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NEWS NOW

July 2010 • Volume 6 • Number 7

the family physician's trusted source for news

Congress Approves Medicare Payment Patch, Provides 2.2 Percent Update

CMS Issues New Guidance to Medicare Contractors

By James Arvantes • Washington

Congress has passed and President Obama has signed a physician payment measure that will rescind a 21.3 percent reduction in the Medicare payment rate and provide a 2.2 percent increase in Medicare payments until Nov. 30.

The Senate passed the payment measure as part of a stand-alone bill on June 18, and the House followed suit on June 24, approving a measure that rescinds the reduction in the Medicare payment rate. That reduction technically went into effect on June 1, but CMS instructed its contractors to hold claims until June 18.

The payment patch will apply retroactively to claims for services provided on or after June 1. The legislation also provides a 2.2 percent update in the Medicare payment rate until Nov. 30, effectively blocking cuts called for by the sustainable growth rate formula for the next five months.

"Although today's vote provides a reprieve from ruinous pay cuts that threaten the financial viability of primary care physicians' practices and — therefore — their patients' access to care, it is not a satisfactory

way to provide long-term stability to Medicare," said AAFP President Lori Heim, M.D., of Vass, N.C., in a prepared statement.

"The stability of federal payment is crucial to the success not just of Medicare but health reform as well," said Heim. "The health reform legislation calls on physicians to invest in changing their practices with health information technology, with new practice models that take

time and money to implement, with new accountability standards and performance measurement reporting."

Physicians, she said, "can't invest in change if they can't count on payment for their services."

CMS released a statement on June 25, saying it has directed "Medicare claims administration contractors to discontinue processing claims at the negative update rates and to temporarily hold all claims for services rendered June 1, 2010, and later, until the new 2.2 percent update rates are tested and loaded into the Medicare contractors' claims processing systems."

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How to Cope With Lower Medicare Payments in Your Practice

By Sheri Porter

As of June 18, CMS began processing Medicare claims with dates of service of June 1 and later with a 21.3 percent physician fee cut.

Although the cut was averted, it is scheduled to take effect again at the end of November. (See related story on this page.)

According to Cynthia Hughes, C.P.C., a coding expert in the Academy's Practice Support Division, physicians must carefully consider the effect Medicare payment cuts — now or in the future — could have on their practice revenue.

Pay cuts affect each physician and each practice differently, said Hughes.

First of all, physicians should keep in mind that private payer plans that base physician payment on the Medicare physician fee schedule usually do not use the current fee schedule, said Hughes. Therefore, revenue from patients on private plans, as well as patients who pay

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The FDA has issued a warning that high doses or long-term use of proton pump inhibitors may increase the risk of bone fractures.



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“Effective testing of the new 2.2 percent update will ensure that claims are correctly paid at the new rates,” CMS said in the statement. “We expect to begin processing claims at the new rates no later than July 1, 2010. Claims for services rendered prior to June 1, 2010, will continue to be processed and paid as usual.”

CMS also said, “Claims containing June 2010 dates of service which have been paid at the negative update rates will be reprocessed as soon as possible.”

Under current law, Medicare payments to physicians and other providers paid under the Medicare physician fee schedule, or MPFS, are based on the lesser of the submitted charge on the claim or the MPFS amount, according to the CMS statement.

Claims containing June dates of service that were submitted with charges greater than or equal to the new 2.2 percent update rate will be automatically reprocessed, CMS said.

Affected physicians who submitted claims containing June dates of service with charges less than the 2.2 percent update amount will need to contact their local Medicare contractor to request an adjustment, according to CMS. Submitted charges on claims cannot be altered without a request from the physician. Physicians should not resubmit claims already submitted to their Medicare contractor, CMS said. ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100625sgrpatch0.html>.

Medicare Payments, *continued from page 1*

out-of-pocket, may not be affected.

Family medicine practices should consider what percentage of their revenue comes from Medicare and TRICARE, a federal health insurance plan that covers U.S. military personnel and their families.

Unfortunately, TRICARE pays at 85 percent of the current Medicare fee schedule, so physicians who have patients with this coverage would see significant decreases in pay, said Hughes.

If just 10 percent of a physician’s patient panel has Medicare coverage, a cut’s effect would be minimal. However “if a family physician specializes in geriatrics, this reduction in pay could have a drastic effect on cash flow,” Hughes said.

Hughes told *AAFP News Now* that physicians might consider implementing some of the following options to help decrease the immediate effect of a pay cut.

- **Limit the number of Medicare and TRICARE patients with nonurgent concerns seen in your practice each week.** Move patients with higher-paying private plans or patients that pay out-of-pocket higher up in the schedule until the payment crisis is resolved.

“Scheduling three patients a day with an ancillary service could generate enough revenue to make up for the Medicare shortfall.”

— Cynthia Hughes, C.P.C., AAFP coding specialist

- **Schedule Medicare patients for preventive services.** Get patients into the office who are due for their routine physical exams for which the patient, not Medicare, picks up the tab. Remember, currently, Medicare only covers a patient’s initial “Welcome to Medicare” physical.
- **Step up the provision of services that provide higher payment.** For example, if a physician’s training in providing endoscopies or cosmetic pro-

cedures is up-to-date, schedule more patients who need or want those services. “Scheduling three patients a day with an ancillary service could generate enough revenue to make up for the Medicare shortfall,” said Hughes.

- **Call families to schedule back-to-school and sports physicals.** Remember,

student athletes need their physicals before they start summer training for fall sports such as football and soccer.

“Physicians need to be creative, and they’re going to have to rely on

their practice managers to help implement some of these things,” said Hughes. She added that if a practice’s profit margins are already razor thin, physicians may have to consider implementing cost-cutting measures — at least in the short term — in addition to seeking extra revenue. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100618physicianoptions.html>.

aafp NEWS NOW

**The Family Physician’s
Trusted Source for News
July 2010
Volume 6 • Number 7**

The official news publication of the American Academy of Family Physicians. Published monthly by the News Department, Communications Division, to keep AAFP members informed. Opinions expressed in *AAFP News Now* do not necessarily reflect the policies of the AAFP.

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Articles in this PDF are excerpted from articles that appeared online in *AAFP News Now* between May 16 and June 28, 2010.

President Obama Calls for Better Payment System for Primary Care Physicians

President Obama has called for changes in the nation's physician payment system to better compensate primary care physicians and thus encourage more medical students to pursue careers in the primary care field.

"This issue of primary care physicians is absolutely critical, and it has the promise of making such a big difference in the overall health of everybody, from children to seniors," said Obama during a June 8 town hall meeting in Wheaton, Md.

"It used to be that most of us had a family doctor," said Obama. "You would consult with that family doctor. They knew your history. They knew your family. They knew your children. They helped deliver babies." Consequently, more people got regular checkups, mak-



Courtesy of the White House

During a town hall meeting for senior citizens in Maryland, President Obama points out that reforming the Medicare payment system to encourage preventive care and to better compensate primary care physicians likely is "the single most important thing that we can do" to ensure good health care.

ing it easier to anticipate medical problems, according to Obama.

"Now in these big medical systems, so often, what happens is that you're shuttled around from (sub)specialist to (sub)specialist," said Obama. "Oftentimes, people don't have a primary care physician that they're comfortable with, so they don't get regular checkups. They don't get regular consultations. Preventable diseases end up being missed, and you don't

have the kind of coordination that's necessary between all these different specialists."

The president told the audience of senior citizens that one of the main goals of the newly enacted health care reform legislation is to increase the number of primary care physicians and to give them more power so that "they are the hub around which a patient-centered medical system exists."

"Sadly, a lot of young medical students, they'd love to go into primary care, but primary care physicians don't get paid as well as (sub)specialists. So, they say to themselves, 'You know what, I don't want to — I've got all these medical school bills that I've got to pay. I've got to become a plastic surgeon or something.'"

The president also assailed the sustainable growth rate, or SGR, formula, saying it is something that has to be fixed. The SGR governs Medicare physician payment rates and regularly calls for a reduction in those rates. Congress recently failed to pass a patch to the system, thus allowing a 21.3 percent reduction called for by the SGR formula to take effect on June 1. (See related story on page 1.)

"What we shouldn't do is have this guillotine hanging over (physicians') heads every year where they're having to figure out, 'Am I going to get reimbursed or is, suddenly, my income going to drop 20 percent?'" said Obama.

It is imperative, he added, "to make sure that your doctor is getting reimbursed so that they can stay in business and keep their doors open." ■

For more information, visit <http://www.aafp.org/news-now/government-medicine/20100609obamasgr.html>.

NCAFP Foundation, NC Blue Cross Blue Shield Foundation Join Forces on Student Interest, Mentoring Program

The North Carolina Academy of Family Physicians, or NCAFP, is teaming up with the Blue Cross and Blue Shield of North Carolina Foundation, or BCBSNC Foundation, to start a mentoring program that aims to encourage more medical students to choose a career in family medicine and to practice in the state.

The BCBSNC Foundation said it is providing a \$1.18 million grant to the NCAFP Foundation to establish the Family Medicine Interest and Scholars Program, a two-tiered effort to increase the number of North Carolina-trained medical students who enter family medicine residency programs and remain in the state to practice. For its part, the NCAFP is providing \$600,000 for the program.

The partnership was announced officially in a June 2 press conference that marked the program's launch.

"This project makes a very loud statement: Primary care is important and family medicine is important," said NCAFP President R.W. "Chip" Watkins, M.D., in his prepared remarks for the press event. "We need to ensure that our state's medical students have every opportunity to learn about our specialty. Through this partnership, we can

make a much greater impact and reach far more medical students than we have in the past."

Brad Wilson, chairman of the BCBSNC Foundation, agreed. "We are already faced with a national shortage of primary care physicians, and the recently passed health care reform legislation will mean an increase in the number of folks seeking care," he said in the announcement.

"We hope that through this initiative, North Carolina medical students will receive the help and incentive they need to make a commitment to family medicine."

The program aims to strengthen relationships between the NCAFP, practicing family physicians, medical school departments and the family medicine interest groups, or FMIGs, at four North Carolina medical schools: the University of North Carolina School of Medicine in Chapel Hill, the Brody School of Medicine at East Carolina University in Greenville, the Wake Forest University School of Medicine in Winston-Salem and the Duke University School of Medicine in Durham. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100602ncafpprogram.html>.

FDA Issues Warning About Proton Pump Inhibitors

The FDA is warning physicians and consumers about a possible increased risk for fractures of the hip, wrist and spine with high doses or long-term use of proton pump inhibitors, or PPIs. The labeling on these products will be changed to describe these risks for both the prescription and OTC product versions, the agency said.

Prescription PPIs reduce the amount of acid in the stomach and are used to treat such conditions as gastroesophageal reflux disease, stomach and small intestine ulcers, and esophagitis.

The FDA said patients should not stop taking the medications unless advised to do so by their physicians. However, the agency also cautioned that OTC PPIs should be used only for 14 days, and no more than three 14-day treatment courses should be used in one year.

In addition, FDA officials advised physicians to follow the dosage recommendations contained in the prescription product labeling and consider whether a lower dosage or shorter duration of PPI therapy would adequately treat a patient's condition.

Patients at risk for osteoporosis should have their bone density status managed according to current clinical practice, and, if indicated, should take vitamin D and calcium supplements, the agency said.

The FDA said its actions were based on a review of seven studies, six of which reported an increased risk of fractures of the hip, wrist and/or spine. The agency's review included one study published May 10 in the *Archives of Internal Medicine* that found that postmenopausal women who used PPIs had a 26 percent increased risk for forearm and wrist fractures, a 47 percent increased risk for spine fractures, and a 25 percent increased risk for total fractures.

An editorial in the same journal noted that PPIs are the third-highest selling class of drugs in the United States, with \$13.9 billion in annual sales. The drugs are overprescribed, the author said, with more than two-thirds of PPI prescriptions written for inappropriate indications. He urged physicians to "offer treatments other than PPIs for functional dyspepsia, prescribe short courses of PPI treatment (after disclosure of possible risks and benefits), and consider a trial of discontinuing PPI therapy in patients who are asymptomatic."

Another study in the same journal issue found that increasing levels of pharmacologic acid suppression are associated with increased risks for nosocomial *Clostridium difficile* infection; the risk was greatest among patients who used PPIs more than once per day. The drugs also are associated with recurrent *C.difficile* infection, according to another study in the same journal. ■

For more information, visit <http://www.aaafp.org/news-now/clinical-care-research/20100601ppiinfraction.html>.

IOM Calls for Heightened Scrutiny of Food, Supplement Health Claims

Report Recommends Increased Authority, Resources for FDA

Health claims made by food and nutritional supplement manufacturers should face the same level of regulatory scrutiny as those made by drug and medical device manufacturers, says a new report from the Institute of Medicine, or IOM.

Food and nutritional supplement marketers often make health claims based on how individual ingredients in their products affect biomarkers (i.e., physiological characteristics that can be measured and evaluated



objectively) such as cholesterol or glucose levels or tumor size. Thus, the manufacturer of a breakfast cereal that contains a cholesterol-lowering ingredient, such as soluble fiber, might boast that its cereal has heart health benefits without clinical proof of improved outcomes.

Faced with a proliferation of health claims being made by food and supplement manufacturers, the FDA's Center for Food Safety and Applied Nutrition asked the IOM in 2008 to recommend a framework for the evaluation of biomarkers. The IOM responded with a 267-page report that recommends the FDA apply the same rigor to evaluating the science behind the health claims of foods and nutritional supplements as it does to assessing new drug applications.

John Ball, M.D., chair of the IOM committee that produced the report and EVP of the American Society for Clinical Pathology, said many consumers assume that the claims made by food and supplement marketers have the same degree of scientific backing as those for medications, but that is not the case. Without changes in the way biomarkers are used and assessed, he said, health care providers, regulators and consumers can't reliably collect or judge information about such claims.

In a preface to the report, Ball said there is neither rationale nor scientific basis for predicating regulatory decisions on different levels of scientific evidence for different substances.

"Science is science," he wrote. "That is, the same level of scientific evidence of benefit and risk should be required of foods as of drugs. Foods are encountered by a greater population than the target group who encounter drugs, and though drugs are subject to professional mediation (e.g., prescription and counseling) foods are not.

"As for risk, no one who is allergic to peanuts, eggs, or shellfish would argue that foods are less risky than drugs." ■

For more information, visit <http://www.aaafp.org/news-now/health-of-the-public/20100609fdbiomarkers.html>.

High Percentage of Docs Use FOBT Inappropriately, Study Finds

By David Mitchell

The majority of primary care physicians who order or perform fecal occult blood tests, or FOBTs, to screen for colorectal cancer fail to follow recommended guidelines for such screenings, according to a study in the *Journal of General Internal Medicine*.

The study, which was sponsored by the National Cancer Institute, the CDC and the Agency for Healthcare Research and Quality, used data from 2006-07. Researchers surveyed more than 1,100 primary care physicians. Of those participants, 25 percent reported using in-office FOBTs exclusively to screen for colorectal cancer, and more than 50 percent reported using both in-office and home tests.

Only 22 percent of respondents used home-based FOBT exclusively for the majority of their

patients, and less than half of those who used home tests had reminder systems to ensure that patients completed and returned the tests.

That's despite the fact that for nearly a decade, the use of serial home-based FOBTs rather than a single in-office FOBT has been recommended by the American Cancer Society, or ACS, for patients who, together with their physicians, decide on annual FOBT as a colorectal cancer screening strategy.

According to a 2003 update of the ACS' guidelines for the early detection of cancer, "FOBT as it is sometimes done in physicians' offices, with the single stool sample collected on the fingertip during a digital rectal examination, is not an adequate substitute for the recommended at-home procedure of collecting two samples from three consecu-

tive specimens."

Even two years earlier, the ACS' guidance on colorectal cancer screening noted that if patients and their physicians chose to screen using annual FOBT, "the recommended take-home multiple sample method should be used."

According to Michael Potter, M.D., a professor in the department of family and community medicine at the University of California, San Francisco, there may be sound clinical reasons to complete an in-office FOBT — such as to evaluate for subacute upper gastrointestinal bleeding — but it should never be used as a method to screen for colorectal cancer.

"Single-sample, in-office guaiac FOBT has an extremely low sensitivity, so a negative test can only provide false reassurance to patients and their physi-

cians," Potter said in an interview with *AAFP News Now*.

"We have had recommendations against in-office FOBT for screening for years now, so it is hard to understand why physicians would use an in-office guaiac test for screening even some of the time," he added.

"Although FOBT is an important option for colorectal cancer screening, our study suggests that its potential to save lives is not currently being realized because many physicians are continuing to use inappropriate implementation methods," the study says.

Colorectal cancer is the third most common cancer diagnosed in the United States and the second leading cause of death from cancer. ■

For more information, visit <http://www.aafp.org/news-now/clinical-care-research/20100525fobt-study.html>.

In Brief *Clinical Update*

FDA Tells Docs to Resume Rotavirus Vaccinations

The FDA has again revised its recommendations for rotavirus vaccines, advising physicians to resume using Rotarix or continue using RotaTeq. In March, the agency called for a temporary halt to the use of Rotarix after DNA from porcine circovirus type 1, or PCV1, was found in the vaccine, which is manufactured by GlaxoSmithKline. Subsequent tests found that DNA from PCV1 and PCV2 were present in Merck and Co.'s RotaTeq vaccine. In a May 14 press release, the FDA said it has found no evidence that PCV1 and PCV2 pose a safety risk to humans. The agency said the known benefits of the vaccines outweigh the risks. <http://www.aafp.org/news-now/clinical-care-research/20100517rotavirus-vacc.html>

Rare Cases of Severe Liver Injury Linked to Orlistat

The FDA has completed its safety review of the weight-loss medication orlistat and has approved a revised label for the prescription version of the medication — which is marketed as Xenical — and a new label warning for the OTC product version, which is mar-

keted as Alli. In a May 26 safety announcement, the agency said it had identified 12 foreign reports of severe liver injury with Xenical and one domestic report of severe liver injury with Alli. Two of the patients died from liver failure, and three required liver transplants. FDA officials said 40 million people worldwide have used the medications. <http://www.aafp.org/news-now/health-of-the-public/20100604orlistatlabel.html>

IV Antibiotics, Antiemetic Recalled Because of Potential Contamination

The FDA is advising physicians not to use certain IV bags of the antibiotics metronidazole and ciprofloxacin and the antiemetic ondansetron because of potential mold contamination. The agency said in a June 1 public health alert that it had received reports of floating matter in intravenous bags manufactured by Claris Lifesciences Ltd. in Ahmedabad, India. In a June 1 news release, Claris said that it was recalling the products as a precautionary measure. <http://www.aafp.org/news-now/health-of-the-public/20100608clarisrecall.html> ■

CDC: One in Five Teens Has Abused Prescription Meds

Twenty percent of U.S. high-school students have taken prescription drugs without a prescription, according to the results of a CDC survey released June 3. A separate report, also issued June 3 by the agency, estimates the direct health care costs of opioid abuse to be more than \$9 billion a year.

"Teens and others have a false assumption that prescription drugs are a safer high," said Grant Baldwin, Ph.D., M.P.H., director of the CDC's Injury Center Division of Unintentional Injury Prevention, in a June 3 media statement. "These data and that from other sources show us that prescription drug misuse is a significant problem in both adolescents and adults."

The 2009 national Youth Risk Behavior Survey, has been conducted every other year since 1991, but this is the first time the survey has included questions about prescription drug use.

The drug poisoning report included recommendations for physicians as well as for private insurance providers, pharmacy benefit managers, and state and federal agencies to aid them in identifying patients who are using opioids for nonmedical uses and notifying prescribing physicians about such patients.

According to the report, there has been a 10-fold increase in the medical use of opioids during the past 15 years as clinicians have become more aggressive in managing patients' pain. During

that time, painkillers have been increasingly associated with non-medical uses and are widely available in illicit markets.

The Drug Abuse Warning Network, or DAWN, which is operated by the Substance Abuse and Mental Health Services Administration, estimates that in 2008, prescription and OTC drugs used nonmedically were involved in roughly the same number of emergency department visits as illicit drugs, with legal and illegal drugs each being linked to about 1 million visits.

Opioids were associated with 306,000 visits, and benzodiazepines were associated with 272,000 visits.

DAWN estimates that people ages 12-20 accounted for 14.5 per-



cent of emergency department visits for nonmedical use of pharmaceuticals in 2008. That figure does not include suicide attempts. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100616cdcdugreports.html>.

Study: Many Physicians Experience Depression During Internship Year

By Barbara Bein

Looking back to 2007, Jennifer Middleton, M.D., M.P.H., a faculty member in a family medicine residency program in Pittsburgh, recalls that a physician who had just graduated from the program and was entering his first year of practice gave few signs that he was going to take his own life. And, she says, an intern at the residency who committed the same act several months later did not show obvious signs of depression.

A recent study suggests, however, that depression is common — at slightly higher than 25 percent — among medical interns and can be linked to multiple factors, including the stresses of the internship experience itself.

According to the study, which was published online April 5 by the *Archives of General Psychiatry*, there is a "marked increase" in symptoms of depression during medical internship, and those symptoms are related to specific individual, internship and genetic factors.

"Internship is known to be a time of high stress," the study says. "New physicians are faced with long work hours, sleep deprivation, loss of autonomy and extreme emotional situations."

For the study, 740 interns entering residency programs in traditional and primary care internal medicine, pediatrics, OB-Gyn, general surgery, and psychiatry were assessed for depressive symptoms using the



nine-item Patient Health Questionnaire, or PHQ-9; various social and psychological factors; and the presence of a particular genotype.

Specifically, researchers sought to examine the interaction of stressors with 5-HTTLPR (serotonin-transporter-linked promoter region), a polymorphic region in the serotonin transporter protein gene SLC6A4 (solute carrier family 6 [neurotransmitter transporter, serotonin], member 4) which has been intensively investigated in depression. Assessments were conducted at baseline (before beginning internship) and at three-month intervals throughout the internship year.

According to the study, the proportion of participants who met PHQ-9 criteria for depression increased from a baseline of 3.9 percent to a mean of 25.7 percent during internship. Almost 42 percent met criteria for major depression at one or more quarterly assessments.

Several factors measured before internship (female gender, U.S. medical education, difficult early family environment, history of major depression, lower baseline depressive symptom score and higher neuroticism) and during internship (long work hours, perceived medical errors and stressful life events) were associated with a greater increase in depressive symptoms. In addition, study participants with at least one copy of a less-transcribed 5-HTTLPR allele reported more depressive symptoms.

The study authors conclude that further research is needed to "more fully explore the consequences of depression among interns, both on patients and the physicians in training themselves." ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100602residcrisis.html>.

Geisinger Health System Reports That PCMH Model Improves Quality, Lowers Costs

By James Arvantes

As pilot projects of the patient-centered medical home, or PCMH, model continue to roll out, some early adopters of the model are beginning to report the results of their PCMH pilots. One such early adopter is Geisinger Health System in Pennsylvania, a physician-led health care system that covers 43 counties. The company recently reported that its investment in the PCMH model has resulted in improved quality, lower costs, and greater physician and patient satisfaction rates.

Geisinger started rolling out the PCMH model in 2007, using it to drive sustained changes in its integrated health care delivery system. The result was the Geisinger ProvenHealth Navigator model, which now encompasses 31 Geisinger primary care practice sites and five non-Geisinger practices.

According to Thomas Graf, M.D., chair of the Geisinger Community Practice Service Line, during the past three years, Geisinger practices testing the Proven-



Health Navigator model saw a 40 percent reduction in hospital 30-day readmissions and a 20 percent reduction in overall hospital admissions when compared to a control group that did not use the system. In addition, the cost of care for patients in the test group was 7 percent less than the cost of care for the patients in the control group, Graf said.

At the same time, said Graf, physician, staff member and patient satisfaction rates among the medical home sites were far greater than the satisfaction rates among the control sites, based on surveys conducted by Geisinger.

"The patient-centered medical home allows you to do primary care the way you would want to do it," said Graf. "From our perspective, it is really the way we do business now. It is about knowing who all of the patients in your entire populations are, where they are, what is going on with them and then being proactive about managing them."

Geisinger has data on 85,000 patients covered by the ProvenHealth Navigator model and, thus, is able to compare cost and quality data for these patients with 150,000 patients who are enrolled in non-medical home practices that contract with the Geisinger Health Plan. The health care system is now in the process of expanding ProvenHealth Navigator to other practices it contracts with, as well as to the remaining six Geisinger practices.

ProvenHealth Navigator "is our way of delivering care going forward," said Graf. ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100526geisinger.html>.

TransforMED National Demonstration Project Finds Most Practices Need Support to Make Changes

By Sheri Porter

The long-awaited analysis of a massive patient-centered medical home, or PCMH, national demonstration project, or NDP, conducted from June 2006 to May 2008 now has been published in a special supplement to the May/June *Annals of Family Medicine*.

The demonstration project, which was designed by TransforMED, a wholly owned subsidiary of the AAFP, tested the ability of family medicine practices to implement and sustain the medical home model of care.

Thirty-six diverse family medicine practices were chosen to participate; however, only 31 completed the project. The practices were split into two groups: one had the benefit of experienced practice facilitators to guide them, and the other, nonfacilitated, group worked through practice changes on their own.

According to a press release from the AAFP, the NDP practice redesign initiative "served as a learning lab to gain better insight into the kinds of hands-on technical support family physicians want and need to implement the PCMH model of care."

The final report on the project, titled "Evaluation of the American Academy of Family Physicians' Patient-Centered Medical Home National Demonstration Project," comprises eight manuscripts written by an independent evaluation team. Topics range from methods for evaluating practice change to implementing the PCMH and assessing patient outcomes.

The two-year project engineered by TransforMED made it clear that "most practices need some level of support to make the necessary changes," said TransforMED's President and CEO Terry McGeeney, M.D., M.B.A.,

One unanticipated finding, said McGeeney, was that patient satisfaction with family medicine practices in the project did not improve, indicating that the disruption trickles down to affect patient perceptions.

The evaluation team's observations echoed McGeeney's, albeit in slightly stronger terms: "The level of change needed is daunting and requires tremendous motivation of all practice participants," wrote the report authors in the summary section.

They noted that although the PCMH "represents the essentials for better primary care," the model is still evolving. In addition, they said, funding from a combination of federal, state and local governments, as well as from insurance companies and other health system sources, is vital to a successful redesign.

"Expecting practices to front the cost of transformation with the hope of more appropriate reimbursement in the future is unlikely to succeed," the evaluators concluded.

"Ultimately, for the PCMH to spread and become the norm, the delivery system must be reformed to support this approach to care." ■



For more information, visit <http://www.aafp.org/news-now/practice-management/20100607tmedndpfindings.html>.

Medicare Enrollment Process Fraught With Opportunities for Missteps

By Sheri Porter

A three-physician, family medicine practice in Lexington, Va., recently found itself with roughly \$40,000 in unpaid Medicare claims — practice revenue that was in limbo because of a cascade of blunders in Medicare's physician enrollment process.

Brenda Harlow, office manager for Lexington Family Practice since 1981 and, thus, no newcomer to the Medicare game, said she'd never seen anything like the mess in which the practice found itself recently.

The nightmare started with the completion of Medicare enrollment forms in January. A series of events, including Medicare contractor mailroom mishaps and a lack of clarity about what information the contractor needed from the practice, stretched on for nearly two months, according to Harlow.

Then the hammer came down. "Payments from Medicare were stopped on March 12," said Harlow. Subsequently, the practice was notified that, as of May 25, all three physicians in the practice could be "barred from Medicare for a year."

Robert Pickral, M.D., has been serving Medicare patients at the Lexington practice since 1981. "What is the message to the physicians of America when this kind of disruption happens?" he asked.

"We operate a small practice in a small community. Revenue is way down, and federal quarterly taxes are due," said Pickral, adding that Medicare patients account for nearly 25 percent of the practice's patient panel.

As of June 2, the practice still had no resolution regarding the Medicare enrollment problems, and it had not received any Medicare payments.

According to Kent Moore, the AAFP's manager of health care financing and delivery systems, there is no way to know for sure how many other Academy members are experiencing similar problems with Medicare. But "I do know that Pickral's practice is not alone," he said.

Medicare's Provider Enrollment, Chain and Ownership System, or PECOS, may be the source of many problems, including those experienced by Pickral's practice, according to Cynthia Hughes, C.P.C., an AAFP coding expert who works with Moore in the AAFP's Practice Support Division.

The Internet-based PECOS was established in 2003, and physicians who have not submitted an enrollment application since it went operational need to re-enroll, said Hughes.

She also cited physician revali-

ation rules laid out in the Medicare Program Integrity Manual. According to the manual, Medicare providers and suppliers "must resubmit and recertify the accuracy of their enrollment information every five years in order to maintain Medicare billing privileges."

Moore recommended that physicians first try to resolve the matter with their local Medicare contractor. If help isn't forthcoming at the contractor level, the next step is a phone call to the practice's CMS regional office. The states covered in each of the 10 regions are listed on CMS' website. According to Moore, "nine times out of 10, the regional office can sort out the problem between the contractor and the physician because the regional office can hold a stick over the contractor." ■

For more information, visit <http://www.aafp.org/news-now/practice-management/20100604medicareenrollment.html>.

In Brief *Government in Medicine*

CMS Clarifies Signature Requirements for Medicare Participating Docs

AAFP's Practice Support Division recently created new content for the coding resources area of the Academy's website in response to CMS' new signature guidelines for physicians and other Medicare providers. The information there spells out CMS directives on such issues as handwritten signatures and acceptable signature formats, valid electronic signatures, attestation statements on unsigned documentation, and signature logs. CMS makes it clear that it will not accept physician signature stamps for Medicare or Medicaid claims. <http://www.aafp.org/news-now/practice-management/20100602signaturereqs.html>

CMS Expands PERM Program Nationwide in 2010

More federal government oversight of the Medicaid program is unfolding as CMS expands its Payment Error Rate Measurement, or PERM, program to all fifty states in 2010. The PERM program looks at how often the payers for Medicaid and the state Children's Health Insurance Program pay correctly and according to program guide-

lines. PERM was implemented in 2006 and, in 2008, began using a 17-state rotation whereby each state and the District of Columbia is reviewed once every three years. States on PERM auditors' radar screens for 2010 are Alabama, California, Colorado, Georgia, Kentucky, Maryland, Massachusetts, Nebraska, New Hampshire, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, Vermont and West Virginia. <http://www.aafp.org/news-now/practice-management/20100615permprogram.html>

Enforcement of 'Red Flags' Rule Stalls Again

The Federal Trade Commission announced May 28 that enforcement of the antifraud identity theft Red Flags Rule would be delayed again — this time through Dec. 31. The delay was requested by members of Congress so they could consider legislation that would affect the scope of entities covered by the rule. The antifraud regulation went into effect on Jan. 1, 2008, with an original compliance date of Nov. 1, 2008. Since that time, enforcement of the rule has stalled several times. <http://www.aafp.org/news-now/practice-management/20100601redflagstalls.html> ■

Needed: Standard Examination Process for Student Athletes

By James Arvantes • Washington

A uniform and consistent method for administering preparticipation medical evaluations for American youth athletes could reduce the chances of injuries and improve the overall quality and safety of student athletics. And a coalition that includes the AAFP is advocating widespread adoption of such a method.

The Preparticipation Physical Evaluation, or PPE, Campaign and Coalition for Youth Sports Health and Safety

urged the sports and medical communities to adopt its updated PPE guide during a press conference here on May 14.

Six organizations, including the AAFP, collaborated on the 180-page PPE monograph, which provides guidance on how to conduct physicals for student athletes. It also provides medical background for decisions by an individual athlete's physician or team physician.

"The CDC estimates that there are more than 2 million injuries among high-school student athletes, more than half of which are probably preventable," said David Bernhardt, M.D., professor of pediatrics



and orthopedics/rehabilitation in the division of sports medicine at the University of Wisconsin School of Medicine and Public Health, Madison, and co-author of the monograph. "This coalition and campaign is committed to making sports even more of a health-enhancing experience ... by addressing the health and well-being of our young athletes before training and competition."

The monograph, which is in its fourth edition, is twice the size of previous editions and places a greater emphasis on conditions that might affect a student athlete's overall health status, such as cardiovascular health, heat and hydration, head injuries, concussions, and asthma. The latest edition also contains more information on women athletes and athletes with special needs.

According to family physician Yvette Rooks, M.D., of Baltimore, vice chair and assistant professor in the University of Maryland Department of Family & Community Medicine, program director of the University of Maryland Medical Center Family Medicine Residency and head team physician for the University of Maryland at College Park, she is "always picking up pre-existing conditions in our athletes who need further work-up."

"If we had an exam coming in or had a proper exam at the high-school level, we could have picked up some of these (conditions) that needed to be evaluated," said Rooks, who spoke at the event. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100525ppesports.html>.

Integrated Curriculum Leads to Student Success on USMLE Step 1

Educators consider medical students' performance on the United States Medical Licensing Examination, or USMLE, Step 1 to be a measure of how well students learned basic science and medical concepts. So, the University of Texas Medical Branch, or UTMB, School of Medicine in Galveston was pleased when failure rates on this critical examination plunged by more than two-thirds after the school implemented comprehensive curriculum changes. An even greater drop in failure rates was seen among underrepresented minorities.

In a paper presented at the recent annual meeting of the American Educational Research Association, UTMB faculty members said the failure rates of students the first time they took the exam declined from 7.5 percent

in the classes matriculating in 1995-97 to 2.3 percent in the classes starting in 2003-05 — a drop of 69 percent.

In addition, mean scores on Step 1 increased by 14 points, with improvements across the entire range of student scores on the Medical College Admission Test, or MCAT, according to faculty members.

The difference, said the educators, was that the 2003-05 classes were exposed to an integrated medical curriculum that emphasized problem-based learning as opposed to traditional rote memorization and lectures.

Lead author Steven Lieberman, M.D., vice dean for academic affairs and a professor of internal medicine at UTMB School of Medicine, told *AAFP News Now* that both admin-

istrators and faculty members were surprised at the enormous improvement after the comprehensive curriculum changes.

Lieberman said that in 1998, the medical school started implementing changes to the curriculum during the program's first two years — the basic science/preclinical years — to modernize the program. The changes were implemented gradually and continue to be fine-tuned, he said.

One central change was a hybrid set of teaching methods that emphasized problem-based learning and active, student-centered learning and inquiry. The methods also highlighted self-direction, applicability of material to students' careers and solving authentic problems.

Tests stressed knowledge integration and the application of

concepts learned to clinical scenarios. Examinations were rewritten in the style of the Step 1 exam so students could gain deliberate practice in taking Step 1.

The school also launched a support system that included peer tutoring and professional academic counseling. Students at high risk for academic difficulty were identified early and offered additional preparation and support.

The increases in mean Step 1 scores are "the largest reported in the literature and are seen across the entire range of MCATs, indicating that our approach benefits students independent of their previous academic performance," Lieberman said. ■

For more information, visit <http://www.aafp.org/news-now/resident-student-focus/20100615utmbcurriculum.html>.

Combined M.D./M.P.H. Programs Get a Thumbs Up

By Barbara Bein

A new four-year doctor of medicine/master of public health, or M.D./M.P.H., program, sponsored by The University of Texas Health Science Center at San Antonio School of Medicine and The University of Texas Health Science Center at Houston School of Public Health, represents a happy marriage of health promotion and disease prevention that enables physicians to care for both individual patients and entire communities, according to family medicine educators. Students in the program say it has given them a broader medical perspective.

The program is described in an article in the April *Texas*

Medicine. The combined, four-year program — one of fewer than 10 in the country — integrates medical and public health training so graduates can address population-based prevention and wellness issues more effectively, including such societal problems as obesity, diabetes, substance abuse and health disparities.

“In medically underserved regions like South Texas, in the face of rising national and local public health and prevention-oriented physicians are needed urgently,” the article’s authors say. “A definite need exists for a four-year integrated dual-degree M.D./M.P.H. curriculum to close

the training gap between medicine and public health.”

One of the authors, Sharon Cooper, Ph.D., professor and regional dean of the University of Texas-Houston School of Public Health, San Antonio Regional Campus, told *AAFP News Now* that administrators do not know which specialties or subspecialties the 65 students in the new dual degree program — which started in 2007-08 — eventually will choose.

A fourth class of students has just been admitted, so it is too early to have data on whether the dual program is a good strategy for growing primary care physicians, she said. However, Cooper said the department of family and com-

munity medicine in the San Antonio medical school has a “clear public health orientation,” with the largest concentration of faculty having these dual degrees. ■

For more information, visit <http://www.aaafp.org/news-now/resident-student-focus/20100519md-mph.html>.

TransformMED Rolls Out New Product

TransformMED, a wholly owned subsidiary of the AAFP, has launched a new service to help small primary care practices implement the patient-center medical home, or PCMH, model of care.

TransformMED’s Small Practice Package program bundles together the necessary tools and components and streamlines the process to enable practices with four or fewer physicians to implement the components of the TransformMED PCMH model in two years.

Elements of the new program that are available to each participating practice include a

- medical home assessment to help identify practice expectations, define processes and understand objectives;
- gap analysis to evaluate a practice’s current situation and PCMH opportunities;
- comprehensive transformation plan that will prioritize goals and set timelines; and
- dedicated TransformMED facilitator.

The package is available to practices for \$1,250 per quarter for virtual online support or \$2,500 per quarter for practices that choose TransformMED’s on-site option. Practices must commit to a two-year program enrollment. ■

For more information, visit <http://www.aaafp.org/news-now/practice-management/20100526t4mpcmhproduct.html>.

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Degree of Fellow

AMA Delegates Back New Medicare Payment Option

By Barbara Bein

In response to concerns about patients' access to care, the AMA will draft legislation that calls for an additional payment option in Medicare fee-for-service that allows patients and physicians to contract for fees different from those included in the Medicare physician payment schedule. The legislative draft will be available by Sept. 30.

That is the gist of a substitute resolution adopted by delegates who attended the 2010 annual meeting of the AMA House of Delegates, June 12-16 in Chicago.

The substitute resolution offered by the AMA's reference committee on legislation combined several measures that, among other things,

- criticized Medicare's continuing use of the sustainable growth rate, or SGR, formula to set physician payment rates;
- pointed out that implementation of the annual negative payment updates mandated by the SGR formula repeatedly has been postponed by the U.S. Congress "specifically to maintain access to physician services for America's seniors and others through Medicare Part B";
- decried the fact that Congress has failed to provide a permanent replacement for the SGR formula;
- denounced the fact that Medicare restrictions on balance bill-

ing "reduce compensation to primary care physicians and discourage young physicians from entering the primary care specialties"; and

- deplored Medicare's policy of total nonpayment of claims by Medicare enrollees who receive care under private contract with a physician.

AAFP President Lori Heim, M.D., of Vass, N.C., testified about one of the original measures during a June 13 hearing of the legislation reference committee.

In a subsequent interview with *AAFP News Now*, she said, "The ability of patients to be able to negotiate with a physician who has 'opted out' of the Medicare program — but not give up their benefits — is a critical component. The final resolution acknowledged the needs of the patients and the physicians."

Heim added that "this is a very important issue for our members: the ability to negotiate with the patient directly. This is especially important in light of the failure to resolve the SGR. More and more physicians are looking at whether they can financially afford to remain a Medicare provider because of the instability of the system." ■

For more information, visit <http://www.aafp.org/news-now/professional-issues/20100618ama-medicare.html>.

AMA Delegates Call for Changes to Government Guideline Panels

USPSTF Breast Cancer Screening Recommendations Generate Lengthy Debate

By David Mitchell

Delegates to the 2010 annual meeting of the AMA House of Delegates in Chicago adopted a measure on June 15 that directs the AMA to "encourage government panels and task forces dealing with specific disease entities to have representation by physicians with expertise in those diseases."

A second part of the same resolution, calling specifically for physicians to follow the American Cancer Society's guidelines for breast cancer screening, was referred to the AMA Board of Trustees.

The resolution was introduced by the Illinois delegation to the AMA in response to controversial screening guidelines released by the U.S. Preventive Services Task Force, or USPSTF, in November 2009.

The USPSTF's updated guidelines recommend against routine screening mammogra-

phy for women ages 40-49 who aren't at increased risk for breast cancer. That change was made as a level C recommendation, which means that although the task force recommends against routinely providing the service and there is at least moderate certainty that the net benefit is small, there may be considerations that support providing it in an individual patient.

The task force said in its explanation of the revised recommendations that it encourages individualized, informed decision-making about when to start mammography screening and that the decision should take into account patient context, including the patient's values regarding benefits and harms.

The USPSTF also recommended a switch from annual to biennial screening mammography in women ages 50-74, with the

intent of reducing the potential harms of screening.

Critics have blasted the task force's recommendations, however, with some fearing the changes might prompt payers to reject coverage for annual screening or for screening women younger than 50. Others have pointed out that the USPSTF comprises primary care physicians, epidemiologists and public health experts, but does not include subspecialist physicians.

The Illinois resolution, in fact, referred to the task force as being made up of "public health academics and medical statisticians, with no representation by physicians involved in the diagnosis or treatment of breast cancer."

AAFP president-elect Roland Goertz, M.D., M.B.A., of Waco, Texas, subsequently told *AAFP News Now* that primary care physi-



cians are well suited for such independent expert panels because they don't have the biases or special interests of a surgeon or radiologist. He said it was unfortunate that both resolves were not referred for additional study. ■

For more information, visit <http://www.aafp.org/news-now/health-of-the-public/20100618ama-publichealth.html>.

AS WE SEE IT

Voices From the AAFP

Editorial

AAFP's Health Care Reform Coverage Statistics Are Impressive

As the dust settles after the nation's protracted battle over health care reform, AAFP members should be pleased to learn just how effective the Academy was in getting its health reform messages out to stakeholders during that battle.

And that effectiveness is chronicled in a new report prepared by staff members in the AAFP's Public Relations Department for the AAFP Board of Directors.

The report describes the Academy's contributions to external media coverage of health

care reform since President Obama took office in February 2009 through April 1 of this year.

It focuses on consumer, business and health care decision-maker media outlets in the "top 100" U.S. media markets and the medical trade media. The report shows that AAFP leaders spoke out strongly and often regarding the importance of health care for all and the urgent need for payment reform and more family physicians, who are the bedrock of a reformed health care system.

According to the report, the AAFP contributed significantly to

829 news pieces in 361 media outlets in the top 100 markets. The AAFP provided Academy leaders for the outlets to interview, coordinated the interviews, and provided extensive background information to media outlets, such as CNN Newsroom, "FOX Business News," Politico, USA Today, The Washington Post, and "CBS Evening News."

The Academy also reached out to media markets outside the top 100 and racked up an additional 627 instances of health care reform coverage in 139 media outlets — for an overall total of 1,456 news pieces in 500 outlets during the time period.

These statistics are, in a word, impressive. They also demonstrate the Academy's commitment to speaking out on issues that family physicians say are important to them. In fact, in the last AAFP Member Satisfaction Survey, respondents said that advocacy should be the AAFP's top strategic objective, and that payment reform, universal coverage and workforce issues should be the AAFP's top three priorities. This was exactly what the AAFP's external media effort was all about. ■

For more information, visit <http://www.aafp.org/news-now/opinion/20100622coveragstats.html>.



Editorial

Well-read and Relevant for 60 Years and Counting

It's not just another stuffy research journal, and it's been that way for 60 years. "It" is *American Family Physician*, the Academy's clinical journal, which is celebrating its 60th anniversary in 2010. You probably don't give it a second thought each time you pick up *AFP* or access it online, but back in 1950, when *GP* (which became *AFP*) made its debut, there was nothing else like it for America's general practitioners.

The journal's founding publisher, Mac Cahal, who also was the Academy's first executive director, once said that his biggest contribution to the Academy was "to give prestige and dignity to the general practitioners. They had been discriminated against for years, and were considered nobodies among medical organizations." He gave them a lively, practical, relevant clinical journal to call their own, one that pioneered the use of color among medical publications.

In the years since its founding, *AFP* has grown and developed alongside the specialty of family medicine, and it's become a mainstay for family physicians nationwide.

Currently, nearly 175,000 family physicians and other primary care clinicians receive the print version of *AFP*. Most AAFP members receive it free, and it's also mailed free to many general internists and osteopathic physicians. When it comes to journal circulation numbers among

primary care clinicians, *AFP* is number three in the United States, behind only the *Journal of the American Medical Association* and the *New England Journal of Medicine*.

But when it comes to readership, *AFP* emerges as number one among family physicians. Surveys have shown that *AFP* is the family physician's favorite clinical journal and that it has more "high readers" (i.e., those who thoroughly read a majority of issues) than any other journal.

When it comes to quality and relevance, *AFP* scores again. In one AAFP survey, *AFP* was rated with the highest overall quality of the journals presented, including *JAMA* and *NEJM*. Furthermore, 98 percent of survey respondents said they glean at least one idea they can use in their practice in a typical issue of *AFP*.

So the next time your issue of *AFP* arrives, pause and reflect on the way it helps you provide the best possible care for your patients. If you have suggestions for how *AFP* could do an even better job, share your thoughts. *AFP* is planning significant changes and additions during the next several years, and your input counts. After all, it's your journal. ■

For more information, visit <http://www.aafp.org/news-now/opinion/20100615afpanniversary.html>.