



AAFP News: AAFP Edition

Policy and Health Issues in the News

Research Shows Complexity of Primary Care

A recently published study of patients with diabetes mellitus offers insight into the complex health problems that family physicians and other primary care physicians help their patients manage. In a report published online in *Primary Care Diabetes*, researchers at the Robert Graham Center for Policy Studies in Family Medicine and Primary Care investigated how the complexity of primary care visits compares with that of subspecialist visits. The study measured the complexity of patient visits based on the number of chronic conditions each patient with diabetes reported, and the number of reasons for each office visit. The study showed that 48% of all visits made by patients with diabetes and no other chronic conditions were to primary care physicians. The number decreased to 45% for those with one other chronic condition, 44% for those with two to four other chronic conditions, and 39% for those with five or more other chronic conditions. In general, patients with diabetes made more visits to subspecialists than to primary care physicians, but those subspecialist visits were more likely to involve only a single diagnosis. For more information, go to <http://www.aafp.org/news/practice-professional-issues/20160126complexitystudy.html>.

AAFP Urges Changes in Chronic Care Policy

A Senate working group exploring ways to revise the delivery of chronic care for patients in government health plans recently sought input from the American Academy of Family Physicians (AAFP). Specifically, the group is interested in policy options to engage persons with multiple chronic conditions while better aligning incentives for health care professionals who coordinate patient care. In response, the AAFP outlined its support for revising evaluation and management codes, eliminating the monthly patient copayment for chronic care management, expanding the use of telemedicine, and changing the way patients join accountable care organizations. The AAFP said the establishment of a code for chronic care management—99490, which pays an average of \$42 per visit—was a positive step, but emphasized that one code is not broad enough to cover complex visits that require more time. Another major change the AAFP advocated is a shift from fee-for-service payments alone to blended payments that include a monthly capitation payment for chronic care as well as fee-for-service. For more information, go to <http://www.aafp.org/news/government-medicine/20160203chroniccareenate.html>.

Report: PCMH Model Shows Steady Progress

An annual report on patient-centered medical homes (PCMHs) shows that the model is contributing to reduced costs and improved patient care on multiple fronts. The Patient-Centered Primary Care Collaborative recently hosted a discussion on Capitol Hill about the report and the future prospects for medical homes. According to the report, PCMH initiatives are making steady progress on reducing costs and the volume of expensive procedures. Among 23 studies that measured changes in cost, 21 reported reductions in one or more categories. Likewise, among 25 studies that evaluated hospital utilization rates, 23 reported reductions in one or more categories. However, the report highlights the need for better support of the primary care practices that are crucial to the success of the PCMH model. For more information, go to <http://www.aafp.org/news/practice-professional-issues/20160205medicalhomes.html>.

AAFP Urges CMS to Bolster Network Standards on Federal Exchanges

As the Centers for Medicare and Medicaid Services (CMS) prepares to update its guidance for insurers on federal exchanges, the AAFP sent the agency a letter emphasizing the importance of creating guidelines to ensure that patients can access the primary care they need without disruptions. In his letter to CMS, AAFP Board Chair Robert Wergin, MD, noted that the AAFP supports CMS' efforts to address the problem of narrow insurance networks. The agency proposed two measurements for determining whether a network adequately covers a designated area: the maximum time and distance a patient must travel for care, or a minimum ratio of physicians to patients for each specialty. In large metropolitan areas, a primary care physician would have to be within 10 minutes and five miles of a patient. In a rural area, the maximum distance would be 40 minutes and 30 miles. The AAFP noted that it supports the proposed standards but suggested that such calculations should account for the availability of public transportation. The letter also asked CMS to minimize the care disruption that comes from shrinking networks. For more information, go to <http://www.aafp.org/news/government-medicine/20160121federalexchanges.html>.

— AAFP AND AAFP NEWS STAFF

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