AMERICAN ACADEMY OF OPHTHALMOLOGY®

SUBSPECIALTY/SPECIALIZED INTEREST SECTION MINUTES
Saturday, April 13, 2019
Renaissance Downton Hotel
Washington, D.C.

I. Welcome/Introductions and Review of Agenda

Council Vice Chair and Section Leader Sarwat Salim, MD convened the Council Subspecialty/Specialized Interest Section meeting, introduced the Deputy Section leader and American Association of Pediatric Ophthalmology and Strabismus Councilor Mary Louise Collins, MD, welcomed the attendees* and reviewed the agenda. The minutes from the Fall 2018 Council section meeting were approved as distributed.

II. Episode Groups & Other Issues for Cost Performance Evaluation
David Glasser, MD – AAO Secretary for Federal Affairs

Dr. Glasser reminded section members that the Merit-Based Incentive Payment System (MIPS) is a budget neutral program. Your MIPS score for 2019 (affecting 2021 payments) will be made up of quality measures (45% - previously PQRS); promoting interoperability (25% - previously labeled EHR Meaningful Use); clinical practice improvement activities (15%) and; resource use cost (15% - formerly value-based modifier). As regards the 15% cost performance evaluation in MIPS, the metrics are solely derived from Medicare Part A and Part B claims data. There is no 'reporting' like there is for quality. The cost score is based on three measures:

1. Total per capita cost per beneficiary; mostly primary care is affected
2. Medicare spending per beneficiary; mostly for inpatient care
3. And the new area in 2019 - cost episode groups, specifically cataract

The total per capita cost includes all risk- and specialty-adjusted Medicare Part A and Part B costs per patient for all patients attributed to an individual tax ID number (TIN) or TIN-National Provider (NPI) combination. Attribution is a two-step process. Step 1 is Medicare's attempt to attribute a patient to a primary care provider, identified by a 2-digit specialty code that goes in with the claims, based on the plurality of primary care services. If the patient has not seen a primary care provider at all during the year, you proceed to step 2 which attributes to a non-primary care provider who provided most of the primary care services. Primary care services are identified by use of the E&M codes (99201-99215) and not by eye visit codes (92002-92014). This is important because if you use E&M codes for frequent office visits, it may result in patient care costs attributed to you for care for which you were not responsible. For example, you could potentially be saddled with expenses related to a patient's chronic obstructive pulmonary disease (COPD). Attribution spread over multiple providers is a vague methodology and ophthalmologists may potentially be inappropriately attributed costs. To avoid misattribution of patients, use eye visit codes (92002-92014) while realizing this is a trade-off for lower reimbursement than would be received for level 4 and 5 E&M codes.

Medicare spending per beneficiary is based on inpatient episodes of care. We are not aware of an ophthalmologist being attributed Medicare spending per beneficiary costs.

The new area is cost episode groups. One of them is *routine cataract removal with intraocular lens (IOL) implantation.* The idea is to compare costs that are under the physicians control. Eligible cases are *routine* cataract surgery only (66984). Excluded from the measure are all

cases that would be excluded in the two cataract PQRS measures. It eliminates high-risk cases that would be difficult to risk-adjust. A minimum of ten eligible cases are necessary to generate a score and 85% of ophthalmologists billing 66984 meet the criteria.

Dr. Glasser reviewed the costs that are included such as:

- Pre-op costs occurring within 60 days prior to surgery (office visits and tests by any provider with cataract as a primary diagnosis and tests/procedures potentially considered part of a cataract workup regardless of diagnosis)
- Costs associated with the procedure itself (physician fee, facility fee, pass through pharmaceuticals and devices, anesthesia fee)
- Post-op costs occurring within 90 days of procedure (only those billed to CMS excluding routine postop visits in the global period; including complications such as retina lens fragment, IOL repositioning or exchange, retinal detachment, endophthalmitis)

How do we eliminate costs that are not under the physician's control such as:

- *Where* surgery is performed. HOPD cases are more costly than ASC cases.
- Unilateral vs. bilateral cases
- Co-managed cases?

Dr. Glasser noted that the answer is by *subgrouping*. Subgrouping eliminates the effects of costs that are not under the physician's control. This attempts to compare only similar cases to one another and to assign subgroup scores based on costs within each subgroup. A final score is calculated based on a weighted average of subgroup scores. An additional way to eliminate costs not under the physician's control are by applying a linear regression model to control for beneficiary characteristics such as:

- Age
- Proctored resident cases (with -GC modifier)
- New vs. established patients
- End stage renal disease status
- Institutionalized in a long-term care facility
- Hierarchical Condition Categories data (70 or 80 diagnoses)

One limitation to cost measures is the small sample size allowed to generate a score (i.e. 10 eligible
cases). A single complicated case could disproportionately affect your score if you only have a few eligible cases. Other limitations include the lack of Part D data and we know that drugs account for a large portion of the variability in cataract surgery costs; the complexity of cost measure reports and the timing of such reports. They are released mid-year or later which makes it too late to make changes in the current year.

Dr. Glasser summarized cost scoring in MIPS for 2019:

- Cost accounts for 15% of MIPS score in 2019, for payment in 2021. This increases to 30% no later than 2022
- Cataract episode group added to the other two scores: total per capita cost and Medicare spending per beneficiary.
- Weighting of episode, total per capita costs, Medicare spending per beneficiary scores for final cost score unknown
    - Ophthalmologists should not have Medicare spending per beneficiary scores, some may have total per capita costs scores
        - Avoid misattribution of patients for total per capita cost by use of eye codes
    - Episode groups will likely be the sole determinant of cost score for most
    - If no score on any of the three measures, cost component of MIPS shifted to quality which would raise that from 45% of your score to 60%

- Cost episode group scores found on CMS' Quality and Resource Use Reports (QRUR) website

Councilor's Questions/Dr. Glasser's response:
Q: I presume that these are all individual calculations and not practice calculations?
A: Correct

Q. Is high myopia considered an exclusion?
A. I believe pathological myopia is, but the specific claim would have to be coded as such.

Q. There are concerns regarding pass-throughs. How is that being handled with cost measures?
A. The only one that is currently included in the cost measure is Omidria. The thinking there is that Omidria is not a drug used for routine cases and only used for difficult cases.

III. Update from AUPO Fellowship Compliance Committee (FCC)
Michael W. Belin, MD – Chair, AUPO Fellowship Compliance Committee

Dr. Belin reviewed the goals of the Association of University Professors of Ophthalmology (AUPO)-Fellowship Compliance Committee (FCC) with includes promotion of educational standards and the protection of the public, institutions and trainees. Fellowship requirements are established by the individual subspecialty societies and both reviewed and approved by the entire FCC. For accountability and enforcement purposes, the FCC uses a web-based system for applications; annual data collection; annual program review by fellows via a exit survey and; triennial and quadrennial program review. In addition to Dr. Belin, officers of the FCC include Hans E. Grossniklaus, MD (Vice Chair), Andrew G. Lee, MD (Treasurer), Nisha Acharya, MD (Secretary), Jennifer E. Thorne, MD (Chair Review Committee) and Elmer Y. Tu, MD (Vice Chair Review Committee). All subspecialty societies with the exception of ophthalmic plastics and reconstructive surgery participate in the FCC. The FCC's Board of Managers includes one representative from each of the subspecialty societies except for retina which has three given the 3 societies representing retina. It also includes organizational representatives from AUPO and is staffed by Kathleen Mitchell, AUPO FCC Manager. Dr. Belin also reviewed the make-up of the AUPO-FCC Review Committee:

i. Jennifer Thorne, MD (Uveitis)
ii. Elmer Y. Tu, MD, Vice-Chair (Cornea)
iii. Daniel Karr, MD (Pediatrics)
iv. David Wilson, MD (Path)
v. Tarek S. Hassan, MD (Retina)
vi. Steven J. Gedde, (Glaucoma)
vii. Andrew G. Lee, MD (Neuro)

- Dr. Belin discussed the process undertaken by the AUPO-FCC Review Committee. The committee meets in the Fall and votes on actions. Programs are then notified of their status and those non-compliant programs have 30 days to appeal. The results are updated prior to the SF Match. Only AUPO-FCC compliant programs display the "AUPO FCC In Compliance" logo by their name which applicants can view immediately. Programs' status is available at both www.aupofcc.org and www.sfmatch.org. Dr. Belin reviewed the compliant/non-compliant programs by subspecialty as well as by the percentage of programs participating by subspecialty. Dr. Belin reported that the AUPO-FCC's revenue and expenses are on target with any minimal variance mostly explained due to timing of accounts received. Each budget line item aligns with the strategic goals and objectives as outlined by AUPO Executive Committee members and the chair. Dr. Belin stated that there are no anticipated shortfalls or expenses anticipated. Dr. Belin discussed the new fellow medical malpractice requirement that was updated for fellows starting in 2019. Effective with fellows starting in 2019, the AUPO-FCC is requiring compliant programs to carry

malpractice insurance including tail coverage or its equivalent. The National Uniform Claim Committee recognizes the AUPO-FCC process and the Educational Commission for Foreign Medical Graduates utilizes FCC status in J-1 VISA applications. In addition, the FCC process was helpful to the Academy when applying for subspecialties to be granted new taxonomy codes including for retina/uveitis, glaucoma and cornea. Dr. Belin reviewed various subspecialty society membership requirements as relates to FCC program graduation:

- AAPOS – has always required FCC program graduation for membership
- AGS- only fellows who complete compliant programs are eligible for Active Membership
- Cornea Society – has new membership category 'fellow of the Cornea Society' with full voting and leadership rights after successful FCC completion and 4 years of practice
- ASRS – Integration of FCC and ASRS data entry. Evaluation of medical retina guidelines and compliance process
- AUS - Graduates of FCC-compliant programs streamlined into membership with letter from fellowship director. AUS also contacts graduates of complaint programs encouraging them to attend & present at the AUS annual meeting

A standard fellowship disclosure form has been developed and is pending approval by the AUPO which includes the following elements for Fellowship applicants:

- Clinical start date (should not be prior to July 1). Date expected at program if different
- Compensation / Salary
- Vacation Allotment
- Educational Meeting Allotment & Funding
- Healthcare coverage
- Malpractice coverage
    - Occurrence based OR Claims made
    - If Claims made estimate of tail expense and who pays
- On call responsibility & frequency

IV. Section Elections

Deputy Section Leader Mary Louise Collins, MD conducted section elections for the following positions:

a. 2020 Deputy Section Leader
b. 2020 Section Representative to the AAO Nominating Committee
c. 2020 Section Nominating Committee

Dr. Collins noted that voting would continue in the General Session for the 2020-2021 Council Chair and Vice Chair and that election results for all Council leadership positions would be announced in the General Session. Drs. Salim and Collins acknowledged all those standing for election and thanked the section nominating committee for their work in determining the slate of candidates.

V. Latest AAO/Subspecialty Society Collaborative Efforts

A. Minority Ophthalmology Mentoring Program
Keith D. Carter, MD – AAO Past Present

Dr. Carter provided an update on the Minority Ophthalmology Mentoring Program a partnership between the Academy and the Association of University Professors of Ophthalmology (AUPO). Dr, Carter is serving as Chair of the Minority Ophthalmology Mentoring Program Executive Committee. The program's mission is to attract underrepresented minorities in medicine to careers in ophthalmology; provide valuable guidance for medical career planning and decision-making and; help students become

competitive ophthalmology residency applicants. Underrepresented minorities in medicine include those who identify as African American/Black, Hispanic/Latino, or Native American (American Indian, Alaska Native, Native Hawaiian). The program officially launched at AAO 2018 with a class of 22 students – 9 MS1; 9 MS2; 2 MS3; 1 MD/PhD and; 1 College Senior. The Academy is providing the students with full access to Academy educational materials and comprehensive Step 1 exam preparation for MS2s including enrollment in an 8-month web-based prep course and a full complement of self-study resources. Dr. Carter reviewed the survey of a comparison of students' interest in ophthalmology prior to and after the student engagement weekend held during AAO 2018. The bar definitely moved with 100% of the 22 participating students reporting 'very interested' after participation in the student engagement weekend. As part of the program, MOM physician participants serve as mentors who guide the students through their formal education and/or as program speakers who introduce medical and undergraduate college students to ophthalmology and the MOM program. AUPO "champions" serve as liaisons for the MOM program at academic institutions; generate support and enthusiasm for the MOM program within institutions and departments; recruit qualified medical students and; identify colleagues to serve as mentors and program speakers. To learn more about the MOM program, Dr. Carter shared the website: aao.org/minority-mentoring where you can view the MOM class of 2018 and review the toolkit of resources to assist in student engagement efforts. He also noted that departments could contribute research opportunities to the MOM research listing by visiting bit.ly/mom-research. Dr. Carter thanked the MOM physician leaders as well as the numerous societies that are joining the Academy and AUPO to help financially support the MOM program including:

a. American Association for Pediatric Ophthalmology & Strabismus
b. American Board of Ophthalmology
c. American Glaucoma Society
d. American Glaucoma Society Foundation
e. American Ophthalmological Society
f. American Society of Cataract and Refractive Surgery
g. American Society of Ophthalmic Plastic & Reconstructive Surgery
h. American Uveitis Society
i. Eye and Contact Lens Association
j. Cornea Society
k. National Medical Association – Ophthalmology Section
l. North-American Neuro Ophthalmology Society
m. Outpatient Ophthalmic Surgery Society
n. Retina Society

B. Merit-Based Incentive Payment System (MIPS)- Penalty Avoidance for Ophthalmologists
Michael X. Repka, MD, MBA – AAO Medical Director for Governmental Affairs

Dr. Repka reviewed how Academy members are faring under the Merit-Based Incentive Payment System (MIPS). The goal of the Academy is to avoid penalties for ophthalmologists. He explained that we are all being graded in the Quality Payment Program (QPP) by either of two reimbursement programs under Medicare Part B: MIPS or Advanced Alternate Payment Models (APMs). Providers qualify for either MIPS or APMs and ophthalmologists are overwhelmingly participating in MIPS. The MIPS program is designed to improve quality by providing bonuses to a few and penalties to some. The program is budget neutral except for in the first five years of the program (2019 – 2013) and in the first payment year, $500M in bonuses is available in the extraordinary performance pool. Medicare Part B, excluding drugs, is about $87 billion dollars so the 'extraordinary performance pool' represents about 1/2 percent. It is not a huge amount of money but definitely an amount the Academy would like see targeted towards ophthalmologists. MIPS payment adjustments – both positive and negative – increase over time starting at +/-4% in 2019 and increasing to +/-9% in 2022. Dr. Repka reminded section attendees that we were first graded in 2017 and bonuses/penalties

are being applied in 2019. What we have learned from this first year is that winners participate and losers figure out how to opt into APMs if they can. Retirees, small, rural and solo practices tend to be the losers. If you were doing nothing to participate, that would result in an approximate $18,600 loss in revenue. The Academy is not aware of any ophthalmologist who will experience such a loss in revenue. For ophthalmologists electronically integrated with the Academy's IRIS® Registry, it was made simple and resulted in penalty avoidance of approximately $186M. Ophthalmology is expected to be among the highest recipients of positive adjustments in 2019 and 2020, but bonuses will be low.

The maximum MIPS bonus in 2019 is 1.88%. If less than exceptional - <70 pts – the bonus will be 0.20% or less. This factor applies to all Part B service claims, but not to Part B drugs. The Academy's Washington D.C. staff was able to get CMS to clarify that drugs were neither a positive or negative factor in the MIPS calculation of bonus or penalty. The expectation is that seventy-one percent (71%) of ophthalmologists will be exceptional, 22% percent will be in the small bonus range, 2% neutral and 5% will be penalized. Dr. Repka noted that ophthalmologists participate to avoid the penalty not necessarily for the bonus or even the advertised bonus. He reminded section attendees that the potential bonus was up to 22%. He also advised not to overspend in order to comply.
In year one (2017) performance, 93% of participants are getting a bonus with many scores at nearly 100. The median score is 89 with large groups faring well and one in five small practice penalized. Ten percent of eligible providers across medicine are receiving the 5% APM bonus.

National scores were very high. Providers were able to perform well but as you move from large to rural to small practices, performance falls off. This will certainly be noticed by members of Congress as they look to refine the program for the future.

Dr. Repka discussed the political uncertainty of MIPS going forward. MedPAC, a political advisory body, has voted 14-2 in advising Congress to eliminate MIPS in favor of a new voluntary value program (VVP) in fee for service Medicare. Tenets of this new proposal include:

- Clinicians can elect to be measured as part of a voluntary group
- Qualify for value payment based on group performance on population-based measures
- Payment increases offset by payment decreases (winners and losers)
- $500MM yearly MIPS exceptional performance bonus funds available ($3B total)
- Budget-neutral, assuming funds are reinvested in Medicare clinician payment
- Administrative costs to create voluntary group
- Reduced clinician reporting burden; and
- No impact on access to care

In year two MIPS performance (2018), data submissions were due January 1, 2019. The threshold was 15 points in 2018 with smaller bonuses anticipated in 2020 as per CMS. The Academy expects 93% of ophthalmologists to be neutral or positive and the bonus to be 1.4%. This would make ophthalmology among the highest specialties with $82M in bonuses and up to $6885 per eligible ophthalmologist. An analysis from *Health Affairs,* predicts that the maximum bonus for year 3 (2020-2022) will be higher at about 4.7% which is about equivalent to an APM. This means there will be more doctors in the penalty.

Your 2019 MIPS performance score is the sum of weighted category scores. A score of 30 points is required to avoid a penalty and earning between 30 and 75 points will lead to a small bonus. Since MIPS is budget-neutral, the sum of the bonuses cannot exceed the sum of the penalties. Clinicians can earn an exceptional performance bonus by reaching 75 or more points.

There are some changes to MIPS eligibility in 2019 that may impact ophthalmology. CMS changed the rules with it being easier to get out of the program based on low volumes. Medicare also added new classes of providers including physical therapists, occupational therapists, social workers, and clinical psychologists. These groups won't necessarily bring a lot of dollars to the system.

Dr. Repka reviewed the changing performance category weightings in MIPS from 2017 to 2019. For the performance category of *quality* (formerly PQRS), weights are scored 60% in 2017, 50% in 2018 and 45% in 2019. For the performance category of *promoting interoperability* (formerly advancing care information and prior to that, meaningful use), the weight remains at 25% for all 3 years. For the performance category of *improvement activities,* the weight remains consistent for all 3 years at 15%. For the category of *cost* (formerly value-based modifier), the score weight starts at 0% for 2017 and increases to 10% in 2018 and 15% in 2019.

Dr. Repka provided 3 steps to avoiding up to a 7% penalty in 2019 and revealed Academy resources which can help you. Step one is to attest to the Improvement Activities category and there is a pathway to attestation through the IRIS Registry. Step two is to report on six quality measures with one being an outcome measure. Step three is to apply by Dec. 31, 2019 and receive and an EHR hardship exception. Among the resources to help avoid a penalty, Dr. Repka noted that there is a "MIPS Desk" at this Mid-Year Forum with staff available to answer your questions. He also noted the following Academy resources:

- A MIPS supplement in the June 2019 edition of *EyeNet* magazine
- Academy Codequest coding courses
- IRIS Registry booth during AAO 2019 in San Francisco
- Articles in the Academy's *Practice Management Express*
- aao.org/medicare
- aao.org/irisregistry
- email: mips@aao.org

Dr. Repka reminded section attendees that organized medicine "accepted" MIPS as a replacement to the SGR.

C. Outcomes of April 8 FDA *Forum on Laser Based Imaging*
Michael X. Repka, MD, MBA – AAO Medical Director for Governmental Affairs

Dr. Repka discussed the Academy's recent collaboration with the FDA on the April 8, 2019 *Forum on Laser Based Imaging* in Silver Springs, Maryland led by Malvina Eydelman, MD, the FDA's Director of the Division of Ophthalmic and Ear, Nose and Throat Devices. Dr. Repka recognized the efforts of Wade Delk from the Center of Organizational Management (CFOM).

Additional partners for the forum included the American Academy of Optometry, the American Optometric Association and the Byers Eye Institute at Stanford University as well as a number of ophthalmic subspecialty societies - AAPOS, AGS, ASCRS, ASRS, AUS, the Cornea Society and the Retina Society. Dr. Repka noted previous collaborations between the Academy, subspecialty societies and the FDA Center for Devices and Radiological Health (CDRH) including the September 16, 2016 session on *Controlling the Progression of Myopia: Contact Lenses and Future Medical Devices* and the 2018 session on *Artificial Intelligence and Deep Learning*.

The premise of the April 8, 2019 forum was to look at how to incorporate into practice and what the value clinically and in terms of reimbursement of laser-based technologies could be. Dr. Repka reported that approximately 230 people attended in a new facility with 40 from the NEI and FDA who were allowed to attend for free. This program is available publicly on

the web. Dr. Repka explained that the FDA desires these partnership programs but doesn't have the resources to pay for them. So, the FDA leverages relationships with the societies and the more society buy-in you have, the more leverage. There is a contractual agreement to charge a registration fee. Any revenue from the forum will be spent on education and if the forum loses money, the societies are contracted to pay. Each society has to determine whether this type of arrangement is "worth" it.

Dr. Repka stated that the FDA is seeking to promote innovation and to expedite the clinical development of optical coherence tomographers (OCTs). As new functionalities are introduced, typically, performance data is compared to a gold standard. What should the agency require? Dr. Repka noted some questions to consider: Does a gold standard comparator exist for the following:

- Quantification of retinal vascularity?
- Quantification of oximetry with visible light OCT?
- Functional assessment of metabolic or indirect structure/blood flow changes?
- AI-assisted segmentation?

The addition of Adaptive Optics technology to imaging platforms (e.g., SLO and OCT) is currently under investigation, but not yet FDA cleared. An outstanding question is whether Adaptive Optics technology introduces new concerns around patient safety and effectiveness.

For cases where there is no clinical gold standard comparator for OCTs or AO-equipped imaging platforms, questions need to be considered such as:

- Can adequate pre-clinical (animal model) and/or non-clinical software (i.e., synthetic images) or hardware (i.e., phantoms) comparators be created?
- What are the impediments to establishing reimbursement for new AO and OCT technologies?

We had science all morning. In the afternoon, health policy leaders of the Academy and other subspecialty organizations including Drs. Repka, David Glasser, MD and Cindie Mattox, MD joined representatives of the CMS and a CMS MAC Medical Director. Dr. Repka noted that there is certainty that Dr. Eydelman and the FDA would like to continue these forums and the societies will have to individually determine their willingness to support them going forward based on return on investment.

VI. Key Take-Aways: 2019 Ophthalmic Advocacy Leadership Group (OALG) Daniel J. Briceland, MD – AAO Senior Secretary for Advocacy

The Academy's Ophthalmic Advocacy Leadership Group (OALG) meets annually in Washington, D.C. to discuss the Academy's Washington agenda, share information, seek input and discuss issues and challenges important for ophthalmology and patients. OALG invitees include leadership (Presidents (Chairs), Presidents-Elect (VPs), EVPs and/or Executive Directors) of twenty subspecialty and specialized interest societies who join with the Academy's advocacy physician leadership and staff. The 2019 OALG meeting provided an opportunity for society leaders to hear the latest advocacy issues impacting ophthalmology and to have an impact on the Academy's legislative agenda.

Dr. Briceland noted that leaders from 18 societies spent the inaugural weekend ensuring their subspecialty/specialized interest society had an impact on the Academy's advocacy agenda for 2019. Based on the presentations and discussions at OALG 2019, the Academy's primary 2019 focuses are:

- Joining policymakers as they look at drug payment policy with the goal of improving access, combatting shortages, and reducing costs

- Continuing our efforts with ophthalmic subspecialty societies to develop meaningful outcome measures that will help our members succeed in the new QPP/MIPS Medicare payment program through the IRIS® Registry
- Solving the excessive use of prior authorization requirements by Medicare Advantage
- Increasing attention to state scope of practice threats

In addition, Dr. Briceland stated that the Academy will continue to build on its previous successes to:

- Preserve access to compounded drugs and lower drug costs for our patients overall
- Prevent expansion of surgical scope and increase awareness of the dangers of optometrist's performing surgery
- Increase support from the current administration by forming new congressional relationships
- Support increased funding for vision research

The date of the 2020 OALG meeting will be January 24th and the Academy reimburses a one-night hotel stay. A new meeting location in D.C. is being determined by the Academy's DC staff and will be announced soon. Agenda items for the 2020 OALG meeting will include physician payment program reform; specialty research potential of the IRIS® Registry; drug payment reform initiatives; surgical Scope battles and; telemedicine,

VII. Adjournment

Dr. Salim thanked the section meeting attendees and adjourned the meeting at 9:17am ET.

*Attendees

Councilors and Alternate Councilors:

Sarwat Salim, MD	**Council Vice Chair**
Mary Louise Collins, MD	**Deputy Section Leader and Councilor,** American Association for Pediatric Ophthalmology & Strabismus (AAPOS)
Richard C. Allen, MD, PhD	Int'l Joint Commission on Allied Health Personnel in Ophthalmology (IJCAHPO)
Donald L. Budenz, MD, MPH	Councilor, Association of University Professors of Ophthalmology (AUPO)
Emily Y. Chew, MD	Councilor, Association for Research in Vision and Ophthalmology (ARVO)
Zelia M. Correa, MD, PhD	Councilor, Pan-American Association of Ophthalmology (PAAO)
Jonathan R. Corsini, MD	Alternate Councilor, Society of Military Ophthalmologists (SMO)
Kathleen M. Duerksen, MD	Councilor, American Society of Ophthalmic Plastic & Reconstructive Surgery (ASOPRS)
Paul A. Edwards, MD	Councilor, American College of Surgeons, Advisory Council for Ophthalmic Surgery
Justis Ehlers, MD	Councilor, American Society of Retina Specialists (ASRS)
G. Baker Hubbard, MD	Councilor, ASRS
JoAnn Giaconi, MD	Councilor, American Glaucoma Society (AGS)
William Barry Lee, MD	Councilor, Eye Bank Association of America
Anat Galor, MD	Councilor, Ocular Microbiology & Immunology Groug (OMIG)
Paul B. Greenberg, MD	Councilor, Association of Veterans Affairs Ophthalmologists
Preeya K. Gupta, MD	Councilor, American Society of Cataract & Refractive Surgery (ASCRS)
Bryan S. Lee, MD, JD	Councilor, ASCRS
Jennifer Lim, MD	Councilor, Retina Society
Gregg T. Lueder, MD	Councilor, American Academy of Pediatrics (AAP), Section on Ophthalmology
Cathleen McCabe, MD	Councilor, Outpatient Ophthalmic Surgery Society (OOSS)
Donald A. Morris, DO	Councilor, American Osteopathic College of Ophthalmology (AOCO)
Regine S. Pappas, MD	Councilor, Women in Ophthalmology (WIO)
Edward L. Raab, MD	Councilor, American College of Surgeons (ACS) – Advisory Council for Ophthalmic Surgery

Russell W, Read, MD, PhD	Councilor, American Uveitis Society (AUS)
Chasidy D. Singleton, MD	Councilor, National Medical Association – Ophthalmology Section
Alison H. Skalet, MD, PhD	Councilor, American Association of Ophthalmic Oncologists and Pathologists (AAOOP)
Sharon D, Soloman, MD	Councilor, Macula Society
Prem S. Subramanian, MD, PhD	Councilor, North American Neuro-Ophthalmology Society (NANOS)
Woodford Van Meter, MD	Alternate Councilor, Cornea Society

Guests:

Maria M. Aaron, MD	AAO Secretary for Annual Meeting
Lynn D. Anderson, PhD	Executive Director, IJCAHPO
Michael W. Belin, MD	AUPO Chair, Fellowship Compliance Committee / Speaker
Audina Berrocal, MD	Retina Society
Ninita H. Brown, MD	LDP XXI, Class of 2019 (NMA – Ophthalmology Section) /Member, AAO YO Advocacy Subcommittee
Daniel J. Briceland, MD	AAO Senior Secretary for Advocacy / Speaker
Keith D. Carter, MD	AAO Past President
Wade Delk	IJCAHPO
William H. Ehlers, MD	IJCAHPO
Jeffrey D. Henderer, MD	AAO Secretary for Curriculum Development
David B. Glasser, MD	AAO Secretary for Federal Affairs / Speaker
Judy E. Kim, MD	AAO Trustee-at-Large
Cynthia Mattox, MD	AAO Trustee-at-Large
William F. Mieler, MD	AAO Trustee-at-Large
Claudia Maria Prospero Ponce	Advocacy Ambassador, AAOOP
Christoper J. Rapuano, MD	AAO Senior Secretary for Clinical Education
Kristin E. Reidy, DO	AOCOO-HNS
Michael X. Repka, MBA	AAO Medical Director for Governmental Affairs
Daniel P. Schaefer, MD	President, ASOPRS
Gregory L. Skuta, MD	AAO Board of Trustees
Ahmaida T. Zeglam, MD	Advocacy Ambassador, Cornea Society

Staff

Cathy Cohen	AAO staff
Flora Lum, MD	AAO staff
Louise Owen	AAO staff
Gail Schmidt	AAO staff