May 25, 2012

Honorable Members
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515
email: physician.feedbackwm112@mail.house.gov

The American Academy of Allergy, Asthma and Immunology (AAAAI), the American College of Allergy, Asthma and Immunology (ACAAI), and the Joint Council of Allergy, Asthma and Immunology (JCAAI) are pleased to submit this joint response to the Committee's letter of April 27, 2012. The AAAAI, ACAAI and JCAAI are the three national physician allergy and immunology organizations representing 4,700 allergists and immunologists in the United States. Our members are all physicians who first complete training and board-certification in the primary care specialties of internal medicine or pediatrics. They then complete additional specialized training in allergy and immunology before being eligible for board-certification in the allergy and immunology subspecialty. Thus, our physician members all have solid training in primary care before becoming specialists in the treatment of asthma and allergic diseases. We are the premier specialty in the care and treatment of individuals with asthma, allergic rhinitis and other allergic diseases.

Rewarding Quality and Efficiency
Pairing patient outcomes with physician payment is particularly sensitive in the treatment of chronic disease, especially in conditions in which documented disparities and challenges to access to appropriate care persist. Despite these limitations, our specialty is committed to quality improvement, and has actively advocated and pursued development in this area for years. We have been developing practice parameters that help our members maintain the highest level of evidenced-based care for over 20 years.

Some of the earliest nationally recognized quality performance measures were for the treatment of asthma. However, these measures are what is known as "low bar" measures and only go so far as documentation of symptoms and prescribing appropriate medications. These measures do drive improvement in the quality of care for asthma. Our organizations have been trying for years to appropriately partner with measures developers to build better measures for both primary care and specialty care for asthma, but have been stymied in this effort by insufficient resources for measure developers focused on delivering measures in diseases most prevalent in the Medicare population.

While this has kept our specialists from appropriately participating in Medicare incentive programs, as quality measures are increasingly used by other payers and considered for other payment models, it further threatens our ability to participate meaningfully. We continue to pursue any option we can find to appropriately develop measures that will drive improved primary and specialist care, but as a small specialty, our efforts have been stymied. Until resources and technical capacity are readily available to small specialties to develop and implement appropriate measures that can drive quality improvement, it is inappropriate to tie physician reimbursement to quality measures at a level that could limit or damage patient access to appropriate specialty care.

Despite our challenges in getting measures developed, we have worked very hard to improve quality care for our patients. Besides our comprehensive approach to developing Practice Parameters our organizations have been involved in other efforts to meet this end. For example, with the launch of ASTHMA IQ in 2009 for specialists and in 2011 for Primary Care, physicians and other health care providers have had free access to a clinical support tool utilizing the most up to date clinical guidelines on effective asthma care. Providers are able to receive Maintenance of Certification credit for using the system when they complete Practice Improvement Modules. We believe that the thousands of patients entered into this system represent improved outcomes delivered by evidence-based practice.

We continue to explore opportunities to develop additional tools to deliver on our commitment to providing quality, evidence-based care, including learning modules, registries, and other clinical care support tools. The AAAAI was an early partner in the American College of Physicians AmericanEHR Partners project to facilitate physician education and implementation of electronic health records, and we continue efforts to educate and prepare our members in selection and implementation of these systems.

Alternative Payment Systems

We are pleased that the Committee is undertaking efforts to review value-based measures and practice arrangements that improve health outcomes and efficiency in the Medicare program. We share the Committee's view that the Medicare physician payment system is in need of reform and we strongly believe that quality and outcome measures have an important role to play in that process. It is important that patients have access to specialty care. We also believe that many of the new payment models such as the Medicare shared savings program (ACOs), bundled episode-of-care based models, the patient-centered medical home, and other initiatives may hold considerable promise for improving care coordination and delivery. We particularly support the most recent iteration of the Patient Centered Medical Home initiative, called the "Medical Home Neighbor" (PCMH-N) model.

The PCMH-N model recognizes the importance of collaboration with specialty and subspecialty practices to achieve the goal of improved care integration and coordination within the Patient-Centered Medical Home care delivery model. Although our specialty, as yet, has very limited experience with this model, we believe it holds promise for ensuring that patients receive appropriate and timely access to specialty care.

We expect that as we gain more experience with these models and analyze the data they yield, important improvements and refinements will be made. At this point, we believe it is too early in the process to endorse any particular arrangement.

We also note that many of these new payment models focus on primary care or on hospital and post-hospital care. As a small specialty that typically practices alone or in groups of 2-3 physicians, and whose focus is on specialized care in the ambulatory setting, allergists have so far played a fairly small role in the implementation of these alternative payment models. However, our specialty and other smaller cognitive based specialties have a critical role to play in the care of our Medicare population and in the delivery of cost-effective care – a role which so far has largely not been recognized by the many alternative or innovative payment demos which have focused largely on primary care or hospital centered care. Because of the structure and focus of the existing alternative payment programs and demos, and the need for significant up-front resources, it has been difficult for smaller physician groups and, in particular, small single-specialty groups, to fully and meaningfully participate. We would hope that in the future these alternative payment models will provide avenues of participation for smaller physician groups.

Last week the CDC unveiled a major new study, *Asthma's Impact on the Nation,* that reported on the tremendous toll this disease exacts on our community including 479,300 hospitalizations, 1.9 million emergency room visits and 8.9 million doctor visits per year and total annual costs estimated at $56 billion per

year.[1] That study found that although teaching patients to manage their disease through an individualized asthma action plan was one key to controlling the disease nationwide, that fewer than 1 in 3 adults had an asthma action plan and less than 7 in 10 adults are taught how to recognize asthma symptoms.

Allergists are uniquely qualified to determine what triggers an asthmatic patient's symptoms and develop an individualized asthma action treatment plan which includes teaching patients how to control their asthma. We believe it is important that alternative payment systems recognize, through both payment incentives and quality measures, the critical role allergy specialty care plays in controlling asthma as well as other allergic diseases. Although our organizations, [as discussed elsewhere in this letter] are actively pursuing the development and expansion of quality measures for asthma and other allergic conditions, we believe that as payment system reform moves forward, it will be important to incorporate economic incentives for proper and timely referral of patients to specialists. This might include, for example, refinements to the ACO shared savings program or patient-centered medical home demonstration projects that would recognize and reward appropriate specialist referral using evidence-based guidelines.

A recent large-scale study done of the Florida Medicaid population provides strong evidence of both quality and cost-effectiveness of allergy specialist care. An analysis of Florida Medicaid claims over an 18 month period found that adults with allergic rhinitis who received allergy-specific immunotherapy (SIT) incurred 50 percent lower per- patient health care costs compared to those who did not, resulting in an average savings of $6,300 per patient. Allergic rhinitis, in addition to being a chronic and often disabling condition by itself, is often a precursor to the development of asthma. Allergy-specific immunotherapy is the only treatment known to provide long-term benefit and alter the course of respiratory allergy disease including prevention of asthma and improving the severity of existing asthma. Allergists have been on the forefront of developing and providing this allergy-specific immunotherapy for our patients. Several other studies have also shown that care by allergists and allergy-specific therapy can significantly reduce U.S. health care costs.[2]

As payment system reform advances and we explore additional methodologies for rewarding cost-effective care, we believe it is essential to incorporate incentives that will result in patients receiving timely and appropriate specialty care.

Patient Involvement and Regulatory Relief

As noted above, many patients are not getting the allergy specialty care that they need. The reasons for this are complex and many are rooted in the structure of our health care system. In most cases, referrals for allergy specialty care come from the physician's primary care physician or from the hospital emergency room physician and not from patient self-referrals. Therefore, it is important that these physicians be educated as to the beneficial role that an allergist can play in treating these conditions.

In the area of asthma, patient education and self-management are critical. However, Medicare generally will not reimburse services of trained non-physician asthma educators when provided in the physician's office. Asthma educators can play a critical role in teaching patients how to manage their condition and in reinforcing positive behaviors. This is one example of where regulatory relief could be beneficial.

Our specialty was recently recognized as a leader in encouraging patient engagement in the pursuit of appropriate, high-value care for participation in the American Board of Medicine Foundation's "Choosing Wisely" campaign. This campaign advocates patients and physicians truly exploring what care and diagnostic procedures are the best use of resources in creating the best outcome for patients.

[1] http://www.cdc.gov/asthma/impacts_nation/default.htm

[2] See attached summary and literature cited therein.

Conclusion
We appreciate the opportunity to present our input on these very important issues that will have an impact in the care of our patients in the future. If you have any questions or would like additional information, please do not hesitate to contact us.

Sincerely,

A. Wesley Burks, MD
AAAAI President

James L. Sublett, MD
JCAAI President

Stanley M. Fineman, MD
ACAAI President

Attachment

Reducing Widespread U.S. Health Care Costs by Improving Quality of Care for Respiratory Allergies

Respiratory allergies affect more than 50 million people in the U.S.[1] The most common respiratory allergy, allergic rhinitis, represents the 5th leading chronic disease overall, and the 3rd leading chronic disease among children under age 18,[2] and often precedes the development of other highly prevalent and costly related conditions, such as asthma.[3]

Each year in the U.S., allergic rhinitis accounts for 13.4 million physician office visits,[4] 3.5 million lost workdays,[3] 2 million missed school days,[3] and $6.5 billion dollars in allergy medications for temporary symptomatic relief.[5]

Because of the serious clinical and economic consequences of respiratory allergies, early diagnosis and aggressive treatment should be national priorities. Unfortunately, only a minority (2-9%) of appropriate U.S. patients receive allergy-specific immunotherapy (SIT),[6-8] the only treatment known to provide long-term benefit and alter the course of respiratory allergy disease.[9] As a result, many U.S. patients do not receive the well-established clinical benefits of SIT (also known as "allergy shots"), which include:[9]

- Reducing allergy symptoms
- Decreasing reliance on prescription and over-the-counter medications
- Preventing asthma
- Improving the severity of existing asthma
- Preventing additional allergies

Several studies have shown that SIT also may significantly reduce U.S. health care costs. [6, 10, 11]

CHILDREN					
	Differences in Median, Per-Patient Health Care Costs over 18 months (No SIT Group Costs minus SIT Group Costs)*				
	Month				Between-Group Differences
Cost Category	3	6	12	18	
Pharmacy	$44	$68	$107	$208	*P* < 0.001 at all time points
Outpatient exclusive of SIT	$405	$691	$1,131	$1,519	
Outpatient inclusive of SIT	$170	$281	$529	$765	

ADULTS					
	Differences in Median, Per-Patient Health Care Costs over 18 months (No SIT Group Costs minus SIT Group Costs)*				
	Month				Between-Group Differences
Cost Category	3	6	12	18	
Pharmacy	$260	$505	$965	$1,310	*P* < 0.0001 at all time points
Outpatient exclusive of SIT	$439	$790	$1,440	$2,012	
Outpatient inclusive of SIT	$310	$584	$1,186	$1,708	
Total	$1,012	$2,003	$4,173	$6,291	
Inpatient	$1,689 NS	$2,952 *P* =0.02	$3,027 *P* =0.02	$2,569 *P*=0.0007	*P*≤0.02 from 6 months

* Positive dollar amounts indicate cost savings conferred by SIT.
- Controls with newly-diagnosed AR who did not receive SIT were matched on age at AR diagnosis; Sex; race/ethnicity; and the presence of asthma, conjunctivitis, or dermatitis to patients with newly-diagnosed AR who did receive SIT.
- There were 1,306 SIT patients matched to 5,137 non-SIT patients.
- NS=not significant.

- An analysis of 10 years of Florida Medicaid claims (1997-2007) found that, over an 18-month period, children with allergic rhinitis who received SIT incurred 33% lower per-patient health care costs than children with allergic rhinitis who did not receive SIT; savings were $1,600 per patient.[10]

- Results of a similar analysis that examined claims data for adult patients were even more compelling. Over 18 months, compared to adults with allergic rhinitis who did not receive SIT, adults who received SIT incurred 50% lower per-patient health care costs, a savings of $6,300 per patient.[11]

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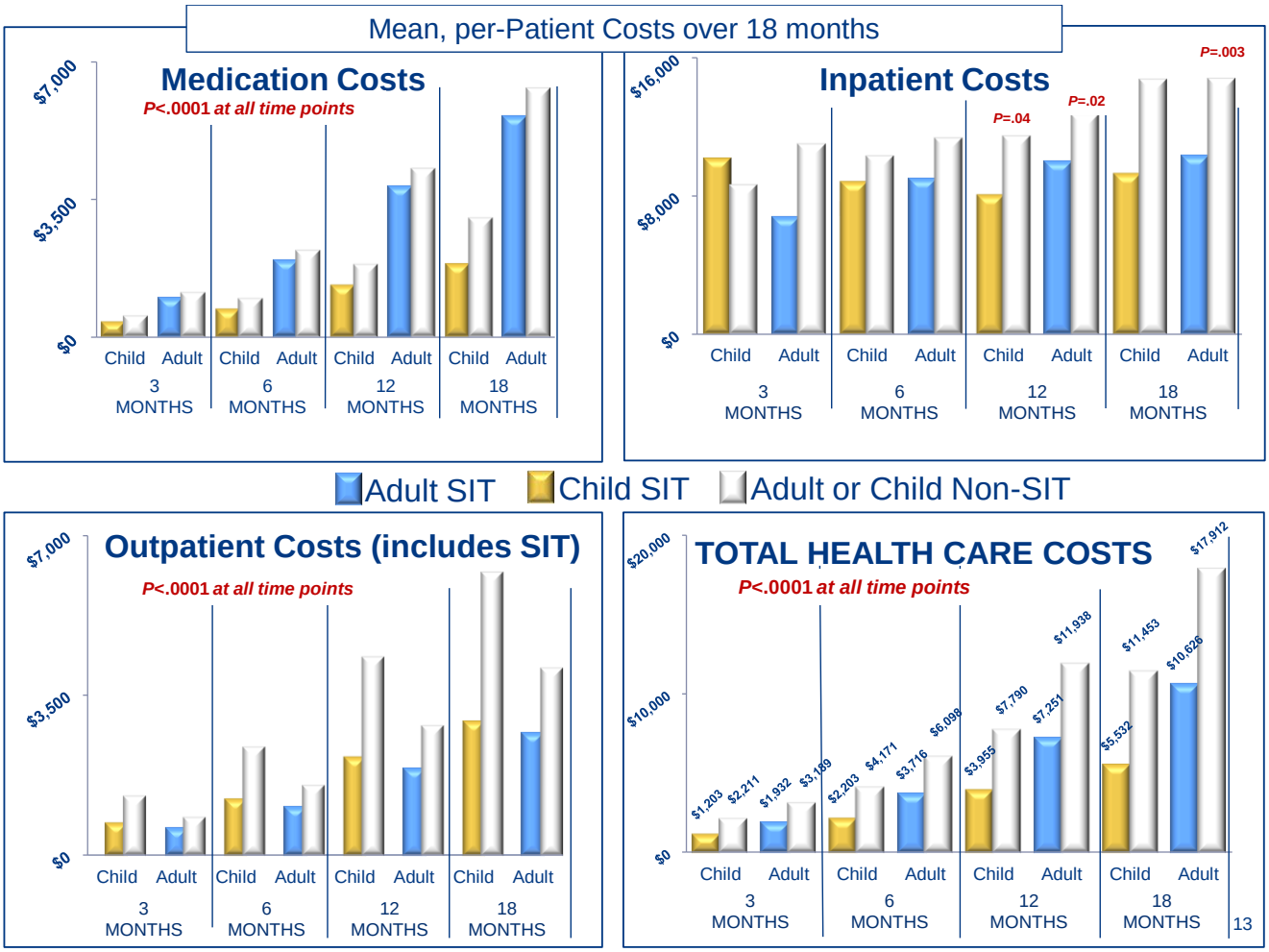
Mean, per-Patient Costs over 18 months
Medication Costs
P<.0001 at all time points
$7,000
$3,500
$0
Child Adult Child Adult Child Adult Child Adult
3 MONTHS
6 MONTHS
12 MONTHS
18 MONTHS
Inpatient Costs
P=.003
P=.04
P=.02
$16,000
$8,000
$0
Child Adult Child Adult Child Adult Child Adult
3 MONTHS
6 MONTHS
12 MONTHS
18 MONTHS
Adult SIT
Child SIT
Adult or Child Non-SIT
Outpatient Costs (includes SIT)
P<.0001 at all time points
$7,000
$3,500
$0
Child Adult Child Adult Child Adult Child Adult
3 MONTHS
6 MONTHS
12 MONTHS
18 MONTHS
TOTAL HEALTH CARE COSTS
P<.0001 at all time points
$20,000
$10,000
$0
$1,203 $2,211 $1,932 $3,189 $2,203 $4,171 $3,716 $6,098 $3,955 $7,790 $7,251 $11,938 $5,532 $11,453 $10,626 $17,912
Child Adult Child Adult Child Adult Child Adult
3 MONTHS
6 MONTHS
12 MONTHS
18 MONTHS
13

Does Allergen-Specific Immunotherapy Provide Cost Benefits for Children and Adults with Allergic Rhinitis?

Results from Large-Scale Retrospective Analyses Jointly Funded by AAAAI and ACAAI

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