Oral Health Benefits in Medicare and Medicaid

It is important the American Association of Oral and Maxillofacial Surgeons (AAOMS) continues to advocate for access to oral healthcare — especially for pediatric, special needs and senior patients. With the recent political changes that have occurred in Washington, DC, and increased calls to have dental benefits added to Medicare, the stakes are high. In a recent poll by the University of Michigan, 93% of adults 65 to 80 years of age favor adding a policy to add dental coverage to Medicare.1 Our specialty has a responsibility to be part of this discussion, communicating ideas that advance sustainable access to safe and effective oral and maxillofacial surgical care. Our extensive experience with Medicare, Medicaid, and private medical and dental insurance industries puts us in a unique position in the dental profession to achieve the best outcome for the public at-large and the dental profession.

For a number of years, leaders in the dental community have examined a pathway for robust dental coverage for the nation’s seniors. A 2017 JADA guest editorial on oral services in Medicare2 was thought-provoking in its reiteration of the relationship between oral health and systemic health and its focus on inadequate public financing for oral healthcare for seniors. Following publication of this piece, a coalition comprised of influential consumer advocacy organizations — such as Families USA, Justice in Aging, AARP, The Gerontological Society of America, and Oral Health America — published a white paper in 2018 titled “An Oral Health Benefit in Medicare Part B: It’s Time to Include Oral Health in Health Care.”3 The ADA contributed to this paper by providing data to ensure a more accurate portrayal of the access to oral healthcare landscape for seniors. The ADA’s continuing efforts have been commendable in educating and informing consumer advocacy organizations, healthcare policymakers, and the public so the dentist perspective on this national health policy issue may be represented and understood.

At about the same time, the 2018 ADA House of Delegates approved a resolution directing the ADA Board of Trustees to create a task force to consider an oral health benefit in Medicare as part of the ADA’s ongoing investigation of available options for serving the dental care needs of a growing elder population.

Meanwhile, a September 20, 2018, letter from 28 U.S. Senators to then-Secretary of the U.S. Department of Health and Human Services Alex Azar and then-Administrator for the Centers for Medicare & Medicaid Services Seema Verma requested Centers for Medicare & Medicaid Services to use existing regulatory authority to provide for traditional Medicare coverage of medically necessary oral and dental treatment.4 Clearly, momentum was building for action.

As the ADA has considered dentistry’s place in Medicare, AAOMS has encouraged a careful examination of the complexities of enrollment and regulation in the program.5 AAOMS has emphasized the importance of policymakers, practicing dentists and the
public to be aware of the distinctions between participating, non-participating and opt-out provider status with Medicare. In considering appropriate Medicare policy for dentistry, AAOMS has noted that it is crucial to first have a clear understanding of the American Medical Association’s resource-based relative value system. Mastery of the process for establishing relative values through the Relative Value Update Committee of the American Medical Association, along with an understanding of the adjustments that can occur relative to geography and budget neutrality, are essential to effective oral and dental health policy development. ADA members and the public should appreciate the value of the ADA holding the copyrights to the Current Dental Terminology (CDT) codes and the challenges that will come with assigning relative values to those codes. Dentistry must be wary of folding CDT codes into the Relative Value Update Committee process. Administrative and support staff to process dental claims with CDT codes are already in place in every state under the Medicaid program. Medicare does not have this in place.

In addition, current public financing of oral healthcare is inadequate to cover the cost for even the most basic of care. Nationally, Medicare covers less than 1% of all the financing for dental care. A 2000 study by the Institute of Medicine (now the National Academy of Medicine) recommended that the following be present for dental care to be considered medically necessary:

1. Benefits of dental care outweigh the harm;
2. Dental care improves the outcome for medical conditions;
3. Effective dental care exists for those oral health risks; and
4. The disease burden from oral health risks on medical condition is substantial.

If one accepts the Institute of Medicine approach, the question persists of how narrowly “medically necessary dental care” should be defined. Certain conditions appear to obviously meet the minimum threshold for the “medical necessity” of needed dental care — such as treatment of dental disease in the presence of potentially life-threatening odontogenic infections, head and neck cancer and aggressive neoplasms, pending treatment of other cancers, pending organ transplantation, pending heart valve repair or replacement, and pending joint replacement surgery. Yet public policy for the financing of oral healthcare still does not clearly and consistently provide for coverage in such cases.

To increase senior access to oral healthcare, there are more effective and sustainable alternatives to the inclusion of dental benefits in Medicare Part B that would occur with the removal of the statutory exclusion in Section 1862(a)(12) of the Social Security Act. Additional to expanding oral health/dental coverage in Medicare Advantage Plan products, expanding the Medicaid program to include dental coverage for financially disadvantaged seniors is a better, more equitable solution. Currently, adult dental benefits are an optional benefit under Medicaid. Some 39 states plus Washington, DC, expanded Medicaid eligibility with the Affordable Care Act. Also, 35 states plus Washington, DC, now provide at least limited dental benefits for adults beyond emergency care while 11 states have emergency-only dental benefits. Expanding Medicaid dental benefits for adult (19 and older) and senior patients in a way that increases provider participation is the goal on which our energies should be focused.

As of 2019, approximately 43% of dentists in the U.S. accepted Medicaid or the Children’s Health Insurance Program. Burdensome administrative requirements, missed appointments, lengthy payment wait times, and low reimbursement rates have been cited as barriers to participation. Practicing dentists can provide valuable insights on how to best overcome these obstacles. While the individual states participate in funding and administering Medicaid, this is not true for Medicare. Medicaid expansion will better allow dentists to participate in the organization and administration of their state programs, likely resulting in higher dentist participation. Robust participation by dentists and dental specialists will be necessary for any oral healthcare program to work. Additionally, the most workable solutions leading to equity in access to dental care will come with input from dentists and oral and maxillofacial surgeons who routinely treat patients vulnerable to discrimination and inadequate opportunity. Given the high number of adult and senior patients seen in hospital emergency departments with dental problems, this should include dentists/oral and maxillofacial surgeons who actively evaluate and treat dental patients in these environments.

While forces continue to push a Medicare dental benefit, the structural environment does not currently exist to simply “add a benefit.” Such an undertaking would involve upending of current reimbursement systems and standardization of what is considered “essential.” Why upend a system and risk developing an inadequate benefit without first maximizing current pathways for coverage of our neediest seniors?

As the debate moves forward, AAOMS will continue to focus on priorities — including collaborative advocacy with the ADA and other stakeholders — in the following areas:
• Improved third-party reimbursements for facility-based dental services provided in hospital and outpatient surgery center operating rooms to appropriate patients, especially 7-year-old and under pediatric, special needs, senior and medically compromised patients.

• Medicare recipient coverage and adult Medicaid recipient coverage for dental extractions (and associated radiographic and pathologic evaluations) when the dental/oral condition places a substantial disease burden on a co-existing medical condition (e.g., cancer, major organ failure, potentially life-threatening odontogenic infections), using ICD-10 to justify medical necessity.

• Expanded adult Medicaid recipient coverage for oral healthcare, especially for basic preventative dental care. Medicaid recipients are already means-tested. Only the financially disadvantaged qualify, and available financial resources will first be distributed to those who cannot afford dental care. Medicare recipients are not means-tested, and benefits are available to everyone over 65 regardless of financial resources.

• Addition of Medicare Advantage Plan products to Medicare Part C that give more options for additional dental coverage.

The ADA Constitution states, “The object of this Association shall be to encourage the improvement of the health of the public and to promote the art and science of dentistry.”10 The mission of AAOMS is to “assure patient access to safe and effective care by advancing, promoting and preserving the specialty of oral and maxillofacial surgery, and the skill and professionalism of AAOMS members.”11 AAOMS will continue to support these complimentary purposes as it participates in the continuing debate on dental care for senior adults.

References

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5. American Dental Association, National Association of Dental Plans and Delta Dental’s letter to US Department of Health & Human Services Secretary Tom Price, April 11, 2017
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11. 2021-2024 AAOMS Strategic Plan