

BETTER MEDICARE

ALLIANCE

June 22, 2015

The Honorable Orrin G. Hatch
Chair
Senate Finance Committee
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

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

Delivered via email: chronic_care@finance.senate.gov

Dear Chairman Hatch and Ranking Member Wyden:

The Better Medicare Alliance (BMA) welcomes the opportunity to provide a response to the Senate Finance Committee's May 22, 2015, request for recommendations based on real world experience and data-driven evidence that improves care for Medicare beneficiaries with chronic conditions. As the Committee request indicates, addressing chronic care is a pressing issue in Medicare. CDC data shows that more than two-thirds (68.4 percent) of Medicare beneficiaries had two or more chronic conditions and more than one-third (36.4 percent) had four or more chronic conditions.¹ The significant personal implications and societal consequences, as well as the financial demands of these numbers warrant the Committee's attention and action.

BMA is a new coalition that brings together Medicare Advantage (MA) beneficiaries, their families and loved ones, health plans, doctors, hospitals and other MA providers, and advocates to highlight the value MA delivers to Medicare beneficiaries and the broader health care system. BMA seeks to offer the experience of Medicare Advantage to policymakers to ensure the strength and sustainability of the choice of Medicare Advantage plans remains a viable option within Medicare. Given the innovation in payment and delivery system models enabled by MA, we believe that our objectives are consistent with the Committee's bipartisan goal of facilitating the delivery of high quality care, increased program efficiency, improved care transitions, better patient outcomes, and cost containment in Medicare spending.

MA has demonstrated sustained success in providing preventive services and coordinated care, improving chronic disease management, closing gaps in patient care, pioneering value-based contracts, reducing cost sharing, and expanding access to wellness, dental and vision that we believe can be informative to the Committee. The approach and design of MA has delivered enhanced value for seniors.

Studies have shown that patients enrolled in MA plans had a lower incidence of preventable hospitalizations than those enrolled in fee-for-service Medicare.² Overall, MA

¹ Lochner, Kimberly A. and Christine S. Cox, "Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries," United States, 2010 2013; 10:120137, http://www.cdc.gov/pcd/issues/2013/12_0137.htm

beneficiaries used fewer hospital resources than those in FFS Medicare by averaging a shorter length of stay and a lower total cost per hospitalization.³ As for chronic disease, a comparative analysis in 2012 found that people with diabetes in Medicare Advantage chronic condition special-needs plans—particularly nonwhite beneficiaries—had lower rates of hospitalization and readmission than their peers in fee-for-service Medicare.⁴

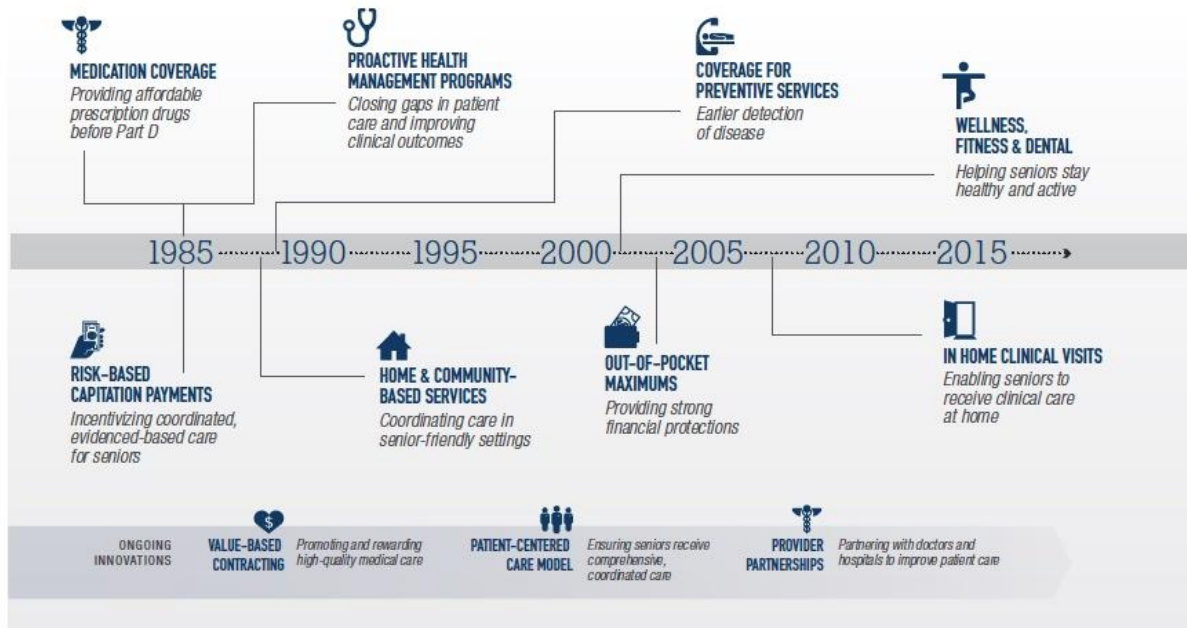
Following are responses to specific questions and issue areas raised by the Committee. Our responses reflect the experience of MA plans in chronic disease management through the focus on primary care, coordinated care, and enhanced benefits and attention to the health status of MA beneficiaries over time. Both seniors and beneficiaries with disabilities report high satisfaction with MA plans. The growth in enrollment in MA plans across the country demonstrates the value of MA plans to our nation's seniors. We hope sharing the experience of MA plans will contribute both to the health and well-being of our seniors and offer lessons for improvements in health care delivery to all Americans.

² Enrollment in Medicare Advantage managed care plans reduces racial/ethnic disparities in primary care quality in some states: Research Activities, December 2011, No. 376. December 2011. Agency for Healthcare Research and Quality, Rockville, MD, <http://archive.ahrq.gov/news/newsletters/research-activities/dec11/1211RA21.html>

³ Bernard Friedman, Ph.D., H. Joanna Jiang, Ph.D., and C. Allison Russo, M.P.H Medicare Hospital Stays: Comparisons between the Fee-for-Service Plan and Alternative Plans, 2006, HCUP Statistical Brief #66, January 2009

⁴ Robb Cohen, Jeff Lemieux, Jeff Schoenborn, Teresa Mulligan, "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients," Health Aff January 2012 vol. 31 no. 1 110-119

MEDICARE ADVANTAGE* INNOVATIONS



* Prior to 2004, Medicare Advantage was known as Medicare+Choice

RESPONSE TO SPECIFIC QUESTIONS

(1) Improvements to Medicare Advantage for patients living with multiple chronic conditions:

According to data from the Centers for Medicare and Medicaid Services (CMS), as of 2015, the MA program has enrolled more than 17 million beneficiaries, with 32 percent market penetration.⁵ MA has hit a record high enrollment each year since the Affordable Care Act's enactment, increasing by 42 percent since 2010.⁶ The population served by the MA program is diverse in socioeconomic status, race/ethnicity, and geographic location. Specifically, 39 percent of MA beneficiaries have annual incomes at or below \$20,000. More than 30 percent of

⁵ Herman, Bob, "Despite rate complaints, Advantage plans continue to grow," Modern Healthcare, April 11, 2012,

<http://www.modernhealthcare.com/article/20150411/MAGAZINE/304119968>

<http://medpac.gov/documents/reports/march-2015-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=0>

⁶ Owens, Caitlin, "CMS Reverses Medicare Advantage Cuts," National Journal, April 6, 2015,

<http://www.nationaljournal.com/health-care/cms-reverses-medicare-advantage-cuts-20150406>.

African-American Medicare beneficiaries and 38 percent of Hispanic beneficiaries choose MA over FFS Medicare. And finally, MA is popular among both rural and urban beneficiaries, with more than 12 million enrollees living in an urban area.

While no two plans are identical, overall MA plans generally outperform FFS Medicare. The Medicare Payment Advisory Commission (MedPAC) has found an increase in plan performance on a large number of quality measures.⁷ And MA plans' performance continues to improve.

Reports indicate that "private sector health insurers have extensive experience in using disease management and care coordination tools to effectively target and better engage patients that have chronic conditions" and that MA plans "have an incentive to manage patient care across all settings." Indeed, per person rather than per episode payment allows MA plans flexibility to manage chronic disease and create a focus on prevention and avoidance of unnecessary hospitalization. As Harvard health economists Joseph Newhouse and Thomas McGuire write, "MA plans have a financial incentive to manage chronic illnesses so as to minimize total medical and pharmaceutical expense.... [G]iven the low likelihood of disenrollment they have an incentive to minimize the progress of any disease and to avoid hospitalization."⁸

There is a growing base of evidence on the improved quality that comes from MA plans over FFS in the early treatment and management of chronic disease:

- A 2013 *Health Affairs* paper found that beneficiaries in Medicare HMOs were consistently more likely than those in FFS Medicare to receive appropriate breast cancer screening, diabetes care, and cholesterol testing for cardiovascular disease.⁹ Such screenings can help to detect, avoid the occurrence of, and treat chronic conditions at earlier stages where they are more manageable.
- Another *Health Affairs* study found that seniors with diabetes in MA special-needs plans had 7 percent more primary care physician office visits and 19 percent fewer hospital admissions and readmissions than beneficiaries in FFS Medicare.¹⁰
- Persons with chronic conditions are more often hospitalized, but even among the elderly, at least 30 percent of hospitalizations are potentially avoidable.¹¹ MA plans had an estimated 30-day readmission rate that is approximately 13 to 20 percent lower than

⁷ MedPAC, *2015 Report to the Congress*

⁸ Newhouse, Joseph P. and McGuire, Thomas G. "How Successful Is Medicare Advantage," *The Milbank Quarterly*, 92:2, 2014, pp. 351-394.

⁹ Ayani, Langdon, Zaslavsky et al, "Medicare Beneficiaries More Likely To Receive Appropriate Ambulatory Services In HMOs Than In Traditional Medicare," *Health Aff (Millwood)* July 2013, 32:71228-1235

¹⁰ Cohen, Robb, Leimieux, Jeff, Schoenborn et al, "Medicare Advantage Chronic Special Needs Plans Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients," *Health Aff (Millwood)* Jan 2012, 31: 110-119.

¹¹ Fain, Mindy, "Want better healthcare? Have doctors make house calls," *Los Angeles Times*, June 4, 2014, <http://www.latimes.com/opinion/op-ed/la-oe-fain-healthcare-house-calls-20140605-story.html>

those of FFS patients for the 2006-2008 period.¹²

- A 2013 National Bureau of Economic Research report found that MA plans reduced hospital utilization across the board. Specifically, the report states that “when more seniors enroll in Medicare managed care, hospital costs decline for all seniors and for commercially insured younger populations.” According to the analysis, a 10 percent increase in MA plan penetration is associated with a 2.4 percent to 4.7 percent reduction in hospital costs for other patients.
- An article in the *American Journal of Managed Care* found that MA plans outperformed FFS in nine out of 11 clinical quality measures—meaning enrollees received the level of effective care recommended by a doctor with greater frequency than patients in Medicare FFS, for nine of the 11 procedures studied. Breast cancer screening was approximately 15 percent higher and diabetes care 4 to 10 percent higher on the four measures studied. The authors noted that these results may be due to the positive effects of these plans’ more integrated service delivery systems on the quality of ambulatory care and that the reliance on these types of service delivery systems may outweigh incentives to restrict care under capitated payment arrangements.^{13 14}
- Newhouse and McGuire determined that “on average, MA plans offer care of equal or higher quality and for less cost than traditional Medicare.”¹⁵

BMA is committed to highlighting further evidence on the MA program's value, including the experience of early identification of chronic conditions and effect on health status and outcomes for patients.

Congressional support for continuity and stability of MA plans has contributed to the capacity of plans to invest in population health that is making a difference in promoting successful innovations in health care delivery for providers and beneficiaries.

There is a specific recent example of policy making that has hurt some MA beneficiaries with chronic disease. In 2013, CMS recalibrated the risk adjustment model to remove diagnosis codes that are reported more frequently in MA than in FFS Medicare. These changes negatively impact diagnosis codes for early stages of renal disease and diabetes and diabetes interactions. At the same time, CMS applies a statutorily-mandated coding

¹² Lemieux, Jeff, Sennett, Cary, Wang, Ray et al, “Hospital Readmission Rates in Medicare Advantage Plans,” *The American Journal of Managed Care*, Feb. 2012, 18: 2, pages 96-104.

¹³ Guran, J., and Moffit, R., *The Medicare Advantage Success Story- Looking beyond the Cost Difference*, N.Eng. J. Med. 366:13 (Mar.29, 2012). A 2013 Health Affairs article (See n. 4) also cites these findings, noting specifically that mammography rates were 13 percent higher, eye tests for individuals with diabetes were 17 percent higher, and cholesterol testing for cardiovascular disease were 7 to 9 percent higher in Medicare Advantage plans than original Medicare.

¹⁴ Brennan, N. and Shepard, M., *Comparing Quality of Care in the Medicare Program*, *The American Journal of Managed Care*, 11: 841-8 (Nov. 19, 2010).

¹⁵ Newhouse and McGuire, “How Successful Is Medicare Advantage.”

intensity adjustment—which increases each year—that also reduces MA plan payments in order to address differences in coding between MA and FFS. CMS' two-pronged approach to addressing coding intensity results in duplicative reductions to MA plan payments.

The new risk adjustment model will have the most significant impact on plans and providers serving the most vulnerable populations, including Chronic Special Needs Plans (SNPs). Appropriately recognizing the cost of treating these patients allows for plans and providers to invest in clinical programs to supplement the lack of resources experienced by these people, many of whom gain access to regular health care services for the first time with their entry into Medicare. Constant changes to risk adjustment will weaken rather than strengthen the predictive power of the risk adjustment model. The risk adjustment is intended to focus on diagnoses that contribute most to predicting the costs of treating Medicare beneficiaries' medical conditions. Eliminating codes for early manifestations of certain diseases and complicating conditions is also at odds with the emphasis on prevention and early detection of disease that is a program-wide Medicare priority.

In addition, establishing a separate risk adjustment comment period in advance of the annual rate notice, similar to what CMS currently does with the STARS program, would increase the transparency and improve the accuracy and credibility of CMS models. Taking into account the views of patients, providers, payers and other thought leaders not only will result in better care, but also lead to greater stability to the annual rate notice process.

- (2) Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models (APMs) currently underway at CMS, or by proposing new APM structures:

MA is transforming access to care for beneficiaries with consistent and dynamic changes to the delivery system and by enhancing benefits to beneficiaries. MA plans focus on paying for value, improving prevention and management of chronic disease, and ensuring access to appropriate care while reducing unnecessary or ineffective care. Unlike new models of care in FFS Medicare that are time limited demonstrations, the MA program has a proven track record of improving quality, achieving a high level of beneficiary satisfaction, and increasing the efficiency of health care delivery. In a recent poll commissioned by BMA and conducted by The Mellman Group and The Winston Group, 91 percent of beneficiaries enrolled in MA reported being satisfied with their coverage.¹⁶

- (3) Reforms to Medicare's current fee-for-service program that incentivizes providers to coordinate care for patients living with chronic conditions:

BMA supports the recent changes in the FFS Medicare program that are intended to promote value-based incentives that move those providers in FFS toward integrated care and accountability for quality over quantity. These changes include Patient Centered Medical Home (PCMH), focus on primary care, adaption of a care management codes,

¹⁶ Better Medicare Alliance, "Seniors highly satisfied with Medicare Advantage," March 11, 2015, <http://bettermedicarealliance.org/press-releases/seniors-highly-satisfied-medicare-advantage>

and the legislative and administrative actions that move providers to alternative payment models. As the FFS system moves in this new direction, lessons can be taken from MA plans that have made capitation and quality metrics integral to its payment system, creating the right incentives to better manage care. Unlike FFS, MA plans have the capacity to use different payment models and care initiatives to determine optimal solutions for patient care for their defined populations and provider networks.

(4) *The effective use, coordination, and cost of prescription drugs:*

Because MA plans often include Part D as part of the single payment structure for beneficiaries, there is opportunity for improved coordination and compliance with pharmaceutical services on behalf of beneficiaries. The Medication Therapy Management (MTM), which is part of all Part D drug plans and of MA plans that offer drug coverage, is demonstrative. MTM services target beneficiaries who have multiple chronic conditions (such as diabetes, asthma, hypertension, hyperlipidemia and congestive heart failure), take multiple medications, or are likely to incur annual costs above a predetermined level. MTM requires the offering of a one-on-one medication consultation with a pharmacist at least annually. Following such a consult, MA and other prescription drug plans give patients written summaries that include medication lists, actions, plans and recommendations. MA plans reach out to the qualified beneficiaries' health care providers with suggested changes to address drug therapy issues. MA plans also follow up with each beneficiary quarterly for targeted medication reviews to discuss medication issues raised by the pharmacist in a comprehensive consult. If patients choose not to have a review with a pharmacist, the MA plan must still review patients' medications quarterly and send prescribers any issues identified and potential solutions.

Many MA plans have gone beyond the CMS MTM requirements. For instance, one plan uses IT tools to measure the performance on nationally recognized care standards (e.g., whether diabetics, persons with congestive heart failure or asthmatics are on medications consistent with guidelines).¹⁶

(5) *Ideas to effectively use or improve the use of telehealth and remote monitoring technology:*

While coverage of telehealth and remote monitoring is limited in FFS Medicare, MA plans are increasingly utilizing electronic visits, video technology, and remote monitoring to provide maintenance and preventive care for their beneficiaries. For example, one plan has launched several tests of remote monitoring. The plan partnered with a provider of senior care technology in a yearlong pilot. The project uses in-home sensors and remote monitoring technology to monitor how changes in daily activities may signal a change in health status for certain MA enrollees. Many of the pilot participants were over age 70 and had multiple chronic illnesses, including congestive heart failure. The remote patient monitoring solutions include Bluetooth-enabled weight scales and blood pressure monitors and interactive voice response technology. In another long-term pilot, services were provided to remotely manage the care of 2,000 congestive heart failure patients in 33 states. The program combines daily monitoring of biometric measures by nurses as well as face-to-face tele-meetings via computer. The MA program can be an optimal environment to conduct such examinations of the benefits of telehealth and remote monitoring.

Capitated payments—unlike FFS—avoid any incentive for overuse of these services.

(6) Strategies to increase chronic care coordination in rural and frontier areas:

MA plans have seen growth in rural areas in both PPOs and HMOs. Rural MA enrollment in March 2014 was nearly 1.95 million, or 20.3 percent of all rural Medicare beneficiaries, an increase of more than 216,000 from March 2013.¹⁷ According to MedPAC, 95 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, and overall, 99 percent of all Medicare beneficiaries have access to an MA plan.¹⁸ MA plans can play a key role in care coordination in both rural and urban areas. Such care coordination is vitally important, particularly to beneficiaries with multiple chronic conditions. Low density rural areas present challenges due to fewer providers and fewer beneficiaries across larger geographic areas, but with adequate funding to meet these challenges, MA plans have the ability to deliver quality, efficient care in rural communities.

(7) Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers:

The quality of care in MA plans is carefully monitored by CMS, and the results are made available to the public and to beneficiaries as part of the Star rating program. Companies participating in the MA program must report quality and patient satisfaction data to CMS annually. Based on this information, each MA plan is awarded one to five stars. The Medicare Stars program rewards the highest-rated companies—the ones with superior quality and service results—with additional payments. The star ratings strategy supports the HHS Triple Aim—better care, healthier people/healthier communities, and lower costs through improvements—with measures in five broad categories:

1. Outcomes: Outcome measures focus on improvements to a beneficiary's health as a result of the care that is provided.
2. Intermediate outcomes: Intermediate outcome measures help move closer to true outcome measures. Controlling blood pressure is an example of an intermediate outcome measure where the related outcome of interest would be better health status for beneficiaries with hypertension.
3. Patient experience: Patient experience measures represent beneficiaries' perspectives about the care they have received.
4. Access: Access measures reflect issues that may create barriers to receiving needed

¹⁷ Kemper, Leah; Barker, Abigail and McBride, Timothy, et al, "2014: Rural Medicare Advantage Enrollment Update," RUPRI Center for Rural Health Policy Analysis, *Rural Policy Brief*, Brief No. 2015-1 January 2015, Brief No. 2015-1 January 2015.

¹⁸ MedPAC March 2015 *Report to the Congress*, <http://www.medpac.gov/documents/reports/march-2015-report-to-the-congress-medicare-payment-policy.pdf?sfvrsn=0>

care. "Plan Makes Timely Decisions about Appeals" is an example of an access measure.

5. Process: Process measures capture the method by which health care is provided.

The Star rating system gives beneficiaries a new and simple way to compare their options when choosing the best plan for themselves during open enrollment each year. Choices can be made based on independent, consistent quality measures that do not exist in the FFS system. Seniors report the value of such information that engages them, as active consumers in their health coverage decision, with 60 percent of MA enrollees enrolled in a four- or five-star plan in 2015, compared to an estimated 17 percent back in 2009, according to CMS.¹⁹ Notably, there is a two-year data lag, which is not ideal and should be addressed to strengthen the program.

Additionally, a key part of patient engagement is ensuring that patients can afford their plans in the first place. MA plans are particularly attractive to beneficiaries with low-incomes and/or higher health care needs (e.g., such as those with multiple chronic conditions). According to CMS, premiums have fallen by almost 6 percent since 2010, and more than 90 percent of Medicare beneficiaries have access to a Medicare Advantage plan for which they do not have to pay a premium.

Patient experience is a key component of the ratings, and plans work to ensure that their members have a meaningful care experience. And plans recognize that patient engagement in their own care can improve outcomes. Some plans are building comprehensive "whole-person care models," particularly for populations with complex ailments like diabetes and obesity, where clinical conditions are often exacerbated by personal, social and behavioral factors. In this model, plans work with both health care providers and a network of care collaborators, including behavioral health specialists, long-term care facilities, and social support resources. The result is greater care coordination and superior results for patients.²⁰

To take one example, in 2012, a plan instituted a pilot self-care program for 18,000 of its diabetic MA patients. The program offers multi-channel, multimedia interventions using an online platform with the company's content, tools, and an online community for diabetes self-management. Early results from the pilot were promising, with a 7 percent improvement in LDL screening, 9 percent improvement in blood sugar screening, 7 percent improvement

¹⁹ Centers for Medicare and Medicaid Services (CMS), "Fact Sheet: Moving Medicare Advantage and Part D Forward." April 6, 2015, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-04-06.html>

²⁰ Subramanian, Sundar, Choudhury, Joyjit Saha and Madan, Sanchi, "How Medicare Advantage Plans Can Thrive in a Winner-Take-All Market," Health Aff blog, June 4, 2015, <http://healthaffairs.org/blog/2015/06/04/how-medicare-advantage-plans-can-thrive-in-a-winner-take-all-market/>

in eye exams, and 6 percent improvement in kidney disease monitoring.²¹

In another example, a plan in North Carolina reached out to its MA beneficiaries with care gaps, focusing on patients in the cholesterol management program for patients with cardiovascular conditions (CMC), as well as those in the comprehensive diabetes care (CDC) population. The plan engaged a health care management services vendor to call patients with care gaps and educate them on the benefits of the screenings. After the beneficiary gives consent, the plan's partner schedules an appointment in an effort to close the care gaps.²²

(8) Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goals of maximizing health care outcomes for Medicare patients living with chronic conditions:

The incentives in MA plans are to identify and treat chronic conditions early, avoid complications, prevent disease episodes, and as possible, reduce progressive worsening of the condition. Access to primary care practitioners and developing and maintaining an ongoing relationship with primary care is an important part of quality health care within MA plans. As a result, compared to FFS Medicare patients, MA beneficiaries have 7 percent more primary care visits, according to a study published in *Health Affairs*.²³ MA plans use their ability to selectively contract in order to ensure high-quality networks of both primary and specialty care providers.

Many MA plans have long recognized the value of coordinated care management which includes not only access to primary care physicians but other primary care practitioners. For example, one plan has programs that embed nurses within physician offices and disease management that helps patients and their doctors manage multiple conditions. The result was improvement in patient engagement and care, as well as a nearly 20 percent reductions in the number of days patients were in the hospital for acute care compared to FFS Medicare.^{24 25}

²¹ Perna, Gabriel, "Humana Rolls Out Diabetes Engagement Platform," *HCI Healthcare Informatics*, August 2, 2012, <http://www.healthcare-informatics.com/news-item/humana-rolls-out-diabetes-engagement-platform>

²² BlueCross BlueShield of North Carolina, "Help Close Cholesterol and Diabetes Care Gaps for Medicare Advantage Members," https://www.bcbsnc.com/content/providers/news-and-information/news/Carenet_Care_Gaps_MedAdv_Mbrs.htm

²³ The Coalition for Medicare Choices, "Medicare Advantage 101," <http://medicarechoices.org/medicare-advantage-101/>

²⁴ Krakauer, Randall, "Aetna's View on Building Effective Care Management in Medicare," *Morning Consult*, Oct. 9, 2014, <http://morningconsult.com/opinions/aetnas-view-building-effective-care-management-medicare/>

²⁵ "Quality Matters: Case Study: Aetna's Embedded Case Managers Seek to Strengthen Primary Care," The Commonwealth Fund, August/September 2010, <http://www.commonwealthfund.org/publications/newsletters/quality-matters/2010/august-september-2010/case-study>

It is not just the larger plans that use such techniques. For instance, in 2013, a nonprofit plan in Western Michigan identified more than 1,000 previously hospitalized, at-risk seniors who were costing on average \$40,000 per capita annually, about four times the average MA per member cost. Health plan teams work with home care agencies, emergency medical services, physicians and nurses to bring healthcare services to these at risk members in their homes. Care team members make house calls, coordinate primary care and offer frequent checks by local paramedics. As a result, there was a 25 percent reduction in the total cost of care for these patients, from reduced hospitalizations, ER visits, and nursing home stays.²⁶

Care coordination may be particularly important to beneficiaries with multiple, serious chronic conditions. According to MedPAC, 10 percent of Medicare beneficiaries accounted for almost 60 percent of annual FFS spending in 2010. More than half (51 percent) of these individuals have five or more comorbidities, including chronic kidney disease, heart failure and chronic obstructive pulmonary disorder (COPD). Even as these very sick and vulnerable patients receive many costly services, including frequently hospitalizations, they often do not get the kind of care that they need and deserve to improve their well-being. The high cost of these services does not translate into higher quality of care or improved outcomes.

New, innovative models of care focused on providing care for the costliest 10 percent of Medicare FFS beneficiaries at the same cost as the current FFS system should be considered for implementation and evaluation. MA plans have the experience and interest in demonstrating models that work for this critical population of Medicare beneficiaries.

CONCLUSION

MA plans have played and continue to play a crucial role in coordinating care, reducing costs for those with chronic conditions, and empowering patients. MA plans offer an option that meets the goals of more integrated care, more patient engagement, and improved health outcomes for Medicare beneficiaries. Affordability, simplicity and quality make MA an attractive option to beneficiaries and a role model for improvements in payment and health care delivery for our nation's seniors and those with disabilities.

Thank you for considering our comments. We welcome the opportunity to work with the Committee as it strives to improve chronic care in Medicare. Should you have questions about this response, please contact info@bettermedicarealliance.org or 202-478-3725.

²⁶ Brino, Anthony, "The Rise of Provider-Sponsored Health Insurance," *Healthcare Payer News*, May 26, 2015, <http://www.healthcarepayernews.com/content/rise-provider-sponsored-health-insurance#.VXmmNRNViOE>

Sincerely,

The Better Medicare Alliance Allies



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American Medical Group Association



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Cc: The Honorable Johnny Isakson and The Honorable Mark Warner, Co-Chairs, Senate Finance Committee, Working Group on Chronic Care