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MIPS and Podiatric Medicine: Participation, Performance, and How to Navigate the Waters

Our panel of experts discusses the next generation of physician quality reporting.

BY MARC HASPEL, DPM

As the medical community moves forward into 2017, a new phase of electronic health record keeping and measure reporting has now come into fruition. With the repeal of the sustainable growth rate formula (SGR), the Merit-Based Incentive Payment System, or MIPS, one of the two new payment tracks established by the Medicare Access and CHIP Reauthorization Act or MACRA, is now taking hold of the Medicare reimbursement paradigm. MIPS appears to be the next generation of physician quality reporting that is born of the previous established PQRS and Meaningful Use programs. For those physicians that have already been reporting the latter, the difficulty of this transition should be marginal.

For those, however, who have not yet adapted to modern and evolving reporting requirements, the potential penalty money may very well be considerable.

Because the terminology of this system can be foreign and confusing to the physician, expert panelist, Dr. Sev Hrywnak has here offered a brief overview of the important components:

"Whereas the SGR set payment rates through a formula based on economic growth," explains Dr. Hwrynak, "MACRA links Medicare reimbursement to quality metrics, rewarding providers for value-based, quality care. Furthermore, under MACRA, eligible providers can choose to be paid on a fee-for-service basis with pay-for-performance incentives and penalties via MIPS,

or alternatively receive a financial incentive for participation in an Advanced Payment Model (APM). These two options form the framework for MACRA's value-based reimbursement plan, the Quality Payment Program (QPP). Medicare payments will vary among providers. Apparently, however, most podiatric physicians will first engage in MIPS as opposed to APM because of the more convenient logistics. MIPS represents the consolidation of three existing CMS programs: the PQRS, the Physician Value-Based Payment Modifier (VM) and the Medicare EHR Incentive Program."

Podiatry Management Magazine has invited a panel with special expertise in the area of MACRA to elaborate on the payment track of MIPS. They

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have tackled issues of participation, performance and successful navigation of this latest mechanism of physician reimbursement. They also have offered candid perspectives on the future role of podiatric medicine given these new reporting requirements. Joining this roundtable panel:

Barbara Aung, DPM has been in private practice for over 21 years in Tucson, Arizona with a focus in care of the lower extremity, advanced wound/limb preservation, and amputation prevention in the diabetic patient population. She is board certified as a Wound Care specialist and a diplomate, American Board of Podiatric Medicine. Dr. Aung is a contributing author for numerous publications providing guidelines for lower extremity management in the diabetic patient population for clinicians as well as being a published author, and she is a national presenter of numerous articles in the field of podiatric medicine and practice management.

Joseph Borreggine, DPM is board certified by the ABFAS, has been in practice for over 25 years in East Central Illinois and is active on both the state and national levels of podiatric medicine. He is the current chair for the Illinois Podiatry Licensing Board. He is also an expert panelist for Codingline and has authored numerous articles in *Podiatry Management Magazine* and has contributed online.

James Christina, DPM is a Magna Cum Laude graduate of West Virginia University and a 1983 graduate of the Pennsylvania College of Podiatric Medicine, completed two years of post-graduate surgical residency training and was in private practice in Rockville, MD for twenty years. He is currently Executive Director/CEO of the American Podiatric Medical Association and prior to that was director of Scientific Affairs for 10 years for APMA. Dr. Christina is a diplomate of the American Board of Foot and Ankle Surgery, a member of the American Diabetes Association and the American Public Health Association and has received both the Stephen W. Toth and John Carson

distinguished service awards from the Podiatric Health Section of the APHA.

Sev Hrywnak, DPM is chief executive officer of the SEV Group, Investments and Real Estate Development. He is a visiting professor, Columbia College, Economics Department. He is former Asst professor at Scholl College, instructor in Internal Medicine, Physical Diagnosis, Practice Management, Business law. Doctor Hrywnak is a preceptor, Northwestern School of Medicine,

providers are not educated about this program and do not plan to participate in any way. That leads me to believe that, even though CMS has made it incredibly easy to avoid a penalty based on 2017 performance, there will still be a lot of penalty money. This will lead to more bonus money available to those who participate. Additionally, CMS has allotted an extra 500 million dollars to distribute to those practitioners they deem to be exceptional performers. They estimate

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one will see it will not be difficult
to achieve a MIPS score of 70 or higher.—Lehrman**

Dept of Family Practice and a national lecturer.

Jon Hultman, DPM is the executive director, California Podiatric Medical Association (CPMA). He is a former assistant clinical professor at UCLA Medical School, chief executive office of Integrated Physician Systems, and president of CPMA. He is the author of *Reengineering the Medical Practice (1994)*, *The Medical Practitioner's Survival Handbook (2012)*, and 450 published articles.

Jeffrey Lehrman, DPM is a fellow of the American Academy of Podiatric Practice Management, serves on the APMA Coding Committee and the APMA MACRA Task Force, and is an expert panelist on Codingline.com. He is also on the board of directors of the ASPS and the APWCA. His Twitter handle is @DrLehrman.

the threshold for getting into this category will be a MIPS score of 70. If one spends some time learning what is involved, one will see it will not be difficult to achieve a MIPS score of 70 or higher. Achieving exceptional performance should lead to a positive payment adjustment of more than four percent.

Every provider's MIPS score will be publically reported. This means private payers will have access to these scores. No one knows for sure what they will do with this information. In fact, they could do nothing with it. On the other hand, they could potentially use it to determine which providers they allow on their panels. They could even follow the lead of CMS, and choose to adjust fee schedules based on publically reported MIPS scores. For those that have a small Medicare patient population, and may choose their level of MIPS participation based only on the impact of a Medicare fee schedule reduction, this is something to consider.

These MIPS scores will be publically reported on the CMS Physician Compare website. My opinion is that most prospective patients are not doctor shopping on this website. I think they are instead using the more popular doctor-rating websites and doing online searches. My ex-

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Q *PM: What do you feel will be the financial and reputational impact of MIPS?*

Lehrman: This is mostly a budget-neutral program. With the exception of exceptional performers, budget neutrality means the amount of bonus money available will be determined by the amount of penalty money taken. It is unfortunate, but many surveys have demonstrated high volumes of

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perience is that when patients do online searches they enter in their pathology, a doctor's name, or something like, "podiatrist in Philadelphia", and these searches do not lead to the CMS Physician Compare website. As such, I do not view a low MIPS score as a threat to a provider's public reputation.

Christina: In 2017, virtually no one should receive a penalty in 2019, based on the minimal requirements for avoidance. As little as one quality measure submitted on one patient will avoid the penalty. Also, incentive payments may be in reach for many, as the MIPS score threshold is 70 for exceptional performance, since potentially a provider may be able to reach that level without even having or using an electronic health record.

What the future holds is unknown, but there will probably be a gradual increase in requirements to avoid the penalty, and also to achieve incentive payments. If, however, they keep the option to report the Quality component by claims, and to report clinical performance improvement activities by claims, then avoiding the penalty in the near future will be achievable.

The reputational aspect is harder to predict. I am not sure that the Physician Compare feature for Medicare beneficiaries is widely used now, so I am not sure how MIPS scores and comparisons being available to the public will impact practices. Unless there is a large push to get beneficiaries to go to this source, I am doubtful that it will have that great of an impact. Remember, many podiatric physicians lamented the fact that they had difficulty achieving meaningful use requirements because their Medicare beneficiaries did not have e-mail addresses, so it follows that these folks are not likely to go online to check potential doctors' MIPS scores.

Aung: Here are a couple of possible repercussions. If a podiatric physician's combined scores are low,

then hospitals can potentially credential that physician with some restrictions, which could negatively impact that physician financially. Further, if other insurance plans use this data, they can potentially not re-contract

able to see how their providers are doing compared to those providers' peers, and how cost effective they are within the Medicare system. I opine, however, this will not have much impact initially on any Medi-

If other insurance plans use this data, they can potentially not re-contract with that physician or limit the contracts that are offered.—Aung

with that physician or limit the contracts that are offered.

Borreggine: MACRA defines two types of financial impacts for clinicians participating in MIPS: A small, annual inflationary adjustment to the Part B fee schedule and MIPS value-based payment adjustments (incentives or penalties) based on the MIPS 100-point final score. Incentives and penalties can will start in 2019 from date obtained in 2017, and then climax in 2022. This ranges starts at +/- 4% and ends at +/- 9%. MIPS performance bonus is available, which can add another 10% to annual incentive received. However, to receive the full incentive, the provider must reach the performance threshold set by CMS based the prior year performance (set number of points). All of this can vary based on how the all providers do on an annual basis. Also, the incentives and penalties must be budget neutral and therefore can sway the final amount of these numbers.

The reputational impact can be quite profound in a positive or negative manner toward a provider involved in the quality payment program. The Quality Payment Program provisions address this consumer demand. MIPS will publish each eligible clinician's annual final score, and the scores for each MIPS performance category within approximately 12 months after the end of the relevant performance year. For the first time, consumers will be able to see their clinicians rated on a scale of 0 to 100 and how their clinicians compare to peers nationally. Consumers who are Internet-savvy will now be

care provider since a majority of the demographic will not even make an effort to view these statistics in light of the availability. If the patients, however, are employed by medical organizations, or hospitals, or plan to do so in the future, even the AMA acknowledges a possible impact.

Q *PM: What are the best and worst-case scenarios for doctors who do not choose to participate in MIPS?*

Lehrman: The worst case scenario is the physician does not participate at all in 2017. This will lead to a 4% reduction to that physician's 2019 Medicare Part B Physician Fee schedule, and a publically reported MIPS score of zero.

The best case scenario is the doctor fully participates, and achieves a MIPS score high enough to qualify as an exceptional performer. This will result in a 4% increase to the 2019 Medicare Part B Physician Fee schedule, and possibly even higher depending on what the rest of the country does. CMS has set aside an additional 500 million dollars (above the budget neutral bonuses) for exceptional performers. Because there is a fixed amount that can be distributed, the amount each exceptional performer receives will depend on how many exceptional performers there are.

Aung: Actually the best case scenarios are for those physicians who will be retired by the time penalties go into effect, and have chosen not to participate, since they will be unharmed. The worst case is that each

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physician has to look at the potential financial impact, and determine if the extra work justifies the possible penalty on future earnings. For example, if one does not have a large Medicare population in one's patient base, then the penalty may not be that impactful, allowing one to choose not to participate.

Christina: Any doctor that receives a 4% penalty in 2019 for not participating in MIPS in 2017 is either woefully uninformed, or just plain foolish. This is giving money away. Ultimately, the worst case scenario for doctors that do not choose to participate in MIPS is a 4% payment reduction in 2019, 5% in 2020, 7% in 2021 and 9% in 2022 and beyond. I do not think there is a best case scenario, other than not having to take some staff time and patient care time to do the requirements. Since, however, this is not an all or none system, not doing at least some aspects that are not that time-consuming, just does not make sense as doing something at least in the initial years, which should lead to penalty avoidance.

Q *PM: How much work or additional time will be required for full participation by podiatric physicians in these programs, above and beyond the former but now converted Meaningful use and PQRS programs?*

Hultman: Because PQRS and Meaningful Use will be eliminated, and rolled into MIPS quality and advancing care measures, and because there will be two lesser performance reporting options that are below the level of the full participation option, podiatric physicians will have several options to consider that require less time than that for full participation. Since many podiatric physicians have considered not participating at all because they fear the amount of time required will take away too much treatment time from patients, it is important that in 2017 they at least choose the minimum reporting option, which requires reporting just one quality measure, one clinical

practice measure, or all advancing care information measures to avoid the 4% penalty in 2019. If doctors decide to do this, then they might consider the second option because it is actually not much more time consuming. This second option allows 90 days to report more than one quality measure, more than one clinical practice improvement activity, or 5 advancing care information measures. Again, the leap from this level to full participation allows the same 90 days to report 6 quality measures,

Christina: Actually, as it is set up now, I agree that it will probably require less time and effort than PQRS and Meaningful Use did previously. Remember, PQRS was 9 measures and, in MIPS, Quality reporting is 6 measures. In Meaningful Use, there were 10 objectives with multiple measures, and either meaningful use was achieved or the practitioner failed. In Advancing Care Information, which replaces meaningful use, there are 5 core objectives, and then, one can choose additional objec-

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2 or 4 clinical practice improvement activities, 5 required advancing care information measures and one additional advanced care information measure. Rather than guessing the amount of time required to meet the full participation option, it is better to re-examine all processes seeking opportunities to see how they all connect, and can be streamlined in ways that save time.

Lehrman: I think it depends on the practice. If a practice was already participating in Meaningful Use and PQRS, there should be no additional effort required once the new system is learned. Participating in MIPS in 2017 is easier than it was to participate in the combination of both Meaningful Use and PQRS in prior years.

Aung: Depending on how one collects the information necessary for reporting, I believe the EMR/EHR should do the majority of the work. Beyond that, all one has to do is to have someone assigned to run the reports, review and do some follow up throughout the process, then do the actual reporting, either through claims, registry or through one's own EMR vendor. I recommend speaking to one's vendors to see how they have set up the templates to collect this information.

tives to try to score the maximum of 100 in that category, which earns 25 MIPS points. One, however, can get less than 100 points in the advancing care information and get a percentage of the 25 MIPS points as this is not an all or none system. This means if a certain objective in meaningful use was causing one to fail, in advancing care information, one may be able to not do that objective, and still get MIPS points.

Borreggine: The fact is that if a provider is already participating in the PQRS and EHR Meaningful Use programs, then there really is not much change in the process of reporting the PQRS measures and EHR attestation of the Stage I and II meaningful use. I recommend just following the guidelines set by CMS in making sure all the necessary requirements for QPP and MIPS are met, and there should not be any problems. Therefore, there should be no penalty assessed, but rather incentives to be achieved instead.

Q *PM: How well will small independent practices fare versus group practices in participating in MIPS? What strategies can smaller practices implement to efficiently participate?*

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Borreggine: One of the concerns for many medical practices is that MACRA's quality initiatives will favor larger practices with vast resources, but create a burden for smaller practices. Larger practices will find it easier to participate in group reporting registries, which are required for many MACRA quality measures and may be able to participate in the Alternative Payment Model (APM) option.

Doctors, working solo, will, at the very best, be able to avoid some cuts, as opposed to reaping some financial benefits. With the current flexibility and changes in MIPS reporting, however, I do not think it will be that bad for reporting in 2017. In the future, things may change, which will make it more difficult for independent practice. In the meantime, I would highly suggest a review of the flexibilities for small practices that CMS has provided on the MACRA program: <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/small-practices-factsheet.pdf>

Hultman: Groups and small practices will face similar challenges. Over the years, compliance and billing have become more complex. The once old style of billing one fee for office visits, new patients, or consultations evolved to five different E/M codes for each. In addition, requirements for documentation got more complex. As time went on, compliance with OSHA and HIPAA became more complex, payers added more hoops, barriers, and complexity in the form of prior authorizations, capitation, PQRS, Meaningful Use, RVU, retrospective audits, quality ratings, ICD-10, and now we have MACRA and MIPS. It is unclear if any of these changes have improved quality, but it is clear that each new requirement going forward must be fit into existing processes. In my opinion, most doctors have never even taken the time to analyze and redesign process workflows to efficiently accommodate these previ-

ous new requirements as they have been put in place.

Every industry has had similar complaints about unnecessary paperwork, Government red tape, compliance costs, etc., but most have determined ways to redesign workflow, and incorporate each new requirement into their business processes. With today's technology, which includes EMRs that are fully integrated with practice management software, and hardware located in every treatment room, the solution is to find

much better for practices with 2 to 9 eligible docs, nearly 70 percent will face a negative adjustment, totaling lost revenue of \$279 million.

Christina: Although lack of administrative oversight and assistance, certainly makes complying with any regulatory programs more difficult for small practices versus large group practices, small group practices can survive, and even thrive under MIPS. The first key strategy is to become very familiar with all of the compo-

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a way to efficiently and logically incorporate any new requirements into more streamlined processes. A sound business efficiency axiom is to enter data one time, at the moment it is created. If all data is entered in this way, today's software can be programmed to locate any data, and simultaneously put it everywhere it needs to be in order to be compliant, document performance measures, produce reports, etc. Again, it is my opinion that if this process is done effectively, the time impact of MIPS and all other requirements will actually be negligible.

Aung: The challenge for smaller practices is that they may not have the live bodies to manage this process, whereas larger practices may be able to hire managers, who can monitor the physicians throughout the months or the year, and take corrective action by education. They, then, may also run reports and coordinate the reporting in whichever way they choose.

Hrywnak: Unfortunately by CMS' own accord, the outlook for small practices in the first year of MACRA is bleak. In its proposed rule for MACRA implementation, CMS projected that 87 percent of participating solo practices will face a negative financial adjustment in year one of MACRA, equating to a total of \$300 million lost. The numbers aren't

nents of MIPS. For 2017, that means understanding the requirements and measures for the Quality component, the Advancing Care Information portion and, finally, the Clinical Performance Improvement Activities. I recommend mapping a strategy of what measures one wants to report and how to report them, and what performance improvement activities one is going to implement. If one has and uses an ONC certified EHR, I recommend understanding what measures must be achieved. I also suggest making sure one understands the reporting time frames and mechanisms to report what has been done. The better one understands the program and each of the components, the easier it is to decide the parts one wants to do and how to go about doing them. APMA has great information for their members at www.apma.org/macra and CMS has a very user friendly website www.qpp.cms.gov.

Lehrman: There should be no difference between the two types of practices. It depends on how well the offices are prepared, and how well the doctors and staff are trained on what needs to be done. The requirements are the same regardless of small practices versus large practices. The only reason it may be easier for doctors in large practices to partici-

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pate is that they tend to provide more help to the doctors and have staff do most of the work required to participate in these programs, but there is no reason why well trained staff cannot be just as helpful in a small private practice. There is nothing in MIPS that favors large practices over small practices. If there is no change to MACRA as it currently stands, large group practices may be better equipped to participate in Alternative Payment Models as they evolve in the coming years, but this has no impact on MIPS in 2017.

Q *PM: What should practitioners be doing now to prepare for participation in the MIPS program? What steps can doctors take to protect or even bolster their bottom line amid pay-for-performance uncertainty?*

Aung: Once again, I suggest starting by speaking to one's EMR vendor and becoming knowledgeable on how this information is collected, for example, where in a particular note or patient registration process can this information be collected. Next, I recommend training one's staff to help patients complete these items through the patient portal or on paper depending on the way information is collected and organized. In the case one intends to report by claims, then making sure that the charge ticket or superbills are impregnated with the correct codes for accurate reporting.

Lehrman: There is no uncertainty. MIPS in 2017 is very clearly described. To prepare, I suggest learning the program and its requirements. For APMA members, there are many resources on the APMA web page, and archived webinars that explain exactly what needs to be done to achieve the level of participation that makes the most sense for each practice. Attending high quality in-person lectures with informed speakers that really understand this topic can be helpful as well. Some electronic health record companies provide information as well.

Hultman: Conversely, it is hard to predict where things will end up given political uncertainty with healthcare and the fact that specialists see little value for the reporting measures identified by MIPS. As mentioned before, doctors should at least prepare by participating in the test phase of the Quality Payment Program by reporting just one quality or clinical practice activity. This will keep their options open in case the program changes, is replaced, or continues as is.

with their cousin, Value Based Modifier, compose up to 85% of future composite performance score, and resultantly, reimbursement. Practitioners should begin to master their efforts in these programs now. MIPS performance year began on January 1, 2017. Next, I think doctors should become familiar with the depth of the details of clinical quality measures in these current programs, and identify the potentially highest performing clinical quality measures

I recommend starting to check measures against crosswalks of other quality program initiatives from which they may also benefit.—Hwrynak

Christina: I suggest understanding the programs and the penalties. Also, certainly not getting caught by not being prepared and not doing something to avoid the penalties. At least early on, there are great opportunities to achieve incentive payments without having to do a lot of extra work. When incentives are available, and do not require significant extra work, I advise making sure to take advantage of those opportunities. It is wise to remember, when e-prescribing and PQRI programs initially rolled out, they were incentive only programs, not penalties, and providers were able to get some nice incentive payments, by being educated about the programs, and making the minimal efforts to participate.

Also, at least to start, CMS is allowing providers to ease into the program. Providers should try some activity in all of the MIPS categories to become familiar with how to do them, find out what works and how to incorporate these activities into work flow for both the physicians and staff. In the future, if more is required, being familiar with each of the categories will make compliance easier.

Hwrynak: Here's my recommended multifaceted approach. First, I recommend understanding that Meaningful Use and PQRS are truly not going away. Elements of those programs will, in fact, along

appropriate to their scope of practice. Also, I recommend starting to check measures against crosswalks of other quality program initiatives from which they may also benefit. This is the best way to maximize efficiency and performance levels. Next, I recommend assuring that doctors' certified electronic health records technology can collect quality data appropriate to those physicians, so that collection of that data is feasible and they are able to then report on those measures. Not all products are certified to collect data on all measures. I suggest researching and selecting the best PQRS reporting vehicle to match the measures identified. Not all measures can be reported via all reporting mechanisms, for example, claims-based reporting, registry reporting, EHR-Direct reporting have different measures available from which to select. I recommend monitoring quality report card dashboards early and often to identify deficiencies, remediate and advance to the next performance level. I would expand the physicians' community-of-care network for optimal patient care and reimbursement. I would become familiar with the Alternative Payment Models concept and investigate participation in one of them. (ACO, Medicare Shared Savings Program, PCMH etc.) The most lucrative per-

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formance opportunities will exist for the highest achieving providers in these organizations. Lastly, I recommend checking out Physician Compare Clinical quality statistics that are now publically reported via this consumer-facing provider evaluation tool. It is currently available for review, online. Attaining one's highest quality scores now positively reflects upon both the physician effort as well as the customer opinion.

Q *PM: Looking into the future: discuss whether "grouping" of practices in order to participate fully in pay-for-performance measures might make sense.*

Hultman: I have always been a big advocate of grouping, and have written several lengthy articles on the advantages of groups. In the past, I have pointed out twelve significant advantages that groups have over smaller practices of only one or two doctors. These advantages include the abilities to: maximize efficiencies, offer a broad array of services, obtain greater negotiation clout, expand patient access, achieve marketing leverage through greater visibility, access capital, afford professional management, develop ancillary services, provide competitive corporate benefits, receive volume discounts from vendors, collect and analyze "best practices" and quality data, and offer an exit strategy upon retirement. If one is considering grouping, it should be to capture all twelve of these advantages, not just the one of participating fully in pay-for-performance measures.

Lehrman: Under MACRA, all doctors will function under either MIPS or an Alternative Payment Model. With very little exception, almost all podiatric physicians will function under MIPS in 2017. I feel grouping of practices offers no benefit as long as podiatric physicians continue to function under the MIPS program. As Alternative Payment Models become more available to doctors of podiatric medicine, grouping, or virtual grouping, may offer

some benefit, but this is far off. Moreover, health policy on a national level is so uncertain right now, I would not suggest investing a lot of resources into this concept.

Borreggine: I think that this does make sense because the larger the

medical group, then the greater the chance that these pay-for performance measures will be met. The fact is that there are numerous similarities between the QPP and the previous PQRS/EHR and VBM programs, but there are many differences, which re-

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quire the provider to provide the best care possible at the lowest cost.

Aung: There have been conference calls with CMS on just that topic in which I have personally participated, where it has been encouraged that smaller practices should form virtual groups. CMS has not released any of the specifications yet, and has not been able to answer the most pressing questions physicians have, including: what would be the advantage of forming informal groups? My best guess is that larger groups can report to CMS directly through its portal. There may also be advantages in being able to pool resources such as finances to hire administrators to help everyone in the group with data collection, management and reporting as well as with education, if one doctor in the group does not appear to be holding up his/her end of the agreement.

Christina: CMS has discussed allowing virtual groups for participation in MIPS. Depending on how it puts this together, it may make sense for some providers. Until the details are fully published, it is difficult to say if this direction will be a sensible option for small and solo providers, but it is something to be examined once it is finalized. If grouping does make sense, it is important to group with providers that are committed to participating and meeting the requirements.

Aung: I happen to agree that the negative, I see here, may be that if a virtual group is formed, and certain ones are the best performers, other members of the group may not take this seriously. As a result, those top performers' composite scores may go down. Also, those at the top may be stuck, having to stay in this group for 1-3 years, which can ultimately can impact their reimbursement 2-3 years down the road in the future.

Q *PM: Physician extenders (PA's, nurse practitioners, etc.) are now providing foot care in many medical arenas, and it has been said that they might be able to fit the*

new quality care model more cost-effectively than podiatric physicians. Will this affect the place of podiatric physicians in these alternative payment models?

Lehrman: I don't think so. If quality is what is being stressed, I think we will be able to prove the superior quality of services provided by podiatric physicians, if need be. The Thomson Reuters Study, "The Economic Value of Specialized Lower-Extremity Medical Care by Podi-

atric Physicians in the Treatment of Diabetic Foot Ulcers" suggested that if all patients with diabetes, insured with commercial and Medicare insurance plans, had a pre-ulcerative visit to podiatric physicians, \$1.97 billion could be saved among those with commercial insurance in one year, and \$1.53 billion could be saved among those with Medicare insurance in one year. A similar study done at Duke University showed that patients who visited podiatric physicians and/or lower-extremity clinician specialists within a year before developing complications were between 23 percent and 69 percent less likely to have amputations. These amputations are incredibly taxing and expensive to the healthcare system, and the fact that podiatric physicians can prevent them carries tremendous value. This profession is well positioned to thrive and deliver value in a model that rewards quality and cost-effective care.

MDs, DOs, and DPMs have been using physician extenders for a long time, and their use definitely increases productivity.—Hultman

Borreggine: I wish I could share Dr Lehrman's positive outlook but unfortunately, I believe that the propriety of podiatric medicine has been carved out by these physician extenders. They can do everything that was previously thought no other providers could do. Now, I think that has all changed. These ancillary non-physician providers have taken

over services of podiatric medicine with gusto and avarice. To make matters worse, they are not just in the realm of palliative care, but they are providing podiatric medical and surgical services to patients who once were solely the patients of podiatric physicians. There are statistics that show these physician extenders are more cost-effective than podiatric physicians, and with the advent of ACOs, and now QPP including MIPS and APM, this will become much more apparent. The data obtained from QPP

will be quite eye-opening to the trustees and providers of this profession, once they see that podiatric medicine is a very expensive medicine in the hands of podiatric physicians versus physician extenders.

Hultman: This question brings to mind a conversation I had with a less than friendly foot orthopedist in the mid-seventies. He was excited to tell me that his foot society had developed a plan to begin training technicians to perform routine foot care. He felt that this would put many podiatrists out of business. My reply was, "please give me a call when these technicians are available because I could use at least seven of them." MDs, DOs, and DPMs have been using physician extenders for a long time, and their use definitely increases productivity. If more quality measures are added, and the amount of time to document and report these measures increases, podiatric physicians will likely need one of these more cost-effective extenders to assist them, especially if the size of the potential quality bonus can justify the cost of the extenders.

Christina: I think it depends. While physician extenders may be able to provide some basic foot care, they will not provide the level of care and expertise that podiatric physi-

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icians are able to provide to their patients. They certainly will not be as capable at identifying at-risk patients, and providing the kind of care that can reduce complications, including ulcerations, infections, hospitalizations, and, ultimately amputations. When looking at alternative payment models, the care provided has to save costs especially when the significant costs considered are related to chronic diseases such as diabetes, heart disease, kidney disease, etc. Even though physician extenders may be able to save a few dollars with regards to providing basic foot care services, what podiatric physicians provide to patients with diabetes or lower extremity vascular disease in terms of preventing and healing ulcerations, reducing hospitalizations and ultimately preventing amputations, brings huge cost savings to the system and improves the health and quality of life for the patients. This is the value component of foot care by podiatric physicians that makes the savings of employing physician extenders look miniscule by comparison. It also makes the case for inclusion of podiatric physicians in alternative payment models.

Hrywnak: Since cost-effective care is the key, podiatric physicians will be affected. Data is being kept by the insurance industry, and this data will only show cost-effective care. Of course, the data will not show which college of podiatric medicines the doctors went to, nor where they did their residency and whether they are board certified or not. What complicates the matter is that the physician extenders already have unrestricted licenses; in other words, they can debride diabetic foot ulcers and adjust insulin and blood pressure medications. They fit perfectly into alternative payment models. I feel that it is time for all the colleges of podiatric medicine to standardize their curriculums and follow allopathic school models both in the classroom and in clinical rotations. The residencies should fall under ACGME like MDs and DOs. This evolution is a must. This profession cannot be an island unto itself

any longer. The practice model of the last century does not work anymore. Podiatric medicine must become part of mainstream medicine, including allowing podiatric physicians to obtain similar unrestricted medical licenses with which to practice going forward. **PM**



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