Lee B. Sacks, M.D.
Executive Vice President and Chief Medical Officer, Advocate Health Care
Chief Executive Officer, Advocate Physician Partners
3075 Highland Parkway, Suite 600
Downers Grove, IL 60515

January 16, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program; CMS-4182-P

Dear Administrator Verma:

Advocate Health Care (Advocate) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule seeking comment on revisions made to the Medicare Advantage program (Part C) regulations and Prescription Drug Benefit program (Part D). We commend you for undertaking this important effort to solicit feedback from providers and other stakeholders.

Advocate Overview

Advocate, named among the nation's leading health systems, operates nearly 400 sites of care in Illinois, 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. Each year, we provide care to a total of more than one million patients and have a payer mix of 35% commercial insurance, 39% Medicare and 19% Medicaid. Advocate has provided care to public exchange enrollees since its inception, and today cares for more than 110,000 exchange enrollees, nearly one third of the total enrollment in Illinois.

Advocate is eager to bring our experiences forward as we contribute to the nation's efforts to transform our health care delivery system to one of value, accountability and superior outcomes. With more than one million value-based lives, Advocate has one of the largest Accountable Care Organizations (ACOs) in the country. Our ACO includes commercial global capitation, commercial shared savings, Medicare Advantage global capitation, Medicaid Managed Care shared savings, and the Medicare Shared Savings Program (MSSP). As one of 392 ACOs participating in the MSSP in 2015, Advocate alone realized $72 million worth of cost savings for taxpayers. In 2016, of 410 participating ACOs, we achieved $60.6 million in savings, the country's 2nd highest total of taxpayer savings, and remained among the highest in our quality results at 97.28% of total points.

Thank you for your consideration of our comments below.

Quality Star Rating Changes

Quality Star rating changes tied to data integrity creates several challenges for providers. Physician Hospital Organizations (PHO) that accept full-risk contracts submit member data to the Health Plan, which then submits to CMS, as well as other PHO/IPA data for specific "H" plans. A PHO's revenue is tied to a contractual percent of CMS premium so data integrity issues related to a Health Plan has a direct adverse effect on a PHOs financial performance. Thus, Advocate fully supports the proposed scaled reduction in Stars rather than an immediate drop to a 1 Star rating. Further, Advocate recommends that a PHO or Health Plan have the ability to address the data integrity issues over a 4-5 month timeframe before any Star rating reduction. Such a change would: (1) benefit the PHO or Health Plan because its Star Ratings would be more reflective of the actual quality of care provided; and (2) improve beneficiaries' abilities to make more informed decisions about their choices of healthcare providers and services because they would have more accurate data and information on which to base such decisions.

Advocate does not support the proposal of Star ratings measured at the Health Plan level rather than the contract level. The proposed policy has significant adverse implications for PHOs that accept full-risk contracts. The ability for a PHO to differentiate itself in its market is compromised when all the unique products, contracts, and networks are consolidated to the Health Plan. For example, a PHO could create its own contract level plan with a high performing Health Plan that achieves a Star rating of 4 or greater. This automatically produces additional revenue to the PHO, as well as the ability to attract more membership due to its quality. If the Star rating was consolidated at the Health Plan level and that Health Plan's overall Star rating is less than the PHOs' contract level plans the PHO is penalized for other providers/PHOs' poor performance. This is particularly relevant in counties with large populations like Metro Chicago where Advocate operates. Advocate does not meet the access requirements for an MA plan, hence the need to contract with an insurer, but many patients will select an Advocate-only option and should be able to see the Star rating for that portion of the network. Moreover, and most importantly, this would be a great disservice to Medicare beneficiaries as they will not be able to tell which product will result in the best health outcomes produced in the most cost-efficient manner; put another way, the proposed policy would not align with CMS's important goal of facilitating informed patient choice on the best health care providers to meet their individual care needs.

Additionally, Advocate recommends that Star thresholds be set before the performance year, so PHOs have a clear set goal to achieve. Knowing performance requirements in advance offers greater clarity and certainty to providers and better helps them to establish policies and processes, which result in improved patient health outcomes, higher-quality care, and increased cost-efficiency in the delivery of health care services.

Medical Loss Ratio (MLR) Changes

While Advocate supports any effort to reduce and detect fraud, we have concerns regarding CMS's proposed changes to the Medicare MLR calculation to allow numerator treatment for fraud reduction expenses and reduce reporting obligations in MA and Part D. In proposing to include fraud prevention, detection, and recovery into the quality calculation and treat as a quality/medical cost versus

administrative cost, this reduces the allocation of available resources on quality and improvements in care.

Flexibility in Benefits/Increasing Choice and Competition

Advocate generally supports the proposed offering of cost-sharing reductions and supplemental benefits offered to individuals based on health status but have concerns that it may become too complicated to implement and manage. We do feel these changes would allow a PHO to get sicker patients enrolled and involved in appropriate improvements. On the flip side, done poorly it could make a PHO a magnet for certain disease without pick up in performance. Additionally, by permitting variation in supplemental benefits by plan segment would allow for true competition between Health Plans on benefit design to strategize on what benefits are factors in increased enrollment. This will heighten supplemental benefit competition and ultimately better serve patients.

Marketing and Enrollment

Narrowing the scope of marketing materials subject to CMS review and approval is beneficial to individuals, but permitting enrollees to make a one-time election change through March 31 would not promote growth as it would simply allow for more cannibalization from one Health Plan to another. This is problematic for a PHO taking full risk as an enrollee could potentially not be shown in the PHO eligibility system, which delays member outreach to schedule wellness visits. However, limiting special enrollment periods (SEPs) for low-income subsidy members will negatively impact enrollment as this population often needs additional guidance, support, and education. Therefore, Advocate recommends that CMS not adopt the proposal to limit SEPs for low-income subsidy members.

Conclusion

Again, we thank you for the opportunity to provide our feedback. Advocate is committed to working with policymakers at all levels of government 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. Advocate appreciates CMS's efforts and we stand ready to be a resource to the Agency as you work to improve access and lower cost of care for individuals, families, providers, and the nation.

Please do not hesitate to contact Meghan Woltman, Vice President, Government and Community Relations (630/929-6614, Meghan.Woltman@advocatehealth.com) should you have any questions or if we can be of any assistance.

Regards,

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