Advocate Health Care
Inspiring medicine. Changing lives.

January 26, 2016

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

The Honorable Johnny Isakson
Co-Chair, Bipartisan Chronic Care Working Group
Senate Finance Committee
219 Dirksen Senate Office Building

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

The Honorable Mark Warner
Co-Chair, Bipartisan Chronic Care Working Group
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman, Ranking Member, and Members of the Finance Committee:

On behalf of Advocate Health Care (Advocate), thank you for your commitment to improving care coordination – and outcomes – for those who are chronically ill; we appreciate your willingness to hear from stakeholders with respect to our own experiences in managing care and improving outcomes for Medicare beneficiaries. We appreciate your leadership on some of the most pressing issues facing hospitals and health systems and the Medicare patients we serve. These issues are incredibly complex and we thank you for facilitating a national discussion regarding how best to coordinate and provide care to Medicare beneficiaries with multiple chronic conditions. We commend you and your staff for your hard work in soliciting input and ideas, reviewing all the recommendations, and curating an impressive list of potential policies and programs contained in the *Bipartisan Chronic Care Working Group's* "Policy Options Document."

Overview of Advocate

Advocate, named among the nation's leading health systems, is the largest health system in Illinois and one of the largest health care providers in the Midwest. Advocate operates more than 250 sites of care, including 12 hospitals that encompass 11 acute care hospitals, the state's largest integrated children's network, five Level I trauma centers, three Level II trauma centers, one of the area's largest home health care companies, and one of the region's largest medical groups.

Advocate is helping to advance the nation's efforts in health system delivery innovation and is eager to bring our experiences forward to the benefit of helping transform the federal government and the nation's health care system. We have established one of the largest accountable care organizations (ACOs) in the country, which includes commercial insurance contracts, a Medicare Shared Savings Program (MSSP), and a Medicaid Accountable Care Entity. Using the Advocate Physician Partners' Clinical Integration Program and care coordination efforts as a model, Advocate**Care**®, Advocate's ACO model, has achieved savings of an estimated two percent below the Chicagoland market costs in our largest commercial

contract and has successfully performed in all quality measures.[1] Advocate is proud to be a national leader in innovative payment and care delivery models, and we seek to enhance and expand such efforts to the benefit of more patients and communities – and the nation.

Advocate embraces the values of compassion, equality, excellence, partnership, and stewardship. In service of its healing mission, Advocate supports – and seeks to advance – policies and programs that ensure access to quality health care for all in need without compromising health care providers' ability to deliver such care. Advocate stands ready to work with policymakers at all levels to promote and preserve the health of the individuals, families, and communities of Illinois and to advance innovation in health care delivery to ensure quality and improve outcomes for all who are served by the nation's health care system. In that spirit, we submit these comments for your consideration as you and the Senate Finance Committee (Committee) give further consideration to the policy options put forth by the *Bipartisan Chronic Care Working Group*.

As our comments are not comprehensive, we thank you in advance for considering the input you will receive from our colleagues in the hospital and provider community, including those submitted by the American Hospital Association.

Receiving High Quality Care in the Home

Proposal: Expanding the Independence at Home Model of Care – p. 6

Advocate supports the expansion of the Independence at Home (IAH) Model of Care demonstration into a permanent, nationwide program. We believe the IAH Model of Care would improve care coordination between physicians and home health care providers, as physicians will be more involved in the home health plan of care. Should the Centers for Medicare and Medicaid Services (CMS) offer an incentive to providers to manage a patient's complex conditions at home, providers would be more inclined to work in a collaborative – and thus more effective – manner with home health agencies (HHAs). Advocate delivers coordinated, team-based care to patients across our acute and post-acute settings. As a result of our efforts, we have demonstrated reduced patient readmissions to the hospital and decreased skilled nursing facility length-of-stays for managed care patients.

Advocate suggests incorporating additional objective clinical measures into the IAH Model of Care that reflect important parameters in chronic care management. For example, blood pressure control, weight management, A1C for diabetes, and the practice of assisting with advance care planning and medication reconciliation or simplification.

Advocate also recommends that when applying the hierarchal condition categories (HCC) score, the model should take into account social factors, such as family assistance at home, financial considerations, and patient compliance. Additionally, to assist in identifying beneficiaries that may benefit from the IAH Model of Care, Advocate recommends HHAs

[1] To learn more about Advocate**Care**® visit http://amgdoctors.com/patients-and-families/advocatecare or our 2015 Value Report, http://www.advocatehealth.com/documents/app/vrweb2015.pdf.

screen beneficiaries utilizing the most current Outcome and Assessment Information Set (OASIS) data. HHAs then could refer patients with chronic conditions who may benefit from the program.

Proposal: Expanding Access to Home Hemodialysis – p. 7

As the health care environment evolves to a more patient-centered model of care, it is imperative that access to care be improved and patients be afforded – in consultation with their health care providers – the opportunity to elect their preferred method and/or site of care. Advocate is supportive of the *Working Group's* proposal to expand Medicare's qualified originating site definition for telehealth services to include free-standing renal dialysis facilities located in any geographic area, thus allowing home dialysis patients to engage with their clinicians via telehealth. However, to ensure patient safety and the prevention of complications, we recommend implementing a requirement that home dialysis patients who conduct monthly visits via telehealth must engage in a face-to-face meeting with their clinicians on a quarterly basis.

Advancing Team-Based Care

Proposal: Allowing End Stage Renal Disease (ESRD) Beneficiaries to Choose a Medicare Advantage (MA) Plan – p .9

Advocate is supportive of the proposal to allow all ESRD beneficiaries to enroll in a MA plan, regardless of the date of diagnosis. To ensure MA plans provide coverage to ESRD patients for all necessary treatments, we recommend MA plans be required to not only cover all of the services that traditional Medicare covers, but provide additional benefits as well, including nutrition counseling, exercise memberships, and non-ambulance transportation to all dialysis facilities and physician offices.

Expanding Innovation and Technology

Proposal: Adapting Benefits to Meet the Needs of Chronically Ill MA Enrollees – pp. 13-14

Advocate supports providing MA plans the flexibility to establish a benefit structure that varies based on chronic care conditions of individual enrollees, including the outlined items in the proposal:

- Additional supplemental benefits not currently allowed that are related to the treatment of the chronic condition or the prevention of the progression of the chronic disease;

- Reduction in cost-sharing for items/services that treat the chronic condition or prevent the progression of the chronic disease;

- Adjustments to provider networks that allow for a greater inclusion of providers and non-clinical professionals to treat the chronic condition or prevent the progression of the chronic disease; and

- Care improvement and/or wellness programs specifically tailored for the chronic condition.

Advocate encourages the *Working Group* to construct a proposal that directs CMS to specify the chronic conditions that would qualify for the above-listed benefits. Much like chronic condition special need plans (C-SNPs), the MA plans, on an annual basis, would be required to verify the enrollee has the qualifying chronic conditions. For example, patients with diabetes require an annual eye exam; under the outlined proposal, the MA plan could reduce or eliminate the patient's co-payment, often considered a barrier, for the ophthalmologist visit, resulting in early detection and diagnosis, in turn reducing or preventing vision loss, which may subsequently improve outcomes and reduce health care costs.

It is necessary for each MA plan to meet additional requirements as well, to ensure the changes to its benefit design are improving care for beneficiaries with chronic conditions. Using the same example as above, we would suggest th**e** MA plan be required to demonstrate to CMS that under the new benefit design, its enrollees with diabetes have higher rates of eye screenings or examinations for diabetic retinopathy as compared to prior to the implementation of the benefit design.

Proposal: Increasing Convenience for MA Enrollees through Telehealth – p. 16

Advocate strongly supports the *Working Group's* proposal to allow MA plans to include telehealth services in the annual bid amounts. We specifically recommend the *Working Group* permits behavioral health telehealth services. Due to geographical restrictions for telehealth services, reimbursement for behavioral health telehealth often is limited, which prevents the widespread deployment of telehealth for a particularly vulnerable population. To ensure patients do not experience barriers to care, we recommend the elimination of geographic restrictions for all telehealth services. Telehealth can efficiently deliver behavioral health services where such services are either non-existent or inadequately represented. The utilization of telehealth to address behavioral health needs within the emergency department and general medical floors of Advocate's hospitals helps to prevent costly inpatient psychiatric services, reduces overall length of stay, and improves patient outcomes. Moreover, utilization of telehealth in the outpatient primary care setting allows for greater access to behavioral health services, due to greater acceptance and less stigmatization. Promoting greater behavioral health access within primary care ultimately leads to lower rates of emergency department and hospital readmissions and helps to promote patient well-being.

Consideration also should be given to expanding telehealth services coverage to outpatient and inpatient behavioral health services provided by a psychiatrist, psychologist, and nurse practitioner. Such behavioral health telehealth services include behavioral health assessments administered in the emergency department, outpatient clinics, inpatient medical floors (for patients with a chronic medical illness and co-occurring behavioral health condition), and a patient's home. Advocate recommends the elimination of geographic restrictions and health care professional limitations for telehealth services.

Proposal: Providing ACOs the Ability to Expand Use of Telehealth – p .17

Advocate supports efforts to expand the use of telehealth in the MSSP two-sided risk model; however, we also recommend modifying the requirements for reimbursement for telehealth services provided by MSSP ACOs in the one-sided risk (or Track One) models. Currently, to provide telehealth services to a patient attributed to our MSSP ACO, the patient must be at a medical facility or in a physician office located in a Rural Health Professional Shortage area (HPSA) or a county outside of a metropolitan area.

We understand the Committee has concerns regarding overutilization of telehealth services; however, there exist numerous incentives for Track One ACOs to only use telehealth in lieu of an in-person clinical visit. For example, in Track One, although there is no downside risk, we aim to generate significant savings, while meeting all quality and outcomes targets. We acknowledge there are limitations with telehealth, but believe that telehealth expands access to care, particularly for medically underserved areas/populations, helps to alleviate access issues posed by health professional shortages, and increases patient satisfaction. Moreover, for many Medicare patients, being afforded the opportunity to access care via telehealth from home or another non-clinical setting can reduce crowding in health care settings and decrease patient exposure to infectious disease.

Proposal: Maintaining ACO Flexibility to Provide Supplemental Services – p.18

Advocate is supportive of policies that grant MSSP ACOs the flexibility to provide valuable services to patients that currently are not covered by fee-for-service Medicare. It is our belief that providing certain non-reimbursable services will improve patient outcomes and reduce costs. For example, providing a non-reimbursable service, such as transportation, enables patients to see their health care providers more readily and therefore could reduce emergency room visits and unnecessary admissions. We also offer in-person home visits by Advocate community health workers to our Medicaid patients to ensure they adhere to the care and drug regimen prescribed by their physicians as well as providing free cell phones to our most vulnerable patient populations to ensure proper monitoring of their care. These types of supplemental services support Advocate's ability to monitor and recognize key health indicators beyond those required by Medicare, prior to the occurrence of more serious ailments, resulting in improved outcomes and increased patient satisfaction.

Proposal: Expanding Use of Telehealth for Individuals with Stroke – p. 19

We strongly welcome and urge the expansion of telehealth services for individuals presenting with stroke. As noted above, telehealth is no longer solely used for rural communities but can and should be used for any and all patients who would benefit from these services, especially stroke patients. With the window for treatment being relatively small (up to 3 hours for the only FDA-approved drug; 4.5 hours is the expanded standard of care), many patients would be ineligible for treatment if neurology care is unavailable. Apart from teaching institutions, in many instances, neurologists are not readily available; the utilization of telehealth for instances of stroke would allow patients and providers to connect with experts in a matter of minutes and receive timely and potentially lifesaving treatment.

Identifying the Chronically Ill Population and Ways to Improve Quality

Proposal: Providing Flexibility for Beneficiaries to be Part of an ACO – p. 21

Advocate supports the potential option for MSSP ACOs in Track One to choose prospective or retrospective beneficiary assignment. Regardless of the type of risk, affording ACOs the ability to proactively provide/offer support services to beneficiaries that are assigned to them through prospective beneficiary assignment will ensure beneficiaries receive the highest quality of care and help ACOs contain spending, thus contributing to the success of the ACO model.

Empowering Individuals & Caregivers in Care Delivery

Proposal: Encouraging Beneficiary Use of Chronic Care Management Services – p. 23

Advocate is supportive of the Committee's consideration of policies that encourage beneficiaries to seek chronic care management services. Eliminating one of the primary barriers to access to care – cost – can help to facilitate the provision of care management services to patients with chronic conditions. We also encourage the Committee to consider the development of policies that help to advance patients' understanding of the importance of chronic care management and otherwise incentivize them to seek such services.

Proposal: Eliminating Barriers to Care Coordination under ACOs – p. 25

Advocate is supportive of the Committee's policy proposal that would allow ACOs in two-sided risk models to waive cost-sharing for beneficiaries with chronic disease. However, we strongly recommend the Committee consider expanding the ability to waive cost-sharing for all ACO models, including those in Track One. Granting all ACOs the authority to waive cost-sharing would help encourage our attributed members to solely seek care at Advocate sites of care, thus providing our physicians with real time access to their patients' clinical data through our integrated electronic medical records (EMRs) and patient registries. Clinical data contained in an EMR is much more reliable and meaningful than outdated Medicare claims data. When patients seek care outside of Advocate, however, we often are forced to rely on older claims data to understand where our members sought care or the services they were provided. If given the ability to waive co-payments, we also would consider waiving co-payments for preventative services, such as annual wellness visits.

Waiving cost-sharing for all ACO models of care will help ACOs more easily access real-time patient data, which will result in greater care coordination. Currently, approximately 40 percent of our MSSP ACO beneficiaries seek care outside of our network providers, which impedes the sharing, receipt, and understanding of clinical information and coordination of care between primary care providers, specialists, hospitals, and other acute and non-acute settings of care.

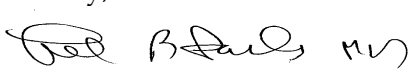
Moreover, Track One ACOs, in addition to two-sided risk ACOs, work to efficiently manage patient care, as all ACOs are financially incentivized to improve outcomes, enhance the care experience, lower the cost of care, and potentially share in a portion of the resulting savings. We encourage the Committee to avoid the burdens of rulemaking and allow both one-sided risk

and two-sided risk ACOs to identify what services are eligible for cost-sharing reductions and the types of cost-sharing that can be waived (i.e., co-payments, co-insurance, or deductibles).

Conclusion

Again, on behalf of Advocate's physicians, nurses, and patients, we thank you and your staff for your efforts to address these critical issues. Advocate stands ready to work with all members of the Committee and your other colleagues to advance policies, programs, and practices that will help improve quality of care and outcomes, reduce spending, and otherwise help ensure that Medicare beneficiaries receive the right care, at the right time, in the specific care setting appropriate for their medical needs and health status. We are eager to be of assistance to the Committee and *Working Group* in the year ahead and welcome the opportunity to elaborate on our comments or provide other insight as you and your staff may desire. Should you or your staff have any questions, please do not hesitate to contact me or Meghan Woltman, Vice President of Government and Community Relations (Meghan.woltman@advocatehealth.com or 630-929-6614).

Sincerely,



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