Resolution 7: Medicare Task Force Report

Medicare Task Force

In 2018, the house of delegates (house) approved the creation of a task force to study adding dental benefits to Medicare, as follows:

> Resolution 19-2018-H: Resolved that CDA form a task force to explore the issues relevant to the inclusion of dental benefits into the Medicare program, including implications in California on the aging population and the delivery of care, and be it further
>
> Resolved, that the board of trustees be urged to approve the scope of work and necessary funding for the task force's activity, and be it further
>
> Resolved, that the task force report be presented to the CDA 2019 House of Delegates

The board of trustees (board) established the Medicare task force (task force) shortly thereafter, further defining the scope of work. The board directed the task force to prepare a report on the potential implications of including dental benefits within the Medicare program, taking into account the changing dental benefits marketplace both in California and nationally. Furthermore, the task force was charged with providing a summary of relevant CDA and ADA policies, current national advocacy efforts, proposed benefit designs and potential economic factors for patients and dentists, including policy or other recommendations.

President Dr. Del Brunner appointed eight members to the task force:

Dr. Gary Herman, chair	Dr. Irving Lebovics
Dr. Wade Banner	Dr. Afshin Mazdeyansnan
Dr. Elisa Chavez	Dr. Richard Nagy
Dr. Gary Dougan	Dr. Julia Townsend

The task force conducted its work over several meetings (detailed below), utilizing an online platform for document sharing and review between meetings.

- May 3, Sacramento
- May 31, WebEx
- June 14, WebEx
- July 18, Sacramento
- August 7, WebEx
- September 13, WebEx

Process

The task force began by gathering information from several sources and experts, including:

- Lu Zawistowich, president, CapView Strategies, an expert in the field of federal health care programs, who provided a basic Medicare program overview, the legislative and regulatory framework, program integrity protections, information on beneficiaries and providers and potential opportunities.
- ADA Health Policy Institute's Marko Vujicic and Cassie Yarborough, who presented findings from consumer and dentist opinion research commissioned by ADA and discussed some projections on the economic impact to dental practices if a dental benefit were added to Medicare Part B. HPI also provided some research Medscape completed in 2014, seeking to capture physicians' experience and satisfaction with Medicare as well as career satisfaction in medicine.
- Dr. Elisa Chavez, who presented The Santa Fe Group's Medicare dental benefit analyses to the group. Dr. Chavez repeated a presentation that was given at the National Oral Health Conference in April in Memphis, Tenn., detailing the activity of The Santa Fe Group and Oral Health America – a collaborative effort that included numerous experts. A 2017 Medicare dental benefit proposal developed by Drs. Judith Jones and Michael Monopoli and published in the *Compendium of*

Continuing Education in Dentistry, October 2017, Volume 38, Issue 10; and a 2018 white paper, "An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care," published by Oral Health America, were also provided to the task force for review. important

Task force members were also provided with background on the national and California health care environments, Medicaid and Medicare programs, data on aging Californians and other relevant materials as they were identified; and they engaged in a detailed analysis of potential benefit approaches and multiple considerations.

Summary of Findings

Task force analysis and discussion produced the following key findings:

Adding a dental benefit to Medicare has the potential to:

- Increase access to dental benefits.
- Increase access to dental services.
- Support better care integration.
- Decrease medical care costs.
- Increase the opportunity for improved health outcomes for aging Americans.

Individual dentists may support adding a dental benefit to Medicare because it:

- Opens up new avenues for care.
- Opens up a market for new patients.
- Is a steady, reliable reimbursement source for care.
- Increases opportunities for dentists to engage in other elements of the health care system/pursue other careers within the health care system.
- Supports dentists to do what's best for the patient and is consistent with a dentist's commitment to professional ethics and their personal, professional mission.

Patients will benefit if a dental benefit is added to Medicare because it:

- Increases access to dental services by providing financial support for (some portion) of patients' dental care needs – care that is primarily an out-of-pocket expenditure now for older Americans.
- Ensures (at minimum) the patient receives a diagnosis and knows the care they need.
- Connects patients to a dental home.

Potential risks for organized dentistry and dentists for remaining on the sidelines:

- Not engaging – taking no action – *is an action* that leaves dentistry, dentists and patients vulnerable to results that are influenced by others who do not know dentistry.
- Failing to engage may negatively impact the professions' reputation, creating the perception that dentistry does not care about the needs of aging Americans.
- Dentistry may miss the opportunity to raise its profile and influence within health care.
- Failing to engage in work to improve access to care for at-risk populations is counter to dentistry's mission.

Potential risks for dentists and organized dentistry if a benefit is established in Medicare:

- For current cash-paying patients over the age of 65, Medicare reimbursements will likely be lower.
- Mature dental practices that have an established patient base and are not seeking new patients may not benefit and may lose patients if they do not participate.
- There may be increased administrative burdens that are unfamiliar to dentists; working with government programs may be perceived as a stressor, especially for the solo practitioner.
- Dentists will incur costs associated with EHR/IT changes and support that may be required
- Dental reimbursement rates in Medicare may influence the benchmarks for commercial rates.
- Rates may become stagnant or be lowered over time.

- Engaging in Medicare benefits advocacy could alienate members who disagree with organizational involvement, decisions or the outcome

Two common misconceptions task force members felt were essential to clarify are:

- The differences between Medicare and Medicaid (Medi-Cal in California) are not well understood, which frequently results in people judging them as similar: poorly run and underfunded. In fact, these two programs are **entirely different**, including the source of their funding, administration and payment structures.
- If Medicare gains a dental benefit, it does not mean that dentists will be required to participate. As with other plans and programs, participating is an active decision made by the dentist.

Thorough discussion of these issues and concerns led the **task force to recommend that organized dentistry be engaged in the Medicare dental benefit advocacy space because:**

- Increasing access to dental services is consistent with our professional mission, as an organization and as individuals.
- Organized dentistry is the expert voice on oral health; we understand and should represent the concerns of patients and clinically practicing dentists.
- Without organized dentistry "at the table," others will design a program that dentists and patients must live with.
- Dentistry's reputation with the public and standing within health care will be enhanced with our engagement. Further, dentistry risks damaging its reputation if dentists are viewed as unconcerned about the needs of aging Americans.

Furthermore, the task force recommended that CDA conduct additional research. Task force members were very aware of what is not yet known and potential risks if a benefit is poorly designed and/or poorly reimbursed. In consideration of this, the task force identified the following areas for additional research:

- Qualitative research into California member preferences, testing various scenarios and the needs of distinct practice types.
- Economic modeling of aggregate effect on dental practices.
- Pilot testing a new Medicare benefit, taking a modified approach (regional, partial Part B benefit, etc.): This approach would allow an incremental process for designing a Medicare dental benefit, learning what works well, what adjustments are beneficial for patients and/or providers and expanding best practices over time.

Conclusion

The task force undertook the charge of the house with diligence and a commitment to understand the Medicare program and advocacy to provide dental benefits to America's seniors and share this information and their evaluation with the house. The task force considered the many forces shaping the national debate, including ongoing advocacy by multiple senior-interest groups; research on consumer desire for dental coverage and concern that the loss of benefits will affect their health as they age; support expressed by segments of the dentist community, especially dentists entering the field and whose practices look different than the generation before them, where expanded patient populations and innovative practice models may mean opportunity and bills introduced by multiple members of Congress.

The task force also recognized that not all dentists will want to participate in Medicare; many will have established practices and be unable to expand to treat additional populations or adjust to the requirements of a new payer system. Furthermore, task force members discussed potential implications of adding a dental benefit to Medicare on other payers and the health care delivery and reimbursement systems as a whole and were optimistic about additional funding becoming available for dental care, but also mindful that much is unknown and the entire healthcare delivery system is in a state of transition. It is in this context that the task force evaluated the pros and cons of potential benefit approaches and the opportunities and risks for organized dentistry, dentists and patients to engage.

This work produced a consensus among task force members that organized dentistry must be actively engaged in the Medicare dental benefits advocacy space. While many reasons were identified, of particular significance to members was that the actions of the profession must be consistent with its mission and role as the expert voice on oral health and be responsive to the needs of this growing and vulnerable portion of America. Members also felt that organized dentistry must participate to ensure that the needs of both patients and practicing dentists are accurately represented and appropriately addressed in program design. If the profession does not proactively exercise its influence and expertise in the process, decisions may be made by others with a limited understanding of the practice of dentistry and what is at stake if a meaningful and sustainable benefit is not produced.

The task force also recognized that there are details that are not yet known and made recommendations for further study in areas where additional information may be beneficial. This work is ongoing.

In October, the board received a presentation of the task force report, with the understanding that the house be asked to file the report in accordance with resolution 19-2018-H.

Financial Impact: None

Attachments

A. Medicare Dental Benefit Research Report

Recommendation: The house of delegates is asked to approve the following resolution:

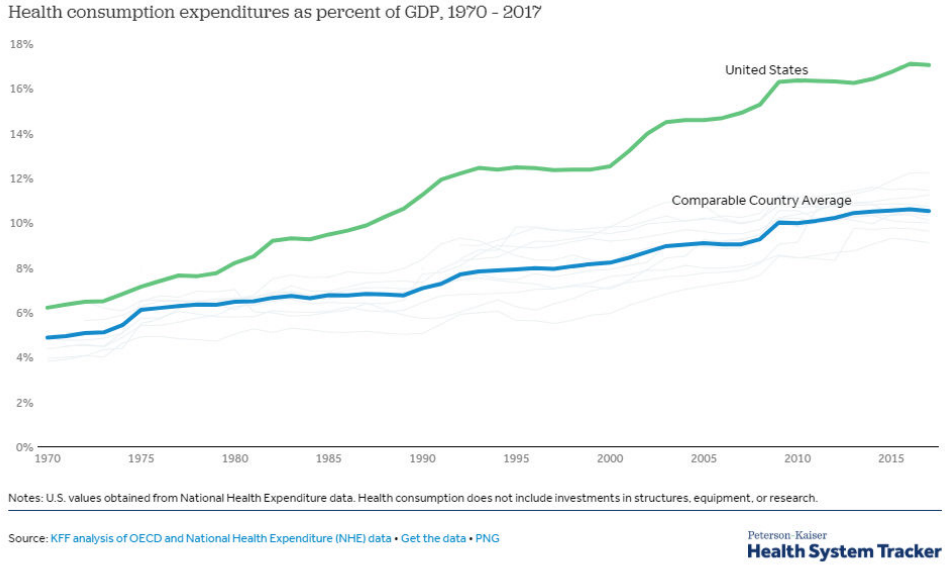
Resolved, that the Medicare Task Force Report be filed.

Medicare Dental Benefit Research Report

Introduction

The U.S. health care system, which spends on health services consistently and disproportionately more than other industrialized countries, has seen extensive growth in costs over the last 40 years.

Since 1980, the gap has widened between U.S. health spending and that of other countries



Large numbers of individuals without health care coverage, ineffective prevention and management of chronic diseases, escalating prescription drug prices and the overuse of emergency rooms for care are just some of the pressures on the health care system that have led to rising costs.

The national response to these pressures and an intensified need to reverse these trends led to the implementation of the Affordable Care Act (ACA) in 2014. The ACA introduced delivery reforms in various programs aimed at improving efficiency, increasing the quality of care and reducing cost. These included, but were not limited to, accountable care organizations (ACOs), bundled payments, value-based reimbursement and medical homes. As the health care system evolves under these changes, Medicare, the biggest single force within the system, is playing an increasingly significant role in testing new approaches.

Furthermore, the forces influencing change within the Medicare program are also shaping the commercial health care marketplace, with plans, both medical and dental, watching closely and adopting similar delivery reforms and cost-control strategies. These reforms are driving change in the dental benefits marketplace, affecting the dental profession in the form of shifting, and often-reduced reimbursement, as well as increased interest in metrics and scrutiny on the evidence base for treatment.

Contributing to this environment of changing practice is a call for better integration of medical and dental care, recognizing dentistry's role in the treatment and care of patients with compromised health conditions such as HIV/AIDS, head and neck cancers, osteoporosis, Alzheimer's disease, diabetes, cardiovascular disease, stroke, chronic obstructive pulmonary disease, pregnancy and others.

Also relevant to this discussion is growing advocacy to add dental benefits for seniors covered under Medicare and work that has begun on proposed dental benefit designs. Additionally, active attention to the need to provide dental coverage for aging Americans is being driven by congressional leaders, who are hearing from constituents displeased to learn that they will not have dental coverage in Medicare, and payers, who are looking at unconventional ways to lower costs and seeing potential savings from better chronic disease management.

ADA is aware of this activity but has yet to establish a position to direct engagement in these efforts. Further, health policy in California has been on a multiyear trajectory to expand coverage to all Californians. There is significant advocacy on issues like reestablishing the individual mandate for health care (to be enacted in 2020), expanding access to care and services covered through the state's Medi-Cal system and establishing a single-payer system. This is the landscape of the current health care coverage environment in which the 2018 house of delegates (house), through Resolution 19-2018-H, directed the appointment of a task force to explore the issues relevant to the inclusion of dental benefits in the Medicare program with a report to the 2019 house.

Background

Government Health Programs: The Medicare and Medicaid programs were established by the U.S. Congress in 1965. According to the Center for Medicare and Medicaid Services (CMS), combined, these two programs provide health coverage to over 133 million individuals (60 million in Medicare, 73 million in Medicaid/CHIP) throughout the United States with over 6.1 million enrollees in California. Approximately 1 in 3 Americans is covered under one of these programs; however, significant gaps in dental coverage remain for adults enrolled in both the Medicaid and Medicare programs.

CMS, an agency of the U.S. Department of Health and Human Services, oversees both the Medicare and Medicaid programs, and though they are sometimes compared to each other, the programs actually vary significantly in terms of benefits, payment mechanisms, funding and administration. Notably, Medicaid programs are developed, partly funded and fully administered by each state under broad federal guidelines. Rules vary significantly from state to state, and the condition of a state's budget has a significant impact on benefits and reimbursements, resulting in variability in coverage as well as volatility year to year as to if or what dental procedures will be covered for adults.

Adult dental benefits are currently covered in California for those who qualify for Medicaid (known as Medi-Cal in California), and of the estimated 5 million people over age 65 in California, 1.4 million qualify for benefits. Almost 20% of older Californians have too much income to qualify for Medi-Cal but not enough to pay for basic needs, including oral health care. Conversely, very sparse dental benefits are provided through Medicare and only under very limited circumstances with a narrow list of specific procedures. Below is a comparison of the Medicaid and Medicare programs.

Medicaid: Medicaid [and the Children's Health Insurance Plan (CHIP)] are safety net public assistance health insurance programs for low-income and disadvantaged Americans. Funded jointly by federal and state budgets and administered by states, these programs provide coverage to nearly 60 million Americans, including the required groups of children, pregnant women, parents, seniors and individuals with disabilities. In order to participate in Medicaid, federal law requires states to cover certain population groups and gives them the flexibility to cover other population groups as they prefer.

According to a Kaiser Family Foundation analysis, Medicaid accounts for 11% of the federal budget and total Medicaid spending exceeded $557 billion in 2017. Unlike Medicare, which employees pay into over their working lifetimes, Medicaid is funded jointly by the federal government and the states. The federal government pays states for a specified percentage of program expenditures, called the federal Medical Assistance Percentage. States pay their portion out of the state's general fund.

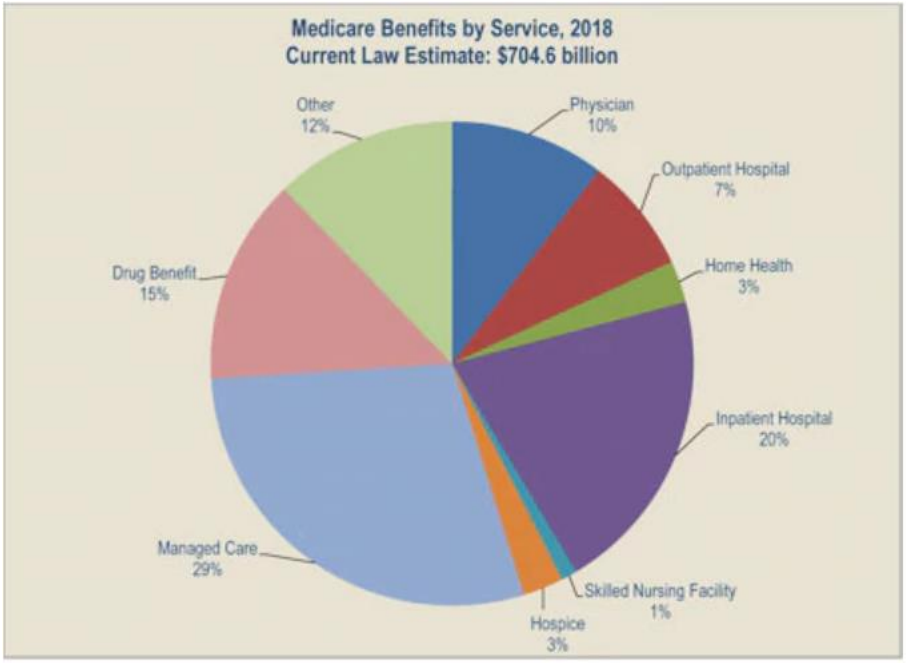
As noted above, states establish and administer their own Medicaid programs and determine the type, amount, duration, scope of services and reimbursement rates within broad federal guidelines. States are required to cover certain "mandatory benefits" and can choose to provide other "optional benefits," including prescription drugs and adult dental benefits. Additionally, states have the option to establish share-of-cost requirements for Medicaid enrollees. States also have choices regarding, and are responsible for, reimbursements and delivery system design under Medicaid.

Federal Medicaid rules require states to provide coverage for dental services for all child enrollees, ages 0-20, as part of a comprehensive set of benefits referred to as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement. Dental services for children under EPSDT must minimally include relief of pain and infections, restoration of teeth and maintenance of dental health.

Adult dental coverage, per federal law, is an optional Medicaid benefit. States have flexibility to determine whether dental benefits are offered to adult Medicaid enrollees, as there are no federal minimum requirements for adult dental coverage. Except for during the years of the Great Recession, 2009-2014, California has provided dental benefits for adults in its Medicaid program, covering care, though sometimes limited, in most treatment categories, including diagnostic, preventive, restorative, endodontic, periodontic, fixed and removable prosthodontics, oral surgery and adjunctive services.

To qualify for Medicaid adult dental benefits in California, a person must be age 21 or older with a family income at or below 138% of the Federal Poverty Level (FPL) ($16,395 for an individual; $35,534 for a family of four). Children, defined as age 20 and under, qualify for Medicaid if their family's income is at or below 266% of FPL ($68,495 for a family of four).

Medicare: Medicare, a national health insurance program initially created to support the health of America's aging population, is wholly run by the federal government and administered by CMS. Over the years, the program has expanded to cover some disabled population groups; its services have also expanded, notably to cover limited long-term care and prescription drugs (optional). States do not pay for nor have implementation oversight for Medicare. It is financed through a combination of three sources of funding: general revenues (43%), payroll taxes (36%) and beneficiary premiums (15%); taxes and interest make up the remaining 4%. Medicare spending accounted for 15% of the federal budget in 2018 and 20% of total national health spending in 2017. Net federal outlays for Medicare in 2018 were reportedly $593 billion according to the U.S. Department of Health and Human Services; percentages for services are represented in the graph below:



CMS Medicare Budget Overview: https://www.hhs.gov/about/budget/fy2018/budget-in-brief/cms/medicare/index.html

In 2018, over 60 million Americans benefited from some form of Medicare coverage under Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage Plans) and Part D (prescription drug coverage). Parts A and B are referred to as the "original" or "traditional" Medicare programs, while Part C offers Medicare beneficiaries the option of enrolling in a managed care plan that combines the coverage of

Parts A and B and sometimes D. Part D prescription drug coverage is available for purchase in addition to Parts A and B.

Medicare Advantage enrollees account for 35% of the Medicare population, with close to two-thirds of those enrollees selecting an HMO product. Medicare Advantage plan premiums are generally less expensive than traditional Medicare, and Medicare Advantage plans may offer additional benefits normally not included with traditional Medicare, such as eyeglasses. Dental benefits are offered by some Medicare Advantage plans at an additional premium or, in some instances, included as a loss leader to attract more enrollees. For many of the plans, annual benefit limits and deductibles apply, similar to those of commercial dental plans. Further, Medicare Advantage plans are not required to provide comprehensive nor uniform dental benefits and vary considerably by plan and geographic region. Notably, plans are generally only available in large population centers, leaving rural residents without a plan option. Many of the larger commercial dental plans offer specific Medicare Advantage plans, including Humana, Delta Dental, Aetna, Cigna, Anthem Blue Cross and Blue Shield.

Approximately 65% of Medicare enrollees select traditional Medicare for coverage due to the greater number of physicians who participate with traditional Medicare than with Medicare Advantage plans. Traditional Medicare does not cover dental care, dental procedures or dental prostheses. There are rare instances that permit coverage of dental services that are necessary for the provision of certain Medicare-covered medical services. Medicare may also cover certain medical procedures that dentists are licensed to perform (for example, a biopsy for oral cancer). In addition, some dental items and services, such as dental sleep apnea devices, may be covered in certain geographic areas through local coverage determinations, provided specific requirements are met.

Medicare Part A does provide coverage for dental services in very limited circumstances. These exceptions to the dental service exclusion occur "...in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

Examples of exceptions to the dental service exclusion include:

- Extraction of teeth to prepare for radiation therapy.
- An oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery.

In those instances when Medicare pays for the initial treatment, the program does not pay for any follow-up dental care after the underlying health condition has been addressed. However, Medicare will pay for some dental-related hospitalizations, for example, if the patient develops an infection after having a tooth pulled or the patient requires observation during a dental procedure due to a health-threatening condition.

Medicare provider reimbursement: An important element in a discussion of government health care programs is understanding the differences between the Medicare and Medicaid programs. State Medicaid programs, which rely heavily on state budgets, are commonly reported to provide low reimbursement rates and suffer from poor administration. Medicare is administered entirely by rules established by the federal government and funded in significant part by the individuals who receive services in the form of payroll taxes, premiums and co-pays. Review of a 2014 Medscape survey on physicians' opinions of Medicare that was provided to the task force by ADA reveals that out of 10 common medical plans, Medicare ranked near the bottom of the list for reimbursement rates and fast, accurate responses to questions, but also ranked among the top three on many other plan functions, including fewest denials, ease of precertification and preapproval and speed of claims payments, and was rated fourth overall for the "ease of doing business." It should be noted that this relative provider satisfaction with Medicare contrasts significantly with the dissatisfaction providers typically express with reimbursement and ease of office operations with Medicaid programs.

To understand more about physician reimbursements in Medicare, below is some basic history on the process:

Medicare Part B, which pays for physician inpatient and outpatient services, covers basic diagnostic and preventive services without a patient co-pay. Additional care the patient may need is paid 80% by Medicare and 20% by the patient. At the program's inception, to address the concerns of health care providers and ensure cooperation and successful implementation, physician reimbursement rates were established using a formula known as the customary, prevailing and reasonable system. However, by the 1980s, the weaknesses in this system became increasingly evident and reforms were instituted. The excerpt below, from an article published in 2007 in The Journal of Bone and Joint Surgery Inc., sheds some light on these changes:

> Under the customary, prevailing, and reasonable system, physicians had incentives to raise charges, leading to a rapid increase in program payments. Furthermore, there arose wide geographic fee variations, disconnects between reimbursements and resources utilized, and different payments for the same service depending on the physician's specialty.
>
> The Omnibus Budget Reconciliation Act of 1989 established a Medicare fee schedule for physicians that decoupled Medicare's payment rates from the physicians' charges for services. Rather than continuing to pursue a charge-based payment system, a resource-based relative value system was developed. The Health Care Financing Administration awarded William Hsiao, PhD (Harvard School of Public Health), the contract for evaluating the so-called relative values of physician work. The objective of the resource based relative value system was to assign each Current Procedural Terminology (CPT) code a relative value unit (RVU). An RVU is a nonmonetary relative unit of measure that indicates the relative resources required to perform a medical service. This system permits objective comparison of the work involved in performing each procedure relative to all other procedures.

This change in the rate-setting process led AMA to establish the Specialty Society Relative Value Scale Update Committee (RUC), which develops physician work RVUs annually for new and revised CPT codes using a detailed survey methodology among physicians. While this is not a process led by or under government control, according to the article's authors, "Since 1993, CMS has accepted, on the average, >90% of the annual RVU recommendations made by the RUC. Since 2001, CMS has accepted ≥95% of the RUC's recommendations for new and revised codes."

Subsequent congressional actions led to the requirement that changes to RVUs be budget neutral, so a decision to give a procedure or type of physician visit a higher rating means another will be lowered. Much of this work has been centered on trying to equalize the value of physicians' knowledge and time spent with patients, regardless of whether that is diagnostic skill or technical surgical skill.

While this is a very cursory look at how the system for valuing care and assigning reimbursement to physicians has changed since the program's inception, there are a couple of potentially relevant points for dentistry:

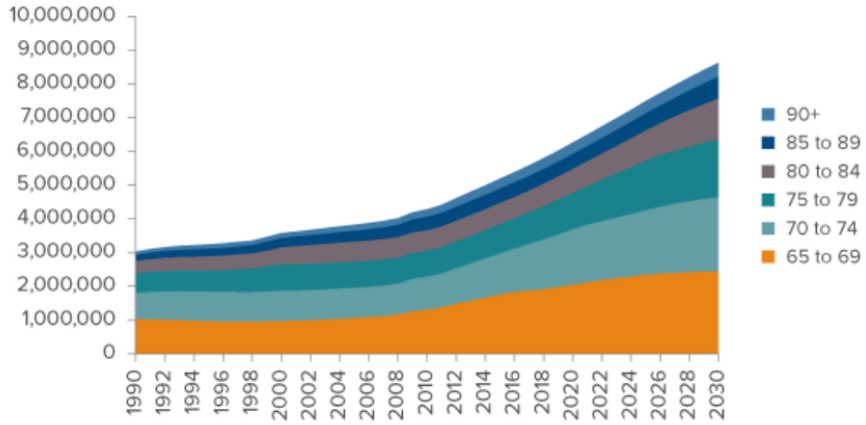
- Changes to the process for setting reimbursements to physicians has been an effort to level payments in a way that values all physicians' competencies – be they for superior diagnostic skills or surgically technical skills.
- Rather than leave this process entirely to the federal government, organized medicine (AMA) stepped up to provide a process (RUC) that engages all physician specialties and seeks to value time and resources when setting rates.
- Should Congress place dental benefits into Medicare Part B, as many are currently advocating, dentistry can reference the history of how benefits are established and how rates are set in medicine to guide its engagement.

Aside from direct-to-physician payments from CMS through Medicare Part B, health plans are also a source of reimbursement to physicians, as Medicare enrollees can purchase coverage for care through Medicare Advantage plans (Part C) and prescription drug plans (Part D). When a beneficiary receives a service covered by a plan they have purchased, the premiums, benefits and reimbursements are administered by the plan – a system that is familiar to dentists. Should dental care become covered by Medicare, depending on where these benefits are placed, dentists may find themselves in new "reimbursement territory" with payments directly from CMS or more familiar "reimbursement territory" with dental plans, or potentially both, as a hybrid benefit may be possible (See Table 3).

The growing senior population: The number of people age 65 and older in the United States is steadily increasing due to the baby boomer population (born1946-1964). As of 2018, there were over 46 million adults over the age of 65. By 2033, the U.S. Census Bureau estimates that, for the first time, the population age 65 and older will outnumber people younger than 18 in the U.S. The 65 and older population will more than double 2018 estimates to 98 million by 2060. People in this age group will comprise of nearly 1 in 4 American residents at that time.

In California, according to a 2015 report of the Public Policy Institute of California, the over-65 population is expected to be 87% higher in 2030 than in 2012, an increase of more than 4 million people. This population will also grow more racially and ethnically diverse and be comprised of more seniors who are single and/or childless than ever before, signaling a necessity to reconsider how the support services and health care needs of this population can be effectively met.

Figure 1. California's senior population will nearly double by 2030



SOURCE: State of California, Department of Finance, State and County Population Projections by Race/Ethnicity, Sex, and Age 2010-2060, Sacramento, California, December 2014.

NOTE: See Technical Appendix A for detailed tables and Technical Appendix B for data and methods used to generate the projections.

Coverage implications: Despite the large number of individuals covered by Medicaid and Medicare, including some who have coverage through Medicaid because of their income level, others who have coverage through Medicare because of their age or disability, and even some who have both (known as "duals" or "Medi/Medi" beneficiaries), the National Association of Dental Plans (NADP) reports approximately 74 million Americans are without dental coverage and 70% of adults over the age of 65 have no dental insurance. Individuals without dental benefits are more likely to have extractions and dentures and less likely to have restorative care or receive treatment for periodontal disease. Furthermore, those without dental benefits report higher incidences of other illness and are 67% more likely to have heart disease, 50% more likely to have osteoporosis and 29% more likely to have diabetes.

According to a Families USA survey released in December 2017, the top reason why adults do not visit the dentist is due to cost. For Medicare-insured adults, cost is identified as the No. 1 reason for not seeing a dentist, followed by having dentures or not having teeth and not needing dental care. Studies also report that the cost barriers for dental care are considerably higher than for other types of health care services.

National activity: Health care costs in the U.S., which consume a significant proportion of the gross domestic product (17.9% in 2017) and continue to rise, are generating intense interest to identify effective strategies to reverse this trend. Concurrently, evidence on the association between disease states of the mouth and body is also growing, and multiple studies have produced data suggesting that the provision of dental services could reduce complications and costs associated with several chronic and costly conditions, which has notable implications for savings in the Medicare program. For example:

- A 2016 analysis by Avalere Health, conducted for Pacific Dental Services, estimated the impact of providing periodontal services for Medicare beneficiaries with diabetes, coronary artery disease and stroke. The proposal placed a benefit for periodontal treatment in Medicare Part B – at a cost of $825 for the initial treatment and $250 for maintenance (in 2016 dollars) – limited to patients with one of the three chronic diseases. Avalere estimated that the benefit would produce $63.5 billion in savings over 10 years – $7.2 billion in additional costs for the periodontal services coupled with $70.7 billion in savings, primarily from fewer hospitalizations and emergency room visits.
- A 2014 study by researchers from the University of Pennsylvania, which reviewed data from records of a health plan with a corresponding dental plan, concluded that patients with Type 2 diabetes who received periodontal treatment had reduced annual total medical costs of $2,840.

Added to evidence for health care savings is concern from consumers, as more and more seniors are losing employer-sponsored insurance after retiring and gaining Medicare but realizing they are losing dental benefits. This concern is being amplified by advocacy organizations, such as Families USA, AARP, the National Committee to Preserve Social Security and Medicare, Justice in Aging and Oral Health America (which recently ceased operation). These groups, appropriate to their missions, are focusing on the needs of and benefits to consumers for adding dental benefits to Medicare.

Relevant to this discussion is research conducted by ADA's Health Policy Institute, which explored consumer and dentist opinions on adding a Medicare dental benefit and discussed some projections on the economic impact to dental practices if a dental benefit were added to Medicare Part B. The "Big Picture Conclusions" from that research were:

- There is strong support among older Americans for a dental benefit within Medicare. It is atop the "wish list" of additional health care services to be covered.
- There is strong support among dentists for a comprehensive dental benefit in Medicare, though there is also a notable pattern with support highest in the youngest age range (79.3% for dentists under the age of 40), declining by age to 66.5% among dentists over the age of 65. Also of interest was data showing that the lowest support (41%) came from ADA members who are male, solo practicing, do not have open chair time and are over the age of 55.
- A large majority of dentists responded positively to the question "If a dental benefit was included in Medicare and payment rates were 80% of typical private dental insurance rates, how likely are you to accommodate Medicare patients in your practice?"
- Dentists report they would be more likely to participate in Medicare if the ADA influenced the design of the benefit.
- Under a Part B scenario, HPI estimated that there would be between 4 million and 14 million new dental patients among Medicare beneficiaries, generating between 26 and 89 new patients and $32,000 to $97,000 of additional income per general dentist (nationwide).

Promoting current research on the interrelationship between diseases of the mouth and body, CDA is participating in a coalition of more than 100 health and advocacy organizations, including AARP, the American Diabetes Association, the American College of Physicians, the Association of State and Territorial

Dental Directors, the American Medical Association, the California Medical Association, Pacific Dental Services, Center for Medicare Advocacy, and Families USA, seeking to clarify existing statute regarding Medicare's responsibility to cover medically necessary health care services.

Also, on the national front, The Santa Fe Group, a think tank of dental educators, researchers and other stakeholders concerned about oral health, is serving as a convener of ideas on this subject. These activities resulted in the development of two proposals:

- The first, developed in 2017 by Drs. Judith Jones and Michael Monopoli (known as the "Compendium"), proposes diagnostic, preventive and basic care be placed into Medicare Part B with no co-pay to "remove barriers to the care needed to eliminate pain, infection, and inflammation." An optional "Level 2"plan with a $1,500 annual maximum would also be available to cover additional options for care.
- The group's second proposal, published in a 2018 Oral Health America white paper entitled "An Oral Health Benefit in Medicare Part B: It's Time to Include Oral Health in Health Care," places dental services in Medicare Part B using the existing medically necessary and reasonable standard that applies to all Part B services. Preventive services such as cleanings, X-rays, screenings and examinations would be covered in a similar fashion to services already provided through Medicare "wellness visits." The plan does not create tiers of covered care, as did the 2017 plan, and though covered services would need to be defined and some services may not be included, the authors envision the full oral health benefit would be in Part B.

Congress is also becoming active on this issue, with Maryland Sen. Ben Cardin, Pennsylvania Sen. Bob Casey, Texas Congressman Lloyd Doggett and California Congresswomen Lucille Roybal-Allard and Nanette Barragan introducing bills that remove the existing restriction on dental services and add either a dental benefit alone, or dental, vision and hearing benefits to Medicare Part B.

Task Force Discussion

As directed by the house, the task force undertook a thorough analysis of this issue, considering the potential implications of the inclusion of a dental benefit into the Medicare program, taking into account the changing dental benefits marketplace both in California and nationally; current national advocacy efforts on this issue; proposed benefit designs; and potential economic factors for patients and dentists. The task force also considered existing professional policy and mission, what we know about our organizational capacity and members' needs, wants and preferences with regard to engaging in activities to expand dental benefits to aging Californians through the Medicare program.

Central to the task force discussion was the basic question: Should organized dentistry take an active role in the advocacy to add dental benefits to Medicare? That discussion involved an exploration of the pros and cons and perceived benefits, opportunities and risks of adding dental benefits to the Medicare program not only for organized dentistry, but for dentists and patients as well.

With regard to organized dentistry's engagement, task force members expressed that doing so would give the profession the opportunity to be the "expert voice" and represent the needs of patients and clinicians as program details are developed; support dentistry/dentists to be equal partners with medicine/physicians; increase the opportunity for dentistry to influence people's health and the health care system; and demonstrate a commitment to the profession's mission to increase access to dental care for vulnerable, at-risk and underserved populations and to improve patient health and well-being.

The task force also noted there are risks if organized dentistry fails to represent the needs of clinically practicing dentists, suggesting that the vacuum left by dentistry's absence allows others to shape the outcomes, leaving dentists vulnerable to a new system designed by "other" advocates and with potentially unfavorable elements that may be forced upon participating dentists. The task force further expressed concern that if dentistry avoids engaging in this discussion and process, it may negatively impact the profession's reputation, creating the public perception that dentistry does not care about the needs of aging Americans. The profession may miss the

opportunity to raise its profile and influence within health care, contributing to perceptions that dentistry is a second-tier profession/dentists are not physicians' equals. Lastly, task force members expressed concern that failing to work to improve access to care for at-risk populations is counter to CDA's mission.

While this discussion produced a consensus among task force members that organized dentistry should be actively engaged in the Medicare dental benefit advocacy space, a concern was also noted that if dentistry *does* step up, there is a risk of disengaging members who disagree with organizational involvement, decisions or the outcome.

The task force extended their analysis on the pros and cons for practicing dentists, identifying the following potential opportunities and risks of including a dental benefit in Medicare:

Opportunities for dentists:

- Allows new models of care to develop.
- Opens up a market of new patients; provides a source of patients for dentists seeking to grow their practice.
- Infuses billions of dollars into dental care; provides a steady, reliable reimbursement source.
- Increases opportunities for dentists to engage in other elements of the health care system/pursue other careers within the health care system.
- Supports dentists to do what's best for the patient and is consistent with a dentist's commitment to professional ethics and their personal, professional mission.

Risks or potential losses for dentists:

- For current cash-paying patients over the age of 65, reimbursements will likely be lower.
- Mature dental practices that have an established patient base and are not seeking new patients may not benefit and may lose patients if they do not participate.
- Dental reimbursement rates in Medicare may change the benchmarks for commercial rates.
- Rates may become stagnant or be lowered over time.
- There may be increased administrative burdens that are unfamiliar to dentists; working with government programs may be perceived as a stressor, especially for the solo practitioner.
- Dentists will incur costs associated with EHR/IT changes and support that may be required; may be less of a risk for larger practices that already have systems in place that may be compatible.

Benefit approaches: In order to look at these issues more closely for both dentists and patients, the task force undertook an evaluation of various proposed approaches for offering benefits, as summarized below:

Table 3

"Where" in Medicare	Part B	New & Separate Benefit: "Part E"	Hybrid of Part B & Part E
Who is covered	All Medicare enrollees.	Enrollees who purchase offered plan.	Prevention & basic care: all enrollees; potential for other "medically necessary" services to be covered by Part B for certain enrollees (e.g. periodontal services for people with diabetes). Treatment/"non-Part B" services: Enrollees who purchase a "Part E" dental plan receive that coverage.
Benefits	Prevention and basic care are covered at	Parameters of benefit package would likely be	Prevention and basic care covered at 100%; potential

	100%; additional services are paid 80% by Medicare and 20% by enrollee; no annual cap/maximum. Details of dental benefits included/excluded in Part B is a government decision and would occur during the program development process.	established during the creation of Part E. Dental plans would also likely have a role in benefit design and reimbursements, which are also likely to be related to premiums paid.	for other "medically necessary" services to be covered by Part B at 80%-20% Medicare-enrollee split. Treatment: Same as Part E for enrollees who purchase a dental plan; NA for enrollees without a plan and paying out-of-pocket.
Claims administration	CMS	Dental plan	Part B covered services: CMS Non-Part B services/other treatment services: Dental plan, if purchased by enrollee.
Funding source	Federal government (no state contribution) through general revenue, payroll taxes and monthly premiums (deducted from enrollee SS checks), as well as enrollee co-pays (20%) for some portions of care.	Enrollee via plan premiums and any required deductibles/co-payments.	Part B covered services: Same as Part B. Non-Part B services/other treatment: Same as Part E for enrollees who purchase a dental plan; NA for enrollees without a plan and paying out-of-pocket.
Reimbursements	Details on how this would work for dentistry are unknown, but physician reimbursements use a relative value unit (RVU) process developed by an AMA committee (RUC) and approved by CMS.	Unknown; likely would be established during the creation of Part E and would be related to benefits and premiums.	Part B covered services: Same as Part B. Non-Part B services/other treatment: Would mirror Part E for enrollees with a plan; out-of-pocket for enrollees without a plan.

These three primary approaches to offer dental benefits to Medicare enrollees:

1. *Place all covered dental benefits into Medicare Part B (blue column).*
2. *Create a new part of Medicare ("Part E") where a standard dental benefit design is developed and made available to all Medicare enrollees for optional purchase, following the same approach that was used to cover prescription drugs through Medicare Part D (yellow column).*
3. *Combine these two approaches whereby a portion of care is placed into Part B (i.e. basic diagnostic and preventive services or even a greater set of services considered "medically necessary" to reduce/manage co-morbid conditions, such as diabetes, CVD or stroke) and a Part E plan is offered for purchase to support coverage for other dental services (green column).*

To support a deeper understanding of these options, the task force evaluated potential pros and cons to dentists and patients for each. Understanding that much is still unknown, task force members agreed that all the options under discussion have the potential to increase:

- Access to dental benefits.
- Access to dental services.
- Better care integration.
- Decrease medical care costs.
- Opportunity for improved health outcomes.

However, the task force also noted that these approaches have different strengths relative to each other. The task force advised that regardless of the coverage approach taken, if dental coverage is added as a Medicare benefit, organized dentistry must be engaged in shaping benefits and reimbursements and ensuring that the

needs of clinically practicing dentists are well-represented, as well as being engaged in supporting members with regard to understanding billing/coding and other required administrative changes.

The task force also expressed concern that there are two commonly held misconceptions regarding Medicare and it is important to ensure that members have correct information and understand that:

- Medicare and Medicaid (Medi-Cal), though both government benefit programs, are entirely different programs. Their funding, administration and payment structures are very different (see extensive discussion above).
- If Medicare gains a dental benefit, it does not mean that dentists will be required to participate. As with other plans and programs, participating is an active decision made by the dentist.

Table 4 summarizes key points captured in this discussion, without prioritization or value-weighting.

"Where" in Medicare	Part B	New & Separate Benefit: "Part E"	Hybrid of Part B & Part E
Pros for dentists/ dentistry	• All Medicare enrollees (millions of people) will have this coverage. • Consistent source of patients and revenue. • No cap/annual maximum. • Utilizes existing 80%-20% payment system whereby the federal government pays most of the cost and the patient pays the rest. • Removes dental plan from middle-man role. • Brings additional funding directly into the dental space; adds resources to the "pie." • Option most likely to immediately raise the visibility of the importance of oral health to general health across the professions and among the public; would place oral health care on the same playing field as the rest of medicine. • Absence of dental services now provides opportunity for organized dentistry to be involved in shaping a new benefit.	• May give dentistry/dental experts the most opportunity to influence the benefit design/create something most ideal. • Working with dental plans is familiar to dentists/requires the least amount of change. • Plan purchase is optional – patients who access care now may continue with their current behavior/decide they do not need to purchase the offered plan.	• Part B is about covering "basic/necessary care," so putting diagnostic and preventive (possibly other) dental services into Part B is consistent with that; adding the option for dental plan purchase (Part E) to assist with treatment costs completes coverage options for consumers. • All enrollees have at least some basic dental coverage; drives patients into offices. • Creates a dental home. • Placing a portion of the dental benefit into Part B (e.g. diagnostic and preventive care) leaves more of the purchased dental benefit available to cover treatment costs (benefit goes farther/is more meaningful). • The benefit of the dental-medical nexus is retained; patients will see dentists more often than their physicians, increasing the opportunity for dentists to contribute to increased overall health (i.e. chronic disease screenings). • May be easiest buy-in/ facilitate dentists to ease into participating in a new system.

Cons for dentists/ dentistry	• Reimbursement rate-setting system (RVU) is already in place for physicians and may be used to set dental reimbursement rates. • Recognizing the "differences" in dentistry may be difficult. • Range of services covered may be limited, so not necessarily a meaningful benefit. • New administrative requirements and potential costs related to coding/billing, EHR, IT support. • Dentists must meet all participation requirements regardless of whether they have many or just a few patients with Medicare dental benefits.	• Uptake/number of lives covered is likely to be smaller. • Dental plans remain involved in the middle-man role; a portion of the funding goes to plans, rather than care; unfavorable plan polices may remain. • Current cash-paying patients may decide to purchase the offered plan, which may change reimbursement levels.	• Plan policies and limitations still in place for portion of care covered by Part E purchased plan. • Still requires updating systems/EHR/coding and billing changes. • If reimbursements in either Part B or Part E are not sustainable, this will not work as intended.
Pros for patients	• Universal access to coverage; everyone gets it regardless of income. • Establishes or maintains a dental home. • No cap/annual maximum. • Utilizes existing 80%-20% payment system. • Simplest /easiest/most familiar to navigate.	• Optional purchase. • Premium reflects benefit and may support offering a more meaningful benefit package.	• Ensures patient receives a diagnosis/knows the care they need; establishes or maintains a dental home. • Preserves more of the dental benefit for care; more value.
Cons for patients	• Raises premiums for all enrollees who pay premiums now* (though less for covered individuals than other coverage options) • Range of services may be limited, so may be a limited benefit. *low-income seniors do not pay Medicare premiums	• Coverage dependent on ability to pay. • Premiums likely higher. • Plan policies may be difficult/limiting.	• Plan policies and limitations still affect patients who purchase Part E portion of the plan. • Trickiest to navigate; requires the most education; potentially too confusing.

Though the task force identified several potential benefits for dentistry, dentists and patients should aging Californians gain dental benefit coverage through Medicare, it was also very aware of what is not yet known and potential risks if the benefit is poorly designed and/or poorly reimbursed. In consideration of this, the task force identified the following areas for additional research:

- Qualitative research of California member preferences, testing various scenarios and the needs of distinct practice types.
- Economic modeling of aggregate effect on dental practices.
- Pilot testing a new Medicare benefit, taking a modified approach (regional, partial Part B benefit, etc.): This approach would allow an incremental process for designing a Medicare dental benefit, learning what works well, what adjustments are beneficial for patients and/or providers and expanding best practices over time.

Conclusion

The task force undertook the charge of the house with diligence and a commitment to understand the Medicare program and current advocacy efforts aimed to provide dental benefits to America's seniors and share this information and their evaluation with the house. The task force considered the many forces shaping the national debate, including ongoing advocacy by multiple senior interest groups; research on consumer desire for dental coverage and concern that the loss of benefits will affect their health and well-being as they age; and support expressed by segments of the dental community, especially dentists entering the field whose practices look different than the generation before them, where expanded patient populations and innovative practice models mean opportunity; and bills introduced by multiple members of Congress.

The task force also recognized that not all dentists will want to participate in Medicare. Many will have established practices or be unable to expand to treat additional populations or adjust to the administration and technological requirements of a new payer system. Furthermore, task force members discussed potential implications of adding a dental benefit to Medicare on other payers and the health care delivery and reimbursement systems as a whole and were optimistic about additional funding becoming available for dental care, but also mindful that much is unknown and the entire health care delivery system is in a state of transition. It is in this context that the task force evaluated the pros and cons of potential benefit approaches and the opportunities and risks for organized dentistry, dentists and patients to engage.

This work produced a consensus among task force members that organized dentistry must be actively engaged in the Medicare dental benefits advocacy space. While many reasons were identified, of particular significance to members was that the actions of the profession must be consistent with its mission and role as the expert voice on oral health and be responsive to the needs of this growing and vulnerable portion of America. Members also felt that organized dentistry must participate to ensure that the needs of both patients and practicing dentists are accurately represented and appropriately addressed in program design. If the profession does not proactively exercise its influence and expertise in the process, decisions may be made by others with a limited understanding of the practice of dentistry and what is at stake if a meaningful and sustainable benefit is not produced.

The task force acknowledged that there is much in the way of details that is not yet known and made recommendations for further study in areas where additional information may be beneficial. That work is ongoing.

Resources

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