Access to Care – Oral and maxillofacial surgery is a unique dental specialty confronted by a number of issues that impact our ability to provide quality care for our patients. Nationwide media coverage in 2007 of a Maryland boy’s death resulting from an untreated abscessed tooth has highlighted the need to expand basic dental coverage to the nation’s uninsured and underinsured children as well as to low-income individuals. AAOMS encourages members of Congress to ensure oral health care services are given the utmost consideration in legislative proposals and actions when addressing access to care issues and supports legislation such as the Action for Dental Health Act of 2015 (HR 539) which seeks to improve essential oral health care for low income individuals by breaking down access to barriers.

Insurance Coverage for Children with Craniofacial Anomalies - Craniofacial anomalies affect an estimated one in 600 children in America every year. However, corrective procedures to address these anomalies are not always covered by private insurers because they might be classified as cosmetic. AAOMS supports the introduction of legislation such as the Children’s Access to Reconstructive Evaluation and Surgery Act (CARES Act), which was last introduced in the 112th Congress. The CARES Act would require insurance companies, including ERISA plans that already provide surgical benefits, to cover corrective procedures that address congenital craniofacial anomalies for children age 21 and under.

Physical Therapy Referral for Medicare Patients - Section 1861(p)(1) of the Social Security Act prohibits dentists from referring their Medicare patients for outpatient physical therapy services. Oral and maxillofacial surgeons are doctors of dental medicine or dental surgery who regularly treat patients with medical conditions that would benefit from physical therapy. AAOMS supports the introduction of legislation such as the Medicare Oral Health Rehabilitative Enhancement Act, last introduced in the 112th Congress. This legislation would make a technical fix to the existing Medicare statute to allow oral and maxillofacial surgeons to refer Medicare patients for physical therapy.

Drug Shortage Prevention – Oral and maxillofacial surgeons are among the health care providers who administer and prescribe essential drugs on a daily basis. This is especially true as it relates to anesthesia and sedation drugs like Propofol and Versed. However, providers are among the last to know when an essential drug will be in short supply or no longer available. AAOMS appreciates Congress’ past efforts to address this issue in the Food and Drug Administration Safety and Innovation Act (P.L. 112-144). We support congressional oversight of the Food and Drug Administration’s implementation of the law’s drug shortage provisions, as well as any other congressional efforts to address contributing factors to the drug shortage issue not addressed by the law.

Medicare Independent Payment Advisory Board (IPAB) - The AAOMS joins other health care providers in having concerns about the IPAB, a 15-member board established by the Affordable Care Act (ACA) as a cost control mechanism for the Medicare program. Its stated task is to advise Congress on how to curb the per capita growth of Medicare spending if that spending exceeds growth rate targets set by the ACA. However, the board is inherently problematic, adversely independent, and completely unaccountable. Furthermore, the IPAB’s recommendations have the very real potential for making indiscriminate cuts to Medicare that would negatively affect patients’ access to healthcare. AAOMS supports legislation introduced in the 114th Congress such as the Protecting Seniors' Access to Medicare Act (HR 1190/S 141), which would repeal the IPAB from the Affordable Care Act.

Prescription Drug Abuse – Several bills to address the growing abuse of prescription drugs have been introduced in the 114th Congress. AAOMS supports the idea that our members can be part of the solution to this problem, as evidenced by the association’s involvement in the Medicine Abuse Project, but we do not support unnecessarily inhibiting our ability to effectively treat real patient pain.
Technology & Research

NIDCR Funding – The National Institute for Dental and Craniofacial Research (NIDCR) conducts nearly 85% of the research for oral disease and conditions. NIDCR is essential to conducting investigative studies necessary for the advancement of oral and maxillofacial surgical and other dental-related procedures and treatment modalities that will improve health care outcomes for all Americans. **AAOMS supports increased NIDCR funding, which helps sponsor such research projects as wound healing, pain management, tissue engineering, and minimally invasive surgery for maxillofacial trauma.**

Practice Administration Reform

Antitrust Reform – The McCarran-Ferguson Act is a federal law that exempts insurers from federal antitrust laws, so long as they are regulated by the states. Since McCarran-Ferguson’s enactment, there has been insufficient competition in the health insurance marketplace, impairing health care providers and consumers. Unfortunately, states do not have the resources to take action against health insurers that break antitrust laws. Amending the McCarran-Ferguson Act, thereby involving the federal government in antitrust enforcement, would increase competition in the health insurance marketplace which would drive health plans to compete more aggressively for purchasers, creating policies with low premiums yet robust benefits. **AAOMS supports legislation such as the Competitive Health Insurance Reform Act (HR 494) which would amend the McCarran-Ferguson Act to revoke the exemption from federal antitrust law for health insurers.**

Medical Device Tax – The Affordable Care Act (ACA) included a provision that levies a 2.3% excise tax on medical devices to be collected at the point of sale. The tax is levied in addition to the sales tax currently placed on such devices. The tax was originally intended to raise revenue from the medical device industry to help pay for the cost of the ACA’s expanded access to care; however a large number of healthcare providers, including oral and maxillofacial surgeons, utilize many of the devices and supplies subject to this tax on a daily basis. **AAOMS appreciates the two-year moratorium on the collection of the tax enacted by Congress in 2015; however, we continue to support a permanent, full repeal.**

Medical Malpractice Reform – The current civil justice system, with its costly and ineffective system for resolving claims of health care liability and injury compensation, is adversely affecting patient access to health care services, the quality of patient care, and the overall cost-efficiency of health care. The current liability system has also increased the prevalence of “defensive medicine” as well as the cost of health care liability insurance. The resulting financial strain has forced some practices to close their doors or relocate, leaving patients behind. **AAOMS supports legislation such as the Medical Care Access Protection (MCAP) Act in the 113th Congress, which would provide for health care liability reforms.**

Physician Quality Reporting – There is growing interest in tying Medicare physician and hospital reimbursement to incentives for improved quality of care. As the primary dental specialty affected by Medicare quality improvement initiatives, oral and maxillofacial surgeons remain committed to the delivery of high quality and efficient care. **The AAOMS advocates, however, that any quality performance incentive system should ensure the continuation of quality care for patients relying on the Medicare program, without compromising the relationship between the patient and the provider.**

Uncompensated Care – The Emergency Medical Treatment and Labor Act (EMTALA) requires physicians to treat patients regardless of their ability to pay. As such, physicians, including oral and maxillofacial surgeons, taking trauma calls can end up providing thousands of dollars each year in uncompensated care. **AAOMS supports legislation that would allow physicians, including OMSs, to offset some of those costs through a tax deduction for the cost of providing such care.**

Balance Billing – Providers who choose not to participate in either Medicare or private insurance plans are not able to receive their full fee-for-service payment even if patients are aware they are seeing a non-participating provider. **AAOMS supported legislation such as the Medicare Patient Empowerment Act in the 113th Congress, which seeks to remove limiting charges under the Medicare program for non-participating physicians with beneficiary notice, and to preempt state laws that prohibit balance billing.**

“Meaningful Use” – Starting in 2015, Medicare providers who fail to adopt certified electronic health records and demonstrate “meaningful use” face a reduction in their Part B reimbursement. **AAOMS supports any efforts to delay the “meaningful use” penalties for providers who are already facing significant regulatory burdens on their practices.**