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Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Re: Medicare Program; Request for Information on Medicare [CMS-4203-NC]

Dear Administrator Brooks-LaSure:

We are writing in response to the recent request for information (RFI) related to the Medicare Advantage (MA) program issued by the Centers for Medicare and Medicaid Services (CMS), “Medicare Program; Request for Information on Medicare.” This letter responds to several of the questions that CMS posed in that document.¹

We appreciate CMS’ interest in improving the MA program. With the MA program now serving around half of all Medicare beneficiaries, it is more important than ever that MA serve beneficiaries efficiently and effectively. However, before discussing ways CMS could improve MA, we note it is essential that CMS also continue its efforts to improve traditional Medicare (TM).² Around half of Medicare beneficiaries remain enrolled in TM, and TM is likely to attract considerable enrollment for the foreseeable future. Moreover, TM’s performance has major implications for the MA program. Payments to MA plans are directly based on TM spending, and competition from TM likely plays an important role in disciplining both MA plans’ bids and the prices that MA plans pay providers.³ While some of the needed changes to TM (such as adding an out-of-pocket limit for beneficiaries or modernizing its benefit design in other ways) would likely require legislation, CMS has a variety of tools it could use to encourage more efficient care delivery in TM, including expanding use of alternative payment models, improving the design of those models, and making targeted use of utilization management tools in TM.

The RFI raises a wide range of issues related to the MA program. In this response, we address seven specific issues raised by the questions posed in the RFI. Specifically, we discuss the following topics:

- Improving risk adjustment accuracy to ensure appropriate plan payments;
- Using risk adjustment to advance health equity;
- Advancing equity by better coordinating care for older adults in HUD affordable housing;
- Improving quality by increasing MA plan accountability for behavioral health care;
- Improving transparency and competition by more accurately displaying MA plan premiums;
- Enhancing understanding of vertical integration between MA plans and providers; and

¹ Please note that the views expressed in this letter are our own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than ourselves.

² J. Michael McWilliams, “Don’t Look Up? Medicare Advantage’s Trajectory And The Future Of Medicare,” *Health Affairs Forefront* (blog), March 24, 2022, <https://www.healthaffairs.org/doi/10.1377/forefront.20220323.773602/>.

³ Matthew Fiedler, “Capping Prices or Creating a Public Option: How Would They Change What We Pay for Health Care?” (Brookings Institution, November 19, 2020), <https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/>.

- Using direct measures of patient access to assess network adequacy.

The remainder of this letter addresses each of these issues in turn.

1. Improving risk adjustment accuracy to ensure appropriate plan payments

We begin by responding to the RFI's question about ways CMS could improve the accuracy of MA risk adjustment. Payments to MA plans are supposed to be based on what a plan's enrollees would spend if enrolled in TM. To that end, CMS calculates county-level per enrollee spending in TM and then risk adjusts that spending to reflect the health status of a plan's enrollees. In our view, there is considerable evidence that risk adjustment currently falls short of fully offsetting health status differences between TM and MA enrollees and, as such, that payments to MA plans are higher than the Medicare statute intends. There are two main reasons for this:

- *Higher diagnosis coding intensity in MA:* MA plans have strong incentives to capture and report as many of their enrollees' diagnoses as possible in order to increase their risk-adjusted payments, while comparable incentives do not exist in TM.⁴ Consistent with this, there is considerable evidence that an identical enrollee will have a higher observed risk score when enrolled in MA than when enrolled in TM. One study with a particularly strong research design estimated that, in the long run, MA enrollment increases risk scores by at least 8.7%.⁵ Using a different methodology, the Medicare Payment Advisory Commission recently estimated that MA enrollment increases risk scores by 9.5%.⁶ Higher coding intensity in MA is only partially offset by the current 5.9% coding intensity adjustment (the minimum adjustment required by statute).
- *Dimensions of health status not captured in risk adjustment:* An additional challenge for the risk adjustment system is that the enrollee characteristics observed for risk adjustment purposes do not (and likely cannot) capture all dimensions of health status. For example, there may be considerable variation in disease severity even across enrollees with identical sets of observed hierarchical condition category (HCC) codes. This can undermine the accuracy of the risk adjustment system if enrollees who are healthier along dimensions that are not well-captured in risk adjustment tend to choose MA over TM, and MA plans have strong incentives to encourage this type of selection through their plan design choices.

There is evidence that MA enrollees are indeed healthier along dimensions not captured in risk adjustment. Research finds that MA enrollees have lower mortality rates conditional on their observed risk scores, even after accounting for coding intensity differences.⁷ While this could, in principle, occur because MA plans do a better job managing care, the observed mortality differences are likely too large to be explained in this way. The implied differences in health risk between MA and TM enrollees (beyond what is accounted for by the risk adjustment system or attributable to higher coding intensity in MA) are

⁴ Providers participating in Accountable Care Organizations and other alternative payment models that use risk adjustment do have some incentive to capture more enrollee diagnoses. However, the coding incentives created by those models are generally smaller than the incentives that exist in MA, and, in any case, such models account for only a portion of TM spending.

⁵ Michael Geruso and Timothy Layton, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment," *Journal of Political Economy* 128, no. 3 (March 2020): 984–1026, <https://doi.org/10.1086/704756>.

⁶ Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2022, https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

⁷ Vilsa Curto et al., "Health Care Spending and Utilization in Public and Private Medicare," *American Economic Journal: Applied Economics* 11, no. 2 (April 2019): 302–32, <https://doi.org/10.1257/app.20170295>; Vilsa Curto et al., "Can Health Insurance Competition Work? Evidence from Medicare Advantage," *Journal of Political Economy* 129, no. 2 (October 5, 2020): 570–606, <https://doi.org/10.1086/711951>.

substantial—on the order of 10% as of 2010—although this method of gauging differences in unobserved dimensions of health risk is imperfect and this differential may have changed over time.⁸

Changes to risk adjustment could help bring MA payments closer to what the statute intends. Several options are available for addressing higher coding intensity in MA. Ideally, CMS would address coding intensity by reducing the scope MA plans have to increase enrollees' risk scores through coding; these approaches would *both* reduce payments to MA plans *and* reduce the real resources wasted on coding efforts. MedPAC has put forward some ideas in this vein that merit CMS' consideration, including beginning to use two years of diagnosis data to fit the risk adjustment model or limiting the use of diagnoses from health risk assessments.⁹ We suspect, however, that fully addressing the payment consequences of coding differences between MA and TM will ultimately require CMS to adopt a larger coding intensity adjustment than is currently in effect.

Different approaches would be needed to address the risk adjustment problems posed by unobserved aspects of health status. One potential approach would be to shift from a pure risk adjustment system to a hybrid risk adjustment/reinsurance system in which risk scores depended in part on enrollees' realized spending.¹⁰ Because all relevant dimensions of health risk are reflected in realized spending, this approach could help address the problems created by the presence of unobserved dimensions of health risk but would have the downside that it would diminish plans' incentives to manage utilization. Another approach, which is in the spirit of economic research on "optimal" risk adjustment, would be to apply a scaling factor to observed risk differences between MA plans and TM to account for the tendency of plans that attract *observably* lower-risk enrollees to likely also attract *unobservably* lower-risk enrollees.¹¹ For example, under a version of this approach with a scaling factor of 1.25, an MA plan with an observed average risk score of 0.9 would be treated as if it had a risk score of 0.875. The key challenge would be developing a methodology for determining a suitable scaling factor.

Changes like the ones described above would likely reduce MA payments and thereby bring MA payments closer to what the statute intends. We note, however, that reducing payments to MA plans is likely appropriate on policy grounds, as evidence suggests that higher MA payments are a poor way of delivering value to Medicare beneficiaries. Research has found that when MA payment benchmarks increase by one dollar, plan bids

⁸ The estimates reported by Curto et al. (2019) imply that health status differences reduced claims risk in MA relative to TM by 17% *beyond what was captured in risk adjustment* as of 2010. Some of this 17% difference likely reflected coding intensity differences beyond the 3.41% coding intensity adjustment in effect for 2010, but under plausible assumptions about the magnitude of the residual coding intensity, the implied difference in health status beyond what is captured on risk adjustment would still be around 10%.

⁹ We note that the latter poses some tradeoffs worth considering. In particular, limiting health risk assessments could create perverse incentives to ensure that enrollees' conditions are treated, even when treatment is not appropriate, so the diagnosis appears on claims.

¹⁰ Versions of this approach are used in Part D and the Affordable Care Act Marketplaces. For a recent proposal along these lines, see Thomas G. McGuire, Sonja Schillo, and Richard C. van Kleef, "Reinsurance, Repayments, and Risk Adjustment in Individual Health Insurance: Germany, the Netherlands, and the US Marketplaces," *American Journal of Health Economics* 6, no. 1 (October 9, 2019): 139–68, <https://doi.org/10.1086/706796>. MedPAC recently explored a proposal inspired by the McGuire, Schillo, and van Kleef proposal, although the modified proposal investigated by MedPAC has some important limitations. See Medicare Payment Advisory Commission (MedPAC), "Medicare and the Health Care Delivery System," June 2022, https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf.

¹¹ Jacob Glazer and Thomas G. McGuire, "Optimal Risk Adjustment in Markets with Adverse Selection: An Application to Managed Care," *The American Economic Review* 90, no. 4 (2000): 1055–71; Jacob Glazer and Thomas G. McGuire, "Setting Health Plan Premiums to Ensure Efficient Quality in Health Care: Minimum Variance Optimal Risk Adjustment," *Journal of Public Economics, ISPE Special Issue*, 84, no. 2 (May 1, 2002): 153–73, [https://doi.org/10.1016/S0047-2727\(01\)00123-2](https://doi.org/10.1016/S0047-2727(01)00123-2). For some discussion of this type of approach in the context of the Affordable Care Act Marketplaces, see Matthew Fiedler and Timothy Layton, "Comment on HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes," December 1, 2021, <https://www.brookings.edu/opinions/comment-on-hhs-operated-risk-adjustment-technical-paper-on-possible-model-changes/>.

increase by \$0.50 cents or more.¹² As a result, increasing benchmarks (whether directly or via inadequate risk adjustment) increases rebates by much less than it increases payments to plans. Moreover, even to the extent that rebates do rise, it is often unclear how much value the supplemental benefits financed by higher rebates generate for enrollees. In principle, higher bids could allow plans to improve the quality of their basic Medicare benefits (e.g., by offering broader networks or lighter utilization controls), in which case higher payments to plans could generate benefits for enrollees separate from any effects on rebates. However, there is little evidence that this occurs in practice.¹³ Instead, much of the additional revenue brought in by higher bids may be dissipated by higher plan costs (e.g., higher marketing spending) or captured by the plans themselves as profits.

Finally, we note that while one purpose of risk adjustment is to ensure that payments to MA plans are at an appropriate level, effective risk adjustment can also improve the basis of competition among MA plans. In particular, changes that reduce the scope for MA plans to increase payments via diagnosis coding can help ensure that the most attractive plans are the ones that manage care appropriately and offer high-value benefits, not the ones best at diagnosis coding. Similarly, changes that improve risk adjustment's ability to account for differences in health status across plans reduce plans' ability to gain an advantage by attracting healthier enrollees, such as via targeted marketing efforts or by structuring their benefits to be unappealing to high-risk enrollees.

2. Using risk adjustment to advance health equity

We next respond to the RFI's inquiries about how risk adjustment can be used to advance health equity. We begin by reiterating a comment we made on a proposal on this topic that was included in the 2023 Advance Notice.¹⁴ Namely, if CMS' goal in modifying risk adjustment is to increase payments on behalf of disadvantaged enrollees (and, in turn, encourage MA plans to offer these enrollees better coverage), incorporating markers of socioeconomic status into the CMS-HCC model may have often have the *opposite* of the intended effect.

As an example, considering adding ZIP-code-level income as a variable in the risk adjustment model. After accounting for the variables that are currently included in the CMS-HCC model (e.g., HCCs, age, and sex), Medicare enrollees living in low-income ZIP codes have lower spending, on average, than those living in higher-income ZIP codes, plausibly because of various barriers low-income enrollees may face in accessing care.¹⁵ Thus, including ZIP-code-level income in the CMS-HCC model would tend to reduce risk scores for enrollees in low-income areas, weakening plans' incentives to appeal to these enrollees. While these findings are for ZIP-code-level income, it is plausible that they extend to other socioeconomic variables as well.

¹² Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?," *The American Journal of Managed Care* 18, no. 9 (September 2012): 546–52; Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare Advantage: Effect of Benchmark Changes on Plan Bids," *Journal of Health Economics* 32, no. 6 (December 1, 2013): 1301–12, <https://doi.org/10.1016/j.jhealeco.2013.09.004>; Mark Duggan, Amanda Starc, and Boris Vabson, "Who Benefits When the Government Pays More? Pass-through in the Medicare Advantage Program," *Journal of Public Economics* 141 (September 1, 2016): 50–67, <https://doi.org/10.1016/j.jpubeco.2016.07.003>; Daria Pelech and Zirui Song, "Pricing and Pass-through in Response to Subsidies and Competition: Evidence from Medicare Advantage before and after the Affordable Care Act," October 2018, https://www.hcp.med.harvard.edu/sites/default/files/Pricing_Pass-through_MA_10-19-2018_HCP.pdf.

¹³ Duggan, Starc, and Vabson, "Who Benefits When the Government Pays More?"

¹⁴ Matthew Fiedler and Richard G. Frank, "Comments on the 2023 Advance Notice on Medicare Part C and D Payment Policies" (Brookings Institution, March 8, 2022), <https://www.brookings.edu/opinions/comments-on-the-2023-advance-notice-on-medicare-part-c-and-d-payment-policies/>.

¹⁵ Savannah L. Bergquist et al., "Data Transformations to Improve the Performance of Health Plan Payment Methods," *Journal of Health Economics* 66 (July 1, 2019): 195–207, <https://doi.org/10.1016/j.jhealeco.2019.05.005>.

Other approaches to modifying risk adjustment could increase payments on behalf of disadvantaged enrollees. CMS could consider directly increasing risk scores for the enrollees of interest without modifying the CMS-HCC model itself. Another strategy would be to make upward adjustments to the spending data used to fit the CMS-HCC model for enrollees in the targeted group *in combination* with adding socioeconomic predictor variables.¹⁶ If implemented appropriately, this approach would increase the risk scores of the targeted group, as desired. These approaches are conceptually similar to the benchmark adjustment introduced in the new ACO REACH model.

If CMS opts to use risk adjustment to increase payments on behalf of disadvantaged enrollees to make progress on health equity, there are three things that the agency should keep in mind.

First, it is uncertain how effective increasing MA payments on behalf of disadvantaged enrollees would be in improving the coverage these enrollees receive. As noted above, evidence suggests that changes in MA payments are generally not fully passed through to enrollees, with a substantial portion likely taking the form of low-value supplemental benefits, accruing to plans as higher profits, or being dissipated by increases in plan costs (e.g., due to more aggressive marketing efforts). That pattern could very well be replicated in the context of payment adjustments targeted at specific groups of enrollees. There is also a question of how much scope insurers have to target plan improvements to these specific groups of enrollees, which could also limit passthrough.

Second, this type of policy would likely cause more of the enrollees targeted by the policy to opt for MA over TM. If enrollee decisions are fully informed and fully rational, that would not be cause for concern, as enrollees would presumably only opt for MA if the benefits it offers (e.g., reduced cost-sharing and supplemental benefits) outweighed its potential disadvantages (e.g., narrower networks and tighter utilization controls). But there is abundant evidence that insurance plan choices can be affected by a range of cognitive biases and that may be a particular concern in the context of MA given plans' intensive marketing efforts. Thus, policymakers would need to carefully consider whether inducing more enrollees in the targeted group to take up MA is desirable.

Finally, we assume that a policy in this vein would need to be implemented in a budget-neutral fashion, so that any increase in risk scores (and thus payments) for disadvantaged enrollees would be offset by reduction in risk scores (and payments) for more advantaged enrollees. This implies that any increase in plan efforts to attract disadvantaged enrollees would likely be mirrored by a reduction in plan efforts to attract other enrollees. In light of the persistent underinvestment in many communities, this type of reallocation may well be justified, but appropriately assessing this type of policy requires taking account of both sides of this tradeoff.

3. Advancing equity by better coordinating care for older adults in HUD affordable housing

The RFI solicits ideas for advancing equity, highlighting the desire to improve the ability to better meet the needs of vulnerable populations. Low-income adults who rely on affordable housing programs are an important vulnerable population that has difficulty obtaining care and is frequently at high risk of institutionalization. Thus, better serving the health needs of this population presents a major opportunity to advance health equity.

The HUD Section 202 program aims to expand the supply of affordable housing with supportive services for older adults. It provides very low-income older adults (age 62+) with the opportunity to live independently but in an environment that provides support activities such as cleaning, cooking, transportation, etc. The 202 program includes more than 400,000 units and is similar to the Supportive Housing for Persons with Disabilities program (Section 811). An estimated 38% of people living in HUD 202 housing are frail or near frail, meaning that they

¹⁶ Bergquist et al.

need help with activities of daily living and are at risk of institutionalization.¹⁷ This suggests that many residents of 202 housing need easy access to both health care services and long-term services and supports.

There is some evidence that creating stronger linkages between primary care and community human services programs can reduce rates of hospitalization, improve medication management, and improve attention to the functional needs of frail, very low-income older adults. In addition, such programs have shown reduced rates of injuries from falls.¹⁸ Yet few 202 programs are strongly linked to health providers and support services. MA plans may be well positioned to facilitate this integration and, in doing so, improve care and support for a very low-income population in which people of color are overrepresented.

CMS could take steps through the MA program to capitalize on the opportunity. For example, CMS could include the establishment of formal memorandums of understanding (MOUs) between MA plans and local housing authorities as a performance indicator. The MOUs would establish nursing and care manager services at 202 sites with multiple plan enrollees. The MOUs would also set forth regular clinical visit times that would augment the site-based nursing services. Similar arrangements have been put in place between state Medicaid programs and housing authorities under the Melville Act.¹⁹ Other approaches to connecting MA plans to enrollees living in 202 and other forms of affordable housing are also worth exploring, given the potentially high payoffs involved.

Another avenue towards supporting the need for long-term services and supports in programs such as 202 is to encourage MA plans to offer supplemental long-term services and support benefits, which plans have been permitted to offer since 2018. While there has been some take-up of this option, only about 12% of plans offer in-home support services today. When plans do offer these benefits, they are frequently quite limited. The limited evidence on why plans have balked at offering these benefits suggest that CMS could offer greater clarity and technical assistance to plans in designing benefits that would meet CMS criteria.²⁰ Such benefits could be targeted to populations living in subsidized housing, where pay-offs may be especially large.

4. Improving quality by improving MA plan accountability for behavioral health care

The nation faces continued challenges in providing adequate access to quality behavioral health services, especially for people with mild to moderate mental illnesses and substance use disorders. CMS has rightfully highlighted the need to improve quality measurement in its Behavioral Health Strategy. Yet the way the MA program holds plans accountable to deliver high-quality behavioral health care needs improvement.

Accountability requires well-defined expectations about performance, careful measurement of performance, and consequences linked to high or low performance. Until recently, the sole component of CMS' efforts in this area was to include the Improving or Maintaining Mental Health measure in the Quality Bonus Program (QBP). CMS

¹⁷ United States Department of Housing and Urban Development, "Worst Case Housing Needs 2019 Report to Congress," June 2020, <https://www.huduser.gov/portal/sites/default/files/pdf/worst-case-housing-needs-2020.pdf>.

¹⁸ Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services, "Support and Services at Home (SASH) Evaluation: Highlights of the Evaluation of Program Outcomes from 2010 to 2016," July 2019, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//190061/SASH5hl-rs.pdf.

¹⁹ "Frank Melville Supportive Housing Investment Act of 2010," Pub. L. No. 111-374 (2011), <https://www.congress.gov/111/plaws/publ374/PLAW-111publ374.pdf>.

²⁰ Molly Knowles et al., "Comparing New Flexibilities in Medicare Advantage with Medicaid Long-Term Services and Supports: Final Report" (Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services, January 2022), <https://aspe.hhs.gov/sites/default/files/documents/03390244d012ecbbe80e81d5c972bf39/medicare-advantage-medicaid-ltss.pdf>.

has currently moved that measure to display status due to distortions created by the COVID-19 pandemic, with the result that no behavioral health care measures are currently used in calculating Star Ratings.

While CMS may intend to resume using this measure to calculate Star Ratings in future years, CMS should use this as an opportunity to consider whether it should transition to alternative measures in the years to come. In particular, there is reason to question whether this particular patient-reported outcome measure accurately reflects patient mental health outcomes and, thus, appropriately encourages plans to delivery quality mental health care.

Over the long term, we believe that CMS should continue to strive to develop measures that reliably capture processes and outcomes for patients with behavioral health care needs. In the meantime, however, it would be constructive to consider drawing on several existing process measures strongly linked to better outcomes that, while more focused, together represent a broad range of mental illnesses that appear in the population of MA enrollees. There are several candidates from existing Medicare and Medicaid measure sets and those used jointly by CMS and SAMHSA, including:

- Screening and Follow-Up for Depression;
- Medication Adherence for Antipsychotic Medications;
- Diabetes Screening for People on Antipsychotic Medications; and
- Adherence to Mood Stabilizers for People with Bipolar Illness (CCBHC measure set).

Other measures developed for other public and private programs (Medicaid, SAMHSA, NQF) would also be reasonable indicators of quality. Inclusion of the existing measures identified above is certainly preferable to having no behavioral health indicators included among Star Rating measures and almost certainly preferable to restoring the previously used Improving or Maintaining Mental Health measure.

One cannot hope to drive improvement without consequences for poor performance. One need only examine the disappointing results for display measures such as the depression screening and follow-up to get a sense of the need for strong incentives to address behavioral health quality. This means that, whatever behavioral health measures CMS selects, it should put sufficient weight on them to meaningfully impact rewards under the QBP.

5. Improving transparency and competition by more accurately displaying MA plan premiums

Currently, Medicare’s plan comparison tools list an MA plan as charging a zero-dollar monthly premium so long as there is no supplemental premium above the Part B premium, regardless of whether the plan also offers a reduction in the Part B premium. Research suggests that this may dampen the demand response to premium reductions below the standard Part B premium amount, in turn encouraging MA plans to use rebate dollars to add supplemental benefits that enrollees might not value at cost.²¹ Listing MA plans that do not buy down the Part B premium as offering zero premiums may also distort enrollees’ choice between TM and MA since some may believe that enrolling in an MA plan advertised as charging “zero premium” allows them to avoid the Part B premium (although plan compare does indicate that the premium excludes the standard Part B premium).

In the interest of equipping consumers with the information they need to make good choices—and thereby establishing appropriate incentives for MA plans—we propose that plan compare report the full premium an enrollee would pay if enrolled in the MA plan. That is, the displayed premium would reflect the Part B premium,

²¹ Karen Stockley et al., “Premium Transparency in the Medicare Advantage Market: Implications for Premiums, Benefits, and Efficiency” (National Bureau of Economic Research, June 12, 2014), <https://doi.org/10.3386/w20208>.

including any buy down of the Part B premium, plus any Part C premium, so that beneficiaries have an accurate view of the financial consequences of making coverage choices in Medicare.

6. Enhancing understanding of vertical integration between MA plans and providers

The large health insurers that dominate the MA market increasingly own related businesses – including physician practices, facilities, and PBMs – that provide at least some services to their own MA plans. About 6% of physicians nationwide now work for Optum, owned by United Healthcare.²² Humana continues to expand its primary care footprint focused on serving the senior population, including its own MA plans, and owns part of “Kindred at Home,” a home health and hospice provider.²³ Kaiser owns Kaiser Foundation Hospitals and the Permanente Medical Groups that all contract with Kaiser MA plans. CVS/Aetna, United, and Cigna all own PBMs that contract with their MA plans. And some own other businesses including physician practices, pharmacies, ambulatory surgery centers, ambulances, and dental, vision, and hearing services providers.

Vertical integration may facilitate improvements in the care of MA enrollees or reduce costs if it aligns incentives between insurers and providers, but vertical integration also raises some concerns that are worth monitoring. For one, provider acquisitions may directly increase horizontal consolidation in certain markets, which research generally suggests will increase prices or reduce quality. It also creates the potential to raise rivals’ costs by reducing the rivals’ access to the providers in question, thereby weakening competition. For instance, an acquired physician group might limit service to rival insurers or demand higher prices to remain contracted, thereby making rival insurance products less attractive to consumers and increasing enrollment in the vertically integrated insurer’s plans. Additionally, evidence suggests that integration between MA plans and providers helps plans increase risk adjustment coding intensity to generate higher payments from the federal government.²⁴

Finally, the ownership of related businesses may help MA plans evade Medical Loss Ratio (MLR) regulations because the profits earned by the related businesses are not subject to any MLR requirements. Concretely, an MA plan that owns a related business can opt to pay inflated prices for services provided by the related business. Such payments can be reported as “incurred claims” for MLR purposes and, as such, help the MA plan meet its MLR obligations, but constitute profits to the parent company. As such, they can be used to circumvent the MLR rules.

We recommend that CMS take two concrete actions to respond to this emerging trend.

First, CMS should begin collecting more information on financial relationships between MA plans and their related businesses as part of its MLR reviews. In particular, CMS should ask plans how they value the services delivered by related businesses when computing incurred claims for MLR purposes and, in particular, how the prices used compare to: (1) Medicare fee-for-service prices; (2) the prices that MA plans pay non-related providers for similar services; (3) the prices that the related providers receive from *other* MA plans for similar services; and (4) any transfer prices the firm may use for its own internal accounting purposes. We encourage CMS to examine a wide range of provider types, but we believe that certain categories of related business are particularly ripe for scrutiny, including pharmacy benefit managers (PBMs), behavioral health carve-outs, related medical practices

²² Seeking Alpha, “UnitedHealth Group Incorporated (UNH) CEO David Wichmann on Q4 2020 Results - Earnings Call Transcript,” January 21, 2021, <https://seekingalpha.com/article/4399998-unitedhealth-group-incorporated-unh-ceo-david-wichmann-on-q4-2020-results-earnings-call>.

²³ Nona Tepper, “Humana Grows Private Equity-Backed Primary Care,” Modern Healthcare, January 20, 2022, <https://www.modernhealthcare.com/insurance/humana-grows-private-equity-backed-primary-care>.

²⁴ Geruso and Layton, “Upcoding.”

and ambulatory surgery centers, and post-acute facilities. We note that PBMs raise some special issues given the complexity of pharmaceutical pricing, and CMS should pay particular attention to how rebates received by the PBM are allocated across different clients and how dispensing fees vary across related and unrelated outlets.

Second, drawing on this information, CMS should take appropriate steps to strengthen the integrity of the MLR requirements. Where plans appear to be using such payments to circumvent MLR requirements in ways that are impermissible under current regulations, CMS should take appropriate enforcement action. In other cases, CMS may uncover practices that violate the spirit of the MLR requirements but do not clearly violate current regulations or guidance. In these cases, CMS should revise its regulations and guidance accordingly. For example, CMS may wish to consider establishing upper limits on the prices MA plans can pay related businesses for health care services and still have the full amount be considered “incurred claims” for MLR purposes.

Third, CMS should collect better information on plan ownership of providers to allow both CMS and outside researchers to better understand the implications of vertical integration for the MA program and for the health care system as a whole. CMS could collect this ownership information in multiple ways. One option would be to require health care providers to report whether they own an MA plan or are owned by a company that operates an MA plan when enrolling in the program. Alternatively, CMS could require MA plans to report similar information. Regardless of how this information is collected, it should be made available to researchers through the existing mechanisms that CMS uses to make information on provider characteristics available to researchers.

7. Using direct measures of patient access to assess network adequacy

The RFI asks how CMS can ensure that MA enrollees have appropriate access to care. One important determinant of access to care is whether an MA enrollee has access to an appropriate network of providers. While MA plans do have some incentive to offer adequate networks, those incentives may not always be as strong as they should be (e.g., because enrollees have difficulty assessing network adequacy), or these incentives may conflict with other incentives plans face (e.g., risk selection incentives arising from inadequate risk adjustment).

Motivated by these concerns, CMS has historically set quantitative standards governing how many providers plans must contract with or how far (or how long) enrollees must travel to reach an in-network provider. Unfortunately, these measures frequently fail to reveal the true ability of beneficiaries to access medical care services when they are needed. Notably, in-network providers may not always be accepting new patients or may not be making appointments available in a timely fashion. In other cases, these standards may be overly stringent and force plans to expand their networks even in instances where the small number of providers included in a plan’s network are able to ensure that a plan’s enrollees have appropriate access to care.

As an alternative, CMS should consider relying more heavily on data that directly reflects enrollees’ experiences accessing care, which CMS already routinely collects via CAHPS. The survey includes questions about whether enrollees are able to get care as soon it is needed, as well whether it was “easy” to get tests or treatment. These survey-based measures are already used in the QBP, but CMS should also consider incorporating them into network adequacy reviews. They could be used to identify instances where plans are failing to provide appropriate access to care despite offering a network that appears adequate “on paper.” Plans could also potentially be allowed to fall below the existing quantitative network adequacy standards in some areas if they demonstrate appropriate performance on these patient-reported measures. CMS could also consider going further by reducing its reliance on freestanding network adequacy reviews and instead increasing the weight the CAHPS-based measures receive in the QBP to strengthen plans’ financial incentives to ensure timely access to care. Making greater use of these

measures would also improve CMS' ability to monitor other aspects of plan design that may affect patient access, such as use of prior authorization and similar utilization management tools.

We note that the current suite of CAHPS access measures is relatively narrow in scope. Thus, if CMS were to move in this direction, CMS should consider whether it would be appropriate to expand the set of CAHPS questions (e.g., to encompass additional specific provider types). It should also examine whether sample sizes are adequate to assess access to care in all relevant subgroups and, if not, consider increasing sample sizes.

We hope that the discussion we have presented is useful to you as you take up the complex task of improving the design and performance of the MA program and the Medicare program as a whole.

Sincerely,

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