National Rural Health Association

NRHA Comments on the Proposed Oral Health Benefits under Medicare

The National Rural Health Association (NRHA) appreciates the opportunity to comment on the dental benefit under Medicare in rural communities. NRHA is fully supportive of the goal of enacting oral, vision, and hearing benefits for rural seniors. Specifically, we support the standard benefit for Medicare being placed under the Part B. The following outlines two primary areas of concern as the benefit is developed in the context of the landscape.

Oral Health Billable Workforce

Compared to their urban counterparts, adults in United States (U.S.) rural locations have higher rates of dental caries and permanent loss of teeth.[1] The lower availability of dentists in rural communities is a likely contributor to this situation. Oral health care workforce shortages in rural areas are a well-known, documented phenomenon. As of June 2021, over 62 percent of dental Health Professional Shortage Areas (HPSA's) are located in a rural area, requiring over 3,300 practitioners to fill the known need.[2] **As such, it will be critical that mid-level oral health practitioners such as dental hygienists, dental therapists, etc. are allowed billable providers under the Medicare benefit.**

Workforce shortages have placed a burden on providers across the country, but particularly in rural America. Doctors and other primary care practitioners hard to obtain in these communities, but dentists are even more difficult. In locations in which the population or economic base is not sufficient to support dentist practice, preventive interventions could include increased use of advanced dental hygiene practitioners or community dental health coordinators.[3] Allowing mid-level oral health practitioners to practice is critical to rural beneficiaries' ability to access a dental benefit. Many predominantly rural states have already made scope of practice changes that allow mid-level oral health practitioners, such as dental therapists, dental hygienists with direct access, and the practice of teledentistry, to assist in expanded access to dental care under Medicaid and other payers. For example, dental therapists are currently recognized in 13 states and two territories as an additional provider for specified dental services in the dental office or other approved practice sites.[4] These professionals typically work with rural and underserved populations to improve access to needed dental services. More can be learned about state scope of practice policies at https://scopeofpracticepolicy.org/practitioners/oral-health-providers/.

Medicare Dental Services Through Rural Health Clinics

As you know, the Rural Health Clinic (RHC) program is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities. To receive certification, they must be located in rural, underserved areas. They are required to use a team approach of physicians working with non-physician providers such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) to provide services. The clinic must be staffed at least 50% of the time with an NP, PA, or CNM. RHCs are required to provide outpatient primary care services and basic laboratory services. **In order for**

[1] http://depts.washington.edu/uwrhrc/uploads/RHRC_FR135_Doescher.pdf
[2] file:///C:/Users/Carrie/Downloads/BCD_HPSA_SCR50_Qtr_Smry.pdf
[3] http://depts.washington.edu/uwrhrc/uploads/RHRC_FR135_Doescher.pdf
[4] https://scopeofpracticepolicy.org/practitioners/oral-health-providers/sop/dental-therapists

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RHCs to be able to participate in the Medicare dental, vision, and hearing benefits, the appropriate provider types will need to be included in the RHC authorizing statute at 1861 (aa) (1) (B) of the Social Security Act.[5] Similar to the above comment, NRHA recommends the full range of mid-level practitioners associated with these services are included as allowable providers.

The main advantage of RHC status is enhanced reimbursement rates for providing Medicare and Medicaid services. Unlike other rural physicians, who are paid on the fee schedule, or Federally Qualified Health Centers, who are paid on a PPS rate, RHCs are reimbursed an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.[6]

NRHA recommends that preventive services under the Medicare dental benefit be paid as part of the RHC AIR. However, when it comes to more complex procedures involved with restorative care or DME (such as dentures) we believe it would make sense to pay for these through a fee schedule.

Very few RHCs currently provide oral health services.[7] Given the staffing and equipment costs associated with adding new oral health service lines, it is likely to not be financially feasible to include anything more than preventative services under the AIR caps of $100 as April 1, 2021 (increasing to $190 in 2028).

Congress could incentivize greater RHC participation by reassessing the December 2020 Consolidated Appropriations Act (CAA), 2021, which imposed changes to RHC payment methodology, particularly as it relates to provider-based (PB) RHCs. By subjecting all new provider-based RHCs to an upper payment limit (those created after 12/31/20) and tying those that were eligible for grandfather status to their 2020 rates, NRHA believes it won't be financially viable to bring on this benefit beyond preventive services. Simply put, reimbursing dental visit beyond preventive services at the $190 upper payment limit come 2028 doesn't seem reflective of the true cost of ramping up and providing services.

Technical Assistance for Rural Oral Health Providers

NRHA is concerned that rural providers more broadly, but RHCs in particular, may be slow to take up a dental practice in their facility. Rural providers operate on tight margins. Reimbursement concerns are among the top we've heard from our members (as described above), but we've also heard concerns about footing the bill for initial capital (devices, chairs, etc.). **NRHA recommends Congress consider a grant program for rural providers to invest in the capital needed to operate a dental benefit.** These funds could be provided through the existing Medicare Rural Hospital Flexibility Program, which works with rural providers including RHCs. It could also be modeled off the Rural Health Innovation Act introduced by Senator Hickenlooper this summer. His legislation creates innovation grants for rural health providers to expand urgent care services. NRHA believes something similar could be created to allow rural providers to expand dental services.

[5] https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
[6] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralHlthClinfctsht.pdf
[7] http://muskie.usm.maine.edu/Publications/rural/WP44/Rural-Health-Clinics-Safety-Net.pdf

Additionally, phasing of the oral health benefit will be critical. We understand that this may take time for CMS to fully implement, but rural providers need to begin preparing now to meet pending demand. In additional to capital support, NRHA recommends Congress consider a cost-plus approach to allow rural providers to build their service structure. This could be done in a manner that providers would receive a percentage add-on payment which phases out after some time. The current financial state of most rural providers may not be conducive to uptake of this benefit, but if the proper policies are put in place at the forefront, they may be better equipped to provide Medicare dental services in the long-run.