CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health
BROWN UNIVERSITY

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Acting Administrator, Jeff Wu
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Comments on the Contract Year 2026 Policy and Technical Changes to the MA Program (CMS-4208-P) - RFI on Medical Loss Ratio (MLR) and Vertical Integration.

Dear Administrator Wu:

Thank you for the opportunity to comment on the Contract Year 2026 Policy and Technical Changes to the MA Program. The Brown University Center for Advancing Health Policy through Research (CAHPR) is a nonpartisan research and policy center that advances the understanding and development of policies that will lower spending growth, improve patient outcomes, and enhance the US healthcare delivery system. As a team of health economists, health services researchers, and lawyers, our Center's investigators conduct research and develop solutions to improve the Medicare Advantage (MA) program.

CAHPR's responses to the Contract Year 2026 Policy and Technical Changes to the MA Program are below. Our comments on the proposed rule focus on the section with the request for information on Medical Loss Ratio (MLR) and vertical integration.

Request for Information on MLR and Vertical Integration

We appreciate the opportunity to provide comments regarding the request for information on Medical Loss Ratio (MLR) reporting and vertical integration within Medicare Advantage (MA) and Part D programs.

Enrollment in MA has recently surpassed traditional Medicare, and MA Organizations (MAOs) are increasingly integrating vertically. Vertical integration refers to the combination of entities that offer different types of products or services in the production process, i.e., among entities that do not directly compete with one another.[1] Today, the largest MA payers are restructuring as vertically integrated

[1] Fuse Brown EC. *Hearing on Strengthening U.S. Economic Leadership: The Role of Competition in Enhancing Economic Resiliency - before the United States Senate Judiciary Committee Subcommittee on Competition Policy, Antitrust, and Consumer Rights*. The Center for Advancing Health Policy through Research (CAHPR); 2024. https://cahpr.sph.brown.edu/sites/default/files/documents/Erin%20Fuse%20Brown%20Testimony%20before%20Senate%20Judiciary%20Committee_6.3.24%20(1).pdf

organizations, acquiring physician practices, post-acute companies, home care providers, and more. While these combinations have the potential to generate efficiencies, there are risks associated with this new form of consolidation. As our work has highlighted, vertical integration pursued by MA organizations raises concerns about regulatory gaming, anticompetitive conduct, and clinician morale.[2]

Among these concerns is the potential gaming of the MLR requirement. MA Organizations may be vertically consolidating to shift revenue to related parties, which would effectively allow them to circumvent the MLR requirement. In addition to undermining the intent of the MLR requirement, these practices may implicate anti-competitive concerns of vertical consolidation in MA markets. For example, if MAOs are overpaying their related parties to evade MLR requirements, this increases the likelihood that vertical integration is failing to produce efficiencies, contrary to traditional assumptions about these corporate combinations. Other forms of regulatory gaming may be at issue here, as MAOs provide financial incentives and access affiliated practices' electronic health records to increase the coding intensity of MA beneficiaries' diagnoses to draw higher MA payments.[3] Further, vertical consolidation in MA may facilitate anticompetitive strategies that harm rivals, independent practices, and beneficiary access through self-preferencing, patient-steering, and foreclosure.

Recommendations for Data Transparency

We share concerns raised by CMS and other commentators about the methodology for calculating MLR and the ways in which it may be manipulated to circumvent the spirit of the law. Our comments here are focused on gathering adequate data to enable researchers and oversight authorities to measure and assess potential MLR abuse. As described above, the data today are insufficient to understand the nature and degree to which MLR gaming may be occurring, and how these strategies may interact with competitive dynamics in MA markets. We provide recommendations for data transparency in three distinct but overlapping categories below.

Ownership Transparency and Related Party Data

Ownership transparency is key to understanding the interplay of MLR gaming and vertical integration. Yet today, with the rise of corporate investment in health care, ownership and control of providers is now more complex and opaque. Advancing ownership transparency requires a modernized data system designed to: (a) gather detailed information about the entities that own or control health care providers and facilities and their corporate organizational structure, (b) monitor changes in ownership or control of health care providers due to mergers, acquisitions, and partnerships across health systems, insurers, retailers, and private equity firms; (c) gather information about related parties and any payments and flow of funds within vertically consolidated MAOs; and (d) make health care ownership and control information available to researchers and the public. Such reform would illuminate the scope and impact of vertical consolidation in health care, including its effects on MLR calculations, health care costs, service

[2] Rooke-Ley H, Shah S, Fuse Brown EC. Medicare Advantage and Consolidation's New Frontier — The Danger of UnitedHealthcare for All. *The New England Journal of Medicine*. 2024;391(2). doi:https://doi.org/10.1056/nejmp2405438

[3] Fuse Brown EC, Williams TC, Murray RC, Meyers DJ, Ryan AM. Legislative and Regulatory Options for Improving Medicare Advantage. *J Health Polit Policy Law*. 2023;48(6):919-950. doi:10.1215/03616878-10852628

use, and care quality. While progress has been made in improving ownership transparency for nursing homes, significant gaps persist across the broader health care system and supply chain, limiting effective oversight and accountability. We recommend that robust information on entities that own, control, or receive payments as related parties be collected across Medicare provider types and MAOs.

Non-Claims Payments

While researchers can access and assess encounter-level payment data for fee-for-service claims, capitated and other risk-sharing arrangements do not currently enable similar transparency. Yet these arrangements are increasingly common, especially in MA which now covers more than half of all Medicare beneficiaries. Health plans may also offer value-based "pay for performance" incentives. Because the MA program places such strong incentives on risk coding and quality metrics, MA plans heavily incentivize physician practices to perform on these metrics. Recent reporting confirmed that individual physicians can earn tens of thousands in bonuses for hitting risk coding targets.[4] However, the amounts and frequency of these non-claims payments are not captured in any systematic way, which impedes assessment of the appropriateness, impact, or magnitude of these billions in expenditures.

CMS should develop a process to track information on non-claims payments by adopting a rule that would standardize how nonclaims data is categorized and collected. The California Department of Health Care Access and Information (HCAI) introduced the Expanded Non-Claims Payment Framework, designed to standardize how non-claims payment data—such as capitated payments and performance incentives—are categorized and collected.[5] This initiative that aims to improve transparency and support deeper analysis of health care spending is a good template for tracking non-claims payments.

The framework incorporates elements from the Health Care Payment Learning and Action Network (HCP-LAN) and the Milbank Memorial Fund-Bailit models, focusing on both the purpose of the payments and the level of risk taken on by providers. Its objectives include:

- Accurately quantifying non-claims payments as part of overall health care spending to support the state's health care cost growth targets.
- Monitoring spending in areas like primary care and behavioral health to understand their role in achieving care delivery goals.
- Tracking the adoption of alternative payment models (APMs) across the state to assess progress toward value-based care.

Data on Payers in the Markets

[4] Bannow T, Herman B, Ross C, Lawrence L. Inside UnitedHealth's strategy to pressure physicians: $10,000 bonuses and a doctor leaderboard. STAT News. Published October 16, 2024. Accessed January 28, 2025. https://www.statnews.com/2024/10/16/united-health-optum-care-medicare-advantage-strategy-dashboard-emails-documents/

[5] Pegany V, Brandt M, Tran N, Valle M, Krawczyk C. A New Standard for Categorizing and Collecting Non-Claims Payment Data . The Milbank Quarterly. Published March 18, 2024. https://www.milbank.org/2024/03/a-new-standard-for-categorizing-and-collecting-non-claims-payment-data/

Understanding the potential anti-competitive effects of vertical integration in MA markets requires comprehensive data to evaluate how ownership changes influence competition and contracting dynamics. Specifically, there is a concern that vertical integration—such as a MAO acquiring a physician practice—may disadvantage rival payers. This concern arises from the potential for practices owned by MAOs to alter their contracting behavior in ways that harm competition.

Data on Contracts and Foreclosure Concerns

To assess these effects, it is critical to examine not only the structure of contracts between physician practices and MAOs but also how these contracts evolve post-acquisition. Key questions include:

- **Contractual Changes**: How do contracts between acquired practices and rival MA payers differ from those with the acquiring MAO? Are rival payers facing higher prices, less favorable terms, or outright exclusion from contracting opportunities?
- **Foreclosure Analysis**: Are rival payers being systematically disadvantaged, resulting in a decrease in their market share or ability to compete effectively? This requires detailed data on contracting terms, reimbursement rates, and the breadth of access to physician networks.

Linking Ownership and Market-Level Data

The impact of vertical integration could also be assessed through longitudinal analysis of MA market dynamics, including:

- **Ownership and Cost Data:** Coupling data on physician practice ownership with cost information can illuminate the financial incentives created by vertical integration and its impact on rival payers.
- **Market Share Trends:** Changes in MA market share over time—both for the acquiring MAO and its rivals—can provide evidence of competitive harm or shifts in market power.
- **Premiums and Bids:** Examining changes in premiums, bids, and cost structures at the plan level can help identify whether consumers face higher costs or reduced benefits as a result of decreased competition.
- **Beneficiary Access:** Additional data on the number of rival plans available, beneficiary enrollment and care trends, and provider access metrics, can help assess whether vertical consolidation in MA affects beneficiary access.

We appreciate the opportunity to provide feedback on this critical issue and appreciate CMS' steps to consider policies that promote transparency, fairness, and accountability. We welcome the opportunity to engage further or provide additional data as needed. Should you have any questions about our comments, please contact Erin Fuse Brown at erin_fuse_brown@brown.edu or Jared Perkins, Director of Health Policy Strategy, at jared_perkins@brown.edu.

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