Advocacy Council:
Who we are and what we do.

James M. Tracy, DO FACAAI

Treasurer, ACAAI

Immediate Past Chair - Advocacy Council of the ACAAI

American College of Allergy, Asthma & Immunology

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The Advocacy Council is like air-conditioning on a hot summer day - only missed if we're not working!

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Objectives

At the end of this discussion participants will be able to:

- Who is the Advocacy Council of the ACAAI?
- Understand what is a physician advocate and who we advocate for?
- What are the critical issues currently being faced by providers and patients and how do advocate to address them?
- How is the ACAAI Advocacy Council doing their job?
- How can you be a Physician Advocate?
- Understand the efforts of the ACAAI in response to the COVID-19 Pandemic.
- Hot topics on the horizon

The Advocacy Council: Who Are We?

- The group formerly known as the JCAAI.
  - Transition in 2015
  - Structurally independent
- House of Delegates & Practice Management Committee now under same umbrella.
- Current Officers and Staff:
  - Warner W. Carr, MD, FACAAI – Chairman
  - Travis A. Miller, MD, FACAAI – Vice chair
  - James M. Tracy, MD, FACAAI – Immediate Past Chairman/Treasurer of ACAAI
  - James Sublett, MD, FACAAI - Executive Director of Advocacy and Governmental Affairs
  - Gary N Gross, MD, FACAAI – Coding Consultant
  - Sue Grupe - Director of Advocacy Administration

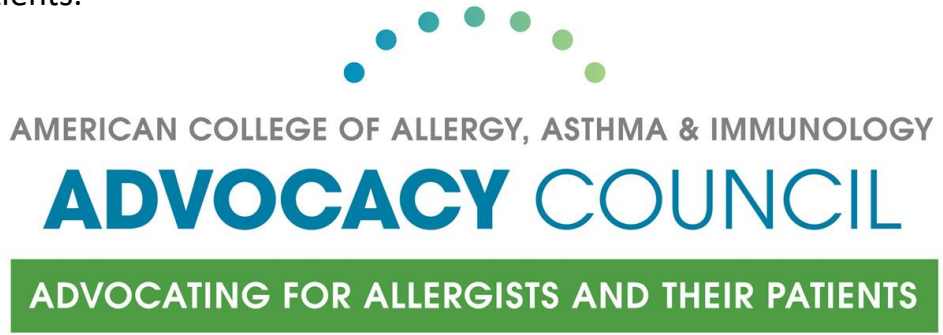
Board Members	
Mark Corbett, MD – ACAAI President	Purvi Parikh, MD
Alnoor Malick, MD	M. Razi Rafeeq, MD – HOD Speaker
Kathleen May, MD – ACAAI Pres. Elect	Melinda Rathkopf, MD
Dane McBride, MD	

The Advocacy Council: Who Are We? Behind the Scenes… Lobbying

- **What is lobbying?**
  - Defensive lobbying – Watch for important legislation both nationally and locally
    - Use and access the critical tools for surveillance
  - Offensive lobbying –
    - Understand how regulations on a state and national level are developed
    - Legislative and policy making structure and help with accessibility to address relevant concern – i.e. Advocate for our patients and us
- **The ACAAI Team**
  - Capitol Associates, Inc.
    - Mr. Bill Finerfrock
    - Matt Reiter
    - Weekly updates – i.e. COVID-19 Federal response
  - Legal Support
    - Becky Burke, JD and Leela Bagget, JD

We had a make over this year….

- A redesigned logo and new tagline for the new year
- Part of the College's Vision Forward Strategic Plan
- Forecasts our philosophy to stakeholders, and, ultimately, elevate the profile of the Advocacy Council.
- Supports the advancement of the specialty and meets the needs of the practicing allergists/immunologists
- Stands for a fresh and expanded commitment in the College's ongoing efforts to represent you and your patients.



What is a Physician Advocate?

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- As physicians, we often find ourselves at the crossroads of a unique and sometimes intimate knowledge of patient needs.
- This places us at a point with the ability to leverage influence on health care system delivery, social barriers, and even impact political policy.
- We need to be very familiar with both patient needs and incorporating social factors of health into patient care.
- Understanding and adapting to an ever-changing healthcare landscape is critical.
- Understand healthcare model as well as front line challenges
- Ensure practice financial viability, especially in the private practice arena

Who are we advocating for?

- First and for most we advocate for our patients…
  - Access to primary care
  - Access to specialty care
  - Affordable Medications with adequate reimbursement and coverage
  - Transparent and affordable coverage
- Second for our Community
  - Understand our community and its specific needs
- Third for ourselves and our Specialty
  - Physician often carry significant debt burdens
  - Adequate reimbursement
  - Recognition of differing population mixes
    - Urban, Suburban, and rural differences
- Make a living so as continue to address our patient and community responsibilities

Critical issues currently faced by allergists and our patients

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1. Reducing Prior Authorization Burdens.
2. Maintaining Telehealth coverage/payment policies post pandemic
3. Fixing the Good Faith Estimate provisions in the No Surprises Act to reduce provider burden
4. Advocating against Medicare reimbursement cuts for allergists
5. 95165 issues(dose limitations)

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No Surprises Act

- December 2020 congress passed the No Surprises Act (NSA)
  - intended to protect patients from unexpected out-of-network (OON) “surprise” medical bills for care provided at an in-network hospital.
  - creates an arbitration process called Independent Dispute Resolution (IDR) to resolve payment disputes
  - Also includes an advanced explanation of benefits (AEOB), which requires providers to send their good faith estimate to the patient’s health plan.
- Surprise billing protections do not apply to OON care furnished in the physician office setting.
  - included some provisions that apply broadly across the healthcare system to help patients better understand the cost of their care.
- Requirement to provide uninsured or self-pay patients with a “good faith estimate” (GFE) for the cost of their care
  - either upon request by the patient or when the patient schedules care.
  - GFE is intended to provide price transparency for uninsured patients and to allow insured patients to compare the self-pay price to their out-of-pocket costs if the bill was submitted to their health plan.
- GFE requirement took effect January 1, 2022
- Administration will not implement some of the more challenging parts of the GFE requirement for at least a year.
  - This is an area of active involvement for the AC

No Surprises Act

- Allergy practices are responsible for complying with the good faith estimate (GFE) for care they reasonably expect to provide to uninsured and self-pay patients.
- The Centers for Medicare and Medicaid Services (CMS) published a GFE template form for practices to use.

https://omb.report/icr/202109-0938-015/doc/115259501

- Of note, the Department of Health and Human Services (HHS) has the authority to expand these protections to other health care settings.
- In a circumstance where NSA applies, the patient's in-network cost-sharing would apply to OON care.
- Cost-sharing on OON care would count towards the annual deductible and out-of-pocket premium.

No Surprises Act

- Providers are prohibited from balance billing the patient for more than their cost-sharing.
- Cost-sharing is not based on the providers' OON charge.
  - based on the qualifying payment amount (QPA), which is defined in the regulation as the health plan's median in-network rate as of January 31, 2019 indexed to inflation.
- The second component is a requirement to provide an advanced "good faith estimate" (GFE) of the anticipated cost for care to uninsured and self-pay patients either upon request or when scheduling care.
- **This provision applies essentially to all health care providers**.
- Self-pay patients have insurance but choose not to have the bill submitted to their health insurance and pay out-of-pocket instead.

Good Faith Estimates

- Many practices already provide cost estimates to patients upon request this policy establishes a timeline.
  - If an uninsured or self-pay patient requests a GFE, the provider has 3 business days to issue the GFE.
  - If an uninsured or self-pay patient schedules care at least 10 business days in advance, the provider has 3 business days to issue the GFE.
  - If an uninsured or self-pay patient schedules care at least 3 business days in advance, the provider has 1 business day to issue the GFE.
  - If an uninsured or self-pay patient schedules care less than 3 business days out, then the provider is not required to issue an uninsured or self-pay GFE.

Good Faith Estimates

- The GFE must include services that the provider “reasonably expects” to provide – the specific costs estimates – with service codes.

- The GFE should also “include the period of time during which any facility equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services that would not be scheduled separately by the individual, are furnished.

- It is the intent of this definition of ”period of care” to clarify that the good faith estimate should include all of the items or services that are typically scheduled as part of a primary item or service for which an individual does not need to engage in additional scheduling.”

- It also aims to provide patients with the ability to compare their health plan’s price with the self-pay price while providing greater price transparency for uninsured patients.

Good Faith Estimates

- Eventually, CMS expects the GFE to include connected care and allergists will need to coordinate with other practices as either the convening provider or the co-provider.
- CMS has delayed enforcement of the requirement for health plans to provide patients with an advanced explanation of benefits (AEOB).
- The AEOB must include the GFE, meaning providers will need to coordinate with the patient's health plan to provide the GFE information necessary for the health plan to comply with the AEOB requirement.
- The NSA also provides patients with some recourse if their bill "substantially" exceeds their GFE. Patients can challenge a bill that exceeds the GFE by $400 or more using a newly established arbitration process modeled off the NSA's IDR process for "surprise" bills.
- The Advocacy Council is developing a comprehensive overview of the GFE that will be available soon.
- CMS has a website dedicated to the NSA with additional resources.

Medicare cuts

- The Advocacy Council, along with other organizations, has been successful in advocating for legislation to alter Medicare physician payment cuts scheduled to begin Jan 1.
  - The legislation required a recalculation of allergy reimbursements.

- The Advocacy Council developed a spreadsheet that compares 2022 reimbursement and relative value units (RVUs) to 2021.

- RVUs for each CPT code are published annually on the Centers for Medicare and Medicaid Services' (CMS) website.

- Health systems and employers often use these RVUs in their compensation formulas.

- When a service is performed in the hospital setting (e.g., the hospital outpatient department or hospital-based clinic), the RVUs are reduced because the practice expense portion of the service is provided by the hospital.

Medicare cuts

- As a result of legislation enacted by Congress in December 2021, there is a temporary one-year increase in the Medicare physician fee schedule reimbursement of 3% above what was originally proposed for 2022. Unfortunately, this went into effect July 1, 2022
- In practical terms, this means that the previously scheduled 3.75% decrease will result only in a .75% decrease.
- The estimated impact of these and other adjustments on the allergy/immunology specialty is 0.8% overall decrease in Medicare payments for 2022, compared to 2021.
- The same legislation will temporarily delay the looming cuts associated with the Statutory Pay-As-You-Go (PAYGO) legislation, delaying the budgetary impact of legislation enacted in 2021 to 2023.
- The PAYGO cuts were previously set to go into effect at 4% (impacting Medicare and other programs including social services, farm programs, and more) on Jan. 1, 2022.

Medicare cuts – Federal Proposals 2023 PFS

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- Ending of the 3% increase unless Congress passes new legislation to provide another increase.
- A proposed 1.55% reduction to the 2023 Conversion Factor compared to the 2022 Conversion Factor (not including the 3% increase passed by Congress).
- An estimated 2 percent reduction to total RVUs for A/I services in 2023 due to the combined effects of all proposed policies in the PFS.
- Congress needs to pass legislation before the end of the year to prevent a 4% reduction in Medicare payments due to the statutory PAYGO requirement for the American Rescue Plan Act.
- This is all without including payment adjustments due to MIPS, sequestration and rising overhead costs due to inflation.
- However, without Congressional action, the allergy/immunology specialty could see a decrease in Medicare reimbursement of up to 9.5% in 2023.

Medicare cuts: Summary Points of Interest

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We will continue to monitor these issues and keep you informed of developments.

- **Jan. 1, 2022**: Providers will receive a cut of approximately 0.75% in payments from 2021 rates.
- **April 1, 2022**: A 1% Medicare sequester cut goes into effect.
- **July 1, 2022**: The Medicare sequester cut increases to 2%.
- **Jan. 1, 2023: Many cuts come back into effect**:
- The one-year 3% PFS boost expires, resulting in a 3% cut from 2022 rates.
- The 4% cuts to Medicare (and other programs) associated with the PAYGO impact of 2021 legislation kicks-in (plus any additional legislation enacted in 2022).
- To determine the exact amount of your Medicare reimbursement for 2022, you should check your Medicare Administrative Contractor's website for the fee schedule applicable to your geographic area. Updated information is expected to be available on the website soon.

RVU Background

RVUs were developed by CMS about 30 years ago in response to congressional legislation to establish the relative value of physician services. The American Medical Association's Relative Value Update Committee (RUC) proposes RVUs based on specialty society surveys and provides recommendations to CMS for consideration. CMS decides whether it will accept the RUC's recommendations.

Restrictions on 95165: Allergy Extracts

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- CPT definition - Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
- Because of increased utilization, third party payers have been putting annual caps on the units, (e.g., 120/90)
- July 2016, Medicare began making public their MUE's (Medically Unlikely Edits)
  - 95165 is 30 doses
  - Medicare does not follow the CPT definition, instead defines dose as 1ml
  - **Does not pay for diluted vials made from the concentrated vial**
- Many state Medicaid and some private payer's have adopted these policies
- Cigna nationally has raised the limit to 150 after correspondence from the AC

Restrictions on 95165: Allergy Extracts

- Communications we have received recently from members suggest there may still be some confusion as to Medicare rules for allergy immunotherapy billing (CPT Code 95165).
- **There has been no change in Medicare's policy which has been in place for several years.**
- Medicare defines a dose, *for billing purposes only*, as 1cc of extract and it does not pay for diluted vials made from the concentrated vial. This policy is set forth in Ch. 12, Section 200 of the Medicare Claims Processing Manual. It explains that the Medicare payment amount is based on the cost of antigens in one cc of a concentrated or maintenance vial.
- Most Medicaid and private plans have not adopted this policy.
- We continue to believe that payers should follow CPT guidance – which defines a dose as the amount of antigen administered in a single injection from a multi-dose vial or drawn from a treatment board in one syringe.
- If you have concerns that a private plan or Medicaid managed care plan is adopting Medicare's rules, rather than the CPT definition of dose, please contact the Advocacy Council.
  - We may be able to help you address the issue with the payer.

Restrictions on 95165: Allergy Extracts

- Our members continue to experience issues with CPT 95165.
- Most recently, UHC has requested documentation for 95165 claims; members submit the documentation and receive a request for more documentation again and again. Not only are members frustrated, but they aren't being paid, so you can understand the urgency to this request.
- College leadership have spoken Academy leadership and all have agreed to work together to help resolve this issue.
- WE HAVE FORMED A NEW TASK FORCE TO ADDRESS THIS

Prior Authorization

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- Patients can be denied access to their medicine for days, even weeks because of a practice called “prior authorization.” It’s the process whereby insurance companies must approve a physician-prescribed medicine, procedure or test before a patient can get coverage.

- Delays can be frustrating, painful or even dangerous for patients—especially for patients with chronic conditions. Meanwhile, physicians and their staff spend hours filling out multi-page forms and submitting labs and patient records. Even then, approval is not guaranteed. If the insurer denies coverage, patients and their physicians can appeal. But that delays treatment even longer and may not lead to approval.

- Insurers claim prior authorization stops unnecessary use of expensive treatments. But it’s become a cost-cutting tool that makes it hard for patients to access treatment, especially newer, more innovative medicines.

- In some cases, the frustrating process may lead patients to abandon treatment altogether.

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Prior Authorization

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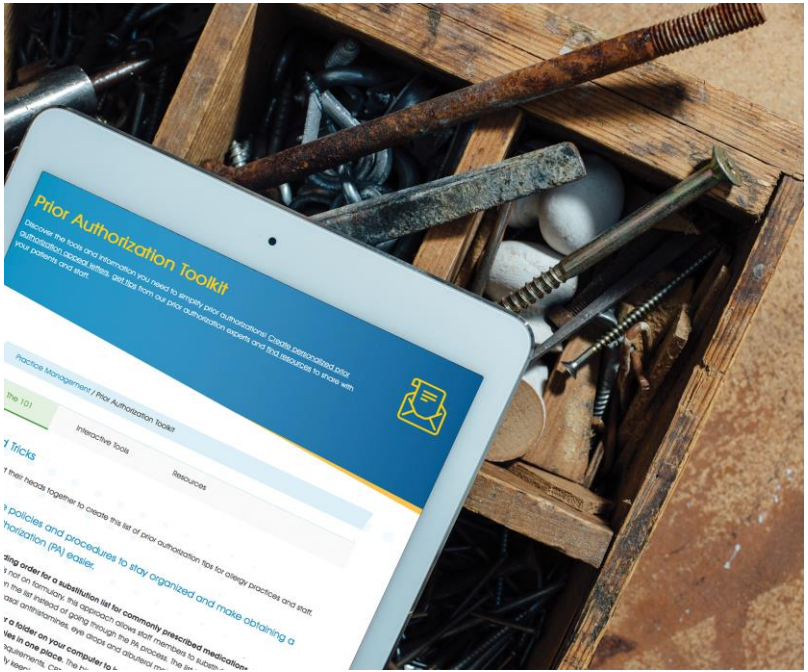
- In some cases, the frustrating process may lead patients to abandon treatment altogether.

- Improving Seniors' Timely Access to Care Act, which has broad bipartisan support in Congress. It would require MA plans to create a process for real-time electronic PA request responses and require MA plans to be more transparent about their PA policies.

Struggling with Prior Authorizations?

- Check out our Prior Authorization Toolkit
- Create customized PA appeal letters in a few easy steps
- 10 different drug/disease combos
- **college.acaai.org/priorauth**



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Step Therapy & PA Issues

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- Advocacy Council joined a coalition that includes several physician and patient organizations in supporting both Federal and State legislation designed to address step therapy issues.
- Ohio has enacted legislation that promises to restrict the ability of insurers to impose unreasonable step therapy requirements.
- Bills are pending in Florida, Georgia, Maine, Massachusetts, New Mexico, Oregon, Rhode Island, Utah and Vermont.
- Close alliance with AfPA
- New Tool Kit on ACAAAI website, partnership with industry

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AfPA | Alliance for Patient Access

Respiratory Therapy Access Working Group

American College of Allergy, Asthma & Immunology

Telehealth and the future of healthcare delivery

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- March 3, 2022 a letter was sent from multiple organizations, to include the ACAAI and AC, to congressional leadership with recommendations for legislation expanding telehealth flexibilities beyond the declared public health emergency (PHE) for the COVID-19 pandemic.
- The Centers for Medicare and Medicaid Services (CMS) and Congress have enacted reforms to expand the use of telehealth during the public health emergency, but we remain concerned that many of these flexibilities are set to expire at the expiration of the PHE, or soon thereafter.
- We urged the federal government to extend these flexibilities, some on a permanent basis, and pass reforms to ensure that our physicians have the tools and resources they need to continue providing increased access to care for their patients through telehealth.
- We support the expanded role of telehealth as a method of health care delivery that may enhance the patient–physician relationship, improve health outcomes, increase access to care from physicians and members of a patient's health care team, and reduce medical.
- Telehealth can be most efficient and beneficial when appropriately utilized in the context of an existing and ongoing patient-physician relationship and can serve as a reasonable alternative for patients who lack in-person access due to circumstantial factors such as transportation limitations or lack of relevant medical expertise in their geographic area.

Telehealth and the future of healthcare delivery

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- Studies have shown the benefits of the use of telehealth.
- Department of Health and Human Services' (HHS) December 2021 report on telehealth use, the number of Medicare fee-for-service beneficiary telehealth visits increased 63-fold in 2020, from approximately 840,000 in 2019 to nearly 52.7 million in 2020.
- A recent study by the Centers for Disease Control and Prevention (CDC) concerning the use of telehealth in health centers suggested that "telehealth can facilitate access to care, reduce risk for transmission of SARS-CoV-2, conserve scarce medical supplies, and reduce strain on health care capacity and facilities while supporting continuity of care."
- An article published by the Commonwealth Fund, notes that "tele- mental health has a robust evidence base and numerous studies have demonstrated its effectiveness across a range of modalities (e.g. telephone, videoconference) and mental health concerns (depression, substance use disorders)."

Telehealth and the future of healthcare delivery

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Extend the Expansion of Telehealth Services Under the 1135 Waiver Authority

- Concerned that some of the telehealth services expanded by CMS under the 1135 waiver authority are set to expire at the end of the PHE.
- These telehealth services allowed Medicare to pay for office, hospital, and other visits furnished via telehealth at a patient's homes and have expanded access to health care for beneficiaries across the country.
- Used by our members to provide evaluation and management (E/M) services to treat chronic conditions and have been a valuable resource to expand access and coordinate patient care.
- **We believe telehealth services should remain in place for at least two years after the end of the PHE to ensure that our physicians are able to continue to use this modality to enhance patient care.**
- We are pleased that Senators Cortez Masto and Young have introduced bipartisan legislation, **S. 3593, the Telehealth Extension and Evaluation Act**, that would extend the telehealth expansions under the 1135 waiver for an additional two years after the end of the PHE. We also appreciate that Representatives Doggett and Nunes have introduced **H.R. 6202, the Telehealth Extension Act of 2021**, that includes a provision to expand 1135 waivers for telehealth services, including Medicare coverage of audio-only telehealth services between physicians and patients, for an additional two years after the PHE declaration expires.

Telehealth and the future of healthcare delivery

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Expansion of Telehealth Services Under the Medicare Physician Fee Schedule

- 2022 Medicare Physician Fee Schedule Final Rule provided coverage through the end of 2023 for all services on the temporary Category 3 list of Medicare-covered services.
- We strongly recommend that Congress enact legislation to ensure the Category 3 list itself is made permanent to provide for a more consistent and efficient on-ramp for new telehealth services to be added.
- Our organizations strongly encourage CMS to add coverage for audio-only E/M telehealth services to the Category 3 list and retain these services until at least the end of CY23.

Comparable Pay for Audio-Only Telehealth Services

- Medicare has covered some audio-only services as if they were provided in-person.
- We are discouraged to learn that CMS will not continue coverage of audio-only telehealth E/M services beyond the PHE, despite mounting evidence about the effectiveness of expanding coverage for these services.
- The abrupt ending of coverage could potentially have negative consequences to access and equitable care, which would particularly impact beneficiaries living in rural areas in addition to those who have transportation and technology limitations.
- Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits.
- These changes have greatly aided physicians who have had to make up for lost revenue while still providing appropriate care to patients.

Telehealth Modifier 93

- Modifier 93 is a new audio-only telemedicine code that went into effect on Jan. 1, 2022.
- Describes services that are provided via telephone or other real-time interactive audio-only telecommunications system.
- Use of this modifier is appropriate only if the real-time interaction occurs between a physician/other qualified health care professional and a patient who is located at a distant site.
- When using modifier 93, the communication during the audio-only service must be of an amount or nature that meets the same key components and/or requirements of a face-to-face interaction.

Telehealth Modifier 93

- Medicare has not issued guidance on the use of modifier 93.
- It is unclear exactly which codes can be used with this modifier for purposes of Medicare reimbursement.
- Medicare added more than 100 CPT codes to the telehealth services list for the duration of the COVID-19 public health emergency (PHE) and also temporarily waived the audio-video requirement for many telehealth services.
- Providers should refer to the policies of other payers to confirm authorized use of modifier 93.
- Modifier 93 (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System) will not be published in the AMA's CPT book until 2023.

Other Recent AC Activities

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- **UHC Xolair Administration Policy**
  - The Advocacy Council and College worked with UHC representatives to clarify policy language and an option for physicians to attest to their patient's continuing administration in their offices.
-
- **Improving Seniors Access to Care Act**
  - We supported legislation to protect patients from unnecessary delays in care by streamlining and standardizing prior authorization in Medicare Advantage plans.
-
- **Supporting the Continuation of Telemedicine**
- **Pediatric Subspecialty Loan Repayment Program (PSLRP)**
  - We joined AAP and other medical organizations dedicated to improving the health of young children and advocated for and received $25 million in funding in fiscal year 2022. Once enacted, the funding will provide much-needed loan repayment to pediatric subspecialists.
- **Strengthening the Vaccines for Children Program Act of 2021**

2019

Authorized reprint for individual use only.
Must be downloaded with registration directly from www.usp.org

USP General Chapter <797> *Pharmaceutical Compounding – Sterile Preparations*

Reprinted from USP 42—NF 37

Links for Supplemental Resources

- Information on USP General Chapter <797>
- USP General Chapter <797> FAQs
- USP General Chapter <797> Education Courses
- Sign up for USP Updates

This text is a courtesy copy of General Chapter <797> Pharmaceutical Compounding – Sterile Preparations, intended to be used as an informational tool and resource only. Please refer to the current edition of the USP-NF for

USP Chapter 797 revision

- Allergen extract is restored as a separate section of the proposed chapter.
- Confirmed previous allergen extract compounding requirements
  - Personnel training and evaluation.
  - Hygiene and garbing.
  - Updated documentation requirements.
- Dedicated Allergenic Extracts Compounding Area (AECA)
- BUD (by use date) remains 12 months

USP: Allergenic Extracts Compounding Area (AECA)

- The requirements for an AECA include:
  - Dedicated area
  - No carpeting
  - Impervious surfaces
  - No outside doors or openable windows
  - A visible perimeter
  - Additional reasonable expectations for sterile compounding in the physician office
- Documentation requirements for:
  - Compounding procedures
  - Temperature logs for refrigeration
  - Prescription set documentation
- Laminar flow hood was not required

Key points of the USP Chapter 797 revision

- Compounding staff will be required to be trained and regularly evaluated on aseptic and compounding technique (mostly reflecting existing requirements)
- Additional requirements
  - Fingertip testing
  - Thumb sampling
- BUD (by use date) remains 12 months
- Large compounders may oppose our separate section
- What happens if I don’t participate in USP?

Our Allergen Extract Mixing toolkit – everything you need to implement the new USP 797 rule!

college.acaai.org/extract

- Step by step guides
- Staff competency assessments
- How to implement the new standards webinar
- Allergen Extract Quiz
- FAQs, logs, forms and more

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A day in the life of the Advocacy Council

- The Advocacy Council notified College members after becoming aware of a United HealthCare (UHC) policy change that would require the home administration of Xolair, effective Oct. 1.
- We sent a comment letter that identifies reasons self-administration is not appropriate for all patients.
- We also developed sample talking points and encouraged all College members to join our grassroots effort. Our efforts made a difference.
- UHC responded the next day and explained that providers can attest that self-administration is not appropriate for every patient and that this should be considered on a case-by-case basis.
- They also confirmed that the new policy change was only “specific to UHC commercial plans” and that “coverage policies under UHC MedicareAdvantage and Community Plans **may differ**.”
- As a result of our efforts, UHC agreed to **evaluate revisions** made to the commercial plans policy.
- This is another great example of our advocacy at work.

Advocacy Council Strike Force: May 6-8, 2019

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- Held in conjunction with AAN Capitol Hill Day
  - Used shared talking points for both groups.
  - Joined by the Executive Vice president and President of the Academy.
- Appointments with Key decision makers:
  - HHS Secretary Azar's Staff
  - House Energy and Commerce Committee (Majority)
  - Senate Finance Committee (Majority)
  - House Ways and Means Committee (Minority)
  - Senate HELP Committee (Majority)
  - Rep. Morgan Griffith (VA) - Thank you for USP help
  - Rep. Ro Khanna (CA) – Thank you for Food Allergy research funding

Advocacy Council Strike Force: May 6-8, 2019

Focus:

- Patient Access to Specialty Care – Surprise Medical Bills

(Narrow Networks)

- Physician Focused Payment Models
- Alternative Payment Model(APM) for Patient-Centered Asthma Care

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Advocacy Council Strike Force: May 2-4, 2022

Focus:

- Surprise Medical Bills
- No Surprise Act
- Telemedicine Access – Voice Only
- Medicare Fee Structure

- We met with: Sen. Tommy Tuberville (R-AL), and staff for Rep. Barry Moore (R-AL), Rep. Robert Aderholt (R-AL), Rep. Morgan Griffith (R-VA), House Majority Leader Steny Hoyer (D-MD), House Energy and Commerce Committee, Senate Finance Committee and Senate HELP Committee. We discussed the NSA Telehealth and preventing Medicare cuts in those meetings.

Held in conjunction with AAN Capitol Hill Day

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ADVOCATING FOR ALLERGISTS AND THEIR PATIENTS

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The Advocacy Council is like air-conditioning on a hot summer day in Tennessee - only missed if we're not working!

Thank you for your support!

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Acknowledgements

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- Questions?

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