



AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

November 14, 2007

The Honorable Richard J. Durbin
309 Hart Office Building
U.S. Senate
Washington, DC 20510

The Honorable Richard Burr
217 Russell Office Building
U.S. Senate
Washington, DC 20510

Dear Senators:

Thank you for the opportunity to review the draft *Medical Homes Act*. We greatly appreciate the considerable efforts that you and your staff have devoted to developing this far reaching legislation. The demonstration of the patient-centered medical home within the Medicaid program and the State Children's Health Insurance Program will provide a significant opportunity to examine the considerable benefits of this care-management and preventive care program.

The legislation, calling on the extensive experience of the Community Care of North Carolina program, would encourage patients to use a personal primary care provider to coordinate all of the patient's health care. This primary care provider would maintain a complete medical record for the patient and would help the patient secure needed medical services and provide the specialist or ancillary service provider with all the information necessary to treat the patient safely and efficiently. Coupled with a local network of service providers to make sure the patient's medical needs are met, the patient-centered medical home will help improve the quality of care and help contain the costs of that care.

On behalf of the 93,800 members of the AAFP, I commend this bipartisan approach to exploring reform of health care. We particularly appreciate the bill's emphasis on primary care as the principal site of the patient-centered medical home and note that the bill requires the medical home to be physician-directed. The evidence pointing to better health outcomes and reduced costs include both factors. I would be remiss, however, if I didn't mention a few concerns that we have with the draft while noting that we are eager to work with you on resolving them.

1. Determining which physician-led practice qualifies as a patient-centered medical home.

The Medical Management Committee, as defined in Section 3 beginning on line 7 of page 5, would be authorized to establish "standards and measures for patient-centered medical homes, taking into account nationally developed standards and measures" (lines 21-24) and would determine "based on statewide quality improvement standards, [which physician-directed practice or health center] has the capability to achieve improvements in the management and coordination of care for targeted beneficiaries" (page 6, lines 17-22). The four organizations with primary care physicians (i.e., AAFP, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association) have been concerned about the emergence of differing definitions of a medical home, many promoted by specific disease management companies or insurance plans for purposes unrelated to improved health care. In order to prevent physicians having to respond to multiple sets of different requirements, the National Committee for Quality Assurance (NCQA) has been working, with the assistance of our four organizations, to develop a single set of standards that would apply nationally to any physician practice that wanted to be designated a patient-centered medical home.

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While the legislation encourages the local medical management committee to "take into account nationally developed standards" for a patient-centered medical home, our concern is that there is no incentive for a practice to look to the national standards or for the medical management committee to use them. We understand your interest in keeping the medical decision making as local as possible, but we would suggest that the legislation at least require the local medical management committees to automatically deem a physician practice to be a qualified medical home if it has achieved recognition by NCQA or other national standard setting organization. Our preference would be to avoid having the medical management committees reinventing the wheel by simply making the NCQA standards the minimally acceptable standards for a patient-centered medical home designation. The success of health reform measures intended to improve quality, health outcomes and cost-effectiveness will depend on universality and consistency across programs. It is self-defeating to promote numerous and varied programs with the same evidence-based and performance measurement purposes.

2. Determining the performance measures that will apply to the patient-centered medical homes.

Again, in order to avoid re-inventing the wheel and creating a proliferation of performance measures for single disease treatments, we would prefer that the legislation require the medical management committees to choose their performance measures from the list determined by the Physicians' Consortium for Performance Improvement, those endorsed by the National Quality Forum (NQF) and those chosen for primary care implementation by the AQA (formerly the Ambulatory Quality Alliance). This process creates a single, reliable, evidence-based list of performance measures. While it is important to adapt the patient-centered medical home to local conditions, it is perhaps unrealistic and certainly unnecessary to ask the local medical management committees to undertake the expensive and time-consuming process of setting their own performance standards.

3. Setting the per-patient per-month care management fee at \$2.50

We appreciate the fact that the legislation is attempting to set a floor for this necessary payment for care management within the Patient Centered Medical Home, but the bill does not provide the states or the Centers for Medicare and Medicaid Services (CMS) with guidance for determining how much this fee should be. As a result, states are likely to use this floor as the payment amount. We would suggest that the payment may be perfectly adequate (as shown in the Community Care of North Carolina program) for some areas but not for others. Instead of specifying a minimum fee, we would propose that each state determine the fee based on a recommendation from a value-determination team made up of a representative of CMS and each of the primary care physician organizations in the state.

4. Payments to the Steering Committees

Beginning on page 17, the bill provides for a state payment of \$2.50 per targeted beneficiary per month to the steering committee and treatment of these amounts as medical assistance for federal matching purposes. The express use of these funds is for the purchase of health information technology and payments to primary care case managers and other purposes determined by the steering committee. Given the significant barriers represented by the cost of installation and maintenance of electronic health records, this amount may be inadequate for the stated purpose. We would recommend the state use the same mechanism that we recommended for the payment to the personal healthcare provider to evaluate and set an appropriate payment rate to the steering committees.

5. Composition of the local medical management committee

The composition of the medical management committee does not seem to be specified beyond "a group of local practitioners." This committee, like the steering committee, should be required to have mostly primary care physicians.

The patient-centered medical home concept is emerging as a potentially powerful mechanism to improve health care and control costs. But its success depends on how it is defined and the tools available to implement the concept. Your legislation is an important step forward in this process and we are grateful for your vision and your efforts. We would be very pleased to continue working with you and your staff on this important legislation.

Sincerely,



Rick Kellerman, MD, FAAFP
Board Chair