MMAPA
Medicaid and Medicare Advantage Products Association of Puerto Rico
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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
CMS-4192-P
7500 Security Boulevard
Baltimore, MD 21244

RE: Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit

The Medicaid and Medicare Advantage Products Association of Puerto Rico (MMAPA) submits the following comments on the *Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit*. Our comments and recommendations herein are offered for the purpose of maintaining some level of "stability" in the Puerto Rico health care system. HHS/CMS must recognize that the proposed rules would have a profound impact on a fragile/underfunded healthcare system with poor beneficiaries with underline chronic conditions.

I. Enrollee Participation in Plan Governance – § 422.107 (Sec. II.A.3)

CMS proposes to require that any MA organization offering one or more Dual Eligible Special Needs Plans (D-SNPs) in a state must establish and maintain one or more enrollee advisory committees (EACs) to serve those D-SNPs. EACs would be composed of a representative sample of the D-SNP(s) population. The EACs would solicit enrollee input on topics such as ways to improve access to covered services, coordination of services, and health equity for underserved populations.

We appreciate CMS' focus on the experience of D-SNP enrollees, which is a subject of the highest importance to MMAPA. Puerto Rico has among the highest enrollment in 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.

We support the concept of EACs but have several concerns with the proposal as described in the proposed rule. Plans will need additional time to establish EACs. MMAPA member plans will require more than a few months to ensure membership represents the different enrollee perspectives in Puerto Rico impacted by access, infrastructure, clinical needs, economic status, and prevalence of social supports. We request that compliance date for establishing EACs be no earlier than 2024.

If finalized, EACs raise several important compliance questions for plans. CMS should provide guidance to answer to following questions upon finalization of an EAC proposal:

- Can operation of the EAC be delegated to a first tier, downstream or related entity (FDR)?
- Can D-SNPs pay their enrollees for participation on an EAC (e.g., through a meeting stipend, reimbursement of expenses, or paying for lunch and transportation)? Ensuring participation for low-income members in Puerto Rico may be difficult without such a support.
- What specific EAC documentation requirements will be added to the CMS audit protocols?

II. Standardizing Housing, Food Insecurity, and Transportation Questions on Health Risk Assessments - § 422.101 (Sec. II.A.4)

CMS would require that all SNPs include one or more standardized questions on housing stability, food security, and access to transportation as part of their health risk assessments (HRAs). Enrollee responses will support required comprehensive risk assessments of enrollee physical, psychosocial, and functional needs and inform the development and implementation of each enrollee's comprehensive individualized plan of care. CMS requests comments on HRA questions and the need for additional guidance.

We agree that the program can always improve the data available on enrollee's social needs to better inform care, reduce disparities, and advance social services and supports. This proposal may allow CMS to better appreciate the lengths MMAPA plans go to the meet the extraordinary needs of their D-SNP enrollees. Housing stability, food security, and access to transportation area all issues of immediate reliance to our enrollees.

CMS should consider providing plans flexibility in how this information is collected and collated. Puerto Rico conditions and the standard expectations of enrollees may be different from those in the states due to a range of cultural, linguistic, social, geographic, and economic factors. CMS has been helpful to MMAPA plans in the past in ensuring CAHPS and other quality measure questions are translated to Spanish as spoken in Puerto Rico and in accounting for differences in Puerto Rico enrollee experiences that may be outside of the plan's control.

We are aware that CMS is receiving comments on establishing standard coding of responses rather than standard questions. Either way, information on housing stability, food security, and access to transportation must be sought in a manner that is culturally and linguistically appropriate to collect comparable information as intended.

III. Redefining Definitions for Fully Integrated and Highly Integrated D-SNPs - §§ 422.2 & 107 (Sec. II.A.5)

CMS proposes to revise the definitions of fully integrated dual eligible SNPs (FIDE SNPs) and highly integrated dual eligible SNPs (HIDE SNPs) on the basis that such changes would help people with Medicare and Medicaid to differentiate diverse types of D-SNPs and clarify their coverage options. The revised definitions would become effective in 2025.

As CMS evaluates refining definitions for FIDE and HIDE SNPs, this process should include potential revisions so that plans in Puerto Rico may be eligible as FIDE-SNPs and receive the frailty adjustment. The current Puerto Rico D-SNP program offered with the local government (Platino) is fully coordinated but lacks certain long-term services and supports and nursing home services, not because of a decision by the local government to not cover these services, but because Congress chose not to provide funding to Puerto Rico for these services in the Medicaid program.

Any revised definition of FIDE-SNP should not exclude plan eligibility based solely on factors outside the control of the plan or the state. In this case, the decision by Congress not to fund all required Medicaid benefits in Puerto Rico

IV. Attainment of the Maximum Out-of-Pocket (MOOP) Limit - §§ 422.100 & 101 (Sec. II.A.12)

CMS proposes that the maximum out-of-pocket (MOOP) limit in an MA plan should be calculated based on the accrual of all cost-sharing in the plan benefit, regardless of whether that cost sharing is paid by the beneficiary, Medicaid, other secondary insurance, or remains unpaid because of state limits on the amounts paid for Medicare cost-sharing and dually eligible individuals' exemption from Medicare cost-sharing. Additionally, the plan would be required to track enrollee out-of-pocket spending and alert enrollees and contracted providers when an enrollee's MOOP limit is reached.

Counting unpaid cost sharing amounts toward the MOOP will speed up the point in the plan year after which the MA plan pays 100% of the cost of covered Parts A & B services for each enrollee. The apparent purpose behind this proposal is (1) reducing state Medicaid costs since the state agency would no longer be billed for any Medicare cost-sharing once an enrollee reaches the MOOP, and (2) allowing providers to increase their revenue as they would no longer be limited in their ability to collect cost sharing under a state Medicaid lesser-of policy. CMS also provides additional justifications, such as providing "equal treatment" under the MOOP for duals and other enrollees, potentially increasing the willingness of providers who treat duals to participate in plan networks and having a more uniform approach to calculating MOOP across plans.

We have concerns with this impact of this proposal. There would be adverse cost impacts on all MA plans, but those impacts would be particularly significant for D-SNPs. Recall, 45% of all MA enrollees in Puerto Rico are D-SNP enrollees, which means that more than 35% of all Medicare beneficiaries in Puerto Rico are in a D-SNP. Those costs would result in higher premiums and/or **reduced supplemental benefits that that enrollees have come to rely on to backfill the social services and supports that are not otherwise available in Puerto Rico to overcome social barriers to health,**

provide adult dental coverage, etc. We also have earnest questions about CMS' authority for imposing this requirement. We strongly urge CMS not to finalize it.

VI. Pharmacy Price Concessions in Negotiated Prices - § 423.100 (Sec. II.H)

CMS proposes to revise the definition of "negotiated price" to eliminate the current exception for contingent pharmacy price concessions (DIR) from POS pricing going forward. Part D plans would be required, under this new definition, to apply "the lowest net price a pharmacy could receive for a covered drug net of the maximum possible negative adjustment or incentive fees receivable under any contingency payment arrangements between the sponsor and pharmacy."

We request that CMS withdraw this proposal. It can be expected to increase premiums and overall costs for enrollees and taxpayers and weaken the tools available to plans to promote quality and cost effectiveness. The proposal would expand CMS' role in private contracting arrangements in an unprecedented way, inconsistent with the intent of the non-interference clause in section 1860D-11(i) of the Social Security Act. The proposed 2023 effective date would fail to provide plans and their contracted PBMs with enough time to reflect these changes in bids, modify contracts and make system changes, thereby further increasing costs and disruption.

Currently, Part D plans may use savings from projected contingent pharmacy price concessions that are not reflected in POS prices to reduce the net Part D drug costs on their bids. This allows plans to offer coverage at lower premiums and/or offer enhanced options at the same premium amount. CMS notes in the proposed rule preamble that when contingent price concessions (DIR) from pharmacies are not passed on to the enrollee at the POS, they are passed on through lower premiums. By requiring Part D plans to include all potential price concessions from pharmacies in calculating cost sharing, the cost of providing the Part D benefit will increase. That means fewer dollars will be available to apply toward reduced premiums or enhanced coverage. It will also increase the cost to the government in subsidizing Part D premiums.

If CMS finalizes this proposal, it will materially reinterpret the non-interference clause of the Part D statute in section 1860D-11(i), constructively rewriting and undermining a fundamental element of the Part D program's continued success. The statutory provision specifies that to promote competition under Part D, the Secretary is prohibited from "interfering with the negotiations between drug manufacturers and pharmacies and [prescription drug plan] sponsors," and from requiring a particular formulary or instituting a price structure for the reimbursement of Part D covered drugs. CMS has regularly interpreted the non-interference clause as being applicable to negotiations between any combination of the manufacturers, pharmacies, and plans, including negotiations between Part D sponsors and pharmacies. Therefore, we strongly request that this proposal be withdrawn.

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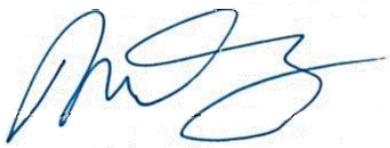
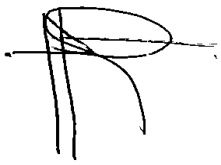
Sincerely,



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



Roberto García Rodríguez, Esq.
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Ricardo Hernandez Rivera, CPA
CEO of Sistema de Salud Menonita and Plan de Salud Menonita
MMAPA Board Member

cc:
Meena Seshamani, MD, PhD, Director, Center for Medicare
Jonathan Blum, Principal Deputy Administrator & Chief Operating Officer
Cheri Rice, Deputy Director, Center for Medicare