

BLUE CROSS AND BLUE SHIELD OF MINNESOTA (BCBSMN) COMMENTS

**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**

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CMS PROPOSAL	BCBSMN COMMENTS
ADVANCE NOTICE PART I	
<p><u>Taking into Account the Number of Conditions of an Individual (pp. 12-20)</u></p> <p>The 21st Century Cures Act directs the Centers for Medicare & Medicaid Services (CMS) to take into account the total number of diseases or conditions of an individual enrolled in an MA plan and states that CMS shall make an additional adjustment as the number of diseases or conditions of an individual increases. Statute states that CMS must phase-in any changes to risk adjustment (including this change and previously listed changes, such as adding new codes), “over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.”</p> <p>CMS considered two ways to add a count of beneficiary conditions to the model and assessed these based on the ability to accurately differentiate between high- and low-cost beneficiaries and ultimately proposed to use the “Payment Condition Count Model”. This model counts all HCCs in the 2017 CMS-HCC model (as opposed to the alternative model that was considered, which counted all payment <u>and</u> non-payment HCCs).</p> <p>CMS interpreted statute to mean that it must start to implement all changes to the model in 2019 to be completed in 2022. The proposed phase-in schedule is as follows:</p> <ul style="list-style-type: none">• 2019: Payment Condition Count HCC model 25%/ 2017 CMS-HCC model 75%• 2020: Payment Condition Count HCC model 50%/ 2017 CMS-HCC model 50%• 2021: Payment Condition Count HCC model 75%/ 2017 CMS-HCC model 25%• 2022: Payment Condition Count HCC model 100%/ 2017 CMS-HCC model N/A (fully phased-in)	<p>BCBSMN supports postponing phase-in of the Payment Condition Count model as the goal of these model changes is to improve risk adjustment for those with chronic conditions and it is not clear that this improvement will result. Further time is needed to evaluate the proposed options. In particular, BCBSMN requests that the risk scores of current Cost plan members (that will be part of the transition to Medicare Advantage in 2019) be included in the data package released to evaluate any proposed changes. Moreover, even after adjusting for risk scores, we believe that MA benchmarks are held lower because Cost plan members are not included in the benchmark calculation. Understanding this dynamic is critical as Minnesota’s population ages and more baby boomers become Medicare eligible.</p>
<p><u>Encounter Data as a Diagnosis Source for 2019 (pp. 23-24)</u></p> <p>For Plan Year (PY) 2019, CMS proposes to increase the proportion of the CMS-HCC model that is based on encounter data from 15% to 25%. CMS would calculate risk scores by adding 25% of the risk score calculated using diagnoses from encounter data and fee-for-service (FFS) diagnoses with 75% of the risk score calculated with diagnoses from the Risk Adjustment Process System (RAPS) and FFS diagnoses.</p>	<p>Given continued concerns regarding inaccuracies in the Encounter Data Processing System (EDPS), BCBSMN supports going back to 0% weighting of encounter data. We are particularly hesitant for encounter data to proceed at any level given concerns regarding data quality raised in the January 2017 GAO report entitled “Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments” and even more recent January 2018 OIG report entitled "Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed" as well as findings from Milliman which show that 50% of MA plans have EDPS scores more than 5% below RAPS risk scores.</p>
ADVANCE NOTICE PART II AND DRAFT CALL LETTER	

CMS PROPOSAL	BCBSMN COMMENTS
Attachment II. Changes in the Part C Payment Methodology for CY 2019	
<p><u>A5. Cap on Benchmarks (pp. 13-14)</u></p> <p>CMS states that it will continue to enforce the cap on the blended benchmarks at the county level. Under this proposal, an MA plan’s blended benchmark, inclusive of any Quality Bonus Payment (QBP), cannot exceed the Applicable Amount for the applicable county under Section 1853(k)(1) of the Social Security Act (the pre-ACA benchmark amount).</p>	<p>BCBSMN continues to strongly support removal of the ACA cap for county benchmarks. We remain especially concerned with the cap given that its determination takes place after application of any quality bonus. Capping QBP undermines CMS’ own Star Ratings incentives and limits the benefits plans are able to offer to Medicare beneficiaries.</p>
<p><u>Section G. MA Employer Group Waiver Plans (EGWPs) (pp. 25-30)</u></p> <p>CMS is proposing to fully phase-in a new payment methodology that was introduced in 2017. Under this approach, EGWP payments for 2019 would be solely based on non-EGWP bid-to-benchmark ratios. However, EGWP payments for 2017 and 2018 have been calculated using a blend of EGWP and non-EGWP bid-to-benchmark ratios, and CMS indicates it is considering maintaining this same 50/50 blend for 2019. In addition, CMS is seeking comment on making an adjustment to account for the fact that EGWP enrollees tend to be disproportionally in Preferred Provider Organizations (PPOs) and not Health Maintenance Organizations (HMOs).</p>	<p>In response to the 2017 and 2018 Rate Announcements, BCBSMN expressed concern that the proposed payment methodology was likely to reduce overall payments to EGWPs with premium increases and/or benefit reductions passed on to members as well as possible adverse selection against employer group business.</p> <p>Our concerns have been borne out by the industry experience to date with reductions being passed on to beneficiaries in the form of substantially higher premiums and out-of-pocket costs and/or elimination of popular benefits like dental, vision, hearing and fitness memberships. In addition, some employer groups have moved beneficiaries to Medicare Supplement coverage or dropped coverage altogether – disrupting benefits, interrupting care plans, and interfering with patient-provider relationships.</p> <p>BCBSMN cautions that if changes to EGWP payments are not reversed the negative impact on MA group coverage will be even more severe in 2019, and may compound in future years making MA a less stable and viable option for employers.</p> <p>If CMS continues down its current path, BCBSMN encourages continued weighting of individual market plan bids at 50% and EGWP bids at 50% to determine the bid-to-benchmark ratios. As well, we strongly support an adjustment be made to the calculation used to determine the bid-to-benchmark ratios to account for the difference in the proportion of beneficiaries enrolled in HMO vs. PPO plan types between EGWPs and individual-market plans.</p>
<p><u>Section J. Frailty Adjustment for PACE Organizations and FIDE SNPs (pp. 34-35)</u></p> <p>Table II-4 outlines the frailty factors for Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) for Non-Medicaid and Medicaid beneficiaries based on activities of daily living (ADL) needs. These range from -0.078 for non-Medicaid with 0 ADL support needs to 0.371 frailty adjustment for Medicaid beneficiaries with 5-6 ADL needs.</p>	<p>BCBSMN appreciates recognition by CMS of the impact of frailty and the effect on costs which is not captured by the HCC model. This has made an important difference in adjusting payment appropriately.</p> <p>With respect to the timing of the frailty factor, we propose that CMS calculate and distribute this adjustment to plans prior to bid submission. This would allow plans to include the adjustment in pricing, which could buy-down additional supplemental benefits for members. At present, plans must decide</p>

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	<p>whether to include this all or nothing factor in the bid, which can have a large impact to revenue. If a plan includes the factor and does not end up receiving the adjustment, it could be placed in a negative margin position. If a plan does not include the factor but receives the adjustment, it could receive an increase in revenue that could have been used to provide extra benefits for the member.</p> <p>Additionally, we question use of the Modified Health Outcomes Survey (HOS-M) as an effective tool to determine frailty. Among our concerns with the use of HOS-M are the very small sample size and known challenges with self-reporting.</p>
<p><u>Section K. Medicare Advantage Coding Pattern Adjustment (pp. 35-36)</u></p> <p>For 2019, CMS proposes to apply the statutory minimum MA coding pattern adjustment of 5.90%. CMS is considering three alternative methodologies to inform its final decision regarding the Coding Intensity Adjustment for PY 2019.</p>	<p>BCBSMN supports CMS' decision to implement the statutory minimum adjustment for coding intensity and requests further opportunity to consider and comment on any alternative methodologies with evidence suggesting that the actual impact of coding intensity varies widely by region due to provider practice patterns (e.g., the 2017 New England Journal of Medicine study of diagnostic imaging).</p>
<p><u>Section N. Encounter Data as a Diagnosis Source for 2019 (pp. 42-43)</u></p> <p>For 2019, CMS is proposing to increase the percentage of risk scores based on diagnoses submitted through EDPS to 25 percent, up from 15 percent in 2018. CMS is also proposing to supplement encounter data-based risk scores with inpatient diagnoses submitted to RAPS. In addition, as described above, CMS is further proposing to use only encounter data in the 2019 Payment Condition Count risk model, which would be phased in over the four-year period from 2019 to 2022 by increasing the new risk model by 25 percent each year. By solely using encounter data in the new risk model, CMS would therefore also be fully phasing in the use of encounter data for risk adjustment by 2022.</p>	<p>Given continued concerns regarding inaccuracies in EDPS, BCBSMN supports going back to 0% weighting of encounter data. We are particularly hesitant for encounter data to proceed at any level given concerns regarding data quality raised in the January 2017 GAO report entitled "Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments" and even more recent January 2018 OIG report entitled "Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed" as well as findings from Milliman which show that 50% of MA plans have EDPS scores more than 5% below RAPS risk scores.</p> <p>Supplementing EDPS data with RAPS inpatient diagnosis codes conflicts with phasing in the blend on EDPS, which is intended to influence the improvement and usability of EDPS data. BCBSMN encourages an adjustment to the EDPS portion of the blended risk score that is done on a plan-specific basis. A uniform adjustment would not account for the wide variability of differences between RAPS scores and EDPS scores. Ideally, the factor would be a ratio of RAPS scores to EDPS scores and applied to the EDPS scores to achieve what is essentially a 0% weight at this time. BCBSMN recommends that the adjustment not be applied to new enrollees since diagnosis data is not used in the calculation of their risk scores.</p>
<p><u>Section O. Quality Payment Program</u></p>	<p>BCBSMN supports CMS' intent to allow an additional way for eligible clinicians to become QPs through participation in innovative payment</p>

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<p>As part of implementation of the Other Payer Advanced Alternative Payment Model (APM) component of the MACRA Quality Payment Program (QPP) starting in 2020, CMS will need to work with MA plans and clinicians to obtain information on payment arrangements in order to determine if they qualify as Other Payer Advanced APMs. CMS will do this using both a payer-initiated process and a clinician-initiated process. The payer-initiated process will be voluntary and will be carried out in 2018 prior to the 2019 performance period. As part of the 2019 bid submission, Medicare plans (including MA plans, Cost plans, and Medicare-Medicaid plans) may submit applications to determine if their payment arrangements are Other Payer Advanced APMs. Payers may request Other Payer Advanced APM determinations from August 1 to December 1 of the same year as the relevant Qualifying Participant (QP) Performance Period.</p> <p>CMS is implementing the payer-initiated process prior to 2019 so that it can publicly announce which payment arrangements are Other Payer Advanced APMs prior to the 2019 performance period. The clinician-initiated process will generally occur after the 2019 performance period, when APM Entities and eligible clinicians will be allowed to submit information on payment arrangements that they believe are Other Payer Advanced APMs, but were not identified through the payer-initiated process.</p>	<p>arrangements through Other Payer Advanced APMs. We recommend CMS provide greater detail on the criteria that will be used to determine what qualifies as Other Payer APMs as far as possible in advance of the application due date, including convening industry-wide phone calls or webinars. This will give us time to ensure our programs are aligned to support provider participation.</p>
Attachment III. Changes in the Payment Methodology for Medicare Part D for CY 2019	
<p><u>Section B. Encounter Data as a Diagnosis Source for 2019 (p. 46)</u></p> <p>CMS proposes to use the same approach as that used for CY17: Weighting the risk score calculated with diagnoses from RAPS and FFS at 75% and the risk score calculated with the diagnoses from EDPS and FFS at 25%.</p>	<p>See above comments from Attachment II, Section N.</p>
Attachment VI. Draft CY 2019 Call Letter	
Section I. Parts C and D	
<p><u>New Measures for 2019 Star Ratings (pp. 107-108)</u></p> <p>Statin Use in Persons with Diabetes (SUPD) (Part D). This measure is the percentage of patients between 40 and 75 years old who received at least two diabetes medication fills and also received a statin medication during the measurement period. CMS proposes to add to the 2019 Star Ratings (based on 2017 data) with a weight of 1 for the first year. In subsequent years, CMS proposes a weight of 3 as an intermediate outcome measure.</p>	<p>BCBSMN disagrees with CMS' assessment that SUPD should be considered an intermediate outcome measure. Not only is prescribing a statin medication not a health outcome, but ongoing statin adherence is already measured at a triple weight as part of the existing adherence measures. To move the SUPD to a triple weighted measure would put excessive weight on the use of statin medications as a proportion of overall Star Ratings.</p>
<p><u>Changes to Measures for 2019 (pp. 108-112)</u></p> <ul style="list-style-type: none"> • Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications (Part D). For the 2017 measurement year, CMS proposes to expand its data sources for identifying all Part D enrollees with end-stage renal disease (ESRD) for exclusion from the measure to include ICD-10-CM codes found in both Parts A & B Claims and RAPS RxHCCs along with the Medicare Enrollment Database ESRD indicator that is currently used. • ADH for RAS Antagonists, Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D). CMS proposes to make an adjustment to the Proportion of Days Covered (PDC) 	<p>Medication Adherence (Part D). BCBSMN supports these changes.</p> <p>MPF Price Accuracy (Part D). BCBSMN opposes the addition of a frequency component to the MPF Price Accuracy measure. We suggest that CMS convene a group of experts to assess the most appropriate measurement of MPF Price Accuracy to reflect performance information that is both meaningful to beneficiaries and accurate.</p> <p>Members Choosing to Leave the Plan (Part C & D). BCBSMN supports this change.</p>

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<p>calculation (which applies to inpatient stays and hospice for MA Prescription Drug Plans (PDPs) and stand-alone PDPs and skilled nursing facility [SNF] stays for PDPs) in cases where a beneficiary has consecutive stays where the admission date of the second stay is one day after the discharge date. CMS proposes to concatenate consecutive stays to create a single admission and discharge date for the PDC adjustment.</p> <ul style="list-style-type: none">• MPF Price Accuracy (Part D). CMS proposes enhancements to the Medicare Plan Finder (MPF) Price Accuracy measure to better measure the reliability of a contract's MPF advertised prices. The changes include: 1) Factoring both how much and how often prescription drug event (PDE) prices exceeded the prices reflected on the MPF by calculating a contract's measure score as the mean of the contract's Price Accuracy and Claim Percentage scores; 2) Increasing the claims included in the measure; and 3) Rounding a drug's MPF cost to two decimal places for comparison to its PDE cost.• Members Choosing to Leave the Plan (Part C & D). CMS proposes to expand the exclusions for this measure to include plan benefit package (PBP) service area reductions that result in the unavailability of PBPs that the enrollee is eligible to move to within the contract.	
<p><u>Removal of Measures from Star Ratings (pp. 112-113)</u></p> <p>Beneficiary Access and Performance Problems (BAPP) (Part C & D). For the 2019 Star Ratings, CMS proposes to retire the current BAPP measure. CMS proposes to modify the BAPP measure to only include Compliance Activity Module data, and this revised BAPP measure would be on the display page for 2019 Star Ratings. CMS solicits stakeholders' input on the utility of this measure focused only on notices of non-compliance, warning letters, and ad-hoc corrective action plans and their severity.</p>	BCBSMN supports this change.
<p><u>Proposed Scaled Reductions for Appeals IRE Data Completeness Issues (pp. 114-122)</u></p> <p>In the past, contracts identified during an audit review to have systematic issues with the completeness of Independent Review entity (IRE) data have had their appeals measures reduced to one star. In response to stakeholder concerns with CMS' prior practice, CMS initiated the Timeliness Monitoring Project (TMP) in CY 2017, and all contracts submitted data during the first year of the project. CMS is now proposing statistical criteria to reduce a contract's Star Rating for data that are not complete or lack integrity using TMP data or audit. This methodology would use scaled reductions (1-star, 2-star, 3-star, or 4-star reductions) based on the degree of missing IRE data.</p> <p>CMS' proposed scaled reduction methodology would be a three-stage process using the TMP data or audit to determine:</p> <ol style="list-style-type: none">1. Whether the contract may be subject to a potential reduction for the Part C or Part D appeals measures. CMS lays out the equations to calculate the error rate for Parts C and D and notes that given different lengths of TMP or audit data collected and evaluated (based on contract size), the number of non-forwarded cases in a three-month period per contract is projected by multiplying the number of cases found not to be forwarded by a constant determined by the associated time period and contract size. CMS proposes that contracts would be subject to a possible reduction due to lack of data completeness if both of the following conditions are met:<ol style="list-style-type: none">a. The calculated error rate is 20% or more; andb. The projected number of cases not forwarded to the IRE is at least ten in a three-month period.2. The basis for determination of the estimated error rate.	BCBSMN supports this change.

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<p>3. Whether the estimated value is statistically greater than the cut points for the scaled reductions of one, two, three, or four stars.</p> <p>Once the scaled reduction for a contract is identified using the methodology, the reduction would be applied to the contract's associated appeals measure-level Star Rating.</p>	
<p><u>2019 Star Ratings Program and the Categorical Adjustment Index (pp. 122-126)</u></p> <p>The Categorical Adjustment Index (CAI) was first implemented in the 2017 Star Ratings program as CMS' interim response to address the within-contract disparity in performance associated with a contract's percentages of beneficiaries with low income subsidy and dual eligible (LIS/DE) and disability status. For the 2019 Stars program, CMS is proposing to continue the use of the CAI with no changes to the overall methodology.</p> <p>CMS also provided a 2019 CAI Measure Selection Supplement document, which provides details related to the selection of the adjusted measure set for 2019. In this document, CMS describes its methodology for measure selection and proposes the following measures for adjustment for 2019:</p> <p>Part C (MA-PDs and MA-only)</p> <ul style="list-style-type: none">• Annual Flu Vaccine• Breast Cancer Screening• Diabetes Care- Blood Sugar Controlled• Medication Reconciliation Post-Discharge• Osteoporosis Management in Women who had a Fracture• Plan All-Cause Readmissions <p>Part D (MA-PDs and PDPs)</p> <ul style="list-style-type: none">• Part D Medication Adherence for Hypertension• Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)	<p>BCBSMN would like to reiterate support of the CAI method as an interim LIS/DE and disabled effect adjustment. The adjustments are a welcome engagement to capture the impact of substantive LIS/DE and disabled member populations on plan Star Ratings. However, we have strong concerns that the effect size of the adjustment is much smaller than we believe is appropriate. If the intent of the adjustment is to account for the impact of LIS/DE and disability status on plan performance, the model specification should be refined to bring additional measurable variables into the statistical adjustment. We understand that the initial specification comes from the RAND Corporation research study; however, there are multiple studies that show up to 18 measures that are impacted by low income/disability. We urge CMS to re-engage RAND to improve the model specification, with the intent to include other unmeasured and unaccounted-for variables that were not part of the original research. This will improve the adjustment and have a direct positive impact on SNPs.</p>
<p><u>2019 Categorical Adjustment Index (CAI) Values (pp. 126-132)</u></p>	<p>BCBSMN believes that those eligible for Medicare based on disability should get the disability factor even after age 65 given that it was their original basis for eligibility. The current approach suppresses CAI, particularly for 100% dual plans.</p>
<p><u>Disaster Implications (pp. 133-140)</u></p> <p>CMS proposes to adjust the 2019 and 2020 Star Ratings to account for the effects of extreme and uncontrollable circumstances that occurred during the performance period such as natural disasters (e.g., Hurricanes Harvey, Irma, and Maria and the California wildfires).</p>	<p>BCBSMN appreciates the rationale for this adjustment and understands its necessity. We are concerned, however, that adjusting scores for just these contracts or excluding them from certain measures could raise the cut points for all other contracts. We request that CMS implement these adjustments in a way that holds harmless those contracts not impacted by extreme and uncontrollable circumstances. For example, CMS could include the actual</p>

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<p>CMS proposes adjustments to the Consumer Assessment of Healthcare Providers and Systems (CAHPS), HOS, the Healthcare Effectiveness Data and Information Set (HEDIS), and other Star Ratings. In general, for contracts that operate solely in Puerto Rico, CMS proposes to make the survey optional, whereas for other affected contracts with more than 25% of beneficiaries living in affected areas at the time of the disaster, CMS would use the higher of the 2018 or 2019 Star Ratings.</p> <p>Additionally, when deriving the cut points from the clustering algorithm for non-CAHPS measures, CMS proposes to exclude the numeric values for affected contracts with 60% or more of their enrollees in the FEMA-designated Individual Assistance area at the time of the disaster.</p>	<p>earned scores for these contracts in the curve for setting overall cut points and then adjust for these contracts after the cut points have been calculated.</p>
<p><u>New 2019 Display Measure (pp. 140-141)</u></p> <p>Plan Makes Timely Decisions about Appeals (Part C). CMS proposes for display a new appeals measure which includes cases dismissed by the IRE because the plan has subsequently approved coverage/payment (using 2017 data). CMS proposes to include the modified measure on the 2019 and 2020 display pages and intends to add it for the 2021 Star Ratings.</p>	<p>BCBSMN recommends this be included at a weight of 1 in 2021 and then 1.5 in 2022.</p>
<p><u>Changes to Existing Display Measures (pp. 141-144)</u></p> <ul style="list-style-type: none"> • Hospitalizations for Potentially Preventable Complications (Part C). The National Committee for Quality Assurance (NCQA) is considering updating specifications for this measure to include hospital stays that are considered observation stays. Therefore, CMS will retain as a display measure for 2019, and intends to propose moving it to Star Ratings with a weight of 1 for the 2022 Star Ratings and increase it to a weight of 3 as an outcomes measure in subsequent years. • Antipsychotic Use in Persons with Dementia (APD) (Part D). For the 2017 measurement year, the APD measure includes an overall measurement rate and breakouts for community-only residents and long-term nursing home residents. CMS proposes to display the rates for the two population breakouts on the 2019 display page (in addition to the overall APD rate currently displayed) and will assess adding the APD measure to the Star Ratings in the future. 	<p>Hospitalizations for Potentially Preventable Complications (Part C). BCBSMN is concerned that these are not medically necessary hospital stays, and as such adding them to the technical specifications for HEDIS is problematic. For example, it is not uncommon in rural areas for a physician to admit a patient for observation overnight due to travel risks. As well, many staffing challenges exist in rural areas which might require hospital admission to do something as simple as place an IV.</p> <p>BCBSMN also assumes NCQA has resolved underlying data concerns regarding the number of outliers. Overall, we support delaying inclusion of this measure until 2022 (2020 dates of service) to allow plans the opportunity to better understand the proposed changes to the measure and further discuss with CMS the appropriate treatment of observation stays.</p> <p>APD (Part D). BCBSMN supports separate reporting for community-only (COMM) residents versus long-term nursing home (LTNH) residents.</p>
<p><u>Potential Changes to Existing Measures (pp. 145-148)</u></p> <ul style="list-style-type: none"> • Plan All-Cause Readmissions (Part C). NCQA is exploring several revisions based on feedback from the field and stakeholders that may impact the definition of the denominator, numerator and risk adjustment model. This includes the inclusion of observation stays, revising the denominator to be the overall plan population, and adding death as a factor in risk adjustment. CMS is also proposing to combine the rates for ages 18-64 and ages 65+ for the revised Plan All-Cause Readmissions (PCR) measure. The new revised measure would be part of the display page for 2019 and 2020 before moving to the 2021 Star Ratings with a weight of 1 the first year and 3 thereafter. The current PCR measure would remain in Star Ratings through 2020. 	<p>PCR (Part C). BCBSMN does not agree with the inclusion of observation stays in the PCR measure. Among other things, as noted above a doctor might reasonably admit for observation in rural areas due to travel risks or due to staffing issues (e.g., LPNs cannot start IVs and a lot of places don't have RNs). BCBSMN does support adding death in the measurement year as a factor in the risk adjustment model. We would support death in the measurement year as a measure exclusion, as well.</p> <p>Telehealth and Remote Access Technologies (Part C). BCBSMN supports including telehealth and remote access technology as eligible encounters for Part C quality measures where there is clinical research evidence that supports the use of such remote access technology. BCBSMN</p>

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<ul style="list-style-type: none"> • Telehealth and Remote Access Technologies (Part C). CMS solicits feedback to share with NCQA on the feasibility of and strategies for addressing telehealth services especially regarding the measures currently reported by Medicare contracts. • Cross-Cutting Exclusions for Advanced Illness (Part C). NCQA is evaluating the clinical appropriateness and feasibility of excluding individuals with advanced illness from selected HEDIS measures. • Medication Adherence (ADH) for Cholesterol (Statins) (Part D). The Pharmacy Quality Alliance (PQA) updated this measure for 2018 to exclude beneficiaries with ESRD. CMS proposes to apply this exclusion to the 2020 Star Ratings (based on 2018 data). • Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (CMR) Measure (Part D). The PQA updated this measure for 2018 to include a new denominator exemption. CMS proposes to apply this denominator exception to the 2020 Star Ratings. • Center for Medicare and Medicaid Innovation (CMMI) Model Tests. CMS is considering excluding Value Based Insurance Design (VBID) Model participants' data when calculating the cut points for relevant measures. 	<p>recommends that CMS and NCQA conduct thorough review of the clinical evidence before approving the use of remote technology for specific Part C quality measures.</p> <p>Cross-Cutting Exclusions for Advanced Illness (Part C). BCBSMN strongly supports this change. We are interested in the methodology used to identify qualifying members.</p> <p>ADH for Statins (Part D). BCBSMN supports this change.</p> <p>MTM Completion Rate for CMRs (Part D). BCBSMN supports this change.</p> <p>CMMI Model Tests. BCBSMN supports this change.</p>
<p><u>Potential New Measures for 2020 and Beyond (pp. 148-156)</u></p> <ul style="list-style-type: none"> • Transitions of Care (Part C). CMS solicits feedback about a new HEDIS Transitions of Care measure with four indicators. CMS plans to propose to include this measure with the four indicators on the 2020 display page for possible inclusion in the 2022 Star Ratings. • Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C). CMS is considering the use of a new HEDIS measure assessing follow-up care provided after an emergency department visit for patients with multiple chronic conditions. CMS plans to propose to include this measure on the 2020 display page for possible inclusion in the 2022 Star Ratings. • Opioid Overuse (Part C). CMS indicates that for HEDIS 2018, NCQA is collecting data on Use of Opioids at High Doses and Use of Opioids from Multiple Providers. These measures are adapted from the PQA's opioid measures. CMS welcomes feedback from stakeholders about the value of including these Part C measures on the display page, given the similar Part D measures that constitute data for Patient Safety reports back to plans and which may also be reported on the display page. CMS also indicates that for HEDIS 2019, NCQA will be testing a new measure concept that addresses members who were previously naïve to opioids who become long-term or “chronic” users and is also considering testing of a second measure concept that addresses the concurrent prescription of opioids and central nervous system depressants. • Assessment of Care for People with Multiple High-Risk Chronic Conditions (Part C). NCQA is considering a new measure concept that would adapt the current Care for Older Adults measure by expanding the number of indicators and broadening the population covered by the set of measures. • Depression Screening and Follow-Up for Adolescents and Adults (Part C). NCQA has developed a measure, which is part of the new effort to collect data using an Electronic Clinical Data System (ECDS). Depending on the results during the first year of implementation, CMS may consider for the display page and Star ratings in the future. 	<p>Transitions of Care (Part C). While BCBSMN supports CMS' focus on Transitions of Care, we have some comments related to the measurement specifications:</p> <ul style="list-style-type: none"> • The one-day notification timeframe is concerning given that the timeframe can be - and often is - lengthened due to factors outside of a plan's control (e.g., different electronic medical records or other data exchange barriers). • We recommend CMS expand the "eligible" practitioners for follow up to include more than the primary care provider. <p>BCBSMN strongly supports delaying the inclusion of this measure until plans have the opportunity to better understand the proposed changes to the measure. Two full years of display data at least are recommended.</p> <p>Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C). BCBSMN recommends a timeframe of 30 days. Additionally, we recommend a broad definition of follow up visits (e.g., face-to-face, office visit, telephone, web, home visit, etc.)</p> <p>Opioid Overuse (Part C). BCBSMN does not agree with creating a new Part C measure on Opioid Overuse. There are currently three Part D measures relating to opioid adherence. There are only eight Part C-only plans, so this would be duplicative for most plans. It creates a poor member experience to have members included in two separate measures that are so closely related.</p>

CMS PROPOSAL	BCBSMN COMMENTS
<ul style="list-style-type: none">• Readmissions from Post-Acute Care (Part C). NCQA is pursuing opportunities to measure acute facility readmissions during or following a skilled nursing facility stay by developing a new measure or a potential adaption of the PCR measure. CMS welcomes feedback on the feasibility, utility and burden of such a modification/stratification or new measure.• Adult Immunization Measure (Part C). Building on the pneumococcal measure, NCQA is evaluating the relevance, scientific soundness, and feasibility of a composite measure for HEDIS that assesses the receipt of routine adult vaccinations.• Anxiety (Part C). NCQA is exploring the feasibility and acceptability of developing quality measures assessing care for those with anxiety disorders for inclusion in HEDIS.• Polypharmacy Measures (Part D). PQA developed and endorsed two measures that identify potentially harmful concurrent drug use or polypharmacy.• Additional PQA Medication Adherence Measures (Part D). CMS may consider including these measures within the quarterly outlier reports to Part D contracts through the Patient Safety Analysis Website in the future.	<p>Assessment of Care for People with Multiple High-Risk Chronic Conditions (Part C). BCBSMN does not agree with expansion of the number of indicators for the Care of Older Adults or with broadening the product line beyond SNPs. The measures within the recommend set are primarily process measures and will add additional measurement burden to both providers and health plans.</p> <p>Depression Screening and Follow-Up for Adolescents and Adults (Part C). BCBSMN appreciates CMS and NCQA efforts to encourage evidence-based depression screening and appropriate follow-up. We do support more efficient means of measurement collection through development of ECDS. However, BCBSMN does not agree with adding this measure. The measure as proposed is a process measure which will add to health plan and provider measurement burden. We recommend CMS and NCQA continue to encourage use of outcomes measures for depression.</p> <p>Readmissions from Post-Acute Care (Part C). BCBSMN recognizes the opportunity to address readmissions after SNF stay and supports development of this measure.</p> <p>Adult Immunization Measure (Part C). BCBSMN supports more efficient means of measurement collection through development of ECDS.</p> <p>Anxiety (Part C). BCBSMN supports the development of new, evidence-based outcomes measures for mental health conditions like anxiety. BCBSMN cautions CMS and NCQA to focus on evidence-based outcomes measures and data collection methods which do not add undue burden to providers and payers.</p> <p>Polypharmacy Measures (Part D). BCBSMN encourages exclusion of those members in long-term care and hospice from this measure.</p> <p>Additional PQA Medication Adherence Measures (Part D). BCBSMN has multiple concerns with this proposal. First, there are often many changes to medications in these classes, specifically non-warfarin agents and short-term use. We are also concerned about the extremely low denominator. Finally, this will need reporting prior to becoming display/actual measures to ensure appropriate management.</p>
<u>Measurement and Methodological Enhancements (pp. 156-157)</u>	<p>BCBSMN advises that CDC Nephropathy Screening is topped out and Diabetes is covered well by other Star measures. Also, please review C24: Customer Service for being topped out.</p> <p>BCBSMN wishes to take this opportunity to remind CMS that with respect to implementation of Comprehensive Addiction and Recovery Act provisions,</p>

CMS PROPOSAL	BCBSMN COMMENTS
	<p>we recommend that beneficiaries designated for lock-in be categorically excluded from CAHPS and HOS, voluntary disenrollment, and Complaint Tracking Module Star measures as their responses/actions may not appropriately reflect true satisfaction and access to the drug plan.</p> <p>As well, we want to flag that new 2018 HEDIS specifications exclude members enrolled in an Institutional Special Needs Plan (I-SNP) or institutionalized members from the following measures: Breast cancer screening, colorectal cancer screening, Osteoporosis Management in Women with a Fracture, and controlling high blood pressure. We believe the intent of this exclusion is to remove both the institutionalized and the institutional-eligible from the measure. CMS defines institutional-eligible as those meeting institutional level of care on the state tool. However, the HEDIS specifications as written exclude the institutional-eligible from the measure whereas institutional-eligible populations are included for all other plan types. We believe this may have been an oversight by the measure developer and are asking that consideration be given in time for HEDIS 2018 to allow all plan types to exclude the institutional-eligible from these measures. The same rationale for exclusion of this population in the I-SNP is valid for the Dual Eligible Special Needs Plan and FIDE-SNP populations – many are not appropriate for these screening measures. Nothing would prevent providers from ordering as appropriate, but they would be excluded from the denominator for quality measurement purposes. This is an enormous issue for states like Minnesota where there are not I-SNPS and all the duals are in FIDE-SNPS due to integration efforts. Additionally, Minnesota has led the nation in “de-institutionalizing” seniors and has large populations of frail seniors now in community placements with significant long-term services and supports. These measures are also the ones where we have the most difficulty with our nursing-home certifiable populations, as our providers are not ordering some of these services since they are not appropriate.</p> <p>Finally, BCBSMN recommends CMS return to pre-determined 4-Star thresholds for Star Ratings. Without these thresholds, plans do not have the ability to appropriately focus limited resources on areas and measures that most benefit our members.</p>
<p><u>Validation Audits (pp. 160-164)</u></p> <p>Threshold for Requiring an Independent Validation Audit. CMS currently requires sponsoring 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.</p>	<p>Threshold for Requiring an Independent Validation Audit. BCBSMN supports the proposed changes to modify the threshold used to determine when a sponsoring organization must hire an independent auditing firm. We support excluding CPE conditions from the threshold calculation as we agree these are unique findings that require a customized audit approach</p>

CMS PROPOSAL	BCBSMN COMMENTS
<p>In response to comments that there are challenges in hiring an independent auditing firm when only a limited number of conditions require validation, CMS proposes to exclude Compliance Program Effectiveness (CPE) conditions from the threshold calculation. As a result, CMS estimates that the number of sponsoring organizations that will be required to hire an independent auditing firm will decrease by approximately 3%.</p> <p>Conflict of Interest Limitations on Independent Auditing Firms. CMS clarifies that sponsoring organizations are not precluded from selecting the same independent auditing firm for their validation audit as their annual external CPE audit, as long as the firm has not provided consulting services or assistance with the correction of audit findings.</p> <p>Required Use of CMS Validation Audit Work Plan Template. Based on CMS' experience in reviewing validation audit work plans and industry input, CMS intends to create a validation work plan template that sponsoring organizations undergoing independent validation audits in 2019 would be required to submit. CMS intends to include the draft template in an upcoming Federal Register proposed information collection in accordance with the Paperwork Reduction Act of 1995.</p> <p>Timeframe to Complete Validation Audits. Currently sponsoring organizations have 150 calendar days from the date that all of their program audit Corrective Action Plans (CAPs) are accepted by CMS to complete a validation audit and submit the independent audit report to CMS for review. CMS proposes to extend this timeframe by 30 days, so sponsoring organizations will have 180 days from the date CMS accepts their program audit CAPs to undergo a validation audit and submit the independent audit report to CMS for review.</p>	<p>that specifically tests correction of the issue but usually requires a lower level of effort from auditors to determine if the non-compliance has been corrected.</p> <p>Conflict of Interest Limitations on Independent Auditing Firms. BCBSMN supports the clarification that sponsoring organizations are not precluded from selecting the same independent auditing firm that is used for the annual external CPE audit. BCBSMN is concerned, however, around the proposed timing of conflict of interest review. CMS indicates that it would collect information in the validation audit work plan to assess potential conflicts of interest. However, no information was provided about what would occur if CMS determined there was a conflict of interest. Additionally, at this point in the process (production of the audit work plan), the sponsor would have already contracted with the audit firm and it would be difficult to terminate the relationship and select a new audit firm in the required timeframe. Therefore, any such assessment should occur prior to formalization of the agreement between the sponsor and the audit firm (at the outset of the audit).</p> <p>Required Use of CMS Validation Audit Work Plan Template. BCBSMN supports the proposed changes provided they would allow plans the flexibility to distinguish among the findings that relate to particular contracts.</p> <p>Timeframe to Complete Validation Audits. BCBSMN supports the increase from 150 to 180 days to complete a validation audit provided there is still an opportunity for an extension if needed.</p>
<p><u>Plan Finder Civil Money Penalty (CMP) Icon or Other Type of Notice (pp. 164-165)</u></p> <p>Starting with the 2019 Annual Election Period (AEP), CMS intends to display an icon or other type of notice on Plan Finder for sponsoring organizations that have received a CMP. CMS expects that the icon or notice would provide current and prospective enrollees with general information about a CMP and may link to the CMP letter on the CMS website for that particular sponsoring organization.</p>	<p>BCBSMN does not support adding the Plan Finder CMP icon or other type of notice for the 2019 AEP. While we support the goal of informed beneficiary choice, we believe that adding a CMP icon will not contribute to increased beneficiary information, and may in fact cause confusion. The Final CMP Methodology published by CMS at the end of December 2016 has only been in effect for CY 2017. As stated, the methodology to calculate CMPs has evolved over time. The calculation of the CMP amount is now based on a standard formula; however, the formula is complex and the penalty amount may be adjusted for aggravating factors that contributed to the deficiency. A beneficiary will not have enough information by which to determine the type of penalty received, the circumstances under which it was imposed, the calculations relating to the penalty, the factors considered by CMS in determining beneficiary impact, and the final calculations that determined the penalty. Given the multiple factors and considerations that determine CMPs arising from a Program Audit finding, we do not believe that adding the icon for 2019 AEP will assist beneficiaries in making an</p>

CMS PROPOSAL	BCBSMN COMMENTS
	informed enrollment decision. Finally, the appeal rights provided for CMPs in 42 CFR 422.1000 make addition of the icon somewhat problematic if the CMP is currently under appeal.
<p><u>Enforcement Actions for Provider Directories (p. 165)</u></p> <p>CMS has received several inquiries as to when CMS would impose enforcement actions for provider directory violations. CMS notes that as in all instances of non-compliance, CMPs and other enforcement actions may be imposed against Medicare Advantage Organizations (MAOs) that have received a compliance notice or notices for violations that have gone uncorrected.</p>	<p>BCBSMN disagrees with the imposition of CMPs on the basis of the Provider Directory monitoring activities/results. These monitoring activities by CMS have demonstrated the manifest difficulty for plans to consistently obtain accurate and timely information from providers. Plans are committed to continuing to collaborate with CMS to find an industry-wide solution.</p>
<p><u>Audit of the Sponsoring Organization's Compliance Program Effectiveness (pp. 165-166)</u></p> <p>In response to stakeholders' requests, CMS is considering allowing sponsoring organizations that have undergone a program audit to treat that audit as meeting the annual compliance program audit for one year from the date of the CMS program audit. CMS believes that this will reduce burden on sponsoring organizations already undergoing a CMS program audit and will eliminate the duplication of effort and is seeking comment on this.</p>	<p>BCBSMN supports and appreciates this change. We recommend that that this be implemented as a calendar year exemption for the year following the CMS Program Audit. This approach would allow time for plans to implement and monitor appropriate corrective actions to ensure they are effective.</p>
<p>Section II. Part C</p>	
<p><u>Total Beneficiary Cost (TBC) (pp. 171-173)</u></p> <p>CMS' proposed methodology for developing the CY 2019 out-of-pocket costs model is consistent with last year's methodology. In mid-April, CMS will provide plan specific CY 2019 TBC values and incorporate technical and payment adjustments in the TBC calculation to account for changes from one year to the next.</p> <p>CMS is proposing to increase the TBC change threshold, for most plans, from \$34.00 PMPM to \$36.00 PMPM in CY 2019 to provide flexibility in addressing medical and pharmacy inflation and benefit design and formulary changes.</p> <p>CMS notes that they are also considering elimination of the current TBC evaluation in future years, subject to statutory and regulatory limitations or changes, and seeks comments on this matter and suggestions on other approaches to determine whether plan bids propose too significant an increase in cost sharing or decrease in benefits from one year to the next.</p>	<p>BCBSMN supports eliminating the TBC test beginning in 2019 as this would align with CMS' position on allowing uniformity flexibility and eliminating the meaningful difference requirement and would foster health plan competition and innovation to allow enhanced plan offerings tailored to beneficiary needs. If CMS chooses to move in this direction at a later date, BCBSMN urges the agency to create a glide path in 2019 by increasing the TBC value by \$5 rather than \$2.</p>
<p><u>Tiered Cost Sharing of Medical Benefits (p. 181)</u></p> <p>Plans may choose to tier cost sharing of medical benefits to encourage enrollees to seek care from providers the plan has identified based on efficiency and quality data. For CY 2019, CMS does not expect MAOs to submit a proposal summarizing their intent to tier cost sharing of medical benefits prior to bid submission, but MAOs are expected to indicate that they are tiering medical benefits and the applicable service categories in Section A-6 of the PBP and tiered cost sharing must satisfy standards laid out by CMS.</p>	<p>BCBSMN supports this approach.</p>
<p><u>Outpatient Observation Services (p. 182)</u></p>	<p>BCBSMN thanks CMS for this change.</p>

CMS PROPOSAL	BCBSMN COMMENTS
<p>In an effort to make the cost sharing for observation services more transparent, CMS will distinguish the cost sharing for observation services from other outpatient services by modifying the PBP category B9a to include separate cost sharing data entries.</p>	
<p><u>Coverage of Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (p. 182)</u></p> <p>For CY 2019, MAOs should account for these items and services as a basic benefit and should not include these Medicare-covered items and services as supplemental benefits.</p>	<p>BCBSMN requests clarification from CMS as to what service category this would fall under. As well, BCBSMN wonders how Original Medicare claims will be transmitted.</p>
<p><u>Health Related Supplemental Benefits (pp. 182-183)</u></p> <p>CMS currently defines a supplemental health care benefit as an item or service that is 1) not covered by original Medicare, 2) that is primarily health related, and 3) for which the MA plan must incur a non-zero direct medical cost. An item that meets all three conditions may be proposed as a supplemental benefit in a plan's bid and submitted plan benefit package. CMS has not previously allowed an item or service to be eligible as a supplemental benefit if the primary purpose is daily maintenance (rather than to prevent, cure, or diminish an illness or injury).</p> <p>For CY 2019, CMS intends to expand the scope of the primarily health related supplemental benefit standard. Under the new interpretation, for a service or item to be primarily health related, it must do one of four things: 1) diagnose, prevent, or treat an illness or injury, 2) compensate for physical impairments, 3) act to ameliorate the functional/psychological impact of injuries or health conditions, or 4) reduce avoidable emergency and healthcare utilization.</p> <p>CMS states that the primary purpose of an item or service will be determined by national typical usages of most people using the item or service and by community patterns of care. Prior to bid submission, CMS will issue detailed guidance for MAOs on this issue, which will be based on previous stakeholder feedback and comments in response to this draft Call Letter.</p>	<p>BCBSMN supports this change and encourages CMS to provide detailed guidance as soon as possible after finalizing in order to give maximal lead time in advance of bid submission.</p>
<p><u>Enhanced Disease Management (EDM) for Dual Eligible Special Needs Plans (D-SNPs) and Institutional Special Need Plans (I-SNPs)</u></p> <p>Beginning in CY 2019 D-SNPs and I-SNPs may offer the EDM supplemental benefit that is currently available to non-SNP MA plans. It will not be made available to Chronic Condition Special Needs Plans (C-SNPs) because it is not necessary (C-SNPs must already have comprehensive targeted disease management elements beyond the EDM requirements in order to receive C-SNP designation).</p>	<p>BCBSMN agrees with addition of EDM as an option for supplemental benefits.</p>
<p><u>Medicare Advantage (MA) Uniformity Flexibility (pp. 184-185)</u></p> <p>CMS reiterated discussion from the November proposed rule that it has determined it has authority to permit MA organizations the ability to reduce cost sharing for covered benefits, offer specific tailored supplemental benefits, and offer lower deductibles for enrollees that meet specific medical criteria, provided that similarly situated enrollees are treated the same.</p> <p>Following issuance of the Final Call Letter, CMS will establish a special mailbox for plan questions as to whether a specific targeted supplemental benefit is allowable.</p>	<p>BCBSMN continues to support this proposal and encourages additional guidance (e.g., regarding marketing rules) from CMS be provided as soon as possible.</p>
<p><u>Medicare Advantage (MA) Segmented Service Area Options (p. 185)</u></p>	<p>BCBSMN supports this change.</p>

CMS PROPOSAL	BCBSMN COMMENTS
<p>CMS has determined that it has the authority to allow MA plans to vary supplemental benefits, in addition to premium and cost sharing, by segment, as long as the benefits, premium, and cost sharing are uniform within each segment of plan's service area.</p>	
<p><u>Special Needs Plan (SNP)-Specific Networks Research and Development (pp. 185-186)</u></p> <p>CMS continues to examine the need for SNP-specific network adequacy evaluations and welcomes continued stakeholder feedback.</p>	<p>BCBSMN supports the Principles for Consideration of SNP Specific Network Requirements developed by the SNP Alliance. In particular, BCBSMN recommends inclusion of telemedicine, mobile, and in-home to help meet adequacy requirements. Inclusion of these non-traditional providers allows for greater flexibility in designing programs to support value-based care.</p>
<p><u>Rewards and Incentives for Completion of Health Risk Assessment (HRA) (p. 186)</u></p> <p>Beginning in CY 2019, MA plans may include the completion of an HRA as a permitted health-related activity in a rewards and incentives program.</p>	<p>BCBSMN supports the use of incentives for HRA completion. Higher completion rates will allow for valuable follow up that impact health and utilization. There has been research done that supports the use of incentives in engaging populations. Since the use of incentives potentially drives engagement of the HRA, it provides a larger pool of individuals to further engage or re-engage in the health care system.</p>
<p><u>Improving Beneficiary Communications and Reducing Burden for Integrated D-SNPs (pp. 187-190)</u></p> <p>Based on feedback from previous Call Letter cycles, CMS has identified priority areas for further integration for interested states and plans, as well as areas where administrative alignment for integrated D-SNPs is currently feasible within existing statutory, regulatory, and operational constraints. These include:</p> <ul style="list-style-type: none"> • Oversight • Integrated model materials, including Summary of Benefits, Annual Notice of Change/Evidence of Coverage, and Provider and Pharmacy Directory • D-SNP Non-Renewals • Model of Care <p>CMS is interested in working with additional states to pursue similar efforts and welcomes comments about the opportunities identified as well as any others.</p>	<p>BCBSMN appreciates CMS' support of the current work in Minnesota. We continue to believe and see in practice that the member experience is greatly enhanced when integration is increased.</p>
<p><u>Encounter Data Listening Forums, Monitoring and Compliance Activities (pp. 191-192)</u></p> <p>In the 2018 Call Letter, CMS presented a new approach to monitoring and compliance of encounter data. In November 2017, CMS issued an Health Plan Management System (HPMS) memo on this topic and requested feedback from stakeholders. CMS will review comments and finalize the monitoring metrics and thresholds in an HPMS memo to be distributed in early 2018.</p>	<p>BCBSMN supports the process CMS has undertaken in this area. We appreciate the opportunity to provide feedback on the monitoring and compliance activities CMS has proposed and continue to support an incremental approach to implementation.</p>
<p>Section III. Part D</p>	
<p><u>Formulary Submissions (pp. 193-196)</u></p>	<p>BCBSMN supports the elimination of the NDS file.</p>

CMS PROPOSAL	BCBSMN COMMENTS
<p>Non-Extended Day Supply (NDS) file. Based on feedback from Part D sponsors, CMS has concluded that the burden of maintaining this supplemental file outweighs any benefits, and therefore is eliminating the file for CY 2019.</p>	
<p><u>Expanding the Part D OTC Program (pp. 196-197)</u></p> <p>CMS is considering allowing additional flexibilities for Part D plan sponsors to offer access to over-the-counter drug products (OTCs), such as dietary supplements and cough medicines, without the requirement that the OTC offset the use of a Part D drug. CMS is soliciting feedback from stakeholders on Part D OTC enhancements that could be considered, including information on how well the current program is working, the deficiencies of the current program, what additional flexibilities would be helpful, and what the impact would be on spending (particularly premiums) as a result.</p>	<p>BCBSMN is generally supportive of expanding the Part D OTC program.</p>
<p><u>Tier Composition (pp. 198-199)</u></p> <p>Based on an analysis of CY 2018 formulary and benefits data, CMS proposes a maximum threshold of 25% generic composition for the non-preferred brand tier for CY 2019.</p>	<p>BCBSMN appreciates the examples provided in this section. We are in favor of CMS proposing a maximum threshold for generic composition in the non-preferred brand tier. This has been confusing in the past and having guidelines for tier naming convention is helpful.</p>
<p><u>Improving Access to Part D Vaccines (pp. 199-201)</u></p> <p>CMS does not propose policy changes but encourages Part D sponsors to offer a \$0 vaccine tier or to place vaccines on a formulary tier with low cost-sharing to encourage access.</p>	<p>BCBSMN supports simplifying vaccinations and proposes moving all to either be covered under Part B or Part D. Currently influenza and Hepatitis B are covered by Part B while Tdap and shingles vaccinations are covered by Part D. We recommend covering all vaccinations under Medicare Part B. This would allow plans to put all vaccinations under one benefit category. It would avoid Part D issues of tier exceptions when brand name vaccinations are moved to a lower tier if a standalone vaccination tier is not available. It would support non-discriminatory cost sharing and a better member experience.</p>
<p><u>Improving Drug Utilization Review Controls in Medicare Part D (pp. 202-216)</u></p> <p>CMS proposes new strategies to more effectively address the national opioid epidemic within Part D. These proposals include:</p> <ul style="list-style-type: none"> Enhancing the Overutilization Management System (OMS) by adding additional flags for high risk beneficiaries who use “potentiator” drugs (such as gabapentin and pregabalin) in combination with prescription opioids. OMS already flags concurrent benzodiazepine use. Implementing revisions to the PQA opioid quality measures used by CMS, and consideration of a new PQA measure, Concurrent Use of Opioids and Benzodiazepines (discussed in Star Ratings section). Expecting all sponsors to implement hard formulary-level cumulative opioid safety edits at point-of-sale (POS) in the pharmacy (which can only be overridden by the sponsor) at a dosage level of 90 MME per day, with a 7-day supply allowance. Implementing a days supply limit for initial fills of prescription opioids (e.g. 7 days) for the treatment of acute pain with or without a daily dose maximum (e.g. 50 MME per day) 	<p>BCBSMN recommends that CMS define “oncology diagnosis” as "active oncology diagnosis" for exclusion/exception purposes.</p> <p>While BCBSMN agrees that plans can put in place programs to support opioid management efforts as defined by the CDC, we encourage continued and parallel work educating providers/prescribers and putting programs in place on their end to sufficiently impact this issue.</p> <p>BCBSMN requests clarification as to what is meant by opioid naive.</p>

CMS PROPOSAL	BCBSMN COMMENTS
<ul style="list-style-type: none">Expecting all sponsors to implement soft POS safety edits (which can be overridden by a pharmacist) based on duplicative therapy of multiple long-acting opioids, and request feedback on concurrent prescription opioid and benzodiazepine soft edits. <p>CMS welcomes feedback on these proposals and notes that all Part D sponsors are expected to have a documented, written strategy for addressing overutilization of prescription opioids given the public health crisis.</p>	