June 16, 2008

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
Room 314G
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Administrator Weems:

We are writing to urge the Centers for Medicare and Medicaid Services (CMS) to include physician practices at each tier of the National Committee for Quality Assurance (NCQA) recognition process in order to identify and test the practice transformation needed to furnish patient-centered care in the Medicare medical home demonstration project. We appreciate the CMS willingness to receive input from our respective organizations as it designs the demonstration project and we look forward to future opportunities to collaborate. However, we are aware that CMS will soon need to make preliminary design decisions, including on the parameters that determine eligible practices. Specifically, we recommend that CMS refrain from excluding the lowest tier of medical home practices.

Our understanding is that CMS intends to use a slightly modified version of the NCQA Physicians Practice Connections-Patient Centered Medical Home (PPC-PCMH) practice recognition module to determine which practices qualify as medical homes and, thus, are eligible to participate in the project. Our organizations participated in the development of the PPC-PCMH and are pleased that CMS will use this standardized tool to determine practice capability. The PCMH scoring methodology enables a practice to be recognized as a medical home if it meets a minimum threshold—in terms of core capabilities and score—and then further distinguishes practices into three tiers of a medical home based on total score.

<u>Rationale for Including Practices at Each Medical Home Tier</u>

Although experience with the PPC-PCMH is limited as NCQA released it for use starting January 2008, our involvement in working with physician practices, our evaluation of existing programs that include some PCMH capability components, and our work with national experts in practice transformation/quality improvement lead us to believe that only a small percentage of primary care practices would by recognized at the even the lowest tier of medical home without making any changes. In other words, recognition at this level would represent a distinct change in the way most offices currently run their clinical operations.

Our expectation is that the Medicare demonstration, which is to include a variety of practice settings in up to eight states, will be large enough that it can include a sufficient number of practices at each of the three medical home tiers. Including practices at each tier will enable the agency to determine the impact of the medical home interventions at each level. Determining whether there are incremental benefits at each level compared to baseline will help identify the

best strategies and economic models to support practice transformation. The ability to answer the question as to whether the benefit of a practice moving from tier I to tier II is equal to the benefit accrued by a tier II practice moving to a tier III would be an invaluable contribution to the evaluation of the medical home concept. To accomplish this measurement, the agency can build a re-testing component into the project to reassess each practice—at least those at the lower two tiers—during the three-year project. Determining whether practices increased their capability and achieved a higher tier would enhance the agency's ability to generate a robust evaluation of the project's impact on quality, cost, and the satisfaction of all stakeholder participants.

We expect that the Medicare payment for the care management service provided by the personal physician in a practice recognized as a medical home will increase progressively with each medical home tier. We strongly support this "laddered" payment approach as it will help make physicians feel that medical home recognition is attainable and that participation in the project—supported by enhanced payments/revenue—is viable. Further, it provides incentive for physicians to increase their practice capability. Requiring that practices receive a minimum of tier II recognition not only prevents a substantial number of physicians from participating, it dampens the hope of those eager to transform their practices to provide patient-centered care through a medical home. Limiting participation to tier II and above generally captures those physicians who have already taken significant steps to transform.

We note that many of the PCMH test projects that involve private payers, which are being developed in collaboration with our organizations and other stakeholders, intend to include tier I medical home practices. Inclusion of tier I practices in the Medicare project will increase the consistency among projects and the ability to assess their impact.

<u>Including Tier I Medical Home Practices Consistent with the Law</u>

Language in the law that authorizes the Medicare demonstration, the Tax Relief and Health Care Act of 2006, supports the inclusion of tier I practices in the project, with the most relevant excerpt being:

> (1) DURATION; SCOPE.—The project shall operate during a period of three years and shall include urban, rural, and underserved areas in a total of no more than 8 States.
> (2) ENCOURAGING PARTICIPATION OF SMALL PHYSICIAN PRACTICES.—The project shall be designed to include the participation of physicians in practices with fewer than three full-time equivalent physicians, as well as physicians in larger practices particularly in rural and underserved areas.

Practices comprised of one or two full-time physicians face the greatest challenge in making the changes need to be recognized as a medical home. Excluding tier I medical home practices will make it difficult for CMS to include these small practices as most are likely to find only the lowest tier attainable in the short term. Further, including only tier II and tier III practices is likely to strain the agency's ability to ensure significant rural participation as many small practices are in rural areas.

We appreciate your consideration of our views on this important demonstration design issue. Please contact Brett Baker, ACP Director of Regulatory and Insurer Affairs, by phone at 202-261-4533 or by e-mail at bbaker@acponline.org if you have questions and/or comments.

Sincerely,

Yul D. Ejnes, MD, FACP
Medical Service Committee Chair
American College of Physicians

Rick Kellerman, MD
Board Chair
American Academy of Family Physicians

cc: Herb Kuhn, Acting Deputy Administrator
Linda Magno, Director, Office of Research, Development, and Information
James Coan, Project Officer, Office of Research, Development, and Information