JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

September 6, 2022

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically to: http://www.regulations.gov

Re: CMS-1770-P (Section II.L.)

Justice in Aging appreciates the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) comments on the proposals and request for information on Medicare Parts A and B Payment for Dental (Section II.L.) in the proposed rule on Medicare and Medicaid Programs: CY2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements, etc. (CMS-1770-P).

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income enrollees and populations that have been marginalized and excluded from justice such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Justice in Aging has long advocated for expansion of oral health coverage for Medicare enrollees and strongly supports CMS's recognition in this proposal that it has the authority to cover "medically necessary" dental care in the Medicare program. Given our focus on the impact of health care programs on low income older adults, our comments primarily discuss the effect this proposal would have on addressing inequities and disparities in health care for older adults of color and other marginalized populations.

A. The proposal to clarify interpretation of the statutory dental exclusion would help to address inequities in access to dental care and improve overall health outcomes

Justice in Aging strongly supports CMS's proposal to clarify and codify the agency's interpretation that certain dental services are not subject to Medicare's payment exclusion for dental services under Section 1862 (a)(12) of the Social Security Act because they are "inextricably linked to, and substantially related and integral to the clinical success of, a certain covered medical service." This proposal is an important recognition and clarification of CMS's existing authority under the Medicare statute to cover

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dental services and will serve to improve overall health by expanding access to more dental care to Medicare enrollees who otherwise cannot afford or access treatment.[1] The proposed clarification is also consistent with coverage determinations for other health conditions including the "medically necessary" exception for foot care that, like routine dental care, is excluded by the Medicare statute.[2]

Most notably, this proposal would help to improve equitable access to dental services and improve health outcomes for Medicare enrollees, thereby advancing the Administration's goals of increasing equitable access to high quality and affordable health care.[3]

Today, the cost of dental care is the biggest barrier to obtaining treatment. Half of Medicare enrollees, a total of 31.1 million older adults and people with disabilities, have an annual income below $26,200.[4] Fifteen million or 25% of Medicare enrollees have an annual income below $15,250.[5] The annual income of Medicare enrollees of color is significantly below that of white Medicare enrollees. While white Medicare enrollees have median per capita income of $30,500, Black Medicare and Hispanic Medicare enrollees have incomes of $17,350 and $13,650 respectively.[6] Medicare enrollees of color are also less likely than white Medicare enrollees to have visited a dentist in the past year: 58% of white Medicare enrollees saw a dentist while just 32% of Black and 39% of Hispanic Medicare enrollees did so.[7]

As a result of longstanding discrimination in health care and across societal sectors like housing, employment, and education, Medicare enrollees of color and low-income Medicare enrollees are also both 1) more likely to experience worse oral health outcomes; and 2) be diagnosed with a chronic condition that is negatively impacted by poor oral health. For example, nearly 25% of Mexican American and 20% of Black older adults have severe periodontitis compared to just 8% of white older adults.[8] In addition, the prevalence of diabetes is much higher among Medicare enrollees of color with 47% of Black and 46% of Hispanic Medicare enrollees diagnosed with diabetes compared to 29% of white Medicare enrollees. Periodontal disease is strongly associated with chronic diseases including diabetes. People with diabetes are three times more likely to develop periodontal disease and periodontal disease, in turn, hinders the ability to control diabetes.[9] Periodontal disease is also associated with

[1] Social Security Act, § 1862(a)(12).
[2] Medicare Benefit Policy Manual, Ch. 15, § 290.
[3] U.S. Dept. of Health and Human Services, "Strategic Plan FY 2022-2026," available at www.hhs.gov/about/strategic-plan/2022-2026/index.html; Centers for Medicare & Medicaid Services, "CMS Framework for Health Equity 2022-2032,", available at www.cms.gov/files/document/cms-framework-health-equity.pdf.
[4] Kaiser Family Foundation, "Income and Assets of Medicare Beneficiaries, 2016-2035," Apr. 21, 2017, available at www.kff.org/medicare/issue-brief/income-and-assets-of-medicare-benefciaries-2016-2035
[5] Id.
[6] Id.
[7] Kaiser Family Foundation, "Medicare and Dental Coverage: A Closer Look," Jul.28, 2021, available at www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/
[8] National Institutes of Health, "Oral Health in America, Section 3B Oral Health Across the Lifespan: Older Adults," Dec. 2021, available at www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf#page=411
[9] Id.

cardiovascular disease and stroke – two chronic conditions that are also more prevalent in communities of color.[10]

Accordingly, based on available clinical evidence and the impact on addressing disparities, we strongly support CMS extending Medicare "medically necessary" dental coverage to as broad a range of clinical scenarios as possible including diabetes and other chronic disease management, certain surgical procedures, all transplants, cancer treatments, immunosuppression, heart disease treatments, and other treatments and procedures. We also strongly support CMS's proposal to implement a process that provides for the future review and addition of further clinical scenarios that meet the criteria laid out in CMS's proposed "medically necessary" dental coverage authority.

B. **Dental Services Should be Made Available in Both Outpatient and Inpatient Settings**

We agree with CMS's proposal to implement Medicare coverage and payment in *either an inpatient or outpatient* setting as it is clinically appropriate and in line with the statutory authority. Today, the majority of dental services are provided by dentists and their teams in a dental office that is not connected to a hospital or inpatient setting. Arbitrary limitations on coverage based on the setting in which services are provided are neither required by nor consistent with the "medically necessary" standard.

Providing "medically necessary" dental services in outpatient settings would also help to address the disparities in access for residents in nursing facilities and other congregate care settings who often receive dental care through mobile clinics. Residents in these facilities face significant barriers in accessing health care outside of the facility and are among those most likely to have a chronic condition or disease and unmet oral health needs.[11]

C. CMS should clarify that coverage for care management services is applicable in connection with "medically necessary" dental services.

Historically, oral health has not been integrated with other medical care. This is particularly problematic for people of color who are more likely to have multiple chronic health conditions, people with disabilities, and people with complex health needs. To highlight this issue, take an individual who is diagnosed with leukemia and suffers from untreated periodontal disease. An oncologist would not proceed with chemotherapy until the dental condition is treated since the risk of infection with starting chemotherapy and weakening the immune system is too great. The solution seems easy: the patient just needs to see a dentist who will deliver the proper treatment and then they can receive their chemotherapy. In reality, however, patients ping-pong between their medical doctors and their oral health providers, delaying life-saving treatment. Better integration and coordination of medical and oral

[10] Sanz M, et al. Periodontitis and Cardiovascular Diseases. Consensus Report. Glob Heart. 2020 Feb 3;15(1):1. doi: 10.5334/gh.400. PMID: 32489774; PMCID: PMC7218770; Peruzzi M, et al. Current knowledge on the association between cardiovascular and periodontal disease: an umbrella review. Minerva Cardio Angio. 2022 Mar 25. doi: 10.23736/S2724-5683.22.06022-7. Epub ahead of print. PMID: 35332749; and Kaiser Family Foundation, "Racial and Ethnic Health Inequities and Medicare," Feb. 2021, available at https://files.kff.org/attachment/Report-Racial-and-Ethnic-Health-Inequities-and-Medicare.pdf.

[11] See, e.g., Center for Oral Health, "A Healthy Smile Never Grows Old," 2018, finding that half of residents in nursing facilities had untreated tooth decay and 27% of residents needed immediate periodontal treatment, available at www.centerfororalhealth.org/wp-content/uploads/2018/11/Oral-Health-of-Older-Adults.pdf.

health care would take the responsibility of the patient to attempt to navigate these conversations and complex treatment plans during a health crisis and would lead to better access to care. We urge CMS to provide updated policies and guidance to make clear that reimbursable care management services are applicable and expected to be utilized to deliver "medically necessary" dental services.

D. The rule should permit "general supervision" of dental hygienists/therapists

Under the proposed rule, CMS includes language throughout regarding "direct supervision" of auxiliary personnel, including for example dental hygienists and dental therapists.[12] Direct supervision unduly hinders the provision of "medically necessary" dental services by these licensed professionals. In particular, direct supervision would limit the extent to which these licensed professionals could extend the availability of "medically necessary" dental services into congregate residential and community-based settings that would help to address known disparities in access to dental services for these populations. We recommend that CMS adopt the more appropriate standard of "general supervision" that is referenced in the proposed rule as services "furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service."

E. Potential future payment models for dental and oral health care services

We appreciate CMS soliciting comments on additional ways to integrate the payment for dental and health care services using the Innovation Center's waiver authority. We encourage CMS to consider a model to improve oral health outcomes in residential care settings like nursing facilities as well as for Medicare enrollees with disabilities who utilize home and community-based services. These populations are disproportionately communities of color, more likely to have multiple chronic conditions, and more likely to have poor oral health. Such a demonstration could provide valuable information on the impact of a robust package of oral health services on both enrollee health outcomes and on Medicare savings from the inclusion of oral health care.

Thank you again for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at achrist@justiceinaging.org.

Sincerely,

Amber Christ
Managing Director, Health Advocacy

[12] See, e.g., NPRM, 87 Fed. Reg. 46036 (July 29, 2022): "Medicare payment could be made for services furnished incident to the professional dental services by auxiliary personnel, such as a dental hygienist, dental therapist, or registered nurse who is *under the direct supervision* of the furnishing dentist or other physician or practitioner, if they meet the requirements for "incident to" services as described in § 410.26 of our regulations."