Regulatory Report

As of November 9, 2011

Congress passed the *Affordable Care Act* (*ACA*) in March of 2010 and now the Administration is busy publishing federal regulations and issuing formal guidance to implement this substantial new law. Some *ACA* provisions take effect immediately, but most provisions become effective in several years and will therefore be subject to further regulatory rule-making. In addition to the *ACA*, the Department of Health & Human Services (HHS) must simultaneously put into practice the electronic health record (EHR) incentive program established in the *American Reinvestment & Recovery Act* (ARRA) and the Centers for Medicare & Medicaid Services (CMS) must annually revise payment policies in the Medicare physician fee schedule.

Recently Released Regulations:

1. On November 1, CMS released the final 2012 Medicare Physician Fee Schedule. CMS projects that total payments made under the 2012 fee schedule will approximately be $80 billion. In the final rule, CMS updated their estimate for the conversion factor at $24.6712 which represents a decrease of 27.4 percent. In a statement issued when the final fee schedule was released, the AAFP continued to call on the Joint Select Committee on Deficit Reduction and the Congress as a whole to stabilize Medicare payments to physicians by repealing the flawed SGR formula and specify a payment rate for the next three to five years while demonstration programs generate data to determine the best payment method. To begin closing the gaping disparity between primary care and subspecialist services, the AAFP strongly recommends that the committee stipulate at least a 3 percent higher rate for primary care physicians. On November 7, the AAFP released a summary of the final 2012 Medicare Physician Fee Schedule.
2. CMS released the final Medicare ACO regulation on October 20. AAFP prepared a summary for members.
3. On October 18, as part of the Administration's effort to reduce unnecessary regulations, HHS released two proposed regulations designed to reduce procedural burdens on physicians and hospitals. The proposed update to the Medicare and Medicaid Hospital and Critical Access Hospital conditions of participation changes hospitals' medical staffing policies, reforms policy surrounding patient-administered drugs, and eases verbal order requirements. They also proposed the *Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction* regulation. It makes improvements to the Medicare physician enrollment process, updates e-prescribing technical requirements for Medicare Prescription Drug Plans, and revises qualifications to be a physical or occupational therapist. CMS says the efforts aim to promote efficiency and transparency, and reduce health care providers' overall regulatory burden. The agency estimates the three rules will save $5 billion over five years. The AAFP will provide formal comments on the proposals by the mid-December due date.
4. On October 14, the Centers for Medicare & Medicaid Services (CMS) finalized two new national coverage determinations that cover alcohol misuse screening and behavioral counseling for Medicare beneficiaries as well as screening for depression. In August, the AAFP sent letters supporting these proposals.
5. On October 3, CMS released the *Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2013*. In addition to implementing provisions called for in the *Affordable Care Act*, of particular interest to physicians, the proposed rule allows physicians to request reconsiderations on their patient's behalf without obtaining a signed authorized representative form, enables prescribers to order trial fills for initial prescriptions and requires

prescription drug plans to submit prescription drug event (PDE) records to include prescribers' National Provider Identifiers (NPIs).

In 2011, the Academy:

1. In a letter sent November 9, the AAFP commented on the proposed *CLIA program and HIPAA privacy rule; Patients' access to test reports* regulation. If finalized in its current form, it requires clinical laboratories to release laboratory test results, including results in electronic form, to patients. Despite a concern over possible instances in which a patient is not able to comprehend the test reports, the AAFP supported this proposal since patients should have the right to access their personal health information and doing so is more patient-centered as it increases the patient's level of engagement.
2. In a letter sent October 21 to the Departments of HHS, Labor, and Treasury, the AAFP commented on a proposed regulation that creates a universal Summary of Benefits and Coverage (SBC) template and a standard glossary of healthcare terms. In the response, the AAFP recognizes that the Departments are trying to use healthcare terms that are easily understood, but we object to their proposed definitions of "primary care physician" and "primary care provider".
3. In a comment letter sent to CMS on September 28, the AAFP responded to the proposed regulation entitled, *Establishment of Exchanges and Qualified Health Plans*. The AAFP response, based on the Family Medicine Principles for State Health Insurance Exchanges, expressed support overall for the exchanges as a way to improve patient access to affordable insurance. In the response, the AAFP committed to reviewing and commenting on the HHS draft template that will, once released, outline the required components of an exchange. The AAFP urged inclusion of primary care physicians and discussed the role of the patient-centered medical home model as one that improves quality while helping to restrain costs. The AAFP also participated in a separate coalition letter sent October 31.
4. In a letter sent September 22 to the U.S. Trade Representative, the AAFP urged exclusion of tobacco products from negotiations on the Trans Pacific Partnership Trade Agreement.
5. The AAFP sent the Office of the National Coordinator for Health Information Technology, an office within the U.S. Department of Health & Human Services, a comment letter on Wednesday, September 21 in response to a proposed rule on the creation of metadata standards (privacy, patient identity, and provenance) for health information exchange. The AAFP expressed concerns with the proposals and offered suggestions on how to create an interoperable infrastructure that is needed to support health information exchange in the clinical environment.
6. The AAFP sent a response letter to CMS on September 28 supporting a CMS proposal to cover intensive behavioral therapy for obesity. Since obesity is a complex condition usually involving comorbidity, the AAFP expressed hesitation over an arbitrary weight loss requirement of 3kg in order for CMS to continue coverage after an initial 6 months.
7. In June 2010, the AAFP participated with several other organizations regarding the coalition's support for permitting states to obtain federal Medicaid funds for tobacco cessation quit-lines. In a coalition letter sent September 27 to the CMS Director of Medicaid and Children's Health Insurance Program, the AAFP and other organizations expressed support over a change in Medicaid policy to now allow as a Medicaid administrative cost expenditure tobacco cessation quit-line services for Medicaid beneficiaries and for expanding tobacco cessation services for pregnant women on Medicaid.
8. In a comment letter sent September 15 to the Centers for Medicare & Medicaid Services (CMS), the AAFP responded to the proposed regulation entitled, "Establishment of Consumer Operated and Oriented Plan (CO-OP) Program." The intent of the CO–OP program is to provide loans to foster the creation of consumer-governed, private, nonprofit health insurance issuers to offer qualified health plans in the Affordable Insurance Exchanges. The AAFP was supportive of the CMS proposal but urged further consideration and inclusion of patient-centered medical home concepts when evaluating CO-OP grants and applications. The AAFP also urged CMS to work further with the Federal Trade Commission to develop "safe-harbors" for the CO-OP program, similar to efforts underway for the Medicare Accountable Care Organization program. The AAFP concluded by urging that CO-OP boards

must utilize primary care physicians in top leadership positions. AAFP staff created a summary of the proposed CO-OP regulation when it was released earlier this year.

9. In a coalition letter sent September 7 to members of the U.S. House of Representatives that support the *Traditional Cigar Manufacturing and Small Business Jobs Preservation Act* (HR 1639), the AAFP and others strongly opposed this legislation which, if signed into law, would remove the Food and Drug Administration's (FDA) authority to regulate many cigars. The FDA received authority to regulate tobacco products when the *Family Smoking Prevention and Tobacco Control Act* was signed into law on June 22, 2009.
10. On August 31, the AAFP sent CMS a letter responding to the adoption of operating rules for eligibility for a health plan and health care claim status transactions.
11. Provided extensive recommendations in a letter sent August 29 to CMS regarding the 2012 proposed Medicare physician fee schedule. In addition to commenting on other topics, the AAFP urged CMS to establish a more timely review of misvalued services and indicated that it would not be productive to ask the Relative Value Scale Update Committee's (RUC) to revalue evaluation and management services under the same structure, procedures, and methodology that it used to establish the current values.
12. Strongly supported two proposed Medicare coverage decision memos in separate letters dated August 18. In one letter, the AAFP supported the CMS proposal to cover annual screenings for depression for Medicare beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up. The AAFP also supported CMS's proposal to begin coverage for screening and behavioral counseling for alcohol misuse.
13. Supported CMS's proposal to retract a policy requiring the signature of a physician or qualified non-physician practitioner on a requisition for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule in a comment letter sent August 18. In 2010, the AAFP had urged CMS not to impose this policy, which went into effect in 2011. In a proposed regulation released in June 2011, CMS discussed that when, "developing educational and outreach materials, we realized how difficult and burdensome the actual implementation of this policy was for physicians and NPPs and that, in some cases, the implementation of this policy could have a negative impact on patient care."
14. Commented with other national and state physician organizations in a joint letter sent August 8 to CMS that several critical issues must be resolved regarding the proposed Availability of Medicare Data for Performance Measurement regulation.
15. Participated with 19 other national physician organizations in a coalition letter sent August 1 to HHS's Office of Civil Rights (OCR) in response to the proposed rule on HIPAA privacy regulations. If the regulation is finalized in its proposed form, electronic health records must be capable of producing a report, upon patient request, that contains information on when a patient's personal health information was accessed over a three year period. The comment letter urged OCR to withdraw the access report requirement and to significantly modify the proposed accounting of disclosures report.
16. With presidents of the organizations that make up the Council of Academic Family Medicine (CAFM), sent CMS a letter on July 26 requesting CMS immediately withdraw or revise problematic language contained in a CMS transmittal. With no notice, CMS changed the requirements for the primary care exception to the teaching physician rule. Historically, the rule has been that teaching physicians (preceptors) could not bill under the primary care exception for visits performed by PG1's in their first six months, unless the teaching physician was present for the key portion of the service. A ratio of one preceptor to no more than four residents was required, with the preceptor having no other duties during that time. The new language still requires one preceptor for 4 residents, but if more than one of the four is a PG1, then an additional preceptor now would be required.
17. Responded to the CMS proposed Five-Year Review of Work Relative Value Units (RVUs) in a letter sent July 25. The AAFP supported the CMS proposal to follow the RUC's recommendations to increase the work value for nursing facility discharge day services and supported the CMS proposal to publish the RVUs for preventive medicine services codes. However, the AAFP expressed extreme

disappointment that CMS maintained the work RVU values for observation care codes since the RUC had recommended increases to most of these codes.

18. Responded to CMS's proposed Changes to the Electronic Prescribing Incentive Program in a July 18 comment letter. The AAFP expressed appreciation that CMS recognized the need to permit additional significant hardship exemption categories in 2011 to help more physicians avoid the 2012 electronic prescribing penalty. In addition, the AAFP supported the provision that would offer an extended timeframe for physicians to request a hardship exemption. The AAFP concurred with a proposal to better align electronic prescribing requirements with the Medicare and Medicaid Electronic Health Record Incentive programs as well as with Medicare Part D standards. In addition to the July 18 comment letter, the AAFP joined other national and state physician organizations in a July 25 letter responding to the same regulation.
19. Submitted comments on July 5 to CMS regarding a proposed rule to bring greater transparency to the process that states use to set Medicaid payment rates. The AAFP voiced its support for the spirit of the proposal and suggested several criteria that may be most helpful in achieving the rule's goals. Additionally, the AAFP urged CMS to require states to notify the public of all Medicaid rate changes, as opposed to only nebulously defined "significant" changes, and also allow physicians and beneficiaries to provide states with feedback. The AAFP also joined the American Academy of Pediatrics, the American Medical Association (AMA) and other national and local organizations in a related letter dated June 20 and a separate coalition letter dated July 5.
20. Nominated Dr. Laura Pickler on June 28 to serve on the Agency for Healthcare Research and Quality (AHRQ) Children's Health Insurance Program Reauthorization Act (CHIPRA) Pediatric Quality Measures Program expert panel.
21. Responded in a letter sent June 29 to a request for comment on HHS's Preliminary Plan for Retrospective Review of Existing Rules. This is in accordance with Executive Order 13563 issued on January 18, 2011. In the letter, the AAFP expressed appreciation that the White House and HHS recognize the importance of a more streamlined, effective, and efficient regulatory framework. The letter then pointed out that regulations are prone to unintended consequences, many of which place unfunded financial mandates on physicians such as costs of providing translators for Medicare and Medicaid patients, time wasted on Part C and Part D prior authorization paperwork, overlapping documentation and certification requirements, convoluted quality and health information technology incentive programs, inconsistent claims review processes by CMS contractors, and the need to reevaluate the Medicare enrollment process and physician signature requirements.
22. Joined with other national and state organizations representing healthcare consumers, providers, employers and unions in a letter sent June 28 to the National Association of Insurance Commissioners to express concern over proposed methods to weaken the minimum medical-loss ratio (MLR) provisions of the *ACA*.
23. Commented in a letter sent June 23 on the Institute of Medicine's (IOM) proposed continuous assessment and improvement study. The AAFP commended the IOM's proposal as representing the noble cause of improving the quality of healthcare, then offered detailed recommendations on certain aspects, such as the measurement, training, potential barriers, and timeline, of their plan.
24. Sent a letter dated June 23 to CMS's Innovation Center urging the elimination of the 72-hour hospitalization requirement prior to skilled nursing home placement for Medicare beneficiaries. The AAFP stated that the hospitalization requirement for Medicare beneficiaries wastes valuable resources and that the AAFP believes this arbitrary waiting period is not in the best interest of the beneficiary's medical needs, nor is it in alignment with CMS's goal to reduce avoidable hospitalizations. This letter stems from Resolution #511 adopted by the 2010 Congress of Delegates.
25. Encouraged CMS to reevaluate its Medicare signature requirements in a letter sent June 23. The AAFP stated that the current signature requirements place an overwhelming compliance burden on physicians, are unnecessarily time-consuming for physicians and their practice support staff, and that CMS should develop a comprehensive yet understandable policy. This letter stems from Resolution #311 adopted by the 2010 Congress of Delegates.

26. Responded to a proposed Influenza Vaccination Standard for Certain Participating Providers and Suppliers regulation in a June 20 letter to CMS. This proposed regulation requires certain Medicare and Medicaid providers and suppliers to offer all patients an annual influenza vaccination, unless it is medically contraindicated or the patient or patient's surrogate declined. The AAFP concurred with the overall intent of the regulation, but urged CMS to include in the final rule a requirement that immunizations made outside of the primary care physicians' office should be, to the greatest extent possible, electronically communicated back to that physician.
27. In partnership with other national and local public health organizations, sent a comment letter dated June 16 commending the release of the National Prevention Strategy.
28. Joined with presidents from the Society of Teachers of Family Medicine, the Association of Family Medicine, the Association of Family Medicine Residency Directors, and the North American Primary Care Research Group in a June 6 comment letter submitted to CMS on the proposed Medicare Accountable Care Organization (ACO) regulation. The letter discussed concerns that the proposed Medicare ACO regulation could have significant negative effect on the Graduate Medical Education (GME) training infrastructure.
29. In a June 6 letter to the HHS's National Vaccine Program Office, commented on the Vaccine Safety Working Group's draft white paper on the federal vaccine safety system.
30. In a May 25 letter, responded to the Federal Trade Commission (FTC) and Department of Justice on the proposed antitrust enforcement policy regarding the Medicare ACO program. This letter outlines concerns with antitrust barriers to physician collaboration and encourages FTC efforts that enable primary care physicians to contract with all insurers on level playing fields. The letter also expresses concern that the revised policy only applies to groups integrating after March 23, 2010 and that the "rule of reason" analysis applies only to the three-year Medicare ACO program period instead of a longer timeframe.
31. In a May 20 letter to CMS, offered extensive comments on the proposed Medicare ACO program, emphasizing the important role that primary care physician practices should play, and describing how the proposed regulations should be changed to enable that to happen. The AAFP also created a summary of the proposed rule.
32. Commented in a March 30 letter to CMS on a new requirement that certain Medicare providers give beneficiaries with information about their right to file a written complaint with the state Quality Improvement Organizations and right to access state survey agencies.
33. In a March 16 letter to CMS commented on a proposed rule that, beginning July 1, prohibits federal payments to state Medicaid programs for "healthcare acquired conditions". Though the AAFP supports efforts to eliminate both "never events" and healthcare acquired conditions, the letter pointed out that little evidence links payment denial with improved outcomes.
34. Responded in a March 14 letter to the Joint Commission on their proposed new Primary Care Home standards. The AAFP commented by comparing their criteria with the recently published "Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs" developed by the AAFP, the American College of Physicians, American Academy of Pediatrics, and the American Osteopathic Association.
35. On March 12, joined with several other national healthcare and consumer organizations in a letter to CMS requesting the agency postpone enforcement until July 1 before the agency begins enforcement of a revised documentation requirement that physicians must see patients "face to face" to certify those patients need home healthcare. On March 31, CMS responded and indicated they will enforce this deadline on April 1 and that they will monitor for problems and unintended consequences.
36. In a March 3 letter to HHS, provided comments on the CO-OP program. In the letter, the AAFP strongly urged HHS to fully incorporate the patient centered medical home concept into the CO-OP program.
37. In a March 1 letter to the Comptroller General of the Government Accountability Office (GAO), nominated Rick Kellerman, MD, FAAFP to serve on the Medicare Payment Advisory Commission.
38. In a February 23 letter to the AHRQ, provided comments to specific quality measures proposed for use in the Initial Core Set of Health Quality Measures for Medicaid- Eligible Adults regulation.

39. Sent the CMS a letter on February 23 regarding the development of a Recovery Audit Contractor (RACs) program for the Medicare Part C (Medicare Advantage) and Part D (Prescription Drug Plan) programs.
40. Joined with 20 national organizations and 5 representative members of the National Association of Insurance Commissioners in a February 22 letter to the CMS's Center for Consumer Information & Insurance Oversight in response to the proposed rate increase disclosure and review regulation.
41. On February 21, sent HHS's Office of Inspector General (OIG) a comment letter in response to the solicitation of new safe harbors and special fraud alerts.
42. Sent a letter dated February 17 to the IOM's Committee on Patient Safety and Health Information Technology in response to their consensus study regarding experiences with health information technology.
43. Sent a letter on February 16 to the Employee Benefits Security Administration, CMS's Center for Consumer Information & Insurance Oversight, and the Internal Revenue Service regarding value-based insurance design in connection with preventive care.
44. Sent CMS a letter on January 19 offering suggestions to evolve the problematic Physician Quality Reporting System (PQRS). The AAFP urged CMS to improve access to the PQRS feedback reports, to phase out the claims-based reporting option, to offer EHR-based reporting options for both full and half year reporting periods and to increase alignment between the PQRS and the Electronic Health Record Incentive Program.
45. Sent HHS's Office of Consumer Information & Insurance Oversight a letter on January 19 regarding medical loss ratio requirements under the *ACA*.
46. Commented in a January 18 letter to the Office of the National Coordinator for Health Information Technology (ONCHIT) on the report by the President's Council of Advisors on Science and Technology entitled Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: the Path Forward.
47. Sent AHRQ a letter on January 12 regarding the agency's priority setting for the Children's Health Insurance Program Reauthorization Act (CHIPRA) Pediatric Quality Measures Program (PQMP). In the letter, AAFP urged AHRQ to consider the core set of pediatric quality measures as an interim set along the way to a more focused set of patient-oriented outcome measures.

In 2010, the Academy:

1. Supported the Food and Drug Administration's (FDA) proposed Required Warnings for Cigarette Packages and Advertisements in a December 22 letter, but also urged the FDA to promptly publish a final rule.
2. Sent CMS a December 22 letter in response to the final 2011 Medicare physician fee schedule.
3. Offered guidance to the Centers for Disease Control & Prevention's (CDC) Office of Prevention through Healthcare Office on their development of a Health Risk Assessment (HRA) in a December 16 letter.
4. Sent formal comments to CMS on December 16 regarding the requirement that Medicaid programs enter into contract with RACs which must identify improper payments made through the Medicaid program and recoup overpayments. The AAFP also participated with 80 state and national medical organizations in a related comment letter dated January 10, 2011.
5. In partnership with 107 other state and national associations urged CMS to immediately reimburse physicians for six payment policy changes that affect 2010 Medicare claims in a December 10 letter. In direct response to the letter, CMS made a February 8 announcement pertaining to the reprocessing of certain 2010 Medicare claims that were affected by the *ACA* and corrections made to the 2010 Medicare physician fee schedule.
6. In anticipation of eventually issuing formal regulations, CMS solicited public feedback on seven general questions pertaining to Medicare ACOs. In a December 3 letter, the AAFP offered our perspective to these questions and highlighted the recently published Joint Principles for Accountable Care Organizations, collaboratively created by AAFP, the American College of Physicians, the American Academy of Pediatrics, and the American Osteopathic Association.

7. Offered suggestions to CMS on their implementation of a Physician Compare Website in a November 30 letter.
8. Participated in a November 5 coalition letter to the Drug Enforcement Agency (DEA) regarding the oral transmission of a Schedule II controlled substance.
9. Supported the National Prevention & Health Promotion Strategy (NPS) through a November 5 coalition letter to the HHS Surgeon General.
10. In partnership with the American College of Physicians, American Osteopathic Physicians, and National Rural Health Association, sent an October 27 coalition letter to CMS encouraging an expansive eligibility standard for the Medicare primary care bonus payment so that it would not penalize rural physicians who are called on to provide a wider scope of services.
11. Nominated three family physicians to the Methodology Committee of the Patient-Centered Research Institute (PCORI) in an October 26 letter to the GAO.
12. In an October 22 letter to GAO, made two nominations to fill upcoming vacancies to the National Committee on Vital & Health Statistics (NCVHS), which is the HHS advisory body in the areas of health data policy, data standards, health information privacy, population-based data, and administrative simplification.
13. Reiterated to CMS in an October 21 letter our support regarding the elimination of consultation codes.
14. Expressed objection in an October 14 letter to the Acting Comptroller of the GAO that no family physicians were included in the list of members of the Board of Governors of PCORI.
15. Expressed in an October 11 letter to the HHS Assistant Secretary for the Office of Healthcare Quality that our existing policy encourages healthcare workers to receive influenza vaccinations. These comments were sent in order to assist in the preparation of the HHS Action Plan to Prevent Healthcare-Associated Infections.
16. Cautioned CMS against relying solely upon the AMA's RUC in an October 8 letter.
17. Urged the FDA to implement and begin prompt enforcement of the *ACA* requirement that the agency develops federal nutrition labeling laws for restaurants with more than 20 locations and vending machine operators with more than 20 machines. In an October 7 letter, AAFP expressed support for the new food menu labeling requirements as a way to help improve patients' knowledge of nutritional choices and help address the prevalence of obesity in the United States.
18. Sent a comment letter on September 27 to the FTC, the HHS Office of Inspector General, and CMS containing the AAFP board-approved ACO principles.
19. Sent a formal comment letter on September 17 to the Departments of HHS, Labor, and Treasury in response to a regulation regarding the *ACA* changes in coverage of preventive services required by both insured and self-insured plans that begin on or after September 23, 2010. The rule utilizes the U.S. Preventive Services Task Force (USPSTF) to establish the benefits affected (currently using a rating of A or B) as well as the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). In the letter, AAFP raised concerns that the new requirements may contain an unforeseen cost and access ramifications to physicians. In addition to the AAFP letter, the Academy participated in a coalition letter regarding the same regulation with 25 other organizations.
20. In a September 17 letter to the HHS Office of Consumer Information & Insurance Oversight, submitted formal comments on a regulation that implements internal claims and appeals and external review processes as required under the *ACA*. In the letter, the AAFP provides suggestions on 6 new requirements that were not required under the previous Department of Labor (DOL) claim procedure regulations for group plans.
21. In a September 16 letter with five organizations representing family medicine providers, expressed appreciation to the Office of Management and Budget (OMB) for the FY 2011 budget amendment which proposed an additional $250 million for Health Professions programs to address the expected demand for primary care.
22. In mid-September, the Academy was pleased to nominate three family physicians (Drs. Mark Ebell, Ted Ganiats, and William Hueston) for service on the USPSTF.

23. In partnership with five other national medical associations, sent CMS a September 14 coalition letter with shared concerns to the CMS home health proposed rule that an *ACA* required provision that requires a face-to-face encounter prior to Medicare certifying home health services. CMS later agreed to adhere to the AAFP recommendation.
24. In partnership with the Council of Academic Family Medicine, submitted August 31 comments to CMS focusing on the graduate medical education provisions within proposed regulatory changes to the hospital outpatient payment system.
25. Sent CMS an August 27 coalition letter in support of their proposed changes to patient visitation rights in Medicare hospitals and critical access hospitals.
26. Suggested topics in an August 26 letter to AHRQ for new clinical preventive health topics to be considered for review by the USPSTF.
27. Sent an August 19 letter to HHS regarding their proposed changes to the HIPAA privacy, security and enforcement rules as required by Congress.
28. Provided feedback in an August 18 letter to the National Quality Forum regarding their proposed member selection criteria, member responsibilities, and operating procedures for the Partnership for Applying Measures to Improve Quality (PAM).
29. Provided comments in an August 3 letter to the National Association of Insurance Commissioners regarding their interpretation of the medical loss ratio provision in the *ACA.*
30. Submitted extensive comments in a July 28 letter to CMS regarding their proposed 2011 physician fee schedule.
31. Nominated family physicians to serve on the National Healthcare Workforce Commission, the Board of Governors of the PCORI, and the Public Health Council in separate August letters to the GAO.
32. Gave guidance to CMS in a February 26 letter on how to define the term "meaningful use" for purposes of the EHR incentive program. AAFP also participated in a coalition letter sent to CMS on March 15.

Regulations to expect:

1. In November of 2011, CMS will publish the 2012 final Medicare physician fee schedule.
2. Further (proposed and final) regulations are expected that implement the state based health insurance Exchanges.
3. HHS is expected to propose the essential benefits package proposed regulation in the Spring of 2012.
4. Before 2012, HHS must publish the quality and cost measures, the implementation dates, and the initial performance period associated with a new Part B value-based payment modifier. The modifier provides differential payments to physicians or groups of physicians based on the quality of care furnished compared to the cost of care during a performance period. This modifier begins to affect payments in 2015 based off 2014 performance data.
5. Further details regarding the additional PQRS participation method through a continuous assessment program, such as a qualified American Board of Medical Specialties Maintenance of Certification (ABMS MOC) program. Physicians that utilize this new method for PQRS reporting years 2011 through 2014 will be eligible for an additional 0.5 percent incentive payment.
6. Further details regarding Medicare's Physician Resource Use and Measurement Reporting Program, which requires HHS to publicly develop episode grouper measurement systems before 2012 so that HHS can use claims data to provide physicians or group practices with confidential reports that measure the resources involved in furnishing care to Medicare patients.
7. Regulations implementing the *ACA* required administrative simplification provisions such as operating rules for the eligibility and claim status electronic transactions, operating rules for EFT and payment and remittance advice, standardized health plan enrollment and claim edits, health claims attachments, and health plan identifiers.
8. Regulations implementing the Medicaid and CHIP pediatric ACO demonstration project. The *ACA* stipulates that states, beginning in 2012, may apply to HHS to participate in the program with a minimum commitment of three years.

9. By 2012, HHS must develop the Independent at Home Demonstration Program that will test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes to applicable beneficiaries
10. Further details surrounding the structure, funding, and members of the Independent Payment Advisory Board (IPAB).