House Ways and Means Committee Health Subcommittee
Hearing on the Medicare Advantage Program
May 8, 2018

Summary
On Tuesday, May 8, the House Ways and Means Committee, Subcommittee on Health held a hearing on the Medicare Advantage program.

For a webcast of the hearing, a copy of the hearing advisory and witness testimonies, see here.

Witnesses that testified at the hearing included:

- **Karoline Mortensen, Ph.D., Associate Professor, Health Sector Management & Policy, University of Miami Business School**
- **Andrew Toy, Chief Technology Officer, Clover Health**
- **Daphne Klausner, Senior Vice President, Senior Markets, Independence Blue Cross**
- **Jack Hoadley, Ph.D., Georgetown University Health Policy Institute**

The hearing discussed what Medicare Advantage (MA) plans are doing well, what can be done to spur plan competition and drive better health outcomes in the Medicare population, and examined the existing quality measurement system in the Medicare Advantage program.

While no specific next steps were announced at today's hearing, we understand the Committee will hold a roundtable on post-acute care as part of their "Reducing Medicare Red Tape" initiative on May 22.

For Chairman Peter Roskam's (R-IL) opening statement, see here.

Witness Karoline Mortensen focused her testimony on research surrounding quality measurement, and how data can be refined to improve information used by policymakers, plans and consumers. Andrew Toy discussed the data driven model developed by Clover Health and how they can best serve Medicare beneficiaries and the challenges faced by new entrants to the system. Daphne Klausner discussed her role which includes oversight of the Medicare star rating system. Jack Hoadley focused his remarks on the findings of recent report from the National Council on Aging and the clear choices campaign on modernizing Medicare pathfinders to improve Medicare beneficiaries shopping experience.

A summary of some of the key topics covered during the hearing follows:

Medicare Advantage (MA) Encounter Data
Rep. Thompson (D-CA) asked what Congress should we be doing to improve data availability. Mortensen referenced that CMS Administrator Seema Verma recently announced that they would make Medicare Advantage (MA) claims data available to researchers. Data can now be accessed, which is very important so researchers can identify some of the issues with the data and can assess if there were unnecessary hospital stays and if patients are getting the care they need.

Rep. Ron Kind (D-WI) mentioned the Reinvestment Act that passed during the recession and asked about the importance of claims data to researchers – how significant is it, and what will evolve from that?

Mortensen responded that through the Reinvestment Act, a lot of money was put into electronic health records (EHR), which is beneficial, but they are not interoperable, there are still hoops to jump through in order to get that data and they are nowhere near a real-time adoption of data which would be very helpful to researchers. She said for example, in Florida she saw slower growth in ambulatory care data, so access to that data is important to researchers and to lawmakers to help inform policy.

Rep. Kind then said as a result of the Affordable Care Act (ACA), as part of the pay-for, there was going to be significant reductions in MA reimbursement rates and asked Hoadley if as a consequence, there

was any adverse impact on enrollment and quality of care of these plans? Rep. Kind said he thinks post-acute care was one of the things missed in ACA, and is there a lot of opportunity for reforming that?

Hoadley responded that there was no drop off in enrollment in MA. He said some of the other questions are harder to answer because we need to look at encounter data to answer questions like whether the quality of care is affected adversely or positively. Hoadley said that yes, there is opportunity for reform, saying that when he was on MedPAC they looked at the broad issue of how to pay for post-acute care and have a series of recommendations on revising the payment systems. Hoadley said MA plans are able to do some of those things today, but what is really needed is better information on what are they doing, have they taken positive steps to ensure that the differential payments in different sites, whether it be a nursing home, home health, or rehab hospital has the same results when the payment systems are different and different incentives to use those services vary, which is preventing improvements.

Consolidation

Rep. Sam Johnson (R-TX) asked Andrew Toy to elaborate on why Clover Health is having problems contracting with providers because of a lack of competition and how is this impacting delivery.

Toy said as a new plan entering the market, they have seen that provider groups that are consolidated, and that have large market share, usually have very high prices in order to be in-network. Klausner said in the Philadelphia market there are many providers so she has not dealt with the same issues as Clover Health, but has noticed providers changing to value based payments which has been positive.

Plan Flexibility/Precision Medicine

Rep. Sandy Levin (D-MI) asked if there is any disagreement among panelists on the suggestions made related to problems with the plan finder. Klausner said she agrees that plan finders should be modernized and the other panelists agreed. Rep. Levin also said the Centers for Medicare and Medicaid Services (CMS) has recently allowed more flexibility in plan design, and asked how this has increased complexity. Hoadley said flexibility is good, but can also add confusion to beneficiaries, so a balance needs to be found between standardization and flexibility.

Klausner said that flexibility is one of the best things that has happened to Medicare Advantage. In her plan she said it is very important for the different populations of the Philadelphia area (which range from low income to high income, to have more choices), especially populations that do not have dental care which her plan is working on. Rep. Levin noted that there is proposed legislation to provide dental insurance to Medicare beneficiaries and Klausner agreed that would be very helpful. Mortensen added that flexibility can be good, particular when they address social determinates of health, but it would be important that it is reflected in the updated quality metrics to see if those investments are paying off. She also said to be wary of unintended consequences and make sure these are benefits that are not just going to Medicare Advantage enrollees, and that traditional fee-for services enrollees are not left out of some of these comprehensive improvements.

Rep. Terri Sewell (D-AL) referenced a constituent who needed transportation to the pharmacy to get her insulin medication and said social determinates of health are driving many of the costs in the Medicare system. Klausner said that this is an important issue and they appreciate flexibility in being able to provide things like transportation. She also mentioned discussions with a provider group to address low income seniors that provides transportation.

Rep. Sewell also mentioned a visit to the University of Alabama Birmingham for the “all of us” program to discuss precision medicine, and asked witnesses to discuss data analysis. Mortensen agreed of the importance of social determinates of health and mentioned a program underway in CMS called accountable health communities, aligning Medicare and Medicaid communities using data that connect beneficiaries through a bridge company with food and other necessities.

Star Ratings

Rep. Adrian Smith (R-NE) mentioned Lexington Regional Hospital, a critical access hospital in his region, who pointed out that star ratings have had negative impact on small critical access hospitals and rural hospitals, and asked witnesses to discuss the need for regional adjustments.

Mortensen said she has not seen this problem in the Miami -Dade area, but it relates to other issues she has seen where contracts with zero or low star ratings are being bought by 4-5 star rankings, which is spread throughout that contract purchase. Hoadley answered that when he was on MedPAC they discussed a peer grouping approach, where you don't want to change the star rating for whatever demographic category is that may have poor performance, comparing for the purposes of payment to hospitals, health plans and other categories in the same care group, is a way to make sure the reward system treats everyone fairly - so this is a peer group approach, rather than actually changing the ratings.

Rep. Lynn Jenkins (R-KS) said that in a 2017 final call letter, CMS first implemented the Categorical Adjustment Index (CAI), however the adjustment seems to impact very few plans. In the 2019 final advance notice and call letter, CMS stated that it remains committed to addressing the unique challenges of serving vulnerable populations. There continues to be additional work in the research community on both identifying the social risk factors and how to best address the impact on clinical quality measurement. Rep. Jenkins then asked questions regarding adjustments to the current star rating measures on socioeconomic status and geography and asked if there should be any measures that should be risk-adjusted?

Klausner said of the current measures that could be expanded to ask additional questions, like the risk of falling for those who are living alone. She said there are probably other measures she couldn't name to address some of those social factors that could have an impact on outcomes, noting that there are currently no questions on nutrition. Mortensen said she agrees that it is troubling that the introduction of this adjustment had very little effect, and that very few plans (about 4%) received improvements in quality when they started adjusting for socioeconomic status. Going back to existing metrics, Mortensen said the re-admission rate could address socio-economic diversity and there is a lot of research that suggests the readmission rate should be adjusted throughout the Medicare program to address these chronic conditions, like where you live, what hospital you're going to, and to where you are being discharged. She noted that additional measures to replace some of the existing quality measures could be more focused on looking at measures and metrics that could adjust for that – citing one example could be what Humana uses in their communities, called "healthy days" metrics, or one that MedPAC has invested in called healthy days at home metrics, where you can use technology to scan data to see how many health days, in the year the patient was not in the hospital, to try to assess more socio-economic and demographic factors.

Jenkins also asked how can the current star ratings measure change to focus on and incentivize better health outcomes? Toy responded that often star ratings are not connected to the outcomes, but are a proxy towards them and ultimately measure the final step to Clover members. He said they are, however, really important to comply with in the short term, and one thing we can do is more closely analyze the data to show correlations and detect indications of homelessness and other populations, etc.

Telehealth/ Electronic Health Records (EHRs)

Rep. Diane Black (R-TN) discussed value based care and praised legislation increasing access to telehealth as well as the VBID for Better Care Act she co-sponsored with Rep. Blumenauer (D-OR). She said MA plans that are increasing the use of technology to manage high cost beneficiaries such as those in long term care facilities was also a concern to her, saying that recently companies are partnering with MA plans to treat using telehealth in nursing facilities. She asked witnesses how else can we support MA plans in integrating technology? Toy said he is a big supporter of at-home care, and Clover identifies those populations ahead of time, providing them with a smart speaker connecting patients to call centers and social work to coordinate care.

Rep. Black said rural areas have difficulty building robust networks, and asked Klausner to discuss how plans can use flexibility and if CMS should adjust network adequacy to include telehealth. Klausner answered that new requirements and new legislation around telemedicine would be very helpful,

particularly for rural areas. She mentioned a partnership with Comcast that connected caregivers with patients which was very helpful.

Education

Rep. Kenny Marchant (R-TX) said his district is very reliant on MA pans and said education needs to be improved in that system. He asked panelists about a concrete system that is taking place to address that. Hoadley responded saying education is critical and there are tools out there to help people, including the plan finder which he discussed.

Rep. Judy Chu (D-CA) discussed the high cost of prescription drugs and barriers to access to mental health needs in Medicare. She asked witnesses to discuss if there are methods where patients can find what their out of pocket costs will be for prescriptions like there is for the plan finder. Hoadley said the plan finder does have the ability to check and see if medications are on your formulary, so if you would only need to pay a co-pay or co-insurance and estimates the potential cost sharing for that drug. There is still improvement that needs to be made, for example different pharmacies have different prices. Toy and Klausner said with the increased flexibility in Medicare they can better address mental health needs.

Rep. Erik Paulsen (R-MN) asked witnesses if CMS could do more on education efforts to increase outreach and enrollment. Klausner said she thinks CMS could focus more on areas where MA enrollment is lower. Hoadley said there may need to be flexibility or a tool within the plan finder that can reach a broad audience depending on the patient needs.