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

March 4, 2022

VIA REGULATIONS.GOV

Meena Seshamani, MD, PhD
Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-2022-0021; Advance Notice of Methodological Changes for CY 2023 for MA Capitation Rates and Part C and Part D Payment Policies

The Medicaid and Medicare Advantage Products Association of Puerto Rico (MMAPA) submits the following comments on the *Advance Notice of Methodological Changes for Calendar Year (CY) 2023 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies*. We wish to thank the Centers for Medicare & Medicaid Services (CMS) for your time and attention to improving the Medicare program for US citizens residing in Puerto Rico. We challenge HHS/CMS to take affirmative actions by implementing policies that provide equal treatment for poor Medicare beneficiaries.

I. SUMMARY OF COMMENTS

Our comments and recommendations herein are offered for the purpose of improving federal funding of a fragile healthcare system and maintaining a level of stability in Puerto Rico. We hope that HHS/CMS takes positive actions to reduce the rate of provider migration to the states. We describe in detail the following requests of MA plans operating in Puerto Rico:

- The Disparity in MA Funding Between Puerto Rico and the Rest of the Country Has Been Widening for 13 Years
- Enrollees in Puerto Rico are Among the Most Vulnerable Beneficiaries in the Nation
- CMS' Goal of "Advancing Health Equity" Must Mean Eliminating the Disparity in Medicare Funding to Beneficiaries in Puerto Rico

- CMS Should Permanently Eliminate the Disparity in the MA Program by Establishing a Specific Minimum Standard Average Geographic Adjustment to Address Anomalies in Existing FFS Data or Increasing Disparities in Lowest Cost Areas
- Legal Authority Clearly Exists for CMS to Establish a Minimum Standard Average Geographic Adjustment
- Long-standing Precedence Exists for CMS Actions to Increase Funding for Health Care in Territories
- Closing the Disparity in MA Funding Would Allow Plans to Meet the Extensive Socio-Economic Needs of Beneficiaries
- Leaving the MA Funding Disparity in Place Relegates Puerto Rico to a Second-Tier Health Care System Within the United States
- CMS Should Continue to Base Puerto Rico Benchmarks on Claims Experience of Beneficiaries Enrolled in Parts A and B Only
- CMS Should Maintain Adjustment to FFS per Capita Costs in 2023 Based on Prevalence of "Zero-Claimants" in Puerto Rico
- CMS Should Protect Against Severe Impacts on Benchmarks from COVID-Related Utilization Declines in FFS during 2020 restrictive lockdowns in Puerto Rico
- MA ESRD Rate Inputs Undervalue the Cost of Delivering ESRD Services in Puerto Rico

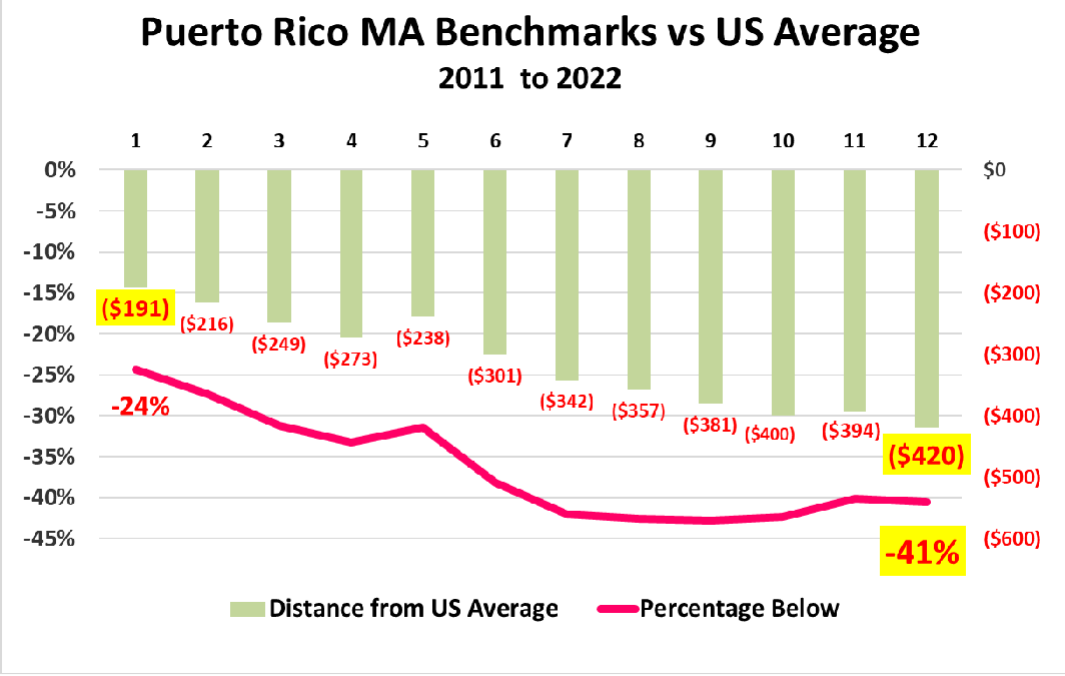
II. RESOLVING DISPARITY IN BENCHMARKS BETWEEN PUERTO RICO AND THE STATES

a. The Disparity in MA Funding for Puerto Rico Has Been Widening for 13 Years

CMS states "We are aware of concerns raised by stakeholders regarding the FFS data used to establish MA benchmarks in Puerto Rico..... [but] there is no evidence that FFS costs in Puerto Rico are higher than the costs observed in the FFS claims data, and thus no basis for overhauling Puerto Rico's Medicare Advantage benchmarks."[1]

Nevertheless, a problem clearly exists in the development of MA benchmarks for Puerto Rico: the average benchmarks for Puerto Rico have been falling further and further behind the US average for 13 years since 2010.

[1] 2023 Advance Notice, pg. 30.



While we appreciate CMS adjustments to the benchmarking process that have limited the damage to the Medicare program in Puerto Rico, the fact remains that Puerto Rico continues to fall further behind the US average even with these adjustments. Average benchmarks in Puerto Rico have fallen from a level of 24% below the national average to a level of 41% below the national average in 2022. The disparity in funding has doubled in that timeframe.

Notwithstanding enrollment trends or the extent of supplemental benefits available through Puerto Rico MA plans, something is wrong if the benchmarking system locks Puerto Rico into ever declining funding within the MA program. We are not aware of any argument that Congress intended MA rates to steadily fall further behind national rates over time, nor are we aware of a rationale as why CMS' current benchmarking methodology steadily depresses MA rates for Puerto Rico.

b. Enrollees in Puerto Rico are Among the Most Vulnerable Beneficiaries in the Nation

The MA enrollees of Puerto Rico represent one of the largest single populations of vulnerable beneficiaries receiving coverage through Medicare or Medicaid nation-wide. Puerto Rico has more MA beneficiaries than 42 states. 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. The Puerto Rico MA penetration rate is 90% among beneficiaries eligible for both Medicare A and B. By all independent measures, the senior population of Puerto Rico is older and sicker than the national senior population.

Dependence upon MA in Puerto Rico high because of the lack of other federal health benefits due to the Island's status as an unincorporated organized territory. Due to the high poverty rate in Puerto Rico, MA is the only way that many beneficiaries can afford Part B benefits. Puerto Rico is excluded statutorily from the Part D Low-Income Subsidy program and the Supplemental Security Income, enrollment in which Medicare Disproportionate Share Hospital payments are partially based upon. Puerto Rico lacks a Medicare Savings Program (MSP) to help pay poor beneficiaries' Part B premiums as well as a Medicaid long-term services and supports program.

Puerto Rico has higher-than-US-average costs for non-labor inputs, which draws scarce funds away from wages. This in part leads to the flight of the professional workforce to the states where wages and reimbursement are much higher. This is especially the case for the health care professional workforce. Additionally, socio-economic factors limit beneficiaries' access to, or ability to follow through on, care. As young professionals increasingly flee to states for high-wages, their aging relatives are left with smaller family-networks for social supports. Drastically lower MA rates harm patients and providers in Puerto Rico due to the nation-wide market for physicians, which leads to providers migrating off the island.

c. *CMS' Goal of "Advancing Health Equity" Must Mean Eliminating the Disparity in Medicare Funding to Beneficiaries in Puerto Rico*

We appreciate that CMS leadership has a specific goal of "Advancing Health Equity" that includes "look[ing] at everything we do through the lens of health equity, because when the system doesn't work, it's those individuals with complex health and social needs who fall through the cracks."[2] Historic socio-economic and legal disparities have made Puerto Rico the prime example of long standing health inequities in federal programs which require administrative action to be eliminated. In the Medicaid program, per capita funding for 2019 for Puerto Rico was more than 60% below the US median, and more than 90% below in the case of Medicaid beneficiaries who are aged or disabled.[3] As stated above, MA benchmarks in Puerto Rico in 2022 are 41% below the national average and 23% below the rates applicable to the US Virgin Islands.

We were encouraged by the President's campaign statement that he "will address historically low [MA] payment rates and their consequences to Puerto Rico's health system by directing the HHS Secretary to develop and recommend payment reforms and enhancements to the program."[4] Bringing the Puerto Rico health care system up to a level of parity with the rest of the nation cannot be accomplished if the single, largest source of health care funding to the

---

[2] Chiquita Brookes-LaSure, Meena Seshamani, Elizabeth Fowler; *Building On the CMS Strategic Vision: Working Together for a Stronger Medicare*. Health Affairs January 11, 2022. https://www.healthaffairs.org/do/10.1377/forefront.20220110.198444

[3] https://www.medicaid.gov/state-overviews/scorecard/how-much-states-spend-per-medicaid-enrollee/index.html

[4] Biden-Harris Plan for Recovery, Renewal and Respect for Puerto Rico.

island, MA, is allowed to fall further and further behind the states. Otherwise, Puerto Rico will be relegated to a second-tier health care system within the United States.

d. Permanently Eliminate Disparity in the MA Program by Establishing a Specific Minimum Standard Average 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 one administrative policy of adjustment for Puerto Rico since rates that fall outside of the normal curve of the benchmark calculation. By assigning a budget neutral minimum equivalent of a 0.70 Average Geographic Adjustment (AGA) in Puerto Rico, CMS would permanently set a lower end to MA benchmarks and prevent Puerto Rico from falling further behind the states. 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 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.**

e. Legal Authority for a Minimum Standard Average Geographic Adjustment

Section 1876(a)(4) of the Social Security Act does not prescribe one method to be used in determining the adjusted average per capita cost (AAPCC)[5] for the purposes of setting the MA benchmark for a service area. The statute only directs that the Secretary "estimates" the AAPCC, giving broad discretion in potential actuarial methods to be used, with a few conditions.[6]

The first general method listed as an option in estimating AAPCC is the "actual experience" of FFS expenditures in a service area. But such expenditure data is only specified to provide "the *basis*" of the Secretary's estimate.[7] **Further, the Secretary may forgo "actual experience" of FFS expenditures for an alternate general method, namely an "actuarial equivalent based on an adequate sample and other information and data."[8]** This broad

[5] MA "base payment amount" as described in SSA § 1853(n)(2)(E)(ii), (c)(1)(D)(i).
[6] SSA § 1876(a)(4)
[7] *Id*. (emphasis added).
[8] *Id*.

alternate method confirms the discretion available to the Secretary and that the AAPCC need not be merely a restatement of actual FFS expenditure experience in a particular service area.

Further, whether using "actual experience" or an "actuarial equivalent" as the basis of estimating AAPCC, the Secretary is not limited to using expenditure data from the service area for the particular MA benchmark. **The statute expressly permits the Secretary to use data from "a geographic area served by an eligible organization or . . . *a similar area.*"[9] CMS is free to select data from a similar geographic area or jurisdiction whose FFS population is expected to be useful in projecting what the amounts payable to the plan *would be* for services provided to its enrollee population in the service area.**

In this case, it is reasonable for the Secretary to look to the USVI (the next closest U.S. jurisdiction, 35 miles away) as a "similar area" that is likely to predict with some accuracy what the FFS expenditures in Puerto Rico would be if its broader population of MA enrollees received care through FFS. AAPCC for Puerto Rico could be calculated by multiplying the national estimated level of FFS per capita cost by the USVI AGA (0.72) to determine a more accurate estimated FFS per capita spending in Puerto Rico. The AGA is calculated using a 5-year rolling average of claims data for beneficiaries in FFS living in each county and includes weighting for enrollment and average risk scores. Even more simply, the Secretary could establish an AGA floor of 0.70 to achieve a similar result.

f. Precedence for CMS Actions to Increase Funding for Health Care in Territories

Establishing a minimum standard AGA would be consistent with similar actions taken by CMS to address disparities in how Puerto Rico was treated under federal health care programs. 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.[10]

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.[11] 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

[9] *Id*. (emphasis added).
[10] See 81 Fed. Reg. 80,269 (Nov. 15, 2016).
[11] See 83 FR 56967 (Nov. 14, 2018).

which are located in Puerto Rico.[12] 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."[13]

Most recently, CMS reinterpreted statute to allow Puerto Rico and other territories to continue to receive level Medicaid funding without the need for repeated Congressional extensions every two years.

g. Closing the Disparity in MA Funding Would Allow Plans to Meet the Extensive Socio-Economic Needs of Enrollees

The health care needs of Puerto Rico's patient and provider populations are significant. The MA program is already the foundation of Puerto Rico's health care system in the past 15 years. Nearly 50% of all funding to Puerto Rico health care providers comes from MA plans. These providers are able to offer care in Puerto Rico because MA plans reimburse at higher ratesthan commercial insurance or Medicaid. Additional funding would allow for increased provider payments to further reverse the flight of providers to the states. Consistent with statutory MLR requirements, new funds may only flow to (1) socio-economic supports for beneficiaries and (2) increased provider reimbursement.

MA plans in Puerto Rico must 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. Currently, MA plans must close the gap in contributions from local Medicaid program to Rx drug coverage for dual eligibles. Plans step into the gap to meet the needs of older, poorer, sicker beneficiaries with supplemental benefits. Research shows when medical care is delivered with certain nonmedical services, patients, caregivers, and the health care system overall are better off. Social services not traditionally considered medical services (i.e., transportation and nutrition) are crucial for meeting the needs of Puerto Rico Medicare beneficiaries, improving health outcomes and lowering costs. Supplemental benefits needed by enrollees include vision, dental, hearing, medical transport, meals following inpatient stays, pest control, food and produce, nonmedical transport, structural home modifications, social needs support.

III. ADDITIONAL COMMENTS ON THE 2023 ADVANCE NOTICE

a. AGA Methodology - Base Puerto Rico Benchmark on Claims Experience of Beneficiaries Enrolled in Parts A and B Only (Sec. B2.)

[12] 84 FR 42048 (Aug. 16, 2019).
[13] *Id.*

We appreciate that CMS intends to maintain this Puerto Rico-specific adjustment. 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, cost and utilization in Puerto Rico is different from enrollment, cost and utilization in the states, for various reasons. A far greater proportion of beneficiaries enroll in the MA program and those that do remain in FFS are much less likely to enroll in Part B. While most beneficiaries in the states are automatically enrolled in Part B, and must proactively opt-out to decline it, beneficiaries in Puerto Rico are required to opt-in to Part B coverage. Additionally, Medicare FFS payment rates tend to be lower in Puerto Rico. Given these differences, it is appropriate for CMS to continue to establish MA rates in Puerto Rico based only on the FFS experience of enrollees in both Part A and Part B. Ending this adjustment would significantly increase the gap in federal support for the MA program between Puerto Rico and the states.

b. Maintain Adjustment to FFS per Capita Costs in 2023 Based on Prevalence of "Zero-Claimants" in Puerto Rico (Sec. B4.)

We thank CMS for again proposing to continue the zero-claims adjustment that is necessary to preserve quality MA benefits for beneficiaries in Puerto Rico. Since 2017, CMS included this adjustment to account for the anomaly Parts A and B FFS beneficiaries' data showing a greater proportion of beneficiaries exhibiting no claims-related encounters or expenses in Puerto Rico 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 yearfor 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 payments 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. Without this adjustment, the gap in federal support for the MA program between Puerto Rico and the states would significantly widen.

c. Protect Against Severe Impacts on Benchmarks from COVID-Related Utilization Declines in FFS

Related to the adjustments based on "zero claims" experience, is the likely need for adjustments based on anomalous lower utilization be FFS beneficiaries in Puerto Rico in 2020. The first year of the COVID-19 pandemic is another example of how the FFS Medicare population in Puerto Rico does not project the costs of covering services for MA enrollees in Puerto Rico. Studies have documented that utilization of services among all FFS beneficiaries significantly declined in 2020. The decline in FFS utilization in Puerto Rico was severe but unrepresentative

of the experience of MA enrollees as plans mobilized from the earliest stages of the pandemic to ensure that enrollees continued to have access to necessary primary care, procedures, and medications. **Due to Puerto Rico's high MA penetration rate, the comparatively lower utilization experience of FFS beneficiaries in 2020 is likely to significantly depress MA benchmarks in Puerto Rico is a way that is not representative of the actual costs borne by plans through higher enrollee utilization during that time.**

d. MA ESRD Rate Inputs Undervalue the Cost of Delivering ESRD Services in Puerto Rico (Sec. D.)

CMS will base the 2023 ESRD MA benchmarks on 2016-2020 FFS reimbursement and enrollment data for beneficiaries in dialysis status for each state. As a part of this process, CMS reprices historical spending on FFS ESRD patients (inpatient and outpatient hospital claims, SNF claims, physician claims) in this timeframe to reflect the most current wage indices or geographic price indices (GPCIs). Therefore, claims in this timeframe are updated with the proxy 1.0 GPCI for Puerto Rico first applied in 2017, and, for the first time, the increase in the Puerto Rico ESRDwage index floor finalized by CMS beginning in 2019.

In the 2019 ESRD PPS final rule, CMS finalized an increase to the wage index floor from 0.40 to 0.50. At the time, we thanked CMS for the increase of the floor to 0.50, which had a material positive impact on the provision of quality dialysis services to beneficiaries. We also commented in 2018 and 2019, that the data supported a higher floor for Puerto Rico.[14] **CMS reported that its own analysis indicates that Puerto Rico's wage index "likely lies between 0.5100 and 0.5500."[15] Alternatively, if CMS incorporated adjusted hospital wage index data, including the recent CMS adjustment for IPPS low wage index areas, instead of unadjusted data, this would grant Puerto Rico dialysis centers with reimbursement based on a wage index of approximately 0.63.**

We appreciate that CMS bases MA ESRD rates on historic claims data for dialysis patients, incorporating claims from inpatient and outpatient facilities, physicians, SNFs, and dialysis centers, **but additional revisions to the ESRD PPS are necessary before Medicare payments reflect the actual cost of care in Puerto Rico. In managing the ESRD PPS, CMS should either increase the wage index floor consistent with CMS' own data, or incorporate adjusted inpatient wage index data to reflect the IPPS wage index fix and maintain consistency in the treatment of wage index policy.** Doing so would increase FFS payments to Puerto Rico dialysis centers and to MA plans for providing comprehensive care and coverage for those suffering from ESRD.

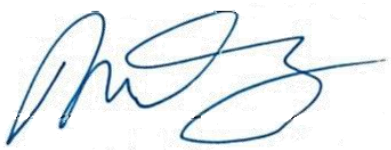
Stakeholders have raised with CMS concerns over how much of the Medicare ESRD population would transfer from FFS to MA once it was permissible for beneficiaries with ESRD to enroll in MA beginning in 2021. Fears have arisen that an insufficient number of ESRD

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

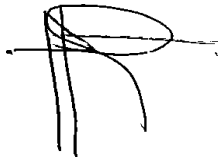
beneficiaries would remain in FFS within a state or territory so that ESRD FFS per capita costs calculated from their experiences over the five-year period would be unable to accurately predict the costs of the MA ESRD population in a state. This is particularly an issue for Puerto Rico where MA enrollment already comprises nearly 80% of the Medicare population. **We project that the vast majority of the Puerto Rico Medicare ESRD population is now in MA in 2022. We request that CMS verify what percentage of the Medicare ESRD population in Puerto Rico remains in FFS. We further ask whether CMS has established a cut-off percentage, below which FFS experience could no longer accurately predict MA ESRD costs.**

***

Sincerely,



Roberto Pando Cintron,
President, Medicaid and Medicare Advantage
Product Association of Puerto Rico (MMAPA)
MCS Medicare Advantage President



Roberto García Rodríguez, Esq.
President & CEO, Triple-s Management
Corp. MMAPA Past President

Orlando Gonzalez-Rivera, Esq., CPA
MMM Healthcare, LLC.
MMAPA Board Member

Juan Dominguez
First Medical Health Plan
MMAPA Board Member

Luis A. Torres-Olivera, Esq.
President, Humana Puerto Rico
MMPA Board Member

Ricardo Hernandez Rivera, CPA
CEO of Sistema de Salud Menonita and
Plan de Salud Menonita
MMAPA Board Member

cc:

Chairman Ron Wyden
Chairman Richard Neal
Governor Pedro R. Pierluisi Urrutia
Resident Commissioner Jenniffer Gonzalez-Colon
Secretary Xavier Becerra
Chiquita Brooks-LaSure, Administrator
Jonathan Blum, Principal Deputy Administrator & Chief Operating Officer
Jennifer Wuggazer Lavio, Office of the Actuary
Cheri Rice, Deputy Director, Center for Medicare
Jennifer Shapiro, Director, Medicare Plan Payment Group
Gretchen Sierra-Zorita, Associate Director for Puerto Rico and the Territories, Office of Intergovernmental Affairs, The White House
Dr. Carlos Mellado, Primary Physician, Secretary of Health of Puerto Rico