ADVOCACY COUNCIL
of the American College of Allergy, Asthma & Immunology

June 22, 2015

The Honorable Orrin Hatch
Chair
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

On Behalf of the American College of Allergy Asthma and Immunology, we are pleased to submit this response to your May 22nd request for comments on improving care and lowering costs for patients suffering with chronic diseases.

By way of background, we are the specialty society for physicians who specialize in Allergy and Immunology (A/I) and represent over 5,000 A/I physicians and allied health professionals.

An Allergist/Immunologist is a physician who specializes in the diagnosis and treatment of allergic diseases and asthma. We complete 4 years of medical school and complete a general residency in internal medicine or pediatrics. Following this residency, these doctors spend two additional years of training, which is called a Fellowship, learning about the prevention, diagnosis, and treatment of immune system problems such as asthma and other allergic conditions. We must pass an exam to become Board Certified.

There is no question that improving how we diagnose, treat and manage patients with chronic diseases, such as asthma, has the opportunity to not only dramatically improve patient outcomes (morbidity and mortality) but also save millions of dollars in

unnecessary and avoidable costs. We welcome this opportunity to engage in this dialogue and offer our ideas and suggestions relative to the care and treatment of patients with respiratory medical problems.

Asthma cannot be cured, but it can be controlled.

The incidence of asthma in America is growing and now stands at an all-time high.

Asthma in America

Prevalence is at an all-time high (8.4 percent)
Affects 26 million people, including 7 million children
Costs $56 billion per year

But we also have an unprecedented opportunity, through the use of appropriate health professionals and technology, to better manage these patients, improve care and lower costs.

The American College of Allergy, Asthma and Immunology produced a report entitled, Asthma Management and the Allergist Better Outcomes at Lower Cost highlighting these opportunities.

Asthma patients under the care of an Allergist consistently experience better outcomes at lower cost because of:

- Fewer emergency care visits
- Fewer hospitalizations
- Reduced lengths of hospital stays
- Fewer sick care office visits
- Fewer days missed from work or school
- Increased productivity in their work and personal lives
- Greater satisfaction with their care
- An improved quality of life

Much of the expense of asthma is attributed to costs that can be avoided or reduced when the disease is controlled. Current data shows that annually, asthma accounts for:

- More than 15.3 million physician office and hospital outpatient department visits
- 1.75 million emergency department (ED) visits

- Almost a half million hospitalizations, including 157,000 for children 17 and under
- 14.2 million lost work days
- 10.5 million lost school days

Before we begin discussing opportunities for achieving the goals you have set out, it is important to understand that this all begins with a proper assessment of patients with chronic disease and determining the patient's severity once the diagnosis has been made.

While we apply a single name to chronic diseases – Asthma, COPD, Primary Immunodeficiency, Chronic Sinusitis, Chronic Urticaria, etc., the fact is that patients suffering from these conditions fall along a continuum or scale of severity that requires different interventions and different treatments.

For example, patients with asthma will be classified as

- Intermittent
- Mild persistent
- Moderate persistent
- Severe persistent

These classifications are based on severity, which is determined by symptoms and lung function tests. Equally important, a patient's classification of severity may change over time. Also, a person in any category can have severe asthma attacks. So proper assessment of the patients level of severity – whether asthma or some other chronic disease – by the appropriate health professional – is critically important.

As you noted in your request for input, we have tremendous opportunity to both improve patient care and save money both programmatically (Medicare, Medicaid commercial insurance) but also societally. We believe there is an opportunity to achieve global savings through the concept of global partnering.

Asthma Care Management - Global Partnering Protocol (Questions 1, 2 and 3)

Know the Signs and Symptoms

As with many diseases, there are certain signs and symptoms that, if properly observed, should sound clinical alarms that mandate a clinical intervention by a specialist.

Unfortunately, it has been our experience that these warning signs are often not observed due to lack of training by the health professional managing the asthmatic patient's care or, even if observed, misunderstood.

Failure to pick up on these triggers results in unnecessary ER utilization, unnecessary hospitalization or, in the most extreme situations, death.

Here is where better use of technology and a better designed payment system can produce tangible global savings and better patient outcomes.

Through EHRs, we have the ability to better document and establish electronic warning systems to physicians about when to bring in a clinical partner.

Under all of the payment models, when a patient is diagnosed with asthma, the severity of the diagnosis should be made or confirmed by an Allergist/Immunologist or Pulmonologist (hereafter "Respiratory Specialist").

Designing New Payment Models

Although you have classified your first three questions based upon payment model (Medicare Advantage, Alternative Payment Models and traditional fee-for-service), we believe the concepts we will outline below can be easily incorporated into any payment model.

The difference in the payment models is not about treating patients differently or establishing different clinical protocols depending upon the payment model. The key distinction between each of the models is the level of financial risk the physician or hospital (or organized group) is willing to take on and for what period of time.

Medicare Advantage (MA) provides a capitated payment to the Health Plan based upon a per member amount. Typically the patient enrolls in the MA plan for one plan year. This is a full risk payment model. Risk adjustment is possible to avoid problems associated with adverse selection. Patients diagnosed with asthma represent a higher cost risk and an end-of-year risk adjusted payment to the plan could be justified – but only if the plan can demonstrate that they followed the clinical protocol we outline below.

The risk adjustment should NOT reward the MA plan for failure to properly manage a patient with a chronic disease by giving that plan a risk adjustment payment if the patient moves from mild to moderate, or moderate to severe. Adjustment should only occur if the plan followed the protocol and still had higher than expected hospitalization or ER costs.

Similarly, a bundled payment (APM) participating practice could receive a risk-adjusted add-on at the end of the year if the APM can demonstrate that they followed the clinical protocol outlined below and still had outlier patients (similar to outlier payments under the DRG system). Under the APM, the managing physician can also have the option to have their asthma bundled payment cover care provided during a 30, 60 or 90 day period.

This limits the financial risk to 30, 60 or 90 day increments. The amount of the bundled payment would be based upon the clinical severity (ICD-10 code) of the asthma patient as determined by the Respiratory Specialist.

As with the MA risk adjustment, this add-on payment would NOT be made for patients whose diagnosis moves from mild to moderate or moderate to severe.

Finally, Medicare Physician Fee Schedule (MPFS) payments to physicians using a team or partnering approach for the care and management of Asthma patients can receive additional payments (above the fee schedule) for care management associated with using the protocol below.

We believe when any of the following situations arise under any plan type (MA, APM, MPFS), the patient should be enrolled in the Asthma Care Management Global Partnering Protocol. Under this Protocol, an asthma patient would be given access to a Respiratory Specialist (either in-person or via a telemedicine visit) to better evaluate the patient to determine the severity of the patient's asthma.

We believe that when an already diagnosed asthma patient has any of the following occur, they should be enrolled in the Protocol and seen by the partnering Respiratory Specialist for evaluation:

1. Any patient hospitalized once during the previous 12 months for an asthma-related event;
2. Any patient who visits an ER twice during the previous 12 months for an asthma-related event;
3. Any Asthma patient who is using 4 or more canisters of Albuterol per year
4. Any Asthma patient on high dose combination therapy
5. Any Asthma patient who is issued two or more prescriptions per year for oral steroids

Each of the above situations is a red flag that a patient's asthma is either not being appropriately managed or the patient is not properly responding to the treatment regimen. Equally important, each of the above events can be easily documented in an electronic medical record and the EHR can be designed to produce a notice to the health professional managing these patients that it is appropriate to bring in a Respiratory Specialist clinical partner (i.e. Allergy/Immunologist, Pulmonologist).

The payment model should reward the primary care physician for bringing in a clinical partner such as a respiratory specialist. The payment model should encourage such partnering and include a partnering fee in the payment methodology. Under this model, the primary care physician or health professional who is managing the asthma patient will receive an additional payment when that patient is seen by the specialist partner. The

specialist partner would also receive an additional payment when the patient is stabilized and no longer under the care of the specialist and has resumed having his/her day-to-day care being managed by the primary care health professionals.

The system described above does several things:

1. It ensures that the patient is being seen by a health professional most appropriate for the level of severity or potential for an acute episodic event thus increasing the likelihood that such an event can be avoided;
2. It eliminates the loss of revenue that might be experienced by the primary care health professional as a result of the specialist being brought in to manage the patient;
3. It encourages the specialist to get the patient back under the care of the primary care health professional.

Streamlining the Payment System to Incentivize the Appropriate Level of Care

First, we believe that there are tremendous opportunities to streamline the payment system. The vast majority of physicians want to deliver the appropriate level of care. Aligning payments to the appropriate level of care, by the appropriate health professional, is the challenge.

We believe that it is possible, through disease/condition based bundled payments, to ensure that the patient is being treated and the chronic condition managed by the appropriate physicians and/or team of health professionals.

With the greater specificity afforded by the use of ICD-10 coding, we can more appropriately diagnose the level of severity of a patient's condition and align a condition-based bundled payment to be consistent with that level of severity. It also allows us to adjust, over time, the payments to reflect a change (up or down) in the patient's severity.

Further, we have the ability to link payment to treatments by the appropriate health professionals. Patients with a diagnosis of intermittent or mild but persistent asthma will likely be handled and the disease well-managed by a primary care physician. But as the patient's severity increases or symptoms suggest the risk of an adverse event, intervention by an Allergist becomes essential. Such interventions can prevent an ER visit or a hospitalization.

In reverse, as an asthma patient diagnosed as severe or moderate persistent comes under control and their asthma is downgraded to mild persistent, they can go back to having their care managed by a primary care health professional.

Care Coordination as a Goal (Question 4)

There is no question that the current fee-for-service system does not encourage care coordination. Individual physicians refer patients to other physicians for disease specific treatment. Even the terminology we use (referral) implies independent or uncoordinated care. The fee-for-service payment system has created a fear amongst some physicians that if a patient is referred to another physician, the referring physician will "lose" that patient.

This mindset discourages appropriate clinical involvement with a specialist whose depth of knowledge and expertise can lead to the development and implementation of a treatment regimen that improves patient care and lowers global healthcare costs for patients with chronic diseases.

The data shows that most patients with a chronic disease have multiple chronic diseases which may necessitate involvement with multiple specialists depending upon the nature of the chronic diseases.

We believe that the payment system should encourage **clinical partnering** between physicians (primary care and specialist) to ensure that the patient is receiving appropriate care and intervention from the physician best able to handle that patient's chronic condition(s).

Adherence to Guidelines

In 1991, the National Institutes of Health (NIH) National Heart Lung and Blood Institute adopted formal guidelines for the diagnosis, care and treatment of asthma patients. These guidelines are periodically updated (last update in 2007).

Unfortunately, more than 20 years after publication of the first NIH Guidelines, a majority of today's asthma patients continue to receive substandard care. Too often asthma patients receive health care services from providers who have little specialized training or knowledge of recent advances in asthma disease management. Many outdated approaches to asthma treatment are still practiced.

If we are going to achieve the clinical improvements we seek while at the same time realizing the savings objectives, it is important that the NIH/NHLBI guidelines are followed.

Effective Use, Coordination and Cost of Prescription Drugs (Question 4)

Appropriate use of prescription drugs for patients with asthma can dramatically improve a patient's quality of life, avoid unnecessary hospitalizations and ER visits and prevent death. But improper use of these same prescription medications can lead to hospitalization, ER visits and death. The failure to properly monitor these patients and

intervene clinically when a patient is not responding appropriately or overusing a drug because it "doesn't seem to be working" can be equally dangerous and costly.

Asthma is often treated with multiple medications in order to control symptoms as soon as they appear. Allergists, with their extensive experience using these medications and understanding of the complexities of asthma, are able to prescribe them properly according to the subtype of asthma diagnosed and other needs of the individual patient.

The primary care physician/specialist partner can make these decisions working with one another.

It is imperative that the patient adhere to the prescription drug regimen and actually take the medications. Studies have shown that as prescription drug costs increase, the cost of asthma care decreases. To incentivize patients enrolled in the **Asthma Care Management - Global Partnering Protocol** to comply with their medication regimens**,** the copay for taking the prescribed medications would be reduced by 50%. The copay for the medications would be collected as usual; however, at the end of six months, if the Physician Partners concur that the patient has complied with the medication regimen, the MA plan or Medicare (APM or MPFFS) would rebate 50% of the copay to the patient for the patient's share of the asthma medications.

Using Telehealth and Remote Monitoring Technology to Improve Patient Care (Question 5).

Both Telehealth and remote monitoring technology hold tremendous promise in improving patient care, better managing patients with chronic disease, and lowering the total cost of care for asthma patients.

- **Remote Technology**

One of the most common tests performed on individuals with compromised respiratory function is the measuring of breath – spirometry. This is a pulmonary function test that measures lung function – the amount and/or speed of air flow that can be inhaled or exhaled by the patient. Advances in spirometry technology have made this equipment highly accurate, portable, useable by the patient, and very affordable.

Through the use of a hand-held device – the FEV1 (Forced Expiratory Volume), a patient can breathe into a device at home, have the information recorded and transmitted electronically to the Allergist who can evaluate the patient's data and make a determination of whether the patient needs to come in for a physical evaluation. The cost of an FEV1 device is less than $100.00. In addition to assessing a patient with asthma, the FEV1 can assess patients with Pulmonary Fibrosis, Cystic Fibrosis and Chronic Obstructive Pulmonary Disease (COPD).

Other remote technology exists to appropriately monitor other patients and there is data to support the conclusion that making such technology available to patients can reduce avoidable ER visits and avoid hospitalization.

- **Telehealth**

Many allergic conditions – Chronic Urticaria, Contact Dermatitis, Adverse Drug Reactions, rashes, etc. – can be evaluated using two-way, real-time communication between the patient and an Allergist. Using a HIPAA secure portal, a specialist can visualize a patient, make an appropriate diagnosis and prescribe a medical treatment – all without asking the patient to travel a long distance to get to the Allergist's office, which for rural residents, can be a long distance.

Similarly, a real-time video visit between an asthma patient and an asthma care coordinator/educator can help to ensure that patients stay on track with their lifestyle decisions that can avoid an ER visit or hospitalization.

Under current Medicare telehealth payment policy, the patient must get to an "originating" site in order to engage in a telehealth visit with the specialist. In many instances, this trip to the originating site is clinically unnecessary because the patient could have had the same clinical experience without ever having to leave his/her home.

Congress should consider removing the requirement that a telehealth patient visit involve a trip to an originating site and instead, pay for telehealth visits that can originate from the patient's place of residence.

- **Chronic Disease Management in Lieu of Surgery**

For some chronic disease sufferers, the option of surgery is sometimes offered as a means of relieving the chronic pain. But surgery comes with risks and is an expensive undertaking. In many cases, patients recommended for surgery still had reasonable medical options available but these patients were not made aware of these options because the physician referring the patient for surgery may not have been aware of medical interventions.

While surgery is a legitimate option for some patients, a determination that all medical options have been ruled out should be made by a respiratory specialist.

Prior to authorization of payment for surgery for a chronic condition such as chronic sinusitis, a respiratory specialist should be brought in to evaluate the patient to make the patient aware of any non-invasive options that might be available, the risks of those non-

invasive options and relative value of further medical treatment versus surgical intervention.

Strategies for Increasing Chronic Care Coordination in Rural and Frontier Areas (Question 6)

Increasing the supply of respiratory specialists would help to increase the supply in rural areas but this will only have a limited impact. We believe that greater and more effective use of technology, such as telehealth and remote monitoring devices, can greatly improve our ability to better manage asthma and allergy patients living in rural or frontier areas.

The same partnering arrangement described above can be applicable with rural physicians and other health professionals, but the actual evaluation and management of the patient shall occur remotely.

Under current policy, Medicare will only pay for a telehealth visit between a patient and a physician, PA or NP. We believe the chronic care management benefit should be made available via a telehealth option so that an A/I physician employing a chronic care management educator can be compensated for care management that occurs remotely.

Incentive for Patients (Question 7)

We also believe that while it is important for patients to have some financial responsibility for the care they receive, patients should be incentivized to request enrollment in the **Asthma Care Management - Global Partnering Protocol** or similar arrangements. Therefore, we would propose that patients who wish to enroll in the Care Management Protocol would have the deductible waived for opting for this protocol and have their copay reduced by 50% if they enroll in an **Asthma Care Management - Global Partnering Protocol** program.

More Effective Utilization of Primary Care Providers and Care Coordination Teams (Question 8)

Throughout this document, we have described a team approach to chronic care management that relies on care coordination and effective use of primary care providers.

But in order to achieve the clinical improvements and global savings we hope to realize, the primary care provider must not be discouraged or penalized for bringing in a specialist when appropriate.

We believe that Medicare can create a care partnership modifier code that, when present, lets Medicare fee-for-service pay for additional visits and additional services with the goal that great use of both primary care and specialty care – in coordination with one

another – will result in better patient outcomes and reduced hospitalization and ER utilization.

We believe the **Asthma Care Management - Global Partnering Protocol** as outlined in this document holds tremendous promise for more effective utilization of both primary care providers AND specialists as part of care coordination teams.

Conclusion

Moving forward, payment models must be flexible enough to adjust to reflect changes and advancements in care. Part of the problem we have today is that providers do what they will get paid for doing. This stifles or discourages innovation and adaptation to what works.

We believe the **Asthma Care Management - Global Partnering Protocol** as outlined in this document holds real potential and is an excellent model for more effective utilization of both primary care and specialty providers. This model should be adapted to other chronic conditions, such as chronic sinusitis and skin diseases. Specialists are important partners of care coordination teams.

We appreciate this opportunity to outline our ideas and look forward to the possibility of future discussions as this process moves forward.

Sincerely,

James L. Sublett, MD, FACAAI
President
American College of Allergy, Asthma and Immunology

Allen Meadows, MD, FACAAI
Chair
Advocacy Council of the American College of Allergy, Asthma and Immunology