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January 15, 2010

Ed Homan, M.D.  
Representative, District 60  
1302 The Capitol  
402 South Monroe St.  
Tallahassee, FL 32399

Honorable Tom Arnold, Secretary  
Agency for Health Care Administration  
2727 Mahan Drive  
Tallahassee, FL 32308

Medical Homes Task Force members  
c/o Agency for Health Care Administration

Dear Dr. Homan, Secretary Arnold and Medical Homes Task Force members:

The people of Florida owe all of you and your very professional staff members much gratitude for your vision and hard work on development/implementation (hopefully) of the medical homes concept for Florida. On behalf of AARP, I extend to you sincerest thanks for your individual contributions to this effort and for allowing AARP to participate on behalf of Florida's consumers in this initiative.

AARP also appreciates the fine effort by Rep. Homan and Carol Gormley, staff director for the House Health Policy Council, to develop a first draft of a potential bill to implement the medical homes concept. For your review, consideration and further discussion, AARP attaches some initial concerns, questions and comments on that draft bill.

Sincerely,

Jack L. McRay  
Advocacy Manager, AARP  
Member, Medical Homes Task Force

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AARP  
1.14.10 COMMENTS ON DR. HOMAN'S DRAFT BILL  
MEDICAL HOMES

● There are undefined terms (e.g., “medical home”) used in the substantive language, and it appears that multiple terms are used to define the same thing: e.g., “community network” v. “medical home network.” The definitions need to be comprehensive and the defined terms should be used throughout.

● Section 409.91207 is an existing section of the Florida Statutes. I assume subsequent drafts will show additions and deletions to existing sections. The importance?--Will the waiver provisions under s. 409.91207(6) suffice or do they need amendment?

● Lines 12-13: As set forth in subsection (1), the medical home model is for care in a “fee-for-service (FFS) environment.” The Task Force (“TF”) indicated that medical home networks should be authorized to receive payment on a FFS basis or on a capitated basis (or, perhaps on some hybrid). Later sections would authorize MCO participation as a medical home (or network), but with payment based on fee-for-service rates that would otherwise be applicable. If inconsistent, this should be corrected. Unless otherwise prohibited by the feds, the payment methodology(ies) should be decided by networks, as long as the networks’ choices comply with statutory requirements and principles of the concept.

● I recall the TF recommended that the medical home networks should be developed at the local level (i.e., from the bottom up, instead of the top down). This proposal should clarify what the basic requirements are for two separate designations: (1) who or what type of business organization (arrangement) could be designated a medical home within a network; and (2) who or what type of arrangement would meet established minimum standards for designation as a network. Once established statutorily or by rule (whichever is appropriate), then AHCA could certify networks as meeting minimum standards, and consideration should be given to letting the networks certify participants as medical homes. That could be less costly and less cumbersome administratively. It also could permit networks to be customized to local needs and capabilities.

● Line 39: Perhaps this definition should be clearly labeled as a “medical home primary care provider.” “Primary care provider” is an oft-used term and may lead to confusion amongst the public and providers. Is it appropriate/necessary to limit providers to federally qualified health centers, and some professionals under Ch. 458, 459 and 464? If this term is meant to reflect providers serving as “medical homes,” is it appropriate to preclude hospital systems or other organizations which have the requisite staff and meet other requirements from being a medical home primary care provider?

● Lines 152-154: The transmittal to which this draft is attached reflects a desire for current TF members to serve in that capacity until the “spring of 2011.” The proposed bill would not ensure that outcome. The effective date of the draft legislation is June,

2010. Technically, the successor advisory panel members could be designated anytime on or after that date. Suggested amendment: “On or after (specific date—e.g., July 1, 2011, would retain the TF through the 2011 legislative Regular Session and through the states next fiscal year), a statewide advisory panel shall be established to advise...” Also, should consideration be given to how long advisory panel members could serve (or should they serve at the will of the appointing official and member) and how would a member otherwise be removed? If a term were set, would there be opportunity for reappointment?

- As drafted, lines 176-185 permit AHCA to designate as few as one “medical home.” I think that should be amended to be at least one “medical home network” (or other consistent and appropriate term). One medical home could be one physician—hardly a basis for a statistical analysis of the effectiveness of the medical home concept. Even if “network” should be a more appropriate term, would there need to be further directive to AHCA about increasing the numbers and types of network sites beyond the possibility of only one (large or small)? Another concern is the precept that medical homes would only be available in areas where Medipass is available and that execution of participation agreements would only be by Medipass recipients. If MCOs are permitted to participate in the “medical home” network (and they probably should be authorized to do so), then would fairness dictate that, during open enrollment periods, MCO service recipients could choose instead to receive services in a “medical home?” I understand that comparative analyses between the various service delivery systems should be an eventual outcome of this project, but would it be advantageous to have data on “competing systems” (at least in one or two network areas)?

- Lines 197-199. I believe the intent of this language is to use “fee-for-service” as a baseline for reimbursements for medical home services, regardless of the type of reimbursement for which a network could opt. Lines 220 et seq. denote that MCOs can serve as medical home networks. The reimbursement language (specific legislative intent here) could be clearer.

- Lines 230-233: See comments, above, relative to community network responsibilities.

- Line 263: What is the rationale for choosing the UF vs. another state higher education facility? Is this to preempt application of the purchasing requirements of Ch. 287, F.S.?