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FACTS ABOUT BAPTIST HEALTH

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- AHA and ASA Gold Plus Stroke quality achievement award
- Truven Health Top 100 Hospital and Top 15 Health System
- Regional Cancer Center
- Behavioral health facility
- An affiliate of UAB Health System

To learn more about Baptist Health and our community, please visit our website at www.baptistfirst.org/physicians.

For more information about this opportunity, please contact Bonita Lancaster, system manager of Physician Relations at toll-free (866) 507-3385, (334) 451-5226 or blancaster@baptistfirst.org. Or contact Ginger MacLean, physician recruiter, at (334) 273-4260 or gpmaclean@baptistfirst.org.
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Budget Shortfall Prompts Agency to Seek Delay for RCO Start Date

Citing the current lack of funding for the 2017 fiscal year, the Alabama Medicaid Agency announced May 9 that it would seek to delay the October 1, 2016, start date for regional care organizations (RCOs), the core component of its transformation plans. A revised start date has not been determined, according to Alabama Medicaid Commissioner Stephanie Azar.

Before making a decision on a start date, she emphasized that the next step is to talk with the Centers for Medicare and Medicaid Services and Gov. Robert Bentley to explore options available to the state.

The change in plans became necessary after the Alabama Legislature adjourned May 4 without appropriating additional funds needed by the agency for existing operations and to move forward with its plans to implement RCOs.

A federal waiver that would enable the state to implement the managed care program was approved in February. Azar emphasized that the legislation passed on the last day of the regular session provides the agency flexibility to work with the Centers for Medicare and Medicaid Services and the probationary RCOs on an alternative implementation plan.

Medicaid Budget Cuts Likely Without Additional Funding

Medicaid program cuts became more likely after the Alabama Legislature adjourned its annual session May 4 without providing the additional funds needed by the Alabama Medicaid Agency to maintain its current operations and reform its existing fee-for-service system.

Azar emphasized that without additional funding, the Alabama Medicaid program will have to make significant changes.

“I think it’s important for Medicaid providers and recipients to prepare for the impact of these cuts because this is the budget for Medicaid at this point in time,” she added.

Gov. Bentley had asked for $785 million from the General Fund to continue the existing Medicaid program without payment reductions to primary care physicians and other cuts and to move forward with the agency’s transformation initiative. The Legislature appropriated $700 million to the agency from the General Fund and later overrode the governor’s veto of the $1.8 billion budget.

At an April news conference, Gov. Bentley and Azar warned that the $700 million Medicaid appropriation from the General Fund budget will require the agency to cut services and provider payments to balance its budget in the fiscal year that begins October 1, 2016. No decision has been reached regarding what cuts will be made or the timetable for the cuts to be made, Azar said.

In making cuts, the agency is limited to programs and services that are considered “optional” by the federal government. To make up the shortfall, Medicaid can cut benefits for adult eyeglasses, hospice, outpatient dialysis, prosthetics and orthotics, and medications for adults.

Past Medical Association Board President Receives National Award

Dr. George C. Smith Sr. has been a role model for countless physicians in Alabama, including his son and granddaughter. For more than 50 years, Dr. Smith has practiced medicine in the small community of Lineville, and his years of service and dedication to patient care have garnered him national recognition.

The Federation of State Medical Boards recently honored Dr. Smith with the John H. Clark, M.D., Leadership Award, which recognizes outstanding and exemplary leadership, commitment and contributions to advancing the public good at the state medical board level. “I’m very honored,” Dr. Smith said. “It was very much a surprise. I didn’t know I was nominated.”

Medicine is a family affair for the Smith family. Dr. Smith said he is a fourth-generation Smith from his hometown of Lineville, which has a population of about 2,500 residents. He and his son, Dr. Buddy Smith
New HHS Rule Aims to Improve Health Equity

by Rich Sanders

The Patient Protection and Affordable Care Act of 2010 (ACA) contains Section 1557, which is built on long-standing federal civil rights laws and prohibits discrimination based on race, skin color, national origin, sex, age or disability in certain health programs or activities. Enforced by the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR), Section 1557 protects individuals from discrimination when they participate in (1) any health program or activity that is in any part funded by HHS, (2) any health program or activity that is administered by HHS itself, and (3) health insurance marketplaces and all plans offered by insurers participating in those marketplaces. On May 13, 2016, HHS issued the final rule implementing Section 1557, called “Non-discrimination in Health Programs and Activities.” To comply with the new rule, in addition to treating all people equally, covered entities, including members of the Alabama Academy of Family Physicians, will now be required to provide new accommodations for disabled patients and patients with limited English proficiency.

The rule does not add any new religious exemption. However, it does not displace any existing protections on religious freedom and conscience. The rule additionally states that if the application of any requirement of the rule would violate an applicable federal statute protecting religious freedom and conscience, then that application would not be required. The rule requires that all people, regardless of gender, be treated equally in receiving health care and prohibits denial of health care or health coverage based on sex, including discrimination based on pregnancy, gender identity and sex stereotyping. Ambiguity remains under the rule with respect to whether discrimination on the basis of sexual orientation alone is considered “sex discrimination” under Section 1557. However, the rule clearly states that OCR will evaluate complaints involving sexual orientation to determine if they involve the kinds of stereotypes that can be addressed under Section 1557.

Furthermore, the rule provides protections for people with disabilities and assistance for people with limited English proficiency. Academy members, as covered entities, will now be required to provide meaningful access to individuals with limited English proficiency, and they are also encouraged to develop plans for language access.

While standards in the rule regarding protections for individuals with limited English proficiency are context-specific, HHS states that providing language-assistance services, such as oral language assistance or written translation, may be reasonable steps. Now, academy members will also be required to post a notice of an individual’s rights and to provide information about assistance for individuals with limited English proficiency, and will be prohibited from using low-quality video remote interpreting services or relying on unqualified staff or translators when providing assistance services. The rule will further require Academy members to provide appropriate auxiliary aids and services for individuals with hearing impairments.

Rich Sanders is an attorney in Birmingham representing physicians in corporate and regulatory matters throughout Alabama. He can be reached at rsanders@southernhealthlawyers.com or 205-920-4289.

Jr., work together at the Clay County Medical Clinics. When Dr. Smith Jr.’s daughter, Ashley, receives her medical degree, she will join the clinic later this fall.

“That’s special, and I’m so proud,” Dr. Smith said. “Three generations of doctors, that’s pretty rare.”

As a past member and chairman of the Alabama Board of Medical Examiners and the Board of Censors of the Medical Association of the State of Alabama, and through his current service on the Medical Licensure Commission of Alabama and the Interstate Medical Licensure Compact Commission, Dr. Smith has worked selflessly to ensure the safety, protection and welfare of patients. In 2011, Dr. Smith received the Paul W. Burleson Award from the Medical Association in recognition of a medical career encompassing not only high ethical and professional standards in patient care, but also extraordinary service to physician organizations. His exceptional work has been recognized by his induction into the Alabama Healthcare Hall of Fame in 2014 and by the naming of the Clay County Public Health building in his honor.

Dr. Smith has been a member of the Clay County Medical Society and the Medical Association since 1966.
The NPDB, created in 1986, was designated as a system to facilitate the disclosure of information regarding a practitioner’s incompetence or lack of professionalism. The NPDB was created with the purpose of preventing a practitioner from moving to another state without anybody having knowledge of prior incompetence or lack of professionalism.

All states are required to adopt reporting systems for certain licensure actions. Any authority or organization must report all negative actions and findings regarding entities and practitioners. In accordance with the Affordable Care Act, the Health Integrity and Protection Data Bank (HIPDB) consolidated with the NPDB in 2013. Now, the NPDB collects and discloses all information previously collected and disclosed by the HIPDB.

Additionally, the updated guidebook makes clarifications regarding four particular areas: (1) investigations and reporting, (2) summary suspensions, (3) proctors, and (4) employment actions and professional review actions.

**Investigations and Reporting**
Surrenders of privileges are now reportable if a practitioner fails to renew privileges or if privileges are restricted while the practitioner is under investigation. However, surrenders for personal reasons unrelated to an investigation are not reportable.

**Summary Suspensions**
A summary suspension must now be reported if it is (1) in effect or imposed for more than 30 days, (2) based on the practitioner’s professional competence or professional conduct that could or does adversely affect patient health or welfare, and (3) the result of a health care entity’s professional review action. Summary suspensions that are expected to last for more than 30 days but have not, and that are otherwise reportable, may be reported. However, they must be voided if they do not last more than 30 days.

**Proctoring**
Proctoring, a proctor’s evaluation of a practitioner for clinical competence, is now reportable. If a proctor is assigned to a physician for longer than 30 days because of a professional review action, the action is reportable if the procedure performed requires a proctor’s approval or presence. If the procedure at issue does not require a proctor’s presence or approval, then a professional review action is not reportable.

**Employment Actions and Professional Review Actions**
The updated guidebook distinguishes between employment actions and professional review actions. If an Academy member or other practitioner loses privileges pursuant to a provider’s employment termination process, rather than pursuant to the medical staff bylaws’ professional review process, then this loss of privileges is the result of an employment action and is not reportable.

**Conclusion**
The changes made in the 2015 guidebook will facilitate the process of reporting to the NPDB. The consolidation of the NPDB and the HIPB will help do away with unneeded ambiguity that Academy members and other practitioners previously dealt with, as will the clarifications regarding the reporting process.

Rich Sanders is an attorney in Birmingham representing physicians in corporate and regulatory matters throughout Alabama. He can be reached at rsanders@southernhealthlawyers.com or 205-930-4289.
Regional Medical Center Anniston  
Lower Level Meeting Room (near cafeteria)  
400 East 10th Street • Anniston, Alabama

Please join us for a discussion of how the patient-centered medical home (PCMH) model can transform your practices and improve your reimbursement. Enjoy a day of learning with hands-on activities. Leave with an action plan, sample PCMH policies and a better understanding of the National Committee for Quality Assurance certification process.

Agenda
8-8:15 a.m. ..................... Light Breakfast and Introductions  
8:15-8:45 a.m. .................. Meaningful Use and MACRA  
8:45-9 a.m. ..................... Your Data Is Your Voice  
9-9:30 a.m. ..................... Overview of NCQA PCMH and Current Financial Incentives  
9:30-10:30 a.m. .............. Activity  
10:30-10:45 a.m. .......... Break  
10:45-11:15 a.m. .......... PCMH Application Process  
11:15 a.m.-noon ............ Policy and Standard Review  
Noon-1 p.m. ................. Lunch, Hosted by Blue Cross Blue Shield, with Presentation  
1-2 p.m. ..................... Networking

A Little About the Speakers
Matt Allison, Health Systems Manager, State-Based Mid-South Division, American Cancer Society  
In his current work at the American Cancer Society (ACS), Matt looks to improve health care delivery and continue the fight to eliminate cancer and cancer-related deaths in Alabama. Matt serves as the current chair for the Alabama Comprehensive Cancer Control Coalition and oversees several grant initiatives. Prior to ACS, Matt consulted primary care practices around health care reform, incentive programs, quality improvement, meaningful use and other federal programs.

Adele Allison, Director of Provider Innovative Strategies, DST System  
As the director of provider innovation strategies, Adele monitors health care reform for DST System’s health solutions division. Having served as the co-chair of the ONC Beacon-Her Vendor Affinity Group and being a current project leader for the Department of Health and Human Services’ Workgroup for Electronic Data Interchange (WEDI) accountable care organization task force, Adele has over 25 years of health care experience. A published author, Adele is a member of The University of Alabama at Birmingham’s (UAB) advisory board on curriculum development, serves on UAB’s HITECH (Health Information Technology for Economic and Clinical Health) Committee for health IT curriculum development, and is a member of the Board of Directors for Alabama Healthcare Information and Management Systems Society.

Co-hosted by ACONA, American Cancer Society, Blue Cross Blue Shield of Alabama, Impact, Regional Medical Center  
Includes breakfast, seminar, materials and lunch  
Cost: $50 for ACONA non-members – proceeds go to American Cancer Society.  
RSVP to Debbie Goodman, dgoodman@impactmed.com or 800-252-9094, ext. 220.
The 20th Annual Rural Scholars Convocation, held May 1 at Hotel Capstone in Tuscaloosa, recognized members of this year’s classes of Rural Medical Scholars and Rural Community Health Scholars (graduate students working to earn the master’s degree in rural community health), and welcomed graduates of the Rural Medical Scholars Program to a reception in their honor prior to the convocation. The address was given by Dr. Kevin Leon, associate dean for undergraduate medical education at The University of Alabama School of Medicine. He spoke to students of the importance of primary care and the privilege of serving patients, sharing some of his own experiences.

As part of the ceremonies, the Rural Scholars Programs presented plaques to acknowledge the contributions of many of its partner organizations and institutions that have worked with program faculty and staff to provide rural students with special programs, field trip activities, mentoring, community involvement, and insight into rural health careers, helping to enrich the lives of Rural Scholars from all over the state:

- Auburn University – Cooperative Extension System
- Bibb County Medical Center
- Farmer’s Federation
- Fayette Medical Center
- Federation of Southern Cooperatives
- Hale County Medical Center
- Honors College, University of Alabama
- Pickens County Medical Center
- Tuskegee University – Cooperative Extension Program
- The University of Alabama College of Arts and Sciences – Department of Biology
- The University of Alabama College of Arts and Sciences – Department of Psychology
- The University of Alabama College of Arts and Sciences – Department of Student Services
- The University of Alabama College of Continuing Studies – Department of Academic Outreach
- The University of Alabama College of Education – Department of Higher Education Administration
- The University of Alabama College of Human Environmental Sciences
- The University of Alabama Division of Community Affairs
- The University of Alabama Graduate School
- The University of Alabama at Birmingham – School of Medicine Admissions
- Women Involved in Farm Economics

Four special awards were presented to longtime partners:

- **Alabama Academy of Family Physicians – Outstanding Professional Partner**
  The state’s family physicians through AAFP have consistently provided leadership and welcomed Rural Scholars into conferences, training and advocacy activities in addition to showing scholars what being a family physician means to a community.

- **Ellen Stone – Outstanding Administrative Partner in Rural Health**
  As executive director of the primary funding agency for Rural Scholars programs, Ellen Stone helped to initiate the pipeline and has provided support and guidance in navigating administrative issues as the programs have grown to serve more rural students.

- **Rural Medicine Program, Auburn/Huntsville – Outstanding Rural Medical Educational Partner**
  A sister program to the Rural Medical Scholars Program, the Rural Medicine Program provides another avenue for rural students who are planning to become rural Alabama doctors. Working together, we have opened doors to better serve rural students in the state and provide more doctors for rural communities.

- **West Central Alabama Area Health Education Center (WCAA-HEC) – Outstanding Community Partner**
  As a community-based program that works to recruit and retain health care professionals in West Alabama, the WCAAHEC has joined in providing service opportunities for rural students in the pipeline and contributed to training and mentoring projects that involve scholars in rural communities.

The **Rural Medical Scholars Program Distinguished Service Award**, presented annually to recognize outstanding commitment to rural Alabama, was given to Dr. Jim Coleman, director of the Office of Family Health, Education, and Research at the UAB Huntsville Regional Medical Campus. Dr. Coleman practiced medicine in rural Alabama for many years and has taught family medicine residents and medical students for over 26 years. He was the founding director in 2006 of the Rural Medicine Program established at Auburn University/UAB Huntsville regional campus of the School of Medicine, a sister program to the Rural Medical Scholars Program. He served as its director until 2015.

A special **Rural Medical Scholars Alumni Award for Outstanding Rural Medical Educator** was awarded for the first time this year. Dr. Frannie Koe, a 1999 Rural Medical Scholar who is now a family physician in Collinsville, presented the award on behalf of the Rural Medical Scholars Program alumni to Dr. John Brandon. Dr. Brandon, a family physician in Gordo since 1981, has worked with every class of Rural Medical Scholars as well as Rural Scholars in other University of Alabama Rural Health Leaders Pipeline programs and medical students and resident physicians at The University of Alabama College of Community Health Sciences, serving as preceptor.
mentor and advisor and modeling the role of the rural physician in the community.

In 1999, he became the medical director of the Rural Medical Scholars Program, serving in that role until early this year. Graduates of the program now in practice across the state and those still in training joined together to acknowledge Dr. Brandon for his many contributions to their success. Dr. Koe shared comments and quotes collected from Rural Medical Scholars graduates describing his influence on their lives and education, the way he inspired them to take care of patients, and how he showed them the importance of leading the way for better health care through local health care services and advocating for more effective health policy in the public sector.

The convocation concluded with recognition of members of the 20th class of Rural Medical Scholars by Rural Medical Scholars Program Associate Director Susan Guin, MSN, CRNP, and Dr. Drake Lavender, a member of the first class of Rural Medical Scholars in 1996, who has been a family physician in Gordo since he finished training at CCHS as chief resident and now serves on the CCHS faculty.

2015-2016 Rural Medical Scholars
• A nooshah Ata, Scottsboro
• Helen Cunningham, Fairhope
• Tanner Hallman, Arab
• Gloria (Storm) McWhorter, Pike Road
• Carson Perrella, Salem
• John Pounders, Leighton
• Jayla Robinson, Addison
• Harriet Washington, Carrollton

Helen Cunningham, from Fairhope, is the daughter of Martin and Randolph Cunningham. She attended high school at Bayside Academy. She went on to the University of Richmond in Virginia, where she studied the Medical Humanities focusing on Public Health. She was also a Division I scholar athlete during college, and her tennis team won four consecutive conference championships, advancing to the NCAA tournaments each time. After graduating, she was selected for the CDC Public Health Scholars Program, where she studied health disparities, epidemiology and public health issues in New York City at Columbia University and worked with NYC Mayor Bill de Blasio on key public health initiatives. Dr. Michael McBrearty, a family practice physician in her hometown, significantly influenced her career choice, she says. Helen shadowed him during the summer she participated in Huntsville’s Rural Pre-Medical Internship program.
Value-based payment will bring big changes to practices. Here’s what we know now.

Congress passed game-changing, bipartisan legislation in April 2015 that significantly alters how the federal government pays physicians to deliver health care. The Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA) repealed the flawed sustainable growth rate formula that annually threatened health care administrators, physicians, and other providers with Medicare reimbursement cuts of up to 21 percent.¹

The legislation also established two new tracks for physician payment, the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Model (APM). The U.S. Department of Health & Human Services (HHS) is counting on MACRA to transform physician payment when it is implemented in 2019 and accelerate movement toward value-based payment in the meantime. HHS has goals to move 30 percent of Medicare payments into alternative payment models by 2016 and 50 percent by the end of 2018.

MACRA lays out a basic framework for payment reform but lacks definitions for many key concepts. The Centers for Medicare & Medicaid Services (CMS) is writing regulations to fill in the blanks. A public comment period last fall preceded the planned release of a proposed rule this spring and a final rule later this year. While the fine print of these programs is still unknown, it is possible to discern the big picture for each.

Merit-Based Incentive Payment System track
Physicians who are not practicing in some type of APM will by default be on the MIPS track. Some will qualify for an exception by failing to meet the MIPS’ “low volume threshold,” which is an as-yet undefined minimum number of patients, services, or allowable charges for a performance period, or by being in their first year of Medicare participation.

Beginning in 2019, MIPS will consolidate the Value-Based Payment Modifier (VBPM), Physician Quality Reporting System (PQRS), and Meaningful Use (MU) programs into a single new program, which will also include a new category of performance measures referred to as “Clinical Practice Improvement Activities” (CPIA). A MIPS composite score will be based on physicians’ performance in these four areas. The score will dictate annual payment adjustments. (See “MIPS breakdown.”)

Each physician’s MIPS score will be compared to a “performance threshold” to determine how Medicare will adjust the physician’s payments each year. Only those scoring directly at the threshold will receive no adjustment. Upward or downward payment adjustments will be made on individual claims. (See “MIPS payment adjustments.”)

As you consider MIPS, keep in mind that MIPS bonuses have the potential to be sizable, but so do the penalties. Because MIPS is a budget-neutral proposition, CMS will pay for all of the positive payment adjustments with money it gains from negative payment adjustments. Physicians whose composite scores are in the lowest quartile will automatically receive the maximum penalty for the performance year.

<table>
<thead>
<tr>
<th>MIPS Breakdown</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>50%</td>
<td>45%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource use</td>
<td>10%</td>
<td>15%</td>
<td>30%</td>
</tr>
<tr>
<td>Meaningful use</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Clinical practice improvement activities</td>
<td>15%</td>
<td>15%</td>
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</tr>
</tbody>
</table>
A Medicare Shared Savings Program - 7%

A project under the Medicare Healthcare
- 5%

- 9%

A medical home model expanded under the

2020

“... A demonstration required by federal law.”

Use a certified electronic health record,

Bear more than “nominal financial risk,”

Use as-yet undefined quality measures com-

- 2021

- 4%

- 7%

- 9%

- 2022 (and beyond)

+9% (27% for top performers)

A Medicare Shared Savings Program

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- 5%

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Use a certified electronic health record,

Bear more than “nominal financial risk,”

Use as-yet undefined quality measures com-

- 2021

- 4%

- 7%

- 9%

- 2022 (and beyond)

+9% (27% for top performers)

To calculate a practice’s potential pay-

ment adjustment, multiply the program

year percentage by the number of pro-

viders and total annual Medicare Part

B reimbursements.

For example, using the 2019 program

year, a practice with a single physi-

ician and annual Medicare Part B reim-

bursements of $100,000 faces a poten-

tial maximum negative adjustment of 4

percent, or -$4,000, for not meeting the

performance threshold. Practices meeting

the performance threshold would receive

no adjustment. Practices that exceed the

performance threshold would receive a

positive adjustment of at least 4 per-

cent, and top-performing practices could

receive up to three times the normal posi-

tive adjustment. If the example practice

were among the top performers in 2019,

it would receive a 12 percent adjustment,

or +$12,000.

For comparison, the same practice par-

ticipating in an Alternative Payment

Model would receive a bonus equal to

5 percent of its total annual Part B

reimbursements in 2019 through 2024

— $5,000 for the example practice —

instead of payment adjustments tied to

performance thresholds.

Alternative Payment

Model track

As the law is currently written, qualified APMs

are any of the following:

• A Medicare Shared Savings Program

Accountable Care Organization,

• A medical home model expanded under the

Center for Medicare & Medicaid Innovation

(CMMI),

• A project under the Medicare Healthcare

Quality Demonstration program,

• “A demonstration required by federal law.”

Qualified APMs must also meet the following

eligibility criteria:

• Use as-yet undefined quality measures com-

parable to those in MIPS,

• Use a certified electronic health record,

• Bear more than “nominal financial risk,”

a term that will be defined in rule making,

or be in a medical home expanded under

CMMI.

It is important to note that qualifying APM

participants must also meet thresholds that

increase the volume of Medicare payments

made through the APM each year. Physicians

that meet the APM requirements will receive a

5 percent lump-sum bonus annually between

2019 and 2024, based on their Medicare Part

B claims payments. APM participants will

not be subject to MIPS bonuses and penal-

ties. Beginning in 2026, they will receive an

annual update of 0.75 percent under the

Medicare physician fee schedule.

APMs that don’t meet the threshold are con-

sidered “partially qualifying.” Participants in

“partially qualifying” APMs avoid MIPS

penalties but do not receive financial bonus-

es. Participants in partially qualifying APMs

can switch to the MIPS track. The 5 percent

annual bonus may give APM participants

more financial certainty than MIPS would.

However, the number of physicians wish-

ing to participate in these qualified APMs is

likely to exceed the supply, at least initially.

What next?

While you wait for the details that will help

you choose a payment track under MACRA,

you are still subject to the bonuses and penali-

ties of the VBPM, PQRS, and MU programs.

You should also not wait to implement qual-

ity improvement and other initiatives because

your 2019 MIPS payment adjustment may

depend on your past performance – possibly

that of 2017. For this reason, you should report

PQRS and study your practice’s Quality and

Resource Use Report, which shows how your

practice ranks for these factors. (For more on

this topic, see “What You Need to Know About

Medicare’s New ‘Quality and Resource Use

Report,’” FPM, November/December 2015,


Practices with fewer than 15 eligible providers

as well as those in rural or health professional

shortage areas can receive help in transitioning
to an APM or improving their MIPS score.

MACRA allocates $20 million annually, from

2016 until 2020, to provide free technical

assistance to these practices through Quality

Improvement Organizations and Regional

Extension Centers. Rules for how this assist-

ance is distributed are still being developed.

There is still substantial work to be done
to define all the rules of MACRA. It is at

least clear that Medicare will pay physi-
cians based on an assessment of the value of
care they deliver to their patients. Until the

regulations emerge, focus on the functions

within your practice that will position it for

the future – access, planned care, patient

engagement, risk-stratified care manage-

tment, and care coordination. Enhancing

performance in these areas should contrib-

ute to higher MIPS scores and prepare your

practice for APM participation as soon as

the opportunity arises.

Reference

Fontenot K, Brundt C, McClellan MB. A primer on

Medicare physician payment reform and the SGR.

About the Author

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Practice Management.
Outbreaks of Zika have been reported in tropical Africa, southeast Asia, the Pacific Islands and, most recently, the Americas. Because the mosquitoes that spread Zika virus are found throughout the world, it is likely that outbreaks will continue to spread. The Zika virus is transmitted to people primarily through the bite of an infected Aedes species mosquito, the same mosquito that spreads dengue and chikungunya viruses. Most infections are asymptomatic, with only about one in five people infected with the Zika virus becoming clinically ill. The most common symptoms of Zika infection are fever, rash, joint pain and conjunctivitis. Other common symptoms include muscle pain and headache. The illness is usually mild with symptoms lasting for several days to a week. Severe disease requiring hospitalization is uncommon, and deaths are rare.

Most concerning to the medical community is the potential effect that Zika virus can have on unborn children. While the infection with Zika virus usually causes only mild symptoms, CDC has established a causative link to birth defects and other adverse pregnancy outcomes associated with infection during pregnancy. Congenital microcephaly, a condition characterized by an abnormally small cranium, has been recognized in Brazil in a large number of newborns since the onset of the current Zika outbreak. Infants with microcephaly are at greatly increased risk for neurologic problems, including cerebral palsy, intellectual and developmental problems, and vision loss.

Another possible complication of Zika virus infection is Guillain-Barré syndrome (GBS), an immune-mediated neuropathy that can cause acute muscle weakness or paralysis. GBS has long been recognized to develop following acute infections of many types and has been reported in increased numbers in several countries during the current Zika outbreak, although direct causation by the virus has not been proven.

Health care providers should advise their patients who are pregnant to postpone travel to areas where the Zika virus is being transmitted, including areas in South and Central America, as well as the Caribbean. A list of countries that are currently experiencing Zika outbreaks can be found at www.cdc.gov/zika/geo.

While most cases of Zika are thought to have been transmitted by the bite of infected mosquitoes, transmission from an infected man to his sex partners has also been recognized. For this reason, men who have pregnant partners and who have traveled to areas of Zika transmission, are advised to abstain from sex or to consistently use condoms for the duration of their partner’s pregnancy. Men who have this travel history but who do not have a pregnant partner should also consider abstinence from sex or consistently using condoms, especially if they have a reproductive age partner.

Alabama physicians are asked to follow current recommendations for testing and contact the Department of Public Health’s Infectious Diseases and Outbreaks Division at 800-338-8374 if they have male or nonpregnant female patients with a travel history and signs and symptoms consistent with Zika virus infection. In addition, testing is recommended for pregnant women with a travel history, regardless of whether there have been clinical symptoms. Providers should request the Zika Virus Consultation Form and receive approval from the Department of Public Health prior to submitting specimens for testing.

While much about Zika remains unknown at this time, great strides are being made in understanding how to recognize, diagnose and manage the complications of this virus. For further information about Zika virus, including information about prevention and the steps that the Department of Public Health is taking, visit www.adph.org/mosquito.
Consultants Directory

NEUROSURGERY

Neurological Associates P.C.
Charles H. Clark III, MD
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Thomas A.S. Wilson Jr., MD
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DR. THOMAS WEIDA has joined The University of Alabama College of Community Health Sciences as its new Chief Medical Officer, Associate Dean of Clinical Affairs, and as a professor of Family Medicine.

His background includes a medical degree from Hahnemann Medical College and Hospital in Philadelphia, and a Family Medicine Residency completed at Lancaster General Hospital in Lancaster, Pennsylvania. He is a fellow of the American Academy of Family Physicians, and holds a Certificate of Added Qualification in Geriatric Medicine.

Dr. Weida spent 14 years in private practice in rural Pennsylvania before joining the faculty at the Penn State Hershey College of Medicine in Hershey, Pennsylvania, where he also served as medical director of the Penn State Hershey Medical Group.

He has served on the American Academy of Family Physicians board of directors, and as the AAFP representative to the American Medical Association’s Relative Value Update Committee.

The addition of Dr. Weida represents just one of many examples of the College’s ongoing dedication to fulfilling its mission of improving health in your community.