TOPIC: PAYER-PROVIDER VERTICAL INTEGRATION

Background

Vertical integration in health care refers to the consolidation of different parts of the health care delivery system under a single corporate umbrella.[1,2] Although integration in health care can encompass a range of structural and functional models, this chapter focuses specifically on vertical integration between payers and providers within Medicare Advantage (MA). This is sometimes referred to as a "payvider" model because one company owns both the payer, or insurance, and the provider, or care delivery, sides of health care.[3,4] It can occur when a health insurance issuer acquires providers or when a health system creates its own insurance product. Vertically integrated payer-provider arrangements (which generally participate in MA as well as other markets) aim to improve coordination, reduce fragmentation, and enhance patient outcomes, and they often support value-based care.[5,6] In addition, vertical integration can simplify patient navigation if it can reduce duplicative care management and logistics activities and facilitate more seamless data and information sharing.[7,8] Vertical integration between MA plans and hospitals has increased over time, with 2,190 hospitals integrated with MA plans and 230 MA plans integrated with hospitals or hospital systems as of 2024.[9] Vertical integration of MA plans with other types of providers is also widespread; UnitedHealth Group is reported to have 90,000 physicians (10% of the US physician workforce) and 40,000 advanced practice clinicians who are employees or affiliates.[10] However, there is a lack of transparency and data on ownership and pricing for MA vertical integration, and regulations generally assume providers and payers are separate entities.

Key Points

- Vertical integration between payers and providers in Medicare Advantage may improve coordination and data sharing.
- Vertical integration can also create risks of fraud, waste, and abuse (FWA) through gaming medical loss ratio (MLR) limits, inflating patient risk scores, and steering patients within the integrated organization.
- Mitigation strategies include improving data transparency, updating MLR requirements, creating federal guidance on beneficial integration, increasing enforcement of antitrust laws, and updating or implementing Corporate Practice of Medicine (CPOM) laws.

Potential for Fraud, Waste, and Abuse (FWA)

Despite some potential benefits, there are three ways vertical integration may increase the risk of FWA. First, vertically integrated organizations may shift profits to provider subsidiaries to ***game the medical loss ratio (MLR) limits*** that apply to MA plans and avoid government oversight.[11,12,13] The current MLR threshold is 85%, which means that MA plans must spend at least 85% of their revenue on patient care and quality improvement.[14] If an MA plan fails to meet the MLR threshold for 3 or more consecutive years, the Centers for Medicare & Medicaid Services (CMS) can require the plan to repay the difference or it can issue sanctions, like prohibiting new enrollment.[15,16] Vertically integrated MA plans could game the system by paying higher prices to their own providers relative to others in the same market and by increasing the amount categorized as medical spending, thereby artificially inflating their MLR.[17,18,19] By making higher internal payments, MA plans can mask profits and increase spending without improving quality or delivering more care, which may contribute to FWA in MA.[20] MA plans can then exploit their market power by increasing premiums to cover the apparently higher medical costs.[21] There are similar concerns about MLR limits driving vertical integration and higher provider payments in Marketplace plans where there are similar MLR limits.[22]

Second, vertically integrated entities can ***inflate patient risk scores*** because they may have more influence over providers' coding practices. This can be achieved by implementing coding protocols, embedding prompts in medical record systems, incentivizing aggressive documentation, or conducting retrospective chart reviews to identify every possible condition that can increase a beneficiary's risk score and associated payments from Medicare (see Coding Intensity section).[23] For example, two years after physicians were employed by corporate primary care practices, which often have risk-based or ownership arrangements with MA organizations, their patients' risk scores increased by 25% without additional evidence of increased health care utilization.[24] Vertically integrated MA organizations' greater level of control over medical charts also offers more opportunity to align charts with encounter data, thereby reducing the chance that MA risk adjustment data validation audits will identify unsupported diagnoses and weakening the audits as a tool for combatting inappropriate coding.

One payment arrangement that can accelerate inflation of patient risk scores is sub-capitation, a subset of global capitation where MA plans pay a provider group a set fee upfront, and the provider group then pays its own physicians on a capitated basis.[25] This arrangement is typically structured as a percentage of premium, meaning that as coding intensity increases, Medicare's payment (or premium) to the plan increases, and with it the provider's revenue also increases. The provider may have an incentive to increase coding intensity because it also increases the

sub-capitated payment. Although upcoding is a concern in any sub-capitation arrangement, the risks are greater if the MA organization owns the provider organization because it also carries the risks of MLR gaming and price inflation due to the fact that the entire sub-capitation payment to a contracted provider for clinical services is considered patient care even if it contributes profits to the provider arm of the MA organization.[26]

Third, vertically integrated MA plans may generate "captive revenue" by ***steering their beneficiaries toward their affiliated health care providers,*** or by providers steering their patients to the integrated MA plan. This steering may introduce concerns about conflicts of interest and legal risks related to the federal Anti-Kickback Statute and the Stark Law on physician self-referrals.[27,28,29] Similar to practices that can occur within large provider systems and other limited provider networks, steering within vertically integrated MA plans can restrict patient choice and access and potentially drive up health care costs, producing waste.[30] In addition, steering within vertically integrated plans can adversely affect competition, both for unaffiliated providers that may receive fewer (or more costly) referrals, lower rates, and potentially other unfavorable contract terms, and for rival payers that may face higher provider costs.[31] Risks may increase if competitor information held by a business unit is shared with other parts of the vertically integrated organization, or if sharing of critical patient data outside the organization is blocked.[32,33]

Mitigation Approaches

Improve Data Transparency. There is a lack of understanding concerning the way that vertically integrated MA plans operate, including internal payment data and the scale and impact that vertical integration may have on MLRs. Currently, as part of their bids MA plans directly report to CMS on their arrangements with related parties, including services provided by related parties and how prices for those services compare to costs in the absence of related parties.[34] A policy option for addressing this issue is ***requiring vertically integrated MA plans to disclose and publicly report*** detailed information on any department or subsidiary that provides medical services or products as well as information on payments to providers. [35,36,37,38,39,40,41] Payment information could include transfer prices, which are the internal prices that MA plans pay their affiliated providers, and non-claims or incentive-based payments to affiliated providers. Members of Congress attempted to pass legislation that would require reporting to the Secretary of Health and Human Services as well as some public reporting on ownership, transfer prices, incentive-based payments, and loss recoupment by corporations that own health systems.[42,43] A transparent reporting requirement policy option could be implemented at the federal or state level.[44,45] If applied to MA plans, enhanced transparency could reveal potential conflicts of interest and help antitrust enforcement agencies track patterns of anticompetitive behavior or instances of MLR manipulations to reduce fraud and abuse in

MA.[46] Information on contracts between vertically integrated providers and rival payers could also provide better data on the anticompetitive impacts of vertical integration.[47] Streamlined reporting requirements for small transactions would help enforcement agencies track patterns where multiple small acquisitions contribute to vertical integration.[48]

Update MLR requirements. One policy option is for ***CMS to establish benchmarks for reasonable transfer prices***.[49,50] CMS could use prices from Traditional Medicare (TM) fee schedules as transfer prices, or CMS and MA plans could prospectively develop advance pricing agreements that establish approved methods and pricing for transfer prices.[51] This could occur through an application process whereby MA plans propose their transfer pricing approach and include financial records on how they priced health care procedures in the past.[52] CMS could then review and negotiate with the MA plan about its approach.[53] Any approach that requires MA organizations to use a particular price structure for provider payments is likely to require Congressional action to amend the non-interference clause in the Social Security Act that prohibits CMS from requiring a particular price structure.[54] There are several weaknesses with this option, including difficulties in identifying owned entities, determining appropriate profit margins, and breaking out prices when MA organizations use many different approaches to paying providers, such as salaried employees, capitation, and fee-for-service contracts. Price negotiations between CMS and MA organizations for all contracts also would be very resource intensive. In addition, it is not certain that this option would reduce waste because prices may be set too high, and such an approach could also reduce MA plans' ability to pay higher rates based on quality.

Another policy option is for ***CMS to implement a separate sub-capitated MLR reporting requirement.*** MA plans can pay affiliated providers through sub-capitation or other non-claims payments that essentially transfer some of the insurance risk and profit to the provider. Under MA's current MLR rules, payments to affiliated providers count as medical spending even if the parent company realizes profits from its affiliated provider organization.[55] Similar to the previous option, the disclosure of pricing and mandatory reporting could reduce the ability of vertically integrated MA plans to artificially inflate their MLRs through sub-capitated payments. However, it is not certain that this option alone would reduce waste because the incentives for coding intensity would remain, and it may increase the incentive for engaging in overutilization.

Congress could ***raise the MLR for all MA plans*** to ensure that public funds are spent on care rather than on other activities.[56] A related option could involve raising the MLR standards just for vertically integrated MA plans. However, it is unlikely that higher MLRs would reduce waste or abuse specifically associated with vertically integrated plans, because higher MLRs would increase the incentives to code intensively to maximize payments and engage in unnecessary or overpriced utilization.[57]

Congress also could require that ***MLR standards be expressed as a dollar value per beneficiary*** rather than as a percentage of MA organization revenue. For example, currently, an MA plan receiving a per-beneficiary per-month (PBPM) payment of $1,200 for beneficiaries with an average risk score of 1.0 would have an MLR of $1,020, meaning the plan can spend up to $180 PBPM on non-medical costs/profits. If the same MA plan has beneficiaries with an average risk score of 1.2, the payment would be $1,440 and MLR would be $1,224, meaning that the plan can spend up to $216 PBPM on non-medical costs. Similarly, the average allowance for non-medical costs is much higher in absolute value for plans operating in counties with higher benchmarks or for plans with higher Star Ratings. For example, where the rate is $1,500 PBPM and beneficiaries have an average risk score of 1.0, the MLR is $1,275 and the plan can spend up to $225 on non-medical costs. Expressing the MLR requirement as a dollar value (e.g., an average non-medical cost limit of $180 PBPM) would reduce the profitability of intensive coding. However, it may not reduce the incentive for vertical integration because additional profits beyond the limit could still be hidden if realized by the provider arm of the organization. For this policy to be implemented, CMS, Congress, or other government entities would need to set the initial amount and determine how to adjust for inflation and regional cost differences.

Create federal guidance on beneficial integration. To reduce the fraud, waste, and abuse risks from vertical payer-provider integration, CMS, Congress, the Department of Justice (DOJ), and the Federal Trade Commission (FTC) could ***define the characteristics of beneficial integration***.[58,59] This could include issuing formal guidelines that distinguish high-value consolidation or integration from arrangements that may undermine competition or the quality of care.[60,61] Congress could allocate resources to analyze existing vertically integrated relationships to determine what characteristics of integration are associated with improved outcomes, and agencies could develop best practice guidelines.[62] The agencies could then evaluate new integration proposals against the guidelines, monitor adherence to the guidelines, and potentially enforce noncompliance. A related option would be to offer payment incentives to encourage consolidated organizations to adopt and follow the guidelines.[63] One weakness of this policy option is that it could incentivize consolidated organizations to follow the recommended guideline at the expense of other innovations to improve clinical practice.[64] It also could be costly to implement, and the extent to which it would reduce FWA is unknown.

Increase enforcement of antitrust laws. In December 2023, the DOJ and FTC updated their merger guidelines to include stronger standards for merger review, which included serial acquisitions and patterns of consolidation that can create market power or reduce competition.[65,66] In May 2024, the DOJ created a Task Force on Health Care Monopolies and Collusion, signaling increased interest in addressing competition in health care markets.[67,68] Options for enforcement actions could include breaking up large integrated systems,[69] or requiring vertically integrated organizations to divest either their insurance or provider

entities.[70] However, such breakups would be technically difficult to achieve, and likely to face significant opposition.

To strengthen enforcement, ***Congress could direct more resources to supporting antitrust enforcement and give more authority to antitrust regulators***.[71,72,73,74] For example, Congress could change the law to enable the FTC to enforce prohibitions against anticompetitive conduct by not-for-profit firms, which carry the same vertical integration risks as for-profit health care firms; alter the standard for competitive harm; and change the criteria for presuming that a merger or conduct is illegal.[75] Antitrust laws also can be enforced at the state level. Several states have established requirements and enforcement agencies dedicated to health care transactions.[76,77,78,79] These state-level requirements range from giving notice to needing approval from the state before a consolidation transaction.[80] It is unclear whether state efforts to enforce antitrust laws have successfully decreased fraud and abuse in MA.[81]

A more aggressive policy option is ***banning payer-provider vertical integration practices***.[82,83,84] Some experts advocate for a vertical consolidation policy that would prohibit insurers and pharmacy benefit managers from owning pharmacies and also prohibit insurers from owning medical providers.[85,86] The policy would be modeled after the now-repealed Glass-Steagall Act that prohibited banks from being both commercial and investment banks because of possible conflicts of interest.[87,88] A health care consolidation policy would formally challenge vertical integration in the health care sector and recognize the conflict and risk associated with a single entity being both a provider and a payer.[89] This also has parallels in the Stark Law, which prohibits physicians from referring patients to providers in which they have a financial interest.[90] The proposed Patients Over Profits Act and the Break Up Big Medicine Act would make it unlawful for any person or entity to simultaneously own or control a health insurance issuer and a service provider.[91,92,93] Restricting ownership structures could reduce anticompetitive behavior and conflicts of interest.[94] However, there would be significant implementation challenges because of the high degree of vertical integration in the market currently, which affects all health insurance markets, not just MA. In addition, Congress would have to amend the Medicare law within the Social Security Act to implement prohibitions against ownership structures.[95]

Update or implement corporate practice of medicine (CPOM) laws to reduce risks associated with vertical integration.[96,97,98] CPOM laws generally block unlicensed individuals and lay corporations from owning, employing, or controlling physician and medical practices.[99] As a workaround to CPOM laws, many corporate entities have a professional corporation (PC) or a management services organization (MSO) model.[100,101] CPOM laws require PCs to be mostly owned by a physician, and the PC controls clinical decisions. MSOs help medical practices with administrative services.[102] In an extreme version of the PC-MSO model, the MSO contracts with

a physician who has a financial interest in the MSO.[103] The contract narrowly defines clinical decisions that the physician would have a say in while the MSO controls all other business and administrative decisions.[104] By enforcing physician control, CPOM laws may reduce the risk of upcoding or unnecessary procedures and conflicts of interest between insurers and their provider networks that can contribute to FWA in MA.

Several states have attempted to pass updated CPOM laws.[105,106,107,108] For example, Oregon attempted to place guardrails around the PC-MSO model specifically.[109,110] The proposed bill listed activities that PCs would have ultimate control over, such as coding practices, staffing, and patient time, and provided examples of prohibited partnerships that give control to MSOs, such as stock transfer restriction agreements and dual ownerships.[111,112] The updated law would give the state the authority to block health care transactions that violate CPOM laws but it would not provide resources to monitor, investigate, or bring action to enforce compliance with existing partnerships.[113]

Another policy option that can be implemented at the state or federal level is ***prohibiting certain contract provisions between providers and payers*** that could increase the risk of FWA.[114] Prohibited contract provisions might include noncompete agreements, gag clauses or other mechanisms that prevent sharing information with patients about provider cost and quality, and a physician's ability to control shares of their practice.[115,116] By protecting physician control, contracting laws may reduce the risk of upcoding and unnecessary procedures as well as conflicts of interest between insurer and provider networks that contribute to fraud, waste, and abuse in MA.

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