BETTER MEDICARE
ALLIANCE

November 17, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Slavitt,

Re: Medicare Program: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

The Better Medicare Alliance (BMA) appreciates the opportunity to provide comment to the *Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models.* The focus of our comments today relate to the value of Medicare Advantage (MA) as important to achieving the U.S. Centers for Medicare and Medicaid Services' (CMS) goal of moving providers towards Alternative Payment Models (APMs).

BMA is a coalition of advocacy organizations, aging service agencies, beneficiaries, plans, providers, and retiree organizations who support Medicare Advantage as an option under Medicare. BMA brings these varied stakeholders together to articulate the value that Medicare Advantage delivers to over 17 million beneficiaries—one third of all Medicare beneficiaries across the country. Medicare Advantage offers affordability, simplicity, and enhanced benefits, with a focus on primary care, care coordination, and disease management. BMA works to ensure the strength and sustainability of Medicare Advantage through information, research, education, commentary on policy, and advocacy.

MA has been at the forefront of innovations in payment and delivery system reform that are not only improving care for Medicare beneficiaries, but transforming health care to move from volume to value-based care. These approaches are working for millions of Medicare beneficiaries, and driving change for all Americans.

The incentive to innovate originates in the capitated payment structure of the Medicare Advantage program itself that has been actively utilized within MA to improve quality and health outcomes. Payments to MA plans are determined by benchmarks that reflect per-beneficiary spending in Medicare Fee-For-Service (FFS), but because MA has the flexibility regarding settings of care and are at risk financially, the incentive for the plans and their health care providers is to ensure the use of the most appropriate, timely care in the right settings with the right practitioners. MA has embraced the concepts of payment reform, and new models are being used to promote integrated care, as well as provide

services that supplement and enhance traditional services. They have been innovative in the delivery of care that is attentive to prevention, care coordination, and patient engagement. This has resulted in higher quality care and improved outcomes for MA beneficiaries.

MA focuses on primary care, care coordination, and management of chronic disease. MA plans have invested in innovations in care delivery, including home visiting, case managers, fitness and wellness programs, as well as offering enhanced dental, vision, and hearing coverage benefits. Most MA plans incorporate prescription drug coverage as well. MA uses health information technology, including telemedicine, as a key element in coordinated care systems. Such innovations better integrate providers across settings and disciplines, as well as offer new ways to engage beneficiaries in their own health care. The result of these significant innovations, as evidence has shown, is reduced hospital admissions, increased use of prevention and screening, and higher patient satisfaction.

CMS knows this evidence well, as it requires measurement of performance in a variety of ways. Most importantly, the accountability and incentives offered by the Star Ratings program have driven higher quality in MA across the country. CMS acknowledged these very positive trends as an example of Medicare's success during the 50th Anniversary of Medicare in July.

MA has significant experience in value-based payment arrangements. For many years, MA plans have partnered with providers on the development and implementation of contracts that reward innovation and improvements in care, moving payments to reward value rather than volume. The impact of these value-based payment arrangements is significant and growing, providing support for the ambitious goals to transition to value-based care models set by Congress and the Department of Health and Human Services.

For example, Aetna has set a goal to reach 75 percent of its medical spending in MA to value-based contracting by 2020.[1] Humana aims to have 75 percent of its Medicare Advantage enrollees in value-based care models by 2017.[2] UnitedHealthcare's payments to physicians and hospitals that are tied to value-based arrangements have nearly tripled in the last three years.[3] The flexibility currently available in MA has enabled design and implementation of provider agreements that meet the goals of value based care and assumption of risk and allows MA plans to structure these agreements in ways that meet particular providers' capabilities and best enables them to make changes in their delivery of care to meet the articulated goals. MA is a significant driver of the move to value based payments, and its role in APMs will be important to Medicare reaching its goals going forward.

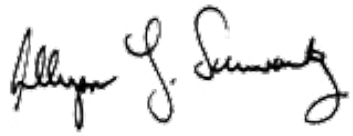
BMA calls on CMS to recognize that MA is well positioned to support and advance the goals CMS has set to move providers towards value-based agreements. We believe that MA can play a key role in the drive towards APMs in Medicare. BMA encourages CMS to engage with MA plans, providers, and senior advocacy organizations to best ensure that the structure and mechanism CMS develops recognizes MA's role and uses the experience of MA in offering value-based coverage and care to millions of American seniors.

[1] Japsen, Bruce. "Value-Based Care Will Drive Aetna's Future Goals." *Forbes*, May 15, 2015.
[2] Walker, Tracey. "Humana provider tools aid value-based care." *Managed Healthcare Executive*, April 3, 2015.
[3] UnitedHealth Group, "More than 11 Million People Can Now Receive Health Care Services from Care Providers Paid by UnitedHealthcare Based on Quality and Patient Outcomes." February 17, 2015.

Specifically, we ask that CMS recognize that the rules and regulations that are necessary to move FFS providers to APMs are different than those that might apply to MA. It is important to make the distinction between these two very different payment models to ensure that the very incentives and flexibility available under MA not be diminished or harmed in the process to move the FFS system to value based care. It is hoped that MA's present capacity to engage in value based provider agreements and the commitment to build on this experience to innovate for the future is taken into account as CMS moves forward.

Thank you again for the opportunity to provide comment to this RFI. The experience of Medicare Advantage demonstrates how value based payment models can improve patient care. As a coalition of Medicare Advantage advocates, beneficiaries, plans, and providers with significant knowledge of value based models, BMA is committed to further advancing the critically important goals set by the Medicare and CHIP Reauthorization Act. We look forward to working with CMS on this effort.

Sincerely,



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