

## FAQ on the ADA's Medicare Benefit Proposal

### **What is happening in Congress?**

Congressional Democrats proposed including a Medicare Part B dental benefit in the Build Back Better reconciliation package. The House of Representatives voted on Build Back Better on November 19, but the final bill that passed the House did not include a Medicare dental benefit. Build Back Better now moves to the Senate for consideration, where a Medicare Part B dental benefit could be added back into the bill. However, the ADA is lobbying to ensure that this does not happen.

### **Why is the ADA lobbying?**

The ADA has a duty to respond when Congress intends to act on adding a dental benefit to Medicare and is lobbying accordingly, based on ADA policy. If the ADA does not lobby this issue, Congress will act without the ADA's input, thereby creating a Medicare dental program that will not benefit patients or practitioners.

### **Does ADA policy support lobbying on Medicare?**

Yes. [ADA policy](#) supports the oral health care of those 65 years old and older by:

- Including a range of services necessary to achieve and maintain oral health for beneficiaries with incomes up to 300% of the federal poverty level;
- Sufficiently funding and efficiently administering the program to ensure access to care; and,
- Allowing freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.

### **Does the ADA support a Medicare dental benefit in the current Medicare Part B program?**

No. The current Medicare program includes distinct “parts” that recognize the variability in delivery of health care services such as hospital care (Part A), physician services (Part B), and prescription drugs (Part D). The dental care system is significantly different from the medical care delivery system. Based on current legislative proposals, an expansion of benefits within the current Part B structure of Medicare would not adequately meet the needs of dentists and Medicare patients. The current Medicare Part B structure is wrong for dentistry for a number of reasons, including:

- **Electronic health record requirements.**
  - Dentistry's utilization of electronic health records is much lower than our physician counterparts and we don't currently have the technical infrastructure that Part B would require.
- **Coding & payment parameters are vastly different between dentistry and medicine.**
  - Payment for physician claims is based on what is called a “relative-value unit” (RVU) system. As it is currently designed this system does not favor practices that have high overhead and equipment costs. A system that fits a dental practice, essentially a surgical suite, would need to be developed and it would need to address all CDT codes. The panel that maintains the RVU system for physicians is headed by the AMA with no representation currently from the dental community. The Congressional Democrat proposal would allow the Secretary of Health and Human Services (HHS) to choose whether to use the RVU system or another payment system (such as Medicaid, Tricare, or VA payment rates) when setting the Medicare dental rates.
- **The administrative burden for Part B does not fit with what patients experience in the dental office today.**

- Claims submission requirements for Medicare are more complex and most dental practices would need to make significant changes including potentially hiring new staff to manage additional paperwork and reporting requirements. Dental practice management software as it currently exists cannot support the administrative tasks that a physician's office engages in. Standards developed for electronic transactions (e.g. verifying eligibility and benefits, remittance advice, etc.) do not adequately address the needs of dental benefits.
- **Audits and reporting requirements are considerable.**
  - These requirements would be difficult for the dental profession to adhere to under current programmatic rules.
- **Reimbursement levels are an unknown.**
  - Physician groups have raised concerns with adequate reimbursement from Part B. Given that the federal agencies and Congress have little knowledge of dental benefits and payment parameters, these issues must be thought through in order to incentivize dental providers to participate.

**What is the ADA's current lobbying position on a Medicare Dental Benefit?**

The ADA believes that any expansion of Medicare to include dental benefits should be through a separate and new program dedicated to providing comprehensive dental care for low income seniors – not the Medicare Part B program that has been part of past and current proposals. In addition, the ADA believes an expansion of Medicare benefits should include a comprehensive dental benefit that meets the needs of beneficiaries up to 300% of the federal poverty level (FPL). This would provide meaningful coverage to an estimated 47% of seniors who presently do not visit a dentist because they cannot afford it, and would target those who are most in need. Our proposal would also start sooner than the Congressional proposal, thus helping low-income seniors right away, rather than making them wait up to 10 years for full coverage.

**Would the ADA's Medicare proposal require dentists to participate in Medicaid?**

No. Medicaid and Medicare are separate programs. Medicaid is a joint federal-state program, which generally covers people under 133% of the federal poverty level and the reimbursement levels for dental services are set by the state. The ADA's Medicare proposal would only be run by the federal government, the income level would be up to 300% of the federal poverty level, and dentists would be paid fair rates through the establishment of geographically adjusted minimum rates based on an independent survey of dental fees. The ADA's Medicare proposal would not require dentists to participate in Medicaid.

**What if dentists aren't in favor of adding a dental benefit within Medicare Part B? What should they do?**

Participating in ADA grassroots advocacy is key. The dentists' voices must be heard. We cannot ignore the process happening in Washington, D.C. if we want to effect change. Let us educate Members of Congress on the right way to meet the needs of both dentists and patients by supporting what would work best instead of sitting on the sidelines.