ALLIANCE REPORT
October 29, 2016: Atlanta, Georgia
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APMA REPORT
Dan Davis, DPM lead off the meeting by congratulating Jim Christina in his first year as APMA's Executive Director for his superb performance. On the precipice of the changing healthcare system and with the introduction of MACRA and MIPS, Dr. Christina has prepared APMA members well with his wealth of knowledge informing the association: A. What MACRA is, B. How we prepare for its implementation and C. How to devise the Clinical Data Registry.

APMA has created the first podiatric specific **Clinical Data Registry** which will provide data across all spectrums of podiatric medicine and surgery from surgical and non-surgical care to wound care. This data will provide patient outcome data and be utilized to provide the podiatrist's value in medicine and information for research and evidence based medicine in preparation for a VBS (Value Based System).

Creation of the Registry is an expensive undertaking and has been funded by the Strategic Reserves, negating an assessment or dues increases to APMA members. The data will be collected from physicians' EMR with seamless transition into APMA's data base. At this writing, two EMR companies have requested being involved in the process. Reimbursement of the Strategic Reserves will be off-set by fees charged to the companies contracted for their participation. Joining a Registry ranges from $300-$500 and APMA considers this a substantial member benefit.

APMA has contracted with Prometheus (recommended by the American Optometry Association) to develop the Registry. The initial upfront cost is several million dollars and costs will be incurred throughout the coming years including maintenance fees. The general structure of the roll out is:

Phase 1: Development of the Registry: APMA will need sample clinical data from 25 physicians in order to submit one measure for integration into the Registry. This test pool of physicians will determine the one measure to qualify for the QCDR (Qualified Clinical Data Registry) for the year 2017.

CMS has qualified Registries (Physician Qualifying Reporting Systems) - these Registries can only submit PQRS measures. In contrast, the Qualified Clinical Data Registries in addition to PQRS, (which will now be a part of the new MIPS program) can also submit outcome measures. This will negate participating in the rigorous process endorsed by the National Quality Forum then adopted by CMS. The Registry allows us to collect data to create our own outcome measures and if, with testing and validation, these measures can be assimilated into the CMS system. *This can dove-tail nicely into APMA Membership Recruitment Campaign since a typical Registry costs the physician approximately $300-$500 and this will be offered to physicians free of charge as an added member benefit.

Phase 2:
As Phase 2 begins, APMA will reach out to a number of EMR companies including EPIC, Cerner's and NexGen as well as many of the large EMR vendors (utilized by hospitals) to ensure appropriate transmission of data into the Registry. Once the core of data is sufficient, researchers can access this. The data will also be invaluable for vendor companies who provide product line (including wound care products) to podiatric physicians. This will be an additional revenue stream for APMA since these companies would pay for the data. The Registry will also contain dashboards allowing podiatric physicians to compare procedures and treatments with other clinicians around the nation in comparing episodes of care.

Two physicians will be selected to analyze the test data acquired through data import and determine whether the data is valid and qualified. This must be completed by December 2016. APMA is on track to meet this timeline.

TALAR CAPITAL PARTNERS: TALAR: **T**aking **C**are of **P**atients while **T**aking **C**are of **P**hysicians - A Podiatry Group Purchasing Organization

Michael King, DPM introduced Talar Capital Partners, a GPO (Group Purchasing Organization) which launched in 2016. Talar Capital Partners was created by Executive Founders Jonathan Brown, President and COO; Ira Kraus, DPM, CMO and CCO and Jeffrey R. DeSantis, DPM, CEO with additional leadership including John Jones, JD (one of the most well recognized attorneys that deals with GPOs to provide Safe Harbor) and Accountant

Jack Evans. National leadership directors were selected for their expertise and visibility in the podiatric profession and include Sam Mendicino, Marybeth Crane, Andy Bahatia, Stephen Corey, William Dabdoub, Michael King, Michelle Butterworth, Franklin Kase, Jeffrey Lehrman, John Hultman, Emily and Jeremy Cook, Lowell Weil Jr, Kris DiNucci and Michael Downey.

The GPO was the brainchild of notable leaders within the podiatric community. In the large picture, with the changing environment in medicine and predictable decrease in reimbursements, TALAR is committed to providing discount purchasing capabilities and reducing costs on variable expense items like office supplies, DME, and other services that make podiatric practices work. Along with this focus, there is also a desire by this organization to provide charitable giving to the profession. Proceeds from the company will be forwarded to: the APMA Education Foundation, State Affinity Program Donations and APMA PAC Government Education Foundation.

TALAR has contracted with a number of notable vendors including Medline (a family owned company from Canada with the largest privately held manufacturer & distributor of healthcare products in the USA), DeRoyal, MPM MedicRal, Inc. (wound care products), SureFit (ancillary services including PADNet, custom bracing and shoes and inserts), Redi-Thotics, Badger Orthotics and Provista (a large company providing a variety of services). TALAR will allow physicians and staff to access a Central Ordering Portal free of charge to purchase items at an average savings of 30-33% savings. This provides a venue for discounted products and services with flexibility to allow physicians to maintain relationships with their preferred companies with whom they have had longstanding relationships. At the end of the year, ALL purchasers will be given a 1% rebate for all of their purchases. Vendors are being considered across the business sector to provide capital equipment, office supplies, DME, medical/surgical products, diabetic shoes and wound care products at competitive pricing. The TALAR website will be enhanced with educational opportunities shared among esteemed leaders of the podiatric profession and will include coding and billing tips, information on documentation and information on wound care. Contact information:

Query: Some states (Ohio) have affinity relationships with MedLine - This issue will be addressed with the TALAR to ensure protection of these relationships.

MIPS

The Final Rule was just published last week and is 2,000 pages including commentary. Dr. Christina provided a webinar on MIPS on Wednesday November 8, 2016 for APMA members to access on the website and this is now available for review.

Clinicians can choose how they want to participate in the Quality Payment Program based on their practice size, specialty, location or patient population. There are 2 tracks to choose from:

1. Advanced Alternative Payment Models (APMs) - an innovative model
2. The Merit-based Incentive Payment System (MIPS) - traditional Medicare

Medicare Part B clinicians billing more than $30.000 a year and providing care for more than 100 Medicare patients a year will participate in MIPS. Clinicians excluded from MIPS are: Newly enrolled Medicare clinicians, Clinicians below the low-volume threshold (those with Medicare B allowed charges

<$30,000 OR 100 or fewer Medicare Part B patients, and physicians participating in APMs.

2017 will be a transitional year; ultimately, there will be 4 categories that will be scored including Cost, Quality of Care (PQRS), Advanced Care and Clinical Performance (Quality Improvement). In 2017, the Cost factor will not be taken into consideration because the federal government does not have data from most of the specialty groups and this category will be deferred until this information is available.

Choosing to Test for 2017:

1. TEST Pace: If you submit a minimum amount of 2017 data to Medicare (i.e. one quality measure or one improvement activity), you can avoid a downward adjustment
2. PARTIAL Participation for 2017: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment. If you are not ready on January 1, 2017, you can choose to start anytime between January 1 and October 2, 2017. Whenever you chose to start, you'll need to send in performance data by March 31, 2018

3. FULL Participation for 2017: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.
4. Participate in an Advanced Alternative Payment Model

GOVERNANCE AND MANAGEMENT TASK FORCE

Dan Davis, DPM discussed the work of the Governance and Management Task Forces. At the inception of his presidency, Dr. Davis selected individuals to make up 4 Task Forces which include:

Financial Task Force, Policy Information Task Force, Governance Authority Task Force and Election Process Task Force. These task forces have been remanded to evaluate the findings of the consulting firm and their recommendations and take a critical and objective look at how APMA can function more effectively and efficiently. These committees have been deliberating by conference call over the last several months and in November, the Chair of each of these committees will meet in Bethesda to exchange information and incorporate their ideas into a final report which will be presented to the Board of Trustees. The BOT will direct the Bylaws Committee to process this information in preparation for the 2017 House of Delegates for their consideration.

Alliance members expressed concerns regarding the consulting firm's analysis without consideration in reviewing the dual membership requirement. This poses a concern given the historical concern expressed by APMA members about this issue. Additionally, a recommendation was made by the firm that state component EDs not be a voting member of their states delegation since this represents a conflict of interest. Dr. Hultman, inquired what the basis of this decision was and expressed concern that the reasoning was not included in the report.

In response, Dr. Christina acknowledged that APMA must do a better job of promoting a value proposition for dual membership. He noted that this information will be released by prior to the HOD. He then reminded the members that the consultants' recommendations do not have to be agreed upon en bloc and that challenge and the rationale therein is encouraged. There will be opportunity for open discussion will be available to all members at Resolutions Committee meeting at the HOUSE where thoughts, recommendations and edits are welcome.

MEMBERSHIP RECRUITMENT CAMPAIGN:
APMA is launching their Membership Recruitment Campaign for 2017/2018. The soft launch will occur in October and if members join now, the dues for the remainder of 2016 will be prorated and there will be a 50% reduction in their annual dues for the 2017/2018 fiscal year. The full campaign will launch in March 2017. There will be incentives for APMA members who get non-members to join and there will be a competition between the state components who drive the greatest number of new member enrollment. This campaign will be tied into the "value proposition concept" of becoming an APMA member. Beth Shaub has devised a one-page summary highlighting the benefits of APMA membership which will be distributed to the state Executive Directors so that when potential members ask questions about the association there is a readily available, concise benefit list. The importance of member retention as part of the value proposition is also important to the stability of the association. This campaign applies to any member who may have dropped out with the exception of those who dropped their membership in the 2016/2017 year. APMA understands that the state components can provide their own incentive programs however encourages the states to also consider the 50% reduction in fees. The nature of the demographics in most organizations has members averaging over the age of 50 and APMA is no exception. There is concern that as members move into senior membership with reduced dues and Life members with no dues, this places constraints on the association since we are losing dues paying members and continuing to provide services for them. 90% of students are currently APMA members and APMSA is considering providing automatic membership to all students. There is change in the application process which now has the ability to acquire cell numbers and other tracking information for this purpose. Dennis Russell is tracking members and determining where we are losing them; whether from student to resident, resident to A-1 etc. There is a graduated dues structure and now APMA allows members to pay on a monthly basis and this should help in the retention rate. Discussion also ensued about the Millennials noting that the Millennials will join as long as they have a *cause*. APMA must ensure that the value proposition delineates that *cause* so that they join. This topic was discussed at the Young Physician's Institute held at Pica headquarters recently. The difficult part of the equation is that young members (< 10 years in practice) have different needs, and their needs constantly change and this is dependent upon what stage they are in practice.

DISCUSSION:
QUERY: Young members are joining large practices where "everything is taken care of" and do not see the value in joining APMA. How is APMA addressing this starting at the residency level since many of the residency directors are not APMA members?

RESPONSE: Dr. Christina acknowledged this issue. APMA is performing direct outreach to the residency directors, Ms. McKenna, APMA recruiter sponsored a meeting for the residency directors (both members and non-member) in the surrounding regions of Boston to discuss the value of APMA membership, considering a special status (reduced dues category) for residency directors, informing the directors that educational materials are

available to their residents who are APMA members even if they are not an APMA member (fostering good will) and recognizing that faculty members of the schools, staff physicians in hospitals and physicians in the VA system who are members of APMA serve as a positive conduit to discuss the benefits of APMA membership with the residents. Their residents through the RedRC on the APMA website.

COMMENT: KASIER in California poses a special concern since they are considered a large group and the majority of APMA benefits do not apply to them.

RESPONSE: Relative value and the RUC are both valuable to the KAISER PERMANENTE

C*OMMENT*: Florida has 22 residency programs and only 5/22 residency directors are members of APMA. Those RD that are not APMA members are preaching that the only viable membership is ACFAS since it is the surgical arm of the association, and since they are being trained as surgeons, they do not need APMA which is considered the non-surgical part of the profession The perception of APMA must be changed to coincide with the reality of the association ASPS has not gained notoriety. The question was posed: Why can't APMA and ACFAS get together and integrate as they had historically.

RESPONSE: Christina responded that APMA has tried to speak with ACFAS and has proposed unity for both organizations and ACFAS is not interested in becoming an Affiliate again and want to remain a separate entity. Christina noted that there is no impediment from APMA's perspective in working with ACFAS. In addition, Christina admitted that APMA has historically done a poor job in reaching out to the students and APMA must focus on student recruitment emphasizing i.e. that APMA does not charge residents to attend their programs, but ACFAS does charge them.

*Podiatrists DO NOT have to be a member of ACFAS to become board certified**:**

POINTS OF INTEREST
Additionally, young members should understand that it was the commitment of APMA that provided adequate residencies for the residents, and through APMA's Educational Foundation, $250,000.00 in scholarships have been awarded to the students as they pursue their career, and it is the CPME supported Fellowships that have been deemed to be legitimate, those initiated by ACFAS have not all been credentialed and recognized. It is this information that legitimizes APMA's position in the lives of students and residents. As an aside, the American Academy of Osteopaths, 50% of whom do not have available residency programs after completion of their medical school.

WEBSITE ARCHITECTURE
The APMA website is currently undergoing revision, and the launch of the new version is anticipated in March 2017. Focus groups (APMA members) have been consulted and the website company has considered proprietary recommendations (i.e. need to be user friendly navigation; reducing dropdown menus etc.) and has taken them into consideration in the final design. The website redesign will cost $50,000.00 with implementation adding an additional $50,000.00-$75,000.00.

PROPOSED BYLAW CHANGE SUBMISSIONS FOR THE 2017
There are no major changes in the bylaws intended at this stage. The committee is currently working on the Pennsylvania Resolution regarding JCRSB and clarifying language in preparation for the 2017 House. Most of the By-Laws Committee's efforts involve clarity of language.

CAC-PIAC MEETING
The CAC-PIAC meeting is scheduled for the weekend of November 4-6, 2016. The schedule includes a panel of speakers including Kate Goodrich, Director, CMS' Center for Clinical Standards and Quality Standards, Brian Debuss, MedPac Commissioner, Kelly Beck, JD Private Insurance and a representative from Health Policy Alternatives discussing the new Medicare Fee Schedule. There will also be discussion among the CAC representatives regarding proposed term limits that are being enforced in a number of regions around the country.

HUMANA

APMA continues to meet with Humana regarding denial of payment for APMA members currently and correctly using the -59 modifier. It has been deemed an appropriate use of the modifier despite Humana's contention that it is not. In an attempt to reduce the frustration of APMA members, there was thought of suggesting a pre-payment audit.

***POINT OF INTEREST*:**

1. *Contracts*: Practitioners must carefully consider all of the provisions set forth within the contract they are signing. APMA had contemplated filing a class action law suit however it has been determined that the majority of contracts signed by APMA members who participate in Humana contain an exclusion prohibiting physicians from filing class action lawsuit. * Recommend members to hire a contract attorney to review the contracts *APMA has solicited the services of a Managed Care litigation firm Watt/Talis to draft a demand letter to Humana addressing grievances. There is federal statute that prohibits insurance carriers from denying claims across the board. HMOS are fraudulently denying claims and there is ongoing discussion regarding what can be done on a legal basis.
2. CMS has put a Moratorium for opt out provisions enrolling Medicare Advantage patients.
3. *Appeals*: YOU MUST APPEAL DENIED CLAIMS! The current appeal rate is only 20% and Humana recognizes that by denying claims they will save money since 80% of practitioners will not appeal. APMA has no ammunition to combat the issues when they do not have claims data to back their argument.
4. *Contract Negotiations* - Do not sign contracts for less than Medicare reimbursements rates. Contracts are negotiable. California members were offered a contract many years ago that was 70% below RBRVS (value below Medicare) and practitioners did not sign on. There is wide discrepancy in the industry regarding reimbursement rates even within one specialty group.
5. *Reimbursement of Paid Claims*: Humana is requesting that practitioners reimburse them for previously paid claims. Read your contract and determine whether this provision and the timing therein is stated in the contract.

OTHER INSURANCE ISSUES:

1. In Ohio, Reimbursement Credentialing is occurring. Practitioners in the top 25% of billing were automatically dropped from the plan(s) since they were costing the insurance carrier too much money. (As practitioners, we are technically prohibited from discussing fees and yet the insurance carriers are protected by Federal law: The Federal Merceron-Ferguson Act: The Insurance companies are exempt from anti-trust litigation regarding discussion. Ohio is dealing with Prior Authorization Legislation which is impacting standard indemnity and Medicare Advantage plans. Reimbursements are being denied after they were authorized. There is a move to develop electronic authorization to diminish these issues. Ohio is developing a state portal to assist with this issue.
2. In New Jersey, there is Tiered Credentialing based upon utilization (i.e. the cost effectiveness of a physician or hospital). Based upon standards being established by the insurance carriers (and not available for public disclosure to physicians or patients), the insurance carriers are deeming physicians and hospitals as Tier 1, Tier 2 or Tier 3. Tier 1 has no copays, Tier 2 has a moderate copay and Tier 3 has a high copay. Patients are being driven economically to a particular sector of doctors and hospitals by co-pay disparity.
3. New York is currently acting within a VBS (Value Based System) in a direction away from fee for service. NYPMA is working with lobbyists to ensure that podiatry is included in preventative care issues including obesity, arterial disease and fall prevention. They have hired consultants to assist in developing a white paper whose focus is to align strategically for inclusion in the preventative care legislation.

APMA: Dan Davis, President APMA

1. APMA had the largest Young Physicians Institute (YPI) on record this year. APMA's Strategic Plan is dedicated to increasing membership and member retention and in that vein, there is a focus on increasing young members' participation and membership which has been promoted as a strong component of the YPI. The institute is conducted on a yearly basis bringing together young members from the component states to teach them about the principles of running a successful practice, negotiating contracts, dealing with the burden of student loan debt etc. It is also a venue to teach young members about legislative advocacy and how to become involved on a state and national level in the legislative process. In this setting, the young physicians are able to commiserate with like minds who are concerned with their same issues.
2. APMA's Coding Resource Center was redesigned and updated

3. Society of Interventional Radiologists: APMA has established a relationship with this society recognizing that this is a great collaboration for our two associations; an untapped resource providing one in which both societies can benefit academically, educationally and financially.
4. American Board of Internal Medicine: The American Board of Internal Medicine has included us in their *Choosing Wisely Program* demonstrating our quality and performance in care.

PHYSICAN 7 SURGEONS JOING TASK FORCE: Jon Hultman, ED California
Dr. Hultman stated that the focus for the Joint Task Force is training and education. Mike Cornelison, DPM, Steve Wan, DPM and Jon Hultman, DPM met with the association of the California Medical Association to educate allopathic medicine on our education and training. The components that have been discussed include AMA's Truth in Advertisement, Patient Safety and a new campaign "Do You Know Your Doctor". The California Board now recognizes that the knowledge level of a first year podiatric resident is the same as a fourth year allopathic student; i.e. the level of general medicine curricula is similar to the allopathic medical students.

In an effort to spearhead this discussion, the CMA was provided an overview of Saint Mary's Program and now acknowledges the equivalency between the podiatric and allopathic educational tracks. CMA has a two-year residency program and we have a three-year requirement. In comparing the MDs, DOs and Podiatric physicians, the CMA couldn't distinguish between these physicians. Our 4/4/3/ year track provides a strong argument for equivalency. At the conclusion of the site visits, the CMA and PSC concluded that the end product is indistinguishable from any other specialty. "The podiatric license is only limited should we consider changing specialties."

In the large picture, two questions remain: 1. Are we podiatric physicians? Or are we considered non-physicians practicing like other allopathic physicians? 2. Is the collaborative process a better process when waging legislative battles? In the future, when addressing these two questions, the language that must reflect our education and training. In terms of legislation, we now have the case regarding objective comparison of the professions with a strong argument in our favor. The next challenge will occur with the orthothopedic association to ensure them that this is not expansion of scope; it is parity.

OPIATE OVERDOSE:
Discussion ensued regarding the well-publicized issue of opiate overdose. Based upon the discussion, it is apparent that different states are requiring different credentialing CME standards for their practitioners including nurses. In Michigan, the state nursing association is requiring 3 CMEs dedicated to opiate use if 2017. Pennsyvania has provided an online course for its physicians. W. Virginia has a mandatory curriculum which has been spear-headed by the Appalachian Opiate Coalition. New Jersey has a one hour CME requirement.

MEDICAL MARIJUANA:
Ohio currently has a ballot initiative. Governor John Kasich has mandated that there will be no plants in his states; oils and vapors are acceptable. Podiatrists are excluded from prescribing medical marijuana.
Illinois: There are limited diagnoses relating to chronic pain that determine physician prescribing. MDs must confirm the diagnoses with a certified physician statement; there are no prescriptions. Podiatrists are excluded from prescribing marijuana based upon the accepted chronic pain diagnoses that have been established by state law.

Jim Christina will discuss podiatric physicians' right to prescribe with the APMA Board at their meeting in November recommending that the BOT approve a policy and author a Resolution regarding inclusion in the legislature. This recommendation will be predicated on marijuana's indication for neuropathic pain.

MEDICAID REIMBURSEMENT RATE DISPARITY:
Due to new policy changes, **Medicaid will no longer pay the full 20% of the Part B coinsurance after Medicare pays its 80%. Instead, the total Medicare/Medicaid payment will not exceed the amount that Medicaid would have paid for a Medicaid-only patient**. If the Medicare payment is greater than the Medicaid fee, Medicaid will make no additional payment. This revised reimbursement methodology was thought to be overturned or not in affect due to Medicaid paying for the 20% after the July deadline but in recent weeks we are seeing Medicaid request refunds for those payments and they are not paying current claims. The 20% coinsurance is also not being paid by the ACA. **The Medicare and Medicaid payment (if any) must be accepted as payment in full**.

The consensus of the Alliance members is that this needs to be addressed through legal channels since the have changed the interpretation of the law. This is concerning because it opens the door to applications within the world of standard indemnity. We need to strike a collaborative effort with the AMA and the Osteopathic physicians to challenge this.

ACA COMPLIANCE REQUIREMENTS:
Depending upon whether Donald J. Trump, President-Elect repeals the ACA, there is a new posting requirement which can be found on the following website:
http://www.nyspma.org/aws/NYSPMA/pt/sd/news_article/127538/_PARENT/layout_details/false