

June 11, 2019

Jeffrey Bailet, MD
Committee Chairperson
Physician-Focused Payment Model
Technical Advisory Committee
Office of the Assistant Secretary
for Planning and Evaluation
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Bailet:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide our strong support for the Patient-Centered Asthma Care Payment (PCACP) proposal that was submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) by the American College of Allergy, Asthma, and Immunology (ACAAI). The AMA has been assisting the ACAAI in the development of the PCACP proposal from its inception. Several foundational elements of this model represent significant advances in the design of physician-focused payment models that the AMA has advocated in comments to the PTAC, meetings with the Center for Medicare & Medicaid Innovation, and discussions with stakeholders and policymakers.

First, rather than focusing only on improving management of asthma after the patient has been diagnosed, PCACP is also designed to ensure the diagnosis is accurate. It does this by paying adequately for a complete diagnostic work-up, development of an initial treatment plan, and management of the patient's condition for an initial period of time, and by measuring the effectiveness of the treatment plan in controlling symptoms as a way of ensuring the diagnosis is accurate. This is an important advance, since neither the fee-for-service system nor current alternative payment models (APMs) appropriately support the work involved in accurate diagnosis. By ensuring that a diagnosis is determined as quickly and accurately as possible for patients who have asthma-like symptoms, PCACP can reduce avoidable spending and improve quality both during and after the diagnostic phase. For example, current payment systems pay for tests, but do not pay physicians for the time needed to determine which tests are necessary and appropriate to rule out alternative diagnoses. Moreover, by paying adequately for educating patients about their condition and how they can best manage exacerbations when they occur, PCACP can begin reducing emergency visits and hospitalizations as soon as symptoms are first identified. PCACP includes utilization and quality measures that are specifically designed to ensure quality and efficiency during this phase of care.

PCACP also incorporates an innovative approach to risk stratification based on the severity of the patient's asthma, including their asthma-related or asthma-like symptoms and comorbidities that are known to exacerbate asthma, such as smoking, obesity, and rhinitis or sinusitis. This is preferable to the

risk adjustment systems in other APMs that use data on other health issues that may have no relationship to effective care for the patient's asthma.

Several aspects of PCACP address comments and recommendations made by the PTAC based on its review of an earlier proposal focused on management of asthma and chronic obstructive pulmonary disease (COPD). The ACAAI's proposal is also responsive to comments from the Secretary of Health and Human Services (HHS) when the department reviewed the PTAC report of this previous proposal. At that time, the PTAC stated that "improvement in the management of Medicare patients with COPD, asthma, and other chronic lung diseases should be a high priority for CMS." In its September 2017 response, HHS said it was "keenly interested in ideas for how to improve specialty care for Medicare beneficiaries with complex chronic illnesses such as COPD and asthma," and further stated that "HHS would be interested in CMS testing an APM with more focus on COPD/Asthma, and is generally interested in APMs that address management of chronic conditions." The PCACP proposal does exactly what HHS said it wanted.

Moreover, PCACP explicitly incorporates the approach to asthma care payment that the PTAC has endorsed previously, while also addressing the specific issues and concerns that were raised by PTAC and HHS two years ago:

- PTAC has said that a combination of per-beneficiary per month payments and a two-sided risk arrangement focused on reducing emergency visits and hospitalizations is an appropriate method of paying for care of patients with asthma. PCACP uses this approach for new asthma patients and those with poorly-controlled asthma—asthma care teams would receive a monthly payment for each such patient in place of current visit payments, and the payments would be increased or decreased based on measures of quality and spending.
- HHS said that it was important to define "how payment amounts and spending targets should be set for Medicare patients who are more likely to have multiple health problems and for whom additional time and resources may be needed to support both proactive outreach and coordination with other physicians." PCACP defines several categories of asthma patients based on the severity of their condition and the number and types of comorbidities they have, and establishes different payment amounts, quality targets, and spending targets for each category.
- Both PTAC and HHS have indicated that an APM needs to explicitly tie payment to quality. PCACP does this in two ways. First, an asthma care team would not receive any payment under the model unless specific quality standards described in the proposal are met. Second, even if the minimum quality standards are met, the monthly payment would be reduced if performance on quality measures is significantly below a benchmark level based on quality levels that are known to be achievable for similar patients.
- PTAC has stated that it believes the spending measure in an asthma care APM needs to include Part D spending. The PCACP APM holds the asthma care team accountable for all aspects of asthma-related spending, including medications.
- Both PTAC and HHS, as well as the AMA, repeatedly have emphasized the importance of supporting integration and coordination of care between specialists and primary care physicians. PCACP payments are explicitly designed to support a team care approach between primary care physicians and allergists or pulmonologists. The first category of payments (for Diagnosis and

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Initial Treatment) would only be available to specialists for a maximum of three months while they determine a diagnosis and effective treatment plan, and the second category of payments (for Continued Care for Patients with Difficult-to-Control Asthma) would only be available to specialists for patients who cannot be successfully managed using standard treatment approaches. For the majority of asthma patients, the model explicitly assumes they should have their care managed by a primary care physician, not by a specialist, but that the specialist should remain an integral member of the patient's asthma care team.

PCACP includes several other important features that are not found in current CMS APMs and that should be tested:

- a separate bundled payment for allergy testing, designed to avoid overuse of multiple separate types of tests without penalizing physicians for using testing when appropriate;
- patient-reported outcome measures;
- accountability elements designed to ensure that small practices are not subjected to large changes in payment due to random variations in patient characteristics or outcomes; and
- instead of a one-size-fits-all approach, there are several options for higher levels of payment "bundling" in PCACP, which parallels the multiple models included in the new Primary Cares Initiative.

Not only will implementation of the proposed payment model support improved care for Medicare patients with asthma and achieve reductions in Medicare spending for these patients, we believe that modified versions of the PCACP design could be used to improve care for patients with other chronic conditions, thereby leading to even greater savings for Medicare and better outcomes for a wide range of patients. Moreover, APMs such as PCACP that support coordinated care by primary care and specialist physicians for patients with difficult-to-manage chronic diseases will complement and help support the success of APMs focused on primary care practices.

The AMA urges you and the other PTAC members to recommend the Patient-Centered Asthma Care Payment model to the Secretary of HHS for priority consideration and rapid implementation. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD

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Physician-Focused Payment Model Technical Advisory Committee
c/o U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation, Office of Health Policy
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via PTAC@hhs.gov

RE: Patient-Centered Asthma Care Payment (PCACP)

Dear Committee Members,

Established in 1943, the AAAAI is a professional organization with more than 6,700 members in the United States, Canada and 72 other countries. This membership includes allergist/immunologists (A/I), other medical specialists, allied health and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunologic diseases. We appreciate the opportunity to provide comments on the Patient-Centered Asthma Care Payment (PCACP), submitted by the American College of Allergy, Asthma & Immunology.

A/I professionals lead in the diagnosis, treatment and ongoing management of asthma, allergy and immunology conditions. By itself, asthma – a chronic disease that affects the airways in the lungs – affects more than 25 million Americans at a total cost of \$56 billion per year. Asthma causes 14.2 million missed days of work and 10.5 million missed days of school, and results in 479, 300 hospitalizations, 1.9 million emergency department visits, and 8.9 million doctor visits. For these and other reasons, we have a strong interest in models that support A/I professionals ability to continue delivering high-quality care at an affordable cost to patients.

We appreciate the tremendous effort that our A/I colleagues have devoted to developing a bundled payment model, which aims to optimize asthma health outcomes, improve beneficiary experience, and reduce utilization of unnecessary services while decreasing Medicare spending. We believe proposals such as this are very important as we transition to value-based healthcare, and anticipate this, and other A/I focused care models, will be proffered in the coming years as emphasis

(more)

on value-driven of reimbursement continues to encompass a greater proportion Medicare spending. We look forward to the discussion that ensues as the PTAC deliberates this model.

We appreciate the opportunity to provide comments on the aforementioned model of interest to our members. Should you have any questions, please contact Sheila Heitzig, Director of Practice and Policy, at sheitzig@aaaaai.org or (414) 272-6071.

Sincerely,

A handwritten signature in black ink that reads "David M. Lang, MD". The signature is written in a cursive, flowing style.

David M. Lang, MD FAAAAI
President