

Policy Analysis & Strategy Options

THE MOST SERIOUS MISTAKES ARE NOT BEING MADE AS A RESULT OF WRONG ANSWERS. THE TRULY DANGEROUS THING IS ASKING THE WRONG QUESTION.

--PETER F. DRUCKER

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What we won't discuss tonight:

MEDICARE BILLING

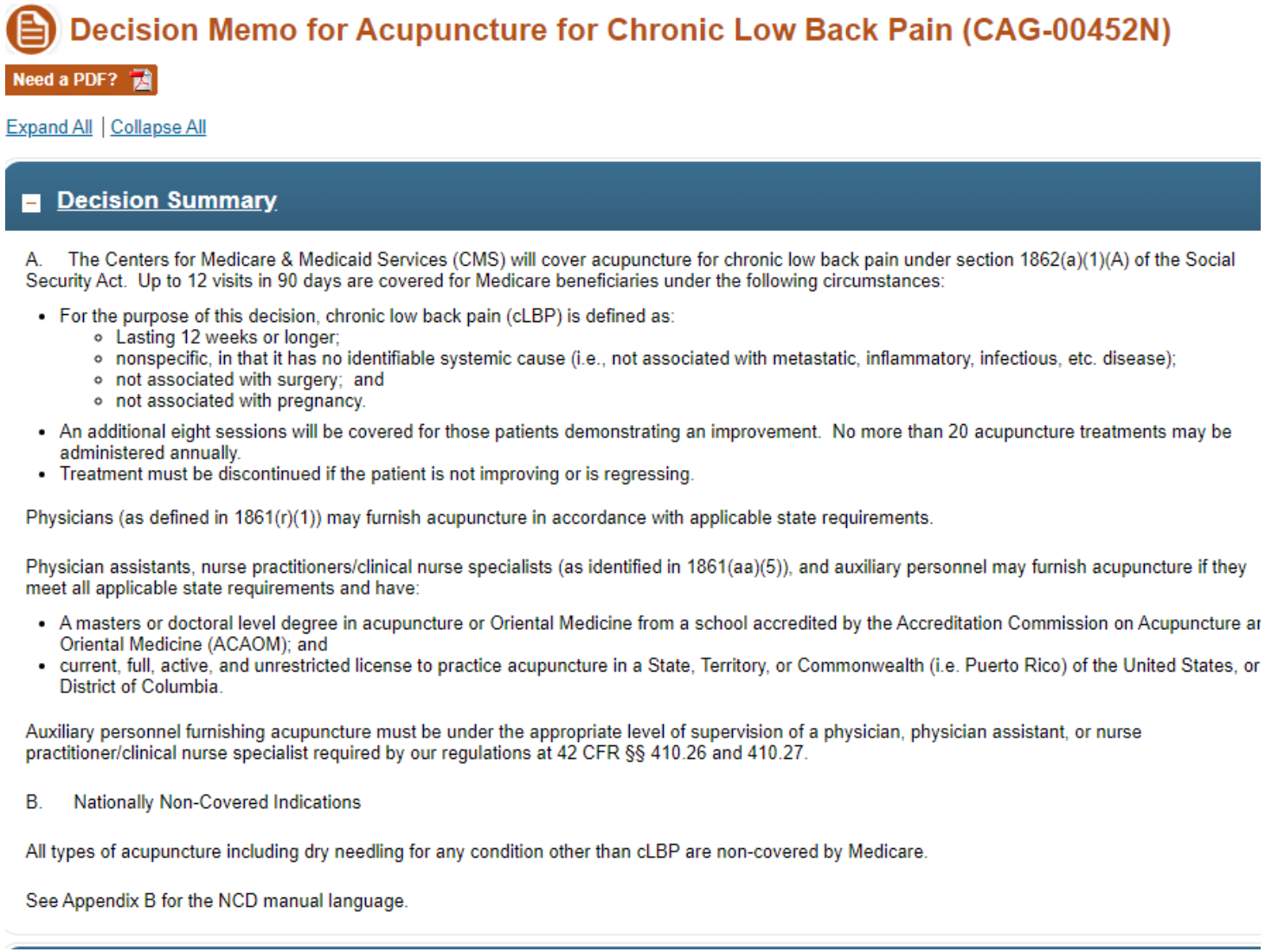
HOW MEDICARE FEE STRUCTURE AFFECTS OTHER INSURANCE FEE STRUCTURES

Why Discuss Medicare Inclusion for Licensed Acupuncturists Now?

How Did We Get Here?

Acupuncture for Chronic Low Back Pain is Now Covered for Medicare Beneficiaries

L.Acs cannot bill Medicare directly & must have some form of supervision by physician, nurse practitioner/clinical nurse specialist or physician assistant



Decision Memo for Acupuncture for Chronic Low Back Pain (CAG-00452N)

Need a PDF?

Expand All | Collapse All

Decision Summary

A. The Centers for Medicare & Medicaid Services (CMS) will cover acupuncture for chronic low back pain under section 1862(a)(1)(A) of the Social Security Act. Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:

- For the purpose of this decision, chronic low back pain (cLBP) is defined as:
  - Lasting 12 weeks or longer;
  - nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
  - not associated with surgery; and
  - not associated with pregnancy.
- An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.
- Treatment must be discontinued if the patient is not improving or is regressing.

Physicians (as defined in 1861(r)(1)) may furnish acupuncture in accordance with applicable state requirements.

Physician assistants, nurse practitioners/clinical nurse specialists (as identified in 1861(aa)(5)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

- A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture ar Oriental Medicine (ACAOM); and
- current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.

Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist required by our regulations at 42 CFR §§ 410.26 and 410.27.

B. Nationally Non-Covered Indications

All types of acupuncture including dry needling for any condition other than cLBP are non-covered by Medicare.

See Appendix B for the NCD manual language.

Acupuncture Licensing Exam (CALE).[3] We propose alternate language for this section *in toto* that simply reads:

- *Licensed Acupuncturists or state equivalents who carry an active and unrestricted license in the state of practice may provide acupuncture.*

This approach would eliminate all confusion and conflicts with state laws, while being more inclusive of the full, qualified licensure group. This bullet could also be simply added to the existing list above, should preservation of that language be desired.

Physician assistants, nurse practitioners/clinical nurse specialists (as identified in 1861(aa)(5)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

- *A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM);*
- *a current certification by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM); and*
- *maintained licensure in a U.S. state or territory to practice acupuncture.*

This language creates a number of problems and is not consistent with existing law in most locales. Specifically, there are no PAs, NPs or clinical nurse specialists who would meet these requirements and not also qualify to be a "Licensed Acupuncturist or state equivalent". These individuals, if there are indeed any, would most likely hold dual licensure as a PA/NP/CNS and as a Licensed Acupuncturist. Graduation from an ACAOM accredited school and passing of the NCCAOM certification exams defines the core of this specific licensure group, which also obtained a unique Bureau of Labor Statistics (BLS) designation.[1] The language as it stands simply obscures the titling of an already existing, designated licensure group. It seems to attempt to give allowance for participation to providers who would not otherwise qualify for inclusion, unless they were already Licensed Acupuncturists.

Auxiliary personnel furnishing acupuncture must be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist.

While we understand the need for direct supervision by a physician during trial purposes, it is inconsistent with every state law that Licensed Acupuncturists be under the direct supervision of physician assistants, nurse practitioners or clinical nurse specialists. There is no precedent for this, nor does it improve patient safety, excellence in study design or provision, or any other aspect of the process. Licensed Acupuncturists are, in all but a very limited number of incidences, independent providers nationally, and have an outstanding safety profile[4]. In Hawaii, for example, only Licensed Acupuncturists (not even medical doctors) can provide acupuncture. In cases where they were or remain under supervision, only medical doctors have been in that supervisory position. We ask that this portion be revised to be consistent with state laws, and remove the terms "physician assistant" and "nurse practitioner/clinical nurse specialist".

Why didn't we **fight** this? Wait…we did.

During a Public Call for Commentary

Your National Association

American Society of Acupuncturists (ASA) put out a

Call to Action with defined language for changes

Reference: ASA July 2019

VIEW PUBLIC COMMENTARY

	Date: 08/09/2019 Comment: It is very encouraging to see this work being moved forward at the federal level and I thank CMS for their work in trying to improve the implementation and study of acupuncture as part of healthcare system. As a practitioner that has worked in More
Geiger, Andrea	Organization: Five Branches University Date: 08/14/2019 Comment: We want all licensed acupuncturists to be included in this study. We want recognition of the California Acupuncture Licensing Exam to be equivalent to the NCCAOM exam for the purposes of this study. We want licensed acupuncturists to be More
Giammarco, Molly	Organization: National Certification Commission for Acupuncture and Oriental M Date: 08/14/2019 Comment: August 14, 2019 Tamara Syrek Jensen, JD Director, Coverage and Analysis Group U.S. Centers for Medicare & Medicaid Services 7500 Security Boulevard Baltimore, MD 21244 Dear Ms. Syrek Jensen and More
Gibbons, MSTOM, Lac, Jenn	Title: Chinese & Functional Medicine Practitioner Date: 07/28/2019 Comment:



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.S.gov
r Medicare & Medicaid Services

ew Public Comments for Acupuncture for Chronic Low Back Pai

: Jones, Dan

18/2019

olutely ZERO valid evidence that acupuncture in any form is effective in any way. I won't provide links to prove it does ssionals, you should already know. Use of public tax dollars to fund this or any other quackery is not only a waste of n ud. There's enough fraud that tax dollars are wasted on. Don't add this scam to the pile. If this is permitted, what's nex ill rock stores accept Medicaid? Where is the line drawn? There are proponents for any version of quackery one can t that proves them wrong. Which will you listen to? The tiny minority that has gone down a very expensive rabbit hole a ous prices the scam artists demand for their quackery? Or the evidence?

Submit Feedback/Ask a Question

s Results [597 Comm

Comment Period: 07/15/2019-08/14/2019

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Please Note: Only displaying linked letters for which there are records.

ge # Go to page First Prev ... 5 6 7 8 9 10 ... Next Last View Items Per Page:

	COMMENT INFORMATION
	Date: 07/16/2019 Comment: Acupuncture for low back pain has proven to be a drug free viable option for me while dealin chronic pain from a degenerative disc issue that has been in existence for years. Prior to acupuncture treatments I was unable to stand or walk for More
	Date: 08/14/2019 Comment: Dear Sir/Madam, I applaud efforts by CMS to study the effects of acupuncture for chronic low back pain (cL in populations covered by Medicare. As many Licensed Acupuncturist (L.Ac.) community other relevant stakeholders affected More
	Title: L.ac Date: 08/14/2019 Comment: We want all licensed acupuncturists to be included in this study We want recognition of the California Acupuncture Licensing Exam to be equivalent to the NCCAOM exam for the purpo this study. We want licensed acupuncturists to be recognized More
	Date: 07/30/2019 Comment: Why limit acupuncture treatment to low back pain? There are many chronic pain conditions Rheumatoid Arthritis that encompass the entire body in which acupuncture would More
	Organization: WAY Wellness Center Date: 08/08/2019 Comment:



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Personnel Furnishing Acupuncture and Direct Supervision

Comment: Several commenters requested that CMS remove the term "auxiliary personnel" from the final decision, and instead refer to these providers specifically as "licensed acupuncturists." Most of these commenters also suggested editing the "direct supervision" requirement to only allow physicians to provide supervision, stating that physician assistants, nurse practitioners/clinical nurse specialists would not be qualified to supervise licensed acupuncturists.

Response: Currently, acupuncturists are not recognized by CMS as Medicare providers, and are not eligible to bill for acupuncture services. It is possible, however, for acupuncturists to provide acupuncture as auxiliary personnel "incident to" a physician's service in certain settings. The incident to regulations requires supervision by a physician or other practitioner. For further details regarding "incident to" services, we recommend that interested parties consult 42 CFR §§ 410.26 and 410.27. We are not able to amend these regulations through the national coverage determination process, however, we will change the specifc reference to "direct supervision" and will substitute "the appropriate level of supervision required by our regulations at 42 CFR §§ 410.26 and 410.27."

The Results: The Language DID CHANGE

Background

Physicians and practitioners who do not wish to enroll in the Medicare program may "opt-out" of Medicare. This means that neither the physician, nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. A private contract is signed between the physician and the beneficiary that states, that neither one can receive payment from Medicare for the services that were performed. The physician or practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The following shows physicians and other practitioners who are permitted by statute to opt-out of the Medicare program:

- Physicians who are:
  - Doctors of medicine or osteopathy;
  - Doctors of dental surgery or dental medicine;
  - Doctors of podiatry; or
  - Doctors of optometry; and
  - Who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed.
- Practitioners who are:
  - Physician assistants;
  - Nurse practitioners;
  - Clinical nurse specialists;
  - Certified registered nurse anesthetists;
  - Certified nurse midwives;
  - Clinical psychologists;
  - Clinical social workers; or
  - Registered dietitians or nutrition professionals; and
  - Legally authorized to practice by the State and otherwise meet Medicare requirements.

MLN Matters® CMS

Official Information Health Care Professionals Can Trust

NEW products from the Medicare Learning Network® (MLN)

- "Transitional Care Management Services," Fact Sheet, ICN 908682, Downloadable only.

MLN Matters® Number: SE1311 Revised | **Related Change Request (CR) #: Not applicable**

Related CR Release Date: N/A | **Effective Date: N/A**

Related CR Transmittal #: N/A | **Implementation Date: N/A**

Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries

Note: This article was revised on September 14, 2015, to eliminate references to a 2-year opt-out period for residents. The references to the 2-year opt-out period for other providers was removed in a prior revision. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and refer services to Medicare beneficiaries and who would otherwise submit claims to Medicare contractors (carriers and Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries.

What You Need to Know

This MLN Matters® Special Edition Article informs physicians and non-physician practitioners who wish to opt-out of Medicare of the need to provide certain information in a written Affidavit to their Medicare contractor (Medicare Carrier or Medicare Administrative Contractor (MAC)). Make sure that your billing staffs are aware of this information.

Physicians/non-physician practitioners who have never enrolled in Medicare are not required to enroll in Medicare before they can opt-out of Medicare.

A nonparticipating physician or practitioner may opt-out of Medicare at any time and the effective date of the affidavit record must comply with the following:

- The opt-out period begins the date the affidavit is signed, provided the affidavit is filed within 10 days after he or she signs his or her first private contract with a Medicare beneficiary.
- Physicians or practitioners that opt out in multiple contractor jurisdictions are required to file a separate affidavit with each contractor. If the physician or practitioner does not timely file all required affidavits, the opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit. The furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subje to standard Medicare rules.

To Enroll or Not Enroll? Are We Beholden To Medicare?



Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for [1], below, you may have to pay.

A.	B. Reason Medicare May Not Pay:	F. Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the [1] listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the [1] listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the [1] listed above, but do not bill Medicare. You may ask to be paid now, but I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the [1] listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call 1-800-MEDICARE or email: [redacted]

Form CMS-R-131 (Exp. 08/2020) Form Approved OMB No. 0938-0566

...MENTS.—
...ll not apply to any contract entered into by a physician or practitioner unless an affidavit described
...ribed in this subparagraph if—
...hysician or practitioner and is in writing and is signed by the physician or practitioner;
...he physician or practitioner will not submit any claim under this title for any item or service provide
...m or service) during the applicable 2-year period (as defined in subparagraph (D)); and[3]
...ed with the Secretary no later than 10 days after the first contract to which such affidavit applies is
...r practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim
...in paragraph (1)(B) for any such item or service) with respect to such affidavit—[4]
...ply with respect to any items and services provided by the physician or practitioner pursuant to any
...under this title for any item or service furnished by the physician or practitioner during the period d
...or service).
...EFFECTIVENESS OF AFFIDAVITS.— In this subsection, the term "applicable 2-year period" means, with
...signed and includes each subsequent 2-year period unless the physician or practitioner involved p
...period, that the physician or practitioner does not want to extend the application of the affidavit fo
...CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect to a
...' PHYSICIANS AND PRACTITIONERS.—
...er than February 1, 2016, the Secretary shall make publicly available through an appropriate publicl
...and practitioners and shall update such information on such website not less often than annually.
...The information to be made available under subparagraph (A) shall include at least the following
...onal specialty or other designation.
...on.
...ng opt-out physicians and practitioners, relative, to the extent feasible, to when they first enrolled i
...sicians and practitioners who billed for emergency or urgent care services.[6]
...rm "medicare beneficiary" means an individual who is entitled to benefits under part A or enrolled
...n" has the meaning given such term by paragraphs (1), (2), (3), and (4) of section 1861(r).
...itioner" has the meaning given such term by section 1842(b)(18)(C).
...ONER.— The term "opt-out physician or practitioner" means a physician or practitioner who has in e



Social Security SEARCH MENU LANGUAGES SIGN IN / UP

Compilation Of The Social Security Laws

FREE CHOICE BY PATIENT GUARANTEED

Sec. 1802. [42 U.S.C. 1395a] (a) BASIC FREEDOM OF CHOICE.—Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participa...
agency, or person undertakes to provide him such services.
(b) USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.—
(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or ...
(A) for which no claim for payment is to be submitted under this title, and
(B) for which the physician or practitioner receives—
(i) no reimbursement under this title directly or on a capitated basis, and
(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this title directly or on a capitated basis.
(2) BENEFICIARY PROTECTIONS.—
(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—
(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;
(ii) the contract contains the items described in subparagraph (B); and
(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.
(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such co...
(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this title for such items or services even if such items or services are otherwise covered by...
(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this title for such ite...
(iii) acknowledges that no limits under this title (including the limits under section 1848(g)) apply to amounts that may be charged for such items or services;
(iv) acknowledges that Medigap plans under section 1882do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not...
(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this title.
Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1128.

If Never Enrolled: Can I TREAT Medicare Beneficiaries?

Yes…ABN Stands for CYB



The Chiropractor's Point of View

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Current Legislation: HR 1183 Acupuncture for our Heroes & Seniors

Summary | Bill Text | Action History | Vote History | Associated Documents

Version: 02/26/2019 1 of 10 Compare: -None-

A BILL To amend title 10, United States Code, to ensure access to qualified acupuncturist services for military members and military dependents, to amend title 38, United States Code, to ensure access to acupuncturist services through the Department of Veterans Affairs, to amend title XVIII of the Social Security Act to provide for coverage of qualified acupuncturist services under the Medicare program, to amend the Public Health Service Act to authorize the appointment of qualified acupuncturists as officers in the commissioned Regular Corps and the Ready Reserve Corps of the Public Health Service, and for other purposes.

be it enacted by the senate and house of representa2 tives of the united states of america in congress assembled

section 1.

short title; table of contents. 4 (a) short title.this act may be cited as the 5 acupuncture for heroes and seniors act of 2019. 6 (b) table of contents.the table of contents of 7 this act is as follows:

sec. 1. short title; table of contents. sec. 2. definitions. sec. 3. inclusion of acupuncture services through military health care system and tricare program. sec. 4. acupuncture health services for tricare program beneficiaries. sec. 5. appointment of acupuncturists as commissioned officers in the armed forces. sec. 6. inclusion of acupuncturist services at veterans health facilities. sec. 7. coverage for acupuncturist services under the medicare program. sec. 8. acupuncturists in the regular corps and the ready reserve corps of the public health service.

8 **sec. 2.**

definitions.

9 in this act, except as otherwise provided: 10 (1) the term qualified acupuncturist services 11 means 12 (a) acupuncturist services 13 (i) that are furnished by a qualified 14 acupuncturist; and 15 (ii) which the qualified acupuncturist 16 is legally authorized to perform under 17 state law; and

1 (b) services and supplies that are fur2 nished by a qualified acupuncturist incident to 3 the services described in subparagraph (a). 4 (2) the term qualified acupuncturist means

Important:
Here is Where You Are Defined in the Bill

A practitioner described in this subparagraph is any of the following:

(i) A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)).

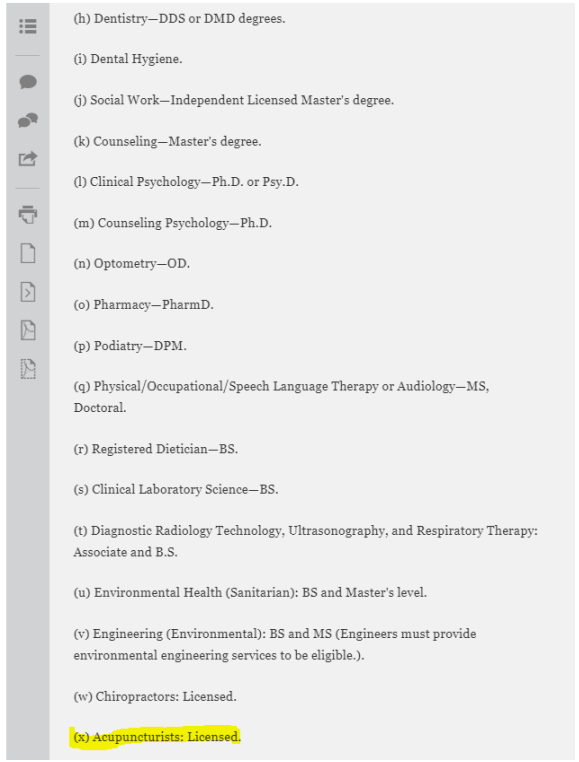
(ii) A certified registered nurse anesthetist (as defined in section 1861(bb)(2)).

(iii) A certified nurse-midwife (as defined in section 1861(gg)(2)).

(iv) A clinical social worker (as defined in section 1861(hh)(1)).

(v) A clinical psychologist (as defined by the Secretary for purposes of section 1861(ii)).

(vi) A registered dietitian or nutrition professional.



(h) Dentistry—DDS or DMD degrees.

(i) Dental Hygiene.

(j) Social Work—Independent Licensed Master's degree.

(k) Counseling—Master's degree.

(l) Clinical Psychology—Ph.D. or Psy.D.

(m) Counseling Psychology—Ph.D.

(n) Optometry—OD.

(o) Pharmacy—PharmD.

(p) Podiatry—DPM.

(q) Physical/Occupational/Speech Language Therapy or Audiology—MS, Doctoral.

(r) Registered Dietician—BS.

(s) Clinical Laboratory Science—BS.

(t) Diagnostic Radiology Technology, Ultrasonography, and Respiratory Therapy: Associate and B.S.

(u) Environmental Health (Sanitarian): BS and Master's level.

(v) Engineering (Environmental): BS and MS (Engineers must provide environmental engineering services to be eligible.).

(w) Chiropractors: Licensed.

(x) Acupuncturists: Licensed.

Loan Repayment Program for Repayment of Health Professions Educational Loans

A Notice by the Indian Health Service on 02/11/2020

I. Funding Opportunity Description

The Indian Health Service (IHS) estimated budget for fiscal year (FY) 2020 includes $34,800,000 for the IHS Loan Repayment Program (LRP) for health professional educational loans (undergraduate and graduate) in return for full-time clinical service as defined in the IHS LRP policy at *https://www.ihs.gov/loanrepayment/policiesandprocedures/* in Indian health programs.

This notice is being published early to coincide with the recruitment activity of the IHS which competes with other Government and private health management organizations to employ qualified health professionals.

This program is authorized by the Indian Health Care Improvement Act (IHCIA) Section 108, codified at 25 U.S.C. 1616a.

Medicare Inclusion: Beyond Billing


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Medicare Inclusion: Beyond Billing

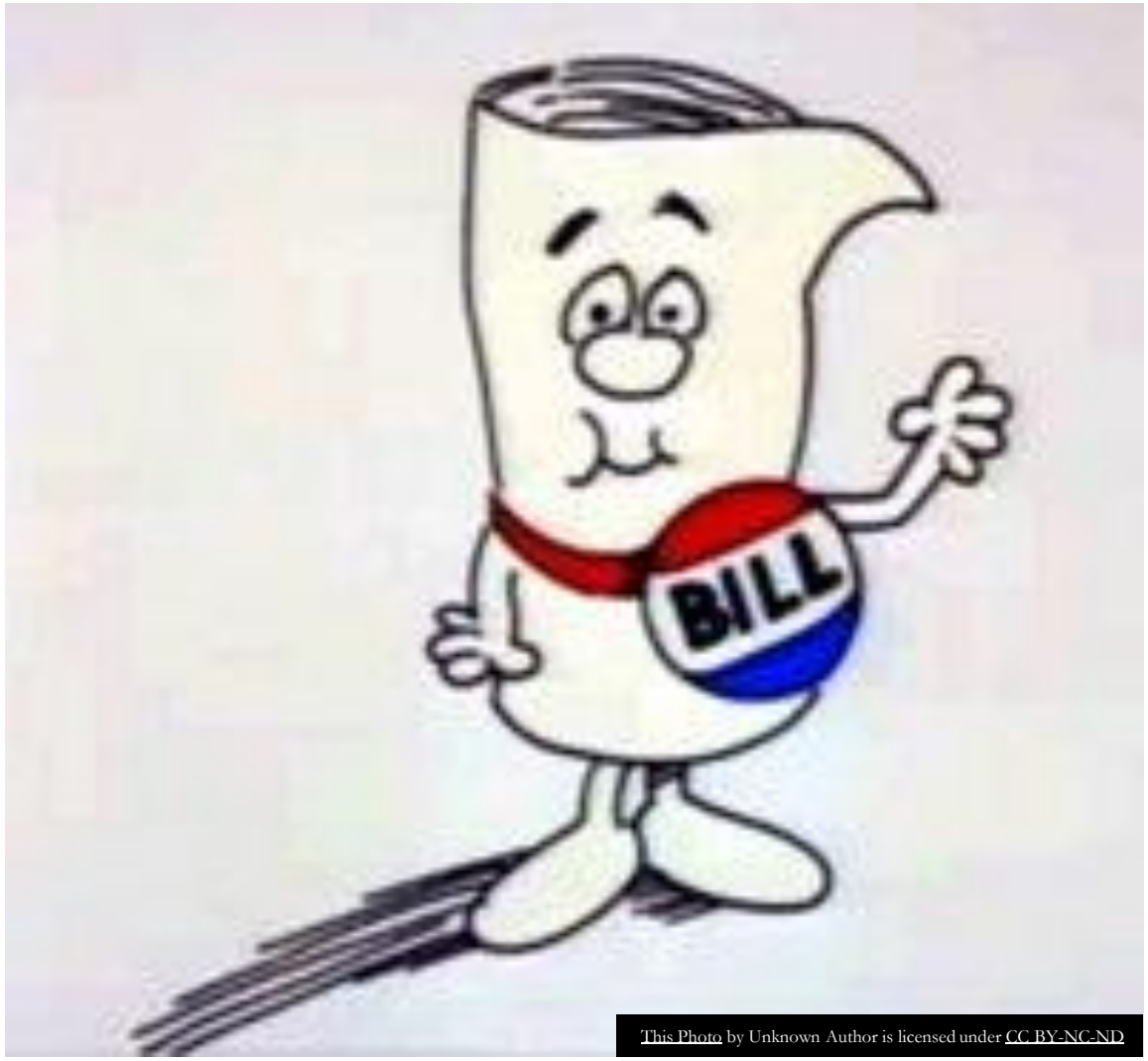
Medicare Inclusion: Beyond Billing



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- Community Mental Health Centers (CMHCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals (CAHs)
- End-Stage Renal Disease (ESRD) Facilities
- Federally Qualified Health Centers (FQHCs)
- Home Health Agencies (HHAs)
- Hospice Organizations
- Hospitals
- Indian Health Service (IHS) Facilities
- Organ Procurement Organizations
- Opioid Treatment Programs (OTPs)*
- Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services
- Religious Non-Medical Health Care Institutions
- Rural Health Clinics (RHCs)
- Skilled Nursing Facilities (SNFs)

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Legislation Efforts Made Easier With Inclusion & Definition in Social Security Act

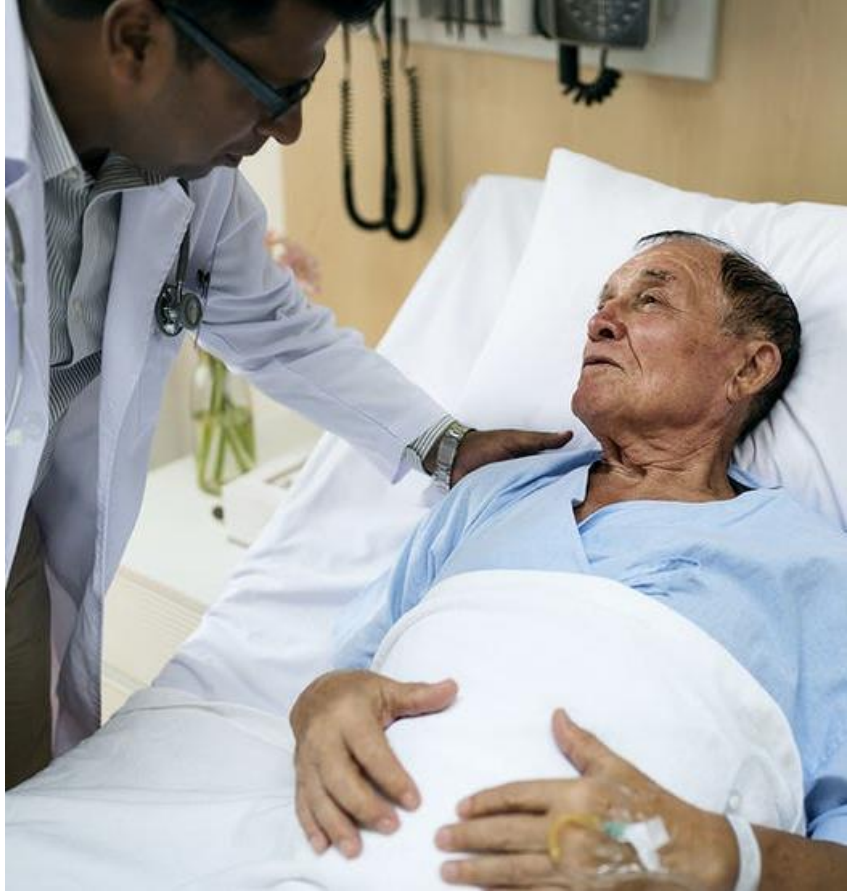
Who Relies on Medicare? A Profile of the Medicare Population

Olivia Dean, Claire Noel-Miller, and Keith Lind
AARP Public Policy Institute

This fact sheet provides 10 key facts about the Medicare population.

1. **Medicare provides health coverage to more than 57 million Americans.**[1] Over 18 percent of the nation's population relies on Medicare for health security.[2] As more baby boomers turn 65, enrollment will reach 64 million in 2020 and 81 million in 2030.[3] In 2016, over one-third of people receiving Medicare benefits were ages 75 and older.[4]
2. **Medicare is not just for those 65 years old and over.** In 2016, about one in six beneficiaries (16 percent) qualified for coverage before turning 65, on the basis of permanent disability.[5] These individuals tend to have lower incomes and higher rates of health problems than older beneficiaries, including cognitive impairments and limitations in activities of daily living.
3. **Many beneficiaries are in poor health.** Two-thirds (66 percent) of the Medicare population lives with two or more chronic conditions.[6] These individuals rely on Medicare to help them afford essential treatment.
4. **Many beneficiaries are between the ages of 65 and 67.** Nearly 9.2 million beneficiaries were between the ages of 65 and 67 in 2016—over 16 percent of the Medicare population.[7] Thus, millions of older adults would be affected by an increase in the Medicare eligibility age.
5. Many beneficiaries live on modest incomes. Half have incomes less than two times the federal poverty level ($26,200 in 2016).[8]
6. Many beneficiaries have limited financial resources. One in four had less than $14,550 in total savings (e.g., retirement accounts and financial assets) in 2016.[9]
7. Traditional Medicare covers only about half of beneficiaries' total health costs.[10] While most beneficiaries in fee-for-service Medicare have supplemental insurance or Medicaid to cover some costs not covered by Medicare, 13 percent had no additional coverage in 2013.
8. Beneficiaries spend a median of $3,685 out of pocket on health care.[11] In 2013, half of beneficiaries spent at least this amount of their own money on medical services and Medicare premiums.

AARP Real Possibilities
Public Policy Institute



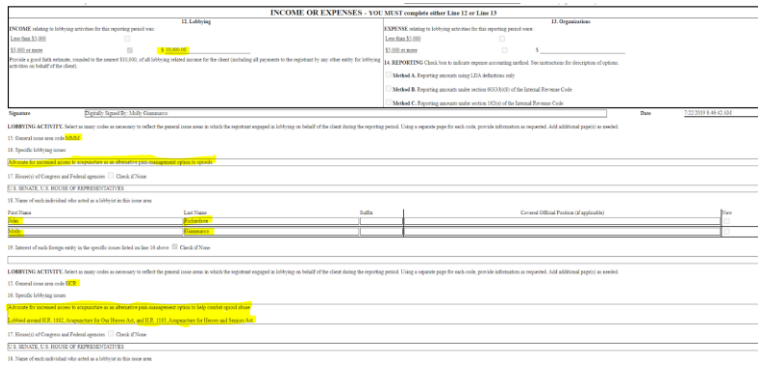


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Don't forget about the patients who need us…

Current Advocacy Efforts





INCOME OR EXPENSES - YOU MUST complete either Line 12 or Line 13

12. Lobbying

13. Organizations

LOBBYING ACTIVITY. Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. Using a separate page for each code, provide information as requested. Add additional page(s) as needed.

15. General issue area code: HCR

16. Specific lobbying issues:

Advocate for increased access to acquisition as an alternative pain management option to help combat opioid abuse

Lobbied around H.R. 1102, Acupuncture for Our Heroes Act, and H.R. 1103, Acupuncture for Heroes and Seniors Act

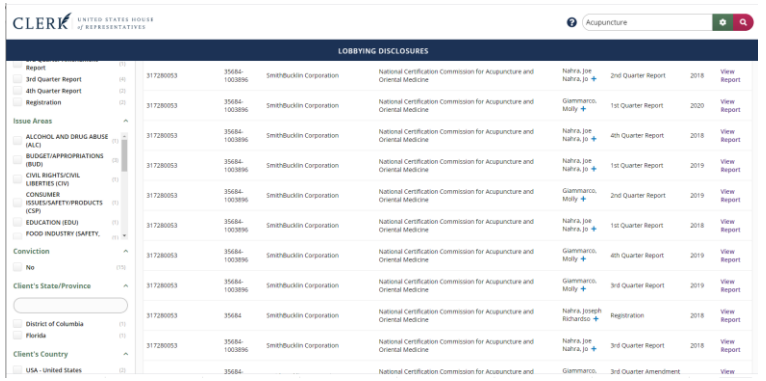
17. House(s) of Congress and Federal agencies: Check if None

U.S. SENATE, U.S. HOUSE OF REPRESENTATIVES

18. Name of each individual who acted as a lobbyist in this issue area

First Name	Last Name	Suffix	Covered Official Position (if applicable)	New
Joe	Nahra			
Molly	Giammarco			

19. Interest of each foreign entity in the specific issues listed on line 16 above: Check if None





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CURRENT LOBBYING EFFORTS

2019 Disclosures:

2019 Disclosures:

Q1, Q2, Q3, Q4

Codes: MMM (Medicare/Medicaid) & HCR (Health Issues) & VET (Veterans Issues)

Q1: $10,000: Advocate for increased access to acupuncture as an alternative pain-management option to opioids.

Advocate for increased access to acupuncture as an alternative pain-management option to help combat opioid abuse

https://disclosurespreview.house.gov/ld/ldxmlrelease/2019/Q1/301034762.xml

Q2: $10,000: Advocate for increased access to acupuncture as an alternative pain-management option to help combat opioid abuse. Lobbied around H.R. 1182, Acupuncture for Our Heroes Act, and H.R. 1183, Acupuncture for Heroes and Seniors Act.

https://disclosurespreview.house.gov/ld/ldxmlrelease/2019/Q2/301054234.xml

Q3:$10,000 Advocate for increased access to acupuncture as an alternative pain-management option to opioids.

Advocate for increased access to acupuncture as an alternative pain-management option to help combat opioid abuse. Lobbied around H.R. 1182, Acupuncture for Our Heroes Act, and H.R. 1183, Acupuncture for Heroes and Seniors Act.https://disclosurespreview.house.gov/ld/ldxmlrelease/2019/3A/301129674.xml

Q4:$10,000 **Code MMM**: Advocate for increased access to acupuncture as an alternative pain-management option to opioids. H.R. 1182/S. 2914, Acupuncture for Our Heroes Act, and H.R. 1183, Acupuncture for Heroes and Seniors Act, H.R. 5172/S. 3067, the Non-Opioids Prevent Addiction In the Nation Act **Code HR**: Advocate for increased access to acupuncture as an alternative pain-management option to help combat opioid abuse.

Lobbied around H.R. 1182/S. 2914, Acupuncture for Our Heroes Act, and H.R. 1183, Acupuncture for Heroes and Seniors Act, H.R. 5172/S. 3067, the Non-Opioids Prevent Addiction In the Nation Act **Code VET:** H.R. 1182/S. 2914, Acupuncture for Our Heroes Act, and H.R. 1183, Acupuncture for Heroes and Seniors Act, H.R. 5172/S. 3067, the Non-Opioids Prevent Addiction In the Nation Act

https://disclosurespreview.house.gov/ld/ldxmlrelease/2019/Q4/301127064.xml

CURRENT LOBBYING EFFORTS: 2020 Disclosures

Lobbying Disclosures 2020:

Q1: MMM, HC & VET Codes:

Advocate for increased access to acupuncture as an alternative pain-management option to opioids.

Lobbied:

H.R. 1182/S. 2914, Acupuncture for Our Heroes Act

H.R. 1183, Acupuncture for Heroes and Seniors Act

Legislative efforts to gain Medicare recognition for certified acupuncturists

Supported:

H.R. 5172/S. 3067, the Non-Opioids Prevent Addiction In the Nation Act

https://disclosurespreview.house.gov/ld/ldxmlrelease/2020/Q1/301175548.xml



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Questions?