

Medicare post-acute care reforms

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Statement of
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Chairman Brady, Ranking Member McDermott, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss MedPAC's work on post-acute care in Medicare.

MedPAC is a congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly.

The Commission has done extensive work on issues related to post-acute care (PAC); the way Medicare pays for these services; and the reforms that are needed to encourage a more seamless, patient-centered approach to match services and settings to the needs of each patient. We have considered reforms that would promote care coordination (such as bundled payments, accountable care organizations, and readmission policies), equalize payments made for similar services, and gather comparable data across PAC settings. Some changes, such as changes to fee-for-service (FFS) payments or the adoption of cross-sector quality measures, could be implemented relatively quickly. Payment reforms that cut across settings and fundamentally alter the way we pay for PAC will require continued hard work to design and implement.

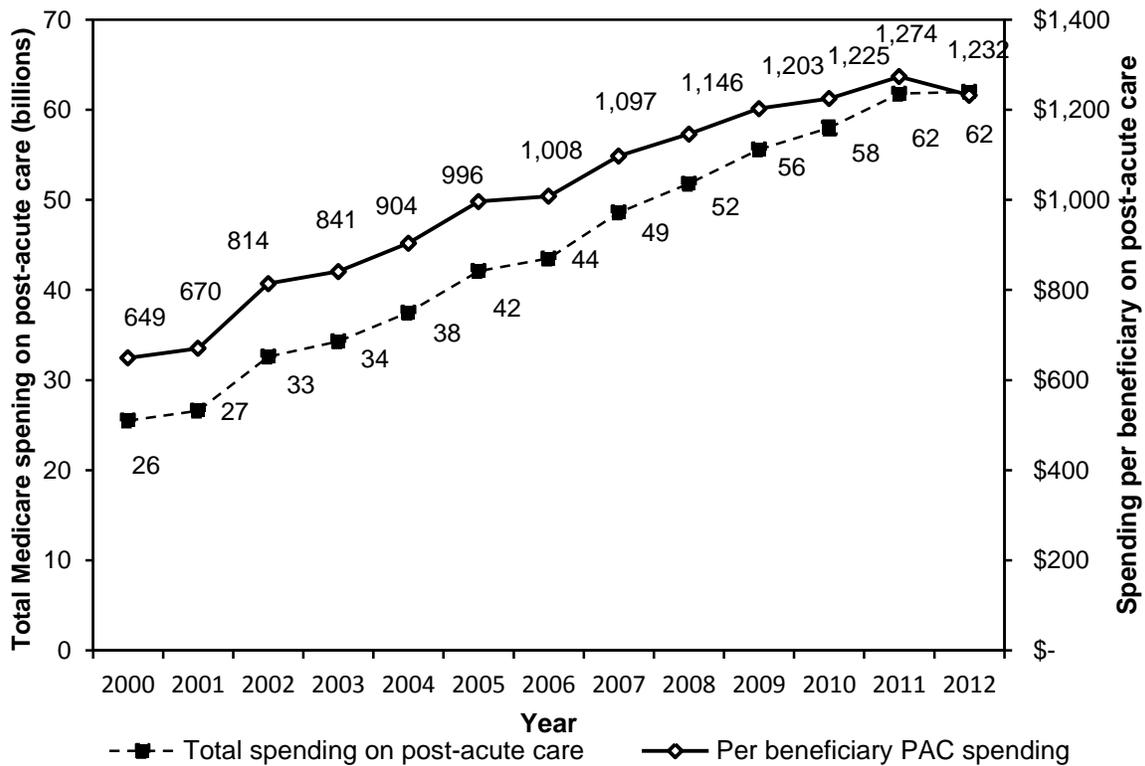
Background

PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). PAC providers offer important recuperation and rehabilitation services to Medicare beneficiaries. In 2011, about 43 percent of Medicare beneficiaries discharged from prospective payment system (PPS) hospitals went to a PAC setting. Of those, almost half went to SNFs, 39 percent received home health care, and the remainder went to other settings, including IRFs and LTCHs. While all or almost all beneficiaries admitted to IRFs, SNFs, and LTCHs have a prior hospital stay, two-thirds of home health episodes are admitted directly from the

community. The characteristics of these community admissions suggest these users have long-term care needs. Beneficiaries can also receive outpatient therapy after a hospital stay. Though rarely the first site of care for conditions that typically use PAC, beneficiaries may receive outpatient therapy after using PAC.

In 2012, PAC FFS spending totaled \$62 billion and accounted for 17 percent of FFS spending. PAC spending has more than doubled since 2000 (Figure 1). During this period, spending on a per capita basis rose 90 percent.

Figure 1. Large growth in Medicare’s total and per capita spending on post-acute care since 2000

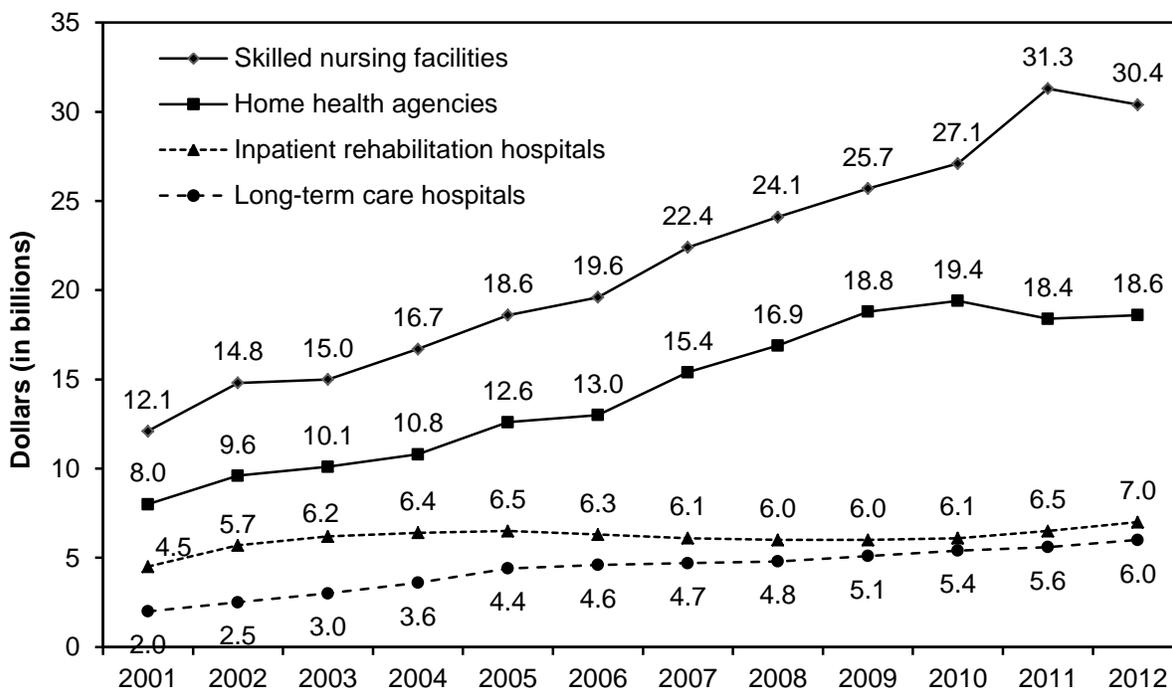


Note: PAC (postacute care). These numbers are program spending only and do not include beneficiary cost sharing.
 Source: CMS Office of the Actuary.

The Commission has documented changes in the numbers of providers, the mix of services they furnish, and the patients they treat (Figure 2). The explosive growth in the number of HHAs, the increase in the number of beneficiaries receiving home health care, and the

amount of care beneficiaries receive explain the more than doubling of Medicare’s spending on home health care services. The intensification of rehabilitation services furnished by SNFs drove the two-and-a-half-fold increase in spending on these services. Medicare payments to IRFs and LTCHs grew rapidly after the adoption of the PPSs until other policies were put in place to control the types of patients treated in these high-cost settings. An almost 60 percent increase in the number of LTCHs during this period contributed to Medicare’s increased spending in this sector.

Figure 2. Medicare’s spending on post-acute care has more than doubled since 2001



Note: These numbers are program spending only and do not include beneficiary cost sharing.

Source: CMS Office of the Actuary.

Challenges that undermine PAC reforms

Over many years, the Commission has discussed and made multiple recommendations regarding current Medicare’s FFS payments and quality measures for PAC and the need for a more coordinated and integrated approach to PAC. Broad reforms to the way Medicare pays for PAC would encourage beneficiaries to go to settings that can provide the best outcomes for the lowest cost. Unfortunately, the FFS and PAC landscapes present many challenges to such reforms.

First, PAC is not well defined and the need for PAC services is not always clear. Some patients can go home from an acute hospital stay without PAC, while others need it but receive services in varying amounts and in different settings. Still other patients may do best by staying a few more days in the acute care hospital and avoiding the transition to a PAC setting. Medicare’s rules and clinical evidence do not clearly delineate the types of patients who belong in each setting and the amount of service needed. The use of outpatient therapy is similarly vexed by the lack of guidelines about when and how much therapy is appropriate for a given condition.

Another complication is that while different PAC settings can furnish similar services, Medicare pays them different rates depending on the setting. For example, patients recovering from the lowest severity strokes are treated in IRFs, SNFs, LTCHs, and with home health care. Furthermore, Medicare’s payment incentives can influence providers’ decisions about which beneficiaries to admit and the care they furnish. For example, the home health care and SNF PPSs favor rehabilitation care over medically complex care because therapy payments are based on the amount of service furnished, and the increases in payments outpace the increases in the costs. Providers can increase their payments by delivering more services. As a result, the variation in PAC service use per beneficiary is larger than for other services. PAC service use varies two-fold between low-use and high-use geographic areas, while inpatient hospital service use varies twenty percent (Table 1). At the extremes, the differences are even larger: PAC spending varies eight-fold, while inpatient hospital services vary 60 percent.

Table 1. Comparison of service use variation across geographic areas

Ratio of high to low service-use areas	Inpatient hospital	Ambulatory care	Post-acute care
Areas at the 90th to 10th percentiles	1.22	1.24	2.01
Highest use to lowest use area	1.59	2.01	7.97

Note: Areas are defined as metropolitan statistical areas for urban counties and rest-of-state nonmetropolitan areas for nonurban counties. Service use is measured as risk-adjusted per capita spending (adjusted for wages and special add-on payments) by sector among fee-for-service beneficiaries in each area.

Source: MedPAC analysis of 2006–2008 beneficiary-level Medicare spending from the Beneficiary Annual Summary File and Medicare inpatient claims.

Even among beneficiaries who used PAC and had similar care needs, Medicare spending on PAC varies more than three-fold (Table 2). These spending differences reflect the mix of post-acute care services (e.g., whether the beneficiary went to a SNF or an IRF) and amount of PAC used (e.g., the number of SNF days or home health care episodes).

Table 2. Medicare spending on post-acute care varies more than three-fold for conditions that often use these services

Condition	Spending on post-acute care within 30 days of hospital discharge			Ratio of 75th to 25th percentiles
	Mean	25th percentile	75th percentile	
Coronary bypass w cardiac catheterization	\$5,286	\$1,864	\$6,913	3.7
Major small & large bowel procedures	\$6,100	\$2,110	\$8,804	4.2
Major joint replacement	\$8,152	\$3,890	\$11,484	3.0
Stroke	\$13,914	\$5,936	\$19,371	3.3
Simple pneumonia & pleurisy	\$7,039	\$2,351	\$10,785	4.6
Heart failure & shock	\$5,997	\$2,034	\$9,331	4.6
Fractures of hip & pelvis	\$11,688	\$8,213	\$14,427	1.8
Kidney & urinary tract infections	\$8,040	\$3,335	\$11,963	3.6
Hip & knee procedures except major joint replacement	\$13,608	\$10,526	\$16,498	1.6
Septicemia or severe sepsis w/o MV 96+ hours	\$8,282	\$3,344	\$11,744	3.5
	Average of 10 conditions			3.2

Note: Post-acute care includes services furnished by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. We risk adjusted spending using Medicare severity–diagnosis related groups (MS–DRGs) and standardized payments for differences in wages and special payments (such as teaching, disproportionate share, and outlier payments). Data shown are for patients assigned to MS–DRG acuity level 1 (no complications or comorbidities). Spending is for care furnished within 30 days after discharge from an inpatient hospital stay.

Source: Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

Current use patterns do not necessarily reflect how much care patients should receive or where they would best receive their care because there are no financial incentives for providers to refer patients to the most efficient and effective setting. Instead, placement decisions can reflect many factors, including the availability of PAC settings in the local market, the geographic proximity to PAC providers, patient and family preferences, or financial relationships between providers (for example, a hospital may prefer to discharge patients to providers that are part of its system or those it contracts with). PAC providers also have no incentive to consider the cost to Medicare of a patient’s total episode of care or

to coordinate care across settings. As a result, providers focus on their silo of care, which may not best serve the beneficiary and potentially generates unnecessary costs to the program and beneficiaries.

Given the wide variation in service use, it is critical that Medicare and its beneficiaries compare the efficacy of services provided in different settings. However, currently PAC settings do not use a common patient assessment instrument, so the patients they treat and the outcomes they achieve cannot be easily compared. Medicare requires providers in the three settings (IRFs, HHAs, and SNFs) to use a tool specific to each setting and does not require LTCHs to assess patients using a uniform tool. Even for patient assessment data that are available, the measures, definitions, and scales differ.

Need to maintain accurate Medicare fee-for-service payments

Though not the end-point of payment reforms, Medicare must continue to ensure that FFS payment methods create appropriate incentives for providers, and the resulting payments are adequate and accurate. Three quick examples illustrate the responsiveness of the PAC industry to the PPSs' incentives and prices. First, the episode-based payment for HHAs created incentives to lower the number of visits per episode, and the average number declined 32 percent following the implementation of the PPS. Second, the SNF PPS and HHA PPS favor therapy services (over treatments required by medically complex patients), resulting in increases in the amount of therapy furnished and a shift to treating patients who require therapy services and away from treating medically complex patients. Last, the LTCH PPS pays much lower amounts for exceptionally short stays, so average lengths of stay now cluster just above the day thresholds to maximize payment with the minimum amount of services. Clearly, Medicare must concurrently refine its FFS policies while exerting pressure on providers to control their costs and be receptive to new payment methods and delivery reforms.

As required by law, each year the Commission makes recommendations regarding how payments should change for the coming year for services furnished under FFS Medicare. In making its determination, the Commission considers beneficiary access to services, the quality of care, providers' access to capital, and Medicare payments in relation to providers'

costs to treat Medicare beneficiaries (referred to as the Medicare margin). In evaluating the adequacy of Medicare's payments, the Commission examines the level and distribution of Medicare margins across each sector and the ability of "efficient" providers to maintain relatively low costs and high quality of care.

This year, we recommended no update payments to IRFs and LTCHs for fiscal year 2014, concluding that providers in those sectors will be able to continue to provide appropriate access to care under current payment rates. For payments to SNFs and HHAs, we reiterated our previous recommendations to lower the level of payments and restructure the PPSs to base Medicare's payments on patient characteristics, not the amount of services furnished. In making these recommendations, the Commission considered the double-digit Medicare margins both sectors have experienced for many years (we estimate Medicare margins in 2013 to be 12 percent for HHAs and 12 percent to 14 percent for SNFs) and their incentives to furnish services for financial rather than clinical reasons and to select patients with certain care needs over others.

The Commission also assesses whether additional policies are needed to influence provider and beneficiary behavior. With poor definitions of the PAC products and a lack of clarity regarding who needs PAC services and how much service is appropriate, the sector is open to potential abuses from providers. Highly questionable patterns of home health care use led the Commission to recommend expanded medical review activities and the suspension of payments to and enrollment of new providers in areas with significant fraud. When providers tailor the amount of service they furnish to take advantage of the designs of the payment systems, Medicare spending can increase even though the care needs of patients did not similarly change. To engage beneficiaries in evaluating their use of home health care, the Commission also recommended a modest copayment for home health services not preceded by a hospital stay.

We recognize that managing updates and PPSs will not address the fundamental problem of paying providers regardless of the quality or the value of these services. To address these problems, two approaches must be taken. First, payments within Medicare FFS need to

encourage quality and care coordination to the extent possible, by—for example— instituting penalties for excessive readmission rates or tying a portion of payments to quality outcomes. Second, Medicare must shift away from FFS payments and toward integrated delivery systems such as bundled payments and accountable care organizations (ACOs).

Reforms that promote care coordination

The Commission has worked on three broad reforms that encourage better care coordination among settings: bundled payments, ACOs, and aligned readmission policies across settings. Bundled payments and ACOs encourage providers to coordinate care to focus on managing patient outcomes and controlling costs. These reforms require providers to accept financial responsibility and accountability for care that extends beyond their immediate purview. Aligned readmission policies would create parallel incentives for hospitals and PAC providers to avoid unnecessary rehospitalizations. Many Medicare Advantage (MA) plans' policies deviate from FFS policies and are likely to be contemplated by entities participating in bundled payments or ACOs. For example, some MA plans are better at coordinating care across settings than others, some pay for home health care on a per-visit basis, and others do not require a prior three-day hospital stay for SNF care.

Bundled payments and risk-based ACOs

Under bundled payments and risk-based ACOs, Medicare would pay an entity for an array of services over a defined period of time. Under bundled payments, one payment bundle would cover all PAC services following a hospitalization. Under an ACO, participating health care providers assume some financial risk for the cost and quality of care delivered to a defined population and share in savings if they can limit costs while maintaining quality. Given the wide variation in PAC use, both reforms could yield considerable savings over time by replacing inefficient and unneeded care with a more effective mix of services. Bundled payments would give providers not ready or unable to participate in ACOs a way to gain experience coordinating care spanning a spectrum of providers and settings, thus facilitating progress toward larger delivery system reforms.

The Commission recommended testing bundled payments for PAC services in 2008 and since then has examined a variety of bundle designs. Today, the Commission releases its June report, which includes a chapter describing the pros and cons of key design choices in bundling PAC services: which services to include in the bundle, the duration of the bundle, how entities would be paid, and incentives to encourage more efficient provision of care. Each decision involves tradeoffs between increasing the opportunities for care coordination and requiring providers to be more accountable for care beyond what they themselves furnish.

We also laid out possible approaches to paying providers, comparing an all-inclusive payment made to one entity with continuing to pay providers FFS. Though a single payment to one entity would create stronger incentives to furnish an efficient mix of services, many providers are not ready to accept payment on behalf of others and, in turn, pay them. Alternatively, providers could continue to receive payments based on FFS. To encourage providers to keep their spending low, a risk-adjusted episode benchmark could be set for each bundle, and providers could be at risk for keeping their collective spending below it. In establishing the spending benchmarks, current FFS spending levels may not serve as reasonable benchmarks given the FFS incentives to furnish services of marginal value. The return of any difference between actual spending and the benchmark could be tied to providers meeting certain quality metrics to counter the incentive to stint on services. For beneficiaries, bundled payments should improve care coordination and reduce potentially avoidable rehospitalizations.

Two-sided risk ACOs represent an opportunity to reward providers who control their costs, improve quality of care, better coordinate care, and become more engaged in their care management. The Commission examined CMS's proposed and final rules regarding how benchmark prices would be set, the structure of risk and rewards, beneficiary notification and assignment, and the quality measures ACOs are required to report. We also considered the ability of ACOs to generate savings in markets with high PAC use. We would expect ACOs to have the most success reducing use in markets with the most excess service use, just as we have seen MA plans have success in reducing their bids below FFS costs in markets with the most service use. In our discussions with ACO leaders, they expect to reduce PAC use but

acknowledge they have fewer utilization management tools at their disposal than MA plans. For example, they cannot implement prior authorization, modify service copayments as a way to constrain service use, or change Medicare FFS payment rules in purchasing PAC (such as the 3-day required hospital stay for SNF coverage or payment for a 60-day episode for home health care). If ACOs can lower their PAC use, Medicare could, in the longer term, realize savings.

Expand readmission policies to PAC providers in FFS

Based on analysis of the sources of variation in Medicare spending across episodes of care, in 2008 the Commission recommended that hospitals with relatively high readmission rates should be penalized. Beginning in October 2012, a readmission policy will penalize hospitals with high readmission rates for certain conditions. To increase the equity of Medicare's policies toward hospitals and SNFs with high readmission rates, last year the Commission recommended payments be reduced to SNFs with relatively high readmission rates, and we are working on similar policies for home health care and IRFs.

The Commission has examined expanding readmission policies to PAC settings so that hospital and PAC incentives are aligned and focused on unnecessary rehospitalizations. If providers are similarly at financial risk for rehospitalizations, they would have a stronger incentive to coordinate care between settings. In addition to minimizing the risks unnecessary hospital stays pose for beneficiaries, rehospitalizations raise the cost of episodes. Among 10 conditions that frequently involve PAC, we found Medicare spending for episodes with potentially preventable rehospitalizations was 70 percent higher than episodes without them (Table 3). Readmissions accounted for one-third of the episode spending. Furthermore, there is large variation in readmission rates, suggesting ample opportunity for improvement. For example, SNF rehospitalization rates for five potentially avoidable conditions vary by more than 60 percent between the best and worst facilities; hospitals' potentially preventable readmissions rates vary even more.

Aligned readmission policies would hold PAC providers and hospitals jointly responsible for the care they furnish. In addition, the policies would discourage providers from discharging

patients prematurely or without adequate patient and family education. Aligned policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality. By creating additional pressure in the FFS environment, the policies would also create incentives to move to bundled payments or ACOs.

Table 3. Lowering readmissions presents an opportunity to improve care coordination and lower Medicare spending

	Readmission rate	Mean episode spending		Ratio of spending for episodes with readmission to those without readmissions
		With readmissions	Without readmissions	
Coronary bypass w/ cardiac catheterization	12%	\$51,159	\$38,585	1.3
Major small & large bowel procedures	9%	\$32,725	\$20,747	1.6
Major joint replacement	5%	\$32,724	\$20,445	1.6
Hip & femur procedures except major joint	8%	\$34,629	\$25,474	1.4
Stroke	8%	\$26,978	\$16,624	1.6
Simple pneumonia & pleurisy	8%	\$19,071	\$8,885	2.1
Fractures of hip and pelvis	7%	\$23,318	\$15,770	1.5
Kidney & urinary tract infections	9%	\$18,309	\$9,112	2.0
Septicemia without ventilator 96+ hours	10%	\$25,249	\$13,726	1.8
Heart failure and shock	13%	\$19,244	\$9,078	2.1
Average for 10 conditions	9%			1.7

Note: Episodes were initiated by a hospital stay and include postacute care (home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals), potentially avoidable readmissions, and the physician services furnished during the hospital stay and during institutional post-acute care within 30 days after discharge from the hospital. We risk adjusted spending using Medicare severity–diagnosis related groups (MS–DRGs) and standardized payments for differences in wages and special payments (such as teaching, disproportionate share, and outlier payments). Data shown are for patients assigned to MS–DRG acuity level 1 (no complications or comorbidities).

Source: Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

Reforms to eliminate price differences across settings

The Commission has long believed that PAC providers should be paid based on the characteristics of the patients they treat, not the site of service. As a broad reform, bundled

payments would establish a single price for an episode of care, leaving decisions about the mix of services beneficiaries will receive to providers.

Equal payments for similar PAC services would build on other Commission work examining Medicare's payments for select ambulatory services. Medicare currently pays more for the services furnished in hospital outpatient departments (OPDs) or ambulatory surgical centers (ASCs) than when the same service is provided in a physician's office. Responding to the payment differentials, many services have migrated from physicians' offices to OPDs, and some ASC owners have sold their facilities to hospitals. As a result of these shifts in site of service, Medicare spending and beneficiary cost sharing have increased.

In 2012, the Commission recommended equalizing payments made to OPDs and freestanding physicians' offices for evaluation and management visits. In our June 2013 report to the Congress, we identified other ambulatory services frequently performed in OPDs, ASCs, and physicians' offices for which there are large differences in Medicare's payments, and which can be safely performed in the lower cost setting. The Commission established criteria for selecting potential services related to the mix of sites used, patient severity, similarity of service definitions, and frequency of an associated emergency department visit (which raises the service costs). Narrowing or eliminating payment differences across ambulatory sites for the same service would lower Medicare spending and beneficiary cost sharing.

This year the Commission began an examination of how Medicare could equalize payments for similar patients treated in long-term care hospitals (LTCHs) and acute care hospitals. Medicare pays LTCHs considerably more than acute care hospitals for comparable patients. Furthermore, a study by RTI International used a definition of chronically critically ill to evaluate patients treated in LTCHs and estimated that one-half of patients admitted to LTCHs did not require this level of care.

The Commission is considering various approaches that would establish a uniform payment for comparable patients treated in acute care hospitals and LTCHs, but acknowledges that designing such a policy is difficult. Ideally, payments to LTCHs for patients who do not require this level of care would be lowered and payments to acute care hospitals that treat

LTCH-equivalent patients would be raised, without using criteria that can be gamed by providers. Eliminating payment differences between LTCHs and acute care hospitals would help ensure that acute care hospitals located in markets without LTCHs were not disadvantaged and would dampen the incentive for LTCHs to admit patients who do not require this level of care.

Our efforts on bundling and site-neutral payments are consistent with work sponsored by CMS to evaluate whether payments could be harmonized across PAC settings. In 2012, CMS released its evaluation of a demonstration that collected comparable nursing and therapy resource use and developed a patient assessment instrument to be used across PAC settings. The evaluation found a common set of patient characteristics that explained much of the variation in nursing and therapy costs across settings. The finding indicates a common case-mix measure could be developed across the institutional settings (SNF, IRF, and LTCH), with more analysis required to integrate HHAs into a common system. The other three institution-based settings had more similar costs and could be more readily integrated in a single case-mix system.

Reforms require comparable data across PAC settings

Without uniform information about the patients discharged from the hospital and treated in different PAC settings, it is difficult to make appropriate placement decisions and to compare the costs and outcomes across settings. In 2005, the Commission called for such a common assessment tool so that patients, their service use, and outcomes could be compared across settings. As noted above, CMS completed a mandated demonstration of a common assessment tool in 2011 and concluded that the tool it developed could serve as a single tool for all settings. CMS now needs to outline its plans for how to adopt this tool, or a subset of its elements, across PAC settings and in hospitals.

Comparable patient information is critical to adjusting payments for differences in patients and their care needs. Accurate risk adjustment helps ensure providers do not select certain patients or stint on the care they furnish. Furthermore, as Medicare moves to value-based purchasing, adequate risk adjustment enables fair comparisons of outcomes across providers.

Otherwise, a provider may appear to be inefficient or to have worse outcomes than its “peer” when, in fact, the provider treats sicker patients.

Comparable data is also needed to evaluate the efficacy of settings. One setting may be less costly but have poorer outcomes. The Commission has pushed for risk-adjusted quality measures that gauge patient outcomes, leaving providers and MA plans the task of deciding how to furnish care (the focus of many process measures). The Commission has also discussed the need for a limited set of measures to simplify the myriad of metrics providers and MA plans are required to report.

Because the goal of PAC is often to get the patient home, the Commission has developed measures for risk-adjusted rates of discharge to the community for SNFs and IRFs. Rehospitalization rates—especially for conditions that are potentially avoidable—are also a good gauge of the care furnished, and we now use this measure in evaluating the quality of SNFs, IRFs, and HHAs. We have developed measures for these same three settings that include a period after discharge so that providers have an incentive to coordinate care across settings. Aligning measures across sites allows comparisons of providers’ quality and could eventually be used to tie payments to outcomes.

In CMS’s demonstration, comparable outcomes data were collected and risk adjusted. The study examined readmission rates and two functional status measures—improvement in self-care and mobility. Some differences among settings were found, but an important take-away is that comparable, risk-adjusted outcomes measures are possible across PAC settings with a common assessment tool. The Commission urges the adoption of common risk-adjusted outcomes-based measures and that CMS move as quickly as practicable to require all PAC providers and acute care hospitals to use a uniform assessment instrument. For sectors currently required to use a different tool, key elements from the common tool could be added to required tools, thus ensuring continuity in running these sectors’ case-mix systems used to make FFS payments.

Conclusion

The Commission has recommended and discussed many changes to PAC that would increase the value of Medicare’s purchases and improve the coordination of care beneficiaries receive. Some reforms—such as revising and rebasing the SNF and HHA FFS payment systems, adopting a common patient assessment tool, and reporting uniform risk-adjusted outcomes-based quality measures—can be implemented relatively quickly. Others, such as site-neutral payments and readmission penalties, would create more equity across providers in different sectors. These changes could be implemented in the near-term and would serve as building blocks for broader payment reforms—such as bundled payments and ACOs. Because these broad reforms span PAC settings and require providers to assume greater risk, they will take longer to design and implement before they are commonplace. The Commission recognizes the hard work that lies in changing the landscape of Medicare’s payments and urges the Congress to begin to make the changes—large and small—necessary to ensure beneficiaries receive more integrated, appropriate, and lower cost PAC.