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WHAT'S NEW

Medicare Clock Ticks Toward 23% Cut Dec. 1

But the final rule from CMS includes a 10% incentive payment to primary care physicians.

BY ALICIA AULT

The Centers for Medicare and Medicaid Services this month issued its final rule governing physician fees for 2011, offering a 10% incentive payment to primary care physicians, but taking away an additional 2% across the board as a result of the statutory requirements of the sustainable growth rate formula.

Unless Congress acts, physician fees under Medicare will be cut by 23% on Dec. 1 as mandated by the SGR; just about 2% more will be cut Jan. 1, bringing the total cut for 2011 to 25%.

Although CMS Administrator Don Berwick has called for a permanent overhaul of the SGR, it was not mentioned in the materials that went out with the new rule. Instead, Dr. Berwick touted the new preventive care benefits that will be covered, and thus reimbursed, as a result of the Affordable Care Act.

Under the final rule, which implements certain ACA provisions, Medicare will pay for an annual wellness visit, "that will allow a physician and patient to develop a closer partnership to improve the patient's long-term health," said Dr. Berwick in a statement.

"The rule will also eliminate out-of-pocket costs for most preventive services beginning Jan. 1, 2011, reducing barriers to access for many beneficiaries," he added.

The wellness visit will be paid at the rate of a level 4 office visit for a new patient.

The ACA also provided the primary care bonus, which is separate from the fee cuts. The payment is available to family physicians, general internists, geriatricians, pediatricians, nurse practitioners, clinical nurse specialists, and physician assistants who can show that 60% or more of their Medicare allowable charges were for primary care.

The incentive payments will be made quarterly, based on the services provided in the previous quarter.

A similar 10% quarterly incentive payment will be made in 2011 to general surgeons in Health Professional Shortage Areas.

The fee schedule also implements a provision of the ACA that increases payment for two codes for dual-energy x-ray

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ACIP: Expand Use Of Tdap to Stop Pertussis Outbreak

BY MIRIAM E. TUCKER

FROM A MEETING OF THE CDC'S ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

ATLANTA – In the face of an ongoing pertussis outbreak in California, a series of three votes by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices aimed to expand and clarify recommendations for pertussis vaccination.

The votes taken at the meeting removed previous language restricting the interval for receipt of the adolescent-adult formulation of the tetanus-diphtheria-pertussis vaccine, and expanded the use of Tdap to adults aged 65 years and older and to undervaccinated children aged 7-10 years.

Kathleen Harriman, Ph.D., of the California Department of Public Health's Immunization Branch updated the committee on the California outbreak. A total of 6,978 cases had been reported as of Oct. 19, 2010,

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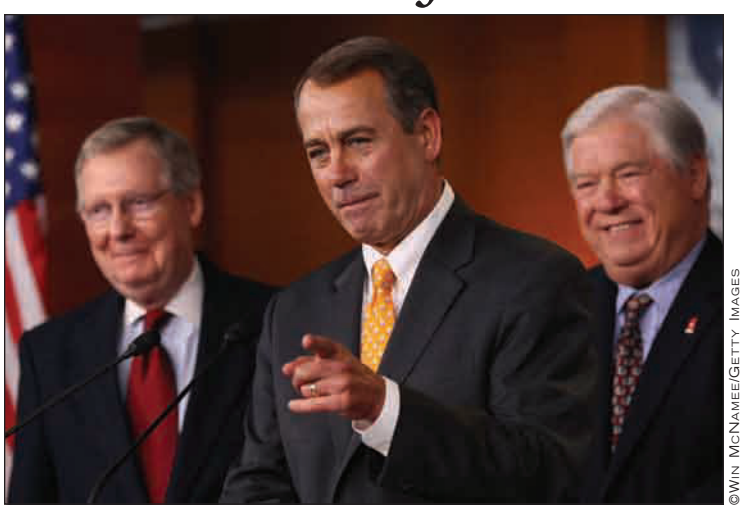
Will the Midterm Election Results Derail Health Reform?



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The Republicans' congressional midterm election victories may not signal the end of the Affordable Care Act, but now the law will very likely undergo the scrutiny that many in the GOP say it did not get as it made its way through Congress. See the story on page 73.

NCQA Seeks Comment On Draft ACO Criteria

BY ALICIA AULT

The National Committee for Quality Assurance has issued draft criteria to define the core capabilities of an accountable care organization.

The accountable care organization (ACO) concept is central to the health system reform envisioned by the Affordable Care Act, but what it would look like or how it would work has been variously and loosely defined. The nonprofit NCQA has stepped in to offer a set of parameters that might standardize the ACO model.

"Our goal is to help people be confident that ACOs meeting the final criteria actually can contain costs without compromising quality," said NCQA President Margaret O'Kane in a statement.

The NCQA has been a leader in establishing quality performance measurement tools that are widely used by health care providers, insurers, and employers. The group receives funding and support from a variety of organizations, including the American College of Physicians and the American Academy of Family Physicians; insurers and pharmaceutical companies also contribute.

The organization has posted the ACO criteria on its Web site and was accepting public comments until Nov. 19.

According to the NCQA, each ACO should have core capabilities in seven categories: program structure operations; access and availability; primary care; care management; care coordination and transitions; patient rights and responsibilities; and performance reporting.

The criteria were developed by the organization's ACO task force, which was headed by Dr. Robert Margolis, CEO of the California-based HealthCare Partners Medical Group; the 18 other task force members included Dr. Duane Davis, vice president and chief medical officer of the Pennsylvania-based Geisinger Health Plan, and Dr. Nicholas Wolter, CEO of the Billings (Mont.) Clinic.

ACOs that participate in the NCQA process also will eventually report outcomes on performance measurements. That is important, Dr. Margolis said in a statement, adding that, "most potential ACOs do not have data that can be used from the start to evaluate performance."

He added that "public feedback will help with finalizing the criteria that will start these organizations to a firm foundation."

After the comment period closes, the task force led by Dr. Margolis will review the comments and make revisions, as appropriate, according to a spokesperson for NCQA.

The group will also align the criteria with any regulations pertaining to ACOs. The criteria will likely be made final by March 2011 and then will be released in the second quarter of 2011, the spokesperson said. ■

Consultation Codes Not Restored

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absorptiometry (DXA) for both 2010 and 2011.

However, CMS decided it would not restore consultation codes for inpatient, outpatient, or nursing facility visits. The consultation codes, which are essential to most physicians who receive referrals, were dropped by Medicare in 2010.

Instead, physicians were told to use new or established office visit codes, initial hospital care codes, or initial nursing facility care codes. At that time, CMS officials said that the codes were no longer necessary, given that the agency had reduced the paperwork burden for consultations.

The final rule for the 2011 fee schedule notes that there is no evidence to support the necessity of the codes, and that coordination of care should not be adversely affected by dropping them.

"If we become aware of such evidence in the future, we would certainly consider whether there is an appropriate policy response to promote more effective coordination of care," according to the final rule.

The agency said there was no evidence that Medicare beneficiaries had been harmed by the loss of the codes.

However, a survey by the American Medical Association this past summer found that a fifth of physicians had stopped seeing new Medicare patients, and almost 40% were cutting back on information technology purchases because of lost revenue.

The ACA also dictated new requirements for physicians who refer patients to MRI, CT, and PET facilities in which they have an ownership interest. Now, the physician will have to disclose in writing to patients that they can receive the service elsewhere. Referring physicians will also have to provide a list of five alternatives within 25 miles of the physician's office.

Payment for imaging procedures will also be reduced. Previously, CMS reimbursed based on the assumption that equipment was used 100% of the time. That assumption has been changed to 75%.

The ACA also reduced incentives for the Physician Quality Reporting System (formerly known as the Physician Quality Reporting Initiative).

In 2011, physicians will be eligible for an incentive payment equal to 1% of the total Medicare charges during the reporting period. For 2012 through 2014, the payment drops to 0.5% of charges. After 2014, physicians who do not report data could see a 1.5% cut in Medicare fees; the penalty increases each year.

There is a carrot, though. Physicians who use a maintenance of certification program to report PQRS data will get an additional 0.5%.

The incentive payment for e-prescribing in 2011 will be 1% of charges during the calendar year. But in 2012, payments will be reduced if physicians are "not successful e-prescribers," according to the CMS.

The final fee schedule rule will be published Nov. 29 in the Federal Register. ■

NCQA: Revised PCMH Application Process Easier

BY M. ALEXANDER OTTO

FROM THE ANNUAL CONGRESS OF DELEGATES OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

DENVER – The National Committee for Quality Assurance has improved its patient-centered medical home recognition process, making application submissions over the Web easier and decision times quicker, according to Patricia Barrett, the group's vice president for product development.

Since NCQA launched its recognition program about 2½ years ago, there have been complaints that the process is too cumbersome.

NCQA's application process changes come as the Joint Commission and URAC both prepare to launch their own PCMH recognition programs next year.

In September, the American Academy of Family Physicians' Congress of Delegates even passed a resolution calling for simpler assessment and documentation tools, and increased transparency and feedback.

"We have heard the criticism," said Ms. Barrett. "We want the difficulty to be in becoming a medical home, not in applying" for recognition.

NCQA has hired additional staff to answer questions and provide feedback, she noted, and has updated its Web portal to make it more user friendly.

Applicants aren't required to mail or e-mail their applications anymore; they can be filled out directly on the Web site.

In addition, applicants can upload larger documents, and uploads are quicker, with documents appearing almost simultaneously at NCQA headquarters. The group now accepts electronic signatures on legal documents, Ms. Barrett said.

NCQA also has streamlined its document requirements to cut down on redundancy, she noted. And those renewing their recognitions don't have to start from scratch – document requirements have been eased for renewals.

In short, "We are meeting our target now" for 60-day decisions on recognition, Ms. Barrett said.

The changes sound good to Dr. Mary Campagnolo, a family physician in Lumberton, N.J., and a member of the state delegation that submitted the resolution at the Congress of Delegates.

The problem has been with the process, not the standards themselves, she said. Doctors at the AAFP meeting agree that the standards need to be rigorous in order to be meaningful, Dr. Campagnolo explained. "The documentation is voluminous," she noted, adding that quicker uploads and other changes should reduce some of the hassle.

Many of the improvements are already in place just in time for NCQA's release of updated PCMH standards early next year.

Though the process is a bit easier, the standards will be tougher. "It will be a more rigorous program," Ms. Barrett said. "We raised the bar significantly." That's in part because NCQA has a better idea of what payers are likely to require for practices to qualify for additional reimbursements as medical homes, she said.

So far, NCQA has recognized about 1,000 PCMHs, and is fielding about 100 PCMH recognition applications per month.

The new standards haven't been finalized, however, so the group was short on details about the changes. But, in general, there will be greater emphasis on the full scope of a patient's health needs – reducing obesity, quitting smoking, and the like – not simply managing the problem that brought her into the clinic.

There also will be more emphasis on coordinating care with other practices, and ensuring records of what's done elsewhere make their way back to the medical home. In addition, meaningful use requirements have been added to electronic health records standards.

Scoring will get tougher, too. For instance, to achieve level 1 PCMH status, practices may have to earn 35 points on the group's 100-point scale – up from 25 under the current system.

The price – currently $1,280 for a three-physician practice, for example – is going up, too, though NCQA isn't certain yet how much. NCQA typically adjusts its program prices every other year, a spokeswoman said.

The changes to NCQA's program come as the Joint Commission and the Utilization Review Accreditation Commission both prepare to launch their own PCMH recognition programs next year. ■