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AFP Edition

Policy and Health Issues in the News

Despite Increase in Allowed Charges, AAFP says CMS Is Still Undervaluing Primary Care

According to the recently released *Emergency Update to the CY 2011 Medicare Physician Fee Schedule Database* that enumerates the Centers for Medicare and Medicaid Services' (CMS') final 2011 Medicare conversion factor, the average payment rate for current procedural terminology (CPT) code 99213—commonly used by family physicians—will increase this year even though the numeric value of the conversion factor has been reduced. As a result of this and other factors, CMS projects that family physicians will see an overall 2 percent increase in their Medicare allowed charges in 2011. Despite the reduction in the Medicare conversion factor, the payment rate for many codes, including 99213, will increase in 2011 because the relative value units for the services are increasing. Changes to conversion factor and relative value units will vary depending on the code in question and the Medicare locality where services are performed because other factors will affect payment rates, including updated geographic practice cost indices. Although CMS has taken steps to reward some primary care services in its rule-making process for the 2011 Medicare Physician Fee Schedule, the American Academy of Family Physicians (AAFP) says CMS continues to undervalue primary care services. In a recent letter to CMS, AAFP Board Chair Lori Heim, MD, of Vass, N.C., said the AAFP recognizes and thanks CMS for its efforts to address primary care issues, noting that CMS made considerable adjustments to the Primary Care Incentive Program that will help ensure more primary care physicians qualify for a 10 percent bonus. Heim also urged CMS to continue its efforts, pointing out that primary care physicians will be essential to meeting the needs of millions of Americans who will have Medicare eligibility in the near future, and millions more who soon will have greater access to health care with the implementation of health care reform. Heim also addressed CPT codes for immunization administration, hospital observation care, and maternity care. In each instance, she criticized CMS for disregarding the recommendations of the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) by adopting relative value units that were less than what the RUC recommended. For more information, visit http://www.aafp.org/news-now/practice-management/20110111convfactor.html and http://www.aafp.org/news-now/government-medicine/20110112feescheduleltr.html.

Registration Open for Medicare, Medicaid EHR Incentive Programs

The federal government is inviting health care professionals to register for electronic health record (EHR) incentive programs that will pay physicians, hospitals, and other eligible professionals that participate in Medicare or Medicaid to adopt, upgrade, implement, and/or demonstrate meaningful use of certified EHR technology. CMS and the Office of the National Coordinator for Health Information Technology opened registration for the Medicare EHR incentive program on January 3, 2011, the same day that the Medicaid EHR incentive program was opened in 11 states: Alaska, Iowa, Kentucky, Louisiana, Michigan, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas. Other states are likely to launch their Medicaid EHR incentive programs during the spring and summer of 2011. CMS expects to start issuing Medicare EHR incentive payments in May 2011. Physicians and other health care professionals who meet the eligibility requirements for both the Medicare and Medicaid EHR incentive programs must select which program they wish to participate in when they register. They cannot participate in both, but after receiving payment, they can change their program selection once before 2015. Physicians interested in participating in the programs can visit CMS' EHR incentive programs Web site at http://www.cms.gov/ehrincentiveprograms. For more information, visit http://www.aafp.org/news-now/practice-management/20110105healthitincentives.html.

Food Safety Act Allows FDA to Proactively Prevent Foodborne Illness Outbreaks

Newly enacted food safety legislation will give the U.S. Food and Drug Administration (FDA) the authority it needs to prevent foodborne illness, rather than merely react to outbreaks after they occur, says the U.S. Department of Health and Human Services Secretary Kathleen Sebelius. According to Sebelius, the FDA Food Safety Modernization Act is the most significant food safety law promulgated in the past 100 years. The legislation includes provisions for the FDA to establish science-based standards for the safe production and harvesting of produce, and to increase inspections domestically and internationally. The law grants the FDA authority to mandate product recalls and suspend the registration of a food facility, thereby preventing it from distributing food. The Centers for Disease Control and Prevention (CDC) recently estimated that one in six Americans have foodborne illness

each year. More than 125,000 of these persons are hospitalized, and more than 3,000 die. Physicians can direct patients with food safety questions or concerns to http://www.foodsafety.gov. The resource offers tips about proper methods of cleaning, handling, preparing, and storing food, as well as information about product recalls. For more information, visit http://www.aafp.org/news-now/health-of-the-public/20110105foodsafety.html and http://www.govtrack.us/congress/billtext.xpd?bill=h111-2751.

Physicians Need Training on How to Examine Obese Patients, Say Physician Educators

Two physician educators at the University of Pittsburgh argue that physicians-in-training need more and better education on how to adapt their physical examination skills to the growing number of Americans who are obese. In a commentary recently published online in the *Journal of the American Medical Association*, the coauthors present a number of these adaptations and recommend that medical students and residents receive formal instruction about them as part of their training. They note that physical diagnosis textbooks currently provide little advice on how to overcome the limitations of the physical examination in patients who are obese. Because of patient and physician factors, obese women are less likely than lower-weight women to obtain regular mammograms, yet the authors note that obesity is a specific risk factor for breast cancer. They point out that physicians who know more about obesity-specific examination techniques have less difficulty in palpating masses during breast and pelvic examinations, suggesting that these are teachable skills. The authors also suggest that obese standardized patients be included in medical training and that physical diagnosis textbooks include illustrations of patients who are obese, address differences in the physical examination of these patients, and provide suggestions for adapting the examination. For more information, visit http://www.aafp.org/news-now/clinical-care-research/20110107physexamobesity.html and http://jama.ama-assn.org/content/early/2010/12/28/jama.2010.1950.full.

AAFP Urges FDA to Expedite Final Rule on New Requirements for Cigarette Warnings

About 3 million Americans could start smoking before new requirements for cigarette warnings take effect, the AAFP said in a recent letter to the FDA. That is because the Family Smoking Prevention and Tobacco Control Act President Obama signed into law in 2009 allows manufacturers more than one year to comply with the new regulations. The AAFP pointed out that although the law was enacted in June 2009, it was not until November 2010 that the FDA published a proposed rule to implement this provision. According to the legislation, the cigarette warning provision does not become effective until 15 months after publication of a final rule. Given the already 17-month delay between enactment of the law and the issuance of a proposed rule for implementation, the AAFP urged the FDA to publish the final rule as soon as possible. For more information, visit http://www.aafp.org/news-now/health-of-the-public/20110104smokingletter.html.

AAFP Launches Social Media Site for Members to Interact, Network

The AAFP recently launched a free, members-only social networking site, called AAFP Connection, at http://www.aafp.org/aafpconnection.html. AAFP members can use the site to connect with each other and share information via discussion forums, a file-sharing feature, Wikis, and more. The site launched with two specialized communities already in place. The rural medicine community allows AAFP members who practice in a rural environment to share resources and success stories, ask questions, solicit input, and discuss the unique challenges of practicing family medicine in a rural setting. The clinical community provides a forum for members to discuss clinical problems and procedures. Future communities on AAFP Connection will be defined by member interest, but communities already under development include emergency and urgent care, the patient-centered medical home, and research. For more information, visit http://www.aafp.org/news-now/inside-aafp/20110112aafpconnection.html.

AAFP Task Force Updates Organization's Bylaws, Member Comment Welcome

An AAFP task force recently reviewed and prepared a revised draft of the AAFP's Bylaws, as requested by the Board of Directors. The task force was charged with updating and modernizing the bylaws, as well as reducing them to the core foundational principles by which the AAFP is governed and operated. The revised draft is available for member review and comment until February 28, 2011, at http://www.aafp.org/online/etc/medialib/aafp_org/documents/about/governance/bylawsdraft.Par.0001.File.dat/BylawsJune2010.mem.doc (AAFP member login required). Comments will be considered and a final proposal will be taken to the 2011 Congress of Delegates for review and action. For more information, visit http://www.aafp.org/news-now/inside-aafp/20110105bylawsrev.html.

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