MOVING INDIANA FORWARD

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INDIANA PODIATRIC MEDICAL ASSOCIATION

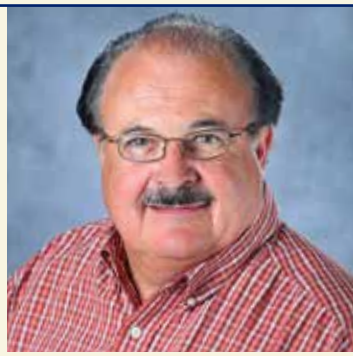
Forward

ISSUE ONE | SPRING 2019

IN THIS ISSUE

PRESIDENT'S MESSAGE

RICHARD LOESCH, DPM | IPMA PRESIDENT



I hope everyone has enjoyed the beginning of spring and the warmer weather. I am excited to begin my term as IPMA President. This year has already been a busy year for IPMA. In March, IPMA members went to Washington, D.C. during the House of Delegates to discuss the important issues facing the APMA and its governance structure. After three hard days of work the delegation made the rounds on Capitol Hill with Indiana's Congressional Delegation. I wanted to thank all those who attended the House of Delegates on behalf of the membership.

I ask you to continue to support the IPMA/APMA with your membership dues and participation. The IPMA needs you to be involved and engaged to make change happen for podiatrists, our patients and our practices.

Our association remains in a strong financial state. We finished 2019 with a seventh straight year of net positive in the IPMA budget. This is allowing the IPMA to continue to growth its strategic rainy-day fund.

As always, we continue to need the time and talents of all members in order to remain a strong organization. If you are interested in getting involved, please do not hesitate to contact me or the IPMA office.

Thank you to all who attended the convention in 2018. I believe that a strong convention is key to the success of the IPMA. The IPMA offers a strong education program while providing an opportunity to meet with other IPMA members. I am hoping all who attended in 2018 will do so again and hope that you take the time to invite a colleague who you have not seen at the convention in a while.

If you have any thoughts, concerns or suggestions regarding the activities of the IPMA please do not hesitate to contact me.

ONLINE LIMITED PODIATRIC RADIOGRAPHY EDUCATIONAL PROGRAM

The Indiana State Department of Health (ISDH) requires all podiatric medical assistants who take x-rays to be licensed as a limited podiatric radiographer.

The IPMA wants to remind the membership of its new limited podiatric radiography program that meets the ISDH requirements and is designed to instruct the podiatry assistant in the safe and effective use of x-rays in the podiatric practice.

Content includes:

- History of the x-ray
- Risks and safety measures associated with radiography
- Image production and film development
- Principles of CT Scan, MRI, and Bone Scan
- Anatomy of the foot and ankle
- Positioning and x-ray machine placement

PROGRAM STRUCTURE

The program consists of four online content modules, each with a final exam, one attestation module, a student manual, and an x-ray log. A Certifying Physician must guide the applicant in the clinical portion of the program and the completion of the x-ray log. The podiatry assistant must document competency by demonstrating the proper performance of 60 x-ray views in the podiatrist's office.

At the successful conclusion of the program, the applicant will have the proficiency and skill necessary to obtain the limited podiatric radiography license and will receive a Certificate of Completion. The Certificate, the completed Application for Proficiency Certification for Limited Radiographer and signed x-ray log should be sent to the IPMA.

To learn more about this program or to register, click here.

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AUDIO/VIDEO RECORDING IN PODIATRY PRACTICES

With emerging technology and the proliferation of smartphones, many patients can record visits with their podiatrists and other healthcare providers. Patients might share these recordings with family members and caregivers and use them to help recall important details and medical advice. However, in some cases, patients and families are recording encounters without providers' knowledge or permission (whether legal or not), and some video has appeared on websites and social media platforms.

At least 1 in 10 U.S. patients now records discussions at medical appointments.[1] In 39 of the 50 states and the District of Columbia, a one-party consent law allows the consent of any one party to a conversation to be sufficient, including the person making the recording. Therefore, a patient may record a clinical visit without obtaining a provider's consent in those states. However, a provider's consent is needed in 11 states that have a two-party recording law.[2] This law makes it illegal to make a recording without the permission of *all* parties to the conversation.

In any state, podiatrists and other healthcare providers can devise policies on using recording devices in their healthcare practices. These policies may distinguish between recordings made in public areas, such as waiting rooms, and recordings made in private areas, such as examination rooms.

Podiatrists may also want to consider prohibiting patients from making recordings in public areas of the office to avoid any allegations of a privacy breach from other patients and staff members. Topics to discuss and the duration of the recording should also be included in audio/video policies.

Give your patients a written copy of the audio/video policy, and be sure to get them to sign it to acknowledge their understanding. If your practice doesn't have a written policy on audio/video recording by patients, you may want to consider this approach if patients ask to record:

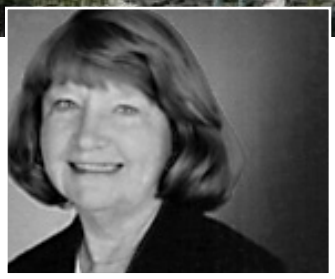
- Ask them why they want to record the conversation so you can learn their intentions. You may learn that some patients need extra attention.
- Consider whether other options exist, such as recording only parts of the clinical encounter. Discuss these options with the patient.
- Accept or decline the request. If you decline, explain why and offer to continue with the appointment. If a patient insists, use your discretion on continuing the appointment.
- Be sure to document in the patient's health record if a recording was made in your office. Documentation should include the duration of the recording, topics discussed, and other pertinent details. Also, ask the patient for a copy of the recording. When possible, retain a copy of the recording with the patient's health record.[3]

Podiatrists may also want to consider prohibiting patients from making recordings in public areas of the office to avoid any allegations of a privacy breach from other patients and staff members. Topics to discuss and the duration of the recording should also be included in audio/video policies.

If a patient initiates a recording but does not give it to the podiatrist, then the recording is not subject to the Health Insurance Portability and Accountability Act (HIPAA) laws. HIPAA laws apply when the recording is "created or received" by a "covered entity," including healthcare practitioners.[4]

It can be very beneficial to patients to have a recording of their clinical visits, and the presence of a recording also can protect healthcare providers. Keeping the lines of communication open about audio/video recording may decrease any threats to other patients' privacy as well as the privacy of staff members. Most importantly, podiatry practices should consider implementing a policy on audio/video recording that covers issues related to consent, limitations on recording locations in the office, duration, and content.

1. *Dallas, M. E. (2017, July 10). More patients are recording their doctor visits. CBS News Healthday. Retrieved from www.cbsnews.com/news/patients-are-tape-recording-their-doctor-visits/*
2. *Ibid.*
3. *Canadian Medical Protective Association. (2017). Smartphone recordings by patients: Be prepared, it's happening. Retrieved from www.cmpa-acpm.ca/en/advice-publications/browse-articles/2017/smartphone-recordings-by-patients-be-prepared-it-s-happening*
4. *Elwyn, G., Barr, P. J., & Castaldo, M. (2017). Can patients make recordings of medical encounters? What does the law say? JAMA, 318(6). Retrieved from https://jamanetwork.com/journals/jama/article-abstract/2643728*



LEGISLATIVE REPORT

BY GLENNA, SHELBY, JD, PARTNER
LEGISGROUP PUBLIC AFFAIRS, LLC

The Indiana General Assembly has reached its midpoint. In total, 938 of the 1349 introduced bills have died, since they failed to pass in their chamber of introduction. 213 Senate bills passed in the Senate and 198 House bills passed in the House. Committees will begin taking up bills from the opposite chamber.

SB 586, the physical therapy bill, passed the Senate, 39-0, and is awaiting committee assignment in the House. The bill includes a "PT text book's definition" of a PT's scope of practice and expands their direct access from 24-42 days. Some amendments have limited their authority to diagnose, but the language puts "wound care" into their scope for the first time in Indiana statute. For years they've claimed to have been doing it. While the bill leaves unchanged current law limiting their authority to perform "sharp debridement," IPMA is seeking an amendment limiting their authority for foot and ankle wound care to Grade 1 wounds except on the order or referral of an MD or DPM. So far the bill's author, Sen. Mark Messmer (R-Jasper) and the PT association have rejected and argued against our amendment request.

IPMA members are urged to contact their State Representatives encouraging them to support an amendment to SB 586, limiting a PT's authority to perform wound care as detailed above. You can find your State Representative and contact information at this site http://iga.in.gov/legislative/find-legislators/ .

HB 1248 was amended in the House Health Committee to include the Physician Assistant bill, HB 1259. Both HB 1248 and HB 1259 were authored by Rep. Steve Davisson. Health Committee Chair Cindy Kirchhofer had indicated she wouldn't have time to hear the PA bill, but she allowed it to be amended into HB 1248, a bill about emergency pharmacy refills. The PA bill would change the standard from "supervision" to "collaboration" with an MD. IPMA will seek to include DPM's as eligible to be in collaborative practice with a PA.

Two identical Advanced Practice Registered Nurse bills creating a route to an APRN achieving independent practice faced different fates in the House and Senate. SB 394 was amended at the request of Indiana State Medical Association to make more stringent the conditions under which an APRN could practice without an collaborative agreement. SB 394 also ends the eligibility of DPM's, OD's, and DDS' to participate in an APRN practice agreement in 2022. SB 394 passed the Senate 43-5. HB 1097, the House APRN bill faced aggressive opposition lobbying

by IU Medical School residents/interns and others. HB 1097 was amended to allow a DPM's collaborative practice agreement in force on 7-1-19 to continue in force for an indefinite period. An MD Representative's amendment requiring 6,000 of active clinical practice became a "poison pill" (no pun intended) and many individual APRNs withdrew their support for the bill. It died when the author, Rep. Ron Bacon (R-Chandler), failed to call the bill for final reading on the House floor. His House republican colleagues had informed him he didn't have enough votes to pass HB 1097.

SB 203, the MD/DPM maintenance of certification bill, passed the Senate, 44-4. It has been referred to the House Health committee. It would prohibit a hospital from denying hospital staff or admitting privileges to an MD or DPM based solely upon the practioner's decision not to participate in maintenance of certification. It would also prohibit a health insurer or an HMO from refusing participation or limiting reimbursement based solely upon the MD/DPM's decision not to participate in maintenance of certification.

HB 1269 reduces membership on a number of professional licensing boards, including the Board of Podiatric Medicine. Boards with fewer than 15,000 licensees are reduced to 5 members. HB 1269 passed the House, 90-0, and has been assigned to the Senate Commerce and Technology committee.

SB 8 urges the Legislative Council to direct an interim study of the factors that are contributing to the growth of health care costs. It passed the Senate 49-0. SB 8 has not yet been assigned to a House committee for consideration.

A number of opioid treatment program bills passed.

The Medical Malpractice bill, SB 26, failed to get a hearing and died.

A number of medical marijuana bills weren't heard and died.

The legislature must adjourn by April 29th; April 26th has been targeted to be the last session day.

The full text of these bills can be found on iga.in.gov/legislative/2019/bills/ and scrolling to the specific bill number.

APMAPAC REPORT

BY CHRISTOPHER GRANDFIELD, DPM
APMAPAC COORDINATOR

QUICK FACTS
IPMA Contributors: 15 Members
IPMA Contribution Member Percentage: 7%
IPMA Contribution Total: $9,485/$17,638
IPMA Contribution Goal Percentage: 54%

DIAMOND LEVEL SUPPORTERS ($2,500-$4,999)
Dr. Patrick DeHeer
Dr. Sandra Raynor

PLATINUM LEVEL SUPPORTERS ($1,000-$2,499)
Dr. Zahid Ladha
Executive Director Matt Solak

GOLD LEVEL SUPPORTERS ($500-$999)
Dr. Walter Warren

SILVER LEVEL SUPPORTERS ($300-$499)
Dr. Brian Damitz
Dr. Patricia Moore

BRONZE LEVEL SUPPORTERS ($150-$299)
Dr. Chris Grandfield
Dr. William Oliver
Dr. Chase Stuart
Dr. Amanda Vujovich
Dr. Aaron Warnock

PATRIOT LEVEL SUPPORTERS (LESS THAN $150)
Dr. Kent Burress
Dr. Robert Freestone
Dr. Miranda Goodale
Dr. David Sullivan

The future of podiatry and your future depends upon your support of APMAPAC. Click here to make a donation.

PURPOSE: The American Podiatric Medical Association Political Action Committee's purpose is to raise and disburse funds to candidates for Federal office that support the legislative priorities and goals of the podiatric medical profession.

IMPORTANT: All amounts are simply suggested amounts. You may contribute or not contribute without concern of being favored or disadvantaged. Occupation/Employer information is required for aggregate annual contributions of more than $200.00 by the Federal Election Campaign Act. Federal election law does not permit corporate contributions to be used for donation to candidates for federal office. Political contributions are not deductible for income tax purposes.

E/M CHANGES EFFECTIVE JANUARY 1, 2021

At the February 2019 AMA CPT panel meeting, there were multiple panel actions that will change coding for office and outpatient Evaluation and Management (E/M) services effective January 1, 2021. The exact CPT language and code descriptors will not be final until just prior to the release of the code set. Furthermore, more specific information than what is shared through panel actions may be released prior to publication of the new code set. Even with those stipulations, these panel actions will have a significant impact on office and outpatient (E/M) coding. APMA had representatives at this CPT panel meeting and these changes will apply to all providers equally.

DELETION OF CPT 99201

The panel voted to delete CPT 99201 (Office or other outpatient visit for the evaluation and management of a new patient). This code saw low utilization and will no longer exist as of January 1, 2021. It is important to note that this does not apply to only a certain payer or a certain part of the country, but rather this code will be deleted from CPT.

CHANGE TO CERTAIN CODE SELECTION CRITERIA

The criteria that is used to determine the level of an office or outpatient E/M service will change dramatically in 2021. Currently, the instruction is to use the thresholds of all three E/M key elements of history, exam, and decision making to determine the level of a new office/outpatient encounter and to use two out of the three key elements to determine the level of an established office/outpatient encounter. Alternatively, time can be used if counseling and coordinating dominate the encounter. Starting January 1, 2021, the key elements of history and exam will no longer play a role in office/outpatient E/M code selection. The performance of a history and/or exam will be necessary in order to report an office/outpatient E/M service, but they will not play a role in code selection. Instead, the code will be selected based upon either the level of medical decision making (MDM) or total time.

CHANGE IN THE DEFINITION OF TIME

Physicians are accustomed to quantifying face-to-face time and time spent counseling and coordinating. However, starting in 2021, the time values associated with each office/outpatient E/M code will indicate the total time spent on the day of the encounter. Physicians will no longer need to determine how much of that time was spent in counseling and coordinating. There will be changes in these time values that are associated with each office/outpatient E/M code.

CHANGE TO OFFICE/OUTPATIENT MDM ELEMENTS

There will be slight changes to the titles of the three elements that are used to determine the level of MDM. “Number of Diagnoses or Management Options” will be changed to “Number and Complexity of Problems Addressed”. In addition, “Amount and/or Complexity of Data to be Reviewed” will change to “Amount and/or Complexity of Data to be Reviewed and Analyzed”. Finally, “Risk of Complications and/or Morbidity or Mortality” will change to “Risk of Complications and/or Morbidity or Mortality of Patient Management”.

OTHER E/M SERVICES AFFECTED?

These changes will only apply to office and outpatient E/M services (CPT 99202 – 99215). Guidelines for hospital observation, hospital inpatient, consultations, Emergency Department, nursing facility, domiciliary, rest home, custodial care, and home E/M services will not change. Therefore, there will be one set of guidelines for determining the appropriate code for office / outpatient E/M services and a different set of guidelines for all other E/M services.

CONCLUSION

While these are the publicly reported panel actions, they should not be considered final until the 2021 CPT book is published. Fortunately, there is more than one year to digest these changes, provide the appropriate training, and be ready in time.

Resources: AMA CPT® Editorial Summary of Panel Actions February 2019
https://www.ama-assn.org/system/files/2019-03/february-2019-summary-panel-actions_0.pdf

PRACTICE FOR SALE

IPMA wanted to make members aware of a long standing, diversified podiatric practice for sale. The practice is mainly in Northwest Indiana, but also a small part in Illinois. Doctor to retire and move. Ground floor rental. Allowed to sublease so may increase patient load or keep as part time. Email replies to: doctorfootstep@gmail.com.

30th Kaplan-Clarke-Foster

Practice Management Seminar

FRENCH LICK RESORT

FRENCH LICK & WEST BADEN · INDIANA

September 11–15, 2019

Resort packages start at $2,027 per person
(based upon double occupancy).

Benefiting apma | Protecting Our Profession

Contact Ben Wallner at 301-581-9231 or email ***bjwallner@apma.org.***

Hotel reservations deadline is August 10, 2019.
Hotel rooms are assigned on an "as available" basis.

www.apma.org/kcf

Fax completed form to Ben Wallner at 301-571-4905. Deadline to register is August 31, 2019.

Amount to Charge: **$300:** Registration Fee **$150:** Non-DPM Registration Fee **$125:** Facility Fee

Payable to APMA Protecting Our Profession

❑ Check this box if you prefer to pay your registration and facility fee in monthly installments.

Name

Address

City State Zip Credit Card Number Expiration Date

Shirt Size: S M L XL XXL

E-mail Address Signature Date

HIGHLIGHTS FROM THE APMA HOUSE OF DELEGATES

On March 16-18, certified delegates and alternates from each component society met at the JW Marriott for the 99th Session of the APMA House of Delegates. The House of Delegates is the legislative and governing body of the APMA. The Indiana Delegated consisted of:

- Patricia Moore, DPM, Chief Delegate
- Walt Warren, DPM, Delegate
- Zahid Ladha, DPM, Delegate
- Brian Damitz, DPM, Alternate Delegate
- Sandra Raynor, DPM, Alternate Delegate

99th APMA House of Delegates Election Results:

- President-elect: Seth A. Rubenstein, DPM
- Vice President: Jeffrey DeSantis, DPM
- Treasurer: Laura J. Pickard, DPM
- Elected to the Board of Trustees: William Long, DPM
- Re-elected to the Board of Trustees: Sylvia Virbulis, DPM; Leslie Campbell, DPM
- Elected Speaker of the House: JD Ferritto Jr., DPM
- Elected HOD liaison to the JCRSB: Priya Parthasarathy, DPM

To read more about the elected candidates, see their profiles in the January/February issue of APMA News. Other highlights include:

- The Delegates approved proposed changes to the APMA Bylaws, the APMA Policy and Procedures Manuel and other governing documents.
- Patrick DeHeer, DPM, chair of the Legislative Advocacy Committee, offered updates from the Legislative Advocacy Committee and encouraged members to make use of APMA's updated eAdvocacy system to contact their legislators about the HELLPP Act,
- Barney Greenberg, DPM, chair of the APMAPAC Board of Trustees, told the delegates that "leaders lead by example," and asked the house to lead by giving to the APMAPAC today.
- Jeff DeSantis, DPM, 2018–19 treasurer, presented a report from the Finance Committee. The house approved the 2020–21 proposed budget.

L3000 COVERAGE UNDER MEDICARE ALERT

APMA has received several recent queries regarding coverage of foot orthotics (L3000–L3060) under Medicare. Medicare's coverage on foot orthotics is extremely limited, making it unlikely that most podiatrists will ever provide foot orthotics meeting Medicare's coverage criteria.

The coverage guidelines specifically preclude foot orthotic coverage unless ***all*** of the following criteria are met:

- The patient is wearing a leg brace that is attached to the shoe (in most cases the brace is externally attached); *and*
- The supplier providing the orthotic has also provided the brace; *and*
- The orthotic is placed into the shoe used with the brace.

It is important to understand that the foot plate component of an AFO does not separately qualify as a foot orthotic, nor does it qualify for coverage under the foot orthotic codes (L3000–L3060).

PDAC validation letters do not in and of themselves imply coverage and reimbursement. Thus, the presence of a "PDAC validation letter" does not qualify any device for coverage. Members should check with the patient's insurance carrier (e.g., DME MAC) regarding coverage issues.

Resources: APMA.org/DME and APMA.org/L3000 (L-Code Foot Orthotic Clarification)
More information on foot orthotic coverage may be found in the Orthopedic Footwear LCD, found in your DME MAC LCD webpage
More information on PDAC jurisdiction and validation process may be found at www.dmepdac.com

CHECK YOUR PRELIMINARY 2019 MIPS ELIGIBILITY ON THE QPP WEBSITE

MIPS, or the Merit-based Incentive Payment System, is a program administered by CMS that determines whether eligible clinicians or clinician groups receive a positive, negative, or neutral adjustment to their Medicare Part B payments. These adjustments scale upward each year, with the 2021 adjustments for the 2019 performance year ranging from 7 percent to -7 percent.

A standard MIPS Score is composed of four performance categories: Cost (15 percent), Quality (45 percent), Improvement Activities (15 percent), and Promoting Interoperability (25 percent). After reporting and/or attesting for each performance category, you will be assigned a raw score, which will be used in calculating your final composite score (out of 100).

If you or your group is eligible for an exception to the Promoting Interoperability and/or Cost categories, those categories will be reweighted to 0 percent and your Quality performance score will be reweighted accordingly. CMS will issue information on how to apply for an EHR exception later in 2019, most likely late summer or early fall.

The Cost and Quality categories are measured over the full year (January 1 through December 31); Improvement Activities and Promoting Interoperability categories are measured over any continuous 90-day period of your choice. Providers will have the first quarter of 2020 to attest to the performance categories.

To see information on specific performance categories or find webinars on the 2019 MIPS performance period, please use the navigational tabs at the top of this page.

WHO IS CONSIDERED ELIGIBLE TO REPORT?

In order to be MIPS eligible, a clinician must:

- identify on Medicare Part B claims as a MIPS eligible clinician type (up-to-date with 2019 performance year information);
- have enrolled in Medicare before 2019;
- not be a Qualifying Alternative Payment Model Participant (QP); and
- exceed the 2019 performance year low-volume threshold
  a. as an individual when reporting individually, or
  b. at the group level by being in a practice that exceeds the low-volume threshold when reporting as a group or virtual group, or
  c. as a MIPS APM participant that exceeds the low-volume threshold at the entity level.

Clinicians and groups fall under the low-volume threshold and are exempt from MIPS if they:

- bill $90,000 or less in Medicare Part B allowed charges for covered professional services payable under the Physician Fee Schedule (PFS), or
- provide covered professional services for 200 or fewer Part B-enrolled individuals, or
- provide 200 or fewer covered professional services to Part B-enrolled individuals

Clinicians who do not meet these requirements are exempt from MIPS.

APMA MIPS APP AND MIPS WHITE GLOVE SERVICES

For the 2019 performance year, we recommend members download the APMA MIPS app. This online tool is free to members, and allows you to monitor your progress and potential MIPS score throughout the year. The APMA MIPS app also allows you to submit your MIPS attestations directly to CMS during the reporting period.

Additionally, while APMA has provided a wealth of resources below that will help a podiatric physician be successful, every practice has different needs and structures. If you are looking for additional support beyond what is available on the website, such as one-on-one assistance with individualized measure selection and personalized planning for your practice's participation with the MIPS program, consider working with a MIPS consultant. APMA has identified two consultants to provide members with individual assistance. These services are available at a preferred rate for APMA members. Find out more at www.apma.org/MIPSwhiteglove.

Additional resources are available from CMS at qpp.cms.gov or by contacting CMS directly at 866-288-8292. CMS Resources:

- *Quality Payment Program Website*
- *2019 QPP Final Rule (PDF)*
- *QPP Final Rule Executive Summary (PDF)*
- *2019 QPP Final Rule Overview Fact Sheet (PDF)*
- *2019 Quick Start Guide to MIPS (PDF)*
- *MIPS Participation and Eligibility Fact Sheet (PDF)*

MEDPAC:

DOCS DON'T NEED RAISE IN BASE MEDICARE PAY

COMMISSION AGREES WITH UPDATE SET BY MACRA LAW

by Joyce Frieden, News Editor, *MedPage Today*

Physicians' current fee-for-service Medicare reimbursement rates can stay as they are in 2020, the Medicare Payment Advisory Commission (MedPAC) said Friday in its annual March report to Congress.

Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress set a number of updates to the Medicare fee-for-service payment schedule in advance. In that schedule, physicians received a 0.5% increase each year from 2015 to 2019; no further increases are scheduled for 2020 to 2025. However, apart from those updates in individual fee-for-service payments, physicians can also earn bonuses of up to 12% — or penalties of as much as -4% — based on their performance in Medicare's new pay-for-performance program.

"Overall, access to clinician services for Medicare beneficiaries appears stable and comparable with that for privately insured individuals," the report authors wrote. "Other measures of payment adequacy are stable and consistent with prior years. Therefore, the Commission does not see a reason to diverge from the current-law policy of no update for 2020." MedPAC also had agreed with the 0.5% increase for 2019.

Although physicians may find their overhead costs increasing more than the updates they're receiving, all indicators are that this isn't stopping them from seeing Medicare patients, MedPAC executive director Jim Mathews, PhD, told *MedPage Today* during a conference call with reporters.

"One of the factors that we look at is the relationship between the update in law relative to measures of costs physicians face," he said. Although there may be some indications that physicians' costs have increased, "all our other indicators of payment adequacy are positive with respect to beneficiary access, physician participation, and quality of care."

"There is always an element of judgment that comes into these determinations, but...the first question we ask is, 'Is any

update warranted to ensure beneficiary access, and if so, what should that update be?'" he continued. "Here, when we look at the preponderance of indicators in the physician sector, the commission came to the conclusion that the update would not be warranted or necessary this year in order to maintain access. But it is something we do explicitly consider in coming to these recommendations."

The commissioners did take issue — but only slightly — with Congress's proposed increase for Medicare hospital payments of 2.8%. "When we look at the number of hospitals participating, the volume of service, beneficiary access to care, and quality of care, those indicators in the hospital sector are generally positive," Mathews said. However, one indicator less positive over the year [is hospitals'] Medicare margin — how well they're doing financially as a result of participating in Medicare."

In particular, "in the last year or two, the margins for the group of hospitals we deem relatively efficient have also gone negative; they were at -2% in 2017," he said. "The reason it's concerning for us when their margins go negative is that our authorizing statute requires us to examine factors related to delivery of care, so when ... a hospital is efficient and still can't stay in the black, that's cause for concern."

To address that problem, "One approach would be to give a broad update across all hospitals," but that's expensive and might end up giving money to hospitals that don't need it, Mathews said. So instead, "this year we took a two-pronged approach."

The first part involves redesigning Medicare's quality incentive program for hospitals. "Currently there are four such programs in operation ... Some of these programs are duplicative, and they impose a fair degree of burden on hospitals, and there is some question about the utility of measures collected under these," he said. "We recommended that these four programs be consolidated and streamlined in a method that doesn't require much reporting burden at all."

In addition, MedPAC recommended that money collected under two "penalty-only" reporting programs —– the Readmissions Reduction Program and the Hospital-Acquired Conditions Program —– be kept by hospitals, "with the money being redirected to hospitals that perform the best under Medicare," said Mathews.

The second piece involves the update itself; instead of doing a 2.8% overall update, "we'd give all hospitals a 2% update and take the other 0.8% and distribute that through our revised hospital incentive program...so hospitals in the aggregate would get all of the dollars they would under current law but more of those dollars being distributed by the Medicare program to those hospitals performing the best on quality and cost metrics," said Mathews. "We are helping the efficient hospitals and turning the tide on their financial performance."

> Although physicians may find their overhead costs increasing more than the updates they're receiving, all indicators are that this isn't stopping them from seeing Medicare patients...

Other recommendations from the March report included:

- No update for ambulatory surgery centers (ASCs). In balancing the goals of maintaining beneficiary access to ASCs, paying providers adequately, appropriately restraining spending on ASC services, and keeping providers under financial pressure to constrain costs, "the commission concludes that the ASC update for 2020 should be eliminated," the report said. In addition, Mathews told reporters, the commission "recommended that the [Health and Human Services Secretary] collect cost data for ASCs to better establish their financial performance under Medicare."
- A 1.9% increase — consistent with the formula set up under the Protect Access to Medicare Act of 2014 — in payments for outpatient dialysis services. "All the indicators [for this sector] are positive," said Mathews. "We see the capacity of providers and the volume of services growing pretty much in lockstep with the number of beneficiaries with end-stage renal disease who need these services."
- A 5% decrease in the base payment rate for home health services. "There is very strong access to care as measured by the capacity and supply of providers," Mathews said. "We had a slight decline in volume in 2017 but we believe this reflects a number of efforts, including some [Medicare anti-fraud] efforts." Although quality of care indicators were mixed, "[there is] very strong financial performance under Medicare with a 2017 margin of 15%."

The next MedPAC report will be issued in June.

SCOUTS TO EXPLORE CAREERS IN PODIATRIC MEDICINE AT 24TH WORLD JAMBOREE

AACPM Actively Recruiting Volunteers to Showcase Careers in Podiatric Medicine

The American Association of Colleges of Podiatric Medicine (AACPM) is pleased to announce an agreement to assist Dr. Bruce Blank concerning a career exploration exhibit tent at the 24th World Scout Jamboree at the Summit Bechtel Reserve in West Virginia from July 22 to August 2, 2019. Dr. Blank has been working extensively with Boy Scouts of America (BSA) to promote podiatric profession.

The AACPM is continually expanding the opportunities necessary to showcase careers in podiatric medicine. We deploy tactics that target prospective students as early as high school in our efforts to encourage exploration of careers in podiatric medicine. One of the most successful ways to garner the interest of high school students is to offer them an opportunity to hear from current podiatric physicians and students and explore podiatric medicine in a hands-on workshop.

In 2019, the World Scout Jamboree will be held at the Summit Bechtel Reserve in West Virginia, a high adventure base and the new home of the National Boy Scouts of America Jamboree since 2013. This will be the first World Jamboree to be held in the United States since 1967. According to recent registration numbers, over 30,000 Scouts will attend from 150 countries across six continents. Youth participants will range from 14-17 years of age. The World Jamboree is a coed event, and all are encouraged to attend.

The AACPM will be assisting Dr. Blank in a Podiatric Medicine Exhibit which will serve as an introduction of scouts and young leaders to modern day Podiatric Medicine and Surgery as a potential career choice. The exhibit tent seeks to engage young students, showcase the profession in a "hands-on" manner and to demonstrate the state-of-the-art technology currently in use by podiatric medical professionals in their day-to-day

practice. Dr. Blank has arranged for representatives of industry leaders like CurveBeam and Wright Medical to supply materials and instruments so that DPM volunteers can offer engaging workshop sessions. Some of the technology to be showcased highlights the future of podiatric medicine, so attendees will have the opportunity to not only be introduced to the practice of today's podiatrist but have a true sense of where the profession is headed.

AACPM and Dr. Blank acknowledge and thank the vendors and members who have contributed to the event as well as the many members of the APMA House of Delegates, including state components, that have offered financial and other support for this exhibit.

DPMs and other interested staff available to volunteer at this special event can sign up by clicking here. Direct inquires to Mandy Nau, Career Promotion Strategist at the AACPM by emailing mnau@aacpm.org.

For additional information, please contact Moraith G. North, AACPM Executive Director at 301-948-9760.

INDIANA · PODIATRIC · MEDICAL · ASSOCIATION

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94th Annual Fall Convention

October 10-13, 2019

Hyatt Regency Indianapolis

SAVE THE DATE

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October 10-13, 2019
Hyatt Regency Indianapolis
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