>
<thead>
<tr>
<th>207H.</th>
<th><strong>Adopted—Consent Calendar Action</strong></th>
<th><strong>Board of Trustees Resolution 207—Proposed Policy, Retirement Account Distributions for Educational Expenses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Resolved,</strong> that the American Dental Association supports allowing early withdrawals from tax-favored retirement savings accounts to be exempt from taxes and/or penalties when the funds are used for an individual’s dental education.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>208H.</th>
<th><strong>Adopted—Consent Calendar Action</strong></th>
<th><strong>Task Force to Eliminate Barriers for Underrepresented Minorities into the Dental Profession Resolution 208—Proposed Resolution to Reauthorize Task Force</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Resolved,</strong> that the Task Force be reauthorized to facilitate the remaining work, which will include the development of an implementation plan, identification of metrics and milestones, and development of a maintenance cycle and communications approach, and be it further</td>
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<td><strong>Resolved,</strong> that the president consider continuity in the composition of the Task Force in his appointments, and be it further</td>
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</tr>
<tr>
<td></td>
<td><strong>Resolved,</strong> that the ADA invite diverse dental groups, including but not limited to American Association of Women Dentists, American Dental Education Association, National Dental Association, Society of American Indian Dentists, Hispanic Dental Association and Korean American Dental Association, to collaborate on the development</td>
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</tbody>
</table>
of an online resource that will house a comprehensive list of pathway programs and resources to grow the pool of historically underrepresented racial/ethnic (HURE) applicants to dental school, and be it further

Resolved, that the Task Force investigate the establishment of a grant program to help support the expansion of current pathway programs that have demonstrated impact and success in increasing the pool of HURE applicants and report its findings to the 2023 House of Delegates.

<table>
<thead>
<tr>
<th>Resolution Number</th>
<th>Action Taken</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>209</td>
<td>Not Adopted</td>
<td>Reference Committee A (Budget, Business, Membership and Administrative Matters) Resolution 209RC in lieu of Council on Membership Resolution 209 and Board of Trustees Resolution 209B—Dental Team Membership</td>
</tr>
</tbody>
</table>

Resolved, that Chapter I. MEMBERSHIP, Section 10. CLASSIFICATION, of the ADA Bylaws be amended by addition of a new classification “Team Member” as follows:

Section 10. CLASSIFICATION. The members of this Association shall be classified as follows:

Active Members  
Life Members  
Retired Members  
Student Members  
Honorary Members  
Provisional Members  
International Members  
Team Members

and be it further

Resolved, that Chapter I. MEMBERSHIP, Section 20. MEMBERSHIP ELIGIBILITY, of the ADA Bylaws be amended by addition of the following new Subsection "H" to read as follows:

H. TEAM MEMBER. An individual who is ineligible for any other classification of membership and meets the following criteria:

a. Is recommended in their application by an ADA member dentist;  
b. Resides in the United States or its territories; and  
c. Maintains membership in good standing in this Association.

The Association may conduct a review of the licensure status of an applicant for team membership to determine if the applicant's license to practice (if any) has been suspended or revoked for any of the reasons listed in Chapter XI, Section 20, of these ADA Bylaws and, if so, the Association has the discretion to deny
membership to the applicant. Applicants seeking membership as team members shall not be entitled to appeal denial of membership in the Association.

And be it further

Resolved, that Chapter I. MEMBERSHIP MATTERS, Section A. Membership, Privileges and Benefits, of the ADA Governance and Organizational Manual be amended by addition of the following new Subsection “8. Team Members” to read as follows:

8. Team Members: Team Members shall receive the following privileges and benefits:

   a. An annual membership card;
   b. A no cost subscription to the electronic versions of The Journal of the American Dental Association and ADA News;
   c. Access to team members content and discounts on ADA CE, products, services, SmileCon and other events;
   d. Eligibility for election as a member of the Council on Membership;
   e. Such other benefits and services as the Board of Trustees may from time to time make available to team members.

And be it further

Resolved, that Chapter I. Membership Matters, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 1. Dues, of the ADA Governance and Organizational Manual be amended by addition of a new subsection “h. Team Members” to read as follows:

   h. Team Members. The dues of team members shall be set from time to time by the Board of Trustees.

And be it further

Resolved, that Chapter I. Membership Matters, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 2. Special Assessments, of the ADA Governance and Organizational Manual be amended by addition of a new subsection “h. Team Members”

   h. Team Members. Team members shall be exempt from the payment of special assessments.

And be it further

Resolved, that Chapter VIII, Councils, Section A. Members, Selections, Nominations and Elections, Subsection 1. Composition, of the ADA Governance and Organizational
Manual be amended by adding a new subsection “d. Council on Membership” to read as follows:

   d. Council on Membership shall be composed of nineteen (19) members selected as follows: one (1) member from each trustee district whose terms of office shall be staggered in such a manner that four (4) members will complete their terms each year except every fourth year when five (5) members shall complete their terms, one (1) new dentist member recommended by the New Dentist Committee and nominated by the Board of Trustees, and one (1) team member recommended by the Council on Membership and nominated by the Board of Trustees.

And be it further

Resolved, that existing subsection d. Remaining Councils, Chapter VIII, Section A.1. of the ADA Governance and Organizational Manual be relettered as subsection “e.”

and be it further

Resolved, that Chapter VIII. Councils, Section A. Members, Selections, Nominations and Elections, Subsection 2. Term and Tenure, of the ADA Governance and Organizational Manual be amended as follows (new language underscored):

   2. Term and Tenure. The term of service recommended by the New Dentist Committee and nominated by the Board of Trustees elected to serve on councils shall be one (1) year; however, such members shall be limited to four (4) one year terms of council service during the period they are characterized as new dentists.

The term of service for a team member elected to serve on the Council on Membership shall be one (1) year; however, such members shall be limited to two (2) one year terms of council service.

And be it further

Resolved, the foregoing ADA Bylaws and ADA Governance and Organizational changes take effect at adjournment sine die of the 2023 House of Delegates.

<table>
<thead>
<tr>
<th>210H.</th>
<th>Adopted</th>
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<tbody>
<tr>
<td><strong>First Trustee District Resolution 210—as amended—COVID-19 Pandemic Effects on Maintaining Continuity of ADA Membership</strong></td>
<td></td>
</tr>
</tbody>
</table>

Resolved, that Chapter I. MEMBERSHIP MATTERS, Section B. Dues, Special Assessments and Related Financial Matters, Subsection 3. Acceptance of Back Dues and Special Assessments, of the GOVERNANCE AND ORGANIZATIONAL MANUAL
OF THE AMERICAN DENTAL ASSOCIATION be amended by addition of the following third new paragraph (new language underscored):

3. Acceptance of Back Dues and Special Assessments. For purposes of establishing continuity of active membership to qualify for life membership, back dues and any special assessment, except as otherwise provided in the Bylaws, shall be accepted for not more than the three (3) years of delinquency prior to the date of application for such payment. The rate of such dues and/or any special assessment, except as otherwise provided in the Bylaws, shall be in accordance with Chapter I, Section 40 of the Bylaws.

For the purpose of establishing continuity of active membership in order to qualify for life membership, an active member, who had been such when entering upon active duty in one of the federal dental services but who, during such federal dental service, interrupted the continuity of active membership because of failure to pay dues and/or any special assessment and who, within one year after separation from such military or equivalent duty, resumed active membership, may pay back dues and any special assessment for any missing period of active membership at the rate of dues and/or any special assessment current during the missing years of membership.

Notwithstanding the foregoing, due to the effects of the COVID 19 pandemic in the U.S., members who resume their ADA membership by December 31, 2022 June 30, 2023 after missing either or both of the 2020-2021 and 2021-2022 membership years shall be considered to have maintained continuous membership with regard to the requirements for all ADA membership categories.

211H. Adopted Fifteenth Trustee District Resolution 211—Data on New Dentist Changes Between Practice Modalities During the 10-year New Dentist Time Period

Resolved, that the appropriate American Dental Association (ADA) agency collect data on new dentist practice location and modalities during the first 10 years of dental practice, and be it further

Resolved, that the data be grouped by solo practice; dentist owned and operated group practice including small, medium, and large groups; and Dental Support Organization practices with and without private equity ownership where possible, and be it further

Resolved, that the data be analyzed to examine trends in new dentist practice modalities, reasons why new dentists change modalities within the first 10-years, and to identify the factors impacting their practice choice at the end of 10 years, and be it further

Resolved, that the data be used by the Council on Membership and any appropriate ADA agency in its recruitment and retention activities, and be it further
<table>
<thead>
<tr>
<th>Resolution</th>
<th>Action</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>212H.</strong></td>
<td>Adopted—Consent Calendar Action</td>
<td>Resolved, that the agency report its findings to the 2023 House of Delegates. Fourteenth Trustee District Resolution 212—Insurance and Paid Extended Leave Resolved, that the appropriate ADA agency explore options to help employer dentists offer paid extended/family leave (such as insurance products) that can be purchased as a member benefit, and be it further Resolved, that the appropriate ADA agency report back to the 2023 ADA House of Delegates.</td>
</tr>
<tr>
<td><strong>213H.</strong></td>
<td>Adopted—Consent Calendar Action</td>
<td>Reference Committee A (Budget, Business, Membership and Administrative Matters) Resolution 213RC adopted in lieu of Fifteenth Trustee District Resolution 213—Improvements to the ADA Career Center National Job Board Resolved, that the appropriate American Dental Association (ADA) agencies investigate and implement improvements based on dentists’ needs to the ADA’s existing job placement programs that will entice ADA members to post job opportunities and attract dentists in the workforce to seek those job opportunities, and be it further Resolved, that the appropriate ADA agencies seek input from the American Student Dental Association, including but not limited to, ease of use, potential areas of improvement and marketability, and how best to promote this improved resource to ADA members and dental students, and be it further Resolved, that a report be made to the 2023 House of Delegates.</td>
</tr>
<tr>
<td><strong>214</strong></td>
<td>--</td>
<td>WITHDRAWN</td>
</tr>
<tr>
<td><strong>300H.</strong></td>
<td>Adopted</td>
<td>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 300—Consent Calendar Resolved, that the recommendations of Reference Committee B on the following resolutions be accepted by the House of Delegates. 1. Resolution 301—Adopt—Amendment of Policy, Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers (Worksheet:3000) $: None COMMITTEE RECOMMENDATION: Vote Yes 2. Resolution 302RC—Adopt Resolution 302RC in lieu of Resolutions 302 and 302S-1—Transparency in Provider Scorecards and Performance Reports (Worksheet:3004) $: None COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td>Resolution 303RC</td>
<td>Adopt Resolution 303RC in lieu of Resolution 303—Advocacy for Dentists to Refer to Tobacco and Vaping Cessation QuitLines (Worksheet:3018) $: 25,000</td>
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<tr>
<td><strong>COMMITTEE RECOMMENDATION:</strong></td>
<td><strong>Vote Yes</strong></td>
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<tr>
<th>Resolution 304RC</th>
<th>Adopt Resolution 304RC in lieu of Resolution 304—Social Media Reviews and Reputation Management (Worksheet:3019) $: 6,500</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMITTEE RECOMMENDATION:</strong></td>
<td><strong>Vote Yes</strong></td>
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</table>

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<thead>
<tr>
<th>Resolution 305RC</th>
<th>Adopt Resolution 305RC in lieu of Resolution 305—Third Party Payer Contracting Practices (Worksheet:3022) $: None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMITTEE RECOMMENDATION:</strong></td>
<td><strong>Vote Yes</strong></td>
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<thead>
<tr>
<th>301H.</th>
<th>Adopted—Consent Calendar Action</th>
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<tbody>
<tr>
<td><strong>Council on Dental Benefit Programs Resolution 301</strong></td>
<td><strong>as editorially corrected by the Speaker—Amendment of Policy, Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers</strong></td>
</tr>
</tbody>
</table>

**Resolved,** that the ADA policy titled, Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers (Trans.1995:610; 2015:243) be amended as follows (additions are underscored; deletions are stricken).

**Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers**

**Resolved,** it is the ADA’s position that all communications from a third-party payer or other benefits administrator which attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, include the following statement:

Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to (insert pertinent provisions of summary plan description) of your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted.

and be it further

**Resolved,** that in reporting the benefit determination to the beneficiary, the following information be reported on the explanation of benefits statement:
1. The treatment reported on the claim by CDT codes as submitted by the dentist; and
2. A statement indicating how the submitted procedures were adjudicated.

and be it further

**Resolved**, that the ADAs model explanation of benefits statement be the basis for any national standard for EOB statements, and be it further

**Resolved**, that if when the EOB statements lists procedures CDT codes on which benefits were used to determined benefits that are different from submitted procedures, what was submitted by the treating dentist then payers should not apply frequency limits to the benefitted procedure code applied for adjudication to limit the frequency of that procedure, and be it further

**Resolved**, that in all correspondence between a third-party carrier and the patient regarding the patient’s dental claims, the carrier should provide the name, area code and telephone number of the individual who is acting on behalf of the carrier, and be it further

**Resolved**, that dentists reviewing claims submissions must be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law.

**Resolved**, that the Council on Dental Benefit Programs work with third-party payers, plan purchasers, benefits consultants, and government agencies to implement this policy.

and be it further

**Resolved**, that the ADA policy titled Legislation to Require Dental Benefit Plans to Provide Dental Consultant Information (Trans.2010:546) be rescinded.

<table>
<thead>
<tr>
<th>302H.</th>
<th>Adopted—Consent Calendar Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 302RC in lieu of Ninth Trustee District Resolution 302 and Seventh Trustee District Resolution 302S-1—Transparency in Provider Scorecards and Performance Reports</td>
<td></td>
</tr>
</tbody>
</table>

**Resolved**, that the ADA Policy titled Dentist Rating by Third Parties (Trans:2014:455) be amended as follows (additions are underscored; deletions are stricken).

**Provider Dentist-Rating by Third Parties**
**Resolved,** that the ADA opposes third-party dentist provider ratings systems based on cost or non-validated utilization patterns because they are inherently flawed, unreliable, and potentially misleading to the public, and be it further

**Resolved,** that the appropriate agencies of the Association inform third party payers of this opposition and urge will advise third parties, particularly those that publish ratings or rankings of dentists or dental practices based on selective and limited criteria, about ADA policies relating to ratings systems and encourage them not to include such ratings in their communications to the public, and be it further

**Resolved,** that the appropriate ADA agency prioritize legislative efforts to prevent the use of such flawed and misleading provider rating systems as part of dental insurance reform, and be it further

**Resolved,** that third parties who publish provider rating systems should clearly convey to the public that provider ratings are not based on care quality but rather practitioner conformity with dental plan design and cost containment for the insurance plans, and be it further

**Resolved,** that third parties who publish provider rating systems should be transparent regarding the methodology, provide detailed quarterly reports to the provider, provide a mechanism to appeal and improve provider scores as well as a mechanism to opt-out from being publicly rated.

**Resolved,** that the ADA pursue appropriate legal, administrative and other actions to oppose and prevent third parties from developing and using such inherently flawed, unreliable, and potentially misleading dentist ratings and ranking systems, and be it further

**Resolved,** that the ADA draft model legislation to oppose such objectionable dentist rating and ranking systems in federally-regulated dental benefits plans and support states in advocacy efforts to oppose such systems in state-regulated plans.

<table>
<thead>
<tr>
<th>303H.</th>
<th>Adopted—Consent Calendar Action</th>
<th>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 303RC—Advocacy for Dentists to Refer to Tobacco and Vaping Cessation QuitLines in lieu of Fourteenth Trustee District Resolution 303—Creation of an ADA Task Force on Referral to Tobacco and Vaping Cessation Quitlines</th>
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<td></td>
<td><strong>Resolved</strong>, that the appropriate ADA Agency:</td>
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<tr>
<td></td>
<td>1. Establish relationships with each state’s QuitLine to gather accurate data on QuitLine referrals by dentists and other dental team members.</td>
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</table>
2. Facilitate a survey by state associations to understand QuitLine referrals by their members.
3. Increase tobacco and vaping cessation counseling and referral to QuitLines.

and be it further

Resolved, that the ADA Agency report back to the 2023 ADA House of Delegates.

<table>
<thead>
<tr>
<th>304H.</th>
<th>Adopted—Consent Calendar Action</th>
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<tr>
<td><strong>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 304RC in lieu of Fourteenth Trustee District Resolution 304—Social Media Reviews and Reputation Management</strong></td>
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</table>

Resolved, that the appropriate ADA agencies curate existing social media reputation management content to develop a Reputation Defense Toolkit to help dentists with the appropriate reaction to social media postings and reviews that are misleading or defamatory, to make the Reputation Defense Toolkit available as a member benefit and to initiate a plan to update the Toolkit as needed, and be it further

Resolved, that the ADA enter into discussions with social media platforms to assess the feasibility of revising user agreements to prohibit misleading or unverifiable posts and reviews, which cannot be responded to due to HIPAA limitations, and the creation of a fair and reasonable process for victims of such posts to appeal to social media platforms for expedited removal, to remove misleading or defamatory posts, and be it further

Resolved, that the ADA confirm the use of actuality of social media platforms using financial incentives to escalate the number of posts or their entering into financial contracts in order to have negative posts removed.

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<thead>
<tr>
<th>305H.</th>
<th>Adopted—Consent Calendar Action</th>
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<tbody>
<tr>
<td><strong>Reference Committee B (Dental Benefits, Practice and Related Matters) Resolution 305RC in lieu of Seventeenth Trustee District Resolution 305—Third Party Payer Contracting Practices</strong></td>
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</table>

Resolved, that the ADA urge that any amendments to existing third party payer contracts between a dentist and a third party payer, dental benefits administrator or a dental network leasing company require signature by the dentist, and be it further

Resolved, that such amendments with any and all changes to the contract terms, policy manual and fee schedule be communicated to the dentist via certified mail with at least 90 days notice prior to the date of implementation and to require the dentist’s signature to opt in, and be it further

Resolved, that when third party payers choose to establish a new network using the name, image and likeness of dentists participating in the carrier’s existing network, then dentists should be provided the opportunity to opt-in to such new networks, and be it further
**Resolved**, that notification of creation of such new networks be communicated to the dentist via certified mail with at least 90 day notice along with any and all changes to the contract terms, policy manual and the applicable fee schedule.

<table>
<thead>
<tr>
<th>Resolution No.</th>
<th>Action</th>
<th>Reference Committee C (Dental Education, Science and Related Matters) Resolution 400—as amended—Consent Calendar</th>
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<tbody>
<tr>
<td>400H.</td>
<td>Adopted</td>
<td><strong>Resolved</strong>, that the recommendations of Reference Committee C on the following resolutions be accepted by the House of Delegates.</td>
</tr>
<tr>
<td><strong>1.</strong></td>
<td>Resolution 401—Adopt Resolution 401 in lieu of 401S-1—Amendment of Policy Statement on Lifelong Learning (Worksheet:4000) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Resolution 402—Adopt—Amendment of Policy, Continuing Dental Education (Worksheet:4003) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Resolution 403RC—Adopt Resolution 403RC in lieu of Resolution 403—Amendment of the Policy, Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited Providers (Worksheet:4007) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Resolution 404RC—Adopt Resolution 404RC in lieu of Resolution 404—Amendment of the Policy on Use of Amalgam as Restorative Material (Worksheet:4020) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Resolution 405—Adopt—Amendment of the Policy on Scientific Assessment of Dental Restorative Materials (Worksheet:4022) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>Resolution 406RC—Adopt Resolution 406RC in lieu of Resolution 406—Amendment of the Policy on Evidence-Based Dentistry (Worksheet:4024) $: None</td>
<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
</tr>
</tbody>
</table>
7. **Resolution 407B**—Adopt Resolution 407B in lieu of Resolution 407—Response to Resolution 65b-2021, Amendment of the Policy, Research Funds (Worksheet:4030) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

8. **Resolution 408**—Adopt—Amendment of the Policy on Precapsulated Amalgam Alloy (Worksheet:4044) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes

9. **Resolution 409**—Adopt—Amendment of the Policy Statement on Complementary and Alternative Medicine in Dentistry (Worksheet:4046) $: None

   **COMMITTEE RECOMMENDATION:** Vote Yes


    **COMMITTEE RECOMMENDATION:** Vote Yes


    **COMMITTEE RECOMMENDATION:** Vote Yes

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<tr>
<th>401H.</th>
<th>Adopted—Consent Calendar Action</th>
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<tr>
<td></td>
<td>Council on Dental Education and Licensure Resolution 401 in lieu of Sixteenth Trustee District Resolution 401S-1—Amendment of Policy Statement on Lifelong Learning</td>
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<tr>
<td></td>
<td><strong>Resolved,</strong> that the Policy Statement on Lifelong Learning (Trans.2000:467) be amended as follows (additions are underlined; deletions are stricken):</td>
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<tr>
<td></td>
<td><strong>Policy Statement on Lifelong Learning</strong></td>
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<td></td>
<td>The Association advocates lifelong learning to enhance and update the knowledge base of dentists, to stimulate ongoing professional growth and development and to improve professional skills. Dentists have a responsibility to pursue lifelong learning throughout their professional careers. The Association recognizes that its members represent a broad community of interest and possess highly diverse learning styles that can be accommodated by a variety of educational methods. Members are encouraged to identify individual needs and develop and implement a plan to meet</td>
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</table>
these needs. This plan may include, but not be limited to, staying current with professional literature, seeking current information applicable to one’s practice, and participating in formal continuing dental education activities. The increasing pace of change in technology and skills necessary to practice dentistry necessitates the continuous deliberate acquisition of knowledge and skills to provide the highest quality of oral health care. A professional should address a broad spectrum of topics to update his or her knowledge and skills in all appropriate areas of the profession.

The Association is committed to serving as a supportive resource to facilitate the lifelong learning process and continuing competency by assisting its members in identifying appropriate sources and mechanisms for meeting this responsibility for the benefit of the public and the profession. The Association encourages the investigation of new methods of supporting continuing competency of its members and urges state dental boards to not utilize methods such as mandated periodic in-office audits and/or comprehensive written examinations and/or clinical, patient-based competency assessments, manikin-based competency assessments, or virtual reality competency assessments as a means of measuring or assessing the continuing competency of dentists or as a requirement for license renewal.

Continuing competency for renewal of state permits (such as anesthesia permits) may require ongoing competency assessments and office audits, in addition to specialty board requirements which may require regular competency assessment to maintain board certification.

and be it further

**Resolved**, that the ADA Policy on Lifelong Continuing Education (*Trans.*1999:941) be rescinded.

### 402H. Adopted—Consent Calendar Action

**Council on Dental Education and Licensure Resolution 402—Amendment of Policy, Continuing Dental Education**

**Resolved**, that the Policy Statement on Continuing Dental Education (*Trans.*2006:331; 2011:465; 2017:274) be amended as follows (additions are underlined; deletions are stricken):

**Policy Statement on Continuing Dental Education**

**Definition of Continuing Dental Education**: Continuing dental education consists of educational activities designed to review existing concepts and techniques, to convey information beyond the basic dental education and to update knowledge on advances in scientific, clinical, and non-clinical related subject matter, including evidence-based dentistry and ethics. The objective is to improve the knowledge, skills and ability of the individual to provide the highest quality of service to the public and the profession. All continuing dental education should strengthen the habits of critical inquiry, balanced judgment and ethics that denote the truly professional and
A scientific person and should make it possible for new knowledge to be incorporated into the practice of dentistry as it becomes available.

Continuing education programs are typically designed for part-time enrollment and are of variable duration. In contrast to accredited advanced dental education programs, continuing dental education programs do not lead to eligibility for ethical announcements or certification in a specialty recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards American Dental Association. Continuing dental education should be a part of a lifelong continuum of learning.

**Acceptable Course Titles and Descriptions:** Continuing education course titles and descriptions should be structured such that the titles and descriptions do not explicitly or implicitly infer that attendees can perform procedures beyond their legal scope of practice.

**Acceptable Subject Matter:** In order for specific course subject material to be acceptable for credit, the stated course objectives, overall curriculum design or topical outlines should be clearly stated. The information presented should enable the dental professional to enhance the oral health and well-being of the public, either directly or through improved effectiveness of operations in dental practice, or through expansion of present knowledge through research. The dental professional should be able to apply the knowledge gained within his or her professional capacity.

**Acceptable Activities:** Continuing education activities are conducted in a wide variety of forms using many methods and techniques which are sponsored by a diverse group of institutions and organizations, including formally structured educational content offered by accredited or approved providers, and other types of activities that state dental boards and/or legislatures may by law specify as acceptable. The Association urges the state dental boards to allow maximum flexibility for an individual to choose content and learning activities based on individual preferences, needs, interests and resources. Additionally, clinical credit should be awarded for all activities related to the delivery of dental procedures including those with ethical components and self-study activities.

Acceptable forms might include but are not limited to:

- participation in a formal continuing education course (a didactic and/or participatory activity to review or update knowledge of new or existing concepts and techniques)
- delivery of a formally structured continuing education course
- general attendance at a multi-day convention type meeting (a meeting held at the national, state or regional level which involves a variety of concurrent educational experiences)
- presentation at a poster session or table clinic
- authorship of publications (e.g., a book, a chapter of a book or an article or paper published in a professional journal)
- completion of self-study activities such as online courses and research, webinars, journal articles and downloadable books (individualized course of study which is structured and organized, but is available on an unscheduled and unsupervised basis; a method of providing feedback to the learner on performance or comprehension must be incorporated into the self-study activity)
- enrollment in a preceptor program (an independent course of study with a formally structured, preplanned and prescheduled curriculum where the participant observes and provides patient treatment using criteria and guidelines provided by the instructors; this type of study does not lead to an academic degree)
- academic service (e.g., instruction, administration or research related to undergraduate, postgraduate or graduate dental or allied dental training programs)
- presenting posters or table clinic
- membership on a state dental board or committee; participation in a state dental board, a board complaint investigation, peer review or quality care review procedures evaluation
- successful completion of Part II of the National Board Dental Examination, a recognized dental specialty examination or the National Board Dental Hygiene Examination if taken after initial licensure, successful completion of the Integrated National Board Dental Examination, fellowship/certification examinations in general dentistry or interest areas in general dentistry, a recognized dental specialty certification examination, the National Board Dental Hygiene Examination, or the Dental Assisting National Board (DANB) Examination
- participation in test development or calibration for written and clinical dental, dental hygiene and dental specialty certification examinations
- volunteering pro bono dental services or community oral health activities through a public health facility providing volunteer pro bono dental services at a non-profit entity or event
- participation in dental research as a principal investigator or research assistant
- attendance at a study club meeting that uses audio, video, live presentations or written materials
- dental coursework taken during postdoctoral education or a CODA-accredited residency program

and be it further

Resolved, that the ADA Policy on Titles and Descriptions of Continuing Education Courses (Trans.2014:463) be rescinded.

<p>| 403H. | Adopted—Consent Calendar Action | Reference Committee C (Dental Education, Science and Related Matters) Resolution 403RC in lieu of Council on Dental Education and Licensure Resolution |</p>
<table>
<thead>
<tr>
<th>403</th>
<th>Amendment of the Policy, Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited Providers</th>
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<tbody>
<tr>
<td></td>
<td><strong>Resolved</strong>, that the ADA Policy on Acceptance of Formal Continuing Medical Education Courses Offered by ACCME Accredited Providers (Trans.2010:576) be amended as follows (additions underlined; deletions stricken).</td>
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<tr>
<td></td>
<td><strong>Acceptance of Formal Continuing Medical Education Courses Offered by ACCME or IPCE Accredited Providers</strong></td>
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<tr>
<td></td>
<td><strong>Resolved</strong>, that the American Dental Association urges state boards of dentistry to accept for licensure renewal purposes dentists’ participation in formal continuing medical education courses offered by continuing education providers accredited by the Accreditation Council for Continuing Medical Education (ACCME) or Joint Accreditation for Interprofessional Continuing Education (IPCE).</td>
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<th>404H</th>
<th>Adopted—Consent Calendar Action</th>
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<tr>
<td>404H</td>
<td>Reference Committee C (Dental Education, Science and Related Matters) Resolution 404RC in lieu of Council on Scientific Affairs Resolution 404—Amendment of the Policy on Use of Amalgam as Restorative Material</td>
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<tr>
<td></td>
<td><strong>Resolved</strong>, that the ADA Policy Statement on Use of Amalgam as Restorative Material (Trans.1986:536) be amended as (additions underlined; deletions stricken):</td>
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<td></td>
<td><strong>Resolved</strong>, that the ADA recommends that clinicians review the risks and benefits of all restorative options with their patients, and that dental amalgam restorations continue to be used when appropriate for patient care, and be it further</td>
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<td><strong>Resolved</strong>, that the ADA supports the globally recognized need to reduce environmental mercury as set forth in the Minamata Convention on Mercury (September 2019) as a common good, and recognizes the responsibility of dentists to care for their patients’ well-being, in keeping with the ADA Principles of Ethics and Code of Professional Conduct, and be it further</td>
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<td><strong>Resolved</strong>, that based on current documented scientific research, the conclusions of conferences and symposiums on the biocompatibility of metallic restorative material, and upon joint reports of the Council on Dental Materials, Instruments and Equipment and the Council on Dental Therapeutics of the Association, the continued use of dental amalgam as a restorative material does not pose a health hazard to the nonallergic patient, and be it further</td>
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<td></td>
<td><strong>Resolved</strong>, that to advocate to a patient or the public the removal of clinically serviceable dental amalgam restorations solely to substitute a material that does not contain mercury is unwarranted and violates the ADA Principles of Ethics and Code of Professional Conduct. and be it further.</td>
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<td>Resolution</td>
<td>Adopted—Consent Calendar Action</td>
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<tr>
<td>Resolved,</td>
<td>that in those instances where state dental boards initiate proceedings on this question that the ADA cooperate in such proceedings by making available scientific personnel as expert witnesses.</td>
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<td>405H.</td>
<td>Council on Scientific Affairs Resolution 405—Amendment of the Policy on Scientific Assessment of Dental Restorative Materials</td>
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<tr>
<td>Resolved,</td>
<td>that the ADA Policy on Scientific Assessment of Dental Restorative Materials (Trans.2003:387) be amended as follows (additions underlined, deletions stricken):</td>
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<tr>
<td></td>
<td>Scientific Assessment of Dental Restorative Materials</td>
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<td></td>
<td>Resolved, that although the safety and efficacy of dental restorative materials has been extensively researched, the Association, consistent with its Research Agenda Priorities and evidence-based practice, will continue to actively promote such research to ensure that the profession and the public have the most current, scientifically valid information on which to make choices about dental treatment requiring restorative materials, and be it further</td>
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<td></td>
<td>Resolved, that the Association use its existing communications vehicles to educate opinion leaders, and policy makers, government agencies, and other communities of interest about the scientific methods used to assess the safety and efficacy of dental restorative materials, and be it further</td>
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<tr>
<td></td>
<td>Resolved, that the Association continue to promptly inform the public and the profession of any new scientific information that contributes significantly to the current understanding of dental restorative materials.</td>
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<tr>
<td>406H.</td>
<td>Reference Committee C (Dental Education, Science and Related Matters) Resolution 406RC in lieu of Council on Scientific Affairs Resolution 406—as editorially revised by the Speaker—Amendment of the Policy on Evidence-Based Dentistry</td>
</tr>
<tr>
<td>Resolved,</td>
<td>that the ADA Policy Statement on Evidence-Based Dentistry (Trans.2001:462; 2012:469) be amended as follows (additions underlined; deletions stricken):</td>
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<tr>
<td></td>
<td>Policy Statement on Evidence-Based Dentistry</td>
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|           | Introduction: In the early 1990s, a process for decision-making emerged in medicine and other health fields that relies on systematic approaches to summarize the large volume of literature to assist patients and health care providers with translating evidence into clinical practice. David Sackett and colleagues defined evidence-based medicine as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice
of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

Simply stated, evidence-based medicine is “the integration of the best research evidence with clinical expertise and patient values.” With rapidly evolving science and technology, dentistry has also faced the complex demands of integrating and effectively implementing changes in treatment modalities that can arise from new scientific evidence.

To address these challenges, the dental profession has endorsed an evidence-based approach to clinical practice and oral health care, which is commonly known as evidence-based dentistry (EBD). The American Dental Association (ADA) continues to pursue a leadership role in the field of EBD to help clinicians interpret and apply the best available evidence in everyday practice.

**Definition of Evidence-Based Dentistry:** The ADA defines the term evidence-based dentistry as an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient’s oral and medical condition and history, with the dentist’s clinical expertise, and the patient’s treatment needs and preferences.

In adopting this definition for EBD, the ADA also recognizes that treatment recommendations should be determined for each patient by his or her dentist, and that patient preferences should be considered in all decisions. Dentist experience, diagnostic findings and other circumstances, such as patients’ characteristics, additionally should be considered in treatment planning and determining treatment needs. EBD does not provide a “cookbook” that dentists must follow, nor does it establish a standard of care. The EBD process must not be used to interfere in the dentist/patient relationship, nor is it to be used as a cost-containment tool by third-party payers.

**ADA Center for Evidence-Based Dentistry Principles of Evidence-Based Dentistry:** The Association supports the concept of evidence-based dentistry developed through systematic examination of the best available scientific data. In 2007, the Association established the ADA Center for Evidence-Based Dentistry to provide leadership in implementing initiatives related to EBD. Evidence-based dentistry provides a framework to help dentists use, appraise and apply research evidence in clinical practice.

A primary goal of evidence-based dentistry is to improve the quality of dental treatment and oral health care through the objective appraisal of the best available evidence and the development of systematic reviews and evidence-based guidelines and recommendations that can assist clinicians in the conscientious and judicious use of current best evidence, taking into consideration the patient’s preferences and values. Another goal of evidence-based dental practice is to improve clinicians’ skills.
in diagnosing oral and dental diseases and providing evidence-based treatment interventions that help achieve optimal outcomes for patients.

The ADA works to support clinicians in making decisions about the provision of patient-centered, evidence-based treatment and care to allow such decisions to be based on current best evidence, individual clinical expertise and the individual patient’s preferences and values. The ADA supports use of quality research findings to systematically build the evidence base used to inform delivery of care, treatment interventions and patient-important outcomes. The ADA also supports the following:

- encouraging incorporation of EBD recommendations in the practice of dentistry;
- supporting teaching about methodology of—and the findings from—EBD recommendations in dental schools;
- advancing policy that encourages patient care in alignment with EBD guidance, where appropriate, and suggests consideration be given to using EBD recommendations to contribute to the development of quality improvement measures;
- the development of EBD resources to guide the practice of dentistry;
- enhancing oral health equity and the equitable provision of patient-centered, evidence-based dental treatment; and
- the development of EBD recommendations that advance evidence-based diagnosis and patient-centered oral health care.

The ADA also recognizes that treatment recommendations should be determined for each patient by his or her dentist, and that patient preferences should be considered in all decisions. Additionally, dentist experience, diagnostic findings and other patient circumstances should be considered in treatment planning and determining treatment needs. EBD does not provide a “cookbook” that dentists must follow, nor does it establish a standard of care. The EBD process must not be used to interfere in the dentist/patient relationship, nor is it to be used as a cost-containment tool by third-party payers.

To realize its vision of disseminating the best available evidence and helping practitioners implement EBD, the ADA Center for Evidence-Based Dentistry works in collaboration with the Council on Scientific Affairs to convene expert panels that review the collective research evidence and develop evidence-based clinical practice guidelines on key clinical issues. The Association will continue developing evidence-based clinical practice guidelines and working with collaborative groups to conduct systematic reviews, critically appraise the reviews and policies developed by other organizations, and develop mechanisms for translating and disseminating information to the membership.

**EBD Resources:** Detailed information on EBD, evidence-based clinical practice guidelines, systematic reviews, EBD terminology, courses/workshops, critical
summaries of systematic reviews and other resources are available on the website of the ADA Center for Evidence-Based Dentistry (http://ebd.ada.org/). Concise, user-friendly EBD resources from the ADA Center for EBD and other organizations are useful resources that can assist practitioners with integrating the best available evidence with clinical expertise and the needs and preferences of the individual dental patient.


<table>
<thead>
<tr>
<th>407H</th>
<th>Adopted—Consent Calendar Action</th>
<th>Board of Trustees Resolution 407B in lieu of Council on Scientific Affairs Resolution 407—Amendment of the Policy, Research Funds</th>
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<tr>
<td>Resolved, that the following policy titled Advancing Equity in Dental Research Funding be adopted:</td>
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<tr>
<td>Resolved, that the American Dental Association supports sustained, robust funding for basic, translational, and clinical oral and craniofacial health research to improve health outcomes in diverse populations across the lifespan, and be it further</td>
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<td>Resolved, that the ADA supports robust efforts to create a diverse, equitable and inclusive dental research workforce that reflects the diversity of the nation and embodies dentistry’s values of diversity, equity and inclusion.</td>
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<td>and be it further</td>
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<tr>
<th>408H</th>
<th>Adopted</th>
<th>Council on Scientific Affairs Resolution 408—Amendment of the Policy on Precapsulated Amalgam Alloy</th>
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<tr>
<td>Resolved, that the ADA Policy on Precapsulated Amalgam Alloy (Trans. 1994:676) be amended as follows (additions underline; deletions stricken):</td>
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<tr>
<td>Precapsulated Amalgam Alloy</td>
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<tr>
<td>409H.</td>
<td>Adopted—Consent Calendar Action</td>
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| **Resolved,** that the ADA strongly recommends that dentists eliminate the use of bulk dental mercury and bulk amalgam alloy and that when using amalgam, they dentists use only precapsulated amalgam alloy, also referred to as encapsulated amalgam alloy, in their dental practices. | **Council on Scientific Affairs Resolution 409—Amendment of the Policy Statement on Complementary and Alternative Medicine in Dentistry**

**Resolved,** that the ADA Policy Statement on Complementary and Alternative Medicine in Dentistry (Trans.2001:461; 2017:277) be amended as follows (additions underlined; deletions stricken):

**Policy Statement on Complementary and Alternative Medicine in Dentistry**

The ADA, consistent with its commitment to evidence-based dentistry and the improvement of oral health, supports including complementary and alternative medicine therapies as an adjunct to traditional diagnostic and treatment approaches, as long as they are based on sound scientific principles and demonstrated clinical safety and effectiveness.

In September 2002, the National Center for Complementary and Alternative Medicine partnered with the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality to commission the Institute of Medicine (IOM) to convene a study committee to investigate scientific, policy and practice questions arising from the use of complementary and alternative medicine (CAM) therapies by the American public.1 The IOM committee’s final report1 describes the current use of CAM in the United States, the populations using them, a summary of current practices and policies, and the development of conceptual framework linked to research and decision-making. One of the key messages from the cited report states:

“The committee recommends that the same principles and standards of evidence of treatment effectiveness apply to all treatments, whether currently labeled as conventional medicine or CAM. Implementing this recommendation requires that investigators use and develop as necessary common methods, measures, and standards for the generation and interpretation of evidence necessary for making decisions about the use of CAM and conventional therapies.”

Historically, dentistry has evolved as a strong and respected profession based on sound science, a moral commitment of service to the public, and an ethical obligation to protect the health of the patient. The ADA strongly supports this tradition of dentistry as a profession rooted in constantly evolving scientific information and an ethical duty to act for the benefit of others.

The dental community has always been open to emerging diagnostic and treatment approaches that over the years have improved the oral health of the public, the
The ADA, consistent with its commitment to evidence-based dentistry and the improvement of oral health, supports those diagnostic and treatment approaches that allow both patient and dentist to make informed choices among safe and effective options. The provision of dental care should be based on sound scientific principles and demonstrated clinical safety and effectiveness.

The ADA is open to the idea of integrating new therapies in clinical practice, along with those that have been already tested and shown to be safe and effective in improving patient outcomes. However, the ADA also acknowledges that interventions which are considered CAM are usually understudied interventions that require further scientific testing and investigation to draw reliable conclusions about their safety, effectiveness and potential benefits beyond placebo.

Health care interventions, whether or not considered CAM, should be subject to testing using similar research standards and scientific rigor to provide a strong, evidence-based foundation for their safety and appropriate use. Within this context, the notion of CAM as a specific subset of interventions that belong to a specific discipline can be considered questionable.

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<th>410H.</th>
<th>Adopted—Consent Calendar Action</th>
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**Resolved,** that the Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists (Trans.2001:470; 2004:313; 2009:443; 2013:328; 2018:326) be amended as follows (additions underlined; deletions stricken):

**Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists**

**Introduction**

The Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists contain criteria that specialty applicants and the recognized specialty sponsoring organizations and certifying boards must meet in order to become and/or remain recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards (National Commission).

A specialty is an area a discipline of dentistry that has a separate, distinct and well-defined focus based on unique advanced knowledge, skills and training that has been formally recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards as meeting the "Requirements for Recognition of Dental Specialists" specified in this document. Dental specialties are recognized to protect the public, nurture the art and science of dentistry, and improve the quality
of care in disciplines of dentistry in which advanced knowledge, skills and training are essential to maintain or restore oral health. It is the Association’s belief that the needs of the public are best served if the profession is oriented primarily to general practice. Specialties are recognized in those areas where advanced knowledge and skills are essential to maintain or restore oral health.¹

Not all areas in dentistry will satisfy the requirements for specialty recognition. However, the public and profession benefit substantially when non-specialty groups develop and advance areas of interest through education, practice and research. The contributions of such groups are acknowledged by the profession and their endeavors are encouraged.

Not all disciplines in dentistry will satisfy the requirements for specialty recognition and there should be no expectation that all disciplines in dentistry will meet the Requirements for Recognition of Dental Specialties. Disciplines of dentistry that are not currently recognized as a specialty by the National Commission and believe they can meet all of the Requirements for Recognition of Dental Specialties. The sponsoring organization must should contact the National Commission for a formal Application for Specialty Recognition. submit to the National Commission on Recognition of Dental Specialties and Certifying Boards a formal application which demonstrates compliance with all the requirements for specialty recognition. When making decisions related to specialty recognition, the National Commission will only determine compliance with the criteria outlined in the Requirements for Recognition.

If a discipline of dentistry is granted specialty recognition by the National Commission, Following recognition of a specialty by the National Commission on Recognition of Dental Specialties and Certifying Boards a national board for certifying diplomates in accordance with the "Requirements for National Certifying Boards for Dental Specialists" may must be established as specified in this document and recognized by the National Commission as the national certifying board for the specialty.

¹ Association policies regarding ethical announcement of specialization and limitation of practice are contained in the ADA Principles of Ethics and Code of Professional Conduct.

Requirements for Recognition of Dental Specialties

A sponsoring organization seeking specialty recognition for an area a discipline of dentistry that is not currently recognized as a dental specialty must be able to provide documented evidence that the discipline satisfies all the requirements specified in this section. Specialty sponsoring organizations recognized by the National Commission must be able to show continued compliance with the Requirements for Recognition of
(1) In order for an area a discipline of dentistry to become and/or remain recognized as a dental specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of that the proposed or recognized dental specialty; (b) in which the privileges to hold office and to vote on any issue related to the specialty are reserved for dentists who have either have completed an advanced education program that is a minimum of two (2) academic years in length accredited by the Commission on Dental Accreditation in that the proposed or recognized specialty or have sufficient educational and/or practice experience in that the specialty as deemed appropriate through written criteria established by the sponsoring organization and its certifying board; and (c) that demonstrates the ability to establish and maintain a certifying board, if the sponsoring organization is not recognized by the National Commission. The recognized specialty sponsoring organization must continue to have a recognized certifying board that continually meets the Requirements for Recognition of National Certifying Boards for Dental Specialists in order to remain recognized.

(2) A proposed or recognized specialty must be a distinct and well-defined field that requires unique advanced knowledge, skills and training beyond those commonly possessed by dental school graduates as defined by the Commission on Dental Accreditation’s Accreditation Standards for Dental Education Programs.

(3) The scope of practice of the a proposed or recognized specialty requires advanced knowledge, skills and training that: (a) in their entirety are separate and distinct from the knowledge, skills and training required to practice in any recognized dental specialty; and (b) cannot be accommodated through minimal modification of a any of the recognized dental specialty specialties.

(4) The specialty applicant A proposed or recognized specialty must document scientifically, by valid and reliable statistical evidence/studies, that it: (a) actively contributes to new knowledge in the field; (b) actively contributes to professional education the educational needs of the discipline at the predoctoral, postdoctoral and continuing education levels; (c) actively contributes to engages in research needs of the profession that establishes evidence-based validity of therapy used by practitioners in the proposed or recognized specialty; and (d) provides oral health services in the field of study for the public demonstrates a need for service that is not currently being met by general practitioners or any of the recognized dental specialties, each of which the specialty applicant must demonstrate would not be satisfactorily met except for the contributions of the specialty applicant.

(5) A proposed or recognized specialty must directly have a direct
benefit/impact some aspect of clinical patient care and meet the needs of its patient population.

(6) A proposed or recognized specialty must have formal advanced education programs accredited by the Commission on Dental Accreditation that are a minimum of two (2) academic years in length, of at least two years accredited by the Commission on Dental Accreditation must exist to provide the special knowledge and skills required for practice of the proposed specialty.

Requirements for Recognition of National Certifying Boards for Dental Specialists

In order to become, and remain, eligible for recognition by the National Commission on Recognition of Dental Specialties and Certifying Boards as a national certifying board for a dental specialty, the specialty shall have a recognized sponsoring organization that meets all of the elements of Requirement (1) of the Requirements for Recognition of Dental Specialties. A close working relationship shall be maintained between the recognized sponsoring organization and the certifying board. A certifying board seeking recognition must be able to provide documented evidence showing that it satisfies all the Requirements for Recognition of National Certifying Boards for Dental Specialists specified in this section.

Certifying boards recognized by the National Commission must be able to show continued compliance with all of the Requirements for Recognition of National Certifying Boards for Dental Specialists as specified in this section. Additionally, the following requirements must be fulfilled.

Organization of Boards:

(1) Each applicant and a recognized certifying board shall have no less than five (5) and no more than twelve (12) voting directors/officers designated on a rotation basis in accordance with a method approved by the National Commission on Recognition of Dental Specialties and Certifying Boards. Although the National Commission does not prescribe a single method for selecting directors/officers of boards, members of directors/officers may not serve for more than a total of nine (9) years. Membership on the board shall be in accordance with a prescribed method endorsed by the sponsoring organization. All board voting directors/officers shall be diplomates of that specific certifying board and only the sponsoring organizations of certifying boards may establish additional criteria/qualifications if they so desire.

(2) Each applicant and a recognized certifying board shall submit in
writing to the National Commission must have on Recognition of Dental Specialties and Certifying Boards a certification program that is sufficiently comprehensive in scope to and meets the needs of the diplomate practitioners in the recognized specialty and the profession and protects the public requirements established by the American Dental Association for the operation of a certifying board. This statement should include evidence of sponsorship of the board by a national organization that meets all the elements of Requirement (1) of the Further, the certifying board must provide evidence of a close working relationship with a recognized specialty sponsoring organization that meets all of the Requirements for Recognition of Dental Specialties.

(3) Each An applicant and a recognized certifying board must shall submit to the National Commission on Recognition of Dental Specialties and Certifying Boards provide evidence of adequate financial support viability to conduct its certification program of certification.

(4) Each An applicant and a recognized certifying board may outsource administrative duties to suitable external consultants and/or external agencies select suitable consultants or agencies to assist in its daily operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates and/or examination functions. If the certifying board does outsource administrative and/or examination functions, the certifying board must submit documentation describing the process. External and internal Consultants consultants who participate in the development and/or administration of clinical certification examinations should must be diplomates in the specialty that is being examined.

Operation of Boards:

(1) Each An applicant and a recognized certifying board shall must only certify qualified dentists as diplomates only in the specialty area of dental practice approved recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards for such certification. No more than one (1) certifying board shall will be recognized by the National Commission for the certification of diplomates in a single area of practice recognized specialty area of practice.

(2) Each An applicant and a recognized certifying board, except by waiver of the National Commission on Recognition of Dental Specialties and Certifying Boards, shall must give at least one (1) examination in each calendar year and shall must announce such examination details at least six (6) months in advance of the examination. In extraordinary circumstances, recognized certifying boards may request a conditional
waiver of exception from the National Commission.

(3) Each An applicant and a recognized certifying board shall must maintain a current list of its diplomates.

(4) Each An applicant and a recognized certifying board shall must submit annually to the National Commission on Recognition of Dental Specialties and Certifying Boards data relative to its financial viability and operations, applicant admission written examination procedures, candidate examination guidelines and procedures, and certification and recertification examination content, test construction and evaluation, and the reporting of results. Examination procedures and results should follow the Standards for Educational and Psychological Testing, including validity and reliability evidence. A diplomate in good standing may, upon written request, obtain a copy of the annual examination technical and financial reports of the certifying board. The recognized certifying boards will submit the required documentation on a cycle established by the National Commission.

(5) Each An applicant and a recognized certifying board shall must encourage require its diplomates to engage in lifelong learning and shall encourage continuous quality improvement.

(6) Each An applicant and a recognized certifying board shall must provide periodically to the National Commission on Recognition of Dental Specialties and Certifying Boards evidence of its examination and certification of a significant number of additional dentists in order to warrant its continuing approval of and continued recognition by the National Commission, on Recognition of Dental Specialties and Certifying Boards. The recognized certifying boards will submit the required documentation on a cycle established by the National Commission.

(7) Each An applicant and a recognized certifying board shall must bear full sole authority and responsibility for the conducting of its the certification programs, the evaluation of the qualifications and competence of those it certifies certified as diplomates, and the issuance of certificates.

(8) Each board shall require an annual registration fee from each of its diplomates intended to assist in supporting financially the continued program of the board.

**Certification Requirements:**

(1) Each An applicant and a recognized certifying board shall must require, for eligibility for certification as a diplomate, the successful completion of
an advanced education program that is two (2) or more academic years in length accredited by the Commission on Dental Accreditation. of two or more academic years in length, as specified by the Commission.

Although full-time, continual attendance in a Commission on Dental Accreditation accredited advanced education program is desirable, the period of advanced study need not be continuous, nor completed within successive calendar years. An advanced educational program equivalent to two (2) or more academic years in length, successfully completed on a part-time basis over an extended period of time as a graduated sequence of educational experience not exceeding four (4) calendar years, may be considered acceptable in satisfying this requirement. Short continuation and refresher courses (educational experience only obtained through continuing education) and teaching experience in a specialty department in dental schools a dental education facility will not be accepted in meeting any portion of this requirement.

Each A certifying board may establish an exception (alternative pathway) to the qualification requirement of completion of an advanced specialty education program that is two (2) or more academic years in length accredited by the Commission on Dental Accreditation for the unique candidate who has not met this requirement per se, but can demonstrate comparable educational and/or training requirements to the satisfaction of the certifying board, equivalent advanced specialty education. A certifying board must submit a separate petition to the National Commission on Recognition of Dental Specialties and Certifying Boards for permission to establish and/or revise such a policy on alternative pathways.

(2) Each An applicant and a recognized certifying board shall establish its minimum requirements for years of practice in the area for which it grants certificates are granted. The years of advanced education in this area the discipline specific specialty may be accepted toward fulfillment of this requirement.

(3) Each An applicant and a recognized certifying board, in cooperation with its recognized specialty sponsoring organization, shall prepare and publicize its joint recommendations on the Commission on Dental Accreditation educational standards for the advanced educational programs for that specialty, and experience requirements which candidates will be expected to meet.

Resolved, that the ADA establish a searchable digital archive of State and Component Publications through Digital Commons, and be it further

Resolved, that the appropriate agency report back to the HOD annually with an assessment of the program’s success in supporting the Association’s Strategic Vision and recommendations on the continuing support of this archive, and be it further

Resolved, that report metrics should include: the number of participating publications, the number of unique articles archived, the search and download activity for its content, and requests for the republication of the content.

<table>
<thead>
<tr>
<th>500H.</th>
<th>Adopted</th>
<th>Reference Committee D (Legislative, Health, Governance and Related Matters) Resolution 500—as amended—Consent Calendar</th>
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<td>Resolved, that the recommendations of Reference Committee D on the following resolutions be accepted by the House of Delegates.</td>
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<tr>
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<td>1. Resolution 501—Adopt—Rescission of the Policy, National Health Service Corps Policy on Scholarships and Loan Repayments (Worksheet:5001) $: None</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
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<td>2. Resolution 502—Refer—Amendment to the Policy, Activity to Stop Unlicensed Dental or Dental Hygiene Practice (Worksheet:5004) $: None</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes on Referral</td>
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<td>3. Resolution 502S-1—Refer—Amendment to the Policy, Activity to Stop Unlicensed Dental or Dental Hygiene Practice (Worksheet:5004a) $: None</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes on Referral</td>
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<td>4. Resolution 503RC—Adopt Resolution 503RC in lieu of Resolution 503—Amendment to the Policy, Dissemination of Information Contrary to Science (Worksheet:5006) $: None</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
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<td>5. Resolution 505—Adopt—Supporting Increased Resources for Department of Veterans Affairs Dental Care (Worksheet:5009) $: None</td>
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<tr>
<td>Resolution</td>
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<td>Proposed Policy</td>
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<td>6. Resolution 506</td>
<td>Proposed Policy, Federal Student Loan Forgiveness</td>
<td>(Worksheet:5011)</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
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<td>7. Resolution 507RC</td>
<td>Adopt Resolution 507RC in lieu of Resolutions 507, 507B and 507BS-1</td>
<td>Proposed Policy, Oral-Systemic Health Integration (Worksheet:5014)</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
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<td>8. Resolution 508RC</td>
<td>Adopt Resolution 508RC in lieu of Resolution 508</td>
<td>Revision of Policy Entitled “Guidelines for Dental Advertising” (Worksheet:5015)</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
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<td>9. Resolution 510</td>
<td>Adopt—Medicaid Dental Loss Ratios: Accountability and Oversight</td>
<td>(Worksheet:5017)</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
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<td>11. Resolution 512</td>
<td>Adopt—Amendment of the Election Commission and Campaign Rules</td>
<td>(Worksheet:5021)</td>
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<td>13. Resolution 514RC</td>
<td>Adopt Resolution 514RC in lieu of Resolution 514</td>
<td>Inclusion of Confidentiality Statement on Meeting Agenda (Worksheet:5037)</td>
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<td>COMMITTEE RECOMMENDATION: Vote Yes</td>
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<td>14. Resolution 515RC</td>
<td>Adopt Resolution 515RC in lieu of Resolution 515 and 515S-1</td>
<td>Amendments to Chapter VIII of the Governance and Organizational Manual of the American Dental Association (Worksheet:5040)</td>
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<td>Resolution</td>
<td>Committee Recommendation</td>
<td>Action</td>
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<td>516</td>
<td>Vote Yes</td>
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<td>518RC</td>
<td>Vote Yes</td>
<td>Adopt</td>
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501H. Adopted—Consent Calendar Action

Council on Government Affairs Resolution 501—Recision of the Policy, National Health Service Corps Policy on Scholarships and Loan Repayments

Resolved, that the policy titled National Health Service Corps Policy on Scholarships and Loan Repayments (Trans.1988:488; 2016:347) be rescinded.

502 Referred to the Appropriate Agency for Further Study and Report to the 2023 House of Delegates—Consent Calendar Action

Council on Government Affairs Resolution 502—Amendment to the Policy, Activity to Stop Unlicensed Dental or Dental Hygiene Practice

Resolved, that the policy titled Activity to Stop Unlicensed Dental or Dental Hygiene Practice (Trans.1999:949) be amended as follows (additions underscored; deletions stricken):

Resolved, that each constituent dental society be urged to support enactment of legislation which gives each Board of Dental Examiners the means to stop the illegal practice of dentistry or dental hygiene by an unlicensed person. The American Dental Association supports the position that states should stop the illegal practice of dentistry or dental hygiene until a valid license is issued or the matter is resolved by a court of law.

502S-1 Referred to the Appropriate Agency for Further Study and Report to the 2023 House of Delegates—Consent Calendar Action

Fourth Trustee District Resolution 502S-1—Amendment to the Policy, Activity to Stop Unlicensed Dental or Dental Hygiene Practice

Resolved, that the following policy titled Timely Prosecution of Unlicensed Individuals Practicing Dentistry or Dental Hygiene be adopted:
503H. **Resolved,** that state attorneys general should be expeditious in prosecuting individuals who are practicing dentistry or dental hygiene without a license, and be it further

**Resolved,** that state dental boards should be empowered to deliver and enforce cease and desist orders and press charges for practicing dentistry or dental hygiene without a proper license, and be it further

**Resolved,** that individuals charged with practicing dentistry or dental hygiene without a license should be prosecuted to the fullest extent of the law.

and be it further

**Resolved,** that the policy titled Activity to Stop Unlicensed Dental or Dental Hygiene Practice (Trans. 1999:949) be rescinded.

**503H.** **Adopted—Consent Calendar Action**

Reference Committee D (Legislative, Health, Governance and Related Matters) Resolution 503RC in lieu of Council on Government Affairs Resolution 503—Amendment to the Policy, Dissemination of Information Contrary to Science

**Resolved,** that the policy titled Dissemination of Information Contrary to Science (Trans. 2006:342) be amended as follows (additions underscored; deletions stricken):

**Resolved, the ADA urges constituent and component societies to**

that it is the position of the American Dental Association that dentists rely on the preponderance of peer-reviewed, evidenced-based science, as that is relevant and available, when advocating positions with state and local governmental authorities.

504 -- **WITHDRAWN**

505H. **Adopted—Consent Calendar Action**

Council on Government Affairs Resolution 505—Supporting Increased Resources for Department of Veterans Affairs Dental Care

**Resolved, that the following policy be adopted:**

**Supporting Increased Resources for Department of Veterans Affairs Dental Care**

**Resolved, that the American Dental Association supports the Veteran Administration Dental Services’ endeavors to achieve optimal oral health for veterans through an increase in funding, specifically dedicated to Veteran Administration dental services, that is sufficiently funded by Congress and administered to ensure access to care and improving the oral health of veterans.**

506H. **Adopted—Consent Calendar Action**

Board of Trustees Resolution 506—Proposed Policy, Federal Student Loan Forgiveness
### Federal Student Loan Forgiveness

**Resolved,** that it is the position of the American Dental Association (ADA) that dentists should not be excluded from government relief of public and commercial student loan debt without obligation or condition, and be it further

**Resolved,** that the following principles guide the ADA efforts to shape specific student loan forgiveness proposals:

1. Education debt associated with graduate and professional programs should be eligible.
2. Any means testing should account for regional differences in cost of living and purchasing power.
3. The consideration for eligibility and amount of forgiveness should account for the cost, length and rigor of dental education programs.

### 507H. Adopted

Reference Committee D (Legislative, Health, Governance and Related Matters) Resolution 507RC—as amended—in lieu of Council on Advocacy for Access and Prevention Resolution 507, Board of Trustees Resolution 507B and Fifth Trustee District Resolution 507BS-1—Proposed Policy, Oral-Systemic Health Integration

**Resolved,** that the ADA supports and encourages treatment to optimize a patient’s oral health status prior to organ transplants, joint replacements, cardiac surgery and other medical procedures and be it further

**Resolved,** that the ADA supports and encourages research, collaboration and appropriate treatment discussions between dentists and other health care providers to help identify systemic diseases which are strongly suspected to have a direct relationship to a patient’s oral health.

### 508H. Adopted—Consent Calendar Action

Reference Committee D (Legislative, Health, Governance and Related Matters) Resolution 508RC in lieu of Council on Ethics, Bylaws and Judicial Affairs Resolution 508—Revision of Policy Entitled “Guidelines for Dentist Advertising”

**Resolved,** that the ADA policy entitled “Guidelines for Dentist Advertising” (**Trans.1979:647**) be amended as follows (additions underscored):

**Resolved,** that the American Dental Association offer its assistance to constituent dental societies and encourage them to cooperate with state boards of dental examiners and/or appropriate state agencies in the development and maintenance of meaningful guidelines based on rules and regulations related to dentist advertising.
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<th>Status</th>
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<th>Resolution Details</th>
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| 510H.             | Adopted—Consent Calendar Action | Council on Advocacy for Access and Prevention Resolution 510—Medicaid Dental Loss Ratios: Accountability and Oversight | **Resolved,** that the American Dental Association recommends that U.S. Centers for Medicare & Medicaid Services (CMS) publish a state by state assessment of managed care organizations with the percentage of allocated Medicaid funding that is being spent on dental services, and be it further  
**Resolved,** that the American Dental Association recommends that CMS require each state Medicaid agency to monitor the dental loss ratio among their contractors. |
| 511H.             | Adopted—Consent Calendar Action | Council on Government Affairs Resolution 511—Advocacy for Tax Policy Advantageous to the Practice of Dentistry | **Resolved,** that the American Dental Association oppose tax policies that would unduly burden the practice of dentistry, and support tax policies that would benefit dentists. |
| 512H.             | Adopted    | Council on Ethics, Bylaws and Judicial Affairs Resolution 512—as amended—Amendment of the Election Commission and Campaign Rules | **Resolved,** that the Election Commission and Campaign Rules be amended as shown in Appendix 1 (additions underscored). |
| 513H.             | Adopted—Consent Calendar Action | Medicaid Task Force Resolution 513—Report of the Medicaid Task Force | **Resolved,** that the Medicaid Task Force be re-authorized for an additional year to complete the work described in its 2022 Report and Appendix 1 (ADA Medicaid Reform Priority Agenda), and be it further  
**Resolved,** that the president be urged to reappoint the current Task Force members with the addition of two dental school deans for insights from the dental education perspective, and be it further  
**Resolved,** that the Task Force report its recommendations to the 2023 ADA House of Delegates. |
| 514H.             | Adopted    | Reference Committee D (Legislative, Health, Governance and Related Matters) Resolution 514RC—as amended—in lieu of Board of Trustees Resolution 514—Inclusion of Confidentiality Statement on Meeting Agenda | **Resolved,** that the following reminder concerning the treatment of ADA confidential information be included on all ADA meeting agendas. |
Members of the [Insert Name of Agency] and ADA staff are reminded that any sensitive or confidential information or material that is disclosed or discussed during the meeting must remain confidential and members shall not disclose that sensitive or confidential information to any individual or entity to whom access has not been provided by the ADA in the ordinary course of its operations and dealings. Divulging ADA confidential information without approval is a violation of the ADA Member Conduct Policy (Trans.2011:530; 2020:335).

and be it further

Resolved, that the ADA nondisclosure agreement be signed by all members of any ADA volunteer agency, excluding the House of Delegates, the ADA Board of Trustees, Councils and Committees each year as a reminder of the existing duty of confidentiality.

515H.  Adopted—Consent Calendar Action

Reference Committee D (Legislative, Health, Governance and Related Matters)
Resolution 515RC in lieu of Board of Trustees Resolution 515 and Sixteenth Trustee District Resolution 515S-1—Amendments to Chapter VIII of the Governance and Organizational Manual of the American Dental Association

Resolved, that The Governance and Operational Manual, Chapter VIII. COUNCILS, Section A.2., Section B.3., and Section E. be amended as follows (additions underscored, deletions stricken through):

2. Term and Tenure. The term of service recommended by the New Dentist Committee and nominated by the Board of Trustees elected to serve on councils shall be one (1) year; however, such members shall be limited to four (4) one year terms of council service during the period they are characterized as new dentists. The term of the member nominated by the New Dentist Committee on councils on which they are voting members, as well as committees of the Board of Trustees shall be one year, with the member being eligible to serve up to four (4) single year terms, for a maximum tenure of four years.

***

3. A member shall not be eligible for appointment to another council or commission for a period of two (2) years after completing a previous council or commission appointment, except that a member who serves no more than fifty percent (50%) of their maximum tenure of four (4) one year terms of council service while they are serving as the nominee of the New Dentist Committee will be exempted from the requirement to wait two years before being eligible to serve on another council.

***
E. Term of Office. Except for members of the Council on Members Insurance and Retirement Programs whose term of office shall be three (3) years, the term of office of members of councils shall be four (4) years except as otherwise provided in the Bylaws or this Governance Manual. Except for (i) members of the Council on Members Insurance and Retirement Programs whose tenure on the council shall be limited to two terms of three (3) years, and (ii) members serving as the nominee of the New Dentist Committee who serve two (2) single year terms or less are eligible thereafter to serve one four (4) year term as a representative of a Trustee District of the ADA or other participating dental organization, the tenure of a member of a council shall be limited to one (1) term of four (4) years except as otherwise provided in the Bylaws or this Governance Manual. The current recipient of the Gold Medal Award for Excellence in Dental Research shall serve on the Council on Scientific Affairs until the award is bestowed on the next honoree.

516H. Adopted—Consent Calendar Action

Fourth Trustee District Resolution 516—Fair Delegate Allocation for Federal Dental Services

Resolved that the ADA Manual of the House of Delegates be amended as follows to allocate a minimum of two delegates to each of the Federal Dental Services (additions underscored; deletions stricken).

Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates

A. Goal of Delegate Apportionment

The allocation of the remaining delegates over the minimum number of delegates allocated to each constituent and the District of Columbia Dental Society shall be made pursuant to the delegate allocation methodology set forth in this section of the Manual of the House of Delegates. The goals of the delegate apportionment scheme adopted by the ADA is to: (i) achieve as close to proportional representation of active, life and retired members of constituents and federal dental services (Army, Air Force, Navy, Veterans Administration, and Public Health) as possible while providing for the minimum representational requirements set forth in the Governance and Organizational Manual of the American Dental Association (Governance Manual); (ii) provide for representation of the American Student Dental Association; and (iii) maintaining the size of the House of Delegates as close to 473 delegates as possible while meeting the other goals recited in this herein.

B. Delegate Allocation Methodology

Commencing in 2014, based on the representational requirements and goals set forth in this Manual and in the Governance Manual, delegates shall be allocated according to the allocation methodology set forth below. Thereafter, to account for membership fluctuations, delegate allocations shall be reviewed and delegates shall be reallocated by the Secretary of the House of Delegates every four (4) years among the Association’s constituents, the five (5) federal dental services and the
Delegates shall be allocated to the American Student Dental Association in accordance with that same methodology. Delegate allocations shall be based on the Association’s year-end membership records for the second calendar year preceding the year in which the delegate allocations become effective. The review of delegates shall take place as soon as possible after the membership numbers on which the delegate allocations are based are available and the Secretary of the House of Delegates shall publish the new delegate allocations expeditiously thereafter to the constituent dental societies, the five (5) federal dental services and the American Student Dental Association. The delegate allocations shall also be published in this Manual. The delegate allocation methodology is as follows:

1. **The Target Delegate Number.** For purposes of allocating delegates, the target number of delegates to be used in calculating the allocation is four hundred seventy-three (473). From that target number two delegates will be deducted for each constituent and federal dental service except that only a single delegate will be deducted from each of the Colegio de Cirujanos Dentistas de Puerto Rico and the Virgin Islands Dental Association unless the number of members in either of those societies is equal to or greater than the number of members in the smallest state constituent, in which case a minimum of two (2) delegates will be deducted from the target delegate number for that entity. One delegate is deducted from the target delegate number for each of the five (5) dental services, except that a minimum of two (2) delegates will be deducted for any federal dental service where the number of members is equal to or greater than the number of members in the smallest state constituent. In addition, five (5) delegates will be deducted from the target delegate number for the American Student Dental Association. For purposes of the delegate allocation methodology set forth in the Manual of the House of Delegates, the remaining number of delegates in the target number of delegates following the deductions of delegates listed above from the target number of delegates shall be referred to as the “net delegate allocation pool.”

2. **Allocation to the American Student Dental Association.** Five (5) delegates shall be allocated to the American Student Dental Association regardless of the number of members.

3. **Determination of the True Proportional Delegate Counts for each Constituent and each Federal Dental Service.** Divide each constituent’s and each federal dental service’s total membership by the total constituent and federal dental service membership of the Association. Multiply the resulting percentage of membership for each constituent and federal dental service by the target number of delegates set forth in section B.1. of this methodology less the number of delegates allocated to the American Student Dental Association in section B.2. of this allocation methodology.
The resulting true proportional delegate numbers will be used later in the delegate allocation methodology.

4. Determination of Constituents and Federal Dental Services that Qualify to Receive More than the Minimum Delegate Allocation.

   a. Divide the total constituent and federal dental service membership of the Association by the target number of delegates set forth in section B.1. of this allocation methodology less the number of delegates allocated to the American Student Dental Association in section B.2. of this methodology. Compare the resulting number against the membership numbers for the Colegio de Cirujanos Dentistas de Puerto Rico and Virgin Islands Dental Association and Public Health Service if they received a single delegate pursuant to the review performed in section B.1. of this allocation methodology. If the membership numbers of any of those entities are less than the result of the calculation, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.

   b. Take the result of the calculation performed in section B.4.a. of this allocation methodology and multiply it by two (2). Compare the resulting number against the membership numbers for each constituent society and each federal dental service for which two (2) delegates were deducted from the target delegate allocation number in section B.1. of this methodology. If the membership of any of those constituent societies and federal dental services are less than that number, allocate the number of delegates deducted from the target delegate allocation number for each such entity and exclude those entities from the remaining steps of the delegate allocation methodology.

5. Calculation of Non-Minimum Membership Total. Subtract the total membership numbers of each constituent and federal dental service identified as being excluded from the remaining steps of the delegate allocation methodology from the total constituent and federal dental service membership of the Association. The resulting nonminimum membership total will be used in the remaining delegate allocation methodology steps.

6. Allocation of Remaining Delegates.

   a. Divide each remaining constituent’s and federal dental service’s membership by the non-minimum membership total determined in section 5, above, to arrive at their percentages of the non-minimum membership total.
b. Calculate the remaining number of delegates to be allocated by subtracting from the target number of delegates listed in section B.1. of this allocation methodology the delegates allocated to the American Student Dental Association in section B.2. of this methodology and the delegates allocated by the minimum allocation steps in sections B.4.a. and B.4.b., above.

c. For each remaining constituent and federal dental service, multiply its percentage of the non-minimum membership total determined by the calculation in section B.6.a., above, and the remaining number of delegates to be allocated as determined by the calculation in section B.6.b. of this allocation methodology. Round the result to the nearest whole number.

d. For each remaining constituent and federal dental service, multiply the resulting percentage of membership obtained in section B.3. above, by the target number of delegates specified in section B.1., above, less the number of delegates allocated to the American Student Dental Association pursuant to section B.2. of this methodology and round the result to the nearest whole number.

e. For each remaining constituent and federal dental service, subtract the result obtained in section B.6.d. of this allocation methodology from the result obtained in section B.6.c. hereof. If the result is negative, use the result obtained in section B.6.d. as that constituent’s allocated delegate total. If the result is zero or positive, use the result obtained in section B.6.c. of this methodology as that constituent’s allocated delegate total.

7. **Finalize the Delegate Allocation.** Add together the final delegate allocations for the constituents, federal dental services and the American Student Dental Association determined through the calculations of sections B.2., B.4.a., B.4.b. and B.6.e. of this allocation methodology. The result is the total delegates allocated. The total delegates allocated should vary no more than five six percent (56%) from the target number of delegates set forth in paragraph B.1. of this subsection.

8. **Calculating the Fairness Ratio.** Divide each constituent’s and each federal dental service’s percentage of total delegates (the constituent’s allocated delegates divided by the total delegates allocated as determined by the calculation set forth in subparagraph B.7 of this methodology less the number of delegates allocated to the American Student Dental Association) by its percentage of total membership as calculated in B.3., above. Except for those constituents that only receive the minimum number of allocated
delegates, the resulting "fairness ratio" should deviate by a small amount on either side of 1, with 1 representing a perfectly proportional delegate allocation. The fairness ratio for constituents and federal dental services that receive only the minimum allocation of delegates may deviate from 1 to a larger degree because those constituents and federal dental services may be overrepresented.

**C. Suspension of The Representation of a Constituent**
The representation of a constituent in the House of Delegates may be suspended by a two-thirds (2/3) affirmative vote of the House of Delegates present and voting upon a determination by the House of Delegates that the constitution or bylaws of the constituent violate the *Constitution or Bylaws* of this Association. Any such suspension shall not be in effect until the House of Delegates has voted that the constitution or bylaws of the constituent violate the *Constitution or Bylaws* of this Association and the constituent has one (1) year following notification of the specific violation within which to correct the violation.

Amendment of this section of the *Manual of the House of Delegates* shall be by a two-thirds (2/3) affirmative vote of the delegates present and voting.

and be it further

**Resolved**, that the ADA *Governance Manual*, Chapter II. CONSTITUENT AND COMPONENTS, Section B.2., be amended as follows:

2. Privilege of Representation.

   a. Delegates. Each state constituent, and the District of Columbia Dental Society and each federal dental service shall be entitled to a minimum of two (2) delegates in the House of Delegates. Each territorial constituent and each federal dental service shall be entitled to a minimum of two (2) delegates in the House of Delegates if its total membership is equal to or greater than the size of the smallest state constituent; otherwise the territorial constituent or federal dental service shall receive one (1) delegate. The remaining number of delegates shall be allocated as set forth in the *Manual of the House of Delegates* (House Manual).
C. Interim Services for Applicants. A dentist who has submitted a complete application for active membership in this Association and the appropriate constituent and component, if such exist, may on a one-time, interim basis: receive complimentary copies of The Journal of the American Dental Association and the ADA News, have access to the ADA.org member-only content areas and purchase items at the member rate through the ADA Catalog. Such interim services shall terminate when the membership application has been processed or within six (6) months of the application submission, whichever is sooner. Applicants shall have no right of appeal from a denial of membership in the Association.

518H Adopted—Consent Calendar Action
Reference Committee D (Legislative, Health, Governance and Related Matters)
Resolution 518RC in lieu of Arizona Dental Association and Washington State Dental Association Resolution 518—Establishment of a Special Committee on ERISA

Resolved, that a Special Committee be convened to develop a broad-reaching strategy for improving patient protections in dental plans regulated under ERISA, and be it further

Resolved, that the Special Committee be comprised of representation of 11 members with 2 representatives from each of the following groups: the Board of Trustees, Council on Dental Benefit Programs, Council on Government Affairs, and 5 at-large ADA Member Dentists with dental benefits advocacy expertise, with such representatives and the Special Committee chair appointed by the ADA President. Individuals with dental benefits advocacy expertise can be utilized as consultants to the Special Committee at the discretion of the Chair.

and be it further

Resolved, that the Special Committee meet electronically and shall submit a report to the 2023 ADA House of Delegates.
Election Commission and Campaign Rules

The Election Commission is composed of three members: the immediate past President, and the chair and vice chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The chair of CEBJ A serves as the Election Commission chair. The Speaker and the President-elect’s campaign manager or appointee will serve as consultants to the Election Commission, each without the right to vote. Except as provided below, in the event that one of the members is unavailable, a replacement member will be selected by the chair of the Election Commission in consultation with the Election Commission. In the event that the chair is unavailable due to a conflict with a candidate, the vice chair of CEBJ A shall serve as chair and shall appoint a replacement member in consultation with the Election Commission. In the event that both the chair and vice chair of CEBJ A are unavailable due to conflicts with a candidate, the senior class of CEBJ A shall select replacement members and the chair of the Election Commission.

The Election Commission is charged with (1) overseeing and adjudicating contested issues arising under the Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Officers (the Campaign Rules); (2) informing anyone identified as being under a disciplinary sentence of suspension or probation for violating his or her duties to the constituent society within whose jurisdiction the member practices or to this Association that they are ineligible to seek elective or appointive office while under that disciplinary sentence; (3) referring any dispute of eligibility to CEBJ A; (4) informing the House of any violation of the Campaign Rules; (5) reviewing and proposing revisions to the Campaign Rules as required; and (6) receiving summaries of campaign revenues and expenses from candidates for all ADA elective offices.

Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers

The following Campaign Rules govern the announcement and conduct of campaigns for ADA elective officers. These Campaign Rules will be distributed annually to all candidates, delegates, alternate delegates and other parties of interest. Candidates for elective officers are expected to abide by the Campaign Rules.

Procedures Concerning Interpretation and Distribution of the Campaign Rules

1. To the extent one or more candidates has a question concerning the interpretation of the Campaign Rules or whether a particular activity is prohibited or permitted under the Campaign Rules, the following procedures shall be followed:
   a. Prior to contacting the Election Commission concerning the question or interpretation, candidates and/or their campaign managers shall communicate and attempt in good faith to reach a consensus on the question.
   b. If a consensus cannot be reached:
      i. The campaign that raised the issue shall contact the Election Commission (copying the other candidates and their campaign managers) via a brief and succinct email, state the question or interpretation that has arisen and that the campaigns were unable to reach a consensus on the issue and provide the campaign’s position on the issue presented.
      ii. Within three business days of the receipt of the email referenced in Paragraph b.i, above, any other campaign desiring to do so shall send the Election Commission a brief and succinct email setting forth that campaign’s position on the question or interpretation presented to the Election Commission.
2. Any communications from a candidate to the Election Commission regarding these Campaign Rules shall be submitted to the chair of the Election Commission via email addressed to electioncommission@ada.org or by such other means as the Election Commission may from time-to-time specify.

3. Each year, a copy of the current Campaign Rules shall be distributed, signed and acknowledged by all ADA trustees and elective officers with the agenda and organizational material provided at the first meeting of the Board of Trustees following adjournment of the House of Delegates. It is the responsibility of each candidate to inform their campaign committee members, the constituent Executive Directors within their trustee districts and other constituent staff within their trustee districts who are assisting the campaign of these Campaign Rules within fourteen (14) days of the candidate’s formation of a campaign committee or announcement of candidacy, whichever first occurs.

4. In order to better familiarize ADA delegates and alternate delegates with the Campaign Rules, a succinct summary of the most important portions of the Campaign Rules will be posted each year in the House of Delegates library on ADA Connect.

Agreements between Candidates

4. Candidates can negotiate and enter into any agreement concerning the conduct of a campaign for elective officer that does not contravene and is not in conflict with any of the Campaign Rules contained herein; agreements between candidates that narrow any of the provisions of these Campaign Rules or agreements by which the candidates forego any campaign activities permitted under these Campaign Rules are permissible. The negotiation and enforcement of any such agreement will be the responsibility of the candidates. The Election Commission will neither facilitate nor enforce any such agreement.

Announcing Candidacy

5. Candidates for President-elect and Second Vice President shall formally announce their intent to run for office on the final day of the annual session immediately preceding their candidacy. A formal announcement shall include, at a minimum, the name of the candidate and an identification of the office being sought. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate’s own trustee district shall begin only after the official announcement at the annual session. Candidates for President-elect and Second Vice President not formally announcing their candidacies on the last day of the annual session immediately preceding their candidacy shall not be permitted to campaign outside their own trustee districts but shall be permitted to be nominated for elective office at the annual session of the House of Delegates pursuant to Chapter VI., Section B.1. of the Governance Manual of the American Dental Association (Governance Manual).

6. Announcements of candidacies for the offices of Treasurer and Speaker of the House of Delegates shall be as stated in Chapter VI. Section B.2. and B.3., respectively, of the Governance Manual.

Travel and Meeting Attendance

7. Candidates for the office of President-elect shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings to which all candidates have been invited. The procedures for attendance at such events shall be as follows:
   a. Candidates for the office of President-elect may accept and attend any such event in a manner mutually agreed upon but only if all candidates have been invited.
b. Candidates for the office of Second Vice President, Speaker of the House of Delegates and Treasurer shall limit campaign travel to attending the district caucus meetings held during the ADA annual session.

c. District caucuses and state constituent societies shall issue timely invitations to the President-elect candidates through the Office of the Executive Director.

d. President-elect candidates shall negotiate a mutually agreeable travel schedule. It is the responsibility of the candidate and/or the campaign managers, through coordination among the campaigns, to determine the candidates’ availability and respond directly to the inviting organizations. Except for conflicts due to a religious holiday observed by one or more of the candidates, candidates shall vote on whether to accept an invitation, with a majority needed to accept; a tie vote will result in accepting the invitation. A religious holiday conflict with a single candidate shall result in all the candidates declining the invitation.

e. Candidates who have scheduling conflicts prohibiting personal attendance at a district or caucus event may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event’s sponsor.

f. After a meeting has been accepted, if an emergency arises and a candidate must cancel their attendance, the remaining candidates may attend as planned. Candidates who cancel their attendance at an event due to an emergency may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event’s sponsor.

9. Caucuses and state meetings are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forums be structured to allow:

   a. All candidates to make presentations;
   b. Caucuses freedom to assess candidates; and
   c. Each candidate to respond to questions.

10. Notwithstanding any of these Campaign Rules, nothing in these Rules shall prevent a candidate from traveling on a personal basis or attending a meeting, conference or other event as an official ADA representative. Campaigning while personally traveling or attending events as an ADA representative is strictly prohibited. When traveling personally or as an ADA representative, candidates shall notify other candidates of such travel as soon as possible once the travel has been scheduled.

11. Candidates shall not use campaign-sponsored social functions or hospitality suite/meeting rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.) Campaign receptions are not to be held at the ADA Annual Session. Additionally, a district that hosts a reception during the ADA annual session and is sponsoring a candidate in a contested election shall not host the reception prior to the officer elections; a reception may be held after the election. Prior to the election, candidates shall not attend events in or visit district hospitality suites. This prohibition shall not apply to a candidate visiting his or her own district’s hospitality suite or attending events hosted by their own district exclusively for the district’s members.

**Publications and Media**

12. News articles on and interviews of a candidate are permissible if published by a state dental journal. Online state dental journal news articles on and interviews of a candidate are permissible. Articles about a candidate's intention to run for office are permissible. Articles about why one
person would make a better candidate are not permissible.

12. When announcing their candidacy for elective officer, except for the candidate's constituent and component, candidates shall notify all organizations and groups to which they belong of their candidacy and shall request that during the campaign such organizations and groups refrain from distributing or publishing any information or material referencing the campaign or the candidate's candidacy.

13. Candidates shall not participate in interviews on their leadership capacity with leadership or national journals that will be published within the timeframe of their campaign. Candidates shall not knowingly seek to have their name, photo, appearance, and writings published in national trade or non-peer reviewed publications or websites during the campaign, and shall avoid submitting articles in non-peer reviewed paper or electronic publications. Candidates who are participants in a speaker's bureau or earn revenue by speaking nationally or regionally shall avoid all unnecessary self-promotion during the campaign related to national speaking engagements.

Use of Social Media

14. In order to facilitate providing information to delegates and alternate delegates by candidates, after announcement of their candidacy, any candidate may establish a closed-group Facebook page for purposes of disseminating information about the candidate's campaign and interacting with delegates and alternate delegates concerning campaign-related subjects and issues. Any such closed-group Facebook page instituted by a candidate shall comply with these Campaign Rules and shall also be governed by the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees. In the event of a conflict between these Campaign Rules, the Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees, these Campaign Rules control.

a. The Election Commission will determine the appropriate administrative settings for the closed-group campaign Facebook page that candidates may use for campaign-related posts. Those settings will be communicated by the Election Commission to the candidates shortly after the candidates announce their intention to run for elective officer.

b. Only delegates, alternate delegates, campaign staff and Election Commission members and staff shall be invited to join a candidate's closed-group campaign Facebook page.

c. Shortly after a candidate's candidacy is announced, the ADA will provide the known email addresses of delegates and alternate delegates. Using that list, invitations to join the closed-group page may be issued via email by a candidate who wishes to initiate a closed-group campaign Facebook page. Invitations to join the closed-group page may also be sent to the candidate's campaign staff and shall be sent to members and staff of the Election Commission.

d. Following the compilation of the list of certified delegates and alternate delegates who will attend the House of Delegates session at which the election will occur, the ADA will send the candidate an updated list of certified delegates and alternate delegates that the candidate may use to send a second closed-group campaign Facebook page invitation so that newly listed delegates and alternate delegates may join the candidate's closed-group campaign Facebook page.

e. Only material that is relevant to the campaign shall be posted on a candidate's closed-group campaign Facebook page. No posts that are negative to any opposing candidate or that may be considered to be negative campaigning shall be permitted on the closed-group campaign page. Any candidate who develops a closed-group campaign Facebook page shall be responsible for the monitoring of posts to the page to ensure that posts comply with these Campaign Rules and that the posts are consistent with
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the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees.

f. No surveys or polls shall be used or conducted via a candidate's closed-group campaign Facebook page.

g. Interactions between a candidate and delegates and alternate delegates using the candidate's closed-group campaign Facebook page shall not count toward any limits on a candidate's contact with individual delegates and alternate delegates contained in these Campaign Rules.

15. Except for the closed-group campaign activity on Facebook specified in Paragraph 14, above, there shall be no campaigning using any social media platform or application.

16. Personal, non-campaign use of social media by candidates during the campaign for elective officer is permitted but candidates shall not post information or material relating to the campaign on personal social media sites. Candidates shall review their personal social media site settings to ensure that privacy and security settings are set to allow review and deletion of any third party post, and candidates shall frequently monitor their own personal Facebook pages and other personal social media sites and delete any posts that references the campaign or the candidate's campaign activities or posts that can be tagged for distribution to third party sites.

Campaign Literature and Communications to Delegates and Alternate Delegates

17. No printed campaign-related material may be distributed in the House of Delegates or to delegates and alternate delegates.

18. Candidates may prepare a piece of campaign literature to be electronically distributed to the delegates and alternate delegates following a candidate's announcement of candidacy for elective officer. Such campaign literature shall be sized so that if printed the literature is no larger than four single-sided sheets of 8½ x 11 inch paper. If desired, a second piece of campaign literature of similar length may be electronically distributed to the delegates and alternate delegates following the candidates' receipt from the ADA of the final list of certified delegates and alternate delegates.

19. Each candidate may prepare a video to be distributed as described below to delegates and alternate delegates and other members of the House of Delegates.

20. Each piece of literature and any video developed by any candidate shall be submitted to the ADA for review and approval prior to being distributed. Such literature review may take up to five (5) business days to complete. Video reviews will be completed as quickly as possible but are dependent on the length of the video. The candidates shall obtain permissions to use the likeness or image of any non-familial third party that appears in a piece of campaign literature or in any video. Candidates shall state that such permissions have been obtained when submitting the literature and any video for review. The permission should be retained by the candidates and submitted to the ADA only if requested.

21. Each candidate is permitted to individually communicate with each delegate and alternate delegate a single time via an electronic communication (i.e., email) for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information. A third party vendor may be used to send such electronic communications so long as the privacy of the email addresses and identities of the recipients are maintained and preserved and there is no ability to reply to all the recipients of the electronic communication. At each candidate's option, the candidate's electronic communication may contain the campaign literature and/or video referenced in these Campaign Rules, either by embedding or attaching the literature and/or the video to the electronic communication or by providing a hyperlink or hyperlinks that connect to the literature and/or the
video that is stored in a remote location maintained by or on behalf of the candidate.

22. Each campaign is permitted to individually initiate a telephonic (phone call or text) communication with each delegate and alternate delegate a single time for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information.

23. Nothing in these Campaign Rules shall prevent a candidate from communicating regarding matters within the specific duties of the candidate's position as an ADA officer, member of the Board of Trustees, task force or workgroup, as long as the communication is strictly related to such responsibilities and is not used for campaigning, electioneering or soliciting votes.

24. Candidates may each schedule up to three (3) telephone or video conferencing forums or town hall events during the campaign. A candidate desiring to hold up to three (3) telephone or video conferencing forums or town hall events shall communicate to the ADA the date of each event and the times at which each such event shall commence and end, together with the instructions and contact information necessary for participants to email and/or call with the questions they would like asked during the telephonic town hall. The ADA will announce the telephone or video conferencing town hall information to delegates and alternate delegates via ADA Connect and provide the information to Election Commission members and staff. Candidates may also publicize the telephonic town halls they sponsor on any closed-group campaign Facebook page that they maintain.

25. The agenda for a candidate's telephonic town hall meeting(s) shall be the prerogative of the candidate, with the candidates being permitted to provide opening and closing statements and whether follow-up questions are permitted. The length of the telephonic town hall event is also discretionary with the candidate.

26. No negative campaigning or negative comments concerning opposing candidates shall be permitted to be made by the candidate or any participant posing questions or making comments during the town hall event. Candidates shall be responsible for ensuring that a screening mechanism is employed during the town hall event so that broadcasting participant comments or questions that violate this provision is avoided.

Contributions

27. Contributions (including money and in kind services) are acceptable only from individual dentists, family members and ADA constituent and component dental societies, which includes component branches and study clubs recognized as part of the constituent society. Contributions from any other sources are not permissible. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in the ADA Bylaws.

28. The sending of a brief note acknowledging a financial contribution or thanking a host of a campaign event to those contributors or hosts outside of the candidate's district is permitted, as long as no additional campaign message is included. Such thank you notes may be sent on campaign letterhead or a notecard containing the campaign logo; envelopes for the thank you note may contain an identification of the campaign or the campaign logo.

29. Any contribution source that could be interpreted to be a conflict of interest or creates the appearance of a conflict of interest must be reported to the Election Commission and the ADA Board of Trustees. In the event a contribution source is deemed to be a conflict of interest or creates the appearance of a conflict of interest, the candidates will be required to return the contribution.

30. Candidates for all ADA elective offices should submit a summary of campaign contributions and expenses to the Election Commission at the end of the campaign.

Violations
32. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred more than fourteen (14) days prior to the House of Delegates convening, then the Election Commission, if it cannot resolve the violation between the candidates, shall post a report of the violation in the House of Delegates section on ADA Connect. In addition, an email reporting on any such violations will be sent by the Election Commission to each certified delegates and alternate delegates with a working email address on file with the ADA on or about fourteen (14) days prior to the convening of the House of Delegates.

33. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred in the period from fourteen (14) days prior to the convening of the House of Delegates through the elections of elective officers, then the Election Commission, if it cannot resolve the violation between the candidates, shall report those violations to the House of Delegates. The report will be given orally by the Election Commission chair (or a designee of the Election Commission if the chair is absent from the House of Delegates session) at the first meeting of the House. If violations occur after that meeting, and before the election, then a report of such violations shall be read to each caucus by a designee of the Election Commission.

34. Should an allegation of a Campaign Rules violation against an individual or entity not affiliated with a campaign be made, the Election Commission shall review the allegation and determine if a violation has occurred. If so, the campaign and candidate affected by the infraction will be notified, and shall be responsible for contacting the individual or entity involved and using their best efforts to curtail the violation.

35. In addition to the foregoing notifications of violations, all violations of the Campaign Rules that occur shall be reported orally at the House of Delegates meeting by the Election Commission.
Oral health care is essential health care.

Healthy mouths are a necessary component of overall health and wellness. A population with good oral health can participate more fully in the economy, school activities and better care for their families. ADA policy prioritizes advocacy for adequate funding to provide oral health care to underserved populations – including Medicaid enrollees – and urges constituent and component dental societies to do the same.

The ADA’s mission is “to help dentists succeed and support the advancement of the health of the public.” In accordance with the mission, the ADA believes that everyone should have a dental home. A dental home is defined as, “the ongoing relationship between the dentist who is the primary dental care provider and the patient, which includes comprehensive oral health care, beginning before age one, and continuing throughout the patient’s lifetime, with appropriate referral as necessary.” Additionally, the ADA’s Code of Ethics includes the principles of “justice” to treat people fairly, and the duty to “do good.” Individuals with Medicaid should be able to access and establish a dental home with similar ease and accessibility as people who are privately insured or self-paying for their dental care.

More than 80 million Americans are covered by Medicaid, with just less than half being children. It 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 ignore Medicaid.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the federal benefit in Medicaid and Children’s Health Insurance Program that has assured children access to preventive and comprehensive health services, including dental care. According to the ADA’s Health Policy Institute (HPI), significant strides have been made in children’s access to dental care and racial and ethnic disparities within the child population are decreasing. However, dental care use has decreased among adults and disparities by race and ethnicity have persisted. This is largely due to the disjointed system of Medicaid dental benefits for adults in different state programs, with many states offering very limited benefits and some states controlling utilization with low annual limits.

Nearly all participating dentists have complaints about working with their state Medicaid program. Obstacles presented by the program include inadequate reimbursement, difficulty with credentialing processes, the fear that making a mistake will result in an unfair audit or legal action, and rules that are not similar to other dental benefit plans or that do not conform to national and professional standards of care. In addition, patients with Medicaid tend to be the most complex in terms of their medical, dental, and socioeconomic needs. Yet, many Medicaid programs limit medically necessary services, place utilization controls, and reimburse dentists very low as compared to other commercial dental plan fees.

The need for our profession to provide high-quality care to underserved patients enrolled in Medicaid compels us to find workable solutions. These solutions must balance important factors: 1) that dentists caring for underserved populations be adequately paid; 2) that all patients with Medicaid have a dental home led by a dentist; and, 3) that dentists maintain the autonomy to choose which insurance plans with which they enter contractual agreements.

Furthermore, the dental profession and field of dental education must better educate students, dentists, and dental team members on how to work with those who live in poverty and the social determinants of health that impact their ability to visit a dentist, comply with treatment, and improve their oral health behaviors. The Medicaid system cannot be fixed with fee increases alone. Having been well over a half-
century since Medicaid’s founding, a comprehensive review of coverage, funding, administration, and health of the covered population is needed by all stakeholders.

For meaningful innovation to occur, reform will need to address both federal and state policies. Systemic change must occur to assure safe and appropriate care for the patient and provide a secure and administratively effective environment for the dentist to practice.

The following is the proposed “Dental Medicaid Reform Agenda” developed by the Medicaid Task Force.

Reform Ideas by Topic:

1) Support comprehensive dental benefits for Medicaid beneficiaries across the lifespan
   a. Work to assure every state provides access to comprehensive dental care to every enrolled adult.
   b. Remove annual limits. If dental care is medically necessary, the dentist must be able to provide that care as needed and not be forced to treat some areas of the mouth and not others. (A patient who needs quadruple bypass heart surgery is not limited to one bypass procedure.)
   c. Support the Medicaid Dental Benefit Act of 2021 (S.3166) and similar future legislation which mandates comprehensive adult benefits with 100% FMAP for 3 years.
   d. Support Oral Health for Moms Act (S. 560), which mandates dental benefits for pregnant and post-partum women on Medicaid for 12 months.
   e. Support a 90/10 match for federal/state funding of Medicaid dental care (ADA policy on Increased Federal Medicaid Funding (Trans.2002:410).

2) Create a sustainable fee structure that:
   a. Assures appropriate number of dentists are engaged in the network including specialists.
   b. Assures patients can receive care near where they live and not be forced to travel an unreasonable distance for care while maintaining choice in providers.
   c. Assures fees are market based, sustainable and benchmarked using state-specific FAIR Health data. The minimum benchmark shall be a percentile of a dentist charges that assures meaningful participation by a majority of dentists. Fees should be adjusted yearly to account for inflationary or deflationary monetary changes.
   d. Reduces the use of code manipulation (e.g. “down-coding”) to result in purely a cost savings to the third party payer without regard to treatment.
   e. Pays for patient health education and case management services universally that are related to social determinants of oral health and not just clinical care. For example, all programs should reimburse for caries risk assessment and case management codes (language translation, transportation, motivational interviewing, care coordination, health literacy, and appointment compliance). Since only 10% of a patient’s oral health is related to dental treatment, dental practices must be compensated for their time to educate patients and coordinate their care with other medical/social agencies.
   f. Reduce systematic and structural procedures and practices that erode fee adequacy such as extensive prior authorization requirements.
   g. Urge that states require their contracted Managed Care Organizations (MCO’s) to publish their dental loss ratio with a minimum of 80% of premiums being applied directly to the provision of patient care.

3) Reduce administrative barriers and rules that impede the delivery of medically necessary care, lead to inefficient program design, put paperwork over patient care, and encourage dentist providers to go against the ADA’s Code of Ethical Conduct
a. Eliminate rules such as “can only treat 4 teeth in a year” and others that put the dentist in an ethnically impossible situation, establish a lesser standard of care that perpetuates inequities, and reduces the likelihood of achieving or improving oral health for the Medicaid population.
b. Streamline credentialing into one process for all dentists wishing to become Medicaid providers. State Medicaid agencies should use a national clearinghouse or application such as CAQH. Every clean application should be processed no later than 30 days after receipt.
c. Support legislation that prevents insurance companies from requiring a prior authorization for a procedure when a provider has been approved for that procedure a threshold number of times, i.e. 90% approval.
d. Establish a pathway to credential dental students to be Medicaid providers in dental school which can be extended to the first year of practice.

4) *Assure that audits and discipline management processes are fair, valid, and reliable* (including federal, state, and managed care driven)
   a. Audit processes should comply with the ADA’s policy on fair Medicaid audits.
b. Audits should be used to educate dentists to promote quality, not impose unrealistic paybacks or fines for minor infractions that will drive them out of the program. They should promote education of dental team over penalties as a first line of action.
c. To protect in-network dentists, patient complaints and issues should be addressed with due process, adherence to dental practice acts, and peer review.
d. Establish a mandatory monthly provider report card from the payers. This report card would include sharing the dentist’s treatment profile compared to the other geographically appropriate dentists.

5) *Other ideas to consider:*
   a. Pilot loan repayment for dentists willing to see a certain threshold of Medicaid patients.
b. Pilot Deferred Compensation programs where a dentist can elect to deposit Medicaid payments into a tax deferred investment plan with other state employees and contractors.
c. Pilot programs that offer pay-for-performance to dentists who provide care in line with predetermined goals set by CMS, are aligned with Healthy People Oral Health Goals, or demonstrate improvement using the Dental Quality Alliance Measures sets. For example, these payment incentives may be for the percent of children who receive sealants, who see dentists in underserved counties, or are awarded for completion of treatment plans.
d. Change the way dental schools think about patients with Medicaid by incentivizing participation in state programs.
   i. Provide incentives for dental education institutions receiving federal funding for grants, research, patient care, subsidized student loans to encourage them to accept Medicaid beneficiaries for treatment within their institution.
   ii. Assure they receive needed funding. Explore disproportionate share funding that hospitals and medical schools receive.
   iii. Collaborate with ADEA to educate students that Medicaid patients have different social determinants of health and how that impacts appointment keeping, compliance, and diversity, equity & inclusion, and provides strategies to address those.
   iv. Encourage all dental schools to include “Understanding poverty, social determinants of health, and Medicaid systems” in their ethics and practice management courses.
v. Consider a Medicaid navigator whom is the "expert" in the school to help
students, staff, and faculty work through patient issues, benefit options, and
submitting claims. Help students learn to navigate this complex system so they
are comfortable working through things when in practice.

vi. Establish an ADA sponsored learning center whose purpose is to assist dental
schools in both the administration and treatment of the Medicaid patient.

Reform Ideas by Agency or Legislative Action

State Legislative and Rules/Regulations Changes
1. Eliminate annual benefit maximums on adult benefits.
2. Encourage states to adopt an appropriate rate setting process or benchmark fees to state’s public
employee dental benefit plan or FAIR Health as appropriate.
3. Benchmark access to care measures against privately insured population.
4. Encourage states to adopt a loss ratio requirement within dental contracts that is not diminished
by sub-contracting. Ensure the loss ratio data is reported and publicly available in an easy to
understand format.
5. Encourage use of Community Dental Health Coordinator (CDHCs) to coordinate whole person
care through integrating dental, medical, and behavioral needs and services. CDHCs can also
help patients without a dental home who visit the ED to find a dental home and get needed care.
6. Support all State Medicaid Agencies covering case management codes and caries risk
assessment codes.
7. Incorporate International Classification of Diseases (ICD) codes as necessary for patient
treatment.
8. Pilot loan repayment for dentists willing to see a certain threshold of Medicaid patients.
9. Pilot Medicaid payments for dentists that he/she can elect go into a tax deferred plan with other
state employees and contractors.
10. Incentivize compliant providers to see more Medicaid patients with enhanced fee schedules, or
with reduced prior authorization requirements.
11. Support legislation that prevents insurance companies from requiring a Prior Authorization for a
procedure after a provider has been approved for that procedure a threshold number of times i.e.
least a 90% approval experience rate.

Federal Legislative
1. Mandating an adult dental benefit in Medicaid which would be supported by a 100% Federal
Medical Assistance Percentage (FMAP) for three years.
2. Allow foster youth to remain on Medicaid until age 26. This is the similar to the ACA which allows
young adults to remain on their parents’ insurance until age 26.
3. Support Oral Health for Mom’s Act (S.560), which mandates dental benefits for pregnant and
post-partum women.

Federal Change of Rules and Regulations
1. Support creation of minimal set of adult benefits similar to Early and Periodic Screening
Diagnostic and Treatment (EPSDT) for children.
2. Define “medical necessity” on a national basis or support well-vetted evidenced based clinical
care guidelines supported by a consortium of professionals and the ADA / ADA accredited
specialty organizations.
3. Support operating room access improvement for those with intellectual and physical disabilities
and children with early childhood caries by urging CMS to establish a new billing code Health
Care Common Procedure Coding System (HCPCS) Level II for the facility.
4. Revise measures of geographical access by working with Health Resources Services Administration (HRSA) to revise the health professional shortage area (HPSA) algorithm to better link providers with beneficiaries.

5. Adopt a utilization measure as established by the Dental Quality Alliance (DQA) and endorsed by the National Quality Forum: utilization would be measured by the percent of Medicaid beneficiaries enrolled for 180 days who received any dental visit for children and adults.

6. Require states to adopt access to care measures defined against privately insured population.

7. Incentivize states to study and target outreach and programmatic efforts toward populations that are not accessing care and utilizing dental services.

8. Work with states to establish benchmarking fees to Fair Health Data.

9. Monitor states to ensure performance in terms of beneficiary access to care, proactively communicate with states regarding shortcomings. Support states in remediation. Require managed care contracts to mandate tracing, share data publicly, and be subject to penalties beyond fines until compliant with measures.

10. Incentivize states to have dentists in network successfully complete cultural competency education for oral health professionals.

11. Support payment parity for teledentistry services to reach homebound, rural households, and those living long distances who need specialty dental consults.

12. Adopt specific measures pertaining to network adequacy and provider participation as the standard for state reporting:

   a. Percent of dentists enrolled in Medicaid and percent of specialists
   b. Distribution of dentists by number of unique Medicaid beneficiaries treated in a year (such as 0, 1-9, 10-99, 100+)
   c. Specialist access consistent with specialty access requirements of commercial plans for the general population
   d. Geo-located with attention to access to public transportation
   e. Consideration of disease prevalence based on population and claims data
   f. Choice of provider and movement of covered patients due to inadequate care systems across health disciplines (MD in town, DDS 30 miles away)
   g. Investigate the use of enhanced fee schedules for dentists located in designated rural areas.

13. Require (where non-existent), and otherwise improve data collection, reporting, and making available from states to include patient demographics (including race), provider taxonomy, linkage of enrollment data to dental MCO’s, procedure level claims submission for FQHCs (not just encounter based data). Require managed care contracts include access to data through rigorous reporting and access to databases for legitimate research.

14. Support parity payment to dentists for Medicaid and CHIP. Phase out the discriminatory practice of different populations or eligibility groups.

15. Incentivize states that increase fees:

   a. Develop a data base to measure the effects of changes to the state Medicaid program, i.e. of increased provider participation, and publish those results on an annual basis.

16. Incorporate risk-sharing principles in managed care contracting from the federal government through states, through MCOs and dental administrators to providers. Incorporate systems business health concepts into programs to improve interaction, efficiency, and care quality.

17. Require/enforce states reporting of dental loss ratio modeled after ACA’s medical loss ratio.

18. Issue guidance to states on innovative payment models and pilots.

19. Incentivize states to offer performance-based pay that aims to treat high need populations and emphasizes disease prevention.

20. Promote uniform credentialing in every state through CAQH.

21. Eliminate outdated rules that go against recognized oral health standards of care, best practices, evidence based dentistry, or the ADA’s Code of Ethical Conduct.
22. Promote auditing practices that are fair, valid, and reliable. (Peer-to-Peer State Dental Medicaid Audits (Trans.2017:234))
23. Explore creation of a national prior authorization policy and process that makes care consistent across the US and eliminates variance and disparity from state to state.