Center on Health Policy at BROOKINGS

January 24, 2025

Jeff Wu
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Re: Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly [CMS-4208-P]

Dear Mr. Wu:

Thank you for the opportunity to comment on this set of policy changes proposed by the Centers for Medicare and Medicaid Services (CMS). This letter makes two comments related to CMS' proposals on Medicare Advantage (MA) Medical Loss Ratio (MLR) requirements:[1]

- **Requiring MA plans to report claims spending disaggregated by type of payment arrangement would fill a major data gap, but barring public release of these data would reduce their value.** CMS proposes to require MA plans to disaggregate their claims spending by type of payment arrangement when they report data for MLR purposes. CMS indicates that it would initially collect data for three types of arrangements: fee-for-service, alternative payment model, and population-based payment.

  These data would help fill major gaps in what is known about how MA plans pay providers. Most existing knowledge is derived from claims data or the hospital price transparency data. Unfortunately, those data typically capture only fee-for-service payments, and MA plans are known to make substantial use of non-fee-for-service payments.[2] Direct information on how much MA plans pay providers using non-fee-for-service methods is essential to understanding how serious this limitation is and how to adjust for it.

  Having a robust picture of how MA plans pay providers could aid policymakers in several ways. Payments to providers account for the large majority of MA plan costs, so the level of those payments has major implications for plan bids and, in turn, federal and enrollee costs. Understanding the level and structure of MA provider payments can also help

[1] The views expressed in this letter are my own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself.

[2] Health Care Payment Learning and Action Network, "APM Measurement: Progress of Alternative Payment Models," November 14, 2024, https://hcp-lan.org/wp-content/uploads/2024/11/2024-HCPLAN-Methodology-Report-11-13.pdf.

illuminate the incentives that providers face when serving MA enrollees and thus help inform efforts to ensure that MA enrollees enjoy appropriate access to care.

CMS indicates that it does not intend to release these data publicly, except in aggregated form. This approach would deprive researchers and other stakeholders of the ability to learn from these data and thus would seriously reduce the value of collecting them.

While CMS does not explain why it would withhold these data, CMS has previously expressed concern that data on MA provider payments are commercially sensitive.[3] This does not offer a compelling rationale for withholding these data. While some have argued that disclosing what plans pay providers could raise negotiated prices, the balance of the evidence suggests that transparency reduces prices, on net, albeit only slightly.[4] Indeed, the belief that greater transparency reduces prices was one motivation for CMS' hospital and insurer price transparency rules. MA plans may also express concerns that disclosing these data will weaken their competitive position (e.g., by making it easier for competitors to enter). However, this strengthens the rationale for disclosure since weakening the market power of incumbent plans would likely benefit beneficiaries and reduce federal costs.

While beyond the scope of this rulemaking, CMS should consider additional ways that it could improve the data available on what MA plans pay providers.[5] This includes allowing researchers to access a version of the MA encounter data that includes information on payments to providers and beginning to collect more granular data on non-fee-for-service payments, ideally data disaggregated by MA contract and provider.

- **Barring MA plans from counting certain incentive and bonus arrangements in the MLR numerator would likely do little to address CMS' MLR gaming concerns but could create unnecessary administrative burdens.** CMS proposes that MA plans would be permitted to include payments under provider incentive and bonus arrangements (e.g. shared savings contracts) in the MLR numerator only if those payments are tied to clinical or quality improvement standards. The proposal is motivated by commercial MLR audit findings that insurers operate payment arrangements that "[transfer] excess premium revenue to providers to circumvent MLR rebate requirements."

  This proposal is unlikely to achieve CMS' goals. CMS appears to be concerned that MA plans are sometimes (directly or indirectly) basing payments under these arrangements on the *plan's* MLR and, specifically, paying providers more when the plan would otherwise fail to meet the MLR standard. However, merely requiring that such payments be tied to

[3] This discussion is adapted from Loren Adler and Matthew Fiedler, "Response to a Request for Information on Improving Data on Medicare Advantage," June 3, 2024, https://www.brookings.edu/articles/response-to-a-request-for-information-on-improving-data-on-medicare-advantage/.

[4] Congressional Budget Office, "Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services," September 29, 2022, https://www.cbo.gov/publication/58222.

[5] For additional discussion, see Adler and Fiedler, "Response to a Request for Information on Improving Data on Medicare Advantage."

clinical and quality improvement standards would not prevent this behavior. Notably, MA plans could ensure that a payment arrangement satisfies this requirement by simply tacking on clinical and quality improvement standards that providers are virtually certain to meet, thereby ensuring compliance while continuing the undesired behavior.

At the same time, this proposal may create unnecessary administrative burdens. It may often be appropriate for plans to operate incentive arrangements where provider bonuses depend solely on spending performance rather than a combination of spending and quality performance. Indeed, past efforts to tie provider compensation to quality performance have often done little to improve quality but have created significant administrative burdens due to the challenges of collecting performance data.[6] Forcing MA plans to implement similar quality measurement and payment regimes in cases where they would otherwise choose not to do so seems likely to lead to similar disappointing outcomes.

Alternative approaches could do a better job of achieving CMS' goals while avoiding these unintended consequences. Notably, CMS could instead make clear that incentive and bonus arrangements must be based on the *provider's* performance (whether that be spending performance, quality performance, or some other performance metric), not performance at the plan level. This requirement would directly target the behavior CMS is concerned about without encouraging plans to implement low-value quality measurement efforts.

Finally, CMS notes that an advantage of its proposal is that it would align MA MLR rules with commercial MLR rules, which might ease compliance for insurers. While this is true, it would be better to achieve alignment by amending the commercial MLR rules to remove the relevant provisions rather than to import those flawed rules into MA.

Thank you for the opportunity to comment on this proposed rule. I hope that this information is helpful to you. If I can provide any additional information, I would be happy to do so.

Sincerely,

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[6] Matthew Fiedler, "Matthew Fiedler's Testimony before the Senate Budget Committee," October 18, 2023, https://www.brookings.edu/articles/matthew-fiedlers-testimony-before-the-senate-budget-committee/.