



January 25, 2016

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 and the Advocacy Council of the American College of Allergy, Asthma and Immunology, we are pleased to submit this response to the Bipartisan Chronic Care Working Group Policy Options Document you released on December 15, 2015.

The College and our more than 6,000 A/I physicians and allied health professionals who specialize in Allergy and Immunology (A/I) support the goal of improving care and lowering costs for patients suffering with chronic diseases.

The Policy Options document you released includes a number of important proposals that, if implemented could achieve the goal of improving care and lowering costs. Unfortunately, the document appears to place the preponderance of emphasis on achieving this objective through the use of large risk-bearing entities such as Accountable Care Organizations (ACOs) and managed care organizations (MCOs). There is little to no acknowledgement that individual or small groups of physicians acting independently of these large risk-bearing organizations can play a role in improving care or reducing costs.

The failure of the report to acknowledge the role of individual physicians or small groups of physicians and the use of alternative payment models to facilitate their ability to continue in private practice is disappointing.

We were encouraged by your May, 2015 request for ideas in which you asked the stakeholder community for suggestions “based on real world experience and data-driven evidence, on ways to improve outcomes for vulnerable Medicare beneficiaries living with multiple chronic health

conditions.” In our response and those of other health professional organizations who provide care to these patients on a daily basis, we sought to not only identify our experience with the current delivery models using the fee-for-service approach but also offer ideas on how to change the payment model to encourage and support greater collaboration among the disparate health professionals who provide care to the millions of patients who suffer from chronic diseases.

It appears from the report that you think the only way we can improve care and reduce costs is if physicians are forced into participating in a managed care organizations or an accountable care organization.

It is important to remember that healthcare is not provided by managed care organizations or ACOs. Healthcare is provided by health professionals. Most of us pursued careers as physicians, physician assistants, nurse practitioners, nurses and allied health professionals so we could care for people, not populations. Many physicians want to remain in private practice and we would hope that **whatever Medicare payment policies are adopted in the future, the ability for a physician to maintain a private practice and his/her services paid for by Medicare would continue to be an option.**

Population Health

Much has been made of the need to develop payment policies geared towards “population health” rather than the seeming alternative, individual health. Certainly the concept of population health can be attractive to a point.

Viewing healthcare delivery exclusively through the lens of “population health” ignores the uniqueness of every patient, their particular medical condition, family situation and economic circumstance. Our patients are not actuarial markers who when lumped together with others suffering from similar conditions make up the statistical “whole”. No two genetic profiles are alike.

We are on the front lines, caring for our patients each and every day. We know their clinical as well as their psycho-social needs because we deal with them face-to-face. We know the barriers that we – and they – face obtaining the medicines they need to manage their illness, the referrals they need to maximize their care and minimize the need for hospitalization and visits to the emergency room. Our patients are people, they are not “populations.”

While the vast majority of our patients are diagnosed with a specific condition such as asthma, or allergies, that is where their similarity both begins and ends. No two asthma patients are alike. No two allergy patients are alike.

For these reasons, we were disappointed that the Working Group seems to be focused almost exclusively on the use of large-scale delivery systems such as ACOs or managed care organizations as the new model for care delivery for patients with chronic diseases.

Preserving the Private Practice of Medicine

It is our fervent hope that in developing new payment models that seek to replace a payment system that rewards volume to one that rewards value, we do not simultaneously prevent physicians from maintaining the ability to remain in solo or small group practice.

The concept of value-based payment and the private practice of medicine are not antithetical. In the response we submitted to your request for ideas in May, we outlined a payment model that achieves the goal of encouraging collaboration between primary care physicians and specialists, rewards physicians for providing care that has value rather than rewarding them simply for “doing more” regardless of whether it had value. And, allowed physicians to remain in solo or small group practices if they so desire.

We hope that as this process evolves, the Working Group will show greater sensitivity to not just how providers are paid for the services they deliver, but also to how the providers organize to meet their patient needs.

There is no doubt that there may be a role for MCOs and ACOs in the future of healthcare delivery, but there is also a role for the privately practicing physician who does not want to be in an MCO or an ACO.

Your consideration of these comments/concerns is greatly appreciated.

Please do not hesitate to contact us if you have any questions or you would like to discuss our concerns directly.

Sincerely,



Bryan Martin, DO
President
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