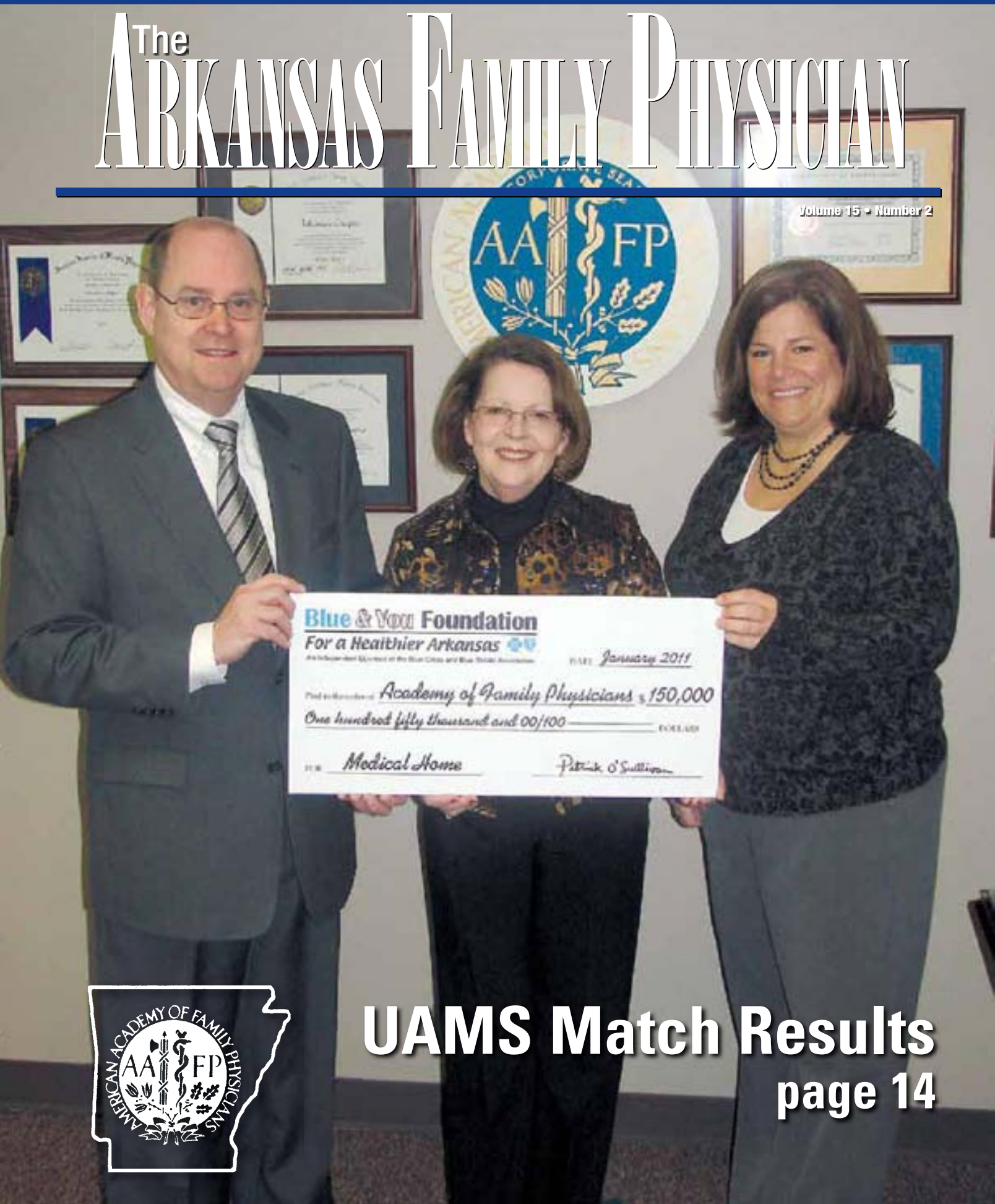
Applications Now Being Accepted For Patient Centered Medical Home Practices In Arkansas!

The Arkansas Family Physician

Volume 15 • Number 2



UAMS Match Results

page 14

Seeking **experts** in **health care**

CoxHealth is seeking BE/BC family medicine physicians in **Cassville** and **Shell Knob, Mo.**

The clinic in **Cassville** has sophisticated imaging technology, provides many procedures to patients and offers a unique schedule – four weeks on, two weeks off. This clinic is located next to Roaring River State Park, a premier trout fishing location with picnic areas and walking trails.

CoxHealth Center **Shell Knob** is an established practice with knowledgeable support staff. This clinic is located next to beautiful Table Rock Lake, a great location for water sports, fishing and hiking.

All CoxHealth hospitals and clinics are accredited by The Joint Commission and for five consecutive years, one of the national's Top 100 Integrated Health Care Networks.

For more information, e-mail Paula.Johnson@coxhealth.com or call 1-800-869-4201.

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- Sign-on bonus
- Relocation expenses
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Southwest Missouri offers many opportunities for you and your family.

- Safe neighborhoods and excellent schools
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The Arkansas Family Physician

The Arkansas Family Physician is the official magazine of the Arkansas Academy of Family Physicians

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Dear Academy Member,

As you can see from our cover, we have now kicked off our Patient Centered Medical Home Grant application made possible through Blue and You Foundation and are excited about offering for the first time a significant grant to three practices to implement the Patient Centered Medical Home. An article in this Journal details the information you need to apply!

The Annual Scientific Assembly program is near completion with a target date of mailing the official program in about a month. We hope you will plan on being with us July 20, 21 and 22 again at the Doubletree Hotel in downtown Little Rock for another excellent scientific program.

As the Arkansas legislative session is in full swing, we have been watching bills of interest to you and have been very pleased with our partnership with the Arkansas Medical Society who is lobbying for us in this session. Of particular interest to all of medicine has been the three scope of practice bills filed which you will find detailed in this Journal that have not been acted upon as of this date.

Other news just received that did not get included in the Journal but of interest is the following from the AAFP Governmental Affairs Division: CMS estimates 29.5 percent reduction in Medicare payments to physicians services for Part B on January 1 unless Congress intervenes. The American Academy will continue to urge Congress to address this issue. In addition, the AAFP and the four academic family medicine groups wrote to President Obama calling for a multi year Medicare schedule which prevents the SGR cuts and narrows the payment differential between primary care and other physicians. Please go to the AAFP website and receive up to date information from AAFP News Now on these issues.

We are excited about our Patient Centered Medical Home initiative in our state and also of our upcoming Annual Scientific Assembly and we look forward to receiving your applications for the PCMH grants and your registration for the Annual Scientific Assembly (hotel and registration information coming soon).

As always, it is a pleasure to work for the AR AFP and with you. Our recruitment effort to reinstate our previous members continues and we urge you to help us with your colleagues. Please do not hesitate to give us a call if we may be of assistance to you!

Sincerely,

Carla Coleman
Executive Vice President

COVER IMAGE: Patrick O'sullivan, Executive Director, Blue And You Foundation Presents Pcmh Grant To Carla Coleman & Michelle Hegwood For The ARAFP Foundation

ARAFP Foundation Grant Applications For Patient Centered Medical Home Now Being Accepted!!

As you have noticed from the front cover photo of this Journal, Blue and You Foundation Executive Director Patrick O'Sullivan presented Carla Coleman and Michelle Hegwood, your Academy staff, with a check for $150,000 in January to begin the grant process for the funding of three Family Physician Practices in our state in becoming a Patient Centered Medical Home!

We are very pleased to announce that you can now apply for one of these three grants. Letters have been mailed to each active member of the Academy and email notices have also been sent along with the application which is attached to the email. If you received the letter , you may access the application online at http://www.surveymonkey.com/s/S8B99BC. If you would like to have a hard copy you may print it from the survey monkey attachment or call us and we will be happy to fax you a copy. Grant applications must be made by April 1 and electronic medical records are necessary to pursue the grant application. If you did not receive a letter or an email, please call us at 501 223 2272.

This grant was made possible from Blue and You Foundation for a Healthier Arkansas. Our application was made in July, 2010 and announcements were made of grant recipients in January, 2011 with an implementation date of January through December, 2011.

The three practices that will be selected for the 24 month process will be funded for full facilitation for the first year and ongoing support the second year through TransforMED, our chapter partner which was founded in 2005 by the American Academy. TransforMED is a physician led organization and has worked with more than 500 primary care sites undertaking the Patient Centered Medical Home transformation.

TransforMED along with the AR AFP Foundation Board will align primary care practices in our state to support the success of three PCMH models: develop an efficient and sustainable primary care base to improve clinical outcomes and reduce patient costs of care: improve physician and staff satisfaction at the practice level through implementing elements of the PCMH model and develop clinical standardization and integration through the combination of leveraging technological capabilities and PCMH efficiencies. There will be a dedicated facilitator and project manager throughout the project with each practice engaging in every area of the TransforMED Patient Centered Model. "Patients Centered" has been the guiding principle of TransforMED by putting patients first in more than just delivering high tech clinical care. During key stages of the transformation process in a PCMH, the patient experience is assessed for which the findings are used to help guide transformation.

It is expected that through implementation of the PCMH project in three practices in our state, more than 69,000 patients will be impacted by just one physician. With a practice with more than one physician the number of patients would double, triple or more.

Recipients of the three grants will be named in July at our Annual Scientific Assembly.

We look forward to this exciting initiative for our chapter and express our appreciation to Blue and You Foundation for making the Arkansas AFP Foundation's opportunity possible to offer funding for three PCMH models in our state! We also look forward to working with TransforMED , our chapter partner through the AAFP who will be providing the services necessary for our selected practices to become Patient Centered Medical Homes.

The Blue & You Foundation for a Healthier Arkansas awarded a total of $1,723,343 in grants to 23 health improvement programs in Arkansas with our Foundation receiving the largest in the amount of $150,000 for the PCMH project. According to Patrick O'Sullivan, Executive Director of the Blue & You Foundation, "grants this year went to programs across the state addressing issues such as obesity, diabetes, healthy life style choices, medical care for low income individuals, and dental health and safety." Arkansas Blue Cross and Blue Shield established the Blue & You Foundation in 2001 as a charitable foundation to promote better health in Arkansas and awards grants annually to non profit or governmental organizations and programs that positively affect the health of Arkansans. In its nine years of operation, the Blue & You Foundation has awarded nearly $12 million to 185 health improvement programs in Arkansas!

Blue & You Foundation
For a Healthier Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association

TransforMED

The TransforMED Patient-Centered Model

A Medical Home for All

Access to Care and Information

- Health care for all
- Same-day appointments
- After-hours access coverage
- Accessible patient and lab information
- Online patient services
- Electronic visits
- Group visits

Practice Management

- Disciplined financial management
- Cost-Benefit decision-making
- Revenue enhancement
- Optimized coding & billing
- Personnel/HR management
- Facilities management
- Optimized office design/redesign
- Change management

Practice-Based Services

- Comprehensive care for both acute & chronic conditions
- Prevention screening and services
- Surgical procedures
- Ancillary therapeutic and support services
- Ancillary diagnostic services

Health Information Technology

- Electronic medical record
- Electronic orders and reporting
- Electronic prescribing
- Evidence-based decision support
- Population management registry
- Practice Web site
- Patient portal

A continuous relationship with a personal physician coordinating care for both wellness and illness

- Mindful clinician-patient communication: *trust, respect, shared decision-making*
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Continuous relationship
- Whole person care

Care Management

- Population management
- Wellness promotion
- Disease prevention
- Chronic disease management
- Patient engagement and education
- Leverages automated technologies

Quality and Safety

- Evidence-based best practices
- Medication management
- Patient satisfaction feedback
- Clinical outcomes analysis
- Quality improvement
- Risk management
- Regulatory compliance

Care Coordination

- Community-based resources
- Collaborative relationships
  - Emergency Room
  - Hospital care
  - Behavioral health care
  - Maternity care
  - Specialist care
  - Pharmacy
  - Physical Therapy
  - Case Management
- Care Transition

Practice-Based Care Team

- Provider leadership
- Shared mission and vision
- Effective communication
- Task designation by skill set
- Nurse Practitioner / Physician Assistant
- Patient participation
- Family involvement options

Find out more at www.TransforMED.com

Arkansas AFP Announces Partnership with Atlantic Health Partners

We are pleased to announce that the ARAFP has found a strong, new partner in helping our members **save money with vaccine purchases**. This new partner – **Atlantic Health Partners** – can help you save precious dollars and advocate on your behalf with payers and manufacturers.

Atlantic, a physician buying group, works directly with Sanofi Pasteur and Merck and has obtained the most favorable pricing and purchasing terms for a wide variety of pediatric, adolescent, adult, and flu vaccines. Members of the Atlantic program make purchases directly from Sanofi and Merck (as many of you do now) but receive better prices and terms.

NOTE – Atlantic members who pre-book Sanofi Fluzone and High Dose Fluzone by March 31st receive the lowest prices!

Atlantic currently works with 25 state AAFP chapters. They serve over 3,000 Family Physicians, and your colleagues report strong satisfaction with the program, most notably for the savings, ability to make smaller purchases, customer support, and how easy it was to enroll – and there is no cost to join!

Jeff Winokur and Cindy Berenson are the primary contact persons at Atlantic, and we encourage you to contact them at 800-741-2044 or at info@atlantichealthpartners.com for more information and details about how your practice can benefit from participation.

Lower your Vaccine Costs with Atlantic Health Partners !

The AR AFP Vaccine Buying Group Partner

BENEFITS OF JOINING ATLANTIC'S VACCINE BUYING GROUP:

- **Lowest prices for Sanofi, Merck and MedImmune vaccines**
- **Deep discounts for medical supplies and injectibles**
- **Office supply savings program**
- **Patient Recall Program Discount**
- **Reimbursement support and advocacy**

Contact Atlantic at 1-800-741-2044 or info@atlantichealthpartners.com

ATLANTIC HEALTH PARTNERS, LLC

www.atlantichealthpartners.com

Arkansas Legislative Session News of Interest

On March 7 Arkansas Surgeon General Joe Thompson, M.D. and Medicaid Director Gene Gessow met with the Health Care Providers Forum which is a collection of all of the health providers that participate with Medicaid.

Governor Mike Beebe has proposed to HHS Secretary Kathleeen Sebelius a total revamping of how Arkansas Medicaid reimburses all providers. They have asked for her approval by May 1 which if granted would allow them to move forward on this "plan."

Under this proposal Medicaid would organize all diagnoses into "episodes of care." Reimbursement will be assigned to each episode of care and paid to a "partnership" of local health care providers along the lines of traditional referral arrangements. Any one provider or group could conceivably belong to multiple partnerships depending on the diagnosis.

Due to the length of the letter by Governor Beebe and the "Transforming Arkansas Medicaid" plan, rather than reprint it you can access both by going to the following site: https://ardhs.shrepointsite.net/DMS%20Public/Forms/AllItems.aspx?RootFolder=/DMS%20Public/Medicaid%20Transformation&FolderCTID=&View=(501C27B5-A45A-4E54-B124-F4A2118D63FO)

You are urged to contact your legislator and the Governor about this proposed plan. To our knowledge, no health care provider groups were involved in the development of this plan and it is uncertain if any will be supportive. If you are unable to access the link, please give us a call and we will forward the letter and plan to you.

In other legislative news, three scope of practice bills have been filed. Senate Bill 1217 by Representative Tyler "An Act to Authorize Advanced Practice Nurses to Bill Medicaid directly for Health Care Services and for Other Purposes." As of this date the bill remains a "shell bill."

House Bill 1172 by Representative Clark Hall and Senate Bill 98 by Senator Wyatt were also filed early on "An Act to Authorize Advanced Practice Nurses to Enter into Collaborative Agreements with Area Health Education Centers." Just yesterday the House version of the bill was amended by Rep. Hall and would allow UAMS to create a program to train APN's for programs operated through the AHEC's and employ APN's as employees of the AHEC's; and shall sign a collaborative agreement with the AHEC: the APN would be an employee of the AHEC and the AHEC would employ the APN at a location within the area served by the AHEC at which the APN will practice. We would be opposed to this bill since not all AHEC's have physicians on site. To view this bill please go to: http://www.arkleg.state.ar.us/assembly/2011/2011R/Amendments/HB1172-H1.pdf

Emails are sent to all Arkansas AFP members when issues arise that requires your attention. If you are not receiving emails from us please give us a call. We only have approximately 65% of our member's email addresses!

Arkansas Chapter News

Dr. Haley Vo of Fayetteville has been appointed by Governor Mike Beebe to a three year term on the Arkansas Early Childhood Commission.

Dr. Ted Lancaster, President of the Arkansas AFP and Carla Coleman, Executive Vice President represented the Arkansas Chapter at the Multi State Meeting in Dallas in February. State chapters of Missouri, Iowa, California, Kansas, Oklahoma, Texas, New Mexico, Arizona, Nevada and Illinois were in attendance at this annual meeting. Arkansas will host the 2012 meeting in Dallas February 18 and 19.

Arkansas Members due for re-election that have not reported sufficient hours for re-election for the period 2008 through 2010 will be terminated from membership if hours are not reported by 3/30/11. These hours must be ones obtained for the three years ending December 31, 2010.

Letters have been mailed to 192 Arkansas Chapter members delinquent in paying 2010 dues. The deadline for paying the dues is May 4.

A contract has been signed with the Doubletree Hotel in Little Rock for the 64th Annual Scientific Assembly in 2012 for June 13-16, 2012 – a month earlier than our normal annual meeting dates so mark your calendars now for 2012!!

ARKANSAS ACADEMY OF FAMILY PHYSICIANS
63rd ANNUAL SCIENTIFIC ASSEMBLY PREVIEW
JULY 20, 21, 22, 2011
DOUBLETREE HOTEL, LITTLE ROCK, ARK.

HIGHLIGHTS

Keynote speaker to be announced later

Evaluation of the Abnormal CBC

Supporting Appropriate Immunizations against the Age Spectrum

HIV Update 2011

Depression in Minorities

Hepatitis C

Allergies and Asthma

Adolescent Psychiatric Issues

Common Infections in Pediatrics

Ocular Emergencies

Eyelid Rashes and Lesions

Fibromyalgia

Cardiac Testing

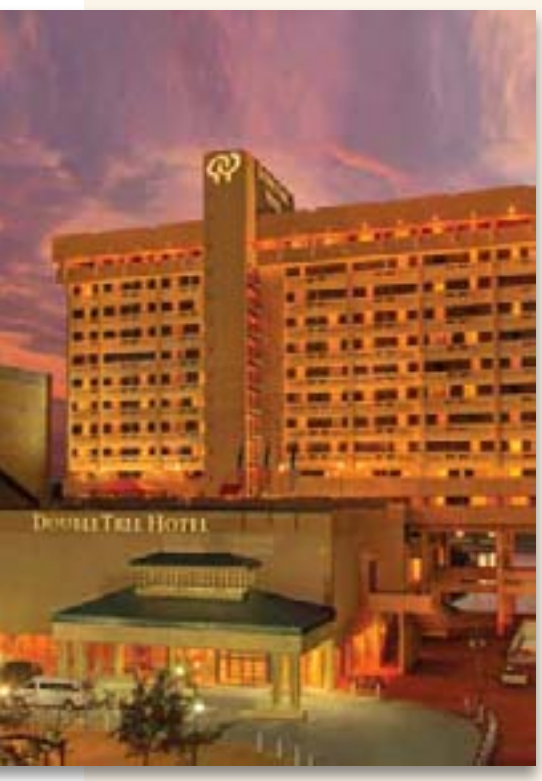
10 Things I learned from Audio Digest

Legislative Update

Snakes, Spiders and Ticks

Update on AAFP

And more



Program will be finalized soon and will be mailed along with hotel accommodation information. Please mark your calendars and plan to be with us!!

In The World Of Neurosciences, St. Vincent Is The Leading Destination.

Announcing The Arkansas Neuroscience Institute At St. Vincent

Some of the most respected neurosurgeons in the world have created a unique resource in partnership with St. Vincent – one with a truly international scope: the **Arkansas Neuroscience Institute**. These skilled physicians and their colleagues are experts in a variety of neurological conditions and advanced treatment options. Working together, we're attracting patients from around the globe – and generating opportunities for the brightest minds – right here in Arkansas. By providing this level of expert care, St. Vincent is once again demonstrating our dedication to serving our community and the world.

ARKANSAS NEUROSCIENCE INSTITUTE

CATHOLIC HEALTH INITIATIVES

St. Vincent

Inspired.

StVincentHealth.com/ANI

DUES LOWERED FOR 1st Year New Physician Active Members

Beginning with the dues billing for 2012, the American Academy of Family Physicians and the Arkansas Chapter will discount dues by 50% for our 1st Year New Physician Active members.

Statistics show that many of our Residents who upgrade to Active status in mid year (and are not required to pay dues for that portion of the year) do not retain their membership their first full year of Active membership. Through contact with those new members, going from not paying any dues at all for membership to paying full dues is very difficult beginning a practice so the AAFP and AR AFP are addressing this issue!

State dues for 1st Year New Physician Active members will be $125 and national dues will be $192.50 for a total of $317.50. Dues billings are mailed in late October each year for **the following year.**

OFFICERS FOR THE FOLLOWING YEAR NOMINATED

At a recent meeting of the AR AFP Board, the Nominating Committee unanimously approved the following for officer positions for the coming year:

President Elect - Lonnie Robinson, M.D., Mountain Home

Vice President - Barry Pierce, M.D., Mountain View

Secretary - Dan Knight , M.D., Little Rock

Treasurer - Bryan McDonnell, M.D., Arkadelphia

Delegate - John E. Alexander, M.D., Magnolia

Alternate Delegate - Rodney Mark Dixon, M.D., El Dorado

There are openings for two Directors to the AR AFP Board and a New Physician opening. If you are interested in serving, please email us at arafp@sbcglobal.net.

Save the Date: National Call on Registration for the Medicare EHR Incentive Program for Eligible Professionals

Fri Apr 1, 12:30-2pm CENTRAL

The Centers for Medicare & Medicaid Services' Provider Communications Group will host a national provider call for eligible professionals about registration for the Medicare Electronic Health Records (EHR) Incentive Program. The presentation, which will include a question and answer session, will cover:

- Eligibility for Incentives
- Switching between the Medicare and Medicaid Incentive Programs
- Reassigning Payments
- Pre-Registration
- Registration
- Helpful Resources

Save the Date! More information, including registration details, will follow shortly. Visit our website at www.cms.gov/EHRIncentivePrograms.

Arkansas Chapter Highlighted In AAFP News Now

In the January 31 issue of ***AAFP News Now***, the Arkansas Chapter was the first of the "**Chapter of the Month Series entitled Arkansas Heroes.**"

The article featured the dozens of Arkansas Family Physicians and other physicians who volunteered for months in fellow Family Physician Trent Pierce's office in West Memphis after he was critically injured.

Our Arkansas "Heroes" stepped in to aid a family physician colleague and kept his office open and provided care to his patients – an effort that the Trent Pierce Family still expresses their amazement and appreciation for.

To read the article, go to AAFP News Now at www.aafp.org.

News of Interest

CHANGES IN CMS PRIMARY CARE INCENTIVE PROGRAM – MORE PHYSICIANS QUALIFY FOR BONUS

After feedback from the AAFP and other primary care organizations, CMS has changed its implementation rules for the Medicare Primary Care Incentive Program or PCIP. These changes will allow approximately 20 percent more family physicians to qualify or the bonus program than previously anticipated.

As of January, the Patient Protection and Affordable Act requires Medicare to pay all primary care physicians whose primary care billings comprise at least 60% of their total Medicare allowed charges a 10 percent bonus. The bonus program lasts until December 2015.

PHYSICIAN PRACTICES WITH ELECTRONIC MEDICAL RECORDS EARN MORE

Medical practices that have implemented an electronic health record system report better financial performance than those that have not according to a recent report by the Medical Group Management Association. You may go online and see the report at www.mgma.com

Regulatory Summary:

On March 7 CMS issued a proposed consumer disclosure notice in an effort to increase pricing transparency in the health insurance market. As required by the Affordable Care Act and effective July 1, the notice requires insurers to report online when they propose a rate increase over 10 percent. Such increases are then subject to a rate review by either the state or the U.S. Department of Health and Human Services.

On March 8, the US Department of Health and Human Services highlighted a Health Affairs report of recent studies that indicates the benefits of using health information technology. The report notes that 92% of studies of health information technology yielded results showing positive effects including improved quality and increased efficiency of health care.

Medicare Physician Group Practice Demonstration

The ACO concept in the health reform law is modeled after a five year CMS pilot project that began in April 2005 called the Medicare Physician Group Practice demonstration. As the law was being written, lawmakers had access to the second year results. Since that time, other outcomes for years three and four have been released.

For the demonstration, CMS contracted with 10 large multispecialty groups with varied organizational structures to see whether care management initiatives could produce cost savings for the system and improve quality.

On top of individual physicians' fee for service claims, groups were eligible for an 80 percent share of Medicare's savings if they collectively achieved quality and cost targets for the patients loosely assigned to their group. There were no penalties for missing the targets. To qualify for these performance payments, groups had to generate savings for Medicare parts A and B of more than 2 percent of their target expenditures. CMS established the spending targets by creating a comparison group of Medicare beneficiaries in the same geographic area and comparing the organization's per capita expenditures in its base year with those for the comparison group.

Results revealed that all 10 entities achieved significant improvements in quality of care and patient satisfaction, with half receiving performance payments of $31.7 million in the fourth year of the program. The groups who earned bonuses attributed the savings to changes in their organizational structure, investments in care management programs and health information technology, and continuing education and feedback for providers.

The four groups who earned performance payments by the second year were affiliated with an academic medical center or were unaffiliated physician groups. The five groups who received no performance payments in the second year were part of integrated delivery systems with hospitals or a physician network sponsored by a hospital. The majority of the savings at all sites occurred in outpatient services. The Marshfield Clinic in Marshfield, Wisconsin received the most over the four year span, a total of more than $40 million.

Resources on Accountable Care Organizations

The American Academy of Family Physicians will publish a set of ACO resources soon but in the meantime the following are links for some resources on ACO's:

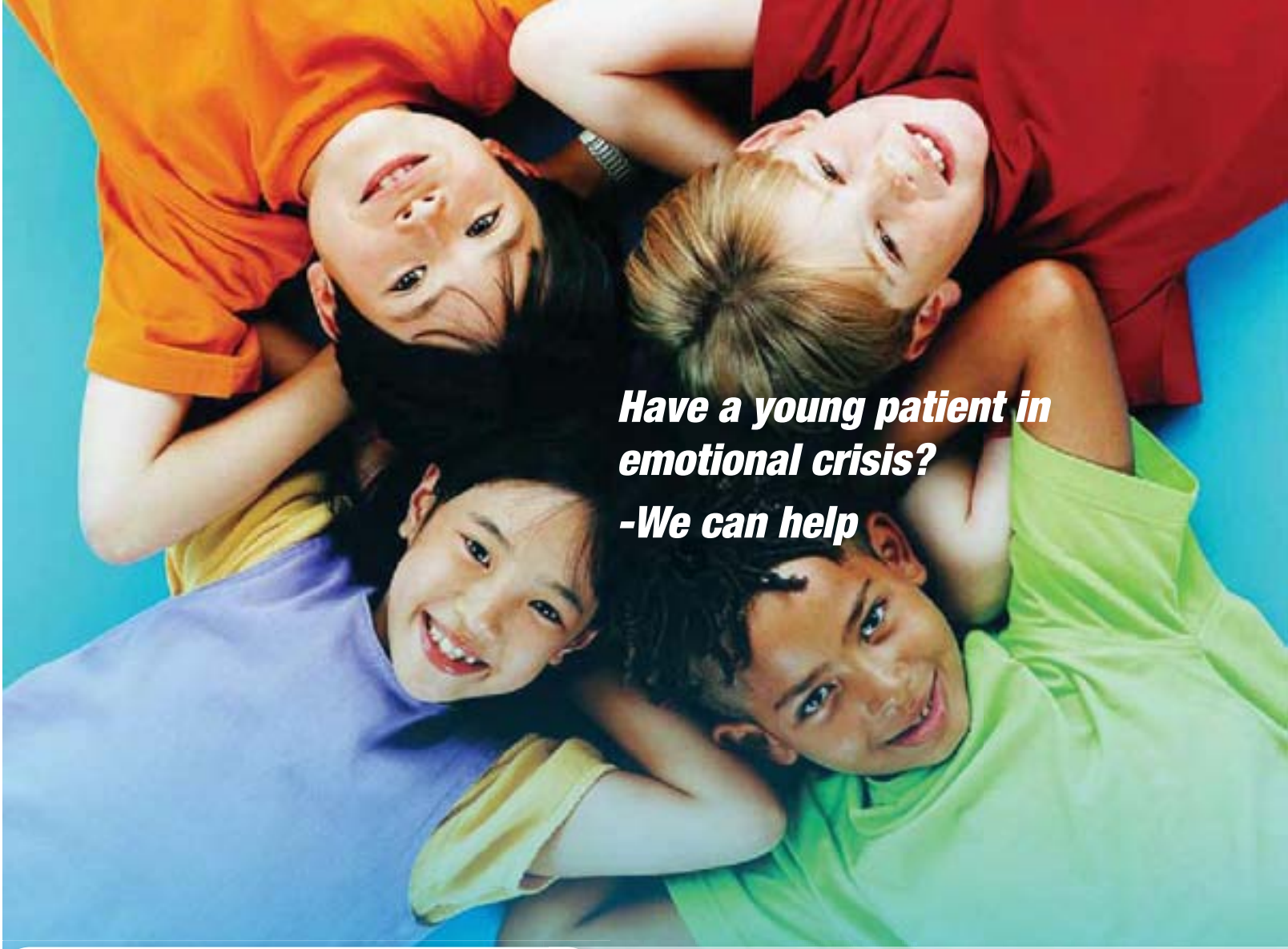
Joint Principles for Accountable Care Organizations http://tinyurl.com/29tr75k

AFP Accountable Care Organization Principles http://tinyurl.com/4en6a4b

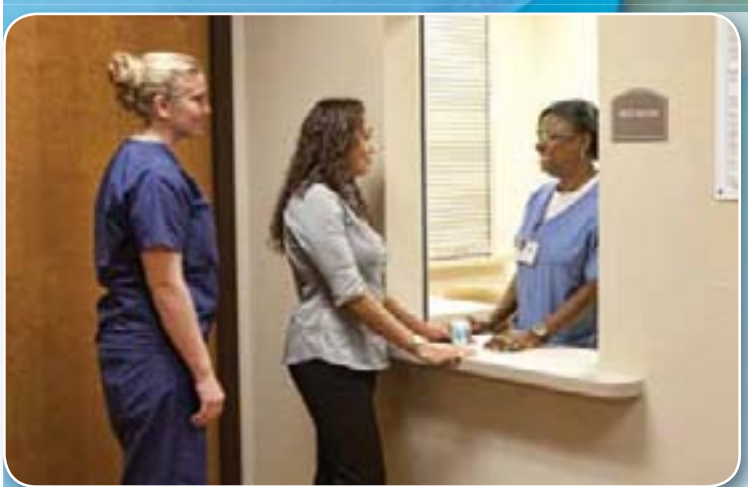
Family Practice Management – Opinion: The PCMH and ACO: Opposed or Mutually Supportive? www.aafp.org/fpm/2010/1100/p6.html

AAFP Accountable Care Organization Task Force Report October 2009 http://tinyurl.com/4ftho96

Private Sector Advocacy: ACOs http://tinyurl.com/4rgnr8v



Have a young patient in emotional crisis?
-We can help



- *Physician's behavioral health resource for young patients in crisis*
- *From a difficult phase or recent trauma to more chronic behavioral issues, Pinnacle Pointe is a single point of access for triage services to hospital or outpatient services in your community*
- *Psychiatrist available for phone consultation or questions*
- *No-cost mobile or 24-hour walk-in assessments available*
- *Tricare-certified acute and residential programs*
- *Accepting Medicaid, Tricare and insurance.*
- *Ages 5-17*
- *V.I.P. 24-hour access to House Supervisor (501) 772-2273*

Pinnacle Pointe
Behavioral HealthCare System

11501 Financial Centre Pkwy
Little Rock, AR 72211
www.pinnaclepointehospital.com
800-880-3322

From AAFP NEWS NOW:

Health Care Personnel Are Focus of ACIP's Revised Pertussis Recommendations

Health care personnel and their immunization needs were a chief focus of the CDC's Advisory Committee on Immunization Practices, or ACIP, during its Feb. 23-24 meeting in Atlanta. And, in recognition of multiple ongoing outbreaks of pertussis, committee members voted to bring guidance for health care personnel in line with pertussis recommendations the ACIP made for the general population last year.

The new ACIP recommendation specifically calls for all health care personnel who have not previously received tetanus, diphtheria and acellular pertussis, or Tdap, vaccine to receive a single dose as soon as feasible -- regardless of the interval since their last dose of tetanus and diphtheria toxoids, or Td, vaccine. Furthermore, health care facilities should take steps to encourage such immunizations, including providing Tdap to their personnel at no cost. Health care personnel already were recommended to receive Tdap, but the precise wording of the new recommendation -- to disregard the interval since receiving Td -- adds a sense of urgency, according to one FP expert.

ACIP TERMINOLOGY CHANGE

During its Feb. 23-24 meeting in Atlanta, the CDC's Advisory Committee on Immunization Practices recommended replacing the term "health care workers" with "health care personnel." The change was based on committee members' belief that use of the new terminology would ensure an understanding that both paid health care workers and health care volunteers are included in its recommendations.

"Because of the pertussis outbreak and the resurgence of pertussis, the recommendation is to do it as soon as possible," said Doug Campos-Outcalt, M.D., M.P.A., the AAFP's liaison to the ACIP and associate head of the department of family and community medicine at the University of Arizona College of Medicine, Phoenix. California, for example, had more than 8,600 reported cases of pertussis throughout 2010, and many other states have reported high rates of the disease. The ACIP also voted to recommend postexposure prophylaxis against pertussis for all health care personnel -- regardless of vaccination status -- who have unprotected exposure to pertussis and are likely to expose high-risk patients, including infants and pregnant women. Personnel who do not have contact with high-risk patients can either receive postexposure prophylaxis or be monitored for 21 days after pertussis exposure and treated at the onset of symptoms of pertussis. All of the committee's existing policies regarding immunizations for health care personnel will be included in a compendium committee members approved for dissemination during last month's meeting. According to Jonathan Temte, M.D., Ph.D., a member of the ACIP and a professor in the department of family medicine at the University of Wisconsin School of Medicine and Public Health, Madison, the compendium likely will be published as a *Morbidity and Mortality Weekly Report* supplement by the end of the year. "There are recommendations for health care personnel in other documents," Temte said. "This is an effort to put everything in one unified document. It provides stakeholders with a go-to source of information." Although the 120-page document could be used as a reference manual for infection control personnel and others in hospitals and other health care facilities, Temte said, a tool that would be more helpful for practicing physicians -- a health care personnel immunization schedule -- likely will be developed based on the larger document.

UAMS COLLEGE OF MEDICINE SENIORS MATCH

BY: Richard Wheeler, M.D., Executive Associate Dean for Academic Affairs
March 11, 2011

The general release of the results of the National Resident Matching Program (NRMP) occurred at 11 a.m. central time March 17, 2011. The NRMP allows senior medical students who are seeking first year post graduate positions and institutions that are offering positions the opportunity to rank their preferences confidentially at a uniform rate. The NRMP matches each student to the program ranked highest on his/her listing that offers a position.

This year, 134 UAMS College of Medicine seniors participated in the NRMP match. Eleven failed to match initially but all who wanted a position had one by Match Day. From a national perspective, there were 23,421 PGY1 positions to be filled through the NRMP match. There were 30,589 total active applicants for these positions (16,559 seniors). 22,386 matched and 8203 failed to match.

In addition to the UAMS seniors who utilized the NRMP, eleven received residencies in early matches. As of this date, 52 seniors were appointed to Arkansas residency positions. Eighty seven received out of state residencies in 32 different states.

Forty eight percent of the seniors received residencies in a primary care specialty (Family Medicine, Pediatrics, Internal Medicine, OBGYN).

IN FAMILY MEDICINE – 21 UAMS Seniors matched with Family Medicine Residency programs, (13 in AHEC programs in Arkansas) - down from 26 in 2010. Eight chose out of state family medicine residency programs.

The following Senior's matched with instate Family Medicine Residency Programs:

Allison Lee, UAMS AHEC Jonesboro:
Herbert Lewis – UAMS AHEC Fayetteville:
Meghan Lyerly, UAMS AHEC Jonesboro:
Michael Lyerly, UAMS AHEC Jonesboro:
Charles Martin, UAMS AHEC Jonesboro:
Deirdre McAuley, UAMS AHEC Fayetteville:
John Pounders, UAMS AHEC Jonesboro:
Heather Powell, UAMS AHEC Pine Bluff:
Rachel Sing, UAMS AHEC Fort Smith:
Carl Vinsett, UAMS AHEC Pine Bluff:
Chen Wang, UAMS AHEC Texarkana.

The two other new Family Medicine Residents in the state were 2010 UAMS graduates one who matched with AHEC in Texarkana and one with AHEC in Fayetteville.

OrthoArkansas
Orthopedics & Sports Medicine

Keeping Arkansas Active For Generations

Welcome

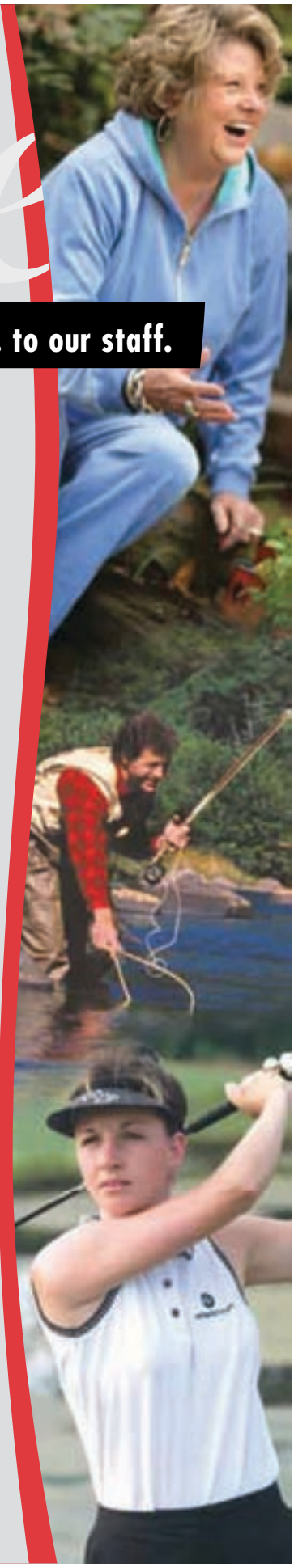
OrthoArkansas is excited to welcome Jason E. Tullis, M.D. to our staff.

Jason E. Tullis, M.D.

Born and raised on the central and southern coasts of California, Dr. Jason Tullis moved around before finding his home in Arkansas. After graduating from Santa Clara University with a degree in English, he enrolled in the Creighton School of Medicine in Omaha, Nebraska. His combined interests in neurologic sciences and surgery brought him to the University of Mississippi Medical Center for his neurosurgery residency. It was there that he developed interests in brain tumors, pituitary tumors, complex spinal surgery, neuro trauma, peripheral nerve injury, hydrocephalus, implantation of spinal devices.

After practicing for four years in a neurosurgery practice, Dr. Tullis joined OrthoArkansas. He looks forward to continuing the long history of compassionate care that this practice has been known for. Dr. Tullis strives to make his patients' lives better through either surgical or non-surgical treatment of conditions of the spine and nervous system.

Dr. Tullis spends time reviewing recent neurosurgical literature and contributes to many publications himself. In his off time, Dr. Tullis enjoys spending time with his family and enjoying the outdoors.



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From AAFP NEWS NOW:

CMS Creates Two Sets of Criteria for E-Prescribing Incentive Program

■ AAFP Dissects Rules for Incentive Payments, Penalties

Family physicians participating in CMS' electronic-prescribing, or eRx, incentive program must meet two different sets of criteria if they want to both avoid a penalty and earn an incentive payment, according to a recent *MLN Matters* article. http://www.cms.gov/MLNMattersArticles/Downloads/SE1107.pdf.

According to the article, physicians must

- submit 10 Medicare claims to avoid a 2012 e-prescribing penalty, and
- submit 25 Medicare claims to *earn* a 2011 incentive and avoid a penalty in 2013.

Additionally, physicians may use a qualified electronic health record, or EHR, or a registry to submit data to qualify for the 2011 incentive payment and avoid the 2013 penalty.

Confused? It all boils down to CMS' interpretation of Section 132 of the Medicare Improvements for Patients and Providers Act of 2008, says Cynthia Hughes, C.P.C., an AAFP coding and compliance specialist and co-author of *Family Practice Management's* "Getting Paid" blog. http://blogs.aafp.org/fpm/gettingpaid/.

CMS specifies that to avoid a penalty against Medicare payments in 2012, physicians must submit 10 Medicare fee-for-service claims before June 30, 2011, that include the additional e-prescribing "G" code 8553 and specific CMS-designated codes in the denominator. http://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp#TopOfPage.

The agency must receive the information from physicians by June 30, 2011, to determine which physicians will incur the penalty beginning Jan. 1, 2012. It's a timing issue, says CMS, noting that it will not even start to receive and process data from EHRs and registries until after Jan. 1, 2012, the date that the agency will apply penalties to physicians' Medicare payments.

CMS will penalize physicians who are not deemed e-prescribers by reducing Medicare payments by

- 1 percent in 2012,
- 1.5 percent in 2013, and
- 2 percent in 2014.

Ironically, physicians who successfully participate in the eRx program by submitting 25 claims within the calendar year via a registry or EHR -- but who do not submit 10 claims with the G8553 code before June 30 -- will be subject to the penalty in 2012, but they still will be eligible for the 2012 eRx incentive.

"Physicians who find themselves in this situation will break even, because they will pay a 1 percent penalty and earn a 1 percent incentive," says Hughes.

Hughes points out that physicians earning the 2011 eRx incentive will be exempt from the eRx penalty in 2013 because CMS will use the 2011 reporting period to determine which physicians incur a penalty in 2013.

Clarification on Primary Care Incentive Program Clears Up Confusion

■ CMS Now Says Docs New to Medicare in 2010 Eligible for 2011 Bonus

Primary care physicians new to Medicare in 2010 may be eligible for the 2011 primary care incentive program, or PCIP, bonus based on claims submitted in 2010. Furthermore, eligibility will be based on the available claims data with no minimum time of Medicare enrollment required.

That's the gist of a recent *MLN Matters* article that answers questions about how CMS will handle newly enrolled Medicare primary care physicians who do not have -- as PCIP rules dictate -- a two-year claims history with which to determine eligibility for the bonus program.

CMS' action should be good news to those AAFP members who had concerns about the program that even AAFP staff had been unable resolve with CMS officials.

The PCIP, which is called for in the Patient Protection and Affordable Care Act, authorizes incentive payments equal to 10 percent of the Medicare-paid portion -- typically 80 percent -- of a primary care physician's allowed charges under Medicare Part B for primary care services provided on or after Jan. 1, 2011, and before Jan. 1, 2016.

The rules for how CMS will handle physicians new to Medicare in 2010 apply to all new Medicare physicians for the duration of the bonus program.

Each year of the PCIP, CMS will determine eligibility for physicians new to Medicare after the third quarter of the incentive year based on the physician's claims data from the prior year. The physician's incentive payment for the entire year will be paid in one lump sum after the fourth quarter of the bonus year.

According to CMS, the payment delay is necessary to allow the agency time to process claims data from physicians who recently signed up to participate in Medicare. All other physicians will receive their PCIP payments on a quarterly basis.

Individual Medicare contractors will post lists of new physicians in their coverage areas who are eligible for the incentive program by Nov. 28 each year.

Cynthia Hughes, C.P.C., an AAFP coding specialist, noted that there are additional details about the PCIP AAFP members should keep in mind. For example,

- bonus payments will be based on the total amount paid to a physician for an entire year for CPT codes 99201-99215 and 99304-99350;
- the Medicare claim must contain a medical group's National Provider Identifier, or NPI, number, as well as the NPI of the individual physician rendering services -- this does not apply in the case of solo physicians with no group number;
- incentive program eligibility and payment amounts are based on the rendering physician's NPI number; and
- bonus payments will be made to the medical group's NPI number.

From AAFP NEWS NOW:

Hypomagnesemia Linked to PPIs Can Cause Serious Adverse Effects

■ Docs Advised to Check Serum Magnesium Levels Before, During Treatment

Long-term use of prescription proton pump inhibitors, or PPIs, can depress serum magnesium levels and, possibly, lead to serious adverse events, the FDA announced recently. Such adverse events can include tetany, arrhythmias and seizures.

According to the agency, about 21 million patients filled prescriptions for PPIs at U.S. retail pharmacies in 2009. Patients stayed on the medications -- which 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 -- for an average of 180 days. In a March 2 safety announcement, the FDA said prolonged use -- longer than one year -- of the medications was associated with adverse events. Eight prescription PPIs were included in the FDA's safety announcement:

- esomeprazole magnesium, which is marketed as Nexium;
- dexlansoprazole, which is marketed as Dexilant;
- omeprazole, which is marketed as Prilosec;
- omeprazole and sodium bicarbonate, which is marketed as Zegerid;
- lansoprazole, which is marketed as Prevacid;
- pantoprazole sodium, which is marketed as Protonix;
- rabeprazole sodium, which is marketed as AcipHex; and
- the combination drug naproxen and esomeprazole magnesium, which is marketed for arthritis relief as Vimovo.

OTC PROTON PUMP INHIBITORS SAFE WHEN USED CORRECTLY, SAYS FDA

The FDA alerted physicians and consumers on March 2 that prescription proton pump inhibitors, or PPIs, may cause hypomagnesemia if taken for prolonged periods. However, the agency said there is little risk of low serum magnesium levels when OTC PPIs are used appropriately. OTC versions of the drugs are marketed at low doses and are intended for a 14-day course of treatment as many as three times per year. Available OTC versions of PPIs include:

- omeprazole, which is marketed as Prilosec OTC;
- omeprazole and sodium bicarbonate, which is marketed as Zegerid OTC; and
- lansoprazole, which is marketed as Prevacid 24HR.

Physicians writing prescriptions for PPIs first should consider obtaining serum magnesium levels, the agency advised. In addition, levels should be checked periodically after beginning PPI therapy in a patient who is expected to need prolonged treatment or who also is taking a medication that causes hypomagnesemia, such as a loop or thiazide diuretic. The FDA said checking serum magnesium levels was particularly important in patients taking the heart medication digoxin because low magnesium can increase the likelihood of serious side effects associated with that drug. Magnesium supplements can be used to treat hypomagnesemia. However, patients who develop the condition may need to discontinue PPI therapy in addition to supplementing their magnesium levels. In one-fourth of the cases reviewed by the FDA, supplementation alone did not improve low serum magnesium levels. The agency issued the following information for physicians:

- Advise patients to seek immediate medical care if they experience signs of hypomagnesemia, including arrhythmias, tetany, tremors or seizures, while taking PPIs. In children, arrhythmias may cause fatigue, upset stomach, dizziness and lightheadedness.
- Consider PPIs as a possible cause of hypomagnesemia, particularly in patients who are clinically symptomatic.
- OTC versions of the drugs are marketed at lower doses and are intended for a 14-day course of treatment as many as three times per year. However, physicians should be aware that consumers may take OTC PPIs for periods of time that exceed directions on OTC labels. Physicians who recommend prolonged use of an OTC product should tell patients about the risk of hypomagnesemia.

Report adverse events involving PPIs to the FDA's MedWatch program.

From AAFP NEWS NOW:

Academy Makes Extra Effort to Equip Members for ICD-10

■ New Resources Available

The date for implementing ICD-10-CM is on the horizon. And to ensure that family physicians are ready, the Academy has added to its cache of resources ahead of the Oct. 1, 2013, implementation date.

Materials new to the ICD-10-CM resource site include

- ICD-10 Codes for Signs and Symptoms (members only; 6-page PDF; About PDFs);
- ICD-10 Codes for Hypertension and Hypotension (members only; 7-page PDF; About PDFs); and
- a presentation titled "5010 & ICD-10 Overviews " (42-page PDF; About PDFs) created by Cynthia Hughes, C.P.C., an AAFP coding and compliance specialist.

According to Hughes, the change from ICD-9 codes to ICD-10 codes will affect just about every family physician.

Similarly, the change to the 5010 transaction standards -- as mandated by the Health Insurance Portability and Accountability Act -- will affect all parties that send health information in electronic formats. For example, the new standards will affect patient eligibility inquiries and claims submissions, and thus, software vendors and clearinghouses, claims processors and payers, and physicians and other health care professionals.

"This is a significant change, and physicians need to get their practices ready," says Hughes.

Billing Manager Stresses 5010, ICD-10 Readiness

Debbie Kalthoff echoes Hughes' concerns regarding practice readiness for ICD-10 and for 5010 transactions that go into effect on Jan. 1, 2012. As the billing manager

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

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

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

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

for Meritas Health Corp., Kalthoff oversees the billing for seven hospital-owned primary care clinics and three subspecialty clinics. She has been deeply involved in preparing the practices that rely on her expertise for the change.

"If you're not ready for it, your claims are not going to go through, and you're not going to get any money. Your cash flow is going to suffer," she says.

Kalthoff advises practices to be in close touch with their software vendors. "The key is your software vendor, because the vendor is going to have to guide you through and help you," she notes.

For example, Kalthoff says her organization's software vendor -- who in her case also serves as the clearinghouse -- is in the "testing mode" and has been sending some test claims through to payers in the new 5010 format.

"They started testing last fall, and as of December, they only had one payer that was accepting 5010 transactions," says Kalthoff.

Academy Collaborates on 2011 ICD-10 Summit

In its extended push to help family physicians get ready for ICD-10 implementation, the Academy has signed on as a collaborating partner of the American Health Information Management Association ICD-10 Summit, which will be held April 11-12 in Baltimore.

AAFP members are eligible for a $200 discount on conference registration. Use coupon code MX5598 when registering for the event.

Selected practice staff members -- those who belong to the American College of Medical Coding Specialists or the Healthcare Billing and Management Association -- also are eligible for the summit discount.

Care Transitions: Focus on Quality and Accountability

By: J. Gary Wheeler, MD, MPS, and Pamela Brown, RN, BSN, CPHQ

As today's health care continuum grows more complex, information management and communication are essential components to ensure the best outcomes for patients. Because patients see multiple physicians and health care providers, there is a growing risk of poor care coordination. This can increase the potential for medication errors, adverse events and more frequent visits to the hospital through readmissions and emergency room visits. Addressing duplication of services and waste by improving care transition will lead to more efficient and higher quality care.

The *Journal of the American Medical Association* details a study which sought "to characterize the prevalence of deficits in communication and information transfer at hospital discharge and to identify interventions to improve this process."[1] The study analyzed hospital and physician communications over an approximately 30-year period. The results revealed infrequent direct communication between hospital physicians and primary care physicians (PCPs), ranging between 3 percent and 20 percent occurrence. Also, discharge summary availability was low at post-discharge visit (12-34 percent) and also at four weeks post-discharge (51-77 percent). This was shown to affect quality of care in approximately 25 percent of follow-up visits and to contribute to patients' dissatisfaction with the PCP. Even when discharge summaries were available, important information such as diagnostic test results, treatment or hospital course, discharge medications, test results pending at discharge, patient or family counseling and follow-up plans was often often missing.[1]

The need for improved care coordination has been widely recognized. In July 2007, a Transitions of Care Consensus Conference (TOCCC) was convened by the Executive Committees of the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM) and the Society of Hospital Medicine (SHM). Fifty-one participants from 30 organizations attended this conference, including a staff representative for the AMA-convened Physician Consortium for Performance Improvement®. Participating organizations included the American Academy of Family Physicians, America's Health Insurance Plans, Case Management Society of America, the Centers for Medicare & Medicaid Services, National Committee for Quality Assurance and the National Quality Forum. Representatives from pharmacist groups and patient groups such as the Institute for Family-Centered Care were also in attendance.[2]

In 2009, the Physician Consortium for Performance Improvement published *Care Transitions: Performance Measure Set* for public comment. This measure set has since been endorsed through the National Quality Forum. The measures focus on safe and effective transitions of care between settings. Processes addressed include:

- Timely delivery of care
- Effective coordination
- Timely transfer of information
- Increasing engagement
- Increasing understanding adherence to treatment plan

The recommendation is to address the measures as an entire bundle which includes:

I. Reconciled medication list is received by discharged patients.
II. Transition record with specified elements received by discharged patient:
   a. Reason for inpatient admission
   b. Major procedures and tests performed during inpatient stay and summary of results
   c. Principal diagnosis at discharge
   d. Advance care plan or reason for not providing
   e. Current medication list
   f. Studies pending at discharge
   g. Contact information valid 24 hours a day, seven days a week, including a physician for emergencies related to inpatient stay
   h. Plan for follow-up care
   i. Physician or other health care professional designated for follow-up care
III. Transition record with specified elements received by discharged patient.[3]

continued on page 24

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continued from page 22

Health care providers who address these measures recognized the role that accurate medication management plans in patient outcomes, the impact of detailed discharge information in patient self-management and follow-up care, and how timely communication of this information can improve continuity of care and reduce readmissions.

Care transitions and the Medicaid Inpatient Quality Incentive program

The Medicaid Inpatient Quality Incentive (IQI) program, implemented in 2006 for state fiscal year (SFY) 2007, awards participating hospitals for achieving improved quality by meeting criteria and reaching improvement thresholds. In 2008, for SFY 2009, the concept of care transitions was introduced to hospitals providing care to Arkansas Medicaid patients. Initially, hospitals were required to implement a discharge process which included a care transitions/ care coordination process. Hospitals' records were reviewed to determine if they had a process which includes a document with required elements for communication. Only 21 of 63 (33.3 percent) passed the validation of this process.

For SFY 2010, the draft three measure set bundle was included in the program for data submission. Forty-eight hospitals chose to participate in the program. The results were as follows:

I. Reconciled medication list is received by discharged patients – 71.6%
II. Transition record with specified elements received by discharged patient – 25.2 %
III. Timely transmission of transition record – 39.8%

Measure II is an "all or nothing" measure. In other words, the transition record must contain all of the elements required to pass the measure. Hospitals achieving the most success with this are those that have implemented a standard form or template for capturing the information. Evaluating processes, understanding the rationale behind the measures and physician support are at the heart of improving these measures.

Going forward

A focus on care transitions is continuing to grow. The Arkansas Medicaid IQI program for SFY 2011 will evaluate three care transitions measures for performance improvement. Hospitals will be required to achieve above the 75th percentile calculated from the statewide baseline for each measure or a 35 percent reduction in failure rate based on the hospital's own baseline performance. Performance rates are also validated. A hospital can achieve one or the other threshold to pass the performance criteria. On a national level, the Joint Commission for Accreditation of Healthcare Organization includes this in both their national Patient Safety Goals and their survey process for accreditation. Care transitions are at the center of the medical home model which establishes a hub or "home" for coordination of a patient's care. The Centers for Medicare & Medicaid Services (CMS) continues to hold care transitions across settings of care as a priority. The multiple professional organizations and stakeholders who have committed to better communications and care coordination only further underscores the importance of this work for improving patient outcomes.

Hospitals showing the most success with this measurement have implemented a standardized process using a format that ensures capture of the key elements and communication of the information to the next provider of care. This strategy is most successful when the care team accepts accountability of patient handoffs. As health care embraces the electronic exchange of information, this process should become more efficient. Until then, organizations are challenged with providing information to the next provider of care which may not have electronic access to a hospital's medical information.

J. Gary Wheeler, MD, MPS, is medical director for quality improvement at the Arkansas Foundation for Medical Care and professor of pediatrics at University of Arkansas for Medical Sciences. Pamela Brown, RN, BSN, CPHQ, is assistant vice president for health care quality improvement at Arkansas Foundation for Medical Care.

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From AAFP NEWS NOW:

E-Guide Spotlights Academy Resources, Benefits for New FPs, Other Members

New family physicians and other AAFP members who want to know more about their Academy membership benefits and how to get the most out of them now have a new electronic guidebook, "New Physicians: You and the AAFP."

The 38-page e-guide, which also can be downloaded as a PDF, walks members through -- among other topics -- the Academy's organization and structure, including information about its constituent chapters, its mission and objectives, and various ways members can become involved in the AAFP. The new guide also describes the AAFP's wide array of membership benefits, including

- **My Academy** -- members' personal web portal on the Academy's website from which they can manage their CME, register for a course, pay dues or even build their practice website;
- ***American Family Physician*** -- the AAFP's highly respected clinical journal;
- ***Family Practice Management*** -- a management journal that focuses on family medicine practice needs;
- ***AAFP News Now*** -- the Academy's online news publication; and
- **FamilyDoctor.org** -- the AAFP's consumer/patient education website.

In addition, the guide provides details on advantage partner discounts for members, AAFP e-mail discussion lists, and the Academy's presence on social media outlets, such as Facebook and Twitter. New physicians will be especially interested to learn about "Experience the AAFP," a program that offers discounts and information targeted to physicians in their first seven years of practice. Students and residents will find information about career services -- including CareerLink, an employment search engine dedicated to family physicians and employers seeking candidates for clinical and faculty positions -- and about making career, practice and contract decisions. Other sections of the guide discuss the AAFP's advocacy activities, as well as the many leadership opportunities the Academy offers. "The nice thing about the guide is that it provides incredible resources within the AAFP to assist members in getting started and throughout their careers," said AAFP Member Relations Strategist Callie Castro. "It's not just about the AAFP and what we do, it's about how members can best succeed in their careers."

Health Care Reform Puts Payment Bundling to the Test

■ Success Demands Primary Care Participation, Says Expert

A primary goal of the Patient Protection and Affordable Care Act is to rein in U.S. health care expenditures without sacrificing quality. To meet that goal, one provision of the act aims to test a new payment methodology by creating integrated care delivery systems that include hospitals, physicians, and other health care service providers and suppliers.

According to one expert in health care law, the success of any such payment strategy absolutely depends on the involvement -- and fair treatment -- of primary care physicians. As described in Section 3023 of the Affordable Care Act the HHS secretary "shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality and efficiency of health care services." In short, the pilot will assess whether Medicare can save money while maintaining quality of care by providing one single payment for an episode of care, with that payment then distributed to all the individual providers of services and goods that were involved in that episode of care. The payment bundling pilot program is to be established no later than Jan. 1, 2013, and will run for a period of five years. No later than Jan. 1, 2016, the HHS secretary shall submit a plan to implement an expansion of the pilot program if doing so will reduce spending and improve -- or not reduce -- the quality of patient care.

Program Definitions and Details

Many of the rules and regulations guiding implementation of the pilot program have yet to be written, but the basic tenets of the program are laid out in the legislation. The provision defines an "applicable beneficiary" as an individual who is entitled to Medicare Part A benefits and enrolled in Part B. In addition, the beneficiary must be admitted to a hospital for a so-called applicable condition. For the purposes of the pilot, HHS will select 10 applicable conditions, ensuring, among other things, that

- the 10 conditions chosen include a mix of chronic and acute medical conditions,
- the conditions chosen involve both surgical and medical conditions,
- each condition selected offers an opportunity for health care professionals and service suppliers to improve quality and reduce total expenditures, and
- each condition is considered high-volume and entails high post-acute care expenditures.

The law specifies that an episode of care encompasses

- the three days prior to the patient's admission to the hospital,
- the patient's length of stay in the hospital, and
- the 30 days following the patient's hospital discharge.

A group of health care professionals and service providers -- "including a hospital, a physician group, a skilled nursing facility and a home health agency" -- will provide patient care during the episodes of care. Although the participation requirements for these groups, or "entities," have not yet been developed, HHS is required to ensure that Medicare patients involved in the pilot program have a choice of providers and services.

Paying for Quality

Under the payment bundling pilot, a single payment will be made to each integrated care entity for all services provided during an episode of care. That payment cannot be more than Medicare would pay for those services outside of the pilot program.

AAFP PERSPECTIVE ON PAYMENT BUNDLING

AAFP President Roland Goertz, M.D., M.B.A., of Waco, Texas, told *AAFP News Now* that it's important for the Academy to closely monitor policy discussions on all payment methodologies. "The Academy has not taken a stand on any specific type of payment, and we are hindered, to a certain extent, by antitrust issues from getting into very detailed discussions about payment models," said Goertz. Even so, Goertz said the Academy "still stands behind the belief that any eventual payment system has to be a blended, three-part model that includes the best of the fee-for-service model, a patient-management or patient-coordination fee, and a quality payment of some sort." Even though a bundled payment makes a nice neat package for the payer, "it puts an awful lot of pressure on the governing body of the entity that is responsible for seeing that all the health care pieces are delivered and that all of the health care professionals are appropriately paid," said Goertz. "If bundled payments advance, family physicians need to have a very explicit and clear understanding of the amount of their piece of that bundled payment," he added. According to Bruce Bagley, M.D., the Academy's medical director of quality improvement, a bundled payment "works great for a broken leg, a fractured hip, or an episode of congestive heart failure that requires hospitalization. There's a very specific start of the episode, and it's easy to ascribe medical services connected to that episode." "However, most people, especially those enrolled in Medicare, don't have just one thing," he noted, "and when you try to apply bundled payment methodology to a patient with multiple chronic illnesses, it just doesn't work well."

The bundled payment will be comprehensive in that it will cover the costs of the health care services provided during an episode of care. In addition, the payment will include remuneration for such services as care coordination, medication reconciliation, discharge planning, transitional care services and other patient-centered activities, as determined by HHS. The agency also will establish procedures to cover payment for post-acute care services that may be required after the last day of an episode of care. To determine the program's effectiveness, the provision calls for the HHS secretary to establish quality measures capable of assessing such factors as

- patients' functional status improvement,
- reductions in the rates of avoidable hospital readmissions,
- rates of discharge to the community,
- rates of admission to an emergency room after a hospitalization,
- incidence of health care-acquired infection, and
- efficiency measures.

HHS also will measure patients' perception of the care they received. The pilot will be evaluated based on improvements in these quality measures, other aspects of patients' health outcomes and patients' access to care, as well as on the program's ability to reduce spending.

Use Your Bargaining Power

Jon Henderson, J.D., is an attorney in the Dallas office of the international law firm K&L Gates. His professional focus includes health care law, and he counts physician groups among his clients. As co-author of an article titled "Two New Cost Containment Measures: Medicare Shared Savings Program and National Pilot Program on Payment Bundling" that was published on the firm's website in September 2010, Henderson has specifically examined cost-containment strategies within the health care industry. In an interview with *AAFP News Now*, Henderson stressed that every bundled payment relationship has two parts -- clinical management and financial management. "It's a matter of getting the metrics right for ensuring payment for what physicians contribute to the patient's care and then having the physicians' financial expectations met in that business deal," he said. Regarding HHS' payment bundling pilot, Henderson said, "There will have to be some part of the regulations that will make things fair for primary care physicians or it will fail because those physicians won't participate." "Primary care is where the magic happens in health care because it results in better patient care and better patient outcomes," said Henderson. "One of the major themes of health care reform is lowering costs, and that means favoring health care delivered by primary care physicians. Most everyone would agree that a hospital is generally the most expensive setting in which to deliver health care," he added. Henderson encouraged primary care physicians to take advantage of their "marketplace leverage" when it comes to negotiating their terms in a bundled payment environment. "If you are critical to the success of (payment bundling strategies) because the rules say 'we have to have primary care on the front and back end,' then you have a strong voice at the table," he said.

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Erika Petersen, M.D., neurosurgeon
Yulong Yan, Ph.D., medical physicist
Karen Baxter-Rhoades, R.N.
José Peñagaricano, M.D., radiation oncologist

Other team members include:
Kenneth Gardner, M.D., radiation oncologist
Eduardo G. Moros, Ph.D., medical physicist
Vaneerat Ratanatharathorn, M.D., radiation oncologist

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