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Congress Approves 12-Month Medicare Payment Patch

Measure Gives Physicians Reprieve From Constant Threat of Cuts

By James Arvantes

Both houses of Congress have now passed a yearlong Medicare payment patch that effectively blocked an impending 25 percent reduction in the Medicare payment rate called for by the sustainable growth rate, or SGR, formula. And President Obama has signed the legislation.

"Today's vote will temporarily end the series of short-term patches that have plagued doctors and their patients throughout 2010," said AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, in a prepared statement.

"It is, however, only one step toward a permanent solution to the flawed sustainable growth rate formula that threatens deep Medicare payment cuts and the financial viability of primary care physician practices."

During the next 12 months, the physician community and Congress must work together to put an SGR patch in place for three to five years that will include a differential payment for primary

care physicians, Goertz stressed. This will give payment reform demonstrations enough time to produce the evidence that should underlie any permanent replacement to the current poorly structured formula, he added.

"We will continue to talk to the leadership at the White House and in Congress to help them bet-

ter understand why a three-to-five-year payment patch is the next step to a permanent fix," said Goertz in an interview with *AAFP News Now*.

The Senate passed the Medicare and Medicaid Extenders Act of 2010 by unanimous

consent on Dec. 8, and the House followed suit on Dec. 9. The legislation marks the fifth and longest physician payment patch enacted this year.

In his statement, Goertz warned that "family physicians cannot sustain practices in an environment with both stagnated Medicare payment and monthly or semi-monthly threats of deep cuts in Medicare

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Language Could Exempt Physicians From 'Red Flags' Rule

By Sheri Porter

Congress has voted on new language that effectively exempts physicians from the Federal Trade Commission's antifraud identity theft regulation known as the "Red Flags" Rule. The Senate passed S. 3987, the Red Flag Program Clarification Act of 2010, on Nov. 30, and the House gave the go-ahead by voice vote on Dec. 7.

President Obama signed the legislation before the Jan. 1 compliance deadline.

The Red Flags Rule, which was drafted in 2008 in connection with the implementation of the Fair and Accurate Credit Transactions Act of 2003, requires financial institutions and creditors, including physician practices, to address the risk of identity theft by implementing identity theft prevention programs.

The Academy had long argued that the rule was an outgrowth of identity theft problems associated with financial institutions and credit card companies and was never intended to

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JANUARY HIGHLIGHTS



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Payment Trends page 3

A new chart compiled by an AAFP member indicates that Medicare payment codes for primary care are trending upward.

Vitamin D Guidelines page 5

The Institute of Medicine has released a report that indicates vitamin D deficiency in the United States may be overestimated.

2010: The Year in Review

To see *AAFP News Now's* complete coverage of the year in review, visit <http://www.aafp.org/news-now>.

Medicare Payment Patch, *continued from page 1*

(payment).” He alluded to a recent AAFP survey that indicates a 25 percent cut in Medicare payments would threaten elderly and disabled patients’ access to needed health care.

Meanwhile, in a statement released by the White House, President Obama said, “For too long, we have confronted this reoccurring problem with temporary fixes and stop-gap measures. It’s time for a permanent solution that seniors and their doctors can depend on, and I look forward to working with Congress to address this matter once and for all in the coming year.”

“I am encouraged by the president’s statement,” Goertz told *AAFP News Now*. “I am also relieved that Congress has recognized the importance of providing some stability for Medicare payment so that we will have time to work together to correct a deeply flawed payment system.”

During the past several months, the AAFP has emerged as a leading proponent of a long-term SGR fix that would eventually lead to a more equitable payment system while providing a payment differential for primary care services. In August, the Academy unveiled a tool kit to help family physicians and their patients generate support for fixing the flawed payment system.

On Dec. 7, the Academy sent an Action Alert to AAFP members urging them to e-mail their congressional representatives to support the one-year payment patch and pave the way for a longer-term SGR fix. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101209finalpatch.html>.

‘Red Flags’ Rule, *continued from page 1*

include America’s physicians. Furthermore, the AAFP maintained that enforcement of the rule would unfairly burden physicians, particularly those working in small and solo practices.

“I am very pleased that the House responded to the Academy’s concerns and voted to join the Senate in modifying the Red Flags Rule,” said AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, in an interview with *AAFP News Now*. “We are committed to providing the best possible care to our patients, and that includes pushing back when unfair regulations diminish the financial resources of physician practices.”

The AAFP helped write a Dec. 6 letter to House Speaker Nancy Pelosi, D-Calif., and House Minority Leader John Boehner, R-Ohio, that urged the House to approve S. 3987 before Congress adjourned for the year.

According to that letter, the

Red Flags Rule defines creditors “as any person that sells a product or service for which the con-

“I am very pleased that the House responded to the Academy’s concerns and voted to join the Senate in modifying the Red Flags Rule.”

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

sumer can pay later.”

“This definition expanded previously accepted definitions and created concern for our organizations,” says the letter. “We urge the House to take immediate action to approve this important legislation, facilitating its enactment into law prior to the Dec. 31 deadline.” The letter was signed by the AAFP and 26 other

national medical and dental associations, including the American Osteopathic Association, the AMA, the American College of Physicians and the National Dental Association.

The Red Flags Rule went into effect on Jan. 1, 2008, but enforcement of the rule was delayed at least five times in an attempt to give entities affected by the rule time to comply. In August 2010, the AAFP joined a group of 26 medical associations that asked to be added as plaintiffs in an existing court case that argued the rule should not apply to physicians.

Congressional action to amend the Red Flags Rule language also could apply to other professional groups, including lawyers, accountants, pharmacists, veterinarians, nurse practitioners and social workers. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101208redflagsexemption.html>.

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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between Nov. 19 and Dec. 10, 2010.

New Pediatric Vaccine Administration Codes Include Counseling Time

The annual revision of the AMA's CPT manual holds some positive changes for family physicians and their pediatric patients. Of particular interest are new CPT codes for reporting administration of vaccines to children.

Specifically, the AMA's *CPT 2011* says that as of Jan. 1, physicians can use CPT codes

- **90460** – for administration of immunizations to children through age 18 via any route of administration, with counseling provided by a physician or other qualified health care professional for the first vaccine or toxoid component; and
- **+90461** – for each addi-

tional vaccine or toxoid component that is listed separately and is in addition to the code for the primary procedure.

CPT defines a "component" as each antigen in a vaccine that prevents disease caused by one organism; combination vaccines contain multiple vaccine components.

Cynthia Hughes, C.P.C., an AAFP coding expert, called the updated codes for pediatric vaccines an encouraging step. She said current code structures promote physician administration of individual vaccines and the reporting of

multiple administration services. "Physicians are simply trying to recover the expenses they



accrue when providing vaccines to patients," said Hughes.

The new pediatric vaccine administration codes take into account the professional time required to counsel parents or

caregivers of children receiving the vaccine. That counseling includes an explanation of each component of a multiple-component vaccine. "The higher payment is intended to cover the cost of the physician's time to do that counseling," said Hughes.

Hughes pointed out that in the case of combination vaccines, the modifier "-51" still is not required. She also assured physicians that the new codes cover vaccines that are administered by injection, orally or intranasally. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101130pedvaccinecodes.html>.

Data Show Upward Trend in Medicare CPT Codes Key to Primary Care *Primary Care Physicians Gained From 2006 to 2011*

By Sheri Porter

During the past six years, Medicare allowances for CPT codes 99213 and 99214 – common codes used by FPs – have seen a cumulative rise of 42 percent and 35 percent, respectively. In real dollars, that means Medicare's allowed amount for CPT code 99213, which was \$52.68 in 2006, will be \$74.85 in 2011, assuming the Medicare conversion factor remains at the 2010 level. Similarly, Medicare's allowance for CPT code 99214, which stood at \$82.62 in 2006, will increase to \$111.36 in 2011, again assuming no change in the conversion factor.

The increase in payment for these two particular CPT codes is critically important to family physicians, according to AAFP Director Thomas Felger, M.D., of Granger, Ind., who adds that payment allowances may vary slightly across the nearly 80 Medicare payment localities because figures have not been geographically adjusted as required by CMS.

"These codes represent basic office visits. It's what we as family physicians do," said Felger, who was the Academy's representative on the AMA's Relative Value Scale Update Committee, also known as the RUC, from 2004-2009 and served on a RUC subcommittee before that.

The RUC is the sole committee that examines the valuation of codes in the Medicare physician fee schedule and makes recommendations to CMS.

For many years, Felger taught physician colleagues the nuances of CPT coding. That background compelled this self-confessed number cruncher to create a chart titled Medicare Physician Fee Schedule:

Conversion Factor	CPT Code	Work RVUs	Practice Expense RVUs	Professional Liability RVUs	Total RVUs	Allowed Payment
2011 – \$36.87*	99213	0.97	0.99	0.07	2.03	\$74.85
	99214	1.50	1.42	0.10	3.02	\$111.36
2006 – \$37.90	99213	0.67	0.69	0.03	1.39	\$52.68
	99214	1.10	1.03	0.05	2.18	\$82.62

	Allowed Payment With 2011 Primary Care Bonus
99213	\$82.43
99214	\$122.49

*The 2011 conversion factor is assumed to be equal to the 2010 conversion factor.

2006-2011 that compares Medicare physician fee schedule allowances for 99213 and 99214 for each year from 2006 through 2011.

"After playing with the numbers, I liked them a lot," said Felger. "The war is not won, but we've succeeded in a darned good forward advance. These little victories add up over time."

Felger pointed out that family physicians take care of a majority of the country's older patients. He estimated that Medicare patients account for 20 percent to 30 percent of the average family physician's patient panel.

"We use 99214 fairly frequently in the Medicare population because those patients often have multiple chronic diseases," said Felger.

"If these payment increases flow over into the private sector – and that's what usually happens – that means family physicians will see better payment across the board for the cognitive work that we're doing," said Felger. ■

For the complete story, visit <http://www.aafp.org/news-now/practice-management/20101201cptcodesrise.html>.

AAFP's METRIC Program Makes Timeline Change *Minimum Implementation Period Now One Month*

A recent modification in the Academy's performance improvement program known as METRIC, or Measuring, Evaluating and Translating Research Into Care, means physician practices will have more flexibility when it comes to implementing practice changes.

On Dec. 3, the required minimum implementation, or "timeout," period for METRIC dropped to one month, a change from the previous three-month minimum implementation time.

The METRIC performance improvement initiative launched in 2005 and offers physicians online learning modules on six clinical topics: asthma, chronic obstructive pulmonary disease, coronary artery disease, depression, diabetes and hypertension. A seventh module aims to improve the care of geriatric patients.

The program combines evidence-based medicine with education, gives physicians the opportunity to evaluate how they manage chronic diseases and then encourages practices to make systematic changes to improve patient outcomes.

Susan Richart, the AAFP's manager of performance assessment and improvement, said the timeline change would help physicians "maximize their flexibility." The pace of practice change differs in each situation, she added.

Much depends on the intervention details, said Richart. "If a practice decides to create a patient registry, it may be three months after implementation of that registry before the practice is able to effectively measure the impact and benefits of that change," she said.

On the other hand, if a practice decides to tweak a flow chart in its electronic health record system to include something relatively simple — such as documentation of foot examinations for patients with diabetes — the practice could assess any increase in the number of foot exams for those patients in as little as one month, said Richart.

There is one caveat to the changes in the METRIC timeout period. Any practice that was engaged in a METRIC module and had electronically "saved" its action plan prior to Dec. 3 should adhere to the previous three-month minimum implementation timeline, said Richart. ■



For the complete story, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20101208metricchange.html>.

Cardiovascular Disease Is Focus of New AAFP Performance Improvement CME Program *\$1 Million GSK Grant Will Fund Inaugural Healthy Communities Collaborative*

Early this year, the AAFP will start rolling out a new performance improvement CME program that will help family physicians enhance the comprehensive care they provide to patients with cardiovascular disease, or CVD. Called the AAFP Healthy Communities Collaborative, or HCC, the Academy is launching the 18-month longitudinal curriculum in collaboration with its Wisconsin and Indiana chapters.

The inaugural AAFP HCC, which is built on the Academy's existing performance improvement CME programs — Measuring, Evaluating and Translating Research Into Care, or METRIC, and the Quality Improvement Practice Enhancement Forum, or PEF — will help 32 family medicine practice teams in Wisconsin and Indiana achieve practice-based improvements aimed at improving cardiovascular care.

The program is being funded through a \$1 million grant from the GlaxoSmithKline, or GSK, Center for Medical Education. The Academy is one of only 20 select CME providers that GSK has said it will continue to support under new criteria announced last year. Of those 20 selected providers, only four, including the AAFP, were awarded grants in the current funding cycle.

According to an executive summary of the program, the AAFP HCC "integrates current best practices in QI (quality improvement), PI (performance improvement) CME and research evaluation to help participants achieve measurable, sustainable improvements in addressing learning needs and practice performance gaps when caring for patients with CVD and related health risk factors and comorbidities."

The program's learning objectives note that family physicians who participate in the AAFP HCC will be better able to

- provide leadership to help their practices cooperate, collaborate, communicate and integrate care in teams to ensure that care for patients with CVD is continuous and reliable;
- apply quality improvement to understand and measure quality of care in terms of structure, process and outcomes in relation to patient and community needs, as well as design and test interventions to change processes and systems of care;
- provide patient-centered care and communication and counsel patients on how to reduce their risk of developing CVD and how to manage related conditions; and
- conduct appropriate screenings on patients with coronary artery disease, or CAD, such as serum cholesterol tests, blood pressure and weight measurement, and provide recommended treatments, such as antiplatelet therapy.

The program will use clinical performance measurement sets developed by the AMA Physician Consortium for Performance Improvement and endorsed by the nonprofit National Committee for Quality Assurance.

The planning and development phase will launch in January with recruitment of physician champions and program coordinators and meetings with program faculty and state chapter leaders. Practice teams and QI coaches are scheduled to be recruited beginning in February. ■

For the complete story, visit <http://www.aafp.org/news-now/cme-lifelong-learning/20101206hcclaunch.html>.



AAFP Healthy Communities Collaborative™
Improving patient health across America

Surgeon General's Report Details How Smoking Harms Body

Benjamin Says Damage From Smoke Immediate

By David Mitchell

It has been more than 45 years since (then) U.S. Surgeon General Luther Terry, M.D., first informed the nation about the dangers of smoking. Twenty-nine more reports from the surgeon general's office on the topic have followed. Most of those documents have focused on the various diseases linked to smoking, but a report released Dec. 9 by current U.S. Surgeon General Regina Benjamin, M.D., M.B.A., stresses that damage from cigarette smoke — including secondhand smoke — is immediate.

"The message from this report for Americans is simple, there is no safe level of exposure to tobacco smoke," said HHS Secretary Kathleen Sebelius during a Dec. 9 news conference to announce publication of *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease*.

The report describes in detail how smoking affects the entire body, and it notes that cigarettes have evolved to become increasingly addictive.

Benjamin, a family physician from Bayou La Batre, Ala., said dur-



ing the news conference that many smokers will need more than one attempt before they are able to successfully quit smoking, and the new data in the report could help cessation efforts.

"We have known that smoking causes a lot of problems, disease and cancer," she said. "We had not known how. I believe it's very important that every American know exactly what's happening with their body, particularly people who are trying to stop smoking. They need to know there is a biological reason it's hard to quit so they don't give up."

Cigarettes contain more than 7,000 chemicals, including hundreds that are hazardous and at least 69 that cause cancer. Benjamin said those chemicals quickly reach a smoker's lungs every time they inhale. Blood then carries the toxins to every organ in the body.

Benjamin said just one cigarette is enough to damage blood vessels throughout the body, making blood more likely to clot. One cigarette — or brief exposure to secondhand smoke — is enough to trigger a heart attack in a person with heart disease, she said.

Benjamin said 70 percent of smokers want to quit, and physicians can play a vital role in helping their patients.

"Patients who have been advised to quit smoking by their doctors have a 66 percent higher rate of success," said Benjamin. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20101210sgsmokingreport.html>.

IOM Updates Guidance on Vitamin D, Calcium

Report Says Deficiency Overestimated Because of Lack of Testing Standards

The number of people in the United States and Canada with vitamin D deficiency may be overestimated because of inconsistent testing methods, according to a report from the Institute of Medicine, or IOM. In fact, the new guidelines say that the majority of people in North America are meeting their needs for vitamin D and calcium.

Steven Clinton, M.D., a member of the IOM committee that reviewed dietary reference intakes for the two nutrients, said during a Nov. 30 news conference that there has been a large and unnecessary increase in the number of tests for vitamin D levels in recent years.

Clinton, a professor of internal medicine at the Ohio State University College of Medicine in Columbus, said vitamin D test-

ing should not be part of routine medical care, and physicians should instead assess individual patients for risk factors.

The committee's report resulted from requests by the U.S. and Canadian governments for the IOM to assess available data on health outcomes related to calcium and vitamin D. The IOM asked the committee to review the evidence and issue updated recommendations for daily intake.

Committee chair A. Catharine Ross, Ph.D., professor and the Dorothy Foehr Huck Chair in the department of nutritional sciences at the College of Health and Human Development at Pennsylvania State University in University Park, said the panel's findings confirmed the benefits of calcium and vitamin D related to bone

health. However, reviews of about two dozen other health outcomes — including cancer, cardiovascular disease, hypertension and diabetes — found insufficient and sometimes conflicting data regarding the nutrients' benefits.

"Although we believe that a role for calcium and vitamin D in other health outcomes should continue to be explored, we could not find solid evidence that consuming more of either nutrient would protect the public from chronic diseases ranging from cancer to diabetes to improved immune function," Ross said.

Despite the committee's findings that the majority of people in North America receive adequate levels of calcium and vitamin D, Ross said supplementation still is appropriate for some groups, including calcium for girls ages

9-18 years and older women.

However, Patsy Brannon, Ph.D., professor in the Division of Nutritional Sciences at Cornell University in Ithaca, N.Y., cautioned that some older Americans are at risk for hypercalcemia because of the misuse of supplements.

Ross said the committee's recommendations are intended for prevention of disease in healthy people. People with chronic conditions should talk to their health care professionals about the levels of vitamin D and calcium they should be receiving, Brannon said. Some chronic conditions, such as kidney disease, affect metabolism of those nutrients. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20101201iomrpt-vitdcal.html>.

CDC Issues Screening, Care Recommendations for Lead Exposure During Pregnancy

By David Mitchell

According to the CDC, about 600,000 American women ages 15-44 have high blood lead levels, putting them and their children at risk for adverse health outcomes.

To address this heightened risk, the CDC has released new guidelines to help physicians identify lead exposure in and manage the care of pregnant and lactating women who have been exposed to the hazardous material.

According to Crystal Cash, M.D., chair of the department of family and community medicine for the Cook County Health and Hospital Systems in Chicago and the AAFP's representative to the CDC workgroup on lead and pregnancy that created the guidelines, the take-home message for physicians is to identify pregnant women who are at risk.

"Providers of care for pregnant women need to be aware that there are certain at-risk populations that need to be screened, especially if

they find that a child in the home has lead poisoning," said Cash, who also is professor of clinical medicine at Loyola University's Stritch School of Medicine in Maywood, Ill. "Then, more than likely, the whole family is at risk for lead exposure."

The following groups are at increased risk for lead exposure, according to the CDC:

- recent immigrants from areas with high lead levels in the environment;
- women who work with lead;
- certain racial and ethnic groups; and
- women who practice pica (i.e., eating nonfood items such as pottery, clay and dirt).

"(Lead exposure) tends to be more of a problem in areas that have heavy immigrant populations," Cash said in an interview with *AAFP News Now*. "If you're in an area that has a large Central and South American population, and you're finding elevated lead (levels) in children, you should be

checking the pregnant women."

Women and children also can be exposed to lead during renovations of older homes.

Mary Jean Brown, R.N., Sc.D., chief of the Healthy Homes and Lead Poisoning and Prevention Branch of the CDC's National Center for Environmental Health, said during an interview on the agency's website that state and local public health officials should identify populations at risk and share that information with physicians to guide them in determining the need for population-based blood lead testing.

The CDC guidelines will be reviewed by the AAFP's Commission on Health of the Public and Science. In 2006, the Academy endorsed the U.S. Preventive Services Task Force, or USPSTF, recommendation against routine screening of pregnant women for elevated blood lead levels. At that time, however, the USPSTF acknowledged that certain groups of women were at



increased risk for lead exposure, including those who

- have a low income,
- live in an urban residence,
- have low educational attainment,
- use ethnic remedies,
- use certain cosmetics,
- have exposure to lead-glazed pottery,
- use alcohol, and
- smoke.

Brown said that physicians and their pregnant patients should discuss each woman's potential for lead exposure. She also said assessment for exposure based on risk-factor questionnaires or blood level testing should take place during a physician's earliest contact with a pregnant woman. ■

For the complete story, visit <http://www.aafp.org/news-now/clinical-care-research/20101208leadguidelines.html>.

In Brief *Health of the Public*

Change in Payment for OTC Drugs Effective Jan. 1

Beginning Jan. 1, 2011, consumers will no longer be able to purchase OTC medications, ranging from pain relievers to cough syrup, with dollars contributed to their flexible spending accounts and health saving accounts unless the medications are prescribed by a health care professional. Insulin is exempt from the new restrictions, which are being enacted in accordance with Section 9003 of the Patient Protection and Affordable Care Act. Ineligible purchases will be subject to a 20 percent penalty tax. <http://www.aafp.org/news-now/news-in-brief/20101208wklynwsbrfs.html>

FDA Warns Makers of Caffeinated Alcoholic Beverages

The FDA has taken action against manufacturers that add caffeine to their alcoholic beverages, warning four companies that their products do not meet legal standards for safety. According to the FDA, the combination of alcohol and caffeine masks the normal signs of intoxication, which could lead to alcohol poisoning, automobile acci-

dents and other risky behaviors. The companies that received warning letters are Charge Beverages Corp., New Century Brewing Co. LLC, Phusion Projects LLC and United Brands Co. Inc. <http://www.aafp.org/news-now/news-in-brief/20101124wklynwsbrfs.html>

ACP Offers Online Diabetes Resources for Physicians, Patients

The American College of Physicians, or ACP, is reminding physicians about its Diabetes Portal, which allows clinicians to access tools and information designed to help health care teams manage the care of patients with diabetes efficiently and effectively. Patients can browse and download educational materials and tools designed specifically to help them and their families manage diabetes. Most of the resources are free, and the information and links are updated regularly to ensure both patients and physicians have access to the latest evidence-based guidance. <http://www.aafp.org/news-now/news-in-brief/20101124wklynwsbrfs.html> ■

CMS Announces New Innovation Center, Multipayer Demonstration Project

Innovation Center 'Integral' in Health Care Transformation, Says AAFP President

By James Arvantes

A new CMS innovation center and a multipayer demonstration project, both of which were called for in the new health care reform law, are expected to promote the patient-centered medical home, or PCMH, model and to lead to better health care outcomes and lower costs in the U.S. health care system.

CMS officially launched the new Center for Medicare and Medicaid Innovation, or CMMI, and the Multi-Payer Advanced Primary Care Practice Demonstration during a Nov. 16 press conference.

The CMMI will be responsible for developing innovative health care and delivery models that will slow the growth of Medicare and Medicaid costs and that will improve quality. In this capacity, the CMMI will test variants of accountable care organizations, PCMH models and payment bundling — all models of care that reward physicians for value rather than volume.

“The formal launch of the Center for Medicare and Medicaid Innovation paves the way for new models of delivering and paying for health care that will have goals of improving quality and safety of care and lowering costs,” said AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, in a press statement.

“The innovation center is integral to ensuring that the transformation of our health care delivery system is based on models that have effec-

tively achieved improved patient outcomes, cost efficiencies and community health,” he added.

The Multi-Payer Advanced Primary Care Practice Demonstration project will involve both the Medicare and Medicaid programs, as well as private insurance plans in Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island and Vermont. The project will evaluate the effectiveness of having physicians and other health care professionals work in a more integrated fashion across the health care system. Health care providers in the demonstration project also will receive coordinated payments from Medicare, Medicaid and private health plans.

The demonstration project is expected to eventually include up to 1,200 medical homes and to serve as many as 1 million Medicare beneficiaries, according to CMS.

“These initial pilot programs will move the nation toward comprehensive, coordinated health care for patients and away from our current fragmented, duplicative and costly sickness care model,” said Goertz. “They emphasize the value of primary care as the keystone to a high quality, efficient health care system.” ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101119innovationcenter.html>.



Manufacturer Removes Propoxyphene Products From Market at FDA's Request

Darvon, Darvocet Linked to Abnormal Heart Rhythms

About 10 million U.S. patients likely will need new prescriptions to treat their mild to moderate pain symptoms after the FDA announced Nov. 19 that two brand-name medications containing propoxyphene are being voluntarily withdrawn from the market because of concerns about their ability to produce potentially serious or even fatal heart rhythm abnormalities.

The opioid — which is manufactured and sold by Xanodyne Pharmaceuticals Inc. as Darvon and, in combination with acetaminophen, as Darvocet — had been on the market since the 1950s.

John Jenkins, M.D., director of the Office of New Drugs in the FDA's Center for Drug Evaluation

and Research, or CDER, said in a Nov. 19 news conference that propoxyphene met FDA standards when it was approved in 1957. However, standards at that time did not include an assessment of a product's effect on the electrical activity of the heart, which now is required of all new drugs.

A citizen petition called for the drug to be removed from the market in January 2009. An FDA advisory committee agreed, voting 14-12 against continued marketing of products containing propoxyphene.

The FDA, however, allowed the drug to stay on the market in a July 2009 ruling that required a new boxed warning be added to the drug's label, as well as devel-

opment of a medication guide for patients explaining the risks associated with the medication.

At that time, Xanodyne also was required to conduct a new safety study to review the drug's effect on the electrical activity of the heart.

According to Jenkins, the results of the recently completed study show that propoxyphene, taken at or slightly above the recommended dose, produces significant changes in the electrical activity of the heart as measured by electrocardiography. The drug significantly increases the QT interval and increases the duration of the PR interval and QRS complex. He said such changes can increase the risk for serious



and even fatal abnormal heart rhythms. ■

For the complete story, visit <http://www.aafp.org/news-now/health-of-the-public/20101122propoxyphenewithdrawn.html>.

Health Care Reform Law Calls for Reassigning Residency Slots to Benefit Primary Care

By Barbara Bein

Part of the focus of the new health care reform law is training more physicians for a revamped, primary care-focused health care system, and one provision of the law could help. It specifies that hospitals' unused graduate medical education, or GME, slots be redistributed to hospitals in regions with health professional shortages that want to expand or establish primary care or general surgery residency programs.

According to Section 5503 of the Patient Protection and Affordable Care Act, if a hospital has residency positions that have

been unfilled for three Medicare cost reporting periods, the hospital will be required to give up a proportion of those positions.

HHS will redistribute those slots — which could number as many as 600, according to one analyst interviewed by *AAFP News Now* — giving preference to hospitals located in states with a low resident physician-to-population ratio or with high numbers of people living in primary care health professional shortage areas, or HPSAs. Preference also will be given to urban hospitals that have accredited rural training tracks and to rural hospitals.

CMS' final rule implementing GME redistribution was published Nov. 24 in the *Federal Register* and took effect Jan. 1.

To receive additional slots, hospitals first must demonstrate that they can fill the additional slots. Then, hospitals will be evaluated according to certain other criteria to determine their priority ranking order to receive the increases.

Analysis by the Council of Academic Family Medicine outlines the preference categories identified by CMS in descending order:

- urban hospitals that have an accredited rural training track;

- hospitals located in states, territories, etc., that have resident physician-to-population ratios in the lowest quartile;

- hospitals located in states, territories, etc., that are among the top 10 in numbers of people living in primary care health professional shortage areas, or HPSAs; and

- hospitals located in rural areas.

Seventy percent of the slots available for redistribution will go to first- and second-level priority category hospitals. A table included in the CMS rule lists, in rank order, the states and the territory in the lowest quartile — namely, Montana, Idaho, Alaska, Wyoming, Nevada, South Dakota, North Dakota, Mississippi, Florida, Puerto Rico, Indiana, Arizona and Georgia.

The remaining 30 percent will be redistributed to third- and fourth-level priority category hospitals. CMS also will give preference to hospitals that will use the additional slots to

- establish a new or expand an existing primary care program that has a demonstrated focus on training residents to pursue true primary care careers;

- establish a new geriatric medicine program or add residents to an existing geriatrics program;

- expand an existing program for which the hospital can demonstrate that more than 50 percent of residents completing it go on to practice in rural areas, primary care HPSAs, or federally designated medically underserved areas; or

- expand an existing emergency medicine program in which residents train in primary care HPSAs. ■

For the complete story, visit

<http://www.aafp.org/news-now/resident-student-focus/>

20101201hcreform-gmeredistrib.html

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State Legislative Conference

FPs Should Get Involved With Implementing Health Care Reform at State Level, Says Former CMS Administrator

By James Arvantes • *New Orleans*

Former CMS Administrator Mark McClellan, M.D., Ph.D., considers the recently passed Patient Protection and Affordable Care Act an opportunity for family physicians to play a major role in implementing health care reform on the state level.



James Arvantes/AAFP News Now
Former CMS Administrator Mark McClellan, M.D., Ph.D., tells attendees at the 2010 AAFP State Legislative Conference that there are opportunities to “make care better and to do it in a way that really reflects primary care and family practice leadership.”

gave the keynote address at the 2010 AAFP State Legislative Conference here on Nov. 13.

“There are some opportunities that we have not had before to make care better and to do it in a way that really reflects primary care and family practice leadership,” said McClellan, director of the Engelberg Center for Health Care Reform and the Leonard D. Schaeffer director’s chair in health policy studies at the Brookings Institution in Washington. “But it is by no means automatic, and it is going to take some very important steps.”

The Patient Protection and Affordable Care Act gives states wide latitude in implementing various provisions of the health care reform law. It provides funding for states to enact the law, and much of the funding is open-ended. This will give states the flexibility

to put in place health insurance exchanges and other provisions of the act in their own way, said McClellan, who served as CMS administrator from 2004-06 and as FDA commissioner from 2002-04.

McClellan identified four key elements of health care reform, including better measurements, payment reform, benefit reform and evidence.

“With better measurements, you can take steps to implement payment reform,” McClellan said. And with better evidence, it is possible to gauge whether health care reforms actually work.

McClellan urged conference participants to think of accountable care organizations, or ACOs, and other proposed models of care as ways of moving from the current fee-for-service system to payments that are aligned with improving care and

reducing costs.

For example, medical homes can provide support and preliminary funding for improving care coordination, one of the tenets of ACOs. McClellan pointed to the Multi-Payer Advanced Primary Care Practice Demonstration recently launched by CMS as an example of demonstration projects that can provide upfront seed money to promote care coordination.

That demonstration involves Medicare, Medicaid and private insurance plans in eight states to evaluate the effectiveness of physicians and other health care professionals working in a more integrated fashion across the system and receiving more coordinated payment from public and private health plans. ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101124statelegmcclellan.html>.

As State Governments Push Ahead With Health Care Reform, FPs Are Poised to Play Major Role

Family physicians are heavily involved in health care reform efforts on the state level, putting them in a strong position as states begin to implement various provisions of the Patient Protection and Affordable Care Act. That was one of the major themes to emerge from the 2010 AAFP State Legislative Conference and a special preconference seminar on states’ roles in implementing health reform held Nov. 12-13 in New Orleans.

Mary Takach, R.N., M.P.H., a program manager for the National Academy of State Health Policy in Portland, Maine, addressed preconference attendees on Nov. 12. She told the audience that she travels throughout the United States as part of her job of advancing patient-centered medical home, or PCMH, initiatives.

“I will tell you that in every state I have traveled to, the state chapter of the Academy of Family Physicians always has been present,” said Takach. “Being there at the table, they provide some of the most valuable insight and some of the most important advocacy that has really propelled state medical home initiatives forward.”

She noted that states are pushing ahead with primary care initia-

tives, a trend that is not likely to abate, regardless of what happens with federal health care reform efforts. “States see the potential to bend (the health care) cost curve with more investments in primary care delivery,” said Takach.

One of the first steps taken by states and other stakeholders is to define medical home criteria to determine who can be a medical home. Although definitions are nonbinding, they drive the entire recognition process, laying out expectations for payers and physicians alike and influencing payment rates for medical homes.

Tkach urged conference attendees to remain active at the state level. “Know what your states are doing around medical home initiatives, know what they are requiring for recognition,” she said. “If you have not aligned your own practices with your state medical home initiatives, you probably want to do that. Your payment, particularly for Medicaid patients, is going to hinge on whether you are recognized.” ■

For the complete story, visit <http://www.aafp.org/news-now/government-medicine/20101201stateleghcreform.html>.

AS WE SEE IT

Voices From the AAFP

Guest Opinion

FamMedPAC is Our Catalyst for Effectiveness in Washington

By Jim King, M.D.

Welcome to 2011 — a year certain to bring opportunities as well as challenges for family medicine’s advocacy effort in Washington. For example, the strong Republican presence in the U.S. Congress will give us an opportunity — finally — for progress on liability reform. The recently enacted Medicare payment patch will give us breathing room to work for a longer-term solution to the sustainable growth rate, or SGR, formula that has plagued us for so long. With some politicians intent on gutting the health reform law, we’ll also have to be vigilant to protect the gains made for primary care in that law.



Jim King, M.D.,
Chair, FamMedPAC
Board of Directors

Fortunately, family medicine will have a seat at the table whenever such issues are discussed, thanks in large part to FamMedPAC, the AAFP’s federal political action committee.

Think of FamMedPAC as a catalyst — something that precipitates change. FamMedPAC boosts the effectiveness of AAFP’s lobbying efforts on the Hill as well as grassroots efforts by individual Academy members who contact their legislators. In Washington, the fact that family medicine has a PAC shows that we’re serious about being involved in the political process — and the more serious you are, the more attention you get. It’s that simple.

How much difference has FamMedPAC made for family medicine? Consider this: In the five years since FamMedPAC was established, Academy representatives in Washington have attended more meetings with congressional and administration leaders, Republican and Democrat, than we did *in the previous 10 years*. That’s an impressive difference.

Success in the 2010 Election Cycle

Donations to FamMedPAC from members like you have fueled this progress. I’m pleased to report that in the 2010 election cycle, in spite of the anemic economy, FamMedPAC received more than \$700,000 in donations from more than 2,000 AAFP members. If you’re one of those family physicians — thank you from the bottom of my heart! With your help, our PAC contributed more than \$675,000 to 146 candidates and committees from both political parties. We even helped a successful candidate retire some of his campaign debt.

Each contribution was presented in a face-to-face meeting with the candidate or at an event attended by AAFP representatives. In many cases, an Academy member met locally with the candidate and presented the FamMedPAC check. This personal contact is a great way to begin or to enhance a relationship with a legislator.

FamMedPAC pools together the donations of many family physicians, so we were able to attend a number of 2010 campaign events that would have been too costly for any one of us to afford. A good example is the

National Republican Congressional Committee event that I attended in my home state of Tennessee. I presented FamMedPAC’s contribution in a room full of Republican leaders who will be key decision makers in Washington this year, as well as some first-time candidates from Tennessee. I talked with several of them about family medicine. Four of those Tennessee candidates won election, and thanks to that event, I’ve already started building relationships with them.

In all, 74 percent of the candidates who received FamMedPAC support won election, a better percentage than those attained by many other PACs in the health care field. Several of the winners are first-timers like the ones from Tennessee. We’re in on the ground floor with them and can educate them about family medicine’s key role in health care and why they should work with us. We’ve positioned ourselves well for working with the new Congress.

Maintaining Our Momentum

Now that the election of 2010 is history, we must turn our attention to the new election cycle that has begun. November 2012 may be months away, but campaigns for congressional seats and the presidency will heat up soon.

We need to be ready to contribute to candidates who are likely to help family medicine and the patients we serve. We also will contribute to both the Republican and the Democratic presidential campaign committees, as we did for the 2008 campaign. Doing so will enable us to have a presence again at the presidential conventions, sharing family medicine’s perspective with the movers and shakers of both political parties.

If you’ve never donated to FamMedPAC, I urge you to begin now. If you have donated in the past, please keep it up. Think of your donation as your political insurance premium. It’s easy to donate online — visit FamMedPAC’s website and click on “Donate Now!” You also can learn more about FamMedPAC at the website, including information on how we choose candidates to support.

Once you’ve donated, wear your FamMedPAC pin and, when your colleagues ask about it, urge them to donate, too. Tell them the specialty needs a well-funded PAC as we go head to head with powerful groups in the next two years — including the trial lawyers, who will be out in force to derail liability reform. Furthermore, a strong FamMedPAC is more important than ever given the recent Supreme Court decision to allow campaign contributions from corporations.

I’ll close with this final thought: If every AAFP member donated just \$100 annually to FamMedPAC, we’d have the largest health care PAC in the nation. Think about how effective we could be if that were our reality. Together, we can make it happen. ■

For the complete story, visit <http://www.aafp.org/news-now/opinion/20110105edtlfammedpac.html>.