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AAFP Leaders Carry Family Medicine Message to White House Meeting

By James Arvantes

AAFP President Roland Goertz, M.D., of Waco, Texas, and AAFP President-elect Glenn Stream, M.D., of Spokane, Wash., represented the interests of family medicine at a Dec. 17 White House meeting that focused on how to reduce hospital readmission rates and how to make accountable care organizations, or ACOs, work better.

Goertz told *AAFP News Now* after the meeting that he addressed the issue of hospital readmission rates by telling administration officials and health care leaders at the meeting that hospitals need to do a better job of collaborating with family physicians and other primary care physicians to reduce readmissions.

"I said hospitals need to stop thinking about themselves as only hospitals. They need to reach out to family physicians and other primary care physicians in the area if they really want to address the readmission problems," said Goertz. "Hos-

pitals can do that in several different ways, but the sharing of patient information — particularly at discharge — is very important."

The White House convened the meeting to ask for input on how to improve patient safety in hospitals and decrease readmission rates. Administration officials also wanted to gather input on how to help physicians and other health care professionals make ACOs work better. The administration is planning to launch a major patient safety initiative in January, as well as releasing rules and regulations for ACOs, which are called for in the Patient Protection and Affordable Care Act.

The meeting was attended by key administration officials, including CMS Administrator Donald Berwick, M.D.; Nancy-Ann DeParle, head of the White House Office of Health Reform; Ezekiel Emanuel, M.D., a White

See White House Meeting, page 2



Don't Pass Total Repeal of Health Care Reform Law, AAFP Urges Congress

By James Arvantes

The AAFP is urging Congress to not pass a bill that would repeal the Patient Protection and Affordable Care Act, saying in a prepared statement that overturning the Affordable Care Act would "return us to

a fragmented, duplicative, expensive system that has progressively weakened primary care in America for more than 30 years."

"To do (a total repeal) now — when abundant evidence shows that an efficient, high-quality

health care system depends on primary care — would result in blocking some of the exact changes the health care system must make to better serve Americans," said AAFP President Roland Goertz, M.D., M.B.A., of

Waco, Texas, in the statement.

The AAFP issued Goertz's statement on Jan. 17, two days before the Republican-controlled House voted, 245-189, to repeal the Affordable Care Act by pass-

See Health Care Reform, page 2

FEBRUARY HIGHLIGHTS



AAFP
STRONG MEDICINE FOR AMERICA

2011 Fee Schedulepage 3

The AAFP is urging CMS to strengthen its efforts to ensure primary care services are no longer undervalued.

AAFP Memberspage 12

AAFP membership hit an all-time high at the end of December. Nearly 3,000 members joined the Academy in 2010.

White House Meeting, *continued from page 1*

House health adviser; and Peter Lee, J.D., director of delivery system reform in the Office of Health Reform at HHS.

Administration officials answered a few inquiries, but they mainly asked questions in an attempt to obtain feedback and guidance, said Goertz.

"I was pleased to represent our members and their patients at the meeting," said Goertz. "I am also extremely happy to note that, during the meet-

ing, others mentioned the importance of family physicians and primary care. We are making a difference, and others are helping."

Goertz vowed to continue "giving the views of family medicine," which, he said, "are essentially the views of physicians who are the front lines of patient care." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101222whitesmtg.html>.

Health Care Reform, *continued from page 1*

ing H.R. 2, known as the Repealing the Job-Killing Health Care Law Act. The Senate, with its Democratic majority, is unlikely to approve the House measure, making the House vote more of a political statement than an actual threat to overturn the Affordable Care Act.

Goertz, in an interview with *AAFP News Now*, said the House-passed bill represents a "necessary" vote for many of the newly elected House members. He expressed hope, however, that members of Congress would soon work together.

"I am really interested in hearing some constructive discussion on those things that need to be done to change our health system for the better," he said.

In his statement, Goertz said the Affordable Care Act "is not perfect," but it nevertheless represents progress on several issues. The Affordable Care Act contains key support for family medicine and primary care. At the same time, it provides some important insurance industry reforms, thus making it possible for the AAFP to support the measure, Goertz said.

"From our position, the status quo was not acceptable," Goertz told *AAFP News Now*. "Family medicine and primary care were being devalued and undersup-

ported. To return to the way it was does not offer a very positive picture of family medicine for the future."

The changes created as a result of the Affordable Care Act are starting to take form, he said, producing "a more positive and robust future for family medicine and primary care."

Meanwhile, the AAFP has vowed to work with Congress and the Obama administration to ensure "effective implementation of health reform provisions that expand coverage, that emphasize access to primary medical care and that support a healthy primary care physician workforce," Goertz said in his statement.

"These are issues that have had bipartisan support in the past and should continue to have that support in the future," he noted.

Goertz also said the AAFP will work with Congress to enact needed improvements to the

health care system, including a permanent solution to the Medicare payment formula and medical liability reform.

"Our health care system must preserve patients' ability to buy insurance coverage for themselves and their children," Goertz said. "It must prohibit practices such as denying coverage due to pre-existing conditions and limiting yearly or lifetime benefits. It must continue progress toward implementing medical homes that ensure patient-centered, coordinated and comprehensive care tailored to each person's needs. It must include provisions to increase the number of primary care physicians, particularly in underserved and rural areas." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110119housesrepeal.html>.

The Affordable Care Act contains key support for family medicine and primary care. At the same time, it provides some important insurance industry reforms, thus making it possible for the AAFP to support the measure.

— Roland Goertz, M.D., M.B.A., AAFP President

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AAFP Chart Details Increases in Primary Care CPT Codes for 2011

CMS' release of the final 2011 Medicare conversion factor, which decreased from 2010, has caused a lot of confusion and consternation among family physicians. To allay those concerns, the Academy now has created a chart that shows why family physicians actually may see payment increases in 2011. Members should be aware, however, that payment allowances in the chart are not adjusted geographically.

Kent Moore, the AAFP's manager of health care financing and delivery systems, noted that many physicians expected that their Medicare payments for 2011 would remain the same because Congress extended the payment rate that was in place for the second half of 2010 through the end of 2011.

However, Moore added, "CMS instituted a number of changes in the payment formula, including rebasing the Medicare economic index, increasing some of the payment codes and recalculating the figures for practice expense." These changes would have resulted in increased costs to the Medicare program, but any changes to the program must remain budget-neutral. Thus, CMS was forced to apply a negative adjustment to the overall conversion factor.

Although the actual 2011 conversion factor went down from \$36.8729 to \$33.9764, changes in relative value units, or RVUs, have resulted in an overall increase in the Medicare allowance for the

CPT codes family physicians use the most. In fact, Medicare allowed charges for family medicine are expected to increase in 2011 by about 2 percent to 3 percent, said Moore.

Many physicians look at the conversion factor to compare their potential revenue from year to year, said Moore. "They see a declining conversion factor and assume their claims will decline by the same amount. But, in fact, the payment formula is increasing payments to primary care, sometimes at the expense of services provided by other, higher-paid specialties." ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20110117cptcodechart.html>.

AAFP Comparison of 2010 and 2011 Medicare Allowances for Services Commonly Provided by Family Physicians

Medicare Conversion Factor as of December 2010: \$ 36.8729
 Medicare Conversion Factor as of January 2011: \$ 33.9764

Code	Descriptor	2010		2011		Change in Allowance	
		RVUs	Allowance	RVUs	Allowance	\$\$\$	%
99201	Office/outpatient visit new	1.08	\$ 39.82	1.21	\$ 41.11	\$ 1.29	3.24%
99202	Office/outpatient visit new	1.86	\$ 68.58	2.09	\$ 71.01	\$ 2.43	3.54%
99203	Office/outpatient visit new	2.71	\$ 99.93	3.03	\$ 102.95	\$ 3.02	3.03%
99204	Office/outpatient visit new	4.21	\$ 155.23	4.66	\$ 158.33	\$ 3.10	1.99%
99205	Office/outpatient visit new	5.28	\$ 194.69	5.80	\$ 197.06	\$ 2.37	1.22%
99211	Office/outpatient visit est	0.53	\$ 19.54	0.58	\$ 19.71	\$ 0.16	0.84%
99212	Office/outpatient visit est	1.08	\$ 39.82	1.22	\$ 41.45	\$ 1.63	4.09%
99213	Office/outpatient visit est	1.81	\$ 66.74	2.03	\$ 68.97	\$ 2.23	3.34%
99214	Office/outpatient visit est	2.71	\$ 99.93	3.01	\$ 102.27	\$ 2.34	2.35%
99215	Office/outpatient visit est	3.66	\$ 134.95	4.05	\$ 137.60	\$ 2.65	1.96%
99221	Initial hospital care	2.64	\$ 97.34	2.86	\$ 97.17	\$ (0.17)	-0.18%
99222	Initial hospital care	3.58	\$ 132.00	3.89	\$ 132.17	\$ 0.16	0.12%
99223	Initial hospital care	5.27	\$ 194.32	5.71	\$ 194.01	\$ (0.31)	-0.16%
99231	Subsequent hospital care	1.05	\$ 38.72	1.13	\$ 38.39	\$ (0.32)	-0.83%
99232	Subsequent hospital care	1.90	\$ 70.06	2.04	\$ 69.31	\$ (0.75)	-1.07%
99233	Subsequent hospital care	2.73	\$ 100.66	2.93	\$ 99.55	\$ (1.11)	-1.10%
99238	Hospital discharge day	1.87	\$ 68.95	2.03	\$ 68.97	\$ 0.02	0.03%

Editor's Note: Shaded boxes indicate a reduction in RVUs for 2011.

Academy Sends Strong Message to Agency

CMS Is Still Undervaluing Primary Care in Physician Fee Schedule

Although CMS has taken steps to reward some primary care services in its rule-making process for the 2011 Medicare Physician Fee Schedule, the AAFP says the agency still is undervaluing primary care services.

"We do want to recognize and thank CMS for its ongoing effort to address primary care issues within the parameters permitted by the current (health care reform law)," said AAFP Board Chair Lori Heim, M.D., of Vass, N.C. in a recent letter to CMS Administra-

tor Donald Berwick, M.D.

But, she noted, millions of Americans will become eligible for Medicare in the near future and primary care physicians will be essential to ensure that the nation's health care needs are met.

In particular, Heim addressed CPT codes for immunization administration and maternity care. In each instance, she criticized the agency for disregarding the recommendations of the AMA/Specialty Society Relative Value Scale Update Committee, or

RUC, by adopting relative value units, or RVUs, that were less than what the RUC recommended.

Heim pointed out that the revised immunization administration codes are an improvement over the previous codes, which did not allow physicians to accurately report the considerable work involved in counseling patients regarding combination vaccines. However, it was inappropriate of CMS to "cross-walk values from predecessor codes to new codes given the

underlying structural differences between the two sets of codes," said Heim.

Heim also disagreed with CMS' determination of CPT codes that define maternity care. In spite of a RUC recommendation to significantly increase these work values, CMS reduced the RVUs for each code in this family of codes by approximately 11 percent, according to Heim. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20110112feescheduleltr.html>.

In Brief *Inside AAFP*

AAFP Ratchets Up Social Media Efforts With Launch of AAFP Connection

The AAFP has taken the plunge into the social media waters with the launch of AAFP Connection at <http://www.aafp.org/online/en/home/membership/resources/aafpconnection.html>. AAFP Connection is a free, members-only social networking site where Academy members can connect with one another and share information via discussion forums, a file-sharing feature, Wikis and more. The site launched with two specialized communities already in place: a rural medicine community and a clinical community. <http://www.aafp.org/news-now/inside-aafp/20110112aafpconnection.html>

AAFP Task Force Updates Bylaws' Language to Reflect Modernization

The AAFP wants members to know that it has reviewed and prepared a revised draft of the organization's Bylaws as requested by the Board of Directors. The revised draft is available for member comment until Feb. 28 at <http://www.aafp.org/online/en/home/aboutus/governance/responsesltr.mem.html>. Members are encouraged to review the bylaws and comment. Comments will be considered and a final proposal will be taken to the 2011 Congress of Delegates for review and action. <http://www.aafp.org/news-now/inside-aafp/20110105bylawsrev.html>

Deadline to Apply for AAFP Vaccine Science Fellowship Program is Feb. 18

Interested AAFP members are invited to apply for the AAFP Vaccine Science Fellowship Program, which is intended to develop a cadre of family physician experts who can help the Academy provide effective input into the deliberations and decisions of federal and state public health agencies that set vaccine policies. Applications and accompanying materials for two one-year vaccine science fellowships are due Feb. 18. Applicants must be active members in practice or teaching and out of residency and fellowship. They also must be U.S. citizens. <http://www.aafp.org/news-now/inside-aafp/20110118vaccinefellows.html> ■

Medicare Electronic Prescribing Penalty Program

AAFP, Other Physician Organizations Slam HHS, CMS for Policy Change

The AAFP has joined the AMA and more than four dozen national physician specialty organizations — as well as medical associations from every state and the District of Columbia — in urging HHS to put pressure on CMS to revise its electronic prescribing, or e-prescribing, penalty criteria, which were scheduled to be implemented Jan. 1.

According to those criteria, which only recently were published in the final 2011 Medicare physician fee schedule, beginning in 2012, CMS will penalize physicians who did not send Medicare prescriptions electronically in the first six months of 2011. However, up until now, the agency's message has been that physicians who were not e-prescribing by 2012 would face a 1 percent reduction in their allowed Medicare charges in 2012 and 2013.

The medical organizations clearly interpret the phrase "by 2012" differently than does the government agency.

"CMS has ruled that physicians who choose to participate in the Medicare electronic health record, or EHR, incentive program cannot participate in Medicare's e-prescribing incentive program in the same program year."

"We strongly oppose basing the 2012 and 2013 e-prescribing penalties on e-prescribing activity that occurs during 2011," says the Dec. 7 letter to HHS Secretary Kathleen Sebelius.

A big issue is CMS' governance of more than one Medicare incentive program. Notably, CMS has ruled that physicians who choose to participate in the Medicare electronic health record, or EHR, incentive program cannot participate in Medicare's e-prescribing incentive program in the same program year.

Because of that restriction and the way the incentive programs are designed, physicians can participate in only one of the two programs in 2011, 2012 and 2013, says the letter. Therefore, many physicians have decided to forgo the e-prescribing incentive program in favor of the EHR incentive program.

"Now, at the eleventh hour ... CMS has significantly changed its policy and decided to penalize physicians who choose to only take part in the Medicare EHR incentive program," says the letter. The parameters of that program don't necessarily require e-prescribing in 2011.

Furthermore, those same physicians who face penalties will implement comprehensive EHRs within the next few years that do much more "than just enable e-prescribing," the letter continues.

The organizations argue that CMS' "sudden change" in program requirements — changes that took effect on Jan. 1 — does not allow enough time to educate physicians on the need for them to take part in the 2011 e-prescribing incentive program to avoid e-prescribing penalties in 2012 and 2013.

Furthermore, says the letter, "such a significant last-minute policy change could substantially hurt the overall move to e-prescribing and EHR adoption."

"Financial penalties should only be levied in 2012 and 2013 against Medicare-eligible physicians who fail to qualify for an exemption and fail to e-prescribe 10 permissible prescriptions by the end of 2012 or the end of 2013," says the letter.

The letter also points out the law that established the Medicare e-prescribing program, the Medicare Improvements for Patients and Providers Act of 2008, clearly supports delaying penalties against physicians who do not e-prescribe in 2012.

The organizations say they "strongly oppose" basing the 2012 and 2013 e-prescribing penalties on e-prescribing activity that occurs during 2011. ■

CDC Publishes Revised Guidelines on Prevention, Control of STDs

CDC officials last week issued comprehensive new clinical guidance for the treatment and prevention of STDs in people who have or are at risk for infection. Although the new guidelines, which update the agency's "2006 Guidelines for Treatment of Sexually Transmitted Diseases," focus largely on treatment approaches, they also discuss prevention strategies and diagnostic recommendations.

According to a "Dear Colleague" letter from the CDC that accompanied release of the guidelines, more than 19 million new cases of STDs are detected each year in the United States, with a disproportionate share of these cases occurring among young people and racial and ethnic minority populations. The estimated annual direct medical cost of treating these infections and their sequelae is \$16.4 billion.

The 2010 guidelines were developed using a nearly two-year-long evidence-based process that included CDC and external expert review of the current scientific literature, as well as extensive CDC consultation with a group of professionals knowledgeable in the field of STDs who met in April 2009. The guidelines are intended to "serve as a source of clinical guidance and advise health care providers on the most effective treatment regimens, screening procedures, and prevention and vaccination strategies for STDs," says the agency's letter.

Among newly updated information contained in the 2010 guidelines is the following:

- expanded STD prevention recommendations, including vaccination against human papillomavirus;
- expanded diagnostic evaluation strategies for cervicitis and trichomoniasis;
- revised gonorrhea treatment regimens that reflect the increasing prevalence of antimicrobial-resistant *Neisseria gonorrhoeae*;
- new treatment regimens for genital warts and bacterial vaginosis;
- assessment of the clinical efficacy of azithromycin for chlamydial infection in pregnant women;
- insight into the role of *Mycoplasma genitalium* and trichomoniasis in the evaluation of urethritis and cervicitis and treatment-related implications; and
- revised guidance on the diagnostic evaluation and management of syphilis, including criteria for spinal fluid examination to evaluate for neurosyphilis. ■

Editor's Note: Errata to the guidelines were published in the Jan. 14, 2011, Morbidity and Mortality Weekly Report. The errors involved dosages recommended for treatment of specific gonorrheal infections and bacterial vaginosis.

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20101222cdcstdguide.html>.

Infectious Diseases Society Issues Guidelines for Treating MRSA Infections

Simple, Uncomplicated Infections May Not Require Antibiotics

Protocols for treating methicillin-resistant *Staphylococcus aureus*, or MRSA, infections vary widely in the United States, according to the Infectious Diseases Society of America, or IDSA. To help clinicians manage this potentially lethal contagion, the organization has released its first guidelines for the treatment of MRSA infection.

The evidence-based guidelines are intended to help physicians determine the most appropriate treatment for both uncomplicated and invasive infections due to the common bacterium, which is responsible for 60 percent of skin infections treated in U.S. emergency rooms.

More than 90,000 Americans were infected with the invasive form of the disease in 2005, the IDSA said, and more than 18,000 of those people died.

"MRSA has become a huge public health problem, and physi-

cians often struggle with how to treat it," said Catherine Liu, M.D., lead author of the guidelines and



Photo courtesy of the CDC

assistant clinical professor in the Division of Infectious Diseases at the University of California, San Francisco, in a Jan. 5 news release. "The guidelines establish a framework to help physicians determine how to evaluate and treat uncomplicated as well as invasive infections."

The guidelines, which appear in the Feb. 1 issue of *Clinical Infectious Diseases*, cover treatment options for both adults and children. They also call for the development of new and improved antibiotics to treat MRSA.

Among the wide range of topics covered in the guidelines document are:

- how to manage skin and soft-tissue infections likely caused by community-associated MRSA;
- how to treat recurrent skin infections;
- recommendations regarding use of vancomycin — including dosing — and other antibiotics;
- how to manage invasive infections, such as pneumonia, and infections in the bones, joints, blood or heart; and
- how to treat newborns who are infected with MRSA.

Regarding the management of uncomplicated infections typically seen in an office setting, the guidelines note that use of antibiotics is not always necessary. For simple abscesses or boils, incision and drainage alone is likely to be adequate.

However, antibiotic therapy is recommended for abscesses

associated with any of the following conditions:

- severe or extensive disease;
- rapid progression of disease in the presence of associated cellulitis;
- signs and symptoms of systemic illness;
- associated comorbidities or immunosuppression;
- extremes of age;
- abscess in an area difficult to drain, such as the face, hands or genitalia;
- associated septic phlebitis; and
- lack of response to incision and drainage.

In addition, patient education about personal hygiene and appropriate wound care is recommended for all patients with recurrent skin and soft-tissue infections. ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20110112mrsaguidelines.html>.

Physicians Must Adapt Exam Skills for Obese Patients

All the statins and lipid-lowering drugs in the world may not do Mrs. Johnson any good if her doctor misses a lump on her annual clinical breast exam. And that's more likely to happen if she's obese.

That's why two physician educators at the University of Pittsburgh are saying 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 published online Dec. 29 in *JAMA: The Journal of the American Medical Association*, the two co-authors present a number of these adaptations and recommend that medical students and residents receive formal instruction about them as part of their training.

Despite a doubling of the prevalence of obesity just in the past generation, "Medical education about physical diagnosis skills for obese patients has not kept pace with the obesity epidemic," say co-

authors Ann Willman Silk, M.D., and Kathleen McTigue, M.D., M.P.H., in their article, "Re-examining the Physical Examination for Obese Patients."

Currently, they note, physical diagnosis texts provide little advice on how to overcome the limitations of the physical exam in patients who are obese. Even obesity management handbooks usually include only a cursory description of how to perform the exam, focusing instead on how to detect obesity-associated disease, such as acanthosis nigricans or adipositas dolorosa.

According to the authors, physically examining a person who is obese — that is, one who has a body mass index, or BMI, of 30 or greater — is particularly challenging because the primary techniques of inspection, palpation, auscultation and percussion can be undermined when internal structures are encased in a thick layer of adipose tissue.

Some physicians, for

example, are reluctant to perform breast and gynecological examinations on obese women because they think the exams are difficult or inadequate. Yet it's especially important to perform clinical breast exams in this population because obesity is a specific risk factor for breast cancer, according to the authors.

"An association between higher BMI and nonpalpable breast cancers may suggest that the clinical breast examination lacks sensitivity in women with large breasts," say the authors. "Any consequences of suboptimal clinical breast examinations are then compounded by the inadequacy of screening mammography in the obese population."

The authors 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."

They offer a number of prac-

tical tips on how to perform the physical examination in patients who are obese, including the following examples:

Because thick chest walls may obscure heart sounds during the cardiovascular exam, palpate the carotid pulse at the same time. Ask sitting patients to lean forward to bring the heart closer to the chest wall. Ask recumbent patients to raise their arms above their heads to spread out chest-wall soft tissues. In addition, a handheld Doppler device can be used to check the patient's pulse.

For the clinical breast exam, spend at least three minutes examining each breast with the patient in a lateral decubitus position.

Because patients may be embarrassed to report skin conditions, ask about problem areas and do a thorough skin examination, paying special attention to intertriginous folds. ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20110107physexam-obesity.html>.

In Brief *Health of the Public*

CDC Updates Guidelines on Prevention of Perinatal Group B Streptococcal Disease

The CDC has released updated guidelines for the prevention of perinatal group B streptococcal, or GBS, disease. The CDC has highlighted more than a dozen items as "key changes" to the updated guidelines, including expanded recommendations on laboratory detection of GBS, clarification of the colony-count threshold required for reporting GBS detected in the urine of pregnant women, and a revised algorithm for management of newborns with respect to risk for early-onset GBS disease. <http://www.aafp.org/news-now/clinical-care-research/20101215gbsguidelines.html>

Ritedose Corp. Recalling Albuterol Sulfate Inhalation Solution

The Ritedose Corp. is recalling its 0.083% Albuterol Sulfate Inhalation Solution 3 mL unit-dose vials in 25-, 30- and 60-count packages because a labeling error could lead to patients receiving five times the recommended amount of the bronchodilator albuterol sulfate, which could cause life-threatening side effects and death. The Columbia,

S.C.-based company said that the correct concentration of 2.5 mg/3 mL is displayed on the products' primary foil overwrap pouches and shelf cartons. However, the single-use vials themselves are incorrectly labeled with the concentration "0.5 mg/3 mL" and, thus, represent a potential health hazard. <http://www.aafp.org/news-now/health-of-the-public/20110105albuterolrecall.html>

AAFP NRN Recruiting Docs to Study Asthma Treatment in Blacks

The AAFP National Research Network, or AAFP NRN, is seeking to recruit as many as 20 family medicine practices for a study that will compare the effectiveness of two different bronchodilating agents — each in combination with inhaled corticosteroids, or ICSs — in delaying the time to exacerbation in black patients with asthma. Each participating practice will be asked to enroll 100 black adults with asthma who meet both of the following conditions: less than a 10-year pack history of smoking, and asthma that is either not controlled on low-dose ICSs or requires combination therapy. <http://www.aafp.org/news-now/clinical-care-research/20110128aafpnrnasthma.html> ■

AAFP Responds to CMS Call for Comments on Shaping ACO Regulations

When CMS recently asked for input from outside entities regarding creation of potential regulations for accountable care organizations, or ACOs, and the Medicare shared savings program, the AAFP was quick to respond.

In a Dec. 3 letter to CMS Administrator Donald Berwick, M.D., AAFP Board Chair Lori Heim, M.D., of Vass, N.C., addressed a series of questions the agency posed.

For example, Heim noted that CMS should require ACOs to provide primary care access that is distributed evenly throughout the communities they serve and avoid exclusive contracts with single providers of primary care services “unless they can demonstrate local patient access for the entire community served.” ACOs should include small practices and should provide resources to support small practices even when doing so requires an “upfront” investment by the ACO, said Heim.

In addition, she noted, CMS “should not accept conceptual models where the ACO is run by a hospital that sets up primary care solely to serve as a feeder route for expensive procedures or hospital services.” She pointed out that small practices will have difficulty participating in ACOs that only serve Medicare patients. “The percentage of patients in a single practice will be too small to warrant the logistical changes required to participate,” said Heim.

The Academy also urged CMS to remove barriers to clinical and financial integration that currently exist. Doing so will allow independent practices to participate in ACO models. “This may require changes to — or waivers from — current antitrust law and regulations governing such business relationships,” said Heim.

In terms of providing small practices access to capital, Heim told Berwick that many small practices have limited access to capital or other resources from which they could generate shared savings for the ACO. Ideally, said Heim, primary care practices should receive per-patient, per-month care management payments, and these payments should not be made from any shared savings calculation because they support ongoing fixed costs not related to individual visits.

Upfront or monthly payments to primary care practices should be recognized as “necessary and ongoing support for nonvisit-based services, such as patient self-management support, care management and care coordination,” said Heim, adding a prepaid monthly care management fee also would help demonstrate the importance of the team approach to health care.

Heim also addressed assessing beneficiary and caregiver experiences in an ACO. “ACOs should be required to survey patients so that service levels can be determined and improved,” said Heim. She added that ACOs should have systems in place to collect and act on patients’ “experience of care” data and show positive trends over time.

Heim noted that patients will need assurances they are receiving better health care and evidence-based health care. For example, said Heim, outcome measures for common chronic illnesses already exist. She urged CMS to develop additional measures for continuity of care and comprehensiveness of care. And she asked CMS to invest in the implementation of measures to monitor a patient’s functional status and quality of life. ■

For the complete story, visit <http://www.aafp.org/news-now/inside-aafp/20101217acoregsltr.html>.

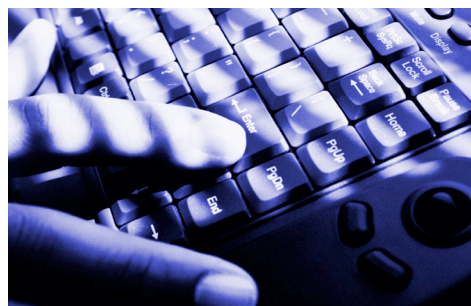
Registration is Open for Medicare, Medicaid Incentive Programs for Health IT *CMS Expects to Start Issuing Payments in May*

As expected, the federal government is inviting health care providers to register for electronic health record, or 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.

“With the start of registration, these landmark programs get under way, and patients, providers and the nation can begin to enjoy the benefits of widespread adoption of electronic health records,” said CMS Administrator Donald Berwick, M.D., in a prepared statement. “CMS has many resources available to help

providers register and participate, and we look forward to working with eligible professionals and eligible hospitals to facilitate the process beginning on Jan. 3 and going forward.”

CMS and the Office of the National Coordinator for Health Information Technology, or ONC, opened registration for the Medicare EHR incentive program on Jan. 3. The Medicaid EHR incentive program also was being rolled out Jan. 3 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, according to CMS.

The American Recovery and Reinvestment Act of 2009 created the Health Information Technology for Economic and Clinical Health, or HITECH, Act to promote the adoption of health information technology among hospitals, physicians and other health care providers. The HITECH Act

makes Medicare and Medicaid incentive payments available to eligible physicians, hospitals and other health care professionals when they adopt certified EHR technology and successfully demonstrate meaningful use of the technology in ways that improve quality, safety and effectiveness of patient-centered care.

Eligible professionals participating in Medicare can receive as much as \$44,000 during a five-year period and as much as \$63,750 if they participate in Medicaid during the next six years. CMS expects to start issuing Medicare EHR incentive payments in May 2011. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/2010105healthitincents.html>.

AAFP, Medical Organizations Fight for Medicare Money Due Docs

As 2010 drew to a close, physician organizations around the country, including the AAFP, were fighting to ensure their members received retroactive Medicare payments due to them. In a Dec. 9 letter to HHS Secretary Kathleen Sebelius, a number of these organizations pointed out that CMS had yet to provide retroactive payment increases for 2010.

"We, the undersigned organizations, urge the administration to take the necessary steps to immediately reimburse physicians for the payment changes that are outlined below," says the letter. The correspondence was coordinated by the AMA and signed by the AAFP and scores of other physician organizations, including medical societies from all 50 states and the District of Columbia.

Language in the Patient Protection and Affordable Care Act — as well as corrections made in the final 2010 Medicare physician fee schedule — resulted in payments that were retroactively owed to physicians.

Of particular interest to family physicians, CMS was directed to extend the 1.0 work geographic practice cost index, or GPCI, floor that expired on Dec. 31, 2009, and raise practice expense GPICs in low-cost areas by reflecting only half the geographic wage and rent cost differences in their calculation.

The letter pointed out that more than 40 states were affected by the GPCI increases. Some of the most significant increases occurred in North Dakota (7.0 percent); Montana (6.7 percent); Wyoming (6.4 percent); Mississippi (5.9 percent); West Virginia (5.6 percent); Kentucky (5.2 percent); and Kansas (4.6 percent).

"Failure to reimburse physicians for ... retroactive payment changes comes on the heels of an extremely disruptive year for our patients," wrote the organizations. "Throughout 2010, Congress enacted short-term, stop-gap measures (to forestall Medicare payment cuts) for durations as short as one month."

The letter calls the payment uncertainties in 2010 due to threatened cuts in Medicare physician payments "highly disruptive." ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101221retroactive.html>.

Health Care Reform Administrative Simplification Rules Could Lessen FPs' Administrative Burden

By Sheri Porter

The burgeoning clerical burden that bogs down most physician offices every day across America could be alleviated by a section of the Patient Protection and Affordable Care Act, leading one analyst to label the legislation as a "wish list" for physician offices.

A 2009 report released by the Healthcare Administrative Simplification Coalition, or HASC, found that about 25 percent of the nation's health care costs — estimated at more than \$2 trillion in 2007 — go toward administrative functions, such as billing and payment tasks. Fortunately, Section 1104 of the Affordable Care Act focuses on reducing those costs by reorganizing and streamlining clerical procedures.

That prospect has Robert Tennant, a senior policy adviser for the Denver-based Medical Group Management Association, or MGMA, excited.

"When we (at MGMA) saw the (health care) bill, I can't tell you how pleased we were, because it really is a 'wish list' for provider offices," Tennant told *AAFP News Now*. MGMA has been fighting the administrative simplification battle for years, and, in 2005, it joined with the AAFP and the American Health Information Management Association to form HASC, which is committed to reducing the administrative costs and complexity of health care.

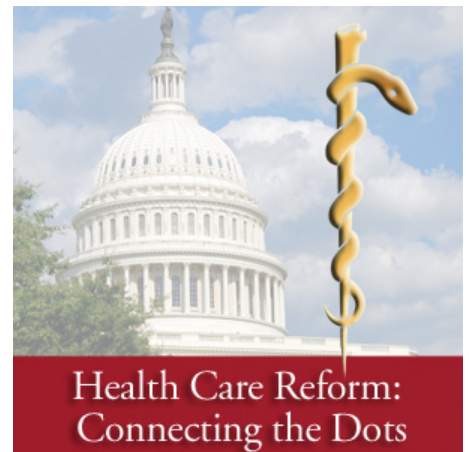
Specific pieces of the new health care reform law should help streamline some very "ornery and inefficient" administrative procedures that slow down physician practices, said Tennant.

For example, the law could help physicians determine patient eligibility. It is important that family physician practices have the ability to verify the validity of a patient's health insurance — and discern the plan's copays and deductibles — before a patient is ushered into the exam room, said Tennant.

According to the law, HHS must find ways to reduce the clerical burden on patients and health care providers by reducing the number of forms — as well as the complexity of paper and electronic forms — in the current health care system. In addition, HHS must promulgate a final rule to establish a unique identifier for health plans, and that rule must be in effect no later than Oct. 1, 2012.

HHS also is charged with adopting a single set of operating rules to uniformly implement electronic standards. These rules will have to be consensus-based, reflect appropriate business rules affecting health plans and health care professionals, and comply with already established privacy standards.

The law makes it clear that physicians must be part of the process of setting the operating rules for administrative simplification, and it specifically states that the HHS secretary will have "ensured consultation with providers." ■



For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101215hcreformadminsimpl.html>.

AAFP, Other Groups Adopt Joint Principles for Medical Education

New Principles Aim to Prepare Physicians for Practice in PCMH Environment

By Barbara Bein

The Academy and three other primary care professional organizations have promulgated a new policy to guide the education of physicians who will be graduating from U.S. medical schools in an era of health care reform that promotes preventive health services and a greater reliance on primary care.

The policy, known as the Joint Principles for the Medical Education of Physicians as Preparation for Practice in the Patient-Centered Medical Home, builds on the Joint Principles of the Patient-Centered Medical Home, or PCMH, which the groups adopted three years ago.

In addition to the AAFP, the new educational principles have been approved by the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association. The principles now will be for-

warded to the Patient-Centered Primary Care Collaborative, which will consider them for endorsement.

Perry Pugno, M.D., M.P.H., director of the AAFP Division of Medical Education, said the new principles are an important guide to medical schools because, in the new health care reform environment, the emphasis is on prevention and the need for increasing access to primary care.

“Training for PCMH practice has been embraced by the graduate medical education community, but at the medical school level, the response has been less — hence, the development of these principles to guide development at the medical school level of training,” said Pugno.

The new medical education principles relate each PCMH component in the Joint Principles of the Patient-Centered Medical Home to the pertinent Accredita-

tion Council for Graduate Medical Education/American Board of Medical Specialties core competencies and describe the corresponding education subprinciples.

The new joint principles acknowledge that integrating PCMH features into undergraduate medical education will require additional resources. In some cases, students simply can be incorporated into existing patient-care and practice-based activities. In other cases, however, additional faculty — such as those with expertise in economics, health policy or business administration — and staff will be needed to create and oversee new experiences for the students.

It’s important for medical schools to recognize the need to invest in the future to provide these educational opportunities, Pugno said.

“We know that the current



model of health care isn’t financially sustainable,” said Pugno. “We need at least some medical schools and their academic medical centers to show leadership and make some difficult choices — and change how they do business. In the short term, it will cost, but the dividends will come in the future.” ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20101217jointprinciplesmeded.html>.

U.S. Supreme Court Rules Against Residents Claiming FICA Exemption

Resident physicians are employees, not students, and so they must pay Social Security and Medicare payroll taxes in accordance with the Federal Insurance Contributions Act, or FICA. That’s according to a U.S. Supreme Court ruling handed down Jan. 11.

According to the unanimous decision, the high court agreed with an appeals court ruling that resident physicians can rightfully be considered “full-time employees,” as defined by the U.S. Treasury Department, and, therefore, are not exempt from paying FICA taxes.

FICA taxes equal 15.3 percent of wages, of which 12.4 percent goes to Social Security. Generally, of that total amount, half is paid by the employer and half by the employee. Thus, a medical resident who earns a \$40,000 annual stipend pays \$3,060 and the hospital/sponsoring institution pays \$3,060 in total FICA taxes.

The Supreme Court’s decision came in a case initially filed in the U.S. District Court for the District of Minnesota by the Mayo Foundation for Medical Education and Research, known as the Mayo Clinic, in Rochester, Minn., and the University of Minnesota. Mayo had sought a refund of money it had withheld and paid on its residents’ stipends during the second quarter of 2005.

In its case, the Mayo Clinic asserted that regulations promulgated by the Treasury Department in 2004 that categorically defined a full-time employee as one who works 40 hours a week or more are invalid.

Mayo argued that the regulations failed to take into account that residents are trained primarily through hands-on experience and the Treasury Department arbitrarily distinguished between hands-on training and classroom instruction.

The Supreme Court opinion, written by Chief Justice John Roberts Jr., supported the Treasury Department’s determination that “employees who are working enough hours to be considered full-time employees have filled the conventional measure of available time with work, and not study.”

Moreover, the court said, the Treasury Department did not act irrationally in concluding that resident physicians “who work long hours, serve as highly skilled professionals and typically share some or all of the terms of employment of career employees are the kind of workers that the U.S. Congress intended to both contribute to, and benefit from, the Social Security system.” ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20110114supcourtfica.html>.

Louisiana AFP Members, PCMH Critical to Health Care Revitalization in New Orleans

By James Arvantes • *New Orleans*

The health care system in New Orleans used to serve as a prime example of a top-heavy system that delivered low-quality care at a high price. For generations, the city relied on a highly centralized public hospital system that made access to care difficult.

Then, in August 2005, Hurricane Katrina slammed into New Orleans. The city's extensive network of levees failed, resulting in a flood that destroyed the city's infrastructure, including its beleaguered health care system.

In the storm's aftermath, pri-

ivate donations and federal funds poured into Louisiana and into New Orleans itself, giving officials the chance to remake the health care system based on the tenets of primary care and the patient-centered medical home, or PCMH.

"As we were thinking about inventing our future, we said, 'Primary care has to be foundational,'" said Karen DeSalvo, M.D., M.P.H., vice dean of community affairs and health policy at Tulane University School of Medicine in New Orleans.

The revamped health care sys-

tem based on the PCMH model has received enthusiastic feedback from the family physicians involved as well as their patients.

"This is no longer a top-down model where the doctor does things, and everyone does what the doctor says," said Sarat Raman, M.D. Raman is a member of the Louisiana AFP and a staff physician with the Daughters of Charity Health Centers in the Bywater neighborhood of New Orleans. The organization has three clinics in the New Orleans area.

According to Raman, the model of care is "patient-centric," and has

led to improved outcome measures for various chronic conditions, such as high blood pressure.

"We have done more with primary care than we ever could have done with (sub)specialists," said Raman, who also is an assistant professor in Tulane University's Department of Family and Community Medicine. He noted that the model allows the various PCMH team players to interact in a variety of ways. For example, care managers do not necessarily need a physician's approval to refer a patient to a mental health professional, which results in better and quicker care for the patient.

Physicians at Algiers Community Health Center can provide patients with access to medical, dental and mental health services, said FP Danyel Edwards, M.D., a staff physician at Algiers Community Health.

"A lot of the patients we have here have difficulty getting to places," said Edwards. The mix of services offered by Algiers Community Health makes it more convenient for them. "They are more adherent in terms of keeping their appointments. They really feel like this is their (medical) home."

"We know the patient experience is good, even though we are taking care of patients who are sicker than the average American," said DeSalvo. She pointed to a Commonwealth Fund 2010 survey that indicates 40 percent of clinic patients in the New Orleans area reported an excellent experience with the health care system; another 90 percent said they had enhanced access to care. ■

For the complete story, visit <http://www.aafp.org/news-now/chapter-of-the-month/20101222louisianacotm.html>.



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Health Care Reform Law Provides Boost for NHSC, Teaching Health Centers

By Barbara Bein

A key goal of the new health care reform legislation is to remedy physician shortage and maldistribution problems by growing the nation's primary care physician workforce and placing those physicians in medically underserved regions of the country. The means to these ends include dramatic increases in funding for the National Health Service Corps, or NHSC, and new funding for teaching health center, or THC, residency programs that are included in the health care reform law.

Funding for the NHSC — the HHS program that allows physicians to exchange medical education debt for service in health professional shortage areas — involves both discretionary (i.e., subject to congressional approval) and mandatory components.

Funding for THCs — described as community-based, ambulatory patient care centers that operate a primary care residency program — also has two components. Development grants to start new THCs, or expand existing ones, are authorized under the Patient Protection and Affordable Care Act, but Congress has not appropriated the money for fiscal year 2011 and it is unlikely to do so, according to Teresa Baker, AAFP government relations representative.

However, mandatory funding totaling \$230 million for FY 2011 to FY 2015 is available for existing THCs' direct and indirect graduate medi-

cal education, or GME, expenses.

The Accountable Care Act also provides new funding for the NHSC. That increased funding — a total of \$1.5 billion during a five-year period — aims to expand the NHSC's scholarship and educational loan repayment programs for primary care physicians and other health care professionals. These programs allow physicians to receive financial aid in exchange for service at practice sites in the nation's rural and urban health professional shortage areas.

"The additional money for the National Health Service Corps basically provides more positions for primary care physicians," said physician workforce expert Perry Pugno, M.D., M.P.H., director of the AAFP Division of Medical Education and a former NHSC physician who served a year in the Mojave Desert community of Barstow, Calif.

"What this means for our community is many more practice sites where our graduates can do full-scope family medicine and get significant debt relief without the new expenses of setting up a practice," Pugno added. ■

For the complete story, visit <http://www.aafp.org/news-now/resident-student-focus/20101222hcreform-nhscthcs.html>.



Physician Compare Website: Keep It Current, Keep It Accurate, Academy Tells CMS

The AAFP has called on CMS to ensure that the information provided on its new Physician Compare website, which was established according to provisions in the Patient Protection and Affordable Care Act, is accurate and up-to-date.

In a letter to CMS Administrator Donald Berwick, M.D., AAFP Board Chair Lori Heim, M.D., of Vass, N.C., said the AAFP has been a "longstanding advocate of quality improvement efforts." As such, the Academy acknowledges the value of and overall trend toward public performance reporting. But, said Heim, that information must be current and accurate.

The Affordable Care Act required CMS to establish, by Jan. 1, the Physician Compare

website, which contains information on Medicare physicians and other eligible professionals who participate in the Physician Quality Reporting System. CMS chose to use its existing Healthcare Provider Directory as a foundation for the Physician Compare website.

The Healthcare Provider Directory offers searchable information on physicians and other health care professionals by type of professional, specialty, location, gender, languages spoken, education and hospital affiliations. It also denotes Medicare participation and nonparticipation status.

"Given the agency's existing efforts, the Academy concurs with CMS' proposal to comply with this (Affordable Care Act) requirement by using the current Healthcare

Provider Directory as the foundation for the Physician Compare website," Heim said.

But, she pointed out, "CMS largely bases the current Healthcare Provider Directory directly on information garnered through the Provider Enrollment, Chain and Ownership System, or PECOS."

"Unfortunately, the currency and accuracy of PECOS is highly suspect in light of the well-documented instances of Medicare contractor delays associated with the Medicare enrollment process," said Heim. "We ... encourage CMS to promptly and drastically improve the Medicare physician enrollment process given its direct connection to the development of a Physician Compare website."

Heim pointed out that Medicare patients and their caregivers go online every day to learn details about Medicare benefits and identify physicians and other potential health care providers.

"AAFP therefore urges CMS to update this website as frequently as is feasibly possible," Heim said. "Frequent, perhaps monthly, updates would improve access to care by quickly connecting newly enrolled physicians or recently established practice locales with prospective patients." ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/201118physiciancompare.html>.

AS WE SEE IT

Voices From the AAFP

From the President

AAFP Membership Hits All-time High

By Roland Goertz, M.D., M.B.A.

I have wonderful news to share with you: AAFP membership surged to a record high in 2010, going above the 97,000-member mark for the first time ever. As of Dec. 31 (the official count date), the AAFP had 97,600 members, nearly 3,000 more than at the end of 2009.

All major membership categories had increases compared with 2009 levels. The rise in student membership was particularly striking, with the Academy adding more than 2,000 student members to its rolls. That's great news for the future of our specialty! Resident membership also increased. So did the percentage of residency graduates who converted to active membership — the first such increase in 10 years.

There also was an uptick in the percentage of active members who renewed their membership, with 94.4 percent renewing. Altogether, the number of active members jumped by nearly 600, including some FPs who had never been members before.

To be honest, I wasn't sure what the AAFP's membership numbers would be at the end of 2010. We had changed our membership cycle. I had heard from members who strongly disagreed with some of our advocacy positions and the Consumer Alliance Program. I had hoped that members recognized a bolder approach to advocacy on their behalf, but I was unsure. It had crossed my mind that the numbers might be flat or even drop, given these issues and the continuing political turmoil surrounding health care reform. Needless to say, I was excited and energized when the actual membership numbers were much better than I expected.

Bolder Than Ever

What sparked this membership increase? I hope and believe that a primary reason is the Academy's bolder-than-ever approach on issues important to family physicians. A few years ago, feedback from members showed that, although they believed in the AAFP, they found it to be "plain vanilla" at a time when they needed stronger advocacy to solve the problems they faced. In response, AAFP leaders vowed that the Academy would become the specialty's "bold champion," representing members with more assertive actions and forceful language



Roland Goertz, M.D., M.B.A.

“AAFP leaders vowed that the Academy would become the specialty’s ‘bold champion,’ representing members with more assertive actions and forceful language than ever before — and we have tried to do just that.”

than ever before — and we have tried to do just that.

As we've become bolder, we've gotten more attention and had more influence with policymakers and other health care stakeholders. And, we've had more success in convincing them of the foundational role family medicine and primary care should play in a reformed health care system.

Our rise in student membership shows that the message also is getting through to medical students. More of them see family medicine as a desirable career option. And young physicians increasingly see the AAFP in a positive light, as shown by the first increase in 10 years in residency grads continuing with us as active members.

The AAFP's robust membership numbers should telegraph a powerful message to legislators and others, who should realize we're increasing in strength at a time when some medical associations may be struggling.

Heartfelt Thanks

If you renewed your membership in 2010, thank you for your loyalty and solidarity in supporting the specialty we all love. I hope you know that we are working hard to lead family medicine and primary care into a bright future, even if you don't agree with every position we take along the way.

If you're a new member, welcome to the Academy, and thank you for supporting family medicine. I know you'll find value in the many benefits of your AAFP membership.

I'd also like to thank our constituent chapters' incredible leaders and staff for their strong collaboration with the AAFP's Commission on Membership and Member Services and Membership Division this past year. They all did excellent work in conveying the value of membership to current and potential members.

As we move into this new year, I promise that AAFP leaders won't waver from our commitment to bold advocacy. We'll keep pushing for changes to advance our specialty and to make it easier for you to practice every day as you help patients lead healthier lives. Physician payment and liability reform top the list of our issues to strongly promote, as does shaping improvements in the regulations to implement health reform.

Powerful together, we will make a significant difference in the coming months. Thank you again for your loyalty and support. ■

For the complete story, visit <http://www.aafp.org/news-now/opinion/20110112edlmembership.html>.