Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-8000 / (800) 382-2000

BlueCross BlueShield Minnesota

January 16, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4182-P
P.O. Box 8013
Baltimore, MD 21244-8013

Comments submitted electronically via http://www.regulations.gov

Re: Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Services, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)

Dear Administrator Verma:

Blue Cross and Blue Shield of Minnesota (Blue Cross) appreciates the opportunity to comment on recently proposed policy and technical changes to Medicare published on November 28, 2017. Blue Cross is a non-profit health service plan corporation that provides coverage to nearly 2.9 million persons. We are the largest health carrier in Minnesota, providing coverage in both public and private markets including significant membership in Medicare.

Blue Cross is pleased that the Centers for Medicare and Medicaid Services (CMS) is taking stock of existing regulatory requirements in Medicare with a goal to streamline and reduce administrative burdens placed on both plans and providers. We applaud the many proposed changes that will allow us greater flexibility in meeting beneficiary needs and ultimately keep costs manageable both for the individual patient and for the system. Among others, we appreciate CMS' proposals to:

- Issue new Star Rating measures through notice and comment rulemaking and place new measures on display for at least two years;
- Permit the full amount of all fraud prevention, detection, and recovery efforts to be included in quality improvement activities in the numerator of the medical loss ratio calculation;
- Continue default enrollment into D-SNP plans where permitted;
- Narrow the scope of marketing materials subject to CMS review and approval; and
- Eliminate CMS required compliance program training for downstream entities.

As well, we support CMS' interpretation of the Medicare Advantage (MA) statute and regulation that would allow greater flexibility in benefit design as it relates to cost sharing, supplemental benefits, and deductibles for beneficiaries who meet appropriate clinical criteria. This will enable more innovative, patient-centered benefits that will ultimately improve outcomes and lower costs.

As it relates to the details of these proposals and the full breadth of changes contemplated in the proposed rule, Blue Cross strongly supports the responses offered by the Blue Cross and Blue Shield Association, America's Health Insurance Plans, and the Special Needs Plan Alliance. In some cases, this includes recommended alternatives that will address operational concerns or words of caution advising further analysis. We appreciate CMS' continued effort to adopt both payment and administrative policies that support overall viability and long-term sustainability in MA. Minnesota Medicare is undergoing a significant transition that will require an ongoing assessment of our market and the extent to which payment and administrative policies require tweaking. We briefly want to underscore the following:

Meaningful Quality Measurement

Blue Cross appreciates the ongoing attention that CMS has given to the issue of adjusting for socioeconomic status and other social determinants in calculating Star Ratings. We continue to believe a long-term solution is critical considering the minimal impact of the Categorical Adjustment Index as applied. We remind CMS that the Office of the Assistant Secretary for Planning and Evaluation has provided very helpful research as a starting point that confirms dual-eligible status as the most powerful predictor of adverse outcomes. In addition, we urge comparison of "like" plans (e.g., D-SNPs to D-SNPs) as a future direction overall.

Comprehensive Addiction and Recovery Act of 2016 (CARA) Implementation

Blue Cross appreciates CMS' work under new CARA authority to develop a thorough approach to drug management programs in Medicare Part D for beneficiaries who are at risk for prescription drug abuse. As CMS finalizes its approach to implementation, to be most effective in battling this epidemic, we recommend that the agency strive to prioritize effective care management approaches without being overly burdensome, particularly in cases where more immediate (waiting less than six months) or continued (expiring after more than 12 months) lock-ins are clearly appropriate.

We also urge CMS to look at ways to address how care management is impacted by varying state laws. For example, the Minnesota Health Records Act does not allow plans to share drug information prescribed by Doctor A with Doctor B, and vice versa, without patient consent. Instead, doctors can voluntarily access a state-sponsored opioid utilization database to review prescriptions for their patients. This slows down how quickly such information can be shared and acted upon, and often means it is incomplete. In addition, each extra step in the process only increases the likelihood of inaction on the prescriber's part.

Finally, we recommend that beneficiaries designated for lock-in be categorically excluded from the Consumer Assessment of Healthcare Providers and Systems and the Health Outcomes Survey, voluntary disenrollment, and Complaint Tracking Module Star measures as their responses/actions may not appropriately reflect true satisfaction and access to the drug plan.

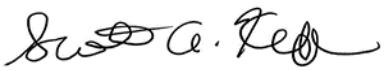
Reducing Provider Burden

Blue Cross appreciates CMS interest in reducing providers' administrative burdens. We also know the critical role of medical records in assuring appropriate Medicare payments through complete and accurate risk adjustment. We look forward to further engagement between CMS and health plans across the industry to address not just how to improve the Risk Adjustment Data Validation audit

process (perhaps limiting tight turnarounds that increase pressure on providers) but also many other existing regulatory audits and requirements that rely on medical records data. Examples would include the Cost plan audit, Model of Care audit, performance audits, monitoring efforts, Fraud, Waste and Abuse investigations, and so forth. As well, we strongly urge CMS to continue to enable and expedite provider adoption of electronic medical records that can automate real-time data exchange as just one important way to alleviate provider burden and leverage efficiencies.

Thank you, as always, for your partnership in ensuring seniors have access to affordable, high quality, seamless health care coverage. We look forward to continuing to partner in innovative ways to best serve the Medicare population in Minnesota.

Sincerely,



Scott Keefer
Vice President, Public Affairs