Blue Cross
Blue Shield
Blue Care Network
of Michigan

Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

March 5, 2017

Demetrious Kouzoukas
Principal Deputy Administrator and Director
Center for Medicare
Center for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted to the Federal Regulations Web Portal: http://www.regulations.gov

**Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 Call Letter**

Dear Mr. Kouzoukas:

Blue Cross Blue Shield of Michigan and Blue Care Network appreciate the opportunity to review and provide comments to the Centers for Medicare & Medicaid Services on the **CY 2019 Advance Notice and Draft Call Letter for Part C and Part D.**

BCSBM has more than 468,000 members enrolled in our Medicare Advantage and Part D plans and has an overall rating of 4 stars. Our HMO, Blue Care Network (BCN), has approximately 88,000 members and an overall rating of 4 stars. Our combined group membership is approximately 382,000 members, many of whom include retired city and state employees. With many years of combined individual and group Medicare experience, we look forward to continuing to partner with CMS to improve member satisfaction and quality outcomes in the Medicare program.

This letter highlights our key concerns and recommendations in response to the CY 2019 Advance Notice and Draft Call Letter.

One issue that is of utmost importance to BCBSM is the payment policy for MA employer/union-only group waiver plans.

**MA Employer Group Waiver Plans**

For 2019, CMS is proposing to fully transition to using only individual market plan bids to calculate the bid-to-benchmark ratios to set MA EGWP payments, as initially discussed in the 2017 Advance Notice and Rate Announcement. CMS also intends to continue to waive the Bid Pricing Tool bidding requirements for all MA EGWPs in 2019.

In 2017, CMS proposed an alternate payment policy in exchange for waiving bidding requirements for all MA EGWPs. The EGWP payment policy was partially implemented, such that 50% EGWP funding was based on 2016 EGWP bid-to-benchmark ratios and 50% of EGWP funding was based on 2016 individual market plan bid-to-benchmark

ratios. In 2018, CMS delayed full implementation of the new payment methodology, maintaining the 50/50 blend.

The alternate payment policy has reduced EGWP funding, putting pressure on benefits, out-of-pocket costs for beneficiaries and on groups' ability to maintain retiree coverage. The significant reduction in payment to MA group plans far outweighs the purported administrative benefits of no longer submitting bids. **Therefore, BCBSM strongly urges CMS to avoid any further negative impacts to MA groups and maintain the blended approach to the EGWP payment policy that applied in 2017 and 2018.**

In addition, CMS is considering making an adjustment to the payment methodology to account for the proportion of Health Maintenance Organization and Preferred Provider Organization beneficiaries enrolled in EGWPs. Because most EGWPs are PPOs, we believe this additional step would provide a more precise comparison to the utilization that occurs in EGWPs. To even more accurately reflect the cost differences in PPO and HMO plans, we recommend CMS base Group PPO payments off individual PPO bid-to-benchmark ratios and Group HMO payments off individual HMO bid-to-benchmark ratios. **BCBSM believes this is a critical step to accurately funding EGWPs and we strongly encourage CMS to implement the payment adjustment regardless of full or partial implementation of the alternate payment policy mentioned above.**

In addition to this important issue and the recommendations above, additional feedback regarding the CY 2019 Advance Notice and Draft Call Letter is outlined in Attachment A. If you have any questions or would like further information about the information provided, please contact please contact Krischa Winright, Senior Vice President, at kwinright@bcbsm.com. BCBSM looks forward to continuing its partnership with CMS in the Part C and D programs. Thank you again for the opportunity to provide feedback.

Sincerely,

Krischa Winright,
Senior Vice President, Business Performance & Development

**ATTACHMENT A**

In addition to our primary concerns outlined in the cover letter, BCBSM would like to provide feedback on the following other important issues.

**CY 2019 Advance Notice Part I**

**CMS Proposal:** In response to the 21st Century Cures Act requirement, CMS is proposing changes to the CMS-HCC Risk Adjustment Model beginning in 2019.

**BCBSM Comments: We strongly recommend that CMS delay the start of implementation of a new model until 2020, and continue to engage with plans to determine the best model for 2020 and future years. By the time a decision is made regarding the 2019 model, nearly half of the 2018 encounter year will have concluded. Plans will need more time to adjust and implement the new model. We are also concerned that significant model changes will require provider education, furthering the need for the new model implementation to begin in 2020, rather than 2019.**

**Lastly, CMS quality program Display Measures communicate potential future changes to Star Measures. We recommend similar methodology be used for changes in the Risk Adjustment model.**

**CMS Proposal:** In response to the 21st Century Cures Act requirement, CMS is proposing updating the data years used to calibrate the risk adjustment model. In addition to updating the data CMS proposes to select 2014 diagnoses for calibration using the same approach used to filer encounter data.

**BCBSM Comments:** We support CMS's proposal of using the encounter data filtration logic to calibrate the FFS risk score. We believe applying the same filtration logic equates to more consistency in risk score calculation. While we support the model, calibration using encounter data logic, we ask CMS to consider calibrating the model using Medicare Advantage data as opposed to FFS data. We feel this change will also equate to more consistency in the model and risk scores. We ask CMS take into consideration the April 2016 MedPAC public meeting discussion where MedPAC indicates support of using MA data to calibrate a risk adjustment model.

**CY 2019 Advance Notice Part II**

**CMS Proposal:** CMS proposes to apply two separate normalization factors calculated using a linear methodology.

**BCBSM Comments:** We recommend CMS use 2011 to 2017 data to determine the normalization factor because 2016 and 2017 data are outliers, the risk score increases appear to be stemming from the use of ICD-10 codes, and as a general principle, CMS should use more data points in order to have more stable estimates of normalization. Using the 2013 to 2017 data points runs the risk of over normalizing for 2019 by setting the normalization factor too high. We are concerned that CMS is placing too much weight on the ICD-10 codes by not using the 2011 and 2012 data points to estimate the normalization trend.

**CMS Proposal:** CMS proposes to keep the basic structure of the ESRD model the same. CMS proposes to maintain the same clinical version as well as retain separate co-efficient for dialysis, transplant, and post-graft beneficiaries.

**BCBSM Comments:** We have concerns that health plans will not be properly reimbursed for members in the ESRD model. In the Michigan market, and nationwide, it is common for one or two dialysis companies to own the vast majority of dialysis centers. With little incentive to negotiate with health plans, dialysis companies command much higher rates for dialysis than the FFS Medicare payments that are the basis for risk adjustment. We are concerned CMS is not taking these types of payment arrangements into consideration.

We also recommend that CMS amend how it applies new enrollee factors. Currently, a new enrollee factor is applied if a member does not have twelve months of Part B enrollment. Individuals who are new to Medicare Advantage with ESRD, who were previously unable to enroll, will be able to enroll in Medicare Advantage as soon as they become Medicare eligible, beginning in 2021. Since this scenario is new to health plans we ask CMS to account for this situation. Our recommendation is to allow members to become full risk eligible if an HCC is identified during the calendar year; if no HCCs are identified a new enrollee factor would be applied.

**CMS Proposal:** CMS proposes to expand the scope of the primary health related supplemental benefit standard.

**BCBSM Comments:** We supports this, but also request more details and guidance on expansion.

## CY 2019 Draft Call Letter

**CMS Proposal:** CMS currently requires organizations that have more than five program audit conditions in their final audit report to hire an independent auditing firm to conduct a validation audit. CMS is seeking comments on whether this threshold should be increased or decreased or limited to conditions that may cause adverse impacts to beneficiaries.

CMS proposes to modify the threshold used to determine when a sponsoring organization must hire an independent auditing firm. CMS intends to exclude Compliance Program Effectiveness (CPE) conditions from the threshold calculation. Sponsoring organizations with more than five non-CPE conditions cited in their final audit report will be required to hire an independent auditing firm. CMS will conduct the validation audits of sponsoring organizations that fall below this proposed threshold.

**BCBSM Comments:** We support the proposal to exclude CPE conditions in the threshold calculation. We feel that the inclusion of CPE conditions in the validation may be problematic in how it can be evidenced during virtual testing. We also recommend that CMS only include conditions that would have beneficiary impact in its threshold.

**CMS Proposal:** Regarding, enforcement actions for provider directories, CMS reminds plans that Civil Money Penalties (CMPs) and other enforcement actions may be imposed against MAOs that have received a compliance notice or notices for violations that have gone uncorrected. CMS has the discretion to take enforcement actions where egregious instance of non-compliance are discovered. If CMPs are imposed for provider directory errors, penalty amounts would initially be calculated on a per determination basis.

**BCBSM Comments: BCBSM recommends that CMS engage with MA plans, providers and other stakeholder to develop a national solution. It is in the best**

**interests of consumers, providers and plans for provider directories to have the best possible information. The current situation, though, is challenging for both providers, who receive requests from a wide array of plans, and for plans, who receive inconsistent information from provider offices due to the complexity. We would like to see a national solution, potentially utilizing standard transactions for provider directory information to simplify the dynamic for providers and plans, and ensure that current, accurate information is available for consumers.**

**CMS Proposal:** CMS is considering allowing sponsoring organizations that have undergone a program audit to treat the program audit as meeting the annual compliance program audit requirement in 42 CFR 422.503(b)(4)(vi)(F), 423.504(b)(4)(vi)(F) for one year from the date of the CMS program audit.

**BCBSM Comment:** We agree that a program audit should count toward the annual audit of CPE for the calendar year in which the program audit was conducted. Additionally, if an annual audit of CPE was conducted prior to a program audit in a calendar year, the program audit should exclude the CPE portion.