MMAPA
Medicaid and Medicare Advantage Products Association of Puerto Rico
mmapapr.com

October 21, 2021.

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

RE: 2023 Enhancements to the Medicare Advantage Program in Puerto Rico

Dear Secretary Becerra:

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 and urge you to take action now to permanently resolve the issue for 2023. In light of the upcoming administration action on the 2023 Advance Notice and subsequent regulatory action for the 2023 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 policy making to protect and support the stability and continuing development of the MA program.

The MA program has evolved to become the cornerstone of the provision of healthcare services to senior across the nations, especially poor seniors living on a fixed income. In Puerto Rico, with the nation's highest MA penetration rate of over 80%, MMAPA member plans are front-line guardians against COVID-19 for the elderly, poor, and those with chronic conditions. While we appreciate some temporary adjustment for MA benchmarks in recent years, we are concerned that the gap between Puerto Rico and US 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.

Addressing the historic underfunding of the MA program in Puerto Rico would significantly advance the policy of the President's Executive Order on *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* by "advancing

equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality."[1]

In this letter we:

- Explain the role of MA in the Puerto Rico health care system and the widening gap between federal payments made to plans on the island compared to the rest of the US;

- Outline the health disparities of Puerto Rico, which is older, lower-income and sicker than the rest of the US, demonstrating the need for new health care funding; and

- Share our proposal for you to establish a specific Minimum Standard Benchmark, defined by a minimum geographic adjustment, to resolve these long-standing disparities in federal support for Puerto Rico health care. The Centers for Medicare & Medicaid Services (CMS) should implement this policy as a part of the *Advance Notice of CY 2023 MA Capitation Rates* and successive Medicare rule making.

I. The Role of MA in the Puerto Rico Health Care System and Disparities in MA Rates

We should first establish key facts regarding the Puerto Rico health care system. MA has become the foundation of Puerto Rico's health care system in the past 15 years, especially for low-income seniors living on a fixed income. 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 **280,000,** 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 population in Puerto Rico is 45% as of September 2021, compared to 14% nationally. This is partly why MA plans in Puerto Rico devote proportionally more time, energy and resources to addressing social determinants of health, such as by identifying risk factors and working directly with beneficiaries, patients' family members, and community-based organizations to meet nonclinical needs and to improve health outcomes. 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. Further, Puerto Rico is statutorily excluded from the regular Medicare Part D Low-

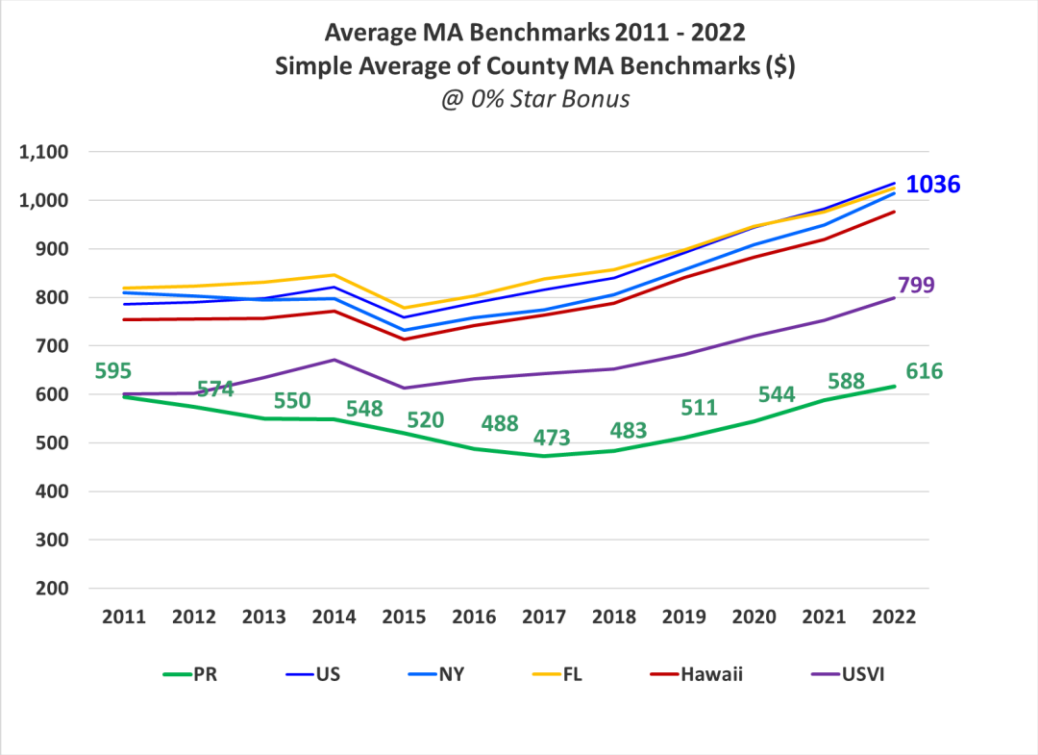
[1] Executive Order 13985 (Jan. 20, 2021).

Income Subsidy (LIS) program. Our plans have many years' experience in delivering care in a cost-efficient manner with quality incentives.

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. Our 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 COVID19 pandemic.

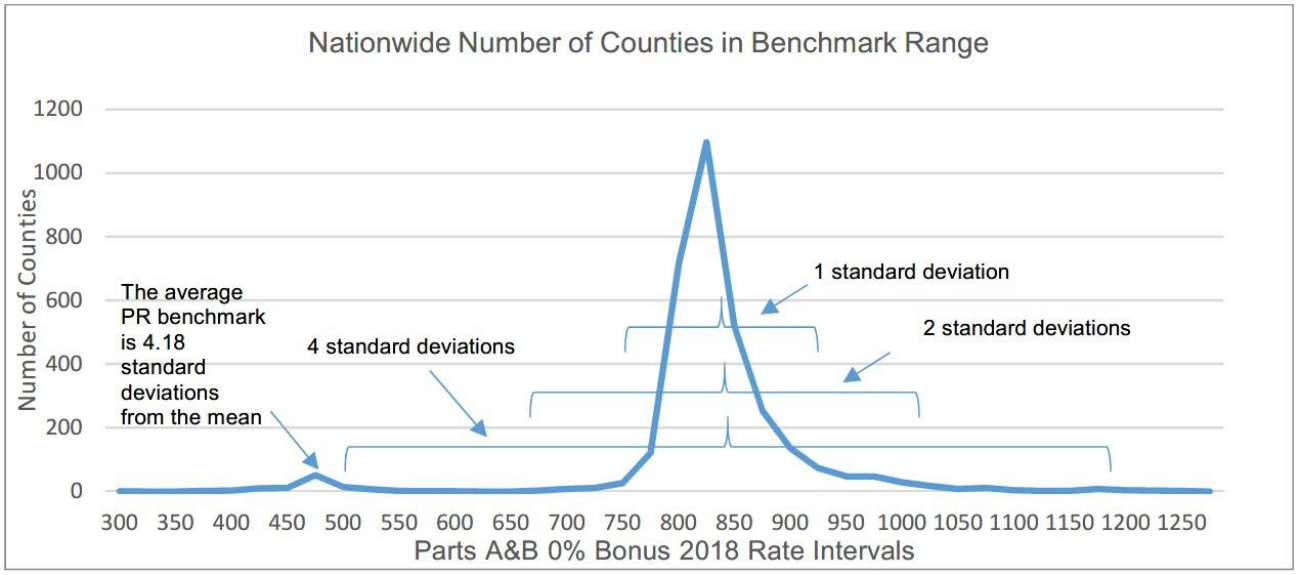
Nevertheless, due to a combination of the statutory changes, historical disparities in various Medicare payment formulas, and differences in populations, economics, and available data sources, MA benchmarks in Puerto Rico fall further behind the rest of the nation. As of **January 2022, Puerto Rico MA benchmarks will be 41% lower than t**he national average, 36% lower than the average in the lowest state (Hawaii), and 22% lower than the rates for the USVI. See Chart 1.

CHART 1



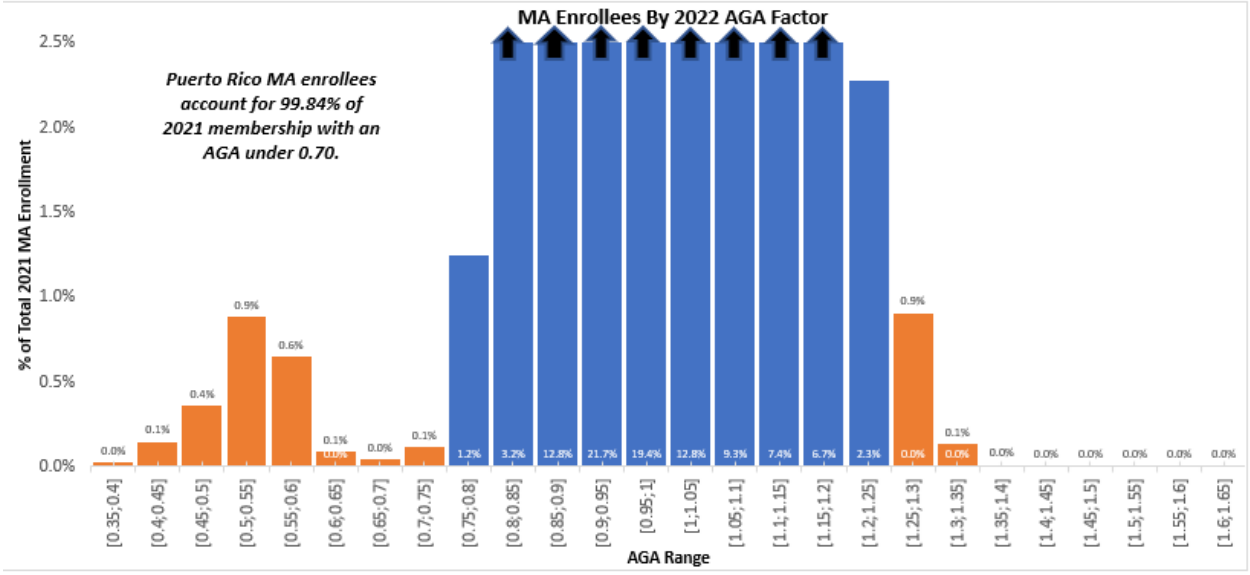
Looking at the data another way, Puerto Rico benchmarks alone are more than 4 standard deviations from the mean county benchmarks. See Chart 2.

CHART 2



The outlier status of Puerto Rico MA is similarly illustrated by an analysis of national MA enrollees by the Average Geographic Adjustment (AGA) Factor applied to their plan. Here, too, Puerto Rico plans and enrollees fall several standard deviations away from the mean. See Chart 3.

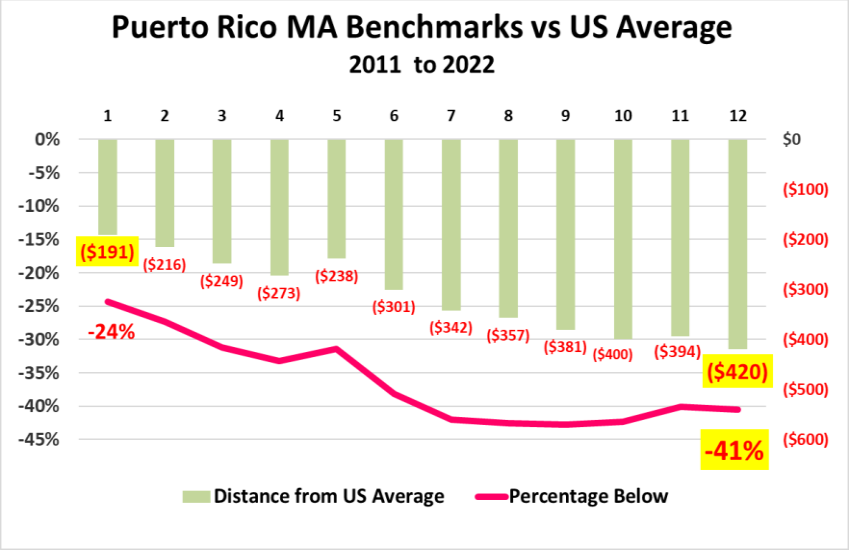
CHART 3



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 temporary payment adjustments to end the downward spiral in Puerto Rico benchmark rates, but the gap and disparity continues to grow between rates in Puerto Rico and the rest of the country. See Chart 4.

Chart 4



Unfortunately, after recent steps the disparity between the PR benchmarks and the national average is the largest it has ever been in 2022. At $420 below the average, the disparity has more than doubled since 2011 when PR MA rates were $191 below the average. 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. Disparities in Puerto Rico's Population Health Profile

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.

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]

	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 [2]

In regards to the Puerto Rico socio-economic context, the population continues to get older and poverty among citizens that are 65 and older is four 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%

[2] U.S. Census Bureau. 2013-2017 American Community Survey, 5- years estimates. [3] https://www.kff.org/racial-equity-and-health-policy/fact-sheet/puerto-rico-fastfacts/#:~:text=Puerto%20Rico%2C%20a%20U.S.%20territory,citizens%20residing%20on%20the%20island.&text=R oughly%20one%20in%20two%20Puerto,in%20the%20island's%20Medicaid%20program.

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 the Kaiser Family Foundation in a Puerto Rico Fast Facts summary.[3]

Disparate Health Employment Situation

The 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. Although the total proportion of practitioners does not seem different than the average, the situation of certain specialties has led to accessibility issues.

May 2020 Bureau of Labor Statistics Data		
	PR	**US**
Health Practitioners and Technical Occupations		
Total Employment	49,380	8,579,580
Employment per 1,000 Employed	60	62
Average Hourly Wages	$18.21	$41.30
Average Annual Wages	$37,880	$85,900
Healthcare Support Occupations		
Total Employment	15,110	6,440,880
Employment per 1,000 Employed	18	46
Average Hourly Wages	$9.66	$15.50
Average Annual Wages	$20,100	$32,250

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 count with technical support, nurse practitioners or physician assistants, for example. The limitations that this situation provokes in 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 compensation. In addition, there have 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 Policy to Resolve the Medicare Advantage Funding Disparities Between Puerto Rico and the Mainland - Establish a Minimum Standard Benchmark, defined by a Minimum AGA

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 a

ssumptions underlying its use for MA benchmarks.

Medicare statute establishes a payment system wherein MA rates are based on the expenditures of the local FFS population. Concerns arise as to how small a local FFS population can become before its utilization patterns are not representative of the MA population and therefore may not provide an actuarially sound basis for MA benchmarks. This is particularly pertinent in Puerto Rico, as MA penetration surpasses 80% of the Puerto Rico Medicare population. This number increases to 90% MA penetration in the Puerto Rico population of Medicare beneficiaries enrolled in both Medicare Parts A and B.

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 suggest that the Puerto Rico FFS population is a group of beneficiaries with particular and significant differences in utilization patterns that makes it unrepresentative of the greater MA population.

Moreover, we encourage CMS to consider ideas to establish a model that mandatorily channels the increments of a new MA AGA floor policy to the core Part A & B benefits. This would direct new resources to physician and hospital compensation, accompanied by infrastructure development. Along these lines, we suggest that any legal or regulatory constraint could be addressed by using the authority of the Center for Medicare and Medicaid Innovation (CMMI), or a similar process that would allow the structuring of the model in the best way for beneficiaries, providers, and health system enhancement.

Establishing a minimum standard AGA would be consistent with similar actions taken by CMS to address disparities in how Puerto Rico was treated under 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 in 2016, CMS determined to extend that national average GPCI proxy to Puerto Rico as well in the interest of consistency across Territories. [3]

In 2018, CMS finalized an increase to the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) wage index floor from 0.40 to 0.50 for 2019 and subsequent years.[4] CMS had evaluated 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.

In 2019, CMS reduced the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values, almost all of which are located in Puerto Rico.[6] CMS made this adjustment under the Inpatient Prospective Payment System ("IPPS") after learning how the prior wage index system "perpetuates and exacerbates the disparities between high and low wage index hospitals."[5]

IV. Conclusion

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 permanent MA parity fix described herein, we are confident we can break the downward spiral of the health care infrastructure and number of providers sustained 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 affordable health promotion, disease prevention, and treatment for American citizens, will help reduce health disparities in Puerto Rico.

We look forward to administrative action for CY2023, and to continuing the analysis and discussions with the CMS leadership towards a permanent solution for the worsening disparities.

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[3] See 81 Fed. Reg. 80,269 (Nov. 15, 2016).
[4] See 83 FR 56967 (Nov. 14, 2018). [6]
84 FR 42048 (Aug. 16, 2019).
[5] *Id.*

We appreciate the considerations of this request in the context of the 2023 Advance Notice and subsequent CMS regulatory action.

Respectfully,

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