Congress of the United States
Washington, DC 20515

October 21, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dr. Donald Berwick
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius and Administrator Berwick:

We write to respectfully request that the Centers for Medicare and Medicaid Services (CMS) consider exercising its authority to employ an alternative calculation method to determine per capita FFS spending in Puerto Rico when setting payment rates for Medicare Advantage (MA) plans in Puerto Rico. Failure to act promptly to ensure that MA plans on the Island are fairly compensated is likely to have negative repercussions for hundreds of thousands of Puerto Rico seniors who rely on these plans to obtain affordable, high-quality health care.

In the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Congress directed the Medicare Payment Advisory Commission (MedPAC) to determine whether county-level per capita FFS spending estimates were sufficiently accurate to use in setting MA rates.[1] In June 2009, MedPAC cited Puerto Rico as a probable exception to its general conclusion that CMS methods produce reliable FFS estimates that could serve as the basis for payments to MA plans. MedPAC recommended that, "[i]n the case of Puerto Rico, CMS should expeditiously use its authority to employ an alternative calculation method to determine" per capita FFS expenditures in Puerto Rico "if CMS finds that the current calculations are anomalous or potentially inaccurate."[2] Similar written appeals for action by CMS were subsequently made by the House Ways and Means Committee, by Congressmen Pierluisi, Rangel and Serrano, and by Senators Baucus and Menendez.

The Medicare Advantage program, which serves as an alternative way for Medicare beneficiaries to receive covered benefits, is widely utilized by seniors in Puerto Rico. In general, MA plans offer additional benefits or require smaller patient payments than FFS Medicare. To enroll in an MA plan, a senior must have both Part A and Part B coverage. For many Puerto Rico seniors, the $96.40 Part B premium poses a serious financial burden. And unlike the 50 states, Puerto Rico is not eligible to receive federal matching funds under the Medicaid program to provide premium (and other cost-sharing) assistance to low-income seniors enrolled in FFS Medicare. To fill this gap—and to attract enrollees—MA plans in Puerto Rico will often pay some or all of the Part B premium for these individuals. The consequence is this: whereas roughly 25% of seniors living in the 50 states are enrolled in MA plans, about 68% of Medicare-eligible

[1] Puerto Rico does not use a county-based system. However, there are 78 municipalities on the Island, each of which is considered a separate "county" for Medicare reimbursement purposes.
[2] MedPAC Report to Congress, Improving Incentives in the Medicare Program, Chapter 7, pg. 179.

beneficiaries in Puerto Rico receive coverage through the Medicare Advantage program. Accordingly, changes to the MA program will have a significant (and disproportionate) impact on the Island.

Under current law, MA plans are paid a fixed monthly amount per enrollee to furnish Part A and Part B services. Payments to MA plans are determined based on an annual bidding process, by comparing a plan's bid for providing required Medicare benefits to the maximum amount FFS Medicare will pay for those benefits in each area (the area's benchmark). If a plan bids below the benchmark, the plan is paid its bid plus a certain rebate. If a plan bids above the benchmark, the plan is paid the benchmark and must charge each enrollee a premium equal to the difference between the bid and the benchmark.

The Affordable Care Act (ACA) changes the way in which payments to MA plans will be calculated. Starting in 2012, the ACA will phase in benchmarks calculated as a percentage of per capita FFS Medicare spending. County benchmarks will be set at either 95%, 100%, 107.5%, or 115% of per capita FFS spending, with higher percentages applied to counties with the lowest FFS expenditures.

Linking FFS costs to MA rates presents a unique challenge for Puerto Rico, because the methodology used by CMS to calculate FFS costs results in artificially low figures for Puerto Rico municipalities. To illustrate, CBO reported in 2007 that average FFS costs in Puerto Rico were $328 per month, compared to $530 per month for the lowest states (Hawaii and New Mexico) and a nationwide average of $684 per month.[3] There are a number of factors that contribute to this discrepancy, most arising from fundamental inequalities in the way Medicare applies to Puerto Rico and its seniors.

First, as MedPAC recognized, Puerto Rico's low Part B participation rate makes the Island a statistical outlier. To estimate per capita FFS spending in a county, CMS performs a separate calculation for enrollees in Part A and enrollees in Part B. As noted above, about two-thirds of Medicare-eligible Puerto Rico residents choose to participate in an MA plan. Of the group enrolled in fee-for-service Medicare, only about half are enrolled in Part B; the remaining individuals have Part A coverage exclusively. In the states, by contrast, 97% of seniors in FFS Medicare have Part B.[4] The small percentage of FFS enrollees in Puerto Rico who have Part B coverage is mainly attributable to two factors: (1) the financial burden of the Part B premium, given the population's relatively low income level and their exclusion from certain federal assistance programs that would otherwise help cover their Part B premiums; and (2) a provision in Medicare law that makes Puerto Rico the only U.S. jurisdiction where seniors enrolled in Medicare Part A must affirmatively opt in to Part B, rather than being automatically enrolled with the ability to opt out.[5] As MedPAC concluded, "[t]he small proportion of FFS beneficiaries in Puerto Rico with Part B coverage could compromise the accuracy" of per capita FFS estimates for the Island.[6]

---

[3] See Congressional Budget Office Letter to Senator Max Baucus, dated April 17, 2007.
[4] See June 2009 MedPAC Report, at 179.
[5] See 42 U.S.C. §1395p(f)(3).
[6] June 2009 MedPAC Report, at 179.

In addition, there are several other factors that artificially depress FFS estimates in Puerto Rico. First, Puerto Rico is the only U.S. jurisdiction under the Inpatient Prospective Payment System in which hospitals do not receive 100% of the national payment rates. Instead, payments to Island hospitals are derived from a formula based on 75% national rates and 25% local costs, yielding Medicare payments to Puerto Rico hospitals that are considerably lower than payments made to stateside hospitals. Second, Puerto Rico hospitals serving large numbers of low-income patients do not receive fair disproportionate share hospital (DSH) payments because Supplemental Security Income (SSI), a major factor in calculating such payments, has not been extended to the Island. Finally, whereas the states receive federal subsidies, based on need, to help their low-income residents purchase prescription drugs under Medicare Part D, Puerto Rico receives only a limited block grant for this purpose. Because of these factors, each of which is unique to Puerto Rico, the Medicare program pays less per FFS enrollee on the Island than it otherwise would (or should).

As the result of all this, linking MA payments to county-level per capita FFS expenditures in the manner prescribed by the ACA is likely to lead to an unfair result in the case of Puerto Rico, to the ultimate detriment of the Island's seniors. The strongest support for this prediction is pre-ACA law itself, which set a statutory floor for county benchmarks in Puerto Rico at about 180% of per capita FFS spending.[7] By contrast, pre-ACA benchmarks in stateside counties "currently range from about 100% to over 150% of FFS costs."[8] Thus, pre-ACA law reflects the recognition that strictly linking MA payments to county-level per capita FFS expenditures would produce an inequitable result in Puerto Rico. This outcome can be avoided only if CMS uses a different methodology to calculate FFS estimates that better reflects the cost of providing Medicare Advantage benefits (i.e., both Part A and Part B services) in Puerto Rico.

We were pleased that, in her September 29, 2010 response to Congressman Rangel, CMS Deputy Administrator Marilyn Tavenner stated as follows: "The Centers for Medicare and Medicaid Services shares your concern, and we will be conducting a detailed analysis of whether the FFS costs in Puerto Rico are lower than they would be if beneficiary characteristics were more like those in the States." As MedPAC observed, relevant law "provides CMS with relatively broad authority to address situations in which the usual method of determining [FFS spending estimates] would yield an anomalous or potentially inaccurate result."[9] We strongly urge CMS to conduct its analysis expeditiously and, if appropriate, to use its authority to employ an alternative calculation method to determine per capita FFS spending in Puerto Rico. We thank you for your attention to this critically-important issue, and we look forward to working with you to ensure that Puerto Rico is treated fairly under the Medicare Advantage program.

---

[7] See June 2009 MedPAC Report, at 173, 179.

[8] Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline, Congressional Research Service, R41196, June 30, 2010 (citing the Congressional Budget Office for the 100%-150% range).

[9] June 2009 MedPAC Report, at 179.

Sincerely,

Pedro R. Pierluisi
Member of Congress

Robert Menendez
United States Senator

José E. Serrano
Member of Congress

Luis V. Gutierrez
Member of Congress

Nydia M. Velazquez
Member of Congress

cc: Jaime Torres, Regional Director, Department of Health and Human Services, Region 2
James T. Kerr, Regional Administrator, Centers for Medicare and Medicaid Services, Region 2