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American Association of Oral and Maxillofacial Surgeons

White Paper

Dental Benefits for Medicare and Medicaid-Eligible Adult Populations: Principles for Advocacy

It has long been established that oral healthcare is essential to overall health. Across all age groups and income levels, financial factors have been cited as greater barriers to access to oral healthcare than non-financial factors, with this being especially true for low-income adults.[1] According to 2020 U.S. Census data, 17.8 percent of the population is covered by Medicaid – with variations from state to state ranging from 10.6 percent to 37.1 percent[2] – while 18.4 percent is covered by Medicare.[3] Socioeconomic disparities and an aging population underscore the growing relevance of Medicare and Medicaid.

With regard to oral healthcare, Medicare-eligible persons are limited to dental coverage through Medicare Advantage (Medicare Part C) and some medically necessary oral healthcare services that are ancillary to certain medical conditions. With Medicaid, only 19 states (as of September 2019) provide extensive dental coverage for low-income adults and certain adults with disabilities, 16 states provide limited adult coverage and 11 provide emergency-only adult coverage.[4] Low reimbursement rates in Medicaid and Medicare as well as administrative challenges make it especially difficult for solo or small practices – which describe most oral and maxillofacial surgery practices – to participate sustainably. Moreover, as practitioners who span the fields of dentistry and medicine, oral and maxillofacial surgeons (OMSs) face challenges with treatment of cases at hospitals and ambulatory surgery centers (ASCs) due in part to facility limitations arising out of the insufficiency of facility fee coding and reimbursements.

The American Association of Oral and Maxillofacial Surgeons (AAOMS) has worked diligently in collaboration with the American Dental Association and various other organizations – as well as federal and state governments – to advance appropriate solutions to increase adult access to and utilization of oral healthcare services. These efforts include advocating for adult Medicaid benefits and improved Medicaid reimbursements as well as supporting more comprehensive coverage through Medicare Advantage plans and improved coverage in Medicare Part B for medically necessary dental services. In addition, AAOMS opposed comprehensive Medicare Part B expansion that would have been detrimental to the interests of both OMSs and their patients. Beyond public health, AAOMS also has joined other organizations to fight for facility fee coding and for coverage of congenital anomalies.

Yet, organized dentistry has been painted in public discourse as a naysayer to efforts to address oral healthcare for Medicare and Medicaid-eligible populations. AAOMS's opposition to comprehensive dental benefits in Part B has been based on a pragmatic outlook – recognizing real-world challenges to implementation, administration and participation. However, AAOMS also understands that populations, including some practitioners, may not be fully aware of these challenges and that the demand for an all-in-one Medicare dental solution that is not a supplemental plan is unlikely to subside. Moreover, legislators are likely to be swayed by the opinions of Medicare-eligible populations because those in that age group are dedicated voters in elections.[5]

AAOMS has been and continues to be dedicated to solutions to improving access to care through methods that sustain the practice and benefit the patient.

Accordingly, the purpose of this policy paper is not to recommend specific advocacy initiatives – which AAOMS leadership, committees and staff have addressed thoughtfully and with expertise – but rather to establish broad principles to guide AAOMS's continued advocacy toward positive solutions to improving access to care for Medicare and Medicaid-eligible populations.

White Paper

Principles on Medicaid

Medicaid and the Children's Health Insurance Program (CHIP) provide 43 million low-income children with dental benefits each year.[6] These programs, when implemented appropriately, have a positive impact on children and support the value of addressing socioeconomic parity in oral healthcare. According to a report of the ADA Health Policy Institute (HPI), "Providing adult dental coverage through Medicaid improves access to and utilization of dental care among low-income adults and has the power to reduce racial disparities, advance health equity and lower medical care costs."[7]

Moreover, given that oral health neglect often translates to both oral and systemic complications, AAOMS supports finding a solution through Medicaid to advance oral healthcare for eligible adults ages 18 to 64. This effort could help mitigate the complexity, demand and cost of dental and medical needs of persons subsequently entering the Medicare system at the age of 65.

The HPI report further states, "Federal and state policymakers have various levers to promote oral health equity across the nation, including designating dental services as a mandatory benefit category for adults, establishing a baseline of comprehensiveness for adult dental services in Medicaid, and bolstering state budgets to ensure adequate funding for successful implementation."[8]

Similarly, the efforts of AAOMS regarding Medicaid should not be singularly at the federal level or solely at the state level but must include both. AAOMS's priorities with Medicaid should continue to be increased reimbursements as well as coverage for low-income adults while exploring opportunities for administrative simplification/efficiency.

Efforts for a federal mandate for consistent adult Medicaid benefits may resolve variability in Medicaid coverage among states. It is important to note, however, that a federal effort – even if it is federal funding for coverage acting as an incentive rather than as a mandate – may not be welcomed by states concerned about being left with the financial burden once federal funding ceases. As an example, some states declined the implementation of expanded Medicaid benefits – providing Medicaid coverage for persons with household incomes up to 133 percent of the Federal Poverty Level, generally – despite federal subsidization of the increased cost. The lesson to be learned here is that one size does not fit all for states striving to address the needs of their populations through Medicaid. State policymakers often wish to have a sense of ownership or buy-in to what is proposed, considering the state's preferences, political environment and mechanisms of implementation.

That said, diversion of expensive care from emergency departments – especially with the continued burden placed on emergent and urgent care providers by the lingering effects of the COVID-19 pandemic – may provide a compelling return-on-investment (ROI) argument for state policymakers to support adult Medicaid coverage and improved Medicaid reimbursement. A 2020 Massachusetts study found that eliminating comprehensive dental benefits for Medicaid enrollees ages 21 and over led to an 11 percent increase in the use of emergency departments for otherwise non-traumatic dental conditions (NTDCs) over a 15-month period while restoration of some of these dental benefits resulted in a 15.7 percent decrease in emergency department use for NTDCs over a five-month period.[9] Collaborating our advocacy efforts with organizations that represent emergency departments and/or emergency department physicians may be mutually beneficial.

Principles on Medicare

Persons ages 65 or older, as well persons under 65 with certain disabilities or diseases, are generally eligible for Medicare.[10] As of 2022, Medicare includes four parts: Part A for inpatient/hospital coverage; Part B for outpatient/medical coverage; Part C as Medicare Advantage; and Part D for prescription drug coverage. Through Medicare Advantage, private benefit plans contract with the federal government to receive per-enrollee funding to deliver all Medicare benefits.

In 2021, 94 percent of those enrolled in Medicare Advantage had access to at least some level of dental coverage, with 86 percent of these persons enrolled in plans offering both preventive and more extensive benefits; however, 78 percent of these enrollees faced annual limits of $1,300 or less for dental coverage while 59 percent faced annual limits of $1,000 or less.[11] Ninety percent of Medicare Advantage enrollees do not pay premiums for

White Paper

Medicare Advantage, and most plans offering preventive and extensive dental benefits fully cover preventive services while requiring a co-insurance for more extensive care.[12]

With the exception of coverage through Medicare Advantage (Part C) and coverage through Part B for some medically necessary dental services ancillary to certain medical conditions, Medicare generally does not cover dentistry. Unfortunately, as of 2019, only 29 percent of Medicare beneficiaries were enrolled in Medicare Advantage plans; 11 percent of Medicare beneficiaries had access to dentistry through Medicaid as they were dually eligible; and 16 percent had access through private plans – leaving 47 percent of Medicare enrollees with no dental coverage (3 percent overlapped with Medicare Advantage and Medicaid as they were enrolled in both).[13]

OMSs are among the few dental specialists who provide Medicare services, although many provide oral and maxillofacial surgery services as out-of-network providers and through Medicare Advantage.[14] As such, it is imperative for AAOMS to advocate pragmatically for Medicare solutions that benefit both the practice of oral and maxillofacial surgery and the patients it serves.

Various parties have called for a comprehensive dental benefit in Medicare Part B, including as part of the FY 2022 budget reconciliation progress in Congress. However, Part B presently includes various requirements in enrolling, billing, electronic claims submission, auditing, finance and administration. These requirements, which can be burdensome for many OMS practices, combined with low reimbursements make it difficult to decide to be a participating provider while sustaining a business model. Patients who may discontinue their Medicare Advantage enrollment in anticipation of oral healthcare through Part B will likely find themselves no longer having that access to oral healthcare.

For these reasons, AAOMS and other communities of interest objected to the inclusion of a comprehensive dental benefit in Part B. In the current (2022) political environment, the enactment of a comprehensive Part B dental package appears unlikely.

AAOMS appreciates – on its face, without a deep dive into its consequences – the appeal of a comprehensive dental benefit in traditional Medicare. A 2021 poll by the Kaiser Family Foundation found 90 percent of respondents favoring Medicare expansion to include dental, hearing and vision.[15] Such data not only serve as a harbinger of future efforts at Part B expansion and the likelihood of policymakers swayed by what they believe their voters want, but they also underscore the importance of educating the public and the profession now about Medicare and its various intricacies.

In addition to education, AAOMS's priorities in regard to Medicare should continue to 1) support dental coverage through Medicare Advantage, 2) explore improvements to Medicare Advantage, and 3) clarify and strengthen coverage for medically necessary OMS care through Part B. In supporting coverage for medically necessary OMS care, AAOMS should be cognizant of efforts to integrate oral healthcare into the medical system and of the potential risks and benefits of doing so. It also is important to explore opportunities for administrative simplification and efficiency throughout Medicare. Importantly, AAOMS should work with the ADA, CMS, private payers and other communities of interest to explore current and new solutions – including alternatives such as menu-based concepts.

Concurrently, AAOMS should continue its federal efforts to advocate for appropriate facility fee coding and adequate payment to enable facility access for OMS patients, advocate against cuts to the Medicare Physician Fee Schedule (MPFS) and embrace any other efforts as appropriate to support the work of OMSs to care for their patients as needed.

In addition, efforts at advocacy for OMSs and patients in the Medicare arena should take into account the role and influence of large equity-backed dental support organizations (DSOs), which generally support Medicare Part B expansion as they may have the capacity to absorb its administrative requirements while the smaller OMS practices will not. The role and influence of the medical provider community also should be considered as it may be recruited to support the positions of AAOMS in part. Therefore, AAOMS must continue monitoring what medical organizations and DSOs are doing regarding incorporating dental benefits in Medicare.

White Paper

Principles on Education and Communication

The intricacies and shortcomings of the Medicare system highlight the need for education of the public and the profession.

Expounding upon that concept, advocating for solutions for Medicare and Medicaid-eligible persons demands the education of the public, policymakers and entire dental profession. Grassroots efforts should include sharing knowledge on the ins-and-outs of the Medicare and Medicaid systems and known coding/reimbursement challenges. Education should be crafted to meet the needs of those who may have the least understanding of the intricacies of Medicare or Medicaid. Making available a primer on Medicare and Medicaid is highly recommended.

Communications addressing public dental benefits should highlight the efforts of AAOMS and OMSs to serve as champions of positive solutions, including the efforts to expand coverage for medically necessary dental services.

Expectations of both practitioners and elected officials also must be managed. For example, a large single-year Medicaid fee increase can be seen as excessive by a politician, but a practitioner may note that this was the first increase in over 40 years and, thus, still well below usual fees when adjusted for inflation. Advocacy efforts should be mindful of different perspectives.

Social media and the proliferation of information – without verification of source or of the information – has led to the ability of misinformed or misguided grassroots groups to advance their advocacy initiatives more quickly. Therefore, it is important for AAOMS to follow what advocacy groups are saying and how they are saying it, and to take a measured approach on any responses.

Principles on Data/Evidence

Having the data on hand to support the ROI of desired initiatives will benefit efforts to procure buy-in from legislators and other policymakers. Where feasible, data should be comprehensive, not selective; a limited selection of data due to the unavailability of additional information may nonetheless be perceived by policymakers as biased, even where that is not the intent.

A data-robust communications campaign should not only highlight revenue concerns – such as the gap between Medicaid/Medicare fees and usual fees – but also convey the true costs of providing services that drive the need for sustainable reimbursements. Collection of accurate data on the true cost of providing what is typically costly dental care is very important to empowering AAOMS to successfully advocate not only for reasonable reimbursement rates but also to stress the importance of managing the costs associated with the implementation of any program.

Understanding the limitations of AAOMS's resources, collaboration with the ADA and its Health Policy Institute – with their robust resources – would be valuable.

Principles on Collaboration

Embracing opportunities to collaborate with organizations, governmental entities, third-party payers and others on matters of common interest will strengthen AAOMS's proactive efforts to craft and promote pragmatic solutions to address dental benefits for Medicare and Medicaid-eligible populations.

Collaboration with the ADA, CMS, other dental organizations and insurance companies has been and will continue to be crucial. However, AAOMS's advocacy efforts also may benefit from expanding the scope of collaboration to include others – such as emergency department physicians and other medical groups as well as advocacy groups such as the Oral Health Consortium or AARP – in those areas where alignment is found.

At the state level, OMS state societies must be encouraged to work with state dental associations. Opportunities to collaborate with state dental associations extend beyond driving improvements to Medicaid as common perspectives and aggregated resources can serve to advance issues across the state advocacy spectrum.

More broadly, AAOMS is confident and encouraged in its opportunities to foster and expand its relationship with the ADA, including through participation with the CAAP Medicaid Provider Advisory Committee and the ADA Elder Care Workgroup.

Success on AAOMS's positions may often be dependent on alignment with the ADA, its state societies and state and federal legislators as well as lack of opposition from the American Medical Association and other medical societies.

White Paper

Conclusion

Medicare and Medicaid cover nearly 1 in 3 Americans.[16] OMSs play a unique role – and AAOMS has the unique opportunity – to make necessary oral healthcare available and accessible to this population. This means advocating for solutions that work but, on occasion, it also means advocating against solutions that do not work. AAOMS has successfully embraced the effort to take a pragmatic approach and drive federal and state initiatives that advance care. However, AAOMS is cognizant the information age brings with it a confluence of opinions in the guise of data and, with that, a groundswell for sweeping reforms without the foresight of their detrimental effects on patients and practices. These comprehensive and thoughtful principles shall hopefully guide AAOMS – and perhaps other organizations – to implement proactive advocacy initiatives to lead policymakers to public health solutions that will advance the oral health of Medicare and Medicaid-eligible populations.

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