MMAPA
Medicaid and Medicare Advantage Products Association of Puerto Rico
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September 29, 2020

The Honorable Alex M. Azar II
Secretary of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

RE: 2022 Enhancements to the Medicare Advantage Program in Puerto Rico

Dear Secretary Azar:

We are writing to thank you for the administrative steps taken in recent years to respond to disparate funding in Medicare Advantage (MA) for U.S. citizens in Puerto Rico. In light of the upcoming administration action on the 2022 MA plan year, we wish to use this opportunity to reiterate for you and your team some essential facts about the Puerto Rico health care system in order to inform CMS policy making to protect and support the stability and continuing development of the MA program. In this letter we (1) enumerate and explain our requests for the 2022 MA plan year; (2) discuss how investing in MA in Puerto Rico supports your long-standing policy objectives; and (3) provide detailed background data on the Puerto Rico health care system and economy.

Our priorities are as follows for the *Announcement of* ***CY 2022 MA Capitation Rates and Part C and Part D Payment Policies*** and successive Medicare rule making:

1. Establish a specific Minimum Standard Benchmark, defined by a minimum geographic adjustment, to address anomalies in existing FFS Data or increasing disparities in lowest cost areas;

2. Continue the adjustment in the base benchmarking process for "zero-claimants" in fee-for-service data;

3. Continue to base Puerto Rico benchmark on claims experience of beneficiaries enrolled in Parts A and B only;

4. Continue the Puerto Rico-specific Categorical Adjustments for stars quality ratings to account for the lack of Low-Income Subsidy (LIS) eligibility for Medicare beneficiaries in the Territories;

5. Continue the Qualifying County Bonus Payment policy;

6. Continue and expand adjustments to FFS provider reimbursement formulas to that would otherwise promote disparities in Puerto Rico funding;
    - Geographic Practice Cost Indices (GPCI)
    - Addressing Wage Index Disparities Between High and Low Wage Index Hospitals
    - ESRD PPS Wage Index Floor

7. New adjustment for Duals Bias in the MA benchmark

8. STARs CAHPS measures Coefficient Adjustment Anomaly

Each of these items is explained in more detail in Section III of the Attachment below.

Puerto Rico as Model for MA Growth - The MA program has evolved to become the cornerstone of the provision of healthcare services to senior across the nation, especially poor seniors living on a fixed income. Puerto Rico, with the highest MA penetration rate in the nation of over 70%, provides a case study of how, in the words of the President's October 3, 2019 Executive Order, "*MA . . . delivers efficient and value-based care through choice and private competition, and has improved aspects of the Medicare program*."

Currently, MMAPA member plans are front-line guardians against COVID-19 for our most frail populations: the elderly, poor, and those with chronic conditions. We ensure that cost is not a barrier to testing and treatment and that our providers have everything they need to deliver care safely. We are also collaborating with providers to advance innovation to alleviate social determinants of health by identifying the risk factors and working directly with beneficiaries, patient's family members and community-based organizations to meet nonclinical needs to improve health outcomes. The MA program has several years' head start over the fee-for-service program in delivering care in a cost-efficient manner with quality incentives. Finally, MA is the only major health care program in Puerto Rico exclusively regulated and closely audited by the federal government.

Perseverance to Meet Our Commitment to Our Enrollees In Spite of Constant Challenges - Demonstrating all the advantages of the MA program has not been easy in Puerto Rico. The average MA benchmarks for Puerto Rico remain 40% lower than the national average, 36% lower than the average in the lowest state (Hawaii), and 22% lower than the rates for the USVI. While we appreciate some benchmark increases in recent years, we are concerned that the gap between Puerto Rico and state average benchmarks continues to widen. Simultaneously, between hurricanes, earthquakes, and pandemics, Puerto Rico has experienced disaster declarations and public health emergencies in each of the last four years.

A Path to Realizing MA Opportunities - The new and continued policy proposals outlined in the attachment below would remedy the historic underfunding of Medicare in Puerto Rico and thereby enhance stability in the local health care system, reduce the rate of provider migration to the mainland, and close long-existing benefit and infrastructure gaps. Permanent, sustainable parity in Puerto Rico MA funding would mean that MMAPA member plans could complete our work to enhance provider compensation, cover benefit gaps, and implement new value-based policies that promote the coordination of healthcare services to tackle challenges in the social determinants of health.

We appreciate the considerations of this request in the context of the 2022 Advance Notice and subsequent CMS regulatory action.

Respectfully,

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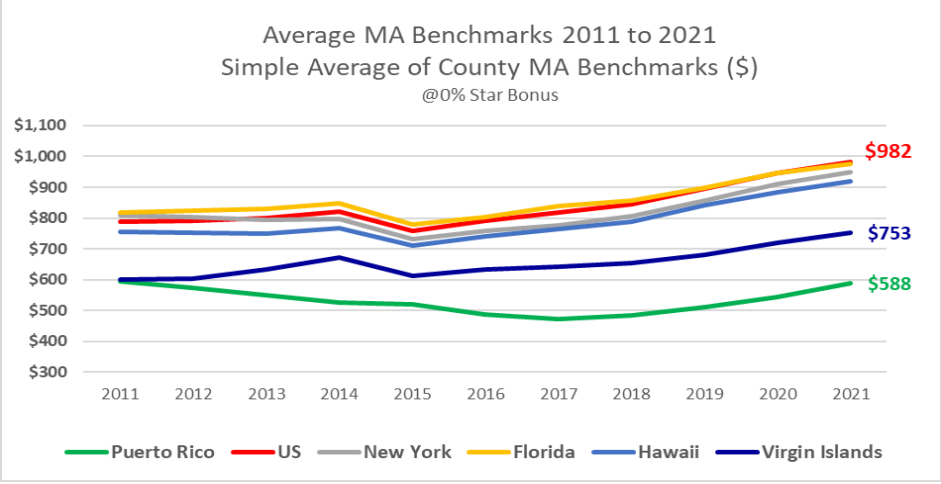
Puerto Rico Medicare Advantage Update

I. General update on status of MA rates in PR

We should first establish key facts regarding the Puerto Rico health care system. Medicare Advantage has become the foundation of Puerto Rico's health care system in the past 15 years. Puerto Rico is unique in overwhelmingly embracing MA early, with the nation's eighth largest enrolled MA population and an MA penetration rate of **90%** among the Medicare A&B eligible beneficiaries. Further, Puerto Rico has among the highest enrollment in MA Dual Eligible Special Needs Plans (D-SNPs) at more than **278,000,** which is third in the Nation after Florida and New York, and greater than Texas, Pennsylvania and California. **The percentage of D-SNP enrollees of the total MA in Puerto Rico is 46% as of September 2020, compared to 13% nationally.** This is partly why the island MA plans have been seen to devote proportionally more time, energy and resources to addressing social determinants of health. Moreover, MMAPA member plans devote significant resources from the MA program to D-SNPs to make up for the shortfall in contributions from the local Medicaid program, which does not cover standard Medicaid benefits like Long Term Services and Supports (LTSS), and the Medicare Part B buy-in program. Puerto Rico is also excluded from the regular Medicare Part D Low-Income Subsidy (LIS) program.

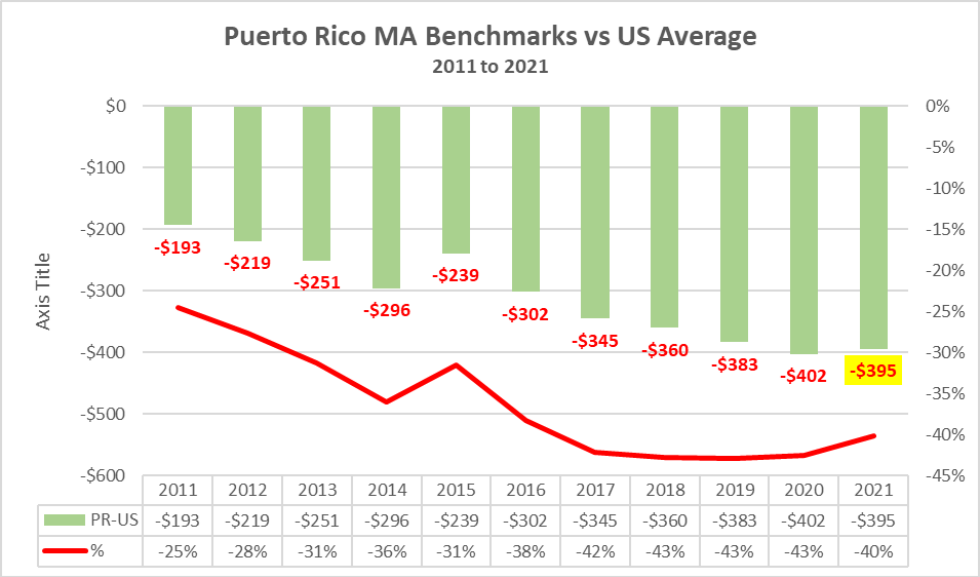
Nevertheless, due to a combination of the statutory changes, historical disparities in various Medicare payment formulas, and differences in populations, economics, and available data sources, **MA benchmarks in Puerto Rico are significantly, 40% as of January 2021, below the national average.** It has been a primary mission of MMAPA to halt and reverse the widening gap between MA benchmarks in the Puerto Rico and the states. We appreciate the assistance of CMS in using its discretionary authority to make payment adjustments to end the downward spiral in Puerto Rico benchmark rates. [See Chart 1, below]

Chart 1



However, Puerto Rico continues to experience disparities in that the gap is growing between Puerto Rico benchmarks and US average benchmarks. [See Chart 2, below]

Chart 2



Progress in reversing the gap has been made in recent years due to CMS' attention to FFS and MA issues raised by MMAPA. We look forward to continued progress in this area as opposed to increasing the gap between Puerto Rico and the rest of the mainland.

II. Puerto Rico's health profile merits additional resources

Aggravating Profile of Chronic Diseases

Available data from the CDC for recent years continues to reflect how the health profile of citizens in Puerto Rico is distinct from the rest of the US.[1],[2]

Chronic Diseases (Crude Prevalence)	Puerto Rico	US Average
Diabetes	**17.20%**	**10.50%**[4]
Asthma	12.20%	9.40%[4]
Cardiovascular Disease		
Angina or Coronary Heart Disease	7.20%	3.90%[4]
Heart Attack (myocardial infarction)	5.00%	4.20%[4]
Stroke	2.50%	3.00%[4]

[1] Center for Disease Control and Prevention. Behavioral Risk Factor Surveillance System: 2017
[2] Median Value reported with no confidence intervals.

Leading Causes of Death[3]

	10 leading causes of death 2017[3]	All US		10 leading causes of death 2017[3]	Puerto Rico
1	Diseases of heart	23.00%		Diseases of heart	18.08%
2	Malignant neoplasms	21.30%		Malignant neoplasms	16.84%
3	Accidents (unintentional injuries)	6.00%		**Diabetes mellitus**	**10.48%**
4	Chronic lower respiratory diseases	5.70%		Alzheimer disease	7.54%
5	Cerebrovascular diseases	5.20%		Cerebrovascular diseases	3.93%
6	Alzheimer disease	4.30%		Chronic lower respiratory diseases	3.80%
7	**Diabetes mellitus**	**3.00%**		Nephritis, nephrotic syndrome and nephrosis	3.22%
8	Influenza and pneumonia	2.00%		Accidents (unintentional injuries)	2.89%
9	Nephritis, nephrotic syndrome and nephrosis	1.80%		Septicemia	2.69%
10	Intentional self-harm (suicide)	1.70%		Influenza and pneumonia	2.68%

Unique Socio-economic Challenges [4]

In regard to our socio-economic context, the population continues to get older and poverty among citizens that are 65 and older is 4 times larger than the national average. Again, this correlates with the high proportion of D-SNP enrollees from all the MA (46%) and the increased attention and use of benefits that address social determinants of health.

Socio-Economic Indicators	Puerto Rico	US Average
Total Population[1]	3,468,964	321,004,407
65 years and over	18.15%	14.90%
85 years and over	2.10%	1.90%
Median age	40.1	37.8
Unemployed	7.80%	4.10%
Median household income	**$19,775**	**$57,652**
With Social Security	43.60%	30.60%
Mean Social Security income	**$12,647**	**$18,778**
With retirement income	15.90%	18.40%
Mean retirement income	**$16,762**	**$25,798**
With Supplemental Security Income	0.50%	5.40%
Below poverty level	**44.90%**	**14.60%**
65 years and over	39.80%	9.30%
With health insurance coverage	93.80%	89.50%
No health insurance coverage	6.20%	10.50%

Some of these indicators are also summarized by Kaiser in a Puerto Rico Fact Sheet released October 2017. [5]

[3] United States: US Department of Health and Human Services; Center for Disease Control and Prevention; National Vital Statistics Reports. Vol. 68 (6): 2017.
[4] U.S. Census Bureau. 2013-2017 American Community Survey, 5- years estimates.
[5] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/puerto-rico-fast-facts/#:~:text=Puerto%20Rico%2C%20a%20U.S.%20territory,citizens%20residing%20on%20the%20island.&text=Roughly%20one%20in%20two%20Puerto,in%20the%20island's%20Medicaid%20program.

Disparate Health Employment Situation

US Bureau of Labor statistics data reflects the realities of our message about the professional resources for health care. Significant wage differences led to a scenario that pulls the best physicians from Puerto Rico to other locations in the mainland where higher compensation is basically guaranteed, and at least 50% higher. Although the total proportion of practitioners does not seem different than the average, the situation of certain specialties has led to accessibility issues.

May 2019 Bureau of Labor Statistics Data		
	PR	**US**
Healthcare Practitioners and Technical Occupations		
Total Employment	50,620	8,673,140
Employment per 1,000 Employed	59	59
Average Hourly Wages	$17	$40
Average Annual Wages	$36,280	$83,640
Healthcare Support Occupations		
Total Employment	14,680	6,521,790
Employment per 1,000 Employed	17	44
Average Hourly Wages	$10	$15
Average Annual Wages	$20,130	$31,010

In relation to support occupations, the much lower proportion of professionals reflects the underfunding and underdevelopment of the health care operations on the island. The tight economics in our system has not allowed for the development of services that typically use technical support, nurse practitioners or physician assistants, for example. The limitations that this situation creates on service access and quality is also exacerbated by the deficient physical and electronic information infrastructure.

Progress in MA has led to important protections and support for improvement in many of these elements. Recent years have seen expanding pay for performance programs with primary care physicians and specialists, where incentives are net increases to total compensation. In addition, there has been a lot more emphasis in the support for the administration of clinics and electronic health information exchanged between physicians and plans to support care coordination.

III. Proposed Adjustments to Avoid Increasing the Medicare Advantage Funding Gap Between Puerto Rico and the Mainland

1. *Establish a specific Minimum Standard Benchmark, defined by a minimum geographic adjustment, to Address Anomalies in Existing FFS Data or increasing disparities in Lowest Cost Areas*

As MMAPA has previously shared, CMS could obviate the necessity for annual minor administrative adjustments to the MA benchmark for Puerto Rico, and simultaneously improve the health care system in Puerto Rico, by establishing a minimum standard benchmark for areas that fall outside of the normal curve of benchmark calculation. **By assigning a minimum equivalent of a 0.70 Average Geographic Adjustment (AGA), CMS would permanently resolve the persistent anomalies in the FFS program data in Puerto Rico.** It is evident that the FFS program that Congress established as the basis for MA rate setting is rapidly eroding in Puerto Rico and no longer aligns with the assumptions underlying its use for MA benchmarks.

Analysis produced by The Moran Company, and previously shared with CMS, illustrates concerns with the use of the data from the FFS program as a valid estimate of the cost of providing Medicare A and B benefits to beneficiaries in Puerto Rico. We further appreciate the ongoing collaboration with CMS on analyzing Puerto Rico FFS data compared to plan experience in expenditures for beneficiaries. In general, not only does the FFS data represent approximately 10% of the Medicare A & B population in the island, but analysis confirms that the Puerto Rico FFS population is a group of beneficiaries that self-selected themselves *out of MA*, with particular and significant differences in character and utilization patterns.

The use of a minimum standard benchmark would be consistent with authority provided to the Secretary to use alternative FFS data sources from "a similar [geographic] area,"[6] when the data from the jurisdiction is not reliable. Such a use of a minimum standard AGA would be consistent with similar actions taken by CMS for the Medicare FFS program. Under the Physician Fee Schedule, CMS earlier used the national average Geographic Practice Cost Index (GPCI) as a proxy to be used in calculating rates for the USVI and other Territories because of insufficient data in those Territories to establish a specific GPCI. Later, CMS determined to extend that national average GPCI proxy to Puerto Rico as well in the interest of consistency across Territories.[7]

On the other hand, CMS has also acknowledged the potential exacerbation of disparities between high cost areas and low-cost areas, when payment formulas use geographic factors.

[6] Social Security Act § 1876(a)(4).
[7] See 81 Fed. Reg. 80,269 (Nov. 15, 2016).

Along these lines, CMS has adjusted and maintained regulations to establish a floor in the wage index factor used for dialysis payments under Medicare FFS. Moreover, the risk of increasing disparities perpetuated by payment formulas was also addressed in the Part A 2020 IPPS payment rule:

> ***"Many responses reflected a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals. To help address these wage index disparities, we are finalizing changes to improve the accuracy of the wage index calculation, including a methodology to increase the wage index for certain low wage index hospitals and to change how the statutory rural floor wage index values are calculated."***[8]
>
> *From:* CMS Press Release in Relation to Final Part A IPPS Rule 2020 (August 2, 2019)

These examples validate how the definition of a minimum AGA factor for MA rate setting is a policy that makes sense to provide a minimum level of protection to all jurisdictions around the Nation, specifically for jurisdictions that have increasingly high MA penetration rates and that offer the lowest priced health care in the US.

2. Maintain Key Adjustment for Zero-Claimants in FFS Data

The ongoing annual zero-claims adjustment is absolutely necessary to preserve quality MA benefits for beneficiaries in Puerto Rico. Since 2017, CMS has implemented this adjustment to the MA benchmark methodology to account for differences in the Puerto Rico health care system and patient populations. Specifically, CMS included an adjustment for Puerto Rico to account for the anomaly in the Parts A and B FFS beneficiaries' data showing a greater proportion of beneficiaries exhibiting no claims-related encounters or expenses than in the 50 States or DC. Approximately 26% of the FFS beneficiaries in Puerto Rico report zero claims, compared to a national average of less than 8% in a given year for those beneficiaries enrolled in both Medicare Parts A and B.

Such an anomaly of a higher proportion of enrolled FFS months without any corresponding utilization in the denominator depresses the benchmark calculation. This selection bias of those who remain in FFS versus those who opt into an MA plan further distorts the FFS data leading to a significant underestimation of FFS costs relative to other jurisdictions. There is no evidence of any change in the high proportion of Medicare zero-claimants in Puerto Rico. Failure to continue this adjustment would result in further depressing Medicare rates for beneficiaries in Puerto Rico based solely on the Island's unique health care system and legal status, and not on a difference in the cost of benefits and services.

[8] https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0

3. Base Puerto Rico Benchmark on Claims Experience of Beneficiaries Enrolled in Parts A and B Only

We appreciate that last year CMS re-affirmed its belief that "it is appropriate to adjust the FFS rate calculation for Puerto Rico used to determine MA rates so that it is based only on the Medicare costs for beneficiaries with both Part A and Part B."[9] Data confirms that the per capita costs for beneficiaries enrolled in both Parts A and B are higher than the costs for those enrolled in Part A and/or Part B.

Medicare enrollment, as well as cost and utilization in Puerto Rico is materially different from in the states. A far greater proportion of beneficiaries enroll in Medicare Advantage plans and those that do remain in FFS are much less likely to enroll in Part B. While most mainland beneficiaries are automatically enrolled in Part B, and must opt out to decline it, Puerto Rican beneficiaries are required to opt-in to Part B coverage. Additionally, Medicare FFS payment rates tend to be lower. Given these differences, it is appropriate for CMS to continue to establish the MA FFS rate in Puerto Rico based on enrollees in both Part A and Part B. To end this adjustment would be to harmfully distort Puerto Rico MA rates downward based on the Island's legal status as a territory.

4. Categorical Adjustment Index (CAI) Specific to Puerto Rico

For 2017 through 2020, CMS has employed for Puerto Rico additional adjustments beyond the standard CAIs for all plans. This adjustment is in recognition of the unique challenges faced by MA plans operating on the island: 1) approximating LIS-eligible beneficiaries to allow Puerto Rico-based plans to be eligible for adjustments under the CAI, and 2) implementing a differential weighting scheme for the medication adherence measures for these organizations in calculating the overall and summary Star Ratings. These adjustments were also codified for 2021 Star Ratings in the 2019 MA and Part D Final Rule published in April 2018.

We are supportive of both adjustments as necessary given systemic disparities between Puerto Rico and other areas. We assume that CMS' intent is that the policy will carry over from prior years and be effective for the 2022 Star Ratings. We recommend that CMS confirm that its current policy remains unchanged for 2022 Star Ratings.

5. Qualifying County Bonus Payment

Beginning in 2018, CMS reinterpreted Section 1853(o)(3)(B) and §1853(c)(1)(B) of the Social Security Act, as a result of the reasoning provided by MMAPA, to establish the eligibility of

[9] CMS, Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, pg. 24 (Apr. 1, 2019).

several counties in Puerto Rico for the Qualifying County Bonus Payments. This means that since 2018, CMS identifies those counties in Puerto Rico that would have had an urban floor county rate, but for the cap established under §1853(c)(1)(B)(iii)(II), to meet the criteria of having an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000. This reinterpretation by CMS was necessary to ensure that the valuable Qualifying County Bonus Payments are made available to all the distressed counties intended by Congress.

6. Adjustments to FFS Provider Reimbursement Formulas to Otherwise Promote Disparities in Puerto Rico Medicare Funding

a) Geographic Practice Cost Indices (GPCI) needs to be maintained

Although GPCI values are calculated for all U.S. States and Puerto Rico, most data sources used do not contain data for other U.S. territories. To provide greater consistency in the calculation of GPCIs given the lack of comprehensive data regarding the validity of applying the proxy data used in the States in accurately accounting for variability of costs for these island territories, CMS implemented in 2017 to treat the Caribbean Island territories (USVI and Puerto Rico) in a consistent manner. CMS assigned the national average of 1.0 to each GPCI index for both Puerto Rico and the Virgin Islands.[10] This adjustment has proven essential to Puerto Rico FFS providers and has contributed to narrowing the gap between Medicare Advantage benchmarks between Puerto Rico and the states.

b) Addressing Wage Index Disparities Between High and Low Wage Index Hospitals

CMS responded to providers' long-standing requests in the *FY 2020 Medicare Inpatient Prospective Payment System Final Rule* by increasing the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage index for these hospitals is equal to half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals. Correspondingly, CMS would decrease the wage index values for hospitals with high wage index values but preserve the rank order among those values.

This policy adjustment was supported by several other organizations that analyzed the situation and called for the current wage index system to be replaced due to deficiencies and inaccuracies, including the Medicare Payment Advisory Commission, the HHS Office of the Inspector General, and the Institute of Medicine. We are grateful that CMS used its authority to institute an alternative system to halt the "death spiral" that perpetuates economic and health

[10] 81 FR 46224 (July 15, 2015).

care disparities arising from the current flawed methodology. These positive changes for FFS providers will ultimately be reflected in MA benchmarks, allowing for enhanced enrollee coverage and increased provider reimbursement.

c) ESRD PPS Wage Index Floor

In the CY 2019 ESRD PPS final rule, CMS finalized an increase to the wage index floor from 0.40 to 0.50 for 2019 and subsequent years.[11] CMS had rrevisited its earlier evaluation of payments to ESRD facilities located in the lowest wage areas to ensure payments under the ESRD PPS were appropriate. All facilities with wage index values below the prior floor of 0.40 were found to be located in Puerto Rico. At the time, we thanked CMS for the increase of the floor to 0.50, which is having a material positive impact on the provision of quality dialysis services to beneficiaries in need in Puerto Rico and has contributed to narrowing the gap between Medicare Advantage benchmarks between Puerto Rico and the states.

We offered comments in 2018 and 2019 that CMS further increase the wage index floor above 0.50.[12] Regarding an alternative wage index floor, in the CY 2019 Proposed Rule, CMS reported that its own analysis indicates that Puerto Rico's wage index "likely lies between 0.5100 and 0.5500."[13] Further, "that any wage index values less than 0.5936 are considered outlier values."[14] Yet, CMS last year finalized a floor of 0.50 and characterized it as "a balance between providing additional payments to affected areas while minimizing the impact on the base rate."[15] Inadequate FFS rates could threaten the viability of providing ambulatory dialysis services in Puerto Rico by one or both of the providers serving Puerto Rico currently. It is in the interest of beneficiaries, the Medicare program, and MA plans that a choice is available between multiple competing dialysis services providers.

The financial viability of dialysis providers in Puerto Rico is under stress without a higher ESRD wage index floor and it is not certain how long each of the two main dialysis providers can maintain operations at current rates of reimbursement. The existence of at least two dialysis providers on the island is essential to ensuring that choice between competing providers exists for beneficiaries, the Medicare program, and MA plans. If the system were reduced to only one dialysis provider, higher rates could be charged to MA plans, squeezing out resources that may otherwise be directed to enhanced coverage for enrollees or reimbursement for other classes or providers.

[11] See 83 FR 56967 (Nov. 14, 2018).
[12] See Puerto Rico Healthcare Community Stakeholders comment letter on the CY 2019 ERSD PPS Proposed Rule (Sept. 10, 2018).
[13] 83 FR 34329 (July 19, 2018).
[14] Id. at 34330.
[15] Id. at 34329.

MMAPA and other key local healthcare stakeholders continue to share its input with the CMS Center for Medicare on improving Medicare ESRD PPS calculation and reimbursement of ESRD wage and labor costs.

New Adjustments in MA Program for Puerto Rico

7. ***New Adjustment for Duals Bias in Benchmark***

For 2022, CMS should adjust the MA benchmark to reflect the minimal and disproportionate representation of dual eligible beneficiaries in the Puerto Rico FFS population. The difference in the proportion of duals in the MA and FFS populations in Puerto Rico is so large that risk scores alone cannot correct the large discrepancy that exists between the two populations without an adjustment at the base rates.

Approximately **278,000** beneficiaries, almost half of all MA beneficiaries in Puerto Rico, are dual eligible. These beneficiaries have selected the integrated MA, Part D and Medicaid program (Medicare Platino) voluntarily for their health care since 2006. However, in 2014 there were only 5,837 Medicare FFS beneficiaries with Parts A & B. This means that 98% of all the dually eligible Medicare A & B population are served by the MA program, and only 2% are served by FFS who are not representative of those served by MA. For example, according to analysis by The Moran Company, in 2014, the weighted risk scores for Puerto Rico MA-enrolled duals were almost 18% higher than FFS duals and almost 14% higher than non-dual beneficiaries enrolled in FFS.

Further, The Moran Company analysis previously shared with CMS also documents a significant number of duals, residing in Puerto Rico, whose Medicaid enrollment is in one of the mainland states, as opposed to Puerto Rico. These beneficiaries have vastly higher PMPM costs compared to Puerto Rico residents with Medicaid enrollment in Puerto Rico, and their cost should be considered.

The very low and eroding number of dually eligible beneficiaries in the Puerto Rico FFS data suggests that this portion of the data used to set MA benchmarks is distorted by selection bias, and projecting the cost of duals in the benchmarking process for Puerto Rico should be based upon different data than that used in mainland states. Because of these large discrepancies, risk adjustment by itself cannot correct for this selection bias. An adjustment should be made in Part B related expenses for the duals in FFS, based on the average proportion of Part A and B costs for duals in Medicare FFS nationally, to avoid an unintended underestimation of the Part B costs for a dual beneficiary in Puerto Rico. In addition, an adjustment should be implemented to reflect dual beneficiary costs in the Puerto Rico FFS data at the weight of at least the US average proportion of duals in Medicare FFS.

8. STARs CAHPS Measures Coefficient Adjustment Anomaly

CMS utilizes several components to arrive at a final Star Rating for each Medicare Advantage plan. One of the large and growing parts is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures based upon patient experience surveys. To normalize for different populations that CMS has identified as unduly influencing results beyond the plans' control, they use Case Mix Adjustments (CMA) to various factors included in the calculation.

According to CMS, for the CMA to be administered correctly, the variables must be identified at the beneficiary level. However, CMS has acknowledged that they have been unable to identify the Medicaid eligibility and low-income status for Puerto Rico beneficiaries that respond to the CAHPS survey. This creates a skewing of the scoring and potentially inaccurate STARs ratings for health plans on the island. CMS has attempted to account for this statistical anomaly by estimating the portion of beneficiaries with Medicaid eligibility and low-income status and applying a proxy percentage to the CMA. This does not fully account for the impact of these beneficiaries either in the CMA or the base factors being adjusted for. Since Puerto Rico is not included in the calculation of these applicable CMA factors, we believe it is imperative that CMS reviews the current methodology to understand the impact of this statistically significant omission, and make appropriate adjustments.

Conclusion

Despite the crippling disparity in federal subsidy assigned to Puerto Rico, the MA program accounts for approximately 50% of all funding to the Puerto Rico health care system and is central to care for the most vulnerable American citizens living on the island. The Island's MA Plans now face exponentially more difficult challenges as the estimated $100 billion in damages caused by Hurricanes Irma and María has been sharply worsened by the recent earthquakes in early 2020 as well as the public health challenges brought by the current COVID-19 pandemic.

The proposals described in our letter are all vital for a real and meaningful impact on the resources available to cover and treat over 607,000 MA beneficiaries in 2022 and beyond. We are committed to the continued improvement in the quality of the Medicare programs in Puerto Rico, demonstrated by the progress made through critical times in recent years. With the adjustments proposed herein, we are confident we can break the downward spiral of the health care infrastructure and number of providers supported significantly by the MA program in Puerto Rico. We are certain that HHS/CMS political will and administrative authority to implement policies that supports the mission and vision of accessibility of affordable means of health promotion, disease prevention, and treatment for American citizens, will help reduce health disparities in Puerto Rico.

We look forward to administrative action for CY2022, and to continuing the analysis and discussions with the CMS leadership as we develop a more permanent solution for the worsening disparities.