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July 30, 2018

The Honorable Mike Kelly
1707 Longworth House Office Building
U.S. House of Representatives
Washington, DC 20515

The Honorable Ron Kind
1502 Longworth House Office Building
U.S. House of Representatives
Washington, DC 20515

The Honorable Markwayne Mullin
1113 Longworth House Office Building
U.S. House of Representatives
Washington, DC 20515

The Honorable Ami Bera, M.D.
1431 Longworth House Office Building
U.S. House of Representatives
Washington, DC 20515

Submitted electronically via InnovationCaucus@mail.house.gov

RE: Health Care Innovation Caucus RFI Submission

Dear Health Care Innovation Caucus,

Better Medicare Alliance (BMA) is pleased to submit this response to your request for information on innovative policy ideas that improve the quality of care and lower costs for consumers. BMA is a community of 115 ally organizations, as well as almost 400,000 beneficiaries, who value the option of Medicare Advantage. Together, our alliance of health plans, provider groups, business groups, and policy and research organizations share a commitment to ensuring Medicare Advantage is a high-quality, cost-effective option for current and future beneficiaries. A list of our ally organizations is attached for your information.

Medicare Advantage is a public-private partnership in which incentives between providers and health plans can be aligned, enabling them to partner in innovative, value-based care delivery and payment models. Medicare Advantage leads the transition to value-based care, with more than 4 in 20 dollars paid through alternative payment models in 2016.[1] As the cost of health care continues to increase as a percentage of the overall economy, Medicare Advantage is positioned as the high-value alternative to Traditional Fee-for-Service (FFS) Medicare.

In fact, research has shown that Medicare Advantage achieves better health outcomes at comparable or lower costs than FFS Medicare for high-need Medicare beneficiaries and those with chronic conditions.[2] Medicare Advantage also delivers value to beneficiaries through tailored benefit structures, limits on beneficiary out-of-pocket costs, and supplemental benefits beyond those covered by FFS Medicare, such as hearing, vision and dental coverage. While Medicare Advantage is leading the transition to value-based care through innovation, BMA believes more can be done to sustain and strengthen this drive to high-quality and cost-effective care.

BMA recommends the following actions by Congress to address barriers to innovation in value-based care:

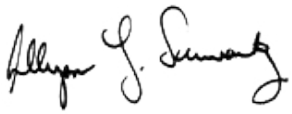
1. Recognize and incentivize value-based payment arrangements in Medicare Advantage as an advanced alternative payment model.
2. Align reporting and quality measurements across public programs, including Medicare Advantage.
3. Expand value-based insurance design (V-BID) to Part D for integrated Medicare Advantage-Part D (MA-PD) plans.
4. Address Medicare Advantage beneficiaries' social determinants of health through supplemental benefits, Star Ratings and risk adjustment.
5. Ensure better communication, outreach, and education on Medicare Advantage to help beneficiaries make informed coverage choices.
6. Support stability by ensuring accurate and adequate payment in Medicare Advantage.
7. Lift the benchmark cap for high-quality health plans to support the move to value.
8. Facilitate smooth transitions to Medicare Advantage by reinstating seamless conversions.

BMA believes that the move to value-based payment already underway in Medicare Advantage offers a positive and transformative path forward for Medicare, as well as for change in health care financing and the delivery of care. Stability and predictability are essential to Medicare Advantage and its capacity to innovate in health care delivery and coverage design.

BMA very much appreciates the leadership of the Health Care Innovation Caucus and its members in advocating for a strong, stable and growing Medicare Advantage option in Medicare. Our more detailed comments on this RFI, including

recommendations for action, as well as supporting evidence found in academic research and examples of successful value-based payment arrangements are attached below. Thank you for the opportunity to submit these comments. We look forward to further discussions and working with you to drive heath care innovation

Sincerely,



Congresswoman Allyson Y. Schwartz
President & CEO
Better Medicare Alliance

Attachment1 – Expanded Comments & Recommendations for Congressional Action

1. Recognize and Incentivize Value-Based Payment Arrangements in Medicare Advantage as an Advanced Alternative Payment Model

Barrier: Currently, providers who participate extensively in innovative Medicare Advantage payment arrangements similar to Advanced Alternative Payment Models (Advanced APMs), may still be subject to Merit-based Incentive Payment System (MIPS) requirements established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). A Centers for Medicare & Medicaid Services (CMS) Report to Congress on the feasibility of integrating APMs in the Medicare Advantage payment system concluded MACRA statutory constraints generally limit the tools available to CMS to encourage further APM adoption.[3]

Solution: CMS recently proposed the Medicare Advantage Qualifying Payment Arrangement Incentive Demonstration in the 2019 Physician Fee Schedule rule to waive MIPS requirements based on provider participation in Medicare Advantage payment arrangements similar to Advanced APMs.[4] The demonstration is consistent with BMA requests to increase the support and recognition for the important work providers are doing through value-based contracting in Medicare Advantage.

Congress should go further to create a level playing field for Medicare Advantage health plans and FFS Medicare in MACRA by recognizing the important work providers are engaging in via risk-based Medicare Advantage contracts. We urge Congress to work with CMS to allow clinicians' contracts with Medicare Advantage health plans that meet risk, quality, and certified electronic health record technology requirements to be considered Advanced APMs. CMS should allow clinicians to use qualified Medicare Advantage payment arrangements to meet the threshold for sufficient participation to qualify for the five percent bonus payment and exclusion from MIPS.

2. Align Reporting and Quality Measurements Across Public Programs, Including Medicare Advantage

Barrier: The Medicare Advantage Quality Star Rating System plays a critical role in ensuring public accountability and enhancing consumer choice by providing quality information on Medicare Advantage health plans. BMA believes that as the Star Rating System reaches its tenth year, an opportunity exists to align measures with other

quality rating systems to obtain meaningful, actionable quality metrics across public programs. We believe this work is enhanced by the input of experts from across the Medicare Advantage and Part D stakeholder community, and we appreciate CMS's ongoing engagement with stakeholders through the Technical Expert Panel on Star Ratings.

Solution: Congress should instruct CMS to analyze ways to align, simplify, and streamline quality measures across public rating systems to focus on outcomes and consumer satisfaction, while reducing administrative and compliance measures. The analysis is consistent with ongoing CMS efforts to implement the "Meaningful Measures" framework to identify the priority quality measurements to achieve high-quality outcomes for beneficiaries.[5] CMS should also consider the MedPAC recommendation to use a small set of population-based quality measures that include potentially preventable hospital admissions, emergency department visits, and readmissions.[6]

3. Expand V-BID to Part D for Integrated MA-PD plans

Barrier: CMS recognized the potential of V-BID strategies in Part C by recently reinterpreting the benefit uniformity requirements beginning in plan year 2019 but stopped short of enabling Medicare Advantage health plans to utilize the same V-BID flexibilities in Part D. V-BID promotes quality and access to care by reducing cost-sharing for high-value services for targeted groups of beneficiaries. This flexibility encourages and enables utilization of services that are clinically recognized as effective for beneficiaries with specific clinical conditions and provides an opportunity to lower beneficiary cost-sharing, particularly for high-value medications. A recent review of the literature published in Health Affairs found improvements in medication adherence through V-BID with no increase in total health spending, suggesting that increased costs associated with more medication use were offset by a reduction in other, low-value care.[7]

Solution: Congress should instruct CMS to leverage the success of V-BID strategies in Part D, particularly for integrated MA-PD health plans. V-BID has the potential to realize billions in cost savings, while improving treatment and outcomes, particularly for beneficiaries with multiple chronic conditions.[8] Expanding V-BID to Part D for MA-PD health plans has the potential to realize cost savings for consumers, while improving quality across the health care system.

4. Improve the Ability of Medicare Advantage to Address Social Determinants of Health Through Supplemental Benefits, Star Ratings and Risk Adjustment

Barrier: Medicare Advantage depends on accurate and adequate payment to have the resources to meet patients' clinical needs, and as possible and allowable, to address social determinants that impact those clinical conditions. Social determinants of health are the social, economic and environmental conditions that lead to inequities in health outcomes. The move to value in health care incentivizes greater attention to addressing social determinants, including safety in the home, healthy food, and access to other health or social services that contribute to patients' health outcomes. Medicare Advantage health plans are able to address the social and physical environments that promote health through supplemental benefits, care coordination, and value-based payment arrangements. These arrangements with providers can include referrals or contracts with community partners or entrepreneurs to improve outcomes and lower health care costs. Congress should address current limitations in supplemental benefits, Star Ratings and risk adjustment to better enable Medicare Advantage to address social determinants of health.

Solution: Congress should encourage CMS to use the new authority, provided by provisions of the Bipartisan Budget Act of 2018 (BBA), to allow supplemental benefits, starting in 2020, to directly address social determinants of health like food insecurity and social isolation.[9] Earlier this year, CMS re-interpreted the "primarily health-related" supplemental benefit standard to allow Medicare Advantage health plans to tailor benefits to specific groups of beneficiaries based on their health status or disease state to improve their quality of life. While this guidance is a step forward in enabling Medicare Advantage to provide services such as expanded care in the home, transportation, and health-related items and medications available without a prescription, CMS stated that supplemental benefits *cannot* target health care services based on social determinants, thus limiting services that have shown benefits in addressing social determinants of health.

Congress should ensure CMS continues to evaluate whether adjustments to the Star Rating System for social risk factors are appropriate and effective. Research has suggested that the Star Rating System does not accurately reflect the quality of care delivered by health plans serving a high proportion of dual-eligible beneficiaries and/or low-income enrollees.[10] To begin addressing this issue, in 2017 CMS

implemented an interim adjustment to overall and summary scores for dual-eligible, low-income, and disabled beneficiaries for certain Star Rating measures called the Categorical Adjustment Index (CAI). CMS should continue to monitor and adjust the CAI to ensure the Star Rating System accurately incorporates needs based on social determinants of health.

Congress should ensure CMS continues to evaluate whether additional conditions or social determinants of health meet the requirements to be included in the risk adjustment model for future payment years. There are six main beneficiary subgroups in the community risk model, including individuals eligible for both Medicare and Medicaid, called dual-eligible beneficiaries. The community risk model adjusts health plan payment for dual-eligible beneficiaries. In recent years, CMS has found that the current risk model underpays Medicare Advantage health plans for dual-eligible beneficiaries. It's critical that the risk adjustment model is accurate and ensures that payments to Medicare Advantage health plans adequately compensate for the costs of treating and managing both high- and low-cost individuals.

5. Ensure Better Communication, Outreach, and Education on Medicare Advantage to Help Beneficiaries Make Informed Coverage Choices

Barrier: As millions of Americans age into Medicare each year, many are unaware of the option of Medicare Advantage. In fact, a recent survey of Medicare-eligible beneficiaries showed 65% of those in FFS Medicare were unaware of the option of Medicare Advantage.[11] With over 10,000 baby boomers aging into Medicare each day, and the population of those aged 85 and older nearly tripling by 2050, it is paramount that eligible individuals have the necessary information and decision-making tools to make informed enrollment decisions.

Choosing suboptimal Medicare coverage may result in beneficiaries experiencing limited access to preferred providers, diminished access to needed medications, or increased out-of-pocket costs. To achieve this goal, the federal government must meet its responsibility to provide the education, outreach and enrollment processes and materials that fully inform beneficiaries and offer consumer-friendly enrollment procedures to eligible beneficiaries on their options under Medicare, including the choice of Medicare Advantage.

Solution: Congress should require the Comptroller General of the United States to provide an assessment on the adequacy and effectiveness of the Medicare Advantage information available to new and current beneficiaries, as well as recommendations for areas that require improvements. This study should include complete assessment of the content, placement of content, ease of comprehension for different populations, appropriateness for different populations given language and literacy levels, ease of access and usability by eligible beneficiaries and their caregivers.

6. Support Stability by Ensuring Accurate and Adequate Payment in Medicare Advantage

Barrier: To build on the success of Medicare Advantage across the country and ensure beneficiaries have access to Employer Group Waiver Plans that provide employer-sponsored retiree coverage and Special Needs Plans that provide specialized care to frail, disabled, and chronically ill individuals, payment stability and predictability is critical. Medicare adjusts the rates it pays Medicare Advantage based on risk adjustment, which allows CMS to pay health plans for the risk of the beneficiaries they enroll. The ongoing challenge of risk adjustment is to calibrate the model to reflect age, health status and other factors such as multiple chronic conditions and social determinants of health. The current risk adjustment model generally under-predicts the actual expenses of the highest-cost beneficiaries. As a result, Medicare Advantage health plans may not be adequately compensated for the cost of delivering care to high-need enrollees.

In addition, Medicare Advantage health plans are paid based on a risk adjustment model that utilizes factors reflecting beneficiaries' health status. Diagnosis coding in FFS Medicare has historically been less accurate than Medicare Advantage diagnosis reporting, due to the lack of financial incentives for providers to correctly and completely code diagnoses. The coding intensity adjustment, which is an arbitrary reduction to Medicare Advantage payments diminishes the resources necessary to deliver quality, cost effective care to beneficiaries.

CMS is in the midst of changing the system used to gather diagnosis codes and is currently using a blended version of two different systems. Through the Risk Adjustment Processing System (RAPS), Medicare Advantage plans filter diagnosis codes, and submit them to CMS, where the files are reviewed and audited for accuracy. With the newer Encounter Data System (EDS), Medicare Advantage plans submit all

unfiltered data directly to CMS, which then applies its own filtering logic to extract diagnosis codes from the data. CMS has acknowledged data accuracy challenges with encounter data, and BMA has urged the agency to validate the EDS to ensure accuracy of risk scores for Medicare Advantage enrollees prior to greater use in payment determination.

BMA has also advocated for payment stability by supporting the delay or repeal of the Health Insurance Tax (HIT) to prevent the increase in the cost of health coverage and preserve access to valued care for seniors, the disabled, and low-income beneficiaries in Medicare Advantage. The tax, which is imposed annually on health insurance plans, applies to individual policies, small groups, employers that are not self-insured, Medicaid managed care, Medicare Part D, and Medicare Advantage. The $8 billion tax was first levied in 2014 and grows every year by the rate of growth in premiums. To prevent premium increases, Congress delayed the HIT in 2017 and 2019, however the HIT is currently scheduled to be reinstated in 2020.

Solution: Congress should ensure accurate risk adjustment and adequate payment in Medicare Advantage by freezing the coding intensity adjustment at the statutory minimum to ensure adequate and stable payment, as well as to support investments in preventive care, care management, and care for high-need beneficiaries. The goal of any adjustment to Medicare Advantage payment should be supported by complete and accurate coding. Congress should also require CMS to delay the phase-in of encounter data as a diagnosis source until data accuracy and processes are verified and reliable.

In addition, to prevent an increase in health care costs for Medicare Advantage beneficiaries, the Senate should join the House in passing a two-year delay of the HIT scheduled to be reinstated in 2020 and expected to rise to as much as $22 billion, negatively impacting over 20 million seniors and disabled individuals enrolled in Medicare Advantage.[12]

7. Lift the Benchmark Cap for High-Quality Health Plans to Support the Move to Value

Barrier: The Affordable Care Act (ACA) capped Medicare Advantage benchmark rates at pre-ACA levels, plus growth updates. Because of this cap, high-performing health plans in certain counties do not receive Quality Bonus Payments (QBPs) because those

payments would exceed the cap. Medicare Advantage health plans must use these QBPs to directly benefit beneficiaries through reduced cost-sharing or enhanced benefits. Nearly 5.8 million beneficiaries are being denied these enhanced benefits because of the benchmark cap, negatively impacting the move to value.

Solution: Congress moved in the right direction this month by voting to require HHS, in consultation with relevant stakeholders, to conduct a study on the impact of the benchmark cap. We appreciate the leadership of Representatives Kelly (R-PA) and Kind (D-WI) in championing H.R.4952, the Improving Seniors Access to Quality Benefits Act.[13] BMA in partnership with twelve ally organizations also submitted a letter in strong support of the bipartisan legislation and the movement towards remedying the benchmark cap issue.[14] We urge the Senate to quickly pass the legislation and ask Congress to act to correct this inequity and encourage CMS to use administrative or demonstration authority to put a moratorium on benchmark caps for 4+ Star plans until a legislative change is made.

8. Facilitate Smooth Transitions to Medicare Advantage By Reinstating Seamless Conversions

Barrier: The seamless conversion program allows health plans to enroll their commercial beneficiaries in a comparable Medicare Advantage health plan when they become eligible for Medicare. Beneficiaries may opt out if they decide to choose a different Medicare Advantage health plan or to enroll in FFS Medicare. Previously, health plans applied to CMS for approval to conduct seamless conversion, but CMS has put a hold on any new applications due to concerns about patient protections. CMS should work with consumer advocates and health plans to reinstate and update the seamless conversion program to ease the transition to Medicare and provide greater continuity of care delivery for beneficiaries.

Solution: Congress should require CMS to reinstate seamless conversion, with appropriate consumer protections. In August 2016, BMA polled 68,258 BMA advocates to gain an understanding of their sentiments surrounding seamless conversion. A total of 749 beneficiaries completed the survey. Less than 4% of respondents found the auto-enrollment process in seamless conversion to be negative. Through follow-up phone conversations, BMA staff found that many seniors feel that seamless conversion alleviates the complexity of researching many health plan options. Congress should instruct CMS to work with consumer advocates and health plans to reinstate the

seamless conversion program, ensure appropriate protections for consumers, ease the transition to Medicare and maintain continuity of care delivery for beneficiaries.

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Attachment 2 – Key Research & Value-Based Payment Model Examples

Key Research

Research shows Medicare Advantage, as a capitated, prepaid system that accepts financial risk for provision of all Medicare benefits, is playing a crucial role as an incubator for innovative value-based care that improves quality and access, while reducing costs. Medicare Advantage delivers an integrated care system, population management, care management, and supplemental benefits. FFS Medicare allows beneficiaries to see any doctor, specialist, or hospital that participates in Medicare, which often leads to over-utilization and fragmented care. As a result, the National Bureau of Economic Research found that health care spending is 25% lower for Medicare Advantage enrollees than for enrollees in FFS Medicare in the same county with the same risk score.[15]

In 2018, about 70% of Medicare Advantage health plans bid below FFS Medicare spending. Medicare Advantage payments averaged 101 percent of FFS Medicare.[16] The effective management of high-value networks in Medicare Advantage delivers better care and cost savings for the Medicare program.[17] Research shows in Medicare Advantage, hospital costs decline due to shorter lengths of stay and lower readmissions, leading to more high-value health outcomes.[18] [19]

Despite lower costs for chronically ill beneficiaries, Medicare Advantage substantially outperforms FFS Medicare on quality and outcomes measures.[20] [21] Studies of provider and payer collaborations across the country have concluded Medicare Advantage value-based contracting arrangements improve clinical outcomes, and generate costs savings, while improving survival rates.[22] [23]

As you may have seen in Avalere research recently discussed in a BMA sponsored Hill Briefing, Medicare Advantage outperforms FFS Medicare for chronically ill beneficiaries, with 29% fewer potentially preventable hospital admissions, 33% fewer emergency room visits, and 23% fewer inpatient hospital stays.[24] [25] Research has also shown integrated MA-PDs increase medication adherence and reduce the risk of hypertension, diabetes, and hyperlipidemia.[26] Value-based care models in Medicare Advantage reduce costs and improve outcomes by utilizing care management and population management strategies to target care to the highest need beneficiaries.[27]

It is clear that Medicare Advantage health plans are committed to advancing value-based payment models. For example, as of December 2017, 66% of Humana's individual Medicare Advantage beneficiaries were enrolled in plans with value-based payment arrangements. Humana's goal is to have 75% of beneficiaries in such arrangements by the end of 2018. In addition, 3.1 million of UnitedHealthcare's Medicare Advantage enrollees are in a value-based program and UnitedHealthcare health plans have paid $90 million in bonus payments to Medicare Advantage physicians in 2017 alone for achieving quality goals and identifying gaps in care. And finally, Aetna is on track to have 75% of its medical spend in value-based contracts by 2020.

It's also clear that the administration is committed to providing Medicare Advantage with the flexibilities necessary to innovate in the delivery of value-based care. Several key policy changes enacted in 2018 expand the types of benefits Medicare Advantage health plans are able to offer beginning in 2019. On February 9, 2018, the Bipartisan Budget Act was signed into law enabling Medicare Advantage plans starting in 2020, to provide supplemental benefits specifically tailored to chronically ill enrollees.[28] The Bipartisan Budget Act contained the CHRONIC Care Act, and a bill to expand allowable supplemental benefits intended to improve the health of chronically ill Medicare Advantage beneficiaries introduced by Reps. Patrick Meehan (R-P.A.), Leonard Lance (R-N.J.), Terri Sewell (D-Ala.), Diana DeGette (D-Colo.), and Joseph Kennedy (D-Mass.). [29] [30] Furthermore, on April 2018, CMS finalized proposals to allow health plans to tailor supplemental benefits to beneficiaries with certain disease conditions.[31, 32]

Medicare Advantage enrollment is outpacing FFS Medicare, and enrollment is projected to be 42% of Medicare by 2028.[33] Enrollment in Medicare Advantage is also expanding through EGWP, SNP and dual eligible beneficiary enrollment growth.[34] Medicare beneficiaries are increasingly benefitting from Medicare Advantage payer-provider collaborations and increased patient engagement that delivers value-based care, as the following examples illustrate.

Examples of Medicare Advantage Value-Based Payment Models

Atrius Health

Atrius Health, the largest not-for-profit independent medical group in the Northeast, delivers an effective system of connected care for more than 675,000 adult and pediatric patients in eastern and central Massachusetts. With 29 medical practices, including more than 50 specialties and 750 physicians, providers work in close collaboration with partners across the care continuum. Atrius Health also partners with a single Medicare Advantage health plan under a fully capitated payment model for its 25,000 Medicare Advantage patients. Overall, Atrius Health receives more than 75% of its total revenue through risk-based contracts, which cover half of all Atrius patients.

Value-based care delivery, facilitated by Medicare Advantage, has allowed Atrius Health to utilize resources to reduce hospitalizations and safely keep patients at home. For example, Atrius Health funds a primary care at home program for its homebound seniors, providing an urgent care visit at home for frail elders who would otherwise go to emergency departments. Atrius is also is developing a hospital at home program.

In addition, clinical pharmacists support better medication management, physicians staff several preferred skilled nursing facilities to smooth care transitions and reduce length of stay, and a data analytics team advanced predictive modeling to identify patients at high risk of hospitalization. These interventions that reduce hospitalizations and emergency department visits are enabled by Medicare Advantage.

Central Ohio Primary Care

Central Ohio Primary Care (COPC), the largest physician-owned primary care medical group in the United States, leverages similar payment models for its 21,000 Medicare Advantage patients.[35] COPC Medicare Advantage contracts utilize shared savings arrangements so that providers retain a portion of the savings they generate by providing cost-effective, high-quality care. Through one value-based contract with Aetna, COPC receives a capitated payment plus additional resources that COPC uses to invest in infrastructure to improve care quality and reduce costs, such as hospitalist services, transition nursing, and home visiting.[36] Through this partnership, COPC has generated more than $2 million in savings on 6,000 Medicare Advantage patients using innovative care coordination programs. More broadly, COPC's population health

initiatives have improved patient access to preventive care, reduced hospitalizations and readmissions, and helps patients stay in their homes.[37]

Iora Health

Iora Health delivers primary care through a team-based model designed specifically for Medicare Advantage beneficiaries.[38] Iora partners with Medicare Advantage health plans that provide a monthly, capitated payment to cover all of the patient's health care needs. This payment model frees Iora providers from typical FFS Medicare payments that incentivize volume over patient-centered, value-based care, ensuring the care team can meet each patient's needs even when a need does not align with a billing code. Through these monthly payments, Iora clinical practices, located across the country, accept 100 percent of the financial risk associated with covering all of a patient's care needs.[39]

The Medicare Advantage payment model allows the Iora care team to align incentives and truly put the patient's health first. Using health coaches, technology, and an emphasis on mental health, the care model keeps seniors happy, healthy, and socially connected. In addition, each physician's patient panel is approximately half of a typical primary care physician's patient panel, allowing Iora physicians to spend an average of one hour with each patient, taking time to listen to patients and understand their concerns and needs.[40] This model of care has helped Iora reduce hospitalizations and emergency department visits.[41]

Visiting Nurse Service of New York

In 2016, the Visiting Nurse Service of New York (VNSNY), the nation's oldest and largest not-for-profit home- and community-based health care organization, became one of the first home care providers to manage post-acute episodic care through managed care contracts. Today, VNSNY also manages post-acute episodic risk up to 90 days post-discharge outside of a Medicare demonstration. Through this innovative model, VNSNY delivers efficient, quality care through a provider and payer case rate payment partnership for 90 days post-discharge, taking on both upside and downside risk.

Currently, more than 30% of managed care patients served by VNSNY Home Care are in one of these "case rate" financial arrangements, with a goal to reach 90% by the end

of 2019. Through these arrangements, VNSNY is responsible for delivering post-acute interdisciplinary clinical care, as well as care management and utilization management for 30-, 60-, or 90-day intervals at a set payment rate. Case rate arrangements include evaluation based on quality metrics, primarily focused on reducing hospitalizations, tied to incentive payments. Based on performance against established benchmarks, VNSNY may receive bonus payments or incur penalties if targets are met or missed, adding both upside and downside risk to the value-based contracts with Medicare Advantage health plans. Preliminary results from VNSNY's case rate contracts show that self-reported rehospitalizations were reduced, and that VNSNY's care management program exceeds target engagement rates and reduces service utilization.

Conclusion

Medicare Advantage is a leader in driving value-based innovation in care delivery and payment arrangements. Our alliance is committed to working with Congress and the Administration to support program stability and address barriers that restrain providers and health plans from working to advance better care at better cost for beneficiaries in Medicare Advantage. We appreciate your consideration of the key solutions we highlighted to better enable Medicare Advantage to provide high-quality, cost-effective care.

Medicare Advantage now covers over 20 million older adults and individuals with disabilities, over one-third of Medicare beneficiaries, and has been shown to increase preventive care, reduce hospitalizations, improve outcomes, and achieve high patient satisfaction. Medicare Advantage is achieving high-quality outcomes at a lower cost for chronically ill beneficiaries than FFS Medicare.

We share a commitment to advancing the transition to value-based payment underway across the U.S. health care system and appreciate your work to promote innovation by seeking ways to strengthen Medicare Advantage and removing obstacles to enable Medicare Advantage to thrive in the provision of value-based care for Medicare beneficiaries. We look forward to working with you and your staff to ensure Medicare Advantage is a strong, stable, sustainable, high-quality, and cost-effective option for current and future beneficiaries.

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Thank you for the opportunity to submit these recommendations and we welcome further discussion. If you have any additional questions, please contact Better Medicare Alliance Director of Government Affairs Peter Stein at 202.758.3157 or pstein@bettermedicarealliance.org.

[1] CMS. "Report to Congress Alternative Payment Models & Medicare Advantage." www.cms.gov, 2017. Web.
[2] Avalere. "Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare." www.bettermedicarealliance.org Published, July 2018. Web.
[3] Ibid.
[4] CMS. "Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration." Innovation.cms.gov, 2018. Web.
[5] CMS. "Meaningful Measures Hub." www.cms.gov, 2018. Web.
[6] MedPAC. "Report to Congress: Medicare and the Health Care Delivery System." www.medpac.gov, June 2017. Web.
[7] Agarwal, Rajender, et al. "Value-Based Insurance Design Improves Medication Adherence Without An Increase In Total Health Care Spending." www.healthaffairs.org, July 2018. Web.
[8] Smarter Health Care Coalition. HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs Request for Information. 16 July 2018. Web.
[9] Rep. Larson, John B. [D-CT-1]. "H.R.1892, Bipartisan Budget Act of 2018." www.congress.gov, 9 Feb. 2018. Web.
[10] ASPE. "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs." Aspe.hhs.gov, 21 Dec. 2016. Web.
[11] Morning Consult poll. "65% Of Seniors on Medicare Are Unfamiliar with Medicare Advantage." www.bettermedicarealliance.org, 30 Oct. 2017. Web.
[12] Rep. Roskam, Peter J. [R-IL-6]. "H.R. 6311, the Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018." Www.congress.gov, 6 July 2018. Web.
[13] Rep. Kelly, Mike [R-PA-3]. "H.R.4952 - Improving Seniors Access to Quality Benefits Act." www.congress.gov, 6 Feb. 2018. Web.
[14] Better Medicare Alliance. "Letter to Congress on Legislation to Address Benchmark Cap (HR 4952)." www.bettermedicarealliance.org, 24 July 2018. Web.
[15] Carto, Vilsa. "Healthcare Spending and Utilization in Public and Private Medicare." www.nber.org, Jan. 2017. Web.
[16] MedPAC. "Report to Congress: Medicare and the Health Care Delivery System." www.medpac.gov, June 2018. Web.
[17] Robert Graham Center. "Understanding the Impact of Medicare Advantage on Hospitalization Rates." www.graham-center.org, 2016. Web.
[18] Landon, Bruce E et al. "Analysis Of Medicare Advantage HMOs Compared With Traditional Medicare Shows Lower Use Of Many Services During 2003–09." www.healthaffairs.org, 2012. Web.
[19] Lemieux, Jeff et al. "Hospital Readmission Rates in Medicare Advantage Plans." www.ajmc.com, 27 Feb. 2012. Web.

[20] Timbie JW et al. "Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States." www.ncbi.nlm.nih.gov, Dec. 2017. Web.
[21] McIntyre-Bolen, Skye. "Integrated Healthcare Association (IHA) Releases 2nd Edition of the California Regional Health Care Cost & Quality Atlas." www.iha.org, 1 Mar. 2018. Web.
[22] Mandal, Aloke K. "Value-Based Contracting Innovated Medicare Advantage Healthcare Delivery and Improved Survival." www.ajmc.com, 10 Jan. 2017. Web.
[23] Claffey, Thomas et al. "Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan." www.healthaffairs.org, Sept. 2012. Web.
[24] Ibid.
[25] Better Medicare Alliance. "Event Recap: Hill Briefing | New Research Comparing Medicare Advantage and Traditional Medicare." www.bettermedicarealliance.org, 17 July 2018. Web.
[26] Yuting Zhang et al. "The Impact of Medicare Part D on Medication Adherence Among Older Adults Enrolled in Medicare-Advantage Products". Medical care. 1 May 2010.
[27] Hoverman, J. Russell. "Three-Year Results of a Medicare Advantage Cancer Management Program." Ascopubs.org, 1 Apr. 2018. Web.
[28] Ibid.
[29] Sen. Hatch, Orrin G. [R-UT]. "S.870 - Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017." www.congress.gov, 6 April 2017. Web.
[30] Congress.gov. " H.R.3044 - To Amend Title XVIII of the Social Security Act to Expand Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees under the Medicare Program, and for Other Purposes." www.congress.gov, 23 June 2017. Web.
[31] Ibid.
[32] Baxter, Amy. "Providers Urge CMS to Enact Medicare Advantage Home Care Proposal." Home Health Care News, 6 Mar. 2018. Web.
[33] CBO. "Medicare—CBO's April 2018 Baseline." www.cbo.gov, 2018. Web.
[34] MedPAC. "Health Care Spending and the Medicare Program." www.medpac.gov, June 2018. Web.
[35] Better Medicare Alliance, "Central Ohio Primary Care (COPC) Spotlight on Innovation," p. 3, June 7, 2017. Web.
[36] Ibid. p. 5.
[37] Ibid. p. 4.
[38] Better Medicare Alliance, "Spotlight on Innovation, Medicare Advantage Facilitates Care Coordination: Iora Health," p. 2, June 2, 2016. Web.
[39] Ibid.
[40] Ibid. p. 4.
[41] Ibid. pp. 4-5.

National, State, and Local Allies

BETTER MEDICARE ALLIANCE

ADVOCACY ORGANIZATIONS

Alliance for Aging Research
American Telemedicine Association
Asian & Pacific Islander American Health Forum
Association for Behavioral Health and Wellness
Association for Community Affiliated Plans
Coalition of Texans with Disabilities
Consumer Action
Council for Affordable Health Coverage
Direct Primary Care Coalition
Healthcare Leadership Council
National Alliance on Mental Illness
National Association of Nutrition and Aging Services Programs
National Caucus and Center on Black Aging
National Coalition on Health Care
National Hispanic Council on Aging
National Minority Quality Forum
National Patient Advocate Foundation
Partnership to Fight Chronic Disease
Population Health Alliance
Smarter Health Care Coalition
SNP Alliance
Society for Women's Health Research
The Gerontological Society of America
The Latino Coalition
WomenHeart

POLICY AND RESEARCH ORGANIZATIONS

Health Care Transformation Task Force
Network for Excellence in Health Innovation
University of Michigan Center for Value-Based Insurance Design

NATIONAL / LOCAL COMMUNITY BASED ORGANIZATIONS

Meals on Wheels America
YMCA of the USA

AGING SERVICE ORGANIZATIONS

Area Agency on Aging Palm Beach / Treasure Coast, Inc.
Consortium for Older Adult Wellness
Elder Services of the Merrimack Valley
Florida Health Networks
International Council on Active Aging
LeadingAge
National Association of Area Agencies on Aging
Philadelphia Corporation for Aging
Senior Resource Alliance

MEDICARE ADVANTAGE PLANS

Aetna
Humana
UnitedHealth Group
SCAN Health Plan

BENEFITS PLANS

Delta Dental of CA, PA, NY, & Affiliates
LIBERTY Dental Plan Foundation
National Association of Dental Plans
VSP Vision Care

PUBLIC SECTOR PURCHASER ORGANIZATIONS

Public Sector Healthcare Roundtable
Teachers' Retirement System of Kentucky

PROVIDER ASSOCIATIONS

Academy of Nutrition and Dietetics
American Association of Nurse Anesthetists
American Association of Nurse Practitioners
American Medical Group Association
American Nurses Association
American Osteopathic Association
American Podiatric Medical Association
American Speech-Language-Hearing Association
Federation of American Hospitals
National Association of Hispanic Nurses
National Association of Hispanic Nurses Garden State Chapter
National Black Nurses Association
National Hispanic Medical Association
National Hospice and Palliative Care Organization
National Medical Association
New Jersey Association of Nurse Anesthetists
New Jersey State Nurses Association
Nurse Practitioner Association of New York State

NATIONAL BUSINESS ORGANIZATIONS

American Benefits Council
National Association of Health Underwriters
National Association of Manufacturers
National Business Group on Health
National Retail Federation
U.S. Chamber of Commerce

HEALTH SYSTEMS/PROVIDER GROUPS

Atrius Health
Banner Health
Central Ohio Primary Care Physicians
ChenMed
Commonwealth Care Alliance
Einstein Healthcare Network
Gundersen Health System
Health Quality Partners
Indiana University Health
Intermed
Iora Health
Lehigh Valley Health Network
Martin's Point Health Care
Mercy Health
Northwell Health
Novant Health
Prevea Health
Summa Health
Temple Health
Virtua
Visiting Nurse Service of New York

STATE/LOCAL BUSINESS ORGANIZATIONS

Business Council of New York State
Chamber of Commerce Southern New Jersey
Commerce and Industry Association of New Jersey
Connecticut Association of Health Underwriters
Delaware State Chamber of Commerce
Denver Metro Chamber of Commerce
Greater Pittsburgh Chamber of Commerce
Greater Philadelphia Business Coalition on Health
Greater Philadelphia Chamber of Commerce
Inland Empire Association of Health Underwriters
New Jersey Business and Industry Association
New Jersey State Chamber of Commerce
Orange County Association of Health Underwriters
Oregon Association of Health Underwriters
Palm Coast Association of Health Underwriters
Pennsylvania Chamber of Business and Industry
Pittsburgh Business Group on Health
Texas Association of Business

HEALTH COMPANIES

Tivity Health
Silver Sneakers – a Tivity Health Company
naviHealth