AMGA
Advancing High Performance Health

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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Brooks-LaSure,

On behalf of the AMGA and its members, I appreciate the opportunity to comment on the "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs" (CMS-4192-P).

Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for over one in three Americans. Our members work diligently to provide innovative, high-quality, patient-centered care in an efficient and cost-effective manner. Many of our member medical groups participate in the Medicare Advantage (MA) program, both under contract with MA plans and via their own sponsored MA plan offerings. AMGA is pleased to offer the following recommendations for your consideration.

Key Recommendations

Network Adequacy: AMGA recommends that CMS finalize its proposal to require Medicare Advantage Organizations (MAOs) submit their proposed provider networks as part of their applications.

Medical Loss Ratio Reporting: AMGA recommends that CMS finalize its proposal to require MAOs to provide more detailed information as part of their medical loss ratio (MLR) submissions.

Health Risk Assessments: CMS should emphasize that its proposal to add questions regarding social determinants of health to plan Health Risk Assessments (HRAs) would help inform, but not direct, a provider's plan of care.

AMGA's full recommendations on the proposed rule are below.

Medicare Advantage and Cost Plan Network Adequacy
In earlier rulemaking, CMS eliminated a requirement that MAOs demonstrate their provider

networks meet adequacy requirements. MAOs must ensure that at least 85% of beneficiaries in micropolitan or rural counties, as well as counties with extreme access conditions have access to at least one provider/facility of each specialty type within the published time and distance standards. As part of the change effective for CY 2019, CMS allowed MAOs to attest to compliance with the network adequacy standards, rather than requiring them to demonstrate compliance as part of the application process. Since the change, as part of its review of the networks, CMS found deficiencies in some MA plans' provider networks. To correct for this problem, CMS now is proposing to require MAOs to submit their proposed contracted network. AMGA agrees with this change and recommends that CMS finalize the proposal.

AMGA in earlier comments[1] recommended that CMS monitor for MA network adequacy to ensure that plans have a sufficient number of providers and facilities to ensure adequate access for beneficiaries. Given the issues with network adequacy that CMS identified, AMGA agrees that MA plans should submit their proposed networks as part of the application process. CMS is not proposing to implement this requirement until the 2024 application cycle, which will provide plans with sufficient time to prepare for the change.

Greater Transparency in Medical Loss Ratio Reporting

CMS is proposing to reinstate MLR reporting requirements that were in effect for contract years 2014 to 2017. Beginning in 2018, CMS streamlined the reporting requirements for MLR and only required that plans report seven elements: contract year, contract number, organization, name, date MLR form finalized, contract information, adjusted MLR, and MLR rebate amount owed. Now, CMS is proposing to require plans to report the more detailed information that was previously required as part of an effort to better assess the accuracy of MLR submissions. Under the revised standard, plans would provide underlying data such as incurred claims, total revenues, and expenditures on quality improvement activities, non-claims costs, and regulatory fees. CMS also is proposing to require MA organizations to report the amounts spent on supplemental benefits that are not available under original Medicare. In addition, the proposed rule would require plans to report additional information related to plan expenditures to assess the accuracy of submissions, the value of services provided by the plan, and the impact of recent changes to remove limitations on expenditures that count toward the 85% MLR requirement.

AMGA recommends that CMS finalize its proposal to require MAOs to provide more detailed information as part of their MLR submissions. However, it is important that CMS clarify how health plans should capture and report such information, as a claims-based reporting framework may not be appropriate for all supplemental benefits. Instead, using a per member per month (PMPM) reporting system would better illustrate what financial support a plan is providing for such benefits.

Health Risk Assessments

The proposed rule would require all Special Needs Plans (SNPs) to include one or more standardized questions as part of their HRAs. As proposed, CMS would require that all SNPs, beginning in 2024, include in their HRAs at least one standardized question on each of the following topics: housing stability, food security, and access to transportation.

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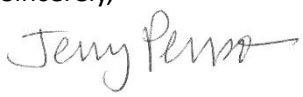
[1] AMGA Comments on Calendar Year (CY) 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program; Medicare Prescription Drug Benefit Program (CMS-4190-P), April 6, 2020

Asking patients about their social needs as part of a comprehensive risk assessment will help form a complete picture of the risk factors that may inhibit beneficiaries from accessing care. Having a full understanding of patients' needs is an important component of care coordination, and it is particularly critical in any value-based payment arrangement.

It is important that CMS emphasize that the proposed rule would not obligate SNPs or providers to address these unmet social needs, but instead would require plans to consult enrollees on their unmet needs as part of the care plan. CMS noted that it is "not explicitly proposing that SNPs be accountable for resolving all risks identified in these assessment questions, but requires that the results from the initial and annual HRAs be addressed in the individualized care plan." We recommend CMS clarify how the proposed HRA questions will be used and take into consideration any obligations this would require for providers.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Director of Regulatory and Public Policy Darryl Drevna at 703.833.0033 ext. 339 or ddrevna@amga.org.

Sincerely,



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