American Association of Oral and Maxillofacial Surgeons
Additional Issues of Interest for the 113th Congress

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 Coordination of Pro Bono Medically Recommended Dental Care Act (HR 963/S 466), which would award grants to coordinate the provision of medically recommended dental care to eligible low-income individuals by volunteer dentists.

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 introduction of legislation such as the Children’s Access to Reconstructive Evaluation and Surgery Act, or the CARES Act, which was introduced last Congress by Rep. Patrick Tiberi (R-OH) and Sen. Mary Landrieu (D-LA) under bill numbers HR 1955/S 1045. 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 legislation such as the Medicare Oral Health Rehabilitative Enhancement Act, which was introduced last Congress by Reps. Dave Reichert (R-WA) and Bill Pascrell (D-NJ) under bill number HR 2863. 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, they 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. 112-108). 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 IPAB is 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 such as the Protecting Seniors’ Access to Medicare Act (HR 351/S 351), 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 113th Congress. These include legislation to reclassify hydrocodone-containing products as Schedule II from Schedule III (H.R. 1285/S. 621), modify the approval of drugs containing controlled-release oxycodone hydrochloride and limit their use for the relief of “severe-only” pain (H.R. 1366), and increase prescriber education requirements (H.R. 672/S. 348). 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.

**Flexible Spending Accounts (FSAs)** - In the current health care environment, hundreds of thousands of Americans—many of whom have middle-class incomes and are without access to dental insurance—rely on FSAs to cover rising out-of-pocket health care costs. Many dental procedures that are provided by oral and maxillofacial surgeons can exceed the $2,500 annual FSA contribution maximum set by the Affordable Care Act (ACA). This restriction forces some patients to forgo necessary dental care. **AAOMS supports legislation such as the Family Health Care Flexibility Act (HR 1248/S 610), which would repeal the restrictions that the ACA put on FSAs and strike the cap on contributions to FSAs.**

**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 Malpractice Reform** – The current civil justice system, with its costly and ineffective health care liability 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 (S 44), which would provide for health care liability reforms.**

**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 supports legislation such as the Medicare Patient Empowerment Act (HR 1310/S 236), 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.**

**Medicare Physician Reimbursement Reform** – Nearly every year, Congress has to pass legislation to prevent Medicare physician reimbursement cuts from taking effect due to the flawed sustainable growth rate formula (SGR). Oral and maxillofacial surgery is one of the few dental specialties that provides Medicare services. The current Medicare formula, based on the SGR, is inherently flawed, creates disruptive payment delays, and should be reformed. **AAOMS supports the elimination of the SGR system and is carefully evaluating legislative proposals that repeal and replace the SGR system with incentives for the adoption of innovative payment and delivery models under the Medicare program.**

“**Meaningful Use**” – Starting in 2015, Medicare providers who fail to adopt certified electronic health records and demonstrate “meaningful use” will 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.**