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Congress passes one-year Sustainable Growth Rate (SGR) fix

In early December, the House and Senate approved legilation preventing implementation of a 24.9% cut in Medicare physician payments scheduled to take effect on January 1, 2011. The "Medicare and Medicaid Extenders Act of 2010" (H.R. 4994) extends current Medicare payment policies for 12 months, expiring on December 31, 2011. The enactment of H.R. 4994 marks the fifth time in 2010 that Congress enacted legislation preventing cuts in Medicare payments for physicians.

In addition to preventing cuts in physician payments, H.R. 4994 extends several provisions set for expiration on December 31. Most notably of those provisions, is a 12-month extension of the floor of 1.0 for the "work" geographic practice cost indices or Geographic Practice Cost Index (GPCI) for all geographic regions. This provision is important to most rural communities and states and provides equity in payments in relation to larger urban areas. In addition, the legislation provides $200 million to the Centers for Medicare and Medicaid Services (CMS) to process and pay claims filed during 2010 that are eligible for higher payments as a result of changes in legislation.

CMS introduces new Center for Medicare and Medicaid Innovation

On November 16, 2010, CMS announced the establishment of the Center for Medicare and Medicaid Innovation (CMMI). This center is charged with identifying, evaluating, and supporting new delivery models in Medicare and Medicaid. Created by the Affordable Care Act, the Innovation Center will examine new ways of delivering health care and paying health care providers that can save money for Medicare and Medicaid while improving the quality of care. The CMMI will focus on three major areas—patient care models, coordinated care models, and prevention and wellness—and will evaluate based on three criteria: patient experiences, outcomes, and costs (defined as the tipping point of improved outcomes per dollar spent).

CMS also announced the launch of new demonstration projects that will support efforts to better coordinate care and improve health outcomes for patients.

- Eight states have been selected to participate in a demonstration project to evaluate the effectiveness of doctors and other health professionals across the care system working in a more integrated fashion and receiving more coordinated payment from Medicare, Medicaid, and private health plans. Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota will participate in the Multi-Payer Advanced Primary Care Practice Demonstration that will ultimately include up to approximately 1200 medical homes serving up to one million Medicare beneficiaries.
- The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration will test the effectiveness of doctors and other health professionals working in teams to treat low-income patients at community health centers. The demonstration will be conducted by the Innovation Center in up to 500 FQHCs and provide patient-centered, coordinated care to as many as 195,000 people with Medicare.
- A new state plan option under which patients enrolled in Medicaid with at least two chronic conditions can designate a provider as a "health home" that would help coordinate treatments for the patient. States that implement this option will receive enhanced financial resources from

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the federal government to support "health homes" in their Medicaid programs.

The Innovation Center also announced an upcoming opportunity for States to apply for contracts to support development of new models aimed at improving care quality, care coordination, cost effectiveness, and overall experience of beneficiaries who are eligible for both Medicare and Medicaid, also known as "dual eligibles." The Innovation Center expects to award up to $1 million in design contracts to as many as 15 state programs for this work.

HRSA announces information on THCGME

On November 29, the Health Resources and Services Administration (HRSA) released information on the Teaching Health Center Graduate Medical Education (THCGME) program. Established under Section 5508 of the Affordable Care Act (ACA), the program is a $230-million, five-year grant opportunity intended to support an increased number of primary care residents and dentists trained in community-based ambulatory patient care settings. These settings include federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service or an Indian tribe or tribal organization, and entities that receive funds under Title X of the Public Health Service Act. To be eligible for funding, the THC must be listed as the institutional sponsor of the program by the relevant accrediting body (the AOA, ACGME, or, for dental programs, the American Dental Association). According to HRSA, the THC may be a central component of a consortium that the appropriate accrediting body lists as the residency's sponsoring institution. Grant funding will include payment for both direct and indirect training expenses. Although the program period is one year, HRSA states that qualified THCs will be funded for the entire five-year period pending satisfactory performance and the availability of federal funds.

CMS expands eligibility criteria for primary care bonus

At the urging of the ACOFP and other primary care organizations, CMS, as part of the 2011 Medicare Physician Fee Schedule, has modified the eligibility criteria for the primary care bonus established by the Affordable Care Act (P.L. 111-148), ensuring that a larger percentage of family physicians and general internists will qualify for the bonus.

Under the revised criteria, CMS will limit the eligibility denominator to Medicare Fee Schedule allowed–charges only—meaning it will exclude lab services and other charges—and they will subtract hospital visits from the denominator. With these changes, CMS estimates that 80% of family physicians and 60% of general internists will qualify for the 10% bonus payment.

2011 Medicare Physician Fee Schedule

According to the 2011 Medicare Physician Fee Schedule, several provisions of the ACA went into effect January 1, including:

- Elimination of the deductible and co-insurance for most preventive services
- Coverage of an annual wellness visit providing a personalized prevention plan
- Incentive payments to primary care practitioners for primary care services
- Incentive payments for major surgical procedures in Health Professional Shortage Areas
- Physician self-referral disclosure requirement for certain imaging services
- Multiple procedure payment reduction policy for therapy services
- Reduction of the maximum period for submission of Medicare claims to not more than 12 months (applies to services furnished after January 1, 2010)

The final rule also implements ACA's changes to the structure and function of the Physician Quality Reporting System (PQRS; formerly known as the Physician Quality Reporting Initiative). Under the ACA, the PQRS incentive payments are authorized through 2014, with penalties thereafter for eligible professionals who do not satisfactorily report data on quality measures. For 2011, physicians and other eligible professionals may earn an incentive payment of 1.0% of the practice's total Medicare Part B–allowed charges for covered professional services furnished during the reporting period. Other changes include:

- PQRS incentive payments of 0.5% are authorized for years 2012 through 2014
- CMS has created an informal review process for eligible professionals who wish to have CMS review its determination
- Eligible professionals may qualify for an additional 0.5% incentive beginning in 2011 if they satisfactorily report data through a Maintenance of Certification program

CMS is also establishing the framework for a new Physician Compare website and is developing a plan to integrate its reporting on quality measures under PQRS with the reporting elements required by the Medicare Electronic Health Record Incentive Program.

In addition, CMS made revisions to its Electronic Prescribing Incentive Program such as clarifying that physicians and other eligible professionals who receive incentives under the Medicare EHR Incentive program for 2011 must still participate and meet the eRx payment adjustment requirements for successful e-prescribers under the eRx Incentive program during the applicable reporting period to avoid the payment reduction applicable in 2012. Eligible professionals who receive incentives under the Medicare EHR Incentive Program for CY 2011 may not receive a

separate, additional incentive payment under the eRx Incentive Program.

Congress passes Red Flag Rule Clarification

On December 7, 2010, Congress passed the "Red Flag Program Clarification Act of 2010" (§3987). This legislation clarifies the Fair and Accurate Credit Transaction Act to ensure that small physician practices do not face undue regulatory burden associated with complying with previous definitions of the Red Flags Rule.

The original rulemaking accepted definitions of "creditors" as any person that sells a product or service for which the consumer can pay later, including physicians and dentists—an interpretation not supported by the ACOFP. The clarification of the definition of "creditors" puts an end to the regulatory and legal wrangling that has plagued this important consumer protection measure since 2008.