

Moving Ahead to Stage 3 Meaningful Use

By Cathy Costello, JD, Director of CliniSyncPLUS

Many providers have heard that new regulations were released in 2015 that define Meaningful Use (MU) from 2015 on. But few providers understand whether the regulations pertain to them. The important message is that ALL providers that bill the Centers for Medicare & Medicaid Services (CMS) for services are affected by the new regulations whether or not they are still eligible for MU incentive payments. MU has been incorporated into every new payment mechanism CMS has created. So how MU will change over the next few years is important for you to understand.

Meaningful Use in 2015 – 2017

A. Measures Removed from Attestation in 2015

The MU incentive program was significantly

restructured starting with the 2015 reporting year. There are many measures that were successfully being attested to by physicians and hospitals in earlier years at a

rate of over 90%, such as demographics, vital signs and smoking status. These measures are considered “topped out” and have been removed from MU attestation starting in 2015. *However, you should continue to track all the removed measures since they are necessary for the successful reporting of quality measures.* A complete list of all removed measures is listed on the following page.

(Continued on page 2)

AMCNO Mini-Internship Program Opens Door to Physicians’ Daily Work Life

Community leaders once again had the opportunity to shadow individual physician members during a “typical” work day through the Academy of Medicine of Cleveland & Northern Ohio’s (AMCNO) annual Mini-Internship Program.

Throughout the two-day program, which took place in late October, the community leaders (or “interns”) were exposed to different aspects of medical care—from surgery procedures to patient visits. This type of exposure allows the interns to gain a broad sense of the complexities involved with health care and the practice of medicine today.

This year’s participating interns were **Alex Dehar**, of Northwestern Mutual, and **Casey Ross**, healthcare reporter for *The Plain Dealer*.

Two other scheduled interns were not able to participate due to personal reasons.

The event, led by Dr. William Seitz, began Oct. 26 with an orientation dinner, where the interns had an opportunity to meet with the four physicians they would be shadowing. On Oct. 28, after the final full day, the participants met up once again at the AMCNO offices for a debrief dinner to discuss what they had learned.

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Dr. William Seitz, Mini-Internship program chair, talks with one of the interns.

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MU Measures Not Being Attested to Separately Starting in 2015

Meaningful Use EP/EH Measures Removed from Attestation	Additional EH Measures Removed from Attestation
Demographics	eMAR
Vital Signs	Advanced Directives
Smoking Status	Electronic Notes
Clinical Summaries	Imaging Results
Structured Lab Results	Family Health History
Patient Lists	Lab Results to Providers
Patient Reminders	
Summary of Care	

B. Measures Required for Attestation in 2015 – 2017

The remaining measures that will be tracked and attested for MU in 2015 – 2017 include measures that currently appear in Stage 1 and Stage 2. The measures have been pulled together into one short list; there are no longer “core” and “menu” measures. These new “blended” measures represent areas that CMS wants to continue to emphasize. These blended measures become the basis for Stage 3. All Eligible Professionals (EPs) and Eligible Hospitals (EHs) will attest to the same measures regardless of their Stage of MU. There are exclusions for providers that might have been at Stage 1 MU in 2015 if they had not been planning to attest to certain measures. By 2016, all providers will be responsible for meeting the same measures and the same threshold percent. *Although the reporting period for MU in 2015 is 90 days, by 2016 the reporting period returns to a full year reporting.* The measures that will be attested to are the following:

2015 – 2017 MU Measures for Attestation
1 Protect Electronic Health Information
2 Clinical Decision Support (CDS)
3 Computerized Electronic Order Entry (CPOE)
4 Electronic Prescribing (eRx)
5 Health Information Exchange (HIE)
6 Patient-Specific Education
7 Medication Reconciliation

- 8 Patient Electronic Access (Patient Portal)
- 9 EP Secure Messaging
- 10 Public Health Reporting (PH Reporting)

Stage 3 Meaningful Use Beginning Either 2017 or 2018

The option is yours which year you want to begin attesting to Stage 3 MU – 2017 or 2018. CMS has built some incentives into the 2017 Stage 3 reporting, though, by lowering some of the reporting thresholds and shortening the reporting period. By 2018, however, all providers will have to attest using Stage 3 and

will be required to have the Stage 3 upgrade to their EHR systems, called 2015 edition CEHRT (i.e., 2015 ed.). There are several advantages to beginning Stage 3 in 2017. If you attest to the blended Stage 2 measures in 2017 (the same ones used in 2016) then your reporting period is 365 days. If you move to Stage 3 in 2017, then your reporting period is reduced to 90 days. Also, by beginning Stage 3 in 2017 there are lower thresholds for some of the measures. If you wait until 2018 to begin Stage 3, you will be required to meet the higher thresholds for all measures. Below is the comparison between beginning Stage 3 in 2017 or 2018.

Selecting a Year to Begin Reporting Stage 3

# Measure or Attestation Information	2017	2018
Reporting Period	90 days	1 year
Certification criteria for CEHRT	Any combination of 2014, 2015 Edition CEHRT	2015 Edition CEHRT
1 Protect Electronic Health Information	Conduct security review in calendar reporting year prior to attestation	Conduct security review in calendar reporting year
2 Electronic Prescribing (eRx)	>60%	>60%
3 Clinical Decision Support	5 related to 4 CQMs	5 related to 4 CQMs
4 Computerized Provider Order Entry (CPOE)	Med orders: >60% Lab orders: >60% Imaging orders: >60%	Med orders: >60% Lab orders: >60% Imaging orders: >60%
5 Patient Electronic Access	Must meet both measures Patient Access: >80% unique patients to portal & API Patient Education: >35% unique pts.	Must meet both measures Patient Access: >80% unique patients to portal & API Patient Education: >35% unique pts.
6 Coordination of Care through Patient Engagement	Must meet 2 out of 3 measures 1) Patient portal VDT/API: 5% 2) Secure message sent: 5% 3) Health data incorporated: 5%	Must meet 2 out of 3 measures 1) Patient portal VDT/API: 10% 2) Secure message sent: 25% 3) Health data incorporated: 5%
7 Health Information Exchange	Must meet 2 out of 3 measures 1) Electronic summary of care sent: 50% 2) Incorporation of summary of care into record: 40% 3) Perform clinical information reconciliation for meds, med allergies and current problems for new patients: 80%	Must meet 2 out of 3 measures 1) Electronic summary of care sent: 50% 2) Incorporation of summary of care into record: 40% 3) Perform clinical information reconciliation for meds, med allergies and current problems for new patients: 80%
8 Public Health & Clinical Data Registry Reporting	Clinical Data Registry reporting and Case reporting options added to current options for both EPs and EHs EPs: 2 (syndromic no longer available except for urgent care) EHs: 4	Clinical Data Registry reporting and Case reporting options added to current options for both EPs and EHs EPs: 2 (syndromic no longer available except for urgent care) EHs: 4
CQM Reporting	2016 Annual Update; attestation or eCQM reporting; 365-day reporting period	2017 Annual Update; eCQM reporting; 365-day reporting period

Deciding When to Begin Stage 3: Working with Your Vendor

When trying to decide which year will be best to begin Stage 3, you will have to talk to your vendor. The timing of your EHR's system's upgrade to Stage 3 will determine whether you can meet Stage 3 in 2017. It will be easier to meet Stage 3 in 2017, so make sure you get on your vendor's implementation list early in 2017 for the upgrade. The earlier you can receive the 2015 ed. CEHRT version for your system, the sooner you can begin establishing the new workflows you will need to meet Stage 3. If you decide to wait until 2018 to begin Stage 3, you will still need to have the 2015 ed. upgrade installed before the end of 2017 to allow for a full year of reporting in 2018. Some of the new Stage 3 measures require additional functionality, so the vendor will have to tell you how it is planning to meet that measure. Plan on talking to your vendor about the API ("Application Programming Interface") that your EHR system will need to have as an option to the patient portal. If you want, you can still use the portal to post patient information. Your vendor, though, will have to offer the API to the patient to access that information through a smartphone or other means that can combine information from different portals and different providers. Either the portal or the API, or both, can be used by your practice to meet the "Patient Electronic Access" measure.

Changes in Workflow Required to Meet New Stage 3 Measures

Some of the Stage 3 measures will be the same ones you are attesting to now, just with higher thresholds (e.g., e-prescribing—with or without controlled substances prescriptions—your choice, CPOE, patient education, patient portal). Some are the same (e.g., security review and clinical decision support), but several are totally new. These are the ones that you will have to work with your staff members to determine how to best meet the measures. Stage 3 is also the first time that CMS has created options as to which MU measures you want to attest to, so you will need to sit down and decide as a group what your target measures will be.

A. "Coordination of Care through Patient Engagement"

This new measure has 3 parts: 1) View, Download, and Transmit (VDT) for patient portal or API; 2) Secure messaging to patients from the practice; and 3) Incorporating clinical data from non-EP or non-EH sources into the patient's record. *You will need to meet 2 out of 3 of the*

parts to meet MU for Stage 3. This measure replaces the old VDT measure for the patient portal and the secure messaging measure from Stage 2. If you begin Stage 3 in 2017, you will need to have 5% of your patients viewing their records in the patient portal (**Part 1**). If you begin in 2018, then the number of patients viewing rises to 10%. For secure messaging (**Part 2**), rather than asking your patients to email you, your practice will be tracked for emailing the patient. You will need to send to 25% of your patients that are seen an email related to their clinical care (not billing or a reminder of a scheduled appointment). There is also a new part to the measure that says a provider needs to add information from a non-EP or non-EH source to the patient's clinical record for 5% of the patients seen (**Part 3**). Items that you might add to the record would include such things as physical therapy notes, home healthcare notes, behavioral health reports, reports gathered through a wearable monitoring device (such as a cardiac monitor), or information from a home health or fitness device.

B. Health Information Exchange

The health information exchange (HIE) measure expands the Stage 2 measures for transitions of care and medication reconciliation. *There are 3 parts and you will need to meet the threshold for 2 of them:* 1) Provide an electronic summary of care record for patient's being referred to another provider (**Part 1**); 2) Retrieve a summary of care record from the HIE or a DIRECT email exchange for new patients (**Part 2**); and 3) Incorporate the summary of care document into the patient's record including performing a "clinical information reconciliation" on information being added to the record (**Part 3**). This measure is designed to make sure that for new patients any information that is available on the patient from previously treating providers is reviewed and, if important, added to the record. The measure is summarized in the chart below:



Health Information Exchange Measures (Must meet 2 out of 3):

- 1) Patients being referred elsewhere for care: Summary of care record sent for 50% of cases (exclusion for < 100 referrals in reporting period).
- 2) New patients seen: Summary of care records sought through DIRECT email from another provider or from the HIE for 40% of new patients.
- 3) New patients seen: Information received on meds, med allergies and problem list are reconciled for 80% of new patients.

C. Public Health/Clinical Data Registry Reporting

Public health reporting changes in different ways with Stage 3. EPs will need to report on 2 public health/clinical data registry measures, while EHs will increase to report on 4 measures. In 2015 and 2016 these measures have focused on reporting to public health agencies, such as the Ohio Department of Health (ODH) for immunization reporting, syndromic surveillance reporting or cancer registry reporting for EPs. Whenever you choose to start Stage 3 (either 2017 or 2018), your reporting options will change. You will no longer have the option to do syndromic surveillance reporting unless you work in an urgent care or emergency department setting. Immunization and cancer registry reporting options will remain for EPs. For Stage 3, EPs will also be allowed to count reporting to private clinical data registries to meet this measure, such as specialty registries for cardiology reporting, orthopedic reporting or surgical reporting run by the specialty societies. Each year, CMS will publish a directory of registries that are ready to receive registrations and can meet the technical requirements for the data transmission for that year. If a registry does not give at least 6 months' notice of its readiness to accept data, it will not be included in the directory for that year. EPs can also report to case registries but these standards are still being developed.

Steps to Take to Prepare for Stage 3

You need to plan to be successful for Stage 3. Many of the measures for Stage 3 represent best practices that you are already using. You and your staff should understand how to capture those practices in a way that will meet the MU requirements. Talk to your vendor, the staff at the CliniSync HIE, and the data registries, but most importantly, talk to your practice and the other practices you refer to. With a little bit of planning, you will be able to glide into Stage 3 with very little effort. ■

Regional Activities

AMCNO Sends Letter to City Council in Support of “Tobacco to 21” Proposal

In November, the AMCNO joined other medical organizations in expressing support for the Tobacco to 21 proposal in Cleveland. The AMCNO president, Dr. Matthew Levy, sent a letter of support to City Council, noting that delaying the age when young people first experiment or begin using tobacco can reduce the risk that they transition to regular or daily tobacco use and increase their chances of successfully quitting, if they do become regular users. He also noted that raising the legal age to purchase tobacco products may decrease the number of adolescents who start smoking by as much as 25%. Additionally, nearly 80% of youth who use tobacco are using flavored tobacco products. They mistakenly think they are safer, and they are attracted to the flavors. Each day in Ohio, the tobacco industry spends \$1 million on advertising, with much of this targeted toward the youth.

Cleveland City Council, by a vote of 13-3, passed Tobacco to 21. Once the legislation is signed by Mayor Jackson, you will need to be 21 years old to purchase cigarettes, other tobacco products and e-cigarettes in the city of Cleveland. The city will join Bexley, Grandview, New Albany and Upper Arlington here in Ohio, as well as Hawaii and 103 other cities around the country that have enacted similar legislation.

State Administrative Activities

No Single MBR Package Anticipated in 2016

The Kasich administration has indicated that it is unlikely to send a large package of government reforms and budget corrections to the General Assembly to consider as part of a Mid-Biennium Review (MBR). In his first four years in office, Governor Kasich would have lawmakers working on a second budget each biennium through the “mid-biennium review.” Each time this has occurred lawmakers would be sent one bill consisting of thousands of pages that would later be divided up by the legislature into separate bills by topic. The administration has indicated that they will be going through a similar process to put together the MBR and will solicit the agencies for comments on policy changes to improve state government—and there may still be some reforms sent to the legislature in

2016—but it is likely there will not be one bill sent to the General Assembly. The administration is also in the process of putting the capital appropriations bill together. The administration has indicated that they will use the same philosophy they have used in previous capital bills and will use the same conservative budgeting.

Ohio Department of Health Achieves National Public Agency Accreditation

The Ohio Department of Health (ODH) has become one of only 11 state health departments to achieve national accreditation through the Public Health Accreditation Board (PHAB). This national program, which is jointly supported by the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation, works to protect and improve the health of the public by advancing the quality and performance of the nation’s public health departments. To achieve accreditation, a health department has to complete a peer-reviewed assessment process to ensure it meets or exceeds a set of quality and performance standards and measures. In Ohio, eight local health jurisdictions have also earned the PHAB accreditation—all of Ohio’s local health jurisdictions must be accredited by 2020.

Board of Pharmacy Announces New Website

The State of Ohio Board of Pharmacy has launched a redesigned website for the state’s prescription monitoring program, known as the Ohio Automated Rx Reporting System (OARRS). A fresh design, new features and improved navigation offers visitors a better user experience. The website is more user-friendly, with content that helps OARRS account holders maximize the information contained in the system.

This new content includes an updated frequently-asked-questions section, guidance documents and three new training videos that take users through the process of registering for an account, running a patient report and reviewing the information contained within an OARRS report. Additionally, the site contains a new statistics feature that allows anyone to create custom county reports and view maps based on aggregate data collected in OARRS.

Established in 2006, OARRS is the only statewide database that collects information on all prescriptions for controlled substances

that are dispensed by pharmacies and personally furnished by licensed prescribers in Ohio. OARRS data is available to prescribers when they treat patients, pharmacists when presented with prescriptions from patients and law enforcement officers only during active investigations. To view the website log on to www.pharmacy.ohio.gov.

Governor Kasich Announces Integration of OARRS into EMRs

Recently, Gov. John Kasich announced an investment of up to \$1.5 million a year to integrate the Ohio Automated Rx Reporting System (OARRS) directly into electronic medical records and pharmacy dispensing systems across the state, allowing instant access for prescribers and pharmacists. To assist hospitals, prescriber offices and pharmacies with utilizing this new integration service, the State of Ohio Board of Pharmacy has created a frequently-asked-questions document. To begin the process an Integration Request Form must be completed and submitted—this form is available at www.pharmacy.ohio.gov/integration. The State is utilizing an integration service called PMP Gateway that is operated by Appriss. More information on this service may be obtained at www.appriss.com. To view more information about this service log on to www.pharmacy.ohio.gov.

Commission Convenes to Discuss GME Spending

Ohio Medicaid subsidizes hospitals \$39,000 on average annually for each graduate medical intern or resident the hospital trains. However, some hospitals receive as much as \$385,000 per resident, while others receive nothing at all. This variation is the subject of a study commission created by the Ohio General Assembly and chaired by the Governor’s Office of Health Transformation.

The Commission has met in November and December to review why the current graduate medical education (GME) formula generates dramatically different results for hospitals that provide similar medical training opportunities. The Commission has until the end of 2015 to report its recommendations for modernizing the Medicaid GME formula and aligning it to support state priorities like recruiting and retaining more physicians in primary care. The AMCNO will provide our members with a detailed report on the committee findings in the future.

SMBO Develops List of “Red Flag” Signs of Prescription Drug Abuse

The State Medical Board of Ohio has developed a list of “Red Flag” signs of prescription drug abuse as a reference tool for prescribers. The document, entitled “Red Flag Signs of Prescription Drug Abuse,” was created to assist physicians and other healthcare providers in identifying signs of potential drug-seeking behavior. The Medical Board encourages you to share this information with your staff and post it in your office. The document is available in the “News” section of the Medical Board’s website, which you can access at www.med.ohio.gov.

Legislation Under Review

AMCNO Provides Testimony in Support of HB 249—Drug Overdoses

Dr. Joan Papp—an AMCNO member, Assistant Professor of Emergency Medicine at MetroHealth Medical Center, and the Medical Director for Cuyahoga County Project DAWN (Deaths Avoided with Naloxone)—recently testified before the House Judiciary Committee in support of HB 249—Drug Overdoses. The bill would provide immunity for the individual summoning emergency medical services as well as the overdose victim from minor drug possession charges. It would not provide immunity for other offenses such as drug trafficking or driving under the influence of drugs.

Dr. Papp noted that over the past few years there has been strong support for the passage of HB 170 and HB 4, which allow increased access to the antidote to opioid overdose — naloxone. Contained within this legislation is a mandate to activate EMS in the event of an overdose when administering naloxone. She



AMCNO member Dr. Joan Papp provides testimony in support of HB 249, a Good Samaritan law related to drug overdoses.

stated that while this provision is vital to overdose response, without protection from arrest this mandate may go unheeded by those responding to overdose.

Ohio is not the first state to consider and adopt legislation similar to HB 249. In fact, 20 states and the District of Columbia have adopted 911 Good Samaritan laws that provide limited immunity and arrest from prosecution. These laws protect the caller and overdose victim from arrest and or prosecution for simple drug possession, possession of paraphernalia and or being under the influence of drugs. The AMCNO also submitted written testimony in support of the legislation.

Senate Bill 129 – Prior Authorization Bill – Clears the Ohio Senate

Senate Bill 129 – the Prior Authorization Reform Act bill – a bill that will make positive reforms to the prior authorization system – has cleared the Ohio Senate. The Ohio State Medical Association, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and several other medical and health care organizations from around the state provided support for this legislation and worked to achieve passage of SB 129 in the Ohio Senate before the end of 2015.

Prior authorizations have disrupted the physician-patient relationship and often lead to a delay in diagnosis and treatment of the patient’s condition. They also cause a significant administrative burden on the physician’s practice and result in little to no improvement in the quality of care. SB 129 would change this process.

These changes will significantly help physicians and patients in our state. Ohio would join roughly 15 other states that have enacted similar meaningful changes and would be one step closer to providing better care and access to patients.

This bill would impose the following changes upon Ohio’s current prior authorization (PA) process:

1. Insurers must have a web-based system to receive PA requests.
2. Insurers must disclose all PA rules to providers.
3. Enrollees of the health plan must receive basic information about which drugs and services will require prior authorization.

4. Faster timeframes for prior authorization decisions for urgent/non-urgent situations.
5. Allows a provider to request a “retrospective review” for unanticipated procedures that were performed during an authorized procedure, with some limitations.
6. A prohibition on retroactive denials regarding coverage or medical necessity, as long as the procedure was performed within 60 days of receiving an authorization.

The legislation is now in the Ohio House and testimony will begin on the bill in January. The AMCNO will continue to offer our support for the bill.

AMCNO Continues to Voice Opposition for HB 216

The AMCNO has taken a position of opposition on HB 216, and we have been working with other medical associations around the state to express concern about this legislation to the members of the Ohio legislature. As introduced, HB 216 would allow Advanced Practice Registered Nurses (APRNs) in Ohio to practice independently, without a standard care arrangement with a collaborating physician.

This bill threatens to fundamentally change how physicians and APRNs work together in a collaborative manner. We must let our elected officials know that Ohio physicians strongly oppose this legislation.

The bill would also grant prescriptive authority to certified registered nurse anesthetists and allow all APRNs to prescribe addictive Schedule II drugs in all settings except for retail clinics. **HB 216 would allow Ohio’s more than 10,000 APRNs to prescribe medications—including addictive and dangerous Schedule II drugs—without consulting a physician.** With overdose deaths on the rise in Ohio we need greater accountability over prescribing, not less. This drastic change in Ohio law from a collaborative team-based approach to an independent practice model of care for APRNs does not provide adequate patient safety assurances and could threaten the quality of care provided to Ohioans.

(Continued on page 6)

AMCNO LEGISLATIVE ACTIVITIES

Just before the end of 2015 a substitute bill was under review, and the AMCNO and other statewide medical associations are reviewing the substitute bill over the winter break and considering next steps. Physician members are encouraged to continue to check the AMCNO website for updates, additional information and other resources about the bill. To view a fact sheet about this issue, see page 7.

SB 243 – Step Therapy

Newly introduced state legislation will help Ohio patients get the first and best medication their doctors say will work for them. State Senators Peggy Lehner (R- Kettering) and Charleta Tavares (D-Columbus) are co-sponsoring SB 243, which would establish guidelines health insurers must follow when they impose “step therapy” requirements. The AMCNO and many other healthcare advocates in Ohio support the bill’s potential to help patients get the medications they need.

Under step therapy, an insurer denies coverage of a prescribed medication, requiring that the patient first try a different medicine, usually at

less cost to the health plan. The patient must “fail first” on the drug chosen by the insurer, at which point the health plan may require additional steps—other medications—before approving the original prescription from the medical professional.

Step therapy is increasingly used by insurers. In 2010, nearly 60% of health insurers reported using step therapy, and in 2013, 75% of large employers reported offering plans that utilize step therapy.

SB 243 would not prohibit step therapy, but it would set up conditions for its use. The bill would:

- Require that step therapy decisions be based on medical guidelines developed by independent experts. This will make step therapy safer for patients.

A recent assessment showed that 18 of the nation’s largest insurers who were asked to cover a biologic or immunologic drug (often used to treat autoimmune diseases) instead required patients to try medications carrying “black box warnings” of side

effects like serious infections, tuberculosis, and cancer. This happened even when the medication requested by their healthcare provider did not carry any such black box warnings. In other words, patients were prescribed medicine that had less serious side effects, and the insurer replaced it with medicine that had potentially more severe side effects.

- Specify conditions under which it is medically appropriate to exempt patients from step therapy. This might include cases in which the patient is already stable on the physician-prescribed medication, or cases where the patient has already tried the drug required by the insurer and it didn’t help.
- Require insurers to have a clear, quick process for physicians to request an override to step therapy. Studies show that 20% of patients who are denied the medication they were prescribed end up not taking any prescription medication at all. Their treatment is effectively delayed, with possible adverse consequences to their health. ■

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Teams Work . . . For Patients

H.B. 216 Myths vs. Facts

House Bill 216 would permit Advanced Practice Registered Nurses in Ohio (certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists and nurse midwives) to practice *independently* with no requirement for physician collaboration. This over-reaching and unnecessary plan would essentially break from the team-based model of health care that exists today jeopardizing the safety of the patient. Below are some of the claims (or myths) made by APRNs in support of House Bill 216.

MYTH: Ohio HB 216 would solve the shortage of providers in rural/underserved areas.

FACT: Current law does not prohibit APRNs from working in rural or underserved areas, and nothing in House Bill 216 guarantees they will work in those areas. In fact the Ohio Board of Nursing 2015 APRN Workforce Data Summary Report shows most APRNs choose to work in a hospital setting and even fewer are electing to work with patients in rural or underserved areas.

MYTH: Ohio HB 216 would stop the flow of APRNs leaving Ohio.

FACT: There is no data to support APRNs are leaving the state because care requirements are too restrictive. According to the 13,000 APRNs surveyed in the 2015 Ohio Board of Nursing Workforce Data Summary Report, **only 21** indicated they were unemployed due to difficulty finding a job. Furthermore, the report also indicates that the number of APRNs working in Ohio has grown by as many as 3,000 since 2013.

MYTH: Ohio HB 216 would disallow high collaboration fees nurses must pay to physicians.

FACT: There is no data or evidence to support the claim that APRNs are paying physicians in Ohio any amount to collaborate.

MYTH: Ohio HB 216 would improve quality of patient care.

FACT: A 2015 study by the American Medical Association shows that when given a choice, patients prefer that their care be coordinated and a physician be included in that team model. Every member of the team plays a critical role. The team approach is efficient and effective. It ensures the patient receives safe, coordinated care that minimizes fragmented or unnecessary expensive treatments.

MYTH: Ohio HB 216 would help prescribing services by getting rid of restrictions.

FACT: House Bill 216 would allow APRNs to independently prescribe addictive and dangerous Schedule II drugs without consulting a physician. At a time when prescription drug abuse is one of Ohio's most serious public health challenges, we need greater accountability of prescribing, not less. Especially for patients using multiple medications, the extensive education and training from physicians would help ensure patient safety for prescription medicines.

MYTH: APRNs have advanced degrees. Freeing them to practice independently removes the barriers to primary care that many Ohioans face.

FACT: A 2015 study by the American Medical Association shows patients value and rely upon the additional education and training that physicians receive and they want a physician in the decision making process. Enabling APRNs to practice independently of the collaborative model dismisses the years of education and experience physicians must have to manage complex chronic conditions or to determine root cause of a complication.

MYTH: Certified Registered Nurse Anesthetists are qualified to administer anesthesia and shouldn't require the oversight of a physician.

FACT: Most surgical procedures go smoothly but on occasion, a patient experiences a complication, and, when that happens, the physician anesthesiologist uses their education and training to manage complex medical problems in the operating room, immediately and safely, when seconds count. Currently only four states allow CRNAs to completely practice independently.

MYTH: Patients have the right to select the health care provider, current law limits that choice.

FACT: Patients are free to choose where they receive their care. Ohio law simply requires collaboration and a standard care arrangement between an APRN and physician. The physician must be continuously available to communicate with the APRN. Collaboration by a health care team led by the physician increases safety and reduces the risk of poor patient outcomes.

MYTH: Doctors oppose Ohio HB 216 because they're protecting their turf.

FACT: Health providers who oppose HB 216 do so because of concerns for patient care. Team-based, coordinated care involving a physician is what patients say they want and it provides the best approach. Physicians in Ohio have worked with other providers on scope of practice issues. Recent negotiations with Physician Assistants (PA) to expand their practice and pharmacists to revise their consult agreements illustrate that physicians recognize the need to make changes to scopes of practice that do not jeopardize patient care.

Ohio's physicians value the abilities and contributions of APRNs and all nurses. However, House Bill 216 goes too far to upset the collaborative effort already underway among all health care professionals.

For more information please contact Monica Hueckel of the Ohio State Medical Association at 614.527.6745 or mhueckel@osma.org or visit www.osma.org.



We would like to thank the American Medical Association's Scope of Practice Partnership for their assistance in this educational campaign.

Enrollment Assisters Available for Patients in Northeast Ohio

By Sarah Hackenbracht, Executive Director, Cuyahoga Health Access Partnership (CHAP)

Open enrollment for the Health Insurance Marketplace kicked off on November 1, 2015 and will remain open until January 31, 2016. Enrollment assisters—navigators and certified application counselors—continue to seek out consumers to help them enroll in the best coverage option for their budget and health needs.

On October 28, 2015, the U.S. Department of Health & Human Services (HHS) Regional Director Kathleen Falk joined Cuyahoga County Executive Armond Budish, a representative of the City of Cleveland, mayors from several other jurisdictions, and leaders from the Ohio House of Representatives and Ohio Senate to promote the beginning of open enrollment. The message from HHS was clear and exciting—there has been an overall decrease in plan costs in Northeast Ohio, which has not been the case in other parts of Ohio and the country. The press event also highlighted the first day of open enrollment with several local events hosted at area churches and community-based settings. The Northeast Ohio Outreach & Enrollment Council (NEO O&E Council) coordinated the press and outreach events in conjunction with hospitals, federally qualified health centers, local government, and community-based agencies interested in helping people get connected to free or affordable health coverage. This diverse partnership continues because of the importance of connecting with consumers who need health coverage and ensuring that they understand the components of the health plan they select and how their type of coverage can be used to improve their overall health and wellness.

This year, there are several key tactics employed by the region's enrollment assisters working in collaboration through the NEO O&E Council. First, targeted zip code data has been provided by HHS and Enroll America to help guide our region's enrollment efforts. Enrollment assisters are using that data to better target communities where higher numbers of uninsured remain. Secondly, the partnership with United Way 2-1-1 continues with their Health Program line receiving calls for consumers that need help getting covered. The United Way 2-1-1 database is regularly updated with regular enrollment locations, special events, and contact information so a caller can receive multiple options for getting covered. A new addition for this year is the use of Get Covered Connector (GCC)—the online scheduling tool. Some enrollment



CHAP Executive Director Sarah Hackenbracht welcomes attendees of the Health Insurance Marketplace open enrollment kick-off event.

assisters are actively using the GCC in addition to their scheduled locations to help internet-savvy consumers sign up for appointments by using the GCC zip code locator. Additionally, United Way 2-1-1's Health Program Line is helping consumers schedule active appointments using the GCC. Consumers can check out the available appointments near them by visiting: <https://www.getcoveredamerica.org/connector/>

While many physicians' offices have tools and resources at their disposal to assist an uninsured consumer, the Cuyahoga Health Access Partnership (CHAP) wants to offer its assistance as it is needed by your staff and patient population. CHAP is the lead convener of the NEO O&E Council and one of two navigator entities in Northeast Ohio. CHAP's certified and licensed Navigators are stationed at 11 community locations each week and also cover other areas for outreach events and by appointment.

There are several ways a CHAP Navigator can assist your patients with their health coverage needs.

Expanded Medicaid

Consumers earning less than 138% of the Federal Poverty Level may be eligible for expanded Medicaid, which requires a 15–20 minute application. Wait times to process Medicaid applications vary by county, but we are pleased with the ongoing cooperation with Cuyahoga County Job and Family Services, which has allowed us to trouble-shoot more

than 450 Medicaid applications. There is no deadline to enroll in Medicaid, and enrollment assistance is available year-round. However, it is important to remind consumers that they will have to renew their Medicaid annually and to look for notifications from the State of Ohio in the mail and take action when they arrive.

Health Insurance Marketplace

Consumers earning up to 400% of the Federal Poverty Level may be eligible for a subsidy, called the Advanced Premium Tax Credit, via the Health Insurance Marketplace. The Cost Sharing Reduction is also available for consumers with the out-of-pocket costs if their income is up to 250% of the Federal Poverty Level. There are a wide variety of plans available on the Marketplace and the web-based interface is easier for consumers to navigate this year than in years past. Because of the diverse needs of consumers trying to choose between one of the many health insurance plans offered and ensure the plan selected meets their health needs and budget, we continue to encourage everyone to take advantage of the free assistance provided by navigators and certified application counselors.

Access Plan

If a consumer is not eligible for any type of private or government-sponsored plan, we do continue to offer our local Access Plan. The Access Plan assists low-income Cuyahoga County residents between 19 and 64 years of age who need help accessing specialty care.

If you'd like to have a CHAP Navigator join you and your staff for an education presentation, discuss options for outreach to your uninsured patients, or help patients from your practice enroll or renew their coverage, please contact CHAP at 1-888-929-2427. Their office is located at 75 Erieview Plaza, Third Floor, Cleveland, OH 44114. ■

Editor's note: CHAP is governed by a diverse collection of community stakeholders representing healthcare providers, payers, local government, and foundations—including the Academy of Medicine of Cleveland & Northern Ohio (AMCNO). These organizations and individuals are instrumental partners in our mission to provide a system of health access to Cuyahoga County's adult uninsured population.

AMEF & AMCNO ACTIVITIES

Doc Opera is a Huge Success – AMEF and AMCNO Sponsor the Event

Now in its 31st year, Doc Opera is a collaborative fundraiser and musical production organized by the students and faculty of Case Western Reserve University School of Medicine and Cleveland Clinic Lerner College of Medicine. This annual variety show is written, directed, and performed entirely by the medical students.

In keeping with Case's commitment to give back to the community, the show's primary mission is to raise funds to provide quality healthcare and related services to individuals and families in our community regardless of their ability to pay through its beneficiaries: The Free Medical Clinic of Greater Cleveland ("The Free Clinic") and the CWRU Student-Run Free Clinic (SRFC). It also provides a venue for creative expression and inter-professionalism among the medical and health professional students of Cleveland. Drawing talent from multiple health graduate programs, all components of Doc Opera are

written, directed, and performed by students and faculty to create a memorable night of skits, musical performances, and dances about medicine and health care.

Doc Opera is a non-profit organization that relies on area businesses to help defray the costs of production and to contribute to the donations made to the program's beneficiaries. This year the Academy of Medicine Education Foundation (AMEF) and the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) were pleased to sponsor the Doc Opera event. ■



Danny Williams, JD, MNO, Executive Director of the Free Clinic addresses the audience.



Medical student performers take the stage during the event.

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AMEF & AMCNO ACTIVITIES

AMCNO and AMEF Co-Sponsor Business Practice Session for Residents

Through the generous support of the Academy of Medicine Education Foundation (AMEF) and the William E. Lower Fund, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) presented a seminar geared toward resident physicians entitled, "Understanding the Legal and Financial Aspects of Practicing Medicine."

At this year's event, which took place at the Cleveland Museum of Natural History, presentations were given by representatives from Sagemark Consulting, Squire Patton Boggs, Walthall, Drake and Wallace, LLP, and McDonald Hopkins, LLC.

Jeremy DiTullio, from Sagemark, discussed financial planning and benefits available to physicians. He highlighted the financial challenges medical professionals face, such as medical malpractice, asset preservation and liability exposure, as well as how to help counteract them. An attorney from Squire Patton Boggs, Ellen Meehan, reviewed estate planning for young physicians. She discussed how residents can protect their assets and how and why they need to create a living will.

Two accountants from Walthall, Cindy Kula and Dean Lisowski, presented on the business and tax aspects of a medical practice, and they provided attendees with an information packet containing additional resources and tools, such as a pocket tax guide. And, an attorney from McDonald Hopkins, Richard Cooper, discussed the legal and other issues for new physicians joining a practice. He distributed a helpful booklet to the residents that outlined the terms of an employment contract as well as other aspects they may encounter during negotiations, such as buy-in offers.



A representative from Squire Patton Boggs, Ellen Meehan, talks to the residents about estate planning.



AMCNO President Dr. Matthew Levy provides opening remarks at the annual resident seminar.

After the session, attendees stated on their evaluation forms that the financial process and taxes were two of the most informative aspects of the seminar. One participant said that it was useful to have terminology clarified, and it was helpful to have a timeline of when financial planning aspects should be addressed.

The topics were in line with the residents' most pressing concerns, such as repaying loans, establishing retirement plans and minimizing debt.

This annual event is always very well-attended and provides valuable insights for residents about to enter the practice of medicine. Presenters at the session included AMCNO physician leadership. The AMCNO and AMEF would like to thank the Cleveland Museum of Natural History for hosting the event this year. The change in venue was well-received by presenters and attendees alike.

Visit the AMCNO Twitter feed and Facebook page to see more photos from the event. ■

Academy of Medicine Education Foundation (AMEF) Update

The Academy of Medicine Education Foundation (AMEF) has accomplished a lot throughout the year to fulfill its mission of providing educational opportunities for physicians and the community as well as funding for medical student scholarships.

The Foundation was pleased to partner with several local organizations to co-sponsor and fund informative, healthcare-related seminars and programs. The main focus of the AMEF, however, is to provide medical students with scholarships. This year, the AMEF presented six students with \$5,000 scholarships, for a total of \$30,000.

The AMEF newsletter was recently mailed to all AMCNO members and included information on how to donate to the AMEF. To view the newsletter online and to learn more about the Foundation's accomplishments this year, please see our link on the AMCNO website at www.amcno.org. And if you would like to contribute to the AMEF, to further support their work for next year, please see our donation page on the website. Thank you!

AMEF Sponsorship Requests

The mission of AMEF is to enhance healthcare through education of the medical profession and the community at large. The purpose of AMEF is to add a charitable component to the AMCNO and to partner with the AMCNO in implementing new initiatives for both physicians and the patient population through charitable, educational and scientific efforts. AMEF enhances the philosophy of the AMCNO in its focus on health-oriented education for physicians, their staff and patients by providing support for meaningful education and highlighting the value and quality of healthcare. A showcase for a philanthropic spirit is provided through the Foundation for physicians who desire to give back to the community and the profession they serve.

In addition to providing scholarships to medical students the Foundation will consider funding support for initiatives that fit the Foundation's following purpose statements and offer an opportunity for the Foundation to benefit the medical profession and the community, such as through CME lectures/seminars, medical student events and public health events.

AMEF Purpose Statements

1. Promoting education and research in the field of medicine by the establishment or financing of fellowships, scholarships, lectures, research projects, and awards, on such terms as this Foundation may deem best;
2. Providing and promoting educational programs on the science of medicine, including presentations on clinical care and new procedures;
3. Providing and promoting health education for the welfare of the community, identifying public health issues and unmet community health care needs and making proposals for dealing with such issues and filling such needs for the benefit of the public;
4. Maintaining and providing educational materials and publications concerning health care to the members, related public service organizations and citizens of the community;
5. Supporting medical education at local

6. Supporting local public health programs and initiatives;
7. Sponsoring seminars on topics of medical education and public health issues;
8. Assisting in the production of educational radio and television programs, telephone recordings, and computer and electronic programs and materials, designed in each case to educate members of the general public on matters of health care and public health issues;
9. Making grants, donations, or contributions of funds or other property of the Foundation to other charitable, scientific, and educational trusts, organizations or institutions.

How to Apply for Sponsorship Funds

Use of AMEF funds must be approved by the AMEF board. Individuals or organizations interested in more information about AMEF or funding support may contact Elayne R. Biddlestone at (216) 520-1000, ext. 100, or ebiddlestone@amcno.org. ■

Save the Date

The Academy of Medicine of Cleveland & Northern Ohio Membership Committee cordially invites physician members, residents, medical students and spouses to attend our 2015 wine tasting experience. This is the perfect opportunity for you to mingle with your colleagues.

- Hors d'oeuvres
- A fine selection of wines
- Discussion with La Cave's wine expert

LA CAVE DU VIN
2785 Euclid Heights Blvd. • Cleveland Heights

Sunday, February 14, 2016 • 5 – 7 p.m.

Cost:
\$30 per member/spouse
\$15 residents & medical students

RSVP by 2/11/2015 abell@amcno.org
Phone: (216) 520-1000 Ext. 101
Fax: (216) 520-0999
Mail: 6100 Oak Tree Blvd., #440
Independence, OH 44131



2016

Medical/Legal Summit

March 11-12, 2016

Summit Details

Location: CMBA Conference Center
1375 East 9th Street, Floor 2, Cleveland, Ohio 44114

Health Care Law Update CLE 6.5 credits

Friday, March 11

8:00 a.m. - 3:00 p.m.

Topics to be covered

- Intro to Medicare and Medicaid
- Fraud and Abuse
- Anti-trust
- Federal and State Update
- Billing / Audits Roundtable
- Life Sciences / Innovations Roundtable

Medical/Legal Summit – Friday Session – March 11

University Hospitals CRME 1 credit, CLE 1.5 credits, CME 1.5 credits

3:30 p.m. Registration

4:15 p.m. Welcome & Introductions

Ann Owings Ford, CMBA President; Matthew E. Levy, MD, AMCNO President, Seminar Co-Chair; David Valent, Esq., Cleveland Clinic, Seminar Co-Chair

4:30 p.m. Keynote Presentation: Welcome to Healthcare in 21st Century America

Margaret O’Kane is the founding and current president of the National Committee for Quality Assurance (NCQA). *Modern Healthcare* magazine has named O’Kane one of the “100 Most Influential People in Healthcare” ten times, most recently in 2015, and one of the “Top 25 Women in Healthcare” three times.

This session will cover: The Affordable Care Act (ACA), quality, accountability in Medicare, managed care for vulnerable populations, delivery system reform, retailization of healthcare, MACRA, bundled payment, consumer engagement, narrowing of networks and other related topics.

6:00 p.m. Networking Reception

Saturday Session – March 12

University Hospitals CRME 4 credits, CLE 4.0. credits, CME 4.0 credits

7:00 a.m. Registration & Breakfast

8:00 a.m. Welcome & Introductions

Plenary Sessions

8:15 a.m. Telemedicine: Achieving High-Quality Innovative Healthcare Delivery

This session will cover: Potential legal concerns/exposure with telemedicine as well as malpractice case law.

9:15 a.m. End of Life Issues

This session will cover: Patients “Right to Die” Legislation and Physician-Assisted Suicide, Futile Medical Therapy and MOLST (Medical Orders for Life-Sustaining Medical Therapy).

10:15 a.m. Break

10:30 a.m. Breakout Sessions

(1) Practicing in an “Opioid Epidemic”

This session will cover: Discussion of best practices, new regulations, and other developments.

(2) HIPAA/Implications of the Use of Electronic Medical Records.

This session will cover: TBD

11:30 a.m. Break

11:45 a.m. Breakout Sessions

(1) Tort Reform

This session will cover: The application of caps to damage awards; collateral sources and the impact of the Affordable Care Act (ACA).

(2) State Medical Board of Ohio (SMBO) Round Up

This session will cover: SMBO Legislative and other regulatory issues, the One Bite Rule and mandatory reporting.

12:45 p.m. Adjourn

Location: CMBA Conference Center
1375 East 9th Street, Floor 2, Cleveland, Ohio 44114

This summit is designed to bring together doctors, lawyers, health care professionals and others who work in allied professions for education, lively discussion and opportunities to socialize.



Keynote Speaker:
Margaret S. O'Kane
Founding and Current President of the National Committee for Quality Assurance (NCQA).

Co-sponsored by the Cleveland Metropolitan Bar Association, Academy of Medicine Education Foundation, and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO).

Co-Chairs: David A. Valent, Esq., Associate Counsel, Cleveland Clinic, Law Department; Matthew E. Levy, MD, St. Vincent Charity Medical Center, and AMCNO President

For more information, call the CMBA at (216) 696-2404 or AMCNO at (216) 520-1000.

Registration

Summit Only

- \$75 CMBA Members, AMCNO Members and other Health Care Providers
- \$125 Non-Members
- \$15 Law and Medical Students (limited seats available)

Health Care Law Update & Summit

- \$175 CMBA Members, AMCNO Members and other Health Care Providers
- \$225 Non-Members
- \$15 Law and Medical Students (limited seats available)

Please select breakout sessions:

First Track: Pain Management OR HIPAA

Second Track: Tort Reform OR One-Bite Rule

Name _____ Atty. Registration No. _____

Firm _____

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Phone _____ E-mail _____

I have submitted a membership application within the last 30 days. Check Enclosed Visa MasterCard Discover AmEx

Credit Card No. _____ Exp. Date _____

Signature _____

Add \$15 to registration fee the day of the program. Registration must be pre-paid by cash, check or credit card to qualify for the advance registration price.

ATTORNEY REGISTRATIONS: Please make checks payable to Cleveland Metropolitan Bar Association. Mail to P.O. Box 931891, Cleveland, Ohio 44193, or fax your reservation form to (216) 696-2129 (all fax reservations must include a credit card number, expiration date, and signature). CANCELLATIONS must be received in writing three business days prior to the program. Refunds will be charged a \$15 administrative fee. Substitutions or transfers to other programs are permitted with 24 hours written notice. **(Transfer is to a single program and the funds may be transferred only once!)** Persons needing special arrangements to attend this program are asked to contact the CMBA at (216) 696-2404, (fax 696-2129) at least one week prior to the program.

PHYSICIAN AND HEALTH CARE PROVIDER REGISTRATIONS: Phone/fax or mail to: AMCNO, 6100 Oak Tree Blvd., Ste. 440, Independence, OH 44131, Phone: (216) 520-1000 FAX: (216) 520-0999. Physicians and other healthcare providers may also pay the AMCNO online at www.amcno.org. Make checks payable to the AMCNO.

This activity was planned and implemented in accordance with the Essential Areas and Policies of the Ohio State Medical Association (OSMA) through the joint providership of The St. Vincent Charity Medical Center and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO). The St. Vincent Charity Medical Center is accredited by the Ohio State Medical Association (OSMA) to provide continuing medical education for physicians. The St. Vincent Charity Medical Center designates this live activity for a maximum of 5.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

*The AMCNO has obtained approval from University Hospitals (UH) for five hours of Clinical Risk Management Education (CRME) credit for those physicians participating in the UH Sponsored Physician Program. Please note: 1 CRME Credit is available for 3/11/16 (Friday) and 4 CRME credits for 3/12/16 (Saturday).

This program will give participants a medical-legal overview of changes in the health care delivery systems, their impact on the practice of medicine, and various strategies to meet these challenges.

Global Desired Learning Outcomes: At the completion of the session, participants should be able to:

- Identify the benefits, risks and legal ramifications of the use of telemedicine,
- Identify the benefits, risks and legal ramifications of the practices associated with end of life issues,
- Describe effective avenues for communication between the medical community and the State Medical Board of Ohio.
- Cite legislative and regulatory initiatives that affect the practice of medicine and understand how these initiatives impact the treatment and the prescribing of opiates to patients.
- Recognize issues related to HIPAA and the appropriate use of electronic health records.
- Cite legislative and regulatory initiatives of the Affordable Care Act (ACA) associated with Tort Reform

Avoiding Medicare Penalties in 2016

By *Tamiya Williams, CMPE, Senior Manager, Medic Management Group, LLC*

As the Centers for Medicare and Medicaid Services (CMS) and the government continue to move toward improved quality and reduced costs across the healthcare continuum, physicians, non-physician providers, and healthcare facilities are being faced with increasing penalties. Regardless of whether you are an independent physician or a hospital-employed physician or if you successfully or unsuccessfully reported/participated in Medicare incentive programs in 2015 or years prior, it is important to strive for complete compliance in 2016.

As an Eligible Provider (EP) it is important to successfully participate in the EHR Incentive Program (Meaningful Use) and Physician Quality Reporting System (PQRS). EPs will also need to know how their 2016 Medicare payments will be affected by the Value-Based Payment Modifier (VBPM), which is based on 2014 PQRS data.

EPs could face a penalty of 3%-4% in 2016 for not meeting Meaningful Use requirements set forth by CMS under their EHR Incentive Program. On October 6, 2015, CMS released the final rule for Meaningful Use. The final rule aligned Stage 1 and Stage 2 Meaningful Use requirements by rolling out significant changes to the program. The changes are as follows:

- Reporting Period
 - o In 2015 the reporting period for both Stage 1 and Stage 2 is 90 days
 - o In 2016 the reporting period is 12 months
- The exception to the rule is if you are a new participant in the program or if you are a provider electing to move on to Stage 3, the reporting period will be 90 days
- Reduced Measure Thresholds that require a patient action
 - o Secure Messaging Measure – changed from 5% of patients to 1 patient (50% of patient base provided access)
 - o View, Download, and Transfer (VDT) – changed from 5% of patients to being able to demonstrate capability (has this function been enabled). In 2016 each EP will need to have 1 patient demonstrate this
- Changed from 17 core and 3 menu objectives to the following 10 core objectives
 - o Objective 1 – PHI Conduct Security Risk Analysis
 - o Objective 2 – Implement 5 Clinical Decision Support Interventions and Enable Drug-Drug and Drug-Allergy Interactions

- o Objective 3 – CPOE of Medication, Radiology, and Labs
- o Objective 4 – E-Prescribing
- o Objective 5 – Health Information Exchange (HIE) Electronically Create and Transmit Summary of Care
- o Objective 6 – Patient Specific Education Resources
- o Objective 7 – Medication Reconciliation
- o Objective 8 – Timely Patient Electronic Access and Patient Electronic Access to VDT
- o Objective 9 – Secure Messaging Enabled
- o Objective 10 – Public Health Reporting

All EPs must attest for the 2015 90-day reporting period by February 29, 2016, in order to avoid penalties. The attestation portal will open on January 4, 2016. It will be important for all EPs to start examining any applicable exclusions or hardship exceptions early in 2016 (hardship applications will be due July 1, 2016).

The PQRS is another program in which EPs could face a penalty of 2% in 2016 for failure to report in 2016. EPs are required to report on 9 quality measures from at least 3 National Quality Strategy (NQS) domains, with at least one of the measures being classified as a cross-cutting measure, which is defined as a measure that is broadly applicable across multiple providers and specialties. If you reported in 2015, it is important to check the 2016 PQRS Measures list because some of the measures have changed.

Practices can report as a group or as an individual provider. It is important to research how each PQRS measure needs to be submitted to CMS. The 2016 PQRS Reporting Mechanisms are as follows:

- Claims Submission – Option for Individual Reporting
- Registry – Option for both Individual and GPRO Reporting
- CEHRT (Certified Electronic Health Record Technology) – Option for both Individual and GPRO Reporting

- QCDR (Qualified Clinical Data Registry; New for GPRO Reporting in 2016) – Option for both Individual and GPRO Reporting
- Web Interface – Option for GPRO Reporting
- CAHPS (Consumer Assessment of Healthcare Providers and Systems) – Option for GPRO Reporting. Must be used in conjunction with another GPRO reporting mechanism and is mandatory for groups of 100+ EPs.

The Value Based Payment Modifier (VBPM) is a program that has caused some confusion in the healthcare world. The VBPM could cause a negative, positive, or neutral adjustment to your Medicare payments. The modifier that will be applied to your TIN is based on cost and quality outcomes and how you compare to national benchmarks. In 2016 Medicare will be applying a Value Modifier to all payments under the Medicare PFS for physicians in groups of 10 or more. 2014 was the performance year that determined what modifier would be applied in 2016. Some providers will be facing an automatic negative 2% Value Modifier and payment adjustment in this upcoming year because they did not successfully participate in PQRS meeting all criteria. 2015 was a performance year for all physicians regardless of group size. 2016 is also a performance year, but the difference is that other healthcare professionals will be added to the program. If you don't know where you or your group practice stands in regard to 2014 PQRS reporting or VBPM, you can obtain both the physician feedback report and the quality and resource use reports by visiting the CMS Enterprise Portal.

Individual physicians and group practices are being required to participate in many government programs in order to protect and maintain their reimbursement from Medicare for services rendered. It is important for physician practices to take the team approach for many of these programs. Staff education and participation is essential in successfully meeting all program requirements. It is also important to monitor and track progress on a monthly basis to ensure success. Health care has always been in a state of continuous change, but how an individual physician or a group practice chooses to provide patient care must now change. Protect your practice...stay informed! ■



2016 Cuyahoga Community College Center for Health Industry Solutions

Date	Time	Title	Fee	Location
1/12/16	9:00am-12:00pm	Tues, Wed, Thurs. Medical Terminology	\$332	CCE
1/26/16	6:00pm-9:00pm	Tues, Wed, Thurs. Medical Terminology	\$332	CCE
2/1/16	8:00am-8:00am	Online Comprehensive Professional Medical Coding Bundle	TBD	Online
2/10/16	9:00am-12:00pm	Tues, Wed, Thurs. Essentials of Electronic Health Records	\$309	CCE
2/23/16	9:00am-12:00pm	Tues, Wed, Thurs. Medical Terminology	\$332	UTC
3/9/16	9:00am-12:00pm	Tues, Wed, Thurs. Fundamentals of Billing Reimbursement	\$404	CCE
4/20/16	6:00pm-9:00pm	Tues, Wed, Thurs. Fundamentals of Billing Reimbursement	\$404	CCE
5/16/16	6:00pm-9:00pm	Tues, Wed, Thurs. Comprehensive Professional Medical Coding	TBD	CCE
5/18/16	9:00am-12:00pm	Tues, Wed, Thurs. Fundamentals of Billing Reimbursement	\$404	UTC
6/15/16	9:00am-12:00pm	Tues, Wed, Thurs. Comprehensive Professional Medical Coding	TBD	UTC
7/1/16	6:00pm-9:00pm	Tues, Wed, Thurs. Patient Access Specialist Fundamentals	\$474	CCE

Take advantage of discounted classes for AMCNO Members and their staff. Contact AMCNO at 216-520-1000 for exclusive AMCNO member course numbers to register and obtain the discounted price reflected above.

Course Locations: Corporate College East 4400 Richmond Rd, Warrensville Hts, OH 44128
Unified Technologies Center Rd 2415 Woodland Ave, Cleveland, OH 44115
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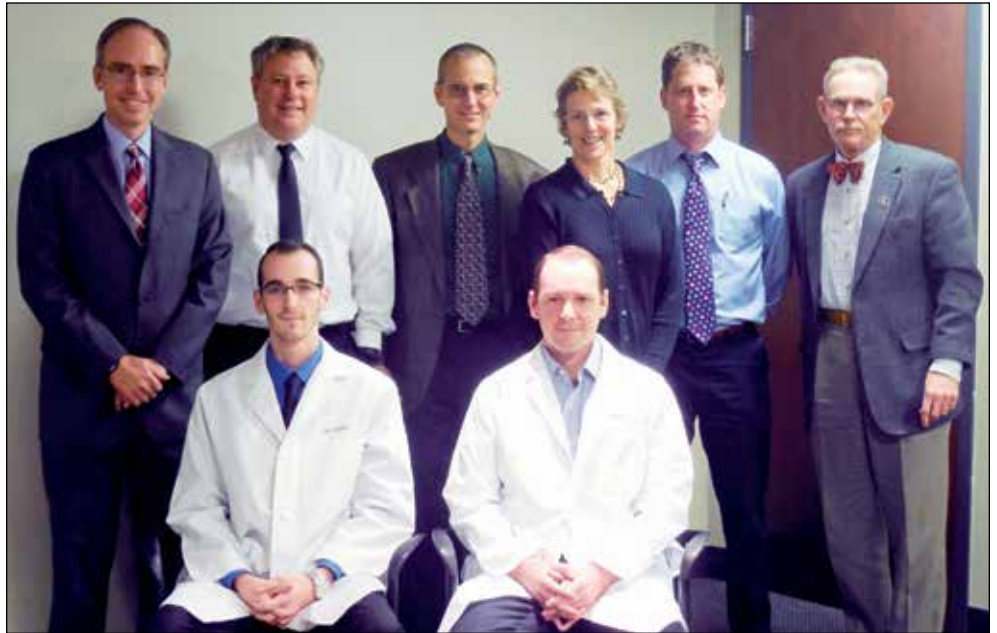
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AMCNO COMMUNITY ACTIVITIES

AMCNO Mini-Internship Program Opens Door to Physicians' Daily Work Life *(Continued from page 1)*

During the debrief, Dr. Seitz thanked the interns and the members for their time and participation. He said the goal of the program is to have the community leaders experience what the physicians experience on a daily basis. Then it's interesting to hear the interns' different perspectives of the interactions. The interns' participation and feedback help the program continue to get better every year, Dr. Seitz said.

Alex Daher said he now has a new appreciation for physicians. "I'm not going to get mad the next time I have to wait for a doctor," he said. Daher was also in awe of the amount of work and effort that goes into being a physician. Viewing surgery in the operating room was eye-opening as well. He said he thought it would be chaotic, like what is portrayed on TV, but it was actually a very normal environment. Overall, Daher said, it was a "fantastic experience, and the best way to spend the last two days."



The interns take a moment to pose with some of the program's physicians. (Standing l-r: Dr. Daniel Sullivan, Dr. Gerard Isenberg, Dr. Philip Junglas, Dr. Elizabeth Feighan, Dr. Matthew Levy, Dr. William Seitz. Seated l-r: Alex Daher, Casey Ross.)



Intern Casey Ross receives his participation certificate from AMCNO President Dr. Levy.

Casey Ross said that his experience was eye-opening, too—"mostly seeing the collegiality between the physician teams." He said that it was also interesting to see, on the clinical side, the pervasiveness of obesity—how it affects a range of different aspects of health. "You hear the statistics, but it's different when you see it," Ross said. He also has a new appreciation for the challenges physicians face, such as documenting all of the health information they receive from their patients and the short amount of time the physicians have with each

patient. He agreed that it was a great experience as well, and he said it also helped form his thinking about health care, with insights he didn't have before.

The physicians shared their side of the experience and general comments as well.

Dr. Mehrun Elyaderani said it was nice to have someone involved who's not purely medical, because they think differently from physicians. "It's refreshing to see their perspective," he said. "It makes you pause and look at what you do."

Dr. Daniel Sullivan echoed Dr. Elyaderani's sentiment, saying that he doesn't always think about everything he does in a day, so he's also grateful for the intern's feedback and questions during and after the program. Intern Casey Ross was paired with Dr. Gerard Isenberg during the program, and when Dr. Isenberg was faced with a medical emergency during their assigned time together, Ross said he was impressed with how the medical team came together quickly and expertly to deal with the emergency.

In closing, Dr. Seitz encouraged the members to recommend the program to their colleagues

so that they could participate in next year's event. And, he asked the interns to share their experiences as well, so that others can also benefit from this program.

At the end of the debrief, each intern received a certificate of completion, presented by Dr. Seitz and AMCNO President Dr. Matthew Levy.

More photos from the event appear on the AMCNO Twitter feed and Facebook page. ■



Dr. Levy presents intern Alex Daher with a participation certificate.