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House Passes HSA and FSA Legislation-More Action Needed

On July 8, the House passed legislation (HR 1270) expanding the role of HSAs and FSAs as options for managing health care expenses. The bill would, among other things, expand HSA contributions by
allowing families and individuals to contribute an amount equal to the combined annual limit on out-of-pocket and deductible expenses under their HSA-qualified insurance plan. It also repeals the Affordable Care Act’s (ACAs) prohibition on the use of HSAs or FSAs to cover over-the-counter expenses. Under the provision of this legislation, these tax changes would be funded through the use of money recouped from those who no longer qualify for ACA insurance subsidies.

Enacting federal legislation that allows for the expanded use of FSAs/HSAs has been a priority for AAOMS during the past two years, and while this legislation is a step in the right direction, we encourage you to urge Congress to consider the broader FSA and HSA reforms included in HR 1185 and HR 1196, respectively.

Congress Sends Comprehensive Opioid Abuse Package to President Obama

Congress passed a final comprehensive opioid abuse package before adjourning for their summer recess. The bill (S 524), which was the result of an agreement between a House and Senate Conference Committee tasked with reconciling different versions of opioid abuse legislation, passed the two chambers in the spring. It authorizes various grants to states for opioid abuse prevention and treatment activities, and establishes an interagency taskforce, which will include a dentist to determine best practices for pain management and prescribing. The bill also includes language that would clarify federal law to allow for the partial filling of prescriptions for Schedule II drugs. AAOMS sent letters of support for the original bills (HR 4599/S 2578) introduced by Rep. Katherine Clark (D-MA) and Sen. Elizabeth Warren (D-MA), respectively. Democrats concerned that the legislation does not guarantee funding for the programs it creates, originally threatened to block the bill’s passage. Republicans have pledged to provide adequate funding through the appropriations process. The House passed S 524 on July 8, by 407-5 vote, while the Senate passed it on July 13 by a 92-2 vote. President Obama is expected to sign the bill.

State Affairs

States Pass Prescription Drug Laws

The governors of New Hampshire and Vermont recently signed legislation related to the prescription of controlled drugs in their states. Both states’ bills require the dental board and other regulatory boards to establish guidelines or rules for prescribing controlled drugs. They also require practitioners to utilize the state’s PDMP. The New Hampshire bill (HB 1423) will require providers to complete a patient evaluation and prescribe at the “lowest possible effective dosage,” while the Vermont bill (S 243) will require practitioners to complete 2 hours of CE on topics related to opioid prescriptions. Vermont further establishes an advisory council, which includes a dentist, to assist the Commissioner of Health with this issue. OMSs are advised to brush up on their individual state requirements and pay attention to notices from state departments with jurisdiction over controlled substances. If you have any questions regarding your state’s requirements, please contact your state dental board.

Louisiana Passes TMJ Coverage Mandate
Louisiana Governor John Bel Edwards (D) signed legislation (SB 476) requiring insurance coverage in the large group market for diagnostic, therapeutic or surgical procedures related to the TMJ under the same requirements as treatment for other joints or bones. The bill will apply to plans issued after January 1, 2018, and was championed by the Louisiana Dental Association.

**Health Information Technology**

**Michigan Considers Removing CON Requirements for CBCT**

The Michigan State Certificate of Need Commission has preliminarily approved the removal of CBCT machines from the state’s certificate of need (CON) process. The 10-year rule currently requires dentists to secure a CON prior to purchasing a CBCT machine in the state, but opponents argue that requirement creates an unnecessary burden and limits patient access. A final vote on this proposal will be taken on September 21. The Michigan Dental Association also introduced legislation to exempt CBCT from the CON law during the current legislative session. If this rule change is approved, the bill will no longer be required.

**CMS Institutes 90-Day EHR Reporting Period in 2016**

CMS proposed a rule that states the 2016 EHR reporting period for all eligible professionals will be any continuous 90-day period, rather than the current full calendar year. The announcement continues a policy originally enacted in 2015 that allowed health care providers to accommodate changes to the EHR program that were not finalized in rulemaking until the end of 2015. CMS hopes that continuation of the program will assist health care providers by increasing flexibility in the program. Comments on this proposal are being accepted until September 6, 2016.

**Practice Management**

**Important Highlights in the Medicare Payment Reform Proposed Rule**

On April 27, CMS released a proposed rule providing the framework for the new Quality Payment Program, which implements key parts of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and replaces the current Medicare fee-for-service program. The AAOMS will update members and their staff once the final rule has been released.

In the interim, it’s important to know that the proposed Quality Payment Program has two paths:

1) The Merit-based Incentive Payment System (MIPS) which streamlines the multiple quality reporting programs; and

2) Advanced Alternative Payment Models (APMs).

**Merit-Based Incentive Payment System (MIPS)**
The MIPS is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier, and the Medicare Electronic Health Record (EHR) incentive program into a single program in which Eligible Professionals (EPs) will be measured and reimbursed on their use of the following:

- **Quality** - 50% of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program
- **Resource Use** – 10% of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use
- **Clinical Practice Improvement** – 15% of total score in year 1
- **Meaningful Use of Certified EHR Technology** - 25% of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as “Meaningful Use”

**Alternative Payment Models (APMs)**

APMs offer new, alternative ways to reimburse providers for the care they give Medicare beneficiaries. For example:

- From 2019-2024, participating health care providers will be given a lump-sum incentive payment.
- Increased transparency of physician-focused payment models.
- Afterwards they will offer some participating health care providers higher annual payments.

Accountable Care Organizations (ACOs), Patient Centered Medical Homes, and bundled payment models are some examples of APMs.

As with the current PQRS program, CMS proposes to continue monitoring claims data to determine each provider’s quality performance efforts and resource use. If a provider reports fewer than six measures and CMS identifies that the provider could have reported more, CMS will provide a zero performance score. CMS proposes to require that all Medicare Part B providers report through MIPS during the first performance year, which begins January 2017. The first payment year for MIPS will be 2019, based on the first performance period of 2017. Medicare Part B providers may be exempted from the payment adjustment under MIPS if they:

- Are newly enrolled in Medicare;
- Have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients; or
- Are significantly participating in an Advanced Alternative Payment Model (APM).

CMS proposes to make a provider’s Quality Payment Program results available on the Physician Compare website to help patients make informed choices. A 30-day preview period will be provided in advance of publishing this information so that providers may review and submit corrections.

For more information, CMS has released a number of different fact sheets and other resources to explain the proposed changes:

**MACRA: (includes MIPS and APMs)**

- CMS’ draft plan to transition to MIPS and APMs
- MACRA timeline
- Listening Sessions
- Fact Sheet for Small Practices
- Quality Payment Program website.