



FALL 2018

SCOPE

AMERICAN OSTEOPATHIC COLLEGES OF OPHTHALMOLOGY AND OTOLARYNGOLOGY, HEAD AND NECK SURGERY



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2019 ANNUAL CLINICAL ASSEMBLY

PRESIDENT

Friends and Colleagues,

I hope that you have all had a wonderful, prosperous and stress-free summer! I was lucky enough to attend the annual AOA Business Meeting in July in Chicago and I'd like to share some highlights with you. First, as some of you may be aware, a member of our College, William Mayo, DO, an Ophthalmologist from Mississippi, was inaugurated as the 122nd president of the AOA. I was lucky enough to share some time with him there at a private reception, as well as at dinner at our ACA, and he certainly is an incredible man. I know that he is going to do a great job leading the AOA this year, and he is certainly a glowing representation of our College. In his inauguration speech, he outlined that promoting AOA board certification and membership will be two of his priorities in the coming year. On a related note, the class action lawsuit regarding the coupling of AOA membership to board certification was officially settled. The result is the official uncoupling of AOA membership to maintaining board certification.

As you may have noticed, the website was revamped and I think is a tremendous upgrade from what we had previously. It is less cluttered, more intuitive and certainly easier to navigate. As I had previously mentioned in my letter that was sent with the dues invoice back in July, we are updating our membership directory, which is outdated. If you didn't update your information at that time, I would ask that you go onto the website and login to make sure we have all the correct information and complete your profile. If any of it is incorrect, you can update it very easily yourself while on the site, instead of having to tediously fill out paperwork or call someone on the phone. I feel that this is one of many important upgrades to the site as we move the College forward from a technology standpoint. It will continue to evolve over time, but this is certainly a wonderful start!

I hope that everyone has a safe and happy winter. It is a privilege to serve such a wonderful organization and give back something in return for all it has given me. I look forward to seeing everyone in Orlando in May!

Dennis J Kitsko, DO, FACS, FAOCO
President, AOCOO-HNS Board of Governors



BEYOND PHYSICIAN BURNOUT

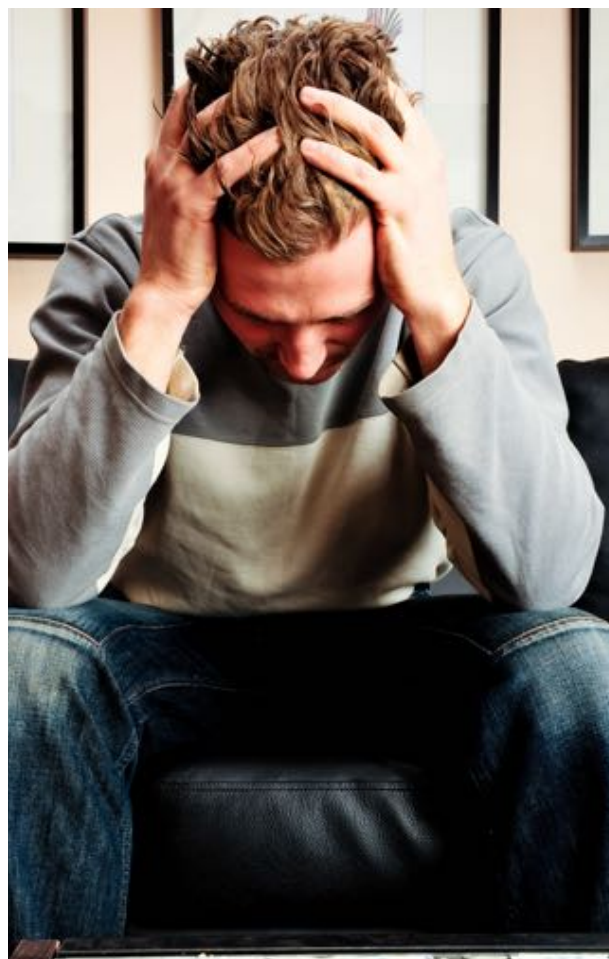
Kristin E. Reidy, D.O. Immediate Past President

As an organization, the AOCOO-HNS, has taken to heart the personal threat of physician burnout and absence of physician self-care. We have brought renowned national lecturers to our meetings to speak on subjects such as physician suicide, work life balance, and stress management. However, the pressing issue of the expected severe physician shortage should be encouraging all physician advocacy groups and patient advocacy groups to go beyond looking at personal physician burnout. We need to be investigating why and when physicians retire and figure out how to keep more physicians working happily for a longer period of time. Most of us truly love what we do, and if we could care for patients in more a hassle free environment, we would retire much later and doing so would quickly solve the expected physician shortage.

In a popular medpage blog KevinMD.com, they looked at retiring physicians are speculated on who retires when. Some young physicians “retire” so early, that they honestly never practice. Two men in my medical school class pursued possibly more lucrative and less time consuming careers in law and didn’t even enter residencies. One woman in my class did not practice because she and her husband had a special needs child shortly after graduation. Another classmate of mine, a family physicians, chose to what I would call “underpractice.” He and his wife, a pediatrician, lived so simply that neither of them needed to work full time. Many physicians, both men and women struggle to have personal time with their spouses and children and cut back or retire early. Furthermore, other physicians are forced to retire early before traditional retirement ages to care for ailing parents or because of their own poor health.

These situations will be worsened by the growing corporate structures that more and more of us work in, where there is not a place for part time physicians at times of their lives where they might need or want to cut back. Such physicians are forced to retire early to make room for more productive full time FTE physicians.

In a Forbes article by Dan Diamond and a Washington Post article by Charles Krauthammer, they each focus on the degrading and demoralizing aspect of medical practice where medical professionals are being forced to adopt expensive electronic health platforms while also being forced to bear the financial penalties and rectify the inaptness of our societal issues that revolve around too much of our GDP going toward healthcare, too many patients being morbidly obese and having chronic conditions like diabetes and cancer.



continued

Kristin E. Reidy, D.O. Immediate Past President


These realities leave a bitterness that makes even the most fulfilled physician consider retiring early.

Early retirement is a serious problem that robs our medical communities of irreplaceable resources. Most physicians are in their mid-thirties before they even hit their stride in practice. From a social standpoint, too much time and financial resources have been expended to prepare them for their careers to not get to the bottom of this issue. Most communities, rural and urban, are desperate for more providers in primary care and subspecialty care. Filling this need is not easily done. The ACGME merger will lead to fewer subspecialty trained osteopathic physicians. The entrepreneurial physicians of the past that built the outstanding and efficient practices we all know seem rarer now. Physicians do not have the same opportunities starting out now. Large group practices of employed physicians will be the norm in the future. They will function in capitated, cost sharing, and cost saving models that will further depersonalize healthcare delivery in the future. Some of the satisfaction of providing care will be taken away but hopefully not lost.

One way to slow retirement and keep physicians engaged in the new health care delivery models will be to train and empower physicians to sit at the hospital boardroom negotiation tables as well as sit in the bedside chairs of their patients. Only by being involved in the decision making of the new health care delivery models will we be able to look out for our patients and ourselves. In September at the AOCOO-HNS Motown Midyear meeting in Detroit, we are excited to bring our members two days of lectures and 15 hours of DO and MD CME designed to empower physicians to best advocate for themselves, their patients, and the medical profession.

"Only by being involved in the decision making of the new health care delivery models will we be able to look out for our patients and ourselves."





**BECOMING
A DOCTOR
IS TOUGH,
BUT SO
ARE YOU.**

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INTERNATIONAL GME

I often get asked by patients, “So what made you choose Ophthalmology?” followed by the statement, “Eyes just creep me out!” There are a million ways to answer back: “At least it’s not butts and guts” or “Well I’m less likely to get divorced in ophthalmology” or “I actually get to see my kids at night in this specialty.” Even though these answers are legit I usually say them in jest. The real reason I personally was converted to ophthalmology gets traced back to the first time I participated in a medical mission to Mexico as a medical student and was reaffirmed and strengthened on my most recent trip to Belize this last June.

I was invited to participate in an annual mission trip to San Ignacio, Belize put on by Drs. Robert Peets and Peter Jensen. They started this annual trip back in 2006 to provide ophthalmic care to those living in poverty. This year we provided 108 patients with quality eye care. We performed 14 cataract surgeries, 2 MIGS devices, 11 pterygium surgeries, 5 intravitreal Avastin injections, 4 Focal Argon laser procedures, 1 PRP, 6 ALT’s and 2 Corneal Foreign body removals. These procedures were great experiences for me as a surgeon to have, but nothing compared to the personal and spiritual experiences I was able to have while interacting with my patients. It was these special experiences that converted me to Ophthalmology. Watching a man with tears in his eyes and a smile from ear to ear walk into the hospital day one after cataract surgery. He was ecstatic that he could walk in on his own, since the day before he was led in by the hand due to his hand motion cataracts. Being able to see a woman, who had been hand motion vision for years, hold her grandchildren’s cheeks and look into their eyes as if it was the very first time. These are the moments that make me feel like what I’m doing is a divine calling and not just a job. These are the moments the make you forget about the hundreds of thousands of dollars of debt it took to get here. Knowing that the only thing these people have to offer us in return for our service is a smile and a “Thank you” is absolutely priceless.

Mission Trips like this one in Belize are important reminders of why I’m here and why I’m doing what I’m doing. I’m so grateful for the AOCOO-HNS International GME funding that allowed me to have this special and sacred experience and hope that others can participate in the joy that I felt while serving my fellow man.

Chase Warner, DO

PGY 3

Belize 2018



INTERNATIONAL GME (CONTINUED)

As an intern I was invited to join Dr. Robert Peets and Dr. Peet Jenson in Belize for their surgical mission trip. By the time I arrived it was near the end of the trip and I was largely involved in doing post-op visits with the many patients they were able to operate on. Bob had been going on this trip annually since 2006 and Peet since 2007. The trip continues and is in the San Ignacio region of Belize, close to this was extremely rewarding as the patients who had received the specialty care which is highly limited to them secondary to cost and they were extremely happy with their vision and I received hug after hug when I returned this summer with them for their 2018 trip I was able to have an entirely different experience.

We all met at the airport in San Ignacio. We stuffed a 15 passenger van full with people and enough luggage to fill our own plane! The 2018 Belize Ophthalmologic Mission trip had begun. This year we traveled in June—the rainy season in western Belize. We headed straight to the clinic to see if a new clinic location would work for our need. For multiple years Dr. Robert Peets and Dr. Peet Jenson have been running this mission out of the San Ignacio Hospital, and it looked like this year we would be back there again as we needed an air conditioned room to operate.

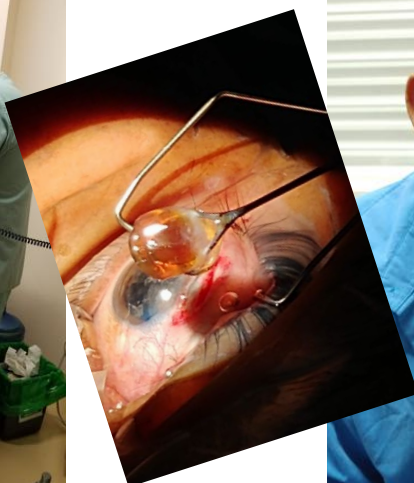
Clinic set-up included locating keys to open the closets holding all of the equipment as well as removing one of the local physicians office equipment to turn the one air-conditioned room in the hospital into a surgical suite. Boxes and boxes were removed and reorganized with surgical equipment, lenses, medicines, cartridges, sutures, etc. The microscope and ultrasound machines were located and with luck they still worked! Lasers were reassembled and tested. Unfortunately the YAG didn't survive another winter, but the Argon was still going strong.

On our first clinic day we arrived to the hospital to get started early in the morning, and already the halls were full of patients and their families. These people had traveled from far distances to have access to ophthalmic care. Pre-screening for possible surgical needs had been performed by a local pharmacist and friend Ruth Galvez and we had a schedule to keep. We hit the ground running with clinic—performing diabetic eye exams, following pressures for known diabetics—some of which were even patients of ours from years past, and performing cataract evaluations. We had some fascinating cases that you certainly don't see every day, and sometimes not even in a career over in the US.

Our OR got up and running along with the help of some of the amazing nursing staff from where Dr. Peet's operates in Ohio. They, along with the generous donations from Alcon, Glaukos, and Dr. Jenson's surgical site in Wyoming

Arwen Christian, DO

Belize 2018



MINDFUL MEDICINE TO TRANSFORM PHYSICIAN BURNOUT

BY: DR. ROMIE MUSHTAQ, MD
PHYSICIAN, SPEAKER, MINDFULNESS EXPERT

FEELING ALONE IN A VALLEY OF BURNOUT

Twelve years ago, I didn't know that the symptoms I was suffering had a diagnosis of physician burnout. As a newly appointed faculty member in neurology at that time, no media headlines or studies were in existence to give my symptoms a name. Instead, I hoped that no one would find out the shame and struggles I was hiding underneath my starched white lab coat.

How do you know if you or a colleague is suffering from burnout? I always ask physician groups to look for the following: a feeling that the lights are on and no one is home. You may be going through the motions, struggling to keep up, and feeling disconnected from your life emotionally.

I just internalized the symptoms of emotional exhaustion and a low sense of personal accomplishment. I thought my problem was that I was a physician failure. I pushed myself to exceed RVU (relative value unit) expectations in the increasingly profit-driven world of medicine. I could never find the time in my 80- to 100-hour work week to catch up on research, medical records, or tend to my personal health.

YOU ARE NOT ALONE & YOU ARE NOT A STATISTIC

Fast forward to 2018, the topic of burnout seems to be overused yet ineffectively addressed. According to the Medscape 2018 report, the number of physicians experiencing burnout continues to be on the rise with an average of 42 percent of physicians having burnout.

A 2017 Mayo Clinic study reports the numbers are higher than 53%. It is commonplace to disassociate intellectually from statistics, assume you are "one of them", and then feel stuck in your current state of mind. The danger of just intellectualizing these studies is that we can dismiss our health return to work feeling hopeless.

Neither you nor I are a statistic, we are humans. Until we bring humanity back into medicine, we will feel alone against the uphill battle of electronic health records, relative value units, patient satisfaction surveys, and medical insurance challenges.

To shift from burnout to a state of balance and healing healthcare, we must address the internal state of being as well as change external circumstances. Healing needs to occur on an individual level before we can create organizational change.

CONSEQUENCES OF BURNOUT ON MENTAL & PHYSICAL HEALTH

Burnout among doctors is generally described in terms of a loss of enthusiasm for one's work, a decline in satisfaction and joy, and an increase in detachment, emotional exhaustion, and cynicism. It manifests in disproportionately high rates of depression, substance abuse, and suicide. Annually, approximately 400 physicians take their own lives in the United States.

My passion as a neurologist to help patients with epilepsy had long extinguished, and now physical symptoms had me fighting for survival. When I couldn't take the stress or had difficulty focusing, I would turn to meditation and mindfulness-based stress reduction techniques. I would close my office door and practice pranayama breathing exercises, hoping that no one would see me.



I started to research why I felt less anxious and reduced pain with my yoga and meditation practice. I traveled the country and the world learning various meditation techniques. I also discovered that there is a wealth of research on the scientific evidence behind the benefits of meditation and mindfulness-based stress reduction on physical and mental health.

THE ROLE OF MEDITATION AND MINDFULNESS FOR HEALING

The majority of us physicians never learn about mindfulness and meditation research in medical school or residency training. Our first introduction to the research is either through headlines in mainstream media or in our own personal journeys of healing.

Fast forward to 2018 where mindfulness-based programs are a part of the curriculum in the top business and law schools, and shifting into corporate cultures of Fortune 500 companies. Why is healthcare and specifically physicians lagging behind in this movement?

In a highly-publicized study from the Annals of Family Medicine in 2014, researchers at Meriter Medical Group in Madison, Wisc. taught physicians simple mindful meditation techniques. These mindful breathing techniques were used to help physicians feel centered and more present with each patient interaction. Results showed decreased symptoms of burnout, stress, depression, and anxiety.

HEALING BURNOUT IS AN INTERNAL PROCESS

I disagree with the opinions of colleagues who dismiss physician wellness and mindfulness programs. As a medical community, we need to understand the importance of prioritizing our physical and mental health. Self-care is not selfish, self-care is essential for maintaining our health and peak performance as physicians. Once we reach symptoms of burnout, mindfulness is a path to heal.

Mindfulness-based practices have been clinically proven to heal symptoms of depression, insomnia, anxiety, and burnout.

PREVENTING BURNOUT IS AN EXTERNAL JOB

One cannot run into a forest fire without first protective gear, supportive team members and a plan of action.

Trying to transform the toxic medical system can feel like you are a physician heading into the forest fire alone, unprotected, and without a plan of action.

Without healing our individual symptoms of burnout, how can we be expected to have the mindset and physical health to lead change. Mindful-based techniques improve leadership, communication, and our ability to create solutions calmly. As a professional speaker and consultant, I work with executive teams of Fortune 500 companies and professional athletes who all realize that to transform a toxic workplace, they must first change their mindset. By healing burnout, we replace anger, cynicism, and despair with hope, creative thinking, and compassion.

When we control our minds, we can then control a situation. Through mindful leadership techniques, physicians can and must lead change on the external issues contributing to physician burnout.

I left the traditional practice of medicine, not because I gave up on the system. I left clinical medicine because I believe in my mission to change the workplace. I will not give up hope for your ability to heal yourself and then together we can and must heal healthcare.

Will you join me?

"When we control our minds, we can then control a situation. Through mindful leadership techniques, physicians can and must lead change on the external issues contributing to physician burnout. "



Dr. Romie Mushtaq, MD is a traditionally trained neurologist with additional board certification in Integrative Medicine. Dr. Romie combines her unique expertise in neuroscience & mindfulness as a highly sought-after speaker to teach stress management and mindful leadership to Fortune 500 companies, universities and associations around the globe. Dr. Romie currently serves as Chief Wellness Officer for Evolution Hospitality bringing meditation and mindfulness to an organization of 6000 employees. You can follow her on social media @DrRomie and learn more at www.DrRomie.com

FINER THAN FROG HAIR

Carl Shermetaro, DO

Residency program director, Otolaryngology/Head & Neck Surgery McLaren Oakland Hospital
Pontiac, MI

I walked into an examination room last year and introduced myself to the patient sitting in the exam chair. I do not recall the details of the visit, but he was an older gentleman from the South. When I asked him how he was doing, he replied, “Finer than frog hair split three ways”. I inquired what he meant and he explained that it was a southern expression meaning one is doing well.

After the visit I did what any curious person would do with the saying, I googled it! Sure enough, it is an actual phrase meaning one is doing fine or well. According to my online search, it originated in the United States in the mid 19th century. In the southern parts of the country the saying expanding to, “As fine as frog hair split three or four ways”.

I have used this saying many times since first learning of it. I get varied reactions from people and most, like me, have never heard of it. However, there are some who react with surprise and claim their uncle or father or other relative used the phrase often. I have learned over the years that when people ask how you are doing, most do not really care and many do not really listen to the answer they are given. Therefore, when you come back with a phrase not expected, a look of confusion comes over them. I hear retorts such as “I did not know frogs have hair!”, or “Is that a good thing?” So I end up explaining to them the true meaning is that one is doing well.

It is human nature to respond in the positive when randomly asked, “How are you doing?”, whether you are doing well or not. We generally do not want to burden the asking individual with negativity to such a mundane and common question. I find by focusing on a positive attitude in my daily life, it becomes a contagious emotion and sets the tone for a more genuine response that is believed.

I have been in the Otolaryngology field for 25 years. As I have gotten older I try to live each day with an underlying positive attitude and embrace my workday in that manner. I feel starting each day with an optimistic outlook serves us all well in our personal and professional lives.

The people we come into contact with throughout the day, whether patients, office staff, nurses or colleagues, can pick up on our emotions and know if we are having a good day or not. It brings confidence to those around us, especially our patients, if we are smiling and encouraging the positive in a situation. It impacts how well the outcome of the office visit or surgery will be.



"It brings confidence to those around us, especially our patients, if we are smiling and encouraging the positive in a situation."

As a program director of an ACGME accredited residency program (yes we made it!), I have become aware of the increased emphasis on wellness of residents both individually and as a group. Physician wellness seems to be a concept that is gaining popularity not only with residents but with attending physicians as well. Physical health as well as mental health goes hand in hand in shaping our daily attitudes, overall performance, and relationships at home and in the work place. Striving to find a balance between the stresses of work life and home life is key to physician wellness, but can be elusive for individuals with driven personalities such as most physicians.

The objective to a balanced life gets put aside by most of us. It is important to try to excel at your chosen craft as this will impact many people along the way. It is important to make a positive impression in the world and leave it better off because of your efforts. It is also important to understand your limitations. But it is equally important to embrace your own existence and live each moment with an upbeat attitude. Frog hair may be fine, but sometimes it is good to split frog hairs and not ask why.



2018 PRESIDENT ELECT REPORT

We are transitioning with the Monstully Management Group. Many obstacles are being dealt with ranging from maintaining our members, encouraging new graduates to join, and mentoring them as medicine becomes more challenging. The increasing audits of HIPPA, MIPS, RAC and meaningful use are some of the challenges we are experiencing in medicine. Dual accreditation is just around the corner. How will this affect our membership?

The 2018 ACA in Bonita Springs was well attended. I personally enjoyed the new location and its facilities. The size of the resort was great for our members and their families. We are looking at future sites. Cypress in Orlando has always been well attended. It would be nice to attend the ACA in different locations. We welcome any recommendation of favorite sites you have visited. Our membership is smaller in member than other groups. This should give us more opportunities to diversify our meeting sites. Locations such as New Orleans, Boston, Indianapolis, and French Lick in Indiana have wonderful sites. It has always been thought that the member prefer hot sunny locations. I visited Costa Rica, The Hotel Riu is wonderful all- inclusive resort, and they have meeting rooms. Direct flight from O'Hare Airport was five hours. Everyone mostly stayed at the resort to converse at the pool. Considerations for "all-inclusive" resorts with all the food, beverages (including alcohol), and desserts have been discussed. Activities are available all day with entertainment at night. Ocean and land outings are available for additional fees. Discussion about meeting on cruise ships revealed concerns for CME.

Ophthalmology Advocacy Leadership Group Update

Medicare drug pricing reform: Trump administration has asked the AAO provide a perspective on competitive acquisition programs. If properly implemented, a competitive acquisition program might be able to ease some of the significant practice burdens of purchasing, storing and providing Part B drugs in physician offices. Need to make sure that any CAP initiative is optional and works for patients.

IRIS Registry: CMS expects ophthalmology to do well under MIPS. They are expected to take the largest portion of the MERIT-Based Incentive Payment System bonus pool for 2018 reporting.

Anthem: Anesthesia during cataract surgery – Anthem informed OLAG that coverage instructions related to cataract anesthesia are not yet in effect. They have clearly marked the guidance reflecting this. But, Anthem continues to maintain problems on their website, causing confusion for patients and surgeons.

Blepharoplasty: Can now be billed separately to patients even when performed in conjunction with a medically necessary/Medicare ptosis repair.

Medicare Advantage Prior Authorization Abuse: Steps to stop the prior authorization abuses in Medicare Advantage. Some plans require PA for each visit for ARMD. Florida Society of Ophthalmology writing plans in that state that are requiring PA for every drug injection.

Ophthalmic Drug shortage: Dorzolamide, lidocaine, atropine, and others. AAO urging FDA to urge manufacturers to increase production or find new avenues for production.

Compounding: AAO continues to advocate access to compounded and repackage drugs.

CMS reinstates deleted diagnosis codes for

Vitrectomy procedures: Last October CMS authorized deletion of 25% of vitrectomy's diagnosis codes including those for vitreous hemorrhage. Macular hole and macular pucker. It took until March 5th for CMS to restore the codes and waited until April before notifying the physician.

New Lecture Structuring Options

There are many more options for our members who want something new.

We have all discussed starting the lectures earlier in the day to allow members to enjoy the resort without missing CME's. Several ways this can be achieved.

- Starting lectures at 6 or 7 a.m.
- Eliminate lunch breaks.
- Have our lunch while watching lectures.
- We would have to limit the crunchy chips for the sake of the lectures.
- End lectures at 2 p.m.
- Begin the workshops at 2 p.m.

We might see a change from the low attended afternoon lectures to low attended 6 a.m. lectures. Lectures starting at 6 am would give one the opportunity to enjoy other desired activities earlier in the afternoon. Most physicians are up early. I prefer early a.m. to get the workday to allow me the afternoon for my desired activities.

Concerns were brought to our attention about moving our ACA meeting earlier vs later. Next year the AAO meetings were changed from their original planned dates. Their changed date is overlapping our ACA dates. The sites for the meeting are negotiated several years in advance. Our options are limited. Approximately \$250,000 would be lost by changing locations.

If we stayed at Cypress in Orlando and move the date forward or backward the loss would be less but we would have to to guarantee return next year and again in 10 years. The BOG has decided to keep the original dates and try to cut our loss to a minimum.

Health Insurance – Individual and Office

I had a rude awakening last year when renewing my health insurance. I had Anthem for myself and my family for 30 years or so. Last November I was thrown into the online healthcare market place. Commercial insurance companies no longer provide individual coverage. This was not an easy task even for someone who deals with the insurance dilemma on a daily basis.

I was finally able to obtain Ambetter. This was one of the more desirable plans. I set up my autopay for 12 months (hoping for something better next year). Constant harassment to make the first payment vs losing my insurance by text and phone calls. Even though they already had received payment. Several months later this repeated again. Stating they have not received my 2 payments, but the payments had cleared from my bank. Our last management group had stated that we would be able to join a conglomerate medical insurance company. This never got accomplished. I will work with Monstully Management to achieve this opportunity for our members. The AAO provides access to medical insurance. Mercer health and Benefits LLC provides many insurance options for its members.

In closure I want everyone to realize, Past President Kristen Reidy DO, performed above and beyond excellence. Sacrificing time away from her family, she and Dr. Kitsko searched diligently, for management groups for us to review and decide upon. She proceeded with extreme passion to move to AOCOO-HNS in a positive direction for our members and the foundation. I anticipate an active year. President Kitsko and the Board of Governors will continue the excellent work passed onto us.

We are always searching for members who would like to step up and continue making improvements to our changing AOCOO-HNS organization.

Young members are encouraged to get involved and take control of your future.

Sincerely,

Judy L. Davis D.O, FAOCO President Elect AOCOO-HNS 2018



"Young members are encouraged to get involved and take control of your future."

2018 MOTOWN MID-YEAR BUSINESS OF MEDICINE SYMPOSIUM

Our 2018 Motown Mid-Year Business of Medicine Symposium did not disappoint. If you attended then you know the amazing lectures we had and the amount of fun that was added this year. A huge shout out to Detroit Soul Revue who had all of us dancing the night away.



MEDICARE AND THE QUALITY PAYMENT PROGRAM

WHAT IS THE QUALITY PAYMENT PROGRAM?

The Quality Payment Program is the new Medicare payment program that has been put in place not only to reform Medicare Part B payments to clinicians but also to improve care across the entire health care system. This is the biggest change to physician reimbursement since Medicare was signed into law by President Johnson in 1965. The new program combines the PQRS, Meaningful Use and Value-Based Modifier programs already in use into one program. This has been done to make reporting easier than in the past.

2017 was the Initial Recording year with 2019 as the reimbursement year for 2017. I expect that most clinicians have heard of QPP and MACRA and MIPS at this point and have chosen the path in which to participate. MACRA has two pathways – MIPS and MACRA. Most providers will fall into the MIPS category (Merit-Based Incentive Payment System) which is geared to the traditional Medicare program, with larger groups choosing the APM path (Advanced Alternate Payment Model). CMS sent letters to all clinicians that were eligible to participate, starting in 2017. The clinician could participate either as an individual or as a group.

Within the MIPS program, providers can choose the activities and measures that are most meaningful to their practice. By now, providers should have reported their activity for 2017 in order to not get a negative 4% reimbursement on their Medicare payments.

Small and/or Rural practices and Healthcare Shortage Areas (HPSAs) have special consideration under the MACRA program. If you are a solo practitioner or in a group of less than 15 providers, you also fall into this category. Your options include: the ability to pick your pace, a lower volume threshold for Medicare annual charges, and flexible data requirements. If you are a Nurse Practitioner, you also have special consideration.

For 2018, CMS has adopted policies that may reduce your reporting burden and let you participate successfully. The 2018 MIPS highlights include:

The performance threshold is raised from 3 points (2017) to 15 points in 2018.

The 2014 and 2015 Editions of your CEHRT are still allowed in 2018, with a bonus for using the 2015 edition only.

For treating complex patients in 2018, you can receive up to 5 points.

If you have been impacted by Hurricane Irma, Harvey, or Maria, your Quality, Advancing Care Information and Improvement activities can be automatically reweighted. Small practices can add 5 points to their final score. 2018 is also the year that Virtual Groups are an option for participation.

You can only use one submission mechanism per performance category.

Facility-based measures are still not available in 2018, year 2 of the program.

The Quality final score is 50% in 2018, vs. 60% in 2017.

The cost category final score is 10% of the total score in 2018 vs. 0% in 2017. CMS will calculate the individual MIPS eligible clinician's and group's cost performance using administrative claims data.

Improvement activities final score for 2018 is 15% of the total score.

Advancing Care Information final score equals 25% of the total score.

For the Quality category, 6 measures including 1 Outcome measure or 1 High-priority measure are required for the full score of 50%. Nurse Practitioners and small groups have fewer Quality measures to complete.

Advancing Care Information – NPs and PAs do not have to complete this category. The ACI category is automatically reweighted to zero and the Quality Category is increased to 25%.

There are also more options for small practices:

If you have less than 200 Medicare Part B patients or have less than \$90,000 in Medicare Part B allowed charges, you are exempt from participation.

As a small practice, you can join a Virtual Group to participate with other practices.

Continuing to award small practices 3 points for measures in the Quality Performance category that do not meet data completeness requirements.

Adding a new Hardship exemption for the Advancing Care information performance category.

For Clinical Improvement Activities, small practices don't need more than 2 activities (2 medium or 1 heavy-weighted activity) to earn a full score for the category.

Small practices receive 5 bonus points if the provider submits data for at least 1 performance category.

For 2018, there is a change for performance periods. The minimum performance period for the Quality Care category is 12 months. The minimum reporting period for both Advancing Care Information and Improvement Activities is a 90-day period. CMS will measure the Cost category for 12 months.

The submission of data for 2018 is the same as it was for 2017. Data can be submitted through claims, Qualified Data Registries or through your EHR.

Information about the Quality Performance Program can be found on qpp.cms.gov. There is a resource library and other helpful information.

If you would like to book MACRA/MIPS Lunch and Learn or other topic Lunch and Learn for your group, or need a speaker for your meetings please call 915-269-4736.

MEDICAL PRACTICE MANAGEMENT CONSULTANTS

Helping Small Practice Succeed

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2019 ANNUAL CLINICAL ASSEMBLY



Plans are already under way for our 2019 Annual Clinical Assembly.

The 2019 ACA will be held at the Hyatt Regency Grand Cypress in Orlando Florida on May 2nd – 4th, 2019.

Room rates are \$225 single/double, \$250 triple and \$275 quadruple occupancy. More information and online registration will be available January, 2019.

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