



American Association of Oral and Maxillofacial Surgeons Additional Federal Legislative Issues of Interest

Patient Access to Care

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, last introduced in the 114th Congress 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 FDA’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 115th Congress such as the Protecting Seniors' Access to Medicare Act (H.R. 849/S. 260), which would repeal the IPAB from the Affordable Care Act.**

Prescription Drug Abuse – OMSs are very conscious of the opioid abuse epidemic and the unfortunate and unintended consequences it has taken on some patients. **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

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 as provided for in H.R. 184/S. 108.**

Non-Covered Services - 39 states currently have laws that prohibit insurers from setting fees on what providers can charge for a service – even if the service is not typically covered and not subject to insurer reimbursement; however, these laws do not apply to federally-regulated plans, such as ERISA plans. **AAOMS supports legislation such as the Dental and Optometric Care Access Act, last introduced in the 114th Congress that would prohibit federally- controlled health care plans (such as ERISA plans) from capping fees on non-covered vision and dental services.**

Quality Payment Program – 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.**