



September 3, 2021

The Honorable Bob Casey
Chair
U.S. Senate Special Committee on Aging
G41 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Tim Scott
Ranking Member
U.S. Senate Special Committee on Aging
628 Hart Senate Office Building
Washington, DC 20510

Re: Aug. 30, 2021, hearing, “Eyes, Ears and Teeth: Expanding Medicare to Cover Whole Person Care”

Dear Chairman Casey and Ranking Member Scott:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) represents more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States. AAOMS appreciates the committee’s concern with providing access to affordable dental care to the nation’s seniors and recognizes significant discussion on this topic is occurring in Congress. As such, AAOMS wishes to use this opportunity to share our questions and concerns with proposals that would expand the types of dental services covered under Part B as well as provide more feasible alternatives that target care to those who need it most with minimal disruption to the healthcare system.

Oral and maxillofacial surgery is the surgical specialty of dentistry and one of the few dental specialties whose members perform Medicare-covered procedures that range from the removal of cancerous tumors in the mouth/jaw area and the extraction of infected teeth to prepare a patient’s jaw for radiation cancer treatment to the repair of tissue or bones in the facial area following trauma. As such, AAOMS members have extensive experience with the Medicare program.

As dentists and surgeons, AAOMS understands the important role oral health can have on a patient’s overall health, and we support efforts to ensure all Americans have access to affordable, high-quality dental care. AAOMS also believes oral health is different than “dental” health. Oral and maxillofacial pathology and infection, for instance, place a burden on the total systemic health of that patient. AAOMS maintains a list¹ of these and other oral and maxillofacial surgery services that it considers “medically necessary” or “essential” because they are integral to a patient’s overall health.

¹ Essentials of Oral and Maxillofacial Surgery Services. American Association of Oral and Maxillofacial Surgeons White Paper. January 2021. AAOMS.org/docs/govt_affairs/advocacy_white_papers/essentials_oms.pdf.

This list also includes – for example, extractions before medically necessary services – when treating oral health will improve outcomes in medically compromised patients.

While AAOMS appreciates the intent of proposals such as the Medicare Dental Benefit Act that would create a comprehensive dental benefit for seniors under Medicare Part B, **the Association has a number of questions and concerns (see appendix A) that remain unanswered in any of the Part B legislative proposals put forth thus far by Congress. Without these answers, the Centers for Medicare and Medicaid Services (CMS) will struggle to successfully implement and dental providers will be unable to commit to participation, ultimately leading to a failed benefit that will do nothing to improve oral health for the nation’s seniors.**

Congress should instead focus on the following efforts to improve access to affordable care for seniors:

- 1) **Expand adult dental coverage in the Medicaid program by enacting legislation such as the Medicaid Dental Benefit Act (HR 4439)** introduced by Rep. Nanette Barragán (D-Calif.) that would make comprehensive dental care mandatory in all state Medicaid programs. Standardizing adult dental Medicaid benefits and committing more federal resources to help states improve their programs will likely do more than currently proposed Medicare expansion programs to assist low-income seniors. Current Part B dental expansion proposals would still leave low-income seniors without access to affordable care because they cover only 80 percent of a patient’s cost for preventative and basic treatments and cap the patient’s costs at 50 percent for major treatments. This is below the private insurer industry standard of 100 percent of preventative and 50 percent of major treatment costs, respectively.² In sum, while middle- and higher-income seniors may benefit from the potential of legislative proposals to reduce costs, low-income seniors may be unable to afford preventative and basic treatment care due to the bill’s cost-sharing obligations. Furthermore, state Medicaid programs already offer existing provider enrollment and reimbursement systems, something the Medicare system does not, and that would require years and significant resources to build.
- 2) **Increase access to dental benefits in the Medicare Advantage (MA) market by incentivizing more MA plans to offer dental benefits to their enrollees.** Many seniors obtain dental care either through dental coverage offered by their MA plan or by paying out-of-pocket. The percentage of Medicare beneficiaries with an MA plan is rising annually, and 68 percent of MA plans now offer some form of dental benefits.³ MA plans also provide coverage to a significant number of lower-income seniors.⁴ For seniors who utilize an MA plan for their dental benefits, there is no need to take away this care delivery option.
- 3) **Correct the Medicare dental inconsistencies by mandating CMS to expand the circumstances when Medicare Part B will cover dental procedures related to a Medicare-covered medical procedure.** Medicare dental coverage is currently limited to a few procedures involving certain medically compromised patients. For example, Medicare will cover an oral exam for a patient prior to undergoing a Medicare-covered kidney

² What Does Dental Insurance Cover? Anthem. Anthem.com/individual-and-family/dental-insurance/coverage/.

³ Medicare Advantage 2021 Spotlight: First Look. Henry J. Kaiser Family Foundation. Oct. 29, 2020. KFF.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look.

⁴ Social Risk Factors Are High Among Low-Income Medicare Beneficiaries Enrolled in Medicare Advantage. September 2020. BetterMedicareAlliance.org/wp-content/uploads/2020/09/BMA-Q3-Data-Brief-FIN.pdf.

transplant – but not any dental treatment needed to ensure the success of the transplant.⁵
AAOMS supports efforts to correct this inconsistency in the Medicare program.

- 4) **Explore a Medicare dental benefit outside Part B that would have its own reimbursement structure and administrative requirements.** A separate program tailored to the dental delivery system would likely lead to higher provider participation and would avoid interruption to the Medicare physician reimbursement program as outlined in Appendix A.

AAOMS would be pleased to work with you and your colleagues further on this important issue. Please contact Jeanne Tuerk, AAOMS Director of Government Affairs, at 800-822-6637, ext. 4321, or jtuerk@aaoms.org.

Sincerely,



B.D. Tiner, DDS, MD, FACS
AAOMS President

⁵ Medicare Benefit Policy Manual. Chapter 15, Section 150. [CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf).

Appendix A

As Congress considers legislative approaches to expand dental benefits to Medicare beneficiaries, AAOMS asks that you address the following important questions directly affecting the providers charged with delivering this benefit:

1. How will dentists be reimbursed?
 - The medical and dental coding systems are very different. The current Medicare Physician Fee Schedule process was designed for the medical – not dental – coding system. Diagnosis codes and modifiers are not generally required to be used in dentistry. In addition, there are overlapping medical and dental procedural codes. Which codes will dentists be directed to utilize?
2. How will dental office practice expense be factored in?
 - Dental offices function very differently than most physician offices and have significantly higher practice expenses, given the wide range and complexity of performed procedures, particularly in an OMS office. Dental procedures will be significantly undervalued if not properly accounted for, resulting in poor provider participation.
3. If Congress moves forward with expansion under the Medicare Part B program, will dentistry be folded into the current Medicare physician reimbursement process?
 - Medicare provider payments are constrained by a budget neutral financing system, which can lead to arbitrary reductions to reimbursement unrelated to the cost of providing care and pits provider groups against each other.
 - This year, for example, Congress had to intervene again to prevent cuts scheduled to occur for many providers to offset increases provided to primary care providers.
 - The additional significant costs associated with providing dental coverage under Part B could trigger budget neutrality cuts for currently covered medical procedures that will impact all Medicare providers.
 - How will the RVS Update Committee (RUC) be reconfigured to include dentistry and its specialty organizations, or will a new system need to be considered? Who will be included in this decision-making process? Will providers have a seat at the table?
4. How will Congress/CMS ensure that the new money assigned to the dental benefit stays within the dental benefit? In other words, what would prevent use of the new money to offset the rest of Part B reimbursement that sees cuts every year?
5. Will dentists be subject to all of the administrative compliance requirements that all other providers are subject to?
 - These range from the Medicare enrollment process; global periods; correct coding or medically unlikely edits and associated modifiers; advanced imaging accreditation and appropriate use criteria; multiple procedure reductions; the use of the Advance Beneficiary Notice and accompanying modifiers to the application of limiting charges on non-participating providers.
 - With the exception of the small number of dentists who perform Medicare-covered procedures, dentists are not currently subject to these burdensome compliance requirements and are unlikely to participate in Medicare if doing so will result in additional and significant compliance.

- Furthermore, dentists are unable to comply with the Merit-Based Incentive Payment System (MIPS) because dental EHRs are non-compliant. As a result, those that reach the program thresholds are penalized in their reimbursement.
 - Will dentistry need to comply with all Part B quality reporting programs, such as the Physician Quality Reporting System (PQRS)?
6. How will you ensure providers will participate in the program? Will they be mandated?
 7. How will Medicare Part B address the issues surrounding Non-Physician Practitioner (NPPs) services? This includes defining NPPs in the dental office, supervision requirements, incident-to billing, etc.
 8. Will adequate numbers of dentists/dental specialists be added to national and local coverage advisory committees to ensure those practicing the specialty are allowed to make key coverage determinations?
 - Past efforts made by AAOMS to include OMSs to serve on national coverage advisory committees have not worked out.
 9. What will be the role of Medicare Advantage (MA) plans?
 - According to the [Kaiser Family Foundation](#), 16 percent of all seniors obtain their dental coverage from MA plans, while 60 percent of MA enrollees had access to some dental coverage. In addition, 68 percent of MA plans offer dental, vision, hearing and fitness benefits, according to the [Foundation's Medicare Advantage 2021 Spotlight: First Look](#). How will you prevent the disruption? Will Medicare dental benefits coordinate with stand-alone dental benefits that some beneficiaries may already have?
 10. How will you ensure low-income seniors can afford their new Medicare benefits?
 - Proposals cap coverage of preventative services at 80 percent and major treatment at 50 percent.
 11. How will dual-eligible beneficiaries in states with existing adult Medicaid benefits be affected?
 - A number of states have reasonable adult dental Medicaid benefits and sizable dentist participation. One concern is whether dual-eligible beneficiaries in those states will lose their Medicaid dental benefits and access to their dental provider, especially if the Medicare dental benefit is not robust and if Medicare provider participation is lower than Medicaid provider participation. Another concern is whether it may lead state Medicaid programs to drop their adult dental benefits altogether.
 12. Has Congress considered how dental benefits offered under a separate program (for example, Part E) may operate more efficiently?
 - A separate program specific to a dental benefit may lead to higher provider participation because it could be tailored to meet the unique needs of dental providers rather than the structure set up to meet the needs of medical providers in Part B. A separate benefit would likely provide greater stability to the dental benefit system by ensuring that beneficiaries who currently utilize an MA plan retain their benefits and that such insurers remain in the system. Keeping dentists out of the Part B program also would avoid further burdens to the Medicare Part B physician reimbursement system, which operates on a budget neutral structure.